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New health policy focuses on primary health care

DH News Service

NEW DELHI, Sept 4

After a gap of 18 years, the Centre today introduced a new health policy that seeks to envisage greater contribution from the Centre in health care, stressing more on primary health care, setting up a Medical Grants Commission and implement a stringent code of ethics for medical research.

The new policy, which is in the draft stage at present, needs to be cleared by the Planning Commission and the Ministry of Finance before the government can start working on the new lines. The draft had been sent to the states and the ministry hopes to receive a favourable response from the Planning Commission.

The earlier policy, drafted in 1983, has become obsolete with emergence of new diseases and the changing disease as well as health care profile in the country in the last two decades. The groundwork for the new policy began in 1998 and several rounds of consultation with states and medical experts took place before finalising the policy.

The policy calls for an increase in health sector expenditure from 5.2 per cent to 6 per cent by 2010. Though the hike looks moderate, the government wanted to increase its contribution from existing 0.9 per cent of GDP to two per cent within the next ten years, Union Health Minister Dr C P Thakur said.

At the same time, states have been asked to increase their health expenditure from existing 5.5 per cent to seven per cent by 2005. Currently per capita health budget per year for a person is Rs 160 and the ministry feels that without a hike, the health infrastructure can not be improved.

Another major development envisaged in the draft policy is setting up a Medical Grants Commission (MGC) in the line of University Grants Commission (UGC) to fund government medical colleges.

Other suggestions to improve medical education include exposing under graduate students to geriatrics (old age diseases) and other frontier areas of medical science.

It seeks extra allocation for primary health centres. The sectoral outlay for primary health care would be 55 per cent of health budget while 35 per cent will go to secondary care and rest for the tertiary sector. It further advocates delivering essential drugs to primary health care centres and introducing user charges at secondary and tertiary health care units.

The new policy, on one hand supports more role for the Centre in the health care sector, primarily because lack of funds available with the states, and more private participation on the other. On medical research, it calls for an expenditure of one per cent of total health spending by 2005.

However, in the wake of several drug trial controversies at Regional Cancer Centre (RCC) in Thiruvananthapuram and Metro Hospital in Noida, the Centre has decided to entrust Medical Council of India (MCI) with the duty of rigorously implementing a code of ethics formulated by Indian Council of Medical Research.

At present the guidelines are valid only for government institutions, but the ministry is contemplating to extend it to the private sector.

Strict enforcement of food and drugs standard, having an estimate of common diseases, operationalising an integrated disease control network by 2005, raising the seats in public health and family medicine disciplines, taking extra care of mental health patients and decentralise implementation of various programmes by the year 2005 are some of the major suggestions envisaged in the draft health policy.

New health policy draft unveiled

By Our Special Correspondent

THE HINDU 6th SEPT, 2001

NEW DELHI, SEPT. 4. The Union Health Minister, Dr. C.P. Thakur, today unveiled the draft of a new National Health Policy, which envisages a massive infusion of public investment to rejuvenate the healthcare system.

According to the document, the expenditure by the Government sector — both Centre and the States — on the health sector would be doubled over the next 10 years, from 0.9 per cent of GDP at present to 2 per cent of GDP by 2010, with the Centre shouldering the bulk of the increase.

While the expenditure by the States is proposed to be increased from 5.5 per cent to 7 per cent by 2005, the Centre's contributions to the national expenditure on health would be increased from 15 per cent to 25 per cent.

Releasing the document at a press conference, Dr. Thakur said the Centre would play a greater role as the States were not in a position to improve their healthcare system on their own.

Almost 94 per cent of the States' budget on health went towards salary and other such expenditures and as a result hardly any money was left for purchase of drugs, let alone improving the infrastructure.

A major thrust of the proposed policy would be to refurbish the State medical colleges, which have been decaying for want of financial support and make them an additional channel for delivery of medical care, apart from the healthcare set up in the form of primary health centres and district hospitals.

The draft policy has been circulated to the States and other Central Ministries for their comments. The general public could also give their comment. It has been put out in the Health Ministry's website, www.mohfw.nic.in.

After one month, it would be finalised and placed before the Union Cabinet for its approval.

2. Strava file for National Health Policy 2001 - related clippings reported

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22 Pages

Subject: health in india
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New health policy will widen inequities

KALPANA JAIN, TIMES NEWS NETWORK

NEW DELHI: The new health policy, revised after a long gap of almost two decades, will only increase the inequities in provision of health care. The policy not only suggests user charges at the district-level hospitals but also a system of licentiate medical practitioners to meet the needs of primary health centres.

Undoubtedly, the policy voices the right concerns on patents, medical research and education, communicable diseases, ethics and women's health. It also seems to be interested in reviving the weakest health care link ^ the PHCs, with its suggestion of additional 55 per cent of the current outlay for them. The secondary and tertiary sectors get only 35 per cent and 10 per cent respectively.

But even as it suggests to revive these sectors, the government does express its inability to get medical doctors to work there. Therefore, it suggests encouraging the practice of licentiate medical practitioners and training of paramedical personnel to provide health care in difficult areas. Clearly, the government has different standards of care for the rich and the poor.

Moreover, it wants to open more centres, which will require additional staff as well. As it is, a large part of government money goes into salaries. The issue then is how far the additional allocation will be useful for reviving PHCs. It would be worth pointing out that for the 23,000 PHCs supposed to be functioning across the country, there is already a sanctioned strength of 25,000 doctors.

The PHCs are expected to take the major disease load while also working at their prevention. But with the current functioning, the burden spills over to specialised and super-speciality centres. It is at this level that the government proposes a user fee, a suggestion which most likely will push more into the hands of the private sector.

Source : The Times of India, September 6, 2001

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DRAFT NATIONAL HEALTH POLICY - 2001

1. INTRODUCTORY

1.1 A National Health Policy was last formulated in 1983 and since then, there have been very marked changes in the determinant factors relating to the health sector. Some of the policy initiatives outlined in the NHP-1983 have yielded results, while in several other areas, the outcome has not been as expected.

1.2 The NHP-1983 gave a general exposition of the recommended policies required in the circumstances then prevailing in the health sector. The noteworthy initiatives under that policy were :-

i. A phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves;
ii. Intermediation through 'Health volunteers' having appropriate knowledge, simple skills and requisite technologies;
iii. Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level;
iv. An integrated net-work of evenly spread speciality and super-speciality services; encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government's facilities is limited to those entitled to free use.

1.3 Government initiatives in the pubic health sector have recorded some noteworthy successes over time. Smallpox and Guinea Worm Disease have been eradicated from the country; Polio is on the verge of being eradicated; Leprosy, Kala Azar, and Filariasis can be expected to be eliminated in the foreseeable future. There has been a substantial drop in the Total Fertility Rate and Infant Mortality Rate. The success of the initiatives taken in the public health field are reflected in the progressive improvement of many demographic / epidemiological / infrastructural indicators over time – (Box-I).

Box-1 : Through The Years - 1951-2000Achievements

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	110	70 (99 SRS)

Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no of cases)	>44,887	Eradicated	
Guineaworm (no. of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries &Hospitals(all)	9209	23,555	43,322 (95–96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors(Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

1.4 While noting that the public health initiatives over the years have contributed significantly to the improvement of these health indicators, it is to be acknowledged that public health indicators / disease-burden statistics are the outcome of several complementary initiatives under the wider umbrella of the developmental sector, covering Rural Development, Agriculture, Food Production, Sanitation, Drinking Water Supply, Education, etc. Despite the impressive public health gains as revealed in the statistics in Box-I, there is no gainsaying the fact that the morbidity and mortality levels in the country are still unacceptably high. These unsatisfactory health indices are, in turn, an indication of the limited success of the public health system to meet the preventive and curative requirements of the general population.

1.5 Out of the communicable diseases, which have persisted over history, incidence of Malaria has staged a resurgence in the1980s before stabilising at a fairly high prevalence level during the 1990s. Over the years, an increasing level of insecticide-resistance has developed in the malarial vectors in many parts of the country, while the incidence of the more deadly P-Falciparum Malaria has risen to about 50 percent in the country as a

whole. In respect of TB, the public health scenario has not shown any significant decline in the pool of infection amongst the community, and, there has been a distressing trend in increase of drug resistance in the type of infection prevailing in the country. A new and extremely virulent communicable disease – HIV/AIDS - has emerged on the health scene since the declaration of the NHP-1983. As there is no existing therapeutic cure or vaccine for this infection, the disease constitutes a serious threat, not merely to public health but to economic development in the country. The common water-borne infections – Gastroenteritis, Cholera, and some forms of Hepatitis – continue to contribute to a high level of morbidity in the population, even though the mortality rate may have been somewhat moderated. The period after the announcement of NHP-83 has also seen an increase in mortality through 'life-style' diseases- diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem. The changed circumstances relating to the health sector of the country since 1983 have generated a situation in which it is now necessary to review the field, and to formulate a new policy framework as the National Health Policy-2001.

1.6 NHP-2001 will attempt to set out a new policy framework for the accelerated achievement of Public health goals in the socio-economic circumstances currently prevailing in the country.

2. CURRENT SCENARIO

2.1 FINANCIAL RESOURCES

The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 20 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual per capita public health expenditure in the country is no more than Rs.160. Given these statistics, it is no surprise that the reach and quality of public health services has been below the desirable standard. Under the constitutional structure, public health is the responsibility of the States. In this framework, it has been the expectation that the principal contribution for the funding of public health services will be from States' resources, with some supplementary input from Central resources. In this backdrop, the contribution of Central resources to the overall public health funding has been limited to about 15 percent. The fiscal resources of the State Governments are known to be very inelastic. This itself is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget. If the decentralized pubic health services in the country are to improve significantly, there is a need for injection of substantial resources into the health sector from the Central Government Budget. This approach, despite the formal Constitutional provision in regard to public health, is a necessity if the State public health services - a major component of the initiatives in the social sector - are not to become entirely moribund. The NHP-2001 has been formulated taking into consideration these ground realities in regard to the availability of resources.

2.2 EQUITY

2.2.1 In the period when centralized planning was accepted as a key instrument of development in the country, the attainment of an equitable regional distribution was considered one of its major objectives. Despite this conscious focus in the development process, the statistics given in Box-II clearly indicate that attainment of health indices have been very uneven across the rural – urban divide.

Box II : Differentials in Health Status Among States

Sector	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mort-ality per 1000 (NFHS II)	Weight For Age- % of Children Under 3 years (<-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 popula-tion	Malaria +ve Cases in year 2000 (in thousands)
India	**26.1**	**70**	**94.9**	**47**	**408**	**3.7**	**2200**
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharastra	25.02	48	58.1	50	135	3.1	138
TN	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

Also, the statistics bring out the wide differences between the attainments of health goals in the better- performing States as compared to the low-performing States. It is clear that national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country. Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide

inter-State disparity implies that, for vulnerable sections of society in several States. access to public health services is nominal and health standards are grossly inadequate. Despite a thrust in the NHP-1983 for making good the unmet needs of public health services by establishing more public health institutions at a decentralized level, a large gap in facilities still persists. Applying current norms to the population projected for the year 2000, it is estimated that the shortfall in the number of SCs/PHCs/CHCs is of the order of 16 percent. However, this shortage is as high as 58 percent when disaggregated for CHCs only. The NHP-2001 will need to address itself to making good these deficiencies so as to narrow the gap between the various States, as also the gap across the rural-urban divide.

2.2.2 Access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially disadvantaged sections of society. The statistics given in Box-III highlight the handicap suffered in the health sector on account of socio-economic inequity.

Box-III : Differentials in Health status Among Socio-Economic Groups

Indicator	Infant Mortality/1000	Under 5 Mortality/1000	% Children Underweight
India	70	94.9	47
Social Inequity			
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

2.2.3 It is a principal objective of NHP-2001 to evolve a policy structure which reduces these inequities and allows the disadvantaged sections of society a fairer access to public health services.

2.3 DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES

2.3.1 It is self-evident that in a country as large as India, which has a wide variety of socio-economic settings, national health programmes have to be designed with enough flexibility to permit the State public health administrations to craft their own programme package according to their needs. Also, the implementation of the national health programme can only be carried out through the State Governments' decentralized public health machinery. Since, for various considerations, the responsibility of the Central Government in funding additional public health services will continue over a period of time, the role of the Central Government in designing broad-based public health initiatives will inevitably continue. Moreover, it has been observed that the technical and managerial expertise for designing large-span public health programmes exists with the

Central Government in a considerable degree; this expertise can be gainfully utilized in designing national health programmes for implementation in varying socio-economic settings in the states.

2.3.2 Over the last decade or so, the Government has relied upon a 'vertical' implementational structure for the major disease control programmes. Through this, the system has been able to make a substantial dent in reducing the burden of specific diseases. However, such an organizational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain. Over a long time-range, 'vertical' structures may only be affordable for diseases, which offer a reasonable possibility of elimination or eradication in a foreseeable time-span. In this background, the NHP-2001 attempts to define the role of the Central Government and the State Governments in the public health sector of the country.

2.4 THE STATE OF PUBLIC HEALTH INFRA-STRUCTURE

2.4.1 The delineation of NHP-2001 would be required to be based on an objective assessment of the quality and efficiency of the existing public health machinery in the field. It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services. As a result of such inadequate public health facilities, it has been estimated that less than 20 percent of the population seeks the OPD services and less than 45 percent avails of the facilities for in-door treatment in public hospitals. This is despite the fact that most of these patients do not have the means to make out-of-pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition.

2.5 EXTENDING PUBLIC HEALTH SERVICES

2.5.1 While in the country generally there is a shortage of medical manpower, this shortfall is disproportionately impacted on the less-developed and rural areas. No incentive system attempted so far, has induced private medical manpower to go to such areas; and, even in the public health sector it has usually been a losing battle to deploy medical manpower in such under-served areas. In such a situation, the possibility needs to be examined for entrusting some limited public health functions to nurses, paramedics and other personnel from the extended health sector after imparting adequate training to them.

2.5.2 India has a vast reservoir of practitioners in the Indian Systems of Medicine and Homoeopathy, who have undergone formal training in their own disciplines. The possibility of using such practitioners in the implementation of State/Central Government public health Programmes, in order to increase the reach of basic health

care in the country, is addressed in the NHP-2001.

2.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

2.6.1 Some States have adopted a policy of devolving programmes and funds in the health sector through different levels of the Panchayati Raj Institutions. Generally, the experience has been a favourable one. The adoption of such an organisational structure has enabled need-based allocation of resources and closer supervision through the elected representatives. NHP- 2001 examines the need for a wider adoption of this mode of delivery of health services, in rural as well as urban areas, in other parts of the country.

2.7 MEDICAL EDUCATION

2.7.1 Medical Colleges are not evenly spread across various parts of the country. Apart from the uneven geographical distribution of medical institutions, ,the quality of education is highly uneven and in several instances even sub-standard. It is a common perception that the syllabus is excessively theoritical, making it difficult for the fresh graduate to effectively meet even the primary health care needs of the population. There is an understandable reluctance on the part of graduate doctors to serve in areas distant from their native place. NHP-2001 will suggest policy initiatives to rectify these disparities.

2.7.2 Certain medical discipline, such as, molecular biology and gene-manipulation, have become relevant in the period after the formulation of the previous National Health Policy. Also, certain speciality disciplines – Anesthesiology, Radiology and Forensic Medicines – are currently very scarce, resulting in critical deficiencies in the package of available public health services. The components of medical research in the recent years have changed radically. In the foreseeable future such research will rely increasingly on such new disciplines. It is observed that the current under-graduate medical syllabus does not cover such emerging subjects. NHP-2001 will make appropriate recommendations in this regard.

2.8 NEED FOR SPECIALISTS IN 'PUBLIC HEALTH' AND 'FAMILY MEDICINE'

2.8.1 In any developing country with inadequate availability of health services, the requirement of expertise in the areas of 'public health' and 'family medicine' is very much more than the expertise required for other specialized clinical disciplines. In India, the situation is that public health expertise is non-existent in the private health sector, and far short of requirement in the public health sector. Also, the current curriculum in the graduate / post-graduate courses is outdated and unrelated to contemporary community needs. In respect of 'family medicine', it needs to be noted that the more talented medical graduates generally seek specialization in clinical disciplines, while the remaining go into general practice. While the availability of postgraduate educational facilities is 50 percent of the total number of the qualifying graduates each year, and can be considered adequate, the distribution of the disciplines in the postgraduate training facilities is overwhelmingly in favour of clinical specializations. NHP-2001 examines the need for ensuring adequate availability of personnel with specialization in the 'public health' and 'family medicine' disciplines, to discharge the public health responsibilities in the country.

2.9 URBAN HEALTH

2.9.1 In most urban areas, public health services are very meagre. To the extent that such services exist, there is no uniform organisational structure. The urban population in the country is presently as high as 30 percent and is likely to go up to around 33 percent by 2010. The bulk of the increase is likely to take place through migration, resulting in slums without any infrastructure support. Even the meagre public health services available do not percolate to such unplanned habitations, forcing people to avail of private health care through out-of-pocket expenditure. The rising vehicle density in large urban agglomerations has also led to an increased number of serious accidents requiring treatment in well-equipped trauma centres. NHP-2001 will address itself to the need for providing this unserved population a minimum standard of health care facilities.

2.10 MENTAL HEALTH

2.10.1 Mental health disorders are actually much more prevalent than are visible on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families. Serious cases of mental disorder require hospitalization and treatment under trained supervision. Mental health institutions are perceived to be woefully deficient in physical infrastructure and trained manpower. NHP-2001 will address itself to these deficiencies in the public health sector.

2.11 INFORMATION, EDUCATION AND COMMUNICATION

2.11.1 A substantial component of primary health care consists of initiatives for disseminating, to the citizenry, public health-related information. Public health programmes, particularly, need high visibility at the decentralized level in order to have any impact. This task is particularly difficult as 35 percent of our country's population is illiterate. The present IEC strategy is too fragmented, relies heavily on mass media and does not address the needs of this segment of the population. It is often felt that the effectiveness of IEC programmes is difficult to judge; and consequently, it is often asserted that accountability, in regard to the productive use of such funds, is doubtful. NHP-2001, while projecting an IEC strategy, will fully address the inherent problems encountered in any IEC programme designed for improving awareness in order to bring about behavioural change in the general population.

2.11.2 It is widely accepted that school and college students are the most receptive targets for imparting information relating to basic principles of preventive health care. NHP-2001 will attempt to target this group to improve the general level of health awareness.

2.12 MEDICAL RESEARCH

2.12.1 Over the years, medical research activity in the country has been very limited. In the Government, such research has been confined to the research institutions under the Indian Council of Medical Research, and other institutions funded by the States/Central Government. Research in the private sector has assumed some significance only in the last decade. In our country, where the aggregate annual health expenditure is of the order

of Rs. 80,000 crores, the expenditure in 1998-99 on research, both public and private sectors, was only of the order of Rs. 1150 crores. It would be reasonable to infer that with such low research expenditure, it would be virtually impossible to make any dramatic break-through within the country, by way of new molecules and vaccines; also, without a minimal back-up of applied and operational research, it would be difficult to assess whether the health expenditure in the country is being incurred through optimal applications and appropriate public health strategies. Medical Research in the country needs to be focused on therapeutic drugs/vaccines for tropical diseases, which are normally neglected by international pharmaceutical companies on account of limited profitability potential. The thrust will need to be in the newly-emerging frontier areas of research based on genetics, genome-based drug and vaccine development, molecular biology, etc. NHP-2001 will address these inadequacies and spell out a minimal quantum of expenditure for the coming decade, looking to the national needs and the capacity of the research institutions to absorb the funds.

2.13 ROLE OF THE PRIVATE SECTOR

2.13.1 Considering the economic restructuring underway in the country, and over the globe, since the last decade, the changing role of the private sector in providing health care will also have to be addressed in NHP 2001. Currently, the contribution of private health care is principally through independent practitioners. Also, the private sector contributes significantly to secondary-level care and some tertiary care. With the increasing role of private health care, the need for statutory licensing and monitoring of minimum standards of diagnostic centres / medical institutions becomes imperative. NHP-2001 will address the issues regarding the establishment of a regulatory mechanism to ensure adequate standards of diagnostic centres / medical institutions, conduct of clinical practice and delivery of medical services.

2.13.2 Currently, non-Governmental service providers are treating a large number of patients at the primary level for major diseases. However, the treatment regimens followed are diverse and not scientifically optimal, leading to an increase in the incidence of drug resistance. NHP-2001 will address itself to recommending arrangements, which will eliminate the risks arising from inappropriate treatment.

2.13.3 The increasing spread of information technologt raises the possibility of its adoption in the health sector. NHP-2001 will examine this possibility.

2.14 ROLE OF THE CIVIL SOCIETY

2.14.1 Historically, the practice has been to implement major national disease control programmes through the public health machinery of the State/Central Governments. It has become increasingly apparent that certain components of such programmes cannot be efficiently implemented merely through government functionaries. A considerable change in the mode of implementation has come about in the last two decades, with an increasing involvement of NGOs and other institutions of civil society. It is to be recognized that widespread debate on various public health issues have, in fact, been initiated and sustained by NGOs and other members of the civil society. Also, an increasing contribution is being made by such institutions, in the delivery of different components of public health services. Certain disease control programmes require close

inter-action with the beneficiaries for regular administration of drugs: periodic carrying out of the pathological tests; dissemination of information regarding disease control and other general health information. NHP-2001 will address such issues and suggest policy instruments for implementation of public health programmes through individuals and institutions of civil society.

2.15 NATIONAL DISEASE SURVEILLANCE NETWORK

2.15.1 The technical network available in the country for disease surveillance is extremely rudimentary and to the extent that the system exists, it extends only up to the district level. Disease statistics are not flowing through an integrated network from the decentralized public health facilities to the State/Central Government health administration. Such an arrangement only provides belated information, which, at best, serves a limited statistical purpose. The absence of an efficient disease surveillance network is a major handicap in providing a prompt and cost effective health care system. The efficient disease surveillance network set up for Polio and HIV/AIDS has demonstrated the enormous value of such a public health instrument. Real-time information of focal outbreaks of common communicable diseases – Malaria, GE, Cholera and JE – and other seasonal trends of diseases, would enable timely intervention, resulting in the containment of any possible epidemic. In order to be able to use an integrated disease surveillance network, for operational purposes, real-time information is necessary at all levels of the health administration. NHP-2001 would address itself to this major systemic shortcoming in the administration.

2.16 HEALTH STATISTICS

2.16.1 The absence of a systematic and scientific health statistics data-base is a major deficiency in the current scenario. The health statistics collected are not the product of a rigorous methodology. Statistics available from different parts of the country, in respect of major diseases, are often not obtained in a manner which make aggregation possible, or meaningful.

2.16.2 Further, absence of proper and systematic documentation of the various financial resources used in the health sector is another lacunae witnessed in the existing scenario. This makes it difficult to understand trends and levels of health spending by private and public providers of health care in the country, and to address related policy issues and formulate future investment policies.

2.16.3 NHP-2001 will address itself to the programme for putting in place a modern and scientific health statistics database as well as a system of national health accounts.

2.17 WOMEN'S HEALTH

2.17.1 Social, cultural and economic factors continue to inhibit women from gaining adequate access to even the existing public health facilities. This handicap does not just affect women as individuals; it also has an adverse impact on the health, general well-being and development of the entire family, particularly children. NHP 2001 recognises the catalytic role of empowered women in improving the overall health standards of the community.

2.18 MEDICAL ETHICS

2.18.1 Professional medical ethics in the health sector is an area, which has not received much attention in the past. Also, the new frontier areas of research – involving gene manipulation, organ/human cloning and stem cell research _ impinge on visceral issues relating to the sanctity of human life and the moral dilemma of human intervention in the designing of life forms. Besides these, in the emerging areas of research, there is an un-charted risk of creating new life forms, which may irreversibly damage the environment, as it exists today. NHP – 2001 recognises that moral and religious dilemma of this nature, which was not relevant even two years ago, now pervades mainstream health sector issues.

2.19 ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS

2.19.1 There is an increasing expectation and need of the citizenry for efficient enforcement of reasonable quality standards for food and drugs. Recognizing this need, NHP – 2001 makes an appropriate policy recommendation.

2.20 REGULATION OF STANDARDS IN PARA MEDICAL DISCIPLINES

2.20.1 It has been observed that a large number of training institutions have mushroomed particularly in the private sector, for several para medical disciplines – Lab Technicians, Radio Diagnosis Technicians, Physiotherapists, etc. Currently, there is no regulation/monitoring of the curriculum, or the performance of the practitioners in these disciplines. NHP-2001 will make recommendations to ensure standardization of training and monitoring of performance.

2.21 OCCUPATIONAL HEALTH

2.21.1 Work conditions in several sectors of employment in the country are sub-standard. As a result of this, workers engaged in such activities become particularly prone to occupation-linked ailments. The long-term risk of chronic morbidity is particularly marked in the case of child labour. NHP-2001 will address the risk faced by this particularly vulnerable section of the society.

2.22 PROVIDING MEDICAL FACILITIES TO USERS FROM OVERSEAS

2.22.1 The secondary and tertiary facilities available in the country are of good quality and cost-effective compared to international medical facilities. This is true not only of facilities in the allopathic disciplines, but also to those belonging to the alternative systems of medicine, particularly Ayurveda. NHP-2001 will assess the possibilities of encouraging commercial medical services for patients from overseas.

2.23 IMPACT OF GLOBALIZATION ON THE HEALTH SECTOR

2.23.1 There are some apprehensions about the possible adverse impact of economic globalisation on the health sector. Pharmaceutical drugs and other health services have always been available in the country at extremely inexpensive prices. India has established a reputation for itself around the globe for innovative development of original process patents for the manufacture of a wide-range of drugs and vaccines within the ambit of the existing patent laws. With the adoption of Trade Related

Intellectual Property (TRIPS), and the subsequent alignment of domestic patent laws consistent with the commitments under TRIPS, there will be a significant shift in the scope of the parameters regulating the manufacture of new drugs/vaccines. Global experience has shown that the introduction of a TRIPS-consistent patent regime for drugs in a developing country, would result in an increase in the cost of drugs and medical services. NHP-2001 will address itself to the future imperatives of health security in the country, in the post-TRIPS era.

2.24 NON – HEALTH DETERMINANTS

2.24.1 Improved health standards are closely dependent on major non-health determinants such as safe drinking water supply, basic sanitation, adequate nutrition, clean environment and primary education, especially of the girl child. NHP-2001 will not explicitly address itself to the initiatives in these areas, which although crucial, fall outside the domain of the health sector. However, the attainment of the various targets set in NHP 2001 assumes a reasonable performance in these allied sectors.

2.25 POPULATION GROWTH AND HEALTH STANDARDS

2.25.1 Efforts made over the years for improving health standards have been neutralized by the rapid growth of the population. Unless the Population stabilization goals are achieved, no amount of effort in the other components of the public health sector can bring about significantly better national health standards. Government has separately announced the 'National Population Policy – 2000'. The principal common features covered under the National Population Policy-2000 and NHP-2001, relate to the prevention and control of communicable diseases; priority to containment of HIV/AIDS infection; universal immunization of children against all major preventable diseases; addressing the unmet needs for basic and reproductive health services; and supplementation of infrastructure. The synchronized implementation of these two Policies – National Population Policy – 2000 and National Health Policy-2001 – will be the very cornerstone of any national structural plan to improve the health standards in the country.

2.26 ALTERNATIVE SYSTEMS OF MEDICINE

2.26.1 Alternative Systems of Medicine – Ayurveda, Unani, Sidha and Homoeopathy – provide a significant supplemental contribution to the health care services in the country, particularly in the underserved, remote and tribal areeas. The main components of NHP-2001 apply equally to the alternative systems of medicine. However, the policy features specific to the alternative systems of medicine will be presented as a separate document.

3. OBJECTIVES

3.1 The main objective of NHP-2001 is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country. Emphasis will be given to increasing

the aggregate public health investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the State level to render effective service delivery. The contribution of the private sector in providing health services would be much enhanced, particularly for the population group, which can afford to pay for services. Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation. Emphasis will be laid on rational use of drugs within the allopathic system. Increased access to tried and tested systems of traditional medicine will be ensured. Within these broad objectives, NHP-2001 will endeavour to achieve the time-bound goals mentioned in Box-IV.

Box-IV: Goals to be achieved by 2000-2015

• Eradicate Polio and Yaws	2005
• Eliminate Leprosy	2005
• Eliminate Kala Azar	2010
• Eliminate Lymphatic Filariasis	2015
• Achieve Zero level growth of HIV/AIDS	2007
• Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
• Reduce Prevalence of Blindness to 0.5%	2010
• Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
• Improve nutrition and reduce proportion of LBW Babies from 30% to 10%	2010
• Increase utilisation of public health facilities from current Level of <20 to >75%	2010
• Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
• Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
• Increase share of Central grants to Constitute at least 25% of total health spending	2010
• Increase State Sector Health spending from 5.5% to 7% of the budget Further increase to 8%	2005 2010

4. NHP-2001 - POLICY PRESCRIPTIONS

4.1 FINANCIAL RESOURCES

The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, the Central Government will have to play a key role in augmenting public health investments. Taking into account the gap in health care facilities under NHP-2001 it is planned to increase health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010. The State Governments would also need to increase the commitment to the health sector. In the first phase, by 2005, they would be expected to increase the commitment of their resources to 7 percent of the Budget; and, in the second phase, by 2010, to increase it to 8 percent of the Budget. With the stepping up of the public health investment, the Central Government's contribution would rise to 25 percent from the existing 15 percent, by 2010. The provisioning of higher public health investments will also be contingent upon the increase in absorptive capacity of the public health administration so as to gainfully utilize the funds.

4.2 EQUITY

4.2.1 To meet the objective of reducing various types of inequities and imbalances – inter-regional; across the rural – urban divide; and between economic classes – the most cost effective method would be to increase the sectoral outlay in the primary health sector. Such outlets give access to a vast number of individuals, and also facilitate preventive and early stage curative initiative, which are cost effective. In recognition of this public health principle, NHP-2001 envisages an increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targetted for 35 percent and 10 percent respectively. NHP-2001 projects that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms for such facilities.

4.3 DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES

4.3.1 NHP-2001, envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, NHP-2001 envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, Malaria and HIV/AIDS would need to be continued till moderate levels of prevalence are reached. The integration of the programmes will bring about a desirable optimisation of outcomes through a convergence of all public health inputs. The policy also envisages that programme implementation be effected through autonomous bodies at State and district levels. State Health Departments' interventions may be limited to the overall monitoring of the achievement of programme targets and other technical aspects. The relative distancing of the programme implementation from the State Health Departments will give the project team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-informed

decision-making.

4.4 THE STATE OF PUBLIC HEALTH INFRASTRUCTURE

4.4.1 As has been highlighted in the earlier part of the Policy, the decentralized Public health service outlets have become practically dysfunctional over large parts of the country. On account of resource constraint, the supply of drugs by the State Governments is grossly inadequate. The patients at the decentralized level have little use for diagnostic services, which in any case would still require them to purchase therapeutic drugs privately. In a situation in which the patient is not getting any therapeutic drugs, there is little incentive for the potential beneficiaries to seek the advice of the medical professionals in the public health system. This results in there being no demand for medical services, and medical professionals, and paramedics often absent themselves from their place of duty. It is also observed that the functioning of the public health service outlets in the four Southern States – Kerala, Andhra Pradesh, Tamil Nadu and Karnataka – is relatively better, because some quantum of drugs is distributed through the primary health system network, and the patients have a stake in approaching the Public health facilities. In this backdrop, NHP-2001 envisages the kick-starting of the revival of the Primary Health System by providing some essential drugs under Central Government funding through the decentralized health system. It is expected that the provisioning of essential drugs at the public health service centres will create a demand for other professional services from the local population, which, in turn, will boost the general revival of activities in these service centres. In sum, this initiative under NHP-2001 is launched in the belief that the creation of a beneficiary interest in the public health system, will ensure a more effective supervision of the public health personnel, through community monitoring, than has been achieved through the regular administrative line of control.

4.4.2 Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment through public funding in the primary health sector. Box-V gives statistics which show clearly that the standards of health are more a function of accurate targeting of expenditure on the decentralised primary sector (as observed in China and Sri Lanka), than a function of the aggregate health expenditure.

Box-V: Public Health Spending in select Countries

Indicator	%Population with income of <$1 day	Infant Mortality Rate/1000	%Health Expenditure to GDP	%Public Expenditure on Health to Total Health Expenditure
India	44.2	70	5.2	17.3
China	18.5	31	2.7	24.9
Sri Lanka	6.6	16	3	45.4
UK	-	6	5.8	96.9
USA	-	7	13.7	44.1

Therefore, NHP-2001, while committing additional aggregate financial resources, places strong reliance on the strengthening of the primary health structure, with which to attain improved public health outcomes on an equitable basis. Further, it also recognizes the practical need for levying reasonable user-charges for certain secondary and tertiary public health care services, for those who can afford to pay.

4.5 EXTENDING PUBLIC HEALTH SERVICES

4.5.1 NHP-2001 envisages that, in the context of the availability and spread of allopathic graduates in their jurisdiction, State Governments would consider the need for expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Systems of Medicine and Homoeopathy. Simple services/procedures can be provided by such practitioners even outside their disciplines, as part of the basic primary health services in under-served areas. Also, NHP-2001 envisages that the scope of use of paramedical manpower of allopathic disciplines, in a prescribed functional area adjunct to their current functions, would also be examined for meeting simple public health requirements. These extended areas of functioning of different categories of medical manpower can be permitted, after adequate training and subject to the monitoring of their performance through professional councils.

4.5.2 NHP-2001 also recognizes the need for States to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in under-served areas.

4.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

4.6.1 NHP-2001 lays great emphasis upon the implementation of public health programmes through local self Government institutions. The structure of the national disease control programmes will have specific components for implementation through such entities. The Policy urges all State Governments to consider decentralizing implementation of the programmes to such Institutions by 2005. In order to achieve this, financial incentives, over and above the resources allocated for disease control programmes, will be provided by the Central Government.

4.7 MEDICAL EDUCATION

4.7.1 In order to ameliorate the problems being faced on account of the uneven spread of medical colleges in various parts of the country, NHP-2001, envisages the setting up of a Medical Grants Commission for funding new Government Medical Colleges in different parts of the country. Also, the Medical Grants Commission is envisaged to fund the upgradation of the existing Government Medical Colleges of the country, so as to ensure an improved standard of medical education in the country.

4.7.2 To enable fresh graduates to effectively contribute to the providing of primary health services, NHP-2001 identifies a significant need to modify the existing curriculum. A need based, skill-oriented syllabus, with a more significant component of practical training, would make fresh doctors useful immediately after graduation.

4.7.3 The policy emphasises the need to expose medical students, through the undergraduate syllabus, to the emerging concerns for geriatric disorders, as also to the cutting edge disciplines of contemporary medical research. The policy also envisages that the creation of additional seats for post-graduate courses should reflect the need for more manpower in the deficient specialities.

4.8 NEED FOR SPECIALISTS IN 'PUBLIC HEALTH' AND 'FAMILY MEDICINE'

4.8.1 In order to alleviate the acute shortage of medical personnel with specialization in 'public health' and 'family medicine' disciplines, NHP-2001 envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these discipline in medical training institutions, to reach a stage wherein ¼ th of the seats are earmarked for these disciplines. It is envisaged that in the sanctioning of post-graduate seats in future, it shall be insisted upon that a certain reasonable number of seats be allocated to `public health' and `family medicine' disciplines. Since, the `public health' discipline has an interface with many other developmental sectors, specialization in Public health may be encouraged not only for medical doctors but also for non-medical graduates from the allied fields of public health engineering, microbiology and other natural sciences.

4.9 URBAN HEALTH

4.9.1 NHP-2001, envisages the setting up of an organised urban primary health care structure. Since the physical features of an urban setting are different from those in the rural areas, the policy envisages the adoption of appropriate population norms for the urban public health infrastructure. The structure conceived under NHP-2001 is a two-tiered one: the primary centre is seen as the first-tier, covering a population of one lakh, with a dispensary providing OPD facility and essential drugs to enable access to all the national health programmes; and a second-tier of the urban health organisation at the level of the Government general Hospital, where reference is made from the primary centre. The Policy envisages that the funding for the urban primary health system will be jointly borne by the local self-Government institutions and State and Central Governments.

4.9.2 The National Health Policy also envisages the establishment of fully-equipped 'hub-spoke' trauma care networks in large urban agglomerations to reduce accident mortality.

4.10 MENTAL HEALTH

4.10.1 NHP – 2001 envisages a network of decentralised mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would envisage diagnosis of common disorders by general duty medical staff and prescription of common therapeutic drugs.

4.10.2 In regard to mental health institutions for in-door treatment of patients, the policy envisages the upgrading of the physical infrastructure of such institutions at Central Government expense so as to secure the human rights of this vulnerable segment of society.

4.11 INFORMATION, EDUCATION AND COMMUNICATION

4.11.1 NHP-2001 envisages an IEC policy, which maximizes the dissemination of information to those population groups, which cannot be effectively approached through the mass media only. The focus would therefore, be on inter-personal communication of information and reliance on folk and other traditional media. The IEC programme would set specific targets for the association of PRIs/NGOs/Trusts in such activities. The programme will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programmes on the targeted groups. The Central/State Government initiative will also focus on the development of modules for information dissemination in such population groups who normally, do not benefit from the more common media forms.

4.11.2. NHP-2001 envisages priority to school health programmes aiming at preventive health education, regular health check-ups and promotion of health seeking behaviour among children. The school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'. This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but the future generation as well.

4.12 MEDICAL RESEARCH

4.12.1 NHP-2001 envisages the increase in Government-funded medical research to a level of 1 percent of total health spending by 2005; and thereafter, up to 2 percent by 2010. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and Malaria, as also the Sub-types of HIV/AIDS prevalent in the country. Research programmes taken up by the Government in these priority areas would be conducted in a mission mode. Emphasis would also be paid to time-bound applied research for developing operational applications. This would ensure cost effective dissemination of existing / future therapeutic drugs/vaccines in the general population. Private entrepreneurship will be encouraged in the field of medical research for new molecules / vaccines.

4.13 ROLE OF THE PRIVATE SECTOR

4.13.1 NHP-2001 envisages the enactment of suitable legislations for regulating minimum infrastructure and quality standards by 2003, in clinical establishments/medical institutions; also, statutory guidelines for the conduct of clinical practice and delivery of medical services are to be developed over the same period. The policy also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages.

4.13.2 To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as 'deemed exports' and will be made eligible for all fiscal incentives extended to export earnings.

4.13.3 NHP-2001 envisages the co-option of the non-governmental practitioners in the national disease control programmes so as to ensure that standard treatment protocols are followed in their day-to-day practice.

4.13.4 NHP-2001 recognizes the immense potential of use of information technology applications in the area of tele-medicine in the tertiary health care sector. The use of this technical aid will greatly enhance the capacity for the professionals to pool their clinical experience.

4.14 ROLE OF THE CIVIL SOCIETY

4.14.1 NHP-2001 recognizes the significant contribution made by NGOs and other institutions of the civil society in making available health services to the community. In order to utilize on an increasing scale, their high motivational skills, NHP-2001 envisages that the disease control programmes should earmark a definite portion of the budget in respect of identified programme components, to be exclusively implemented through these institutions.

4.15 NATIONAL DISEASE SURVEILLANCE NETWORK

4.15.1 NHP-2001 envisages the full operationalization of an integrated disease control network from the lowest rung of public health administration to the Central Government, by 2005. The programme for setting up this network will include components relating to installation of data-base handling hardware; IT inter-connectivity between different tiers of the network; and, in-house training for data collection and interpretation for undertaking timely and effective response.

4.16 HEALTH STATISTICS

4.16.1 NHP-2001 envisages the completion of baseline estimates for the incidence of the common diseases – TB, Malaria, Blindness – by 2005. The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology. The policy also recognizes the need to establish in a longer time frame, baseline estimates for : the non-communicable diseases, like CVD, Cancer, Diabetes; accidental

injuries; and other communicable diseases, like Hepatitis and JE. NHP-2001 envisages that, with access to such reliable data on the incidence of various diseases, the public health system would move closer to the objective of evidence-based policy making.

4.16.2 In an attempt at consolidating the data base and graduating from a mere estimation of annual health expenditure, NHP-2001 emphasis on the needs to establish national health accounts, conforming to the 'source-to-users' matrix structure. Improved and comprehensive information through national health accounts and accounting systems would pave the way for decision makers to focus on relative priorities, keeping in view the limited financial resources in the health sector.

4.17 WOMEN'S HEALTH

4.17.1 NHP-2001 envisages the identification of specific programmes targeted at women's health. The policy notes that women, along with other under privileged groups are significantly handicapped due to a disproportionately low access to health care. The various Policy recommendations of NHP-2001, in regard to the expansion of primary health sector infrastructure, will facilitate the increased access of women to basic health care. NHP-2001 commits the highest priority of the Central Government to the funding of the identified programmes relating to woman's health. Also, the policy recognizes the need to review the staffing norms of the public health administration to more comprehensively meet the specific requirements of women.

4.18 MEDICAL ETHICS

4.18.1 NHP – 2001 envisages that, in order to ensurethat the common patient is not subjected to irrational or profit-driven medical regimens, a contemporary code of ethics be notified and rigorously implemented by the Medical Council of India.

4.18.2 NHP – 2001 does not offer any policy prescription at this stage relating to ethics in the conduct of medical research. By and large medical research within the country is limited in these frontier disciplines of gene manipulation and stem cell research. However, the policy recognises that a vigilant watch will have to be kept so that appropriate guidelines and statutory provisions are put in place when medical research in the country reaches the stage to make such issues relevant.

4.19 ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS

4.19.1 NHP – 2001 envisages that the food and drug administration will be progressively strengthened, both in terms of laboratory facilities and technical expertise. Also, the policy envisages that the standards of food items will be progressively tightened at a pace which will permit domestic food handling / manufacturing facilities to undertake the necessary upgradation of technology so as not to be shut out of this production sector. The policy envisages that, ultimately food standards will be close, if not equivalent, to codex specifications; and drug standards will be at par with the most rigorous ones adopted elsewhere.

4.20 REGULATION OF STANDARDS IN PARAMEDICAL DISCIPLINES

4.20.1 NHP-2001 recognises the need for the establishment of statutory professional

councils for paramedical disciplines to register practitioners, maintain standards of training, as well as to monitor their performance.

4.21 OCCUPATIONAL HEALTH

4.21.1 NHP-2001 envisages the periodic screening of the health conditions of the workers, particularly for high risk health disorders associated with their occupation.

4.22 PROVIDING MEDICAL FACILITIES TO USERS FROM OVERSEAS

4.22.1 NHP-2001 strongly encourages the providing of health services on a commercial basis to service seekers from overseas. The providers of such services to patients from overseas will be encouraged by extending to their earnings in foreign exchange, all fiscal incentives available to other exporters of goods and services.

4.23 IMPACT OF GLOBALISATION ON THE HEALTH SECTOR

4.23.1 NHP-2001 takes into account the serious apprehension expressed by several health experts, of the possible threat to the health security, in the post TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines. To protect the citizens of the country from such a threat, NHP-2001 envisages a national patent regime for the future which, while being consistent with TRIPS, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries. The Policy also sets out that the Government will bring to bear its full influence in all international fora – UN, WHO, WTO, etc. – to secure commitments on the part of the Nations of the Globe, to lighten the restrictive features of TRIPS in its application to the health care sector.

5. SUMMATION

5.1 The crafting of a National Health Policy is a rare occasion in public affairs when it would be legitimate, indeed valuable, to allow our dreams to mingle with our understanding of ground realities. Based purely on the clinical facts defining the current status of the health sector, we would have arrived at a certain policy formulation; but, buoyed by our dreams, we have ventured slightly beyond that in the shape of NHP-2001 which, in fact, defines a vision for the future.

5.2 The health needs of the country are enormous and the financial resources and managerial capacity available to meet it, even on the most optimistic projections, fall somewhat short. In this situation, NHP-2001 has had to make hard choices between various priorities and operational options. NHP-2001 does not claim to be a road-map for meeting all the health needs of the populace of the country. Further, it has to be recognized that such health needs are also dynamic as threats in the area of public health keep changing over time. The Policy, while being holistic, undertakes the necessary risk of recommending differing emphasis on different policy components. Broadly speaking, NHP – 2001 focuses on the need for enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also, the policy is focused on those diseases which are principally contributing to the disease burden – TB, Malaria and Blindness from the category of historical diseases; and HIV/AIDS from the category of 'newly emerging

diseases'. This is not to say that other items contributing to the disease burden of the country will be ignored; but only that, resources as also the principal focus of the public health administration, will recognize certain relative priorities.

5.3 One nagging imperative, which has influenced every aspect of NHP-2001, is the need to ensure that 'equity' in the health sector stands as an independent goal. In any future evaluation of its success or failure, NHP-2001 would like to be measured against this equity norm, rather than any other aggregated financial norm for the health sector. Consistent with the primacy given to 'equity', a marked emphasis has been provided in the policy for expanding and improving the primary health facilities, including the new concept of provisioning of essential drugs through Central funding. The Policy also commits the Central Government to increased under-writing of the resources for meeting the minimum health needs of the citizenry. Thus, the Policy attempts to provide guidance for prioritizing expenditure, thereby, facilitating rational resource allocation.

5.4 NHP-2001 highlights the expected roles of different participating group in the health sector. Further, it recognizes the fact that, despite all that may be guaranteed by the Central Government for assisting public health programmes, public health services would actually need to be delivered by the State administration, NGOs and other institutions of civil society. The attainment of improved health indices would be significantly dependent on population stabilisation, as also on complementary efforts from other areas of the social sectors – like improved drinking water supply, basic sanitation, minimum nutrition, etc. - to ensure that the exposure of the populace to health risks is minimized.

Suggestions on the draft policy are welcome. Kindly mail your suggestions to aeabop@nb.nic.in within 30 days.

To Helena
& Love
MP

NATIONAL POLICY FOR THE EMPOWERMENT OF WOMEN
(2001)

Introduction

The principle of gender equality is enshrined in the Indian Constitution in its Preamble, Fundamental Rights, Fundamental Duties and Directive Principles. The Constitution not only grants equality to women, but also empowers the State to adopt measures of positive discrimination in favour of women.

Within the framework of a democratic polity, our laws, development policies, Plans and programmes have aimed at women's advancement in different spheres. From the Fifth Five Year Plan (1974-78) onwards has been a marked shift in the approach to women's issues from welfare to development. In recent years, the empowerment of women has been recognized as the central issue in determining the status of women. The National Commission for Women was set up by an Act of Parliament in 1990 to safeguard the rights and legal entitlements of women. The 73rd and 74th Amendments (1993) to the Constitution of India have provided for reservation of seats in the local bodies of Panchayats and Municipalities for women, laying a strong foundation for their participation in decision making at the local levels.

1.3 India has also ratified various international conventions and human rights instruments committing to secure equal rights of women. Key among them is the ratification of the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993.

1.4 The Mexico Plan of Action (1975), the Nairobi Forward Looking Strategies (1985), the Beijing Declaration as well as the Platform for Action (1995) and the Outcome Document adopted by the UNGA Session on Gender Equality and Development & Peace for the 21st century, titled "Further actions and initiatives to implement the Beijing Declaration and the Platform for Action" have been unreservedly endorsed by India for appropriate follow up.

1.5 The Policy also takes note of the commitments of the Ninth Five Year Plan and the other Sectoral Policies relating to empowerment of Women.

1.6 The women's movement and a wide-spread network of non-Government Organisations which have strong grass-roots presence and deep insight into women's concerns have contributed in inspiring initiatives for the empowerment of women.

1.7 However, there still exists a wide gap between the goals enunciated in the Constitution, legislation, policies, plans, programmes, and related mechanisms on the one hand and the situational reality of the status of women in India, on the other. This has been analyzed extensively in the Report of the Committee on the Status of Women in India, "Towards Equality", 1974 and highlighted in the National Perspective Plan for Women, 1988-2000, the Shramshakti Report, 1988 and the Platform for Action, Five Years After- An assessment"

1.8 Gender disparity manifests itself in various forms, the most obvious being the trend of continuously declining female ratio in the population in the last few decades. Social stereotyping and violence at the domestic and societal levels are some of the other manifestations. Discrimination against girl children, adolescent girls and women persists in parts of the country.

1.9 The underlying causes of gender inequality are related to social and economic structure, which is based on informal and formal norms, and practices.

1.10 Consequently, the access of women particularly those belonging to weaker sections including Scheduled Castes/Scheduled Tribes/ Other backward Classes and minorities, majority of whom are in the rural areas and in the informal, unorganized sector – to education, health and productive resources, among others, is inadequate. Therefore, they remain largely marginalized, poor and socially excluded.

Goal and Objectives

1.11 The goal of this Policy is to bring about the advancement, development and empowerment of women. The Policy will be widely disseminated so as to encourage active participation of all stakeholders for achieving its goals. Specifically, the objectives of this Policy include

(i) Creating an environment through positive economic and social policies for full development of women to enable them to realize their full potential

(ii) The *de-jure* and *de-facto* enjoyment of all human rights and fundamental freedom by women on equal basis with men in all spheres – political, economic, social, cultural and civil

(iii) Equal access to participation and decision making of women in social, political and economic life of the nation

(iv) Equal access to women to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office etc.

(v) Strengthening legal systems aimed at elimination of all forms of discrimination against women

(vi) Changing societal attitudes and community practices by active participation and involvement of both men and women.

(vii) Mainstreaming a gender perspective in the development process.

(viii) Elimination of discrimination and all forms of violence against women and the girl child; and

(ix) Building and strengthening partnerships with civil society, particularly women's organizations.

Policy Prescriptions

Judicial Legal Systems

Legal-judicial system will be made more responsive and gender sensitive to women's needs, especially in cases of domestic violence and personal assault. New laws will be enacted and existing laws reviewed to ensure that justice is quick and the punishment meted out to the culprits is commensurate with the severity of the offence.

2.2 At the initiative of and with the full participation of all stakeholders including community and religious leaders, the Policy would aim to encourage changes in personal laws such as those related to marriage, divorce, maintenance and guardianship so as to eliminate discrimination against women.

2.3 The evolution of property rights in a patriarchal system has contributed to the subordinate status of women. The Policy would aim to encourage changes in laws relating to ownership of property and inheritance by evolving consensus in order to make them gender just.

Decision Making

3.1 Women's equality in power sharing and active participation in decision making, including decision making in political process at all levels will be ensured for the achievement of the goals of empowerment. All measures will be taken to guarantee women equal access to and full participation in decision making bodies at every level, including the legislative, executive, judicial, corporate, statutory bodies, as also the advisory Commissions, Committees, Boards, Trusts etc. Affirmative action such as reservations/quotas, including in higher legislative bodies, will be considered whenever necessary on a time bound basis. Women–friendly personnel policies will also be drawn up to encourage women to participate effectively in the developmental process.

Mainstreaming a Gender Perspective in the Development Process

4.1 Policies, programmes and systems will be established to ensure mainstreaming of women's perspectives in all developmental processes, as catalysts, participants and recipients. Wherever there are gaps in policies and programmes, women specific interventions would be undertaken to bridge these. Coordinating and monitoring mechanisms will also be devised to assess from time to time the progress of such mainstreaming mechanisms. Women's issues and concerns as a result will specially be addressed and reflected in all concerned laws, sectoral policies, plans and programmes of action.

Economic Empowerment of women

Poverty Eradication

5.1 Since women comprise the majority of the population below the poverty line and are very often in situations of extreme poverty, given the harsh realities of intra-household and social discrimination, macro economic policies and poverty eradication programmes will specifically address the needs and problems of such women. There will be improved implementation of programmes which are already women oriented with special targets for women. Steps will be taken for mobilization of poor women and convergence of services, by offering them a range of economic and social options, along with necessary support measures

to enhance their capabilities

Micro Credit

5.2 In order to enhance women's access to credit for consumption and production, the establishment of new, and strengthening of existing micro-credit mechanisms and micro-finance institution will be undertaken so that the outreach of credit is enhanced. Other supportive measures would be taken to ensure adequate flow of credit through extant financial institutions and banks, so that all women below poverty line have easy access to credit.

Women and Economy

5.3 Women's perspectives will be included in designing and implementing macro-economic and social policies by institutionalizing their participation in such processes. Their contribution to socio-economic development as producers and workers will be recognized in the formal and informal sectors (including home based workers) and appropriate policies relating to employment and to her working conditions will be drawn up. Such measures could include:

Reinterpretation and redefinition of conventional concepts of work wherever necessary e.g. in the Census records, to reflect women's contribution as producers and workers.

Preparation of satellite and national accounts.

Development of appropriate methodologies for undertaking (i) and (ii) above.

Globalization

Globalization has presented new challenges for the realization of the goal of women's equality, the gender impact of which has not been systematically evaluated fully. However, from the micro-level studies that were commissioned by the Department of Women & Child Development, it is evident that there is a need for re-framing policies for access to employment and quality of employment. Benefits of the growing global economy have been unevenly distributed leading to wider economic disparities, the feminization of poverty, increased gender inequality through often deteriorating working conditions and unsafe working environment especially in the informal economy and rural areas. Strategies will be designed to enhance the capacity of women and empower them to meet the negative social and economic impacts, which may flow from the globalization process.

Women and Agriculture

5.5 In view of the critical role of women in the agriculture and allied sectors, as producers, concentrated efforts will be made to ensure that benefits of training, extension and various programmes will reach them in proportion to their numbers. The programmes for training women in soil conservation, social forestry, dairy development and other occupations allied to agriculture like horticulture, livestock including small animal husbandry, poultry, fisheries etc. will be expanded to benefit women workers in the agriculture sector.

Women and Industry

5.6 The important role played by women in electronics, information technology and food processing and agro industry and textiles has been crucial to the development of these sectors. They would be given comprehensive support in terms of labour legislation, social security and other support services to participate in various industrial sectors.

5.7 Women at present cannot work in night shift in factories even if they wish to. Suitable measures will be taken to enable women to work on the night shift in factories. This will be accompanied with support services for security, transportation etc.

Support Services

5.8 The provision of support services for women, like child care facilities, including crèches at work places and educational institutions, homes for the aged and the disabled will be expanded and improved to create an enabling environment and to ensure their full cooperation in social, political and economic life. Women-friendly personnel policies will also be drawn up to encourage women to participate effectively in the developmental process.

Social Empowerment of Women

Education

6.1 Equal access to education for women and girls will be ensured. Special measures will be taken to eliminate discrimination, universalize education, eradicate illiteracy, create a gender-sensitive educational system, increase enrolment and retention rates of girls and improve the quality of education to facilitate life-long learning as well as development of occupation/vocation/technical skills by women. Reducing the gender gap in secondary and higher education would be a focus area. Sectoral time targets in existing policies will be achieved, with a special focus on girls and women, particularly those belonging to weaker sections including the Scheduled Castes/Scheduled Tribes/Other Backward Classes/Minorities. Gender sensitive curricula would be developed at all levels of educational system in order to address sex stereotyping as one of the causes of gender discrimination.

Health

6.2 A holistic approach to women's health which includes both nutrition and health services will be adopted and special attention will be given to the needs of women and the girl at all stages of the life cycle. The reduction of infant mortality and maternal mortality, which are sensitive indicators of human development, is a priority concern. This policy reiterates the national demographic goals for Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) set out in the National Population Policy 2000. Women should have access to comprehensive, affordable and quality health care. Measures will be adopted that take into account the reproductive rights of women to enable them to exercise informed choices, their vulnerability to sexual and health problems together with endemic, infectious and communicable diseases such as malaria, TB, and water borne diseases as well as hypertension and cardio-pulmonary diseases. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases will be tackled from a gender perspective.

6.3 To effectively meet problems of infant and maternal mortality, and early marriage the availability of good and accurate data at micro level on deaths, birth and marriages is

required. Strict implementation of registration of births and deaths would be ensured and registration of marriages would be made compulsory.

6.4 In accordance with the commitment of the National Population Policy (2000) to population stabilization, this Policy recognizes the critical need of men and women to have access to safe, effective and affordable methods of family planning of their choice and the need to suitably address the issues of early marriages and spacing of children. Interventions such as spread of education, compulsory registration of marriage and special programmes like BSY should impact on delaying the age of marriage so that by 2010 child marriages are eliminated.

6.5 Women's traditional knowledge about health care and nutrition will be recognized through proper documentation and its use will be encouraged. The use of Indian and alternative systems of medicine will be enhanced within the framework of overall health infrastructure available for women.

Nutrition

6.6 In view of the high risk of malnutrition and disease that women face at all the three critical stages viz., infancy and childhood, adolescent and reproductive phase, focussed attention would be paid to meeting the nutritional needs of women at all stages of the life cycle. This is also important in view of the critical link between the health of adolescent girls, pregnant and lactating women with the health of infant and young children. Special efforts will be made to tackle the problem of macro and micro nutrient deficiencies especially amongst pregnant and lactating women as it leads to various diseases and disabilities.

6.7 Intra-household discrimination in nutritional matters vis-à-vis girls and women will be sought to be ended through appropriate strategies. Widespread use of nutrition education would be made to address the issues of intra-household imbalances in nutrition and the special needs of pregnant and lactating women. Women's participation will also be ensured in the planning, superintendence and delivery of the system.

Drinking Water and Sanitation

6.8 Special attention will be given to the needs of women in the provision of safe drinking water, sewage disposal, toilet facilities and sanitation within accessible reach of households, especially in rural areas and urban slums. Women's participation will be ensured in the planning, delivery and maintenance of such services.

Housing and Shelter

6.9 Women's perspectives will be included in housing policies, planning of housing colonies and provision of shelter both in rural and urban areas. Special attention will be given for providing adequate and safe housing and accommodation for women including single women, heads of households, working women, students, apprentices and trainees.

Environment

6.10 Women will be involved and their perspectives reflected in the policies and programmes

for environment, conservation and restoration. Considering the impact of environmental factors on their livelihoods, women's participation will be ensured in the conservation of the environment and control of environmental degradation. The vast majority of rural women still depend on the locally available non-commercial sources of energy such as animal dung, crop waste and fuel wood. In order to ensure the efficient use of these energy resources in an environmental friendly manner, the Policy will aim at promoting the programmes of non-conventional energy resources. Women will be involved in spreading the use of solar energy, biogas, smokeless chulahs and other rural application so as to have a visible impact of these measures in influencing eco system and in changing the life styles of rural women.

Science and Technology

6.11 Programmes will be strengthened to bring about a greater involvement of women in science and technology. These will include measures to motivate girls to take up science and technology for higher education and also ensure that development projects with scientific and technical inputs involve women fully. Efforts to develop a scientific temper and awareness will also be stepped up. Special measures would be taken for their training in areas where they have special skills like communication and information technology. Efforts to develop appropriate technologies suited to women's needs as well as to reduce their drudgery will be given a special focus too.

Women in Difficult Circumstances

6.12 In recognition of the diversity of women's situations and in acknowledgement of the needs of specially disadvantaged groups, measures and programmes will be undertaken to provide them with special assistance. These groups include women in extreme poverty, destitute women, women in conflict situations, women affected by natural calamities, women in less developed regions, the disabled widows, elderly women, single women in difficult circumstances, women heading households, those displaced from employment, migrants, women who are victims of marital violence, deserted women and prostitutes etc.

Violence against women

7.1 All forms of violence against women, physical and mental, whether at domestic or societal levels, including those arising from customs, traditions or accepted practices shall be dealt with effectively with a view to eliminate its incidence. Institutions and mechanisms/schemes for assistance will be created and strengthened for prevention of such violence , including sexual harassment at work place and customs like dowry; for the rehabilitation of the victims of violence and for taking effective action against the perpetrators of such violence. A special emphasis will also be laid on programmes and measures to deal with trafficking in women and girls.

Rights of the Girl Child

8.1 All forms of discrimination against the girl child and violation of her rights shall be eliminated by undertaking strong measures both preventive and punitive within and outside the family. These would relate specifically to strict enforcement of laws against prenatal sex selection and the practices of female foeticide, female infanticide, child marriage, child abuse and child prostitution etc. Removal of discrimination in the treatment of the girl child within

the family and outside and projection of a positive image of the girl child will be actively fostered. There will be special emphasis on the needs of the girl child and earmarking of substantial investments in the areas relating to food and nutrition, health and education, and in vocational education. In implementing programmes for eliminating child labour, there will be a special focus on girl children.

Mass Media

9.1 Media will be used to portray images consistent with human dignity of girls and women. The Policy will specifically strive to remove demeaning, degrading and negative conventional stereotypical images of women and violence against women. Private sector partners and media networks will be involved at all levels to ensure equal access for women particularly in the area of information and communication technologies. The media would be encouraged to develop codes of conduct, professional guidelines and other self regulatory mechanisms to remove gender stereotypes and promote balanced portrayals of women and men.

Operational Strategies

Action Plans

10.1 All Central and State Ministries will draw up time bound Action Plans for translating the Policy into a set of concrete actions, through a participatory process of consultation with Centre/State Departments of Women and Child Development and National /State Commissions for Women. The Plans will specifically including the following: -

i) Measurable goals to be achieved by 2010.

ii) Identification and commitment of resources.

iii) Responsibilities for implementation of action points.

iv) Structures and mechanisms to ensure efficient monitoring, review and gender impact assessment of action points and policies.

v) Introduction of a gender perspective in the budgeting process.

10.2 In order to support better planning and programme formulation and adequate allocation of resources, Gender Development Indices (GDI) will be developed by networking with specialized agencies. These could be analyzed and studied in depth. Gender auditing and development of evaluation mechanisms will also be undertaken along side.

10.3 Collection of gender disaggregated data by all primary data collecting agencies of the Central and State Governments as well as Research and Academic Institutions in the Public and Private Sectors will be undertaken. Data and information gaps in vital areas reflecting the status of women will be sought to be filled in by these immediately. All Ministries/Corporations/Banks and financial institutions etc will be advised to collect, collate, disseminate and maintain/publish data related to programmes and benefits on a gender disaggregated basis. This will help in meaningful planning and evaluation of policies.

Institutional Mechanisms

11.1 Institutional mechanisms, to promote the advancement of women, which exist at the Central and State levels, will be strengthened. These will be through interventions as may be appropriate and will relate to, among others, provision of adequate resources, training and advocacy skills to effectively influence macro-policies, legislation, programmes etc. to achieve the empowerment of women.

11.2 National and State Councils will be formed to oversee the operationalisation of the Policy on a regular basis. The National Council will be headed by the Prime Minister and the State Councils by the Chief Ministers and be broad in composition having representatives from the concerned Departments/Ministries, National and State Commissions for Women, Social Welfare Boards, representatives of Non-Government Organizations, Women's Organisations, Corporate Sector, Trade Unions, financing institutions, academics, experts and social activists etc. These bodies will review the progress made in implementing the Policy twice a year. The National Development Council will also be informed of the progress of the programme undertaken under the policy from time to time for advice and comments.

11.3 National and State Resource Centres on women will be established with mandates for collection and dissemination of information, undertaking research work, conducting surveys, implementing training and awareness generation programmes, etc. These Centers will link up with Women's Studies Centres and other research and academic institutions through suitable information networking systems.

11.4 While institutions at the district level will be strengthened, at the grass-roots, women will be helped by Government through its programmes to organize and strengthen into Self-Help Groups (SHGs) at the Anganwadi/Village/Town level. The women's groups will be helped to institutionalize themselves into registered societies and to federate at the Panchyat/Municipal level. These societies will bring about synergistic implementation of all the social and economic development programmes by drawing resources made available through Government and Non-Government channels, including banks and financial institutions and by establishing a close Interface with the Panchayats/ Municipalities.

Resource Management

12.1 Availability of adequate financial, human and market resources to implement the Policy will be managed by concerned Departments, financial credit institutions and banks, private sector, civil society and other connected institutions. This process will include:

(a) Assessment of benefits flowing to women and resource allocation to the programmes relating to them through an exercise of gender budgeting. Appropriate changes in policies will be made to optimize benefits to women under these schemes;

(b) Adequate resource allocation to develop and promote the policy outlined earlier based on (a) above by concerned Departments.

(c) Developing synergy between personnel of Health, Rural Development, Education and Women & Child Development Department at field level and other village level functionaries'

(d) Meeting credit needs by banks and financial credit institutions through suitable policy initiatives and development of new institutions in coordination with the Department of

Women & Child Development.

12.2 The strategy of Women's Component Plan adopted in the Ninth Flan of ensuring that not less than 30% of benefits/funds flow to women from all Ministries and Departments will be implemented effectively so that the needs and interests of women and girls are addressed by all concerned sectors. The Department of Women and Child Development being the nodal Ministry will monitor and review the progress of the implementation of the Component Plan from time to time, in terms of both quality and quantity in collaboration with the Planning Commission.

12.3 Efforts will be made to channelize private sector investments too, to support programmes and projects for advancement of women

Legislation

13.1 The existing legislative structure will be reviewed and additional legislative measures taken by identified departments to implement the Policy. This will also involve a review of all existing laws including personal, customary and tribal laws, subordinate legislation, related rules as well as executive and administrative regulations to eliminate all gender discriminatory references. The process will be planned over a time period 2000-2003. The specific measures required would be evolved through a consultation process involving civil society, National Commission for Women and Department of Women and Child Development. In appropriate cases the consultation process would be widened to include other stakeholders too.

13.2 Effective implementation of legislation would be promoted by involving civil society and community. Appropriate changes in legislation will be undertaken, if necessary.

13.3 In addition, following other specific measures will be taken to implement the legislation effectively.

(a) Strict enforcement of all relevant legal provisions and speedy redressal of grievances will be ensured, with a special focus on violence and gender related atrocities.

(b) Measures to prevent and punish sexual harassment at the place of work, protection for women workers in the organized/ unorganized sector and strict enforcement of relevant laws such as Equal Remuneration Act and Minimum Wages Act will be undertaken,

(c) Crimes against women, their incidence, prevention, investigation, detection and prosecution will be regularly reviewed at all Crime Review fora and Conferences at the Central, State and District levels. Recognised, local, voluntary organizations will be authorized to lodge Complaints and facilitate registration, investigations and legal proceedings related to violence and atrocities against girls and women.

(d) Women's Cells in Police Stations, Encourage Women Police Stations Family Courts, Mahila Courts, Counselling Centers, Legal Aid Centers and Nyaya Panchayats will be strengthened and expanded to eliminate violence and atrocities against women.

(e) Widespread dissemination of information on all aspects of legal rights, human rights and

other entitlements of women, through specially designed legal literacy programmes and rights information programmes will be done.

Gender Sensitization

14.1 Training of personnel of executive, legislative and judicial wings of the State, with a special focus on policy and programme framers, implementation and development agencies, law enforcement machinery and the judiciary, as well as non-governmental organizations will be undertaken. Other measures will include:

(a) Promoting societal awareness to gender issues and women's human rights.

(b) Review of curriculum and educational materials to include gender education and human rights issues

(c) Removal of all references derogatory to the dignity of women from all public documents and legal instruments.

(d) Use of different forms of mass media to communicate social messages relating to women's equality and empowerment.

Panchayati Raj Institutions

15.1 The 73rd and 74th Amendments (1993) to the Indian Constitution have served as a breakthrough towards ensuring equal access and increased participation in political power structure for women. The PRIs will play a central role in the process of enhancing women's participation in public life. The PRIs and the local self Governments will be actively involved in the implementation and execution of the National Policy for Women at the grassroots level.

Partnership with the voluntary sector organizations

16.1 The involvement of voluntary organizations, associations, federations, trade unions, non-governmental organizations, women's organizations, as well as institutions dealing with education, training and research will be ensured in the formulation, implementation, monitoring and review of all policies and programmes affecting women. Towards this end, they will be provided with appropriate support related to resources and capacity building and facilitated to participate actively in the process of the empowerment of women.

International Cooperation

17.1 The Policy will aim at implementation of international obligations/commitments in all sectors on empowerment of women such as the Convention on All Forms of Discrimination Against Women (CEDAW), Convention on the Rights of the Child (CRC), International Conference on Population and Development (ICPD+5) and other such instruments. International, regional and sub-regional cooperation towards the empowerment of women will continue to be encouraged through sharing of experiences, exchange of ideas and technology, networking with institutions and organizations and through bilateral and multi-lateral partnerships.

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Changing the Indian Health System

Current Issues, Future Directions

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Contents

Preface

When I accepted this assignment, little did I realize that the exercise would be so arduous, yet at the same time so rewarding. Never in my long career has my intellectual stamina been so severely tested. But the experience was also deeply satisfying, since the study was so timed that it could make a contribution, however small, to the ongoing exercise of formulating a new health policy. If this Report helps improve understanding of health issues, generates awareness and stimulates an informed debate, our labours will be amply rewarded.

Having worked mainly on global issues since leaving the Health Ministry in 1994, I was glad to return once again to the national health scene. This project provided an excellent opportunity to pick up the threads again and to look at the issues more objectively and in greater depth. Despite some welcome developments, what I found was deeply disappointing. The problems that I had left behind seven years back had not only remained largely unchanged, but had been greatly aggravated, with the health system becoming even more dysfunctional and iniquitous. The fiscal situation in the states had deteriorated to such an extent that they seemed helpless, unable to correct the most glaring inadequacies, even when there was a sincere desire to do so. On the positive side, there were some welcome initiatives in the states that could be regarded as the beginnings of a reform process. There was also a huge improvement in the availability of data as a result of NSSO 42nd and 52nd rounds, NFHS 1 and 2, and NCAER household surveys. Regrettably though, the NIPFP initiative in the early nineties to develop national health accounts was not followed up, so that health finance had become the weakest link in the database. More important, the new data had been analyzed in depth by competent researchers, thanks to the collaborative initiatives of donor agencies and the central government, making available critical inputs to policymakers. The stage was now set for evidence-based policy initiatives.

The Report brings out quite unambiguously the gross inadequacy of public investment in health. It is true that no system can be expected to perform at the current low levels of funding. However, it is also equally true that an increase in funding levels by itself is unlikely to produce the desired results without accompanying systemic changes. As in the case of the energy sector, increased investment must to go hand in hand with system reform. This is why we decided that the most appropriate title for the document would be **Changing the Indian Health System: Current Issues, Future Directions.**

I was ably assisted in my endeavours, by the two co-authors, Rachel Chatterjee (formerly Health Secretary, Andhra Pradesh), and Sujatha Rao (Joint Secretary in the Ministry of Health and Family Welfare). The former made a huge contribution because of her intimate knowledge of the health

system at the state level. The latter provided the valuable and complementary perspective of policymaking and programme management at the central level. The three of us worked as a team and are jointly responsible for every word in the document.

This study was conceived by Professor Jeffrey Sachs, Chair of the Commission on Macroeconomics and Health, and he was instrumental in arranging the funding support from the Bill and Melinda Gates Foundation in record time. He has, all through, been the main inspiration for this work, and has guided it from time to time despite his many commitments. To Dr. Isher Ahluwalia, Director of ICRIER, goes the credit of giving concrete shape to his proposal and sponsoring the study by ICRIER. But for her sustained and ungrudging support, and that of all her colleagues at ICRIER, this Report could never have been completed on schedule.

Studying any health system is a highly complex task, and this is particularly true for a country as vast and diverse as India. Keeping this is mind, we commissioned background papers by reputed scholars and researchers. Despite the very tight schedule, all the contributors were very understanding of our requirements and compulsions. To all the contributors, we owe a debt of gratitude.

From the very beginning, we tried to make this a highly participatory exercise. Consultations were organized with researchers, representatives of the states, NGOs and public health experts – all of whom contributed valuable inputs. A steering committee was constituted with representation from relevant ministries/ departments of the central government, Planning Commission and multilateral agencies involved with health such as the WHO, the World Bank, UNDP, UNICEF and UNAIDS. The committee met regularly and provided valuable guidance to our work. It was the active support and cooperation of all agencies that enabled us to access relevant information and data.

Finally, the support and dedication of our staff, Jai Mansukhani, Anidya Ghosh and Prasanna Ash made it possible to complete the exercise in such a short time. In particular, the contribution of Jai Mansukhani deserves a special mention, as he worked tirelessly, with single-minded devotion, to type out the Report and incorporate the seemingly endless revisions of the drafts.

(Rajiv L. Misra)
Team Leader, India Health Study, ICRIER

New Delhi, August 16, 2001

List of Abbreviations

1. AP	:	Andhra Pradesh
2. HP	:	Himachal Pradesh
3. MP	:	Madhya Pradesh
4. NE	:	North Eastern
5. TN	:	Tamil Nadu
6. UP	:	Uttar Pradesh
7. Lakh	:	Hundred thousand
8. Crore	:	Ten million
9. *Dai*	:	Traditional Birth Attendant
10. Anganwadi	:	Village level worker in the nutritional and child welfare programmes
11. Panchayati Raj Institutions	:	Elected local bodies, (Panchayat for group of villages, Panchayat Samiti for around 1,00,000 population, and Zila Parishad for the district). These Institutions discharge many responsibilities for local self government and development in respect of rural areas

1. AIIMS	:	All India Institute of Medical Sciences
2. APAC	:	Aids Prevention and Control
3. CBHI	:	Central Bureau of Health Information
4. CDSCO	:	Central Drug Standard Control Organization
5. CIDA	:	Canadian International Development Agency
6. CMH	:	Commission for Macroeconomic Health
7. CSIR	:	Council of Scientific and Industrial Research
8. CSO	:	Central Statistical Organization
9. DCG	:	Drug Controller General
10. DCH&MO	:	District Chief Health and Medical Officer
11. DFID	:	Department for International Development
12. DGH&MS	:	Director General of Health and Medical Services
13. DGHS	:	Director General of Health Service
14. DSPRUD	:	Delhi Society for Promotion of Rational Use of Drugs
15. GOI	:	Government of India
16. ICMR	:	Indian Council for Medical Research
17. IICT	:	Indian Institute of Chemical Technology
18. IIHMR	:	Indian Institute of Health Management and Research
19. IIPS	:	Indian Institute of Popular Science
20. JICA	:	Japanese International Co-operative Agency
21. MHFW/MOHFW	:	Ministry of Health and Family Welfare
22. MLEC	:	Modified Leprosy Eradication Campaign
23. MRS	:	Medical Relief Societies
24. NACO	:	National AIDS Control Organization
25. NCAER	:	National Council for Applied Economic Research
26. NDA	:	National Drug Authority
27. NFHS	:	National Family Health Survey
28. NICD	:	National Institute od Communicable Diseases
29. NII	:	National Institute of Immunology
30. NIPFD	:	National Institute of Public Finance and Development
31. NMEP	:	National Malaria Eradication Programme
32. NPPA	:	National Pharmaceutical Pricing Authority
33. NSSO/NSS	:	National Sample Survey Organization
34. PSPU	:	Policy and Strategic Planning Unit
35. SIDA	:	Swedish International Development Association
36. SRS	:	Sample Registration System
37. TNSACS	:	Tamil Nadu State Aids Control Society
38. USFDA	:	United States Food and Drug Administration
39. VHAI	:	Voluntary Health Association of India

1. WHR	:	World Health Report
2. WDR	:	World Development Report

1. ANC	:	Antenatal Care
2. ANM	:	Auxiliary Nurse Midwife
3. APAC	:	Aids Prevention and Control
4. ARI	:	Acute Respiratory Infection
5. BIA	:	Benefit Incidence Analysis

6. BMI	:	Body Mass Index
7. BOD	:	Burden of Diseases
8. BPL	:	Below Poverty Line
9. CAM	:	Complementary Alternative Medicine
10. CBR	:	Child Birth Rate
11. CCIM	:	Central Council of Indian Medicine
12. CDR	:	Crude Death Rate
13. CGHS	:	Central Government Health Scheme
14. CHC	:	Community Health Centre
15. CHD	:	Coronary Heart Disease
16. CHW	:	Community Health Worker
17. CMR	:	Child Mortality Rate
18. CMS	:	Commercial Sex Worker
19. CVD	:	Cardiovascular Disease
20. DALYs	:	Disability Adjusted Life Years
21. DOTS	:	Directly Observed Treatment, Short-course
22. ECO	:	Emergency Obstetric Care
23. EDL	:	Essential Drug List
24. EMCP	:	Enhanced Malaria Control Programme
25. EOC	:	Emergency Obstetric Care
26. GBDS	:	Global Burden of Disease Study
27. GDI	:	Gender Development Index
28. HAART	:	Highly Active Anti-Retroviral Therapy
29. HDI	:	Human Development Index
30. HMO	:	Health Maintenance Organization
31. HPI	:	Human Poverty Index
32. IAVI	:	International Aids Vaccine Initiative
33. IDU	:	Intravenous Drug User
34. IFA	:	Iron and Folic Acid
35. IMR	:	Infant Mortality Rate
36. IOL	:	Intra Ocular Lenses
37. IP	:	Inpatient
38. ISM	:	Indian Systems of Medicine
39. LEB	:	Life Expectancy at Birth
40. MCH	:	Maternal and Child Health
41. MDT	:	Multi Drug Therapy
42. MMR	:	Maternal Mortality Rate
43. MPW	:	Multipurpose Health Worker
44. NAMP	:	National Anti – Malaria Programme
45. NCD	:	Non Communicable Disease
46. NCE	:	New Chemical Entity
47. NDDS	:	Novel Drug Delivery System
48. NHP	:	National Health Policy
49. NMHP	:	National Mental Health Programme
50. NMHP	:	National Mental Health Programme
51. NTP	:	National TB Programme
52. ODA	:	Official Development Assistance
53. OP	:	Outpatient
54. ORS	:	Oral Rehydration Salt
55. ORT	:	Oral Rehydration Therapy
56. PDS	:	Public Distribution System
57. Pf	:	P falciparum
58. PHC	:	Primary Health Centre
59. PPP	:	Public Private Partnership
60. QI	:	Quality Improvement
61. QOC	:	Quality of Care
62. RCH	:	Reproductive and Child Health Programme
63. RMP	:	Rural Medical Practitioners
64. RNTCP	:	Revised National TB Control Programme
65. RTI	:	Reproductive Tract Infection
66. SCC	:	Short Course Chemotherapy
67. STD	:	Sexually Transmitted Diseases
68. TBA	:	Traditional Birth Attendant
69. TFR	:	Total Fertility Rate
70. UIP	:	Universal Immunisation Programme

1. EME	:	Established Market Economies

2.	ESIS	:	Employees State Insurance Scheme
3.	IEC	:	Information, Education, Communication
4.	IPR	:	Intellectual Property Right
5.	MNC	:	Multinational Company
6.	PDS	:	Public Distribution System
7.	SC/ST	:	Scheduled Caste / Scheduled Tribe
8.	TOR	:	Terms of Reference
9.	TRIPS	:	Trade Related Aspects of Intellectual Property Rights

List of Tables, Figures and Annexes

Changing the Indian Health System: Current Issues, Future Directions
Executive Summary

This Report had as its starting point the terms of reference of the WHO-appointed Commission for Macroeconomics and Health (CMH). During the CMH meeting hosted by ICRIER in New Delhi in April 2000, detailed presentations made by four Indian states clearly brought out the diversity of socioeconomic conditions, health outcomes and approaches in different parts of the country. This diversity, together with the quality of research and data available, suggested that India could make a significant contribution to the CMH exercise. A team at ICRIER, led by Rajiv Misra, former Secretary Health, Government of India, prepared the Report with a view to making inputs into the CMH thinking and contribute to the ongoing debate on the National Health Policy. The Report thus evolved into a country-specific study with a focus on national issues relevant to Indian policymakers, while maintaining an international dimension that addresses the CMH terms of reference. The project was funded by the Bill and Melinda Gates Foundation.

I. Introduction

It is increasingly recognized that good health is an important contributor to productivity and economic growth, but it is, first and foremost, an end in itself. In a poor country like India, where the only asset most people have is their bodies, health assumes even greater significance for their economic status. Good health, and its natural corollary, defense against illness, is fundamental to every man and woman and child, not only for their well being, but for their very survival. If the State exists to safeguard the right of its citizens to the fundamental prerequisites of survival, this same State must own up to its responsibility to protect its citizens from illness and premature mortality.

The Indian State has articulated this responsibility often enough. Since Independence, the government, ostensibly driven by socialistic goals, has expressed its intentions to discharge this responsibility in one Five-Year Plan after the other. Ambitious systems, programmes and schemes have been drawn up to alleviate poverty while promoting the goal of universal healthcare, although the close linkages between the two have not been fully appreciated.

There have indeed been large gains in health status since Independence. Life expectancy has gone up from 36 years in 1951 to 62 years in 1995. Infant Mortality Rate is down from 146 in 1951 to 71 in 1997. Crude Birth Rate has been reduced from 36.9 in 1970 to 26.1 in 1998, and Crude Death Rate from 14.9 to 8.7 in the same period. One of the major reasons for these gains has been the development of an impressively vast, three-tiered system of rural health infrastructure, with sub-centres for each 5000 population, PHCs for each 30,000

population, and CHCs for each 1,00,000 population. Immunization to control communicable diseases has made a major contribution to these gains; success stories include small pox eradication, the near elimination of leprosy, and the extraordinary social mobilization for polio eradication. Improvements in determinants such as water supply and sanitation have also helped achieve outcomes. These aggregations, however, mask the wide differentials between and within states. The health indicators of Kerala are comparable to those of middle-income countries, while Uttar Pradesh, Madhya Pradesh and Orissa are almost at the level of Sub-Saharan Africa. There are huge disparities between urban and rural areas, and between developed and relatively remote areas inhabited by the marginalized sections of society.

Moreover, the figures regarding achievements present an impressive picture only when viewed in splendid isolation. First, a comparison of targets and goals dilutes the gains considerably. The National Health Policy 1983 set some targets for 1985, 1990 and 2000. A comparison of goals with actual achievements reveals the real picture: we are nowhere near targets, except for life expectancy Crude Death Rate and polio immunization. Second, while India seems to have performed better than countries with the same level of per capita income, such a comparison is obviously misleading. With its knowledge base, its administrative and institutional strengths, and its growth potential, India is capable of much higher levels of achievement.

It is clear that those health systems that direct their resources and energies towards the health needs of the poor have a better overall health status. This is a logical association, since the poor carry the larger burden of disease. But the facts make a mockery of such logic as they establish the raw deal the poor are getting from the public healthcare system. A recent NCAER study reveals that the richest 20% enjoy three times the share of public subsidy for health compared with the poorest quintile. The poorest 20% of Indians have more than double the mortality rates, fertility rates and undernutrition levels of the richest 20%. The poor suffer disproportionately more from pre-transition diseases such as malaria and TB. On an average, they spend 12% of their incomes on healthcare, as opposed to only 2% spent by the rich. Treatment or hospitalization for chronic illness often means the liquidation of meagre assets, even permanent indebtedness. One episode of hospitalization is enough to wipe out all the assets of the family. It is no wonder then that the number of the poor who did not seek treatment because of financial reasons increased from 15% to 24% in rural areas and doubled from 10% to 21% in urban areas in the decade 1986-96.

The obvious question then is Why? If the State has universal healthcare and poverty alleviation as basic objectives; if there have been gains, however patchy and inadequate; if there are systems in existence if not actually thriving, why is the current health scenario so bleak?

The obvious and most important reason is that for a State that promises universal healthcare through the public health system, India has one of the lowest health budgets in the world. How is the objective to be met if there are no

resources to put policy and schemes into actual practice? This gross mismatch between objectives and resources is at the heart of both the inadequacies and the inequities of the Indian health system. Higher public health expenditures are clearly and unequivocally associated with better health outcomes, and thus productivity, especially in a poor country. Any attempt at understanding the failures of the health system, and setting these derailed intentions and structures back on course, would involve, for a start, a much higher priority to the health sector. This higher priority will then have to be translated into increased allocation of resources. Otherwise financial risk protection for the poor, who are beset by illness as well as the threat of loss of work, will remain what it has been for the last several decades: pious declarations on paper.

The State's role in health has been so far from its declared intentions that not only has it failed to provide healthcare to the majority of the population through the public sector; it has also countenanced a large and thriving private sector to grow practically without regulation. In recent times, one point of view has offered the private sector as the panacea for all ills; another view perceives the private sector as a negative accompaniment to liberalization and links its growth with that of inequity. Neither view takes into account two facts: one, that in the context of a public health system that does not deliver services to those who need them, the private sector has grown to be the main provider of curative healthcare. It currently dominates both outpatient and inpatient care, and this evidence shows no significant variations by income group, rural/urban location, gender, caste or tribe. Two, the private sector is almost entirely unregulated so that its costs, its quality of care and its spatial distribution are for the large part incompatible with national health goals. It is not surprising then that the poor are forced into a situation where they have to pay for private healthcare they cannot afford. Their deprivation and vulnerability make the poor ill more easily; and illness makes them even poorer. There is no dearth of evidence that establishes this nexus. A recent analysis of the World Bank (*India – Raising the Sights: Better Health Systems for India's Poor*, May 2001) concludes that "the hospitalized Indian spends more than half of his total annual expenditures on buying healthcare; more than 40% of hospitalized people borrow money or sell assets to cover expenses and 35% fall below the poverty line." The same study also suggests that out-of-pocket medical costs alone may push 2.2% of the population below the poverty line in one year.

Given this context, the first task of policymakers is to define realistic goals and provide the necessary financial resources for their achievement. Besides, the lack of clarity on the relative roles of the centre and the states has caused the centre to focus on the day-to-day management of institutions and programmes, rather than concentrating on its stewardship role. The result is that even the meagre available resources have not been put to optimal use. Clearly, along with increased resources, the need of the hour is wide-ranging systemic reforms, both at the centre and the states. We believe that the reform process must begin with a thorough restructuring of the Ministry of Health and Family Welfare on the lines indicated in the Appendices of this Report.

II. The Current Health Scenario: Issues

1. Present Challenges

Communicable Diseases: One of the biggest blots in the current health scenario is the failure to control communicable diseases, despite the availability of cost-effective and relatively simple technologies. These pre-transition communicable and infectious diseases constitute a major cause of premature death in India: they kill over 2.5 million children below the age of five and an equal number of young adults every year. The proportion of total deaths caused by communicable diseases (including maternity related conditions and nutritional deficiencies) continues to be unacceptably high at 42%. (Of the 269 million disability-adjusted life years or DALYs lost, communicable diseases accounted for 50.3%.) Despite the global eradication of small pox, and despite expectations that current efforts will ensure the elimination of leprosy and polio within the next five years, environmental and social factors impose severe constraints on the control of two of the communicable diseases that pose a special threat – malaria and TB. The total number of TB patients is estimated at 15 million. Moreover, India has been identified as a hot spot for Multi Drug Resistant (MDR) TB, which is both difficult and expensive to treat. The resurgence of malaria and TB in forms difficult to control or treat, along with the exponential rate of development of HIV/AIDS, have imparted a new sense of urgency to disease control. Special projects have been launched for the control of communicable diseases such as malaria, TB and leprosy with the support of the World Bank and other donors, and they constitute an appropriate strategic response to the increasing threat. They have improved performance considerably through stable funding and programmatic reforms. However, except in the case of leprosy where the objective of elimination appears achievable, the coverage in other programmes is still low, and large uncovered areas have been receiving even less attention than before. These projects must cover the entire country, and central funding support must be extended to 100%, rather than matching 50:50 with the states, as in many cases at present. The sustainability of these special programmes once external assistance ceases also needs to be addressed.

- *TB:* India accounts for one-third of global TB, and the largest number of persons suffering from active TB in the world. According to available estimates, about 2.2 million persons are added each year to the existing load of about 15 million active TB cases. Of these new cases, about 800,000 are infectious, and about 450,000 die. Most disturbing is that 20% of 15 year olds are reportedly infected; and among women in the reproductive age group of 15-44 years, it causes more deaths than all the

various causes of maternal mortality put together. Added to this are the facts that every sputum positive case carries the potential to infect 10-15 individuals in a year, and that TB is the principal opportunistic infection of HIV. The result is the alarming possibility that deaths caused by TB can go up to 4 million in the next decade. At present, the DOTS strategy is implemented under the aegis of the RNTCP in about 200 districts, covering a population of 350 million. The programme is supported by about Rs.746.76 crores of external funding. The results of the RNTCP are impressive, but nevertheless the future scenario of TB control appears grim. First, only an estimated 20-25% of TB patients in the country have been brought under DOTS. The same familiar reasons crop up as barriers to further expansion and better performance : low budgets; weak institutional capacity; the dangers of MDR exacerbated by unregulated private practitioners following their disparate, sometimes irrational treatment regimes, as well as unplanned, unprepared and hasty expansion of the programme. Multiple systems of TB control – conventional, SCC and RNTCP – are all being implemented with different financing mechanisms. And as in other programmes, poor community support is a hindrance. In addition to all this, the future of TB control has to be viewed in light of the ominous fact that nearly two-thirds of opportunistic infection among AIDS patients is TB, portending a dual epidemic of TB and HIV in the near future.

- *Malaria:* The prevalence of malaria was brought down to about 2 million cases by 1984; but in 1994, once again, there were several focal outbreaks resulting in high mortality. The most dangerous strain of malaria, caused by the parasite Plasmodium falciparum (Pf), has been steadily rising to account for almost half of all malaria cases in 2001. As expected, the disadvantaged sections are the worst hit: in Andhra Pradesh, the rate of Pf malaria among tribal groups accounted for 75% of malarial deaths in the state.

Several reasons have been cited for the failure to reduce malarial prevalence: parasite resistance to drugs and vector resistance to insecticides in some high endemic areas, environmental changes caused by development activities such as irrigation projects, and rapid urbanization. A three-pronged strategy was drawn up, which is now being implemented throughout the country under the National Anti-Malaria Programme (NAMP). The main objective of the strategy is interrupting the transmission of disease by

- early detection and prompt treatment to reduce the reservoir of infection;
- reduction of the vector population through selected vector control using anti-adult and anti-larval measures;

- enhancement of community based action, such as undertaking bioenvironmental control measures and promoting personal prophylactic measures.

The effectiveness of these efforts is hampered by weak and often non-functional public health systems, non-availability of required manpower, inaccessibility of areas most effected (e.g. tribal areas), and poor community participation. The removal of these constraints is a major challenge for the programme.

- *Maternal and Child Health (MCH):* Children below five and women in the reproductive age group make up 36.2% of the population of India, and in terms of survival and well being, they also constitute the most vulnerable group in society. Income levels and social exclusion only serve to exacerbate this vulnerability: health indicators for SC and ST women and children reveal that they are considerably worse off. As in other aspects of the health sector, the database so essential for planning and setting of priorities is not reliable. But the estimates available show that the Maternal Mortality Rate (MMR) continues to remain at an unacceptable level – 408 for 1,00,000 live births. The causes for these poor indicators of maternal health are well documented: the low socioeconomic status of women, the undernourishment and anemia rampant among them, the low proportion of institutional deliveries, and the absence of trained birth attendants in as many as two-thirds of cases. Again, only a revamping of the primary healthcare system, along with effective referrals for complications, will help improve antenatal and maternity care. Simultaneously, a fundamental link – between high mortality on the one hand and high fertility and age at delivery on the other – must be addressed to get a handle on the problem of maternal survival and health.

  The poor status of maternal health is inextricably linked with the gender disparities that pervade all aspects of life in India. The results of the 2001 Census seem to indicate that the reported decline in the sex ratio during the last century has, at last, been not only arrested but also marginally reversed. But the sex ratio in the 0-6 age group has worsened, and this is cause for serious concern. Again, the tempo of decline in Infant Mortality Rate (IMR) and under-5 mortality achieved between 1981 and 1991 has not been sustained. The critical point is that IMR has been hovering around 72, and under-5 mortality around 95 per 1000 live births, during the last few years. The rate of decline has, during the last four years, reached a disturbing plateau.

- *Other Infections:* Linked with child survival and health is the range of water-related or soil-transmitted illnesses. Acute

diarrhea, worm infestations and digestive tract infections become illnesses to reckon with in view of their debilitating impact on the immunity system, particularly those of children and of those already undernourished. In addition to comprehensive health education – which would promote community hygiene and healthy living – India needs to make adequate investments in water supply, sewerage systems and sanitation to reduce the infectious disease load. Acute Respiratory Infections (ARI) continue to take a heavy toll, especially among children, despite the availability of inexpensive and effective anti-microbials, causing almost a million avoidable deaths every year. This again is due to a dysfunctional public health system and lack of access to quality primary and secondary care.

The threat of communicable diseases, as well as perinatal morbidity and mortality, looms larger because of the poor nutritional status of a substantial part of the population. Despite a nationwide programme for nutritional supplementation of pregnant women and children, NFHS II (1998-99) shows only a slight improvement over NFHS I (1992-93). The percentage of underweight children has only reduced from 52% to 47%, and of the severely underweight from 20% to 18%. 74% of children were found to be anemic; the same study found that 52% women have some anemia, which is a major cause of maternal mortality.

The present challenges of communicable diseases and maternal and child survival show up the weaknesses of the health system. But even as the system struggles to meet the current demands of disease control, a new challenge, again a communicable disease, is emerging in the form of HIV/AIDS, threatening to sharpen existing problems of resources, health infrastructure and inequities.

2. Emerging Challenges

HIV/AIDS: The threat presented by the rapidly growing HIV/AIDS infection has not received the priority attention that it deserves, partly because of the long gestation period between HIV infection and the development of full-blown AIDS. Also, it is the opportunistic infections (such as TB) that get noticed; the root cause of morbidity and mortality often remains undiagnosed. The major route of transmission in India is sexual contact, but sex as a subject is weighed down with taboos in a traditional society. The high prevalence of STDs in India also makes the country particularly vulnerable to the AIDS threat. In the year 2000, the number of Indians infected with HIV was estimated at 3.86 million, or roughly a prevalence rate of 0.7%, quite low when compared to the prevalence rates of 25% and over in South Africa, Zimbabwe and Botswana. But the infection in India is no longer confined to high-risk groups or

only to urban areas and it is spreading rapidly. And since the epidemic is more than a decade old, mortality due to AIDS is increasing: in 1999 alone, nearly 300,000 Indians are estimated to have died of AIDS. As of March 2000, 11,251 cases have been reported to NACO: 79% are males, 21% female. This is, however, only a fraction of AIDS morbidity in the country, reflecting the stigma and the ignorance surrounding the infection. Widespread discrimination against the infected hinders their access to healthcare. Similarly, the low income levels of the infected, coupled with lack of resources in the government funded programme – despite the manufacture and availability of the drugs in India at more affordable prices – preclude the widespread use of highly active anti-retroviral therapy (HAART). As a result, morbidity and mortality of those infected continues to be high.

The most important contribution of the National AIDS Control Programme (NACO) has been sentinel surveillance; it has also heightened awareness regarding blood safety. The Programme has now begun its second phase, which is to focus on targeted interventions among high-risk behaviour groups. But awareness levels are still low or uneven; information, education and communication (IEC) remain a crucial element. If India is to avoid the catastrophe that Africa is struggling with, far greater efforts will have to be made to keep the epidemic at bay. Fortunately, we have a model in the state of Tamilnadu, which has successfully arrested the increase in the level of infection by concentrating on high-risk segments of the population, and by devising innovative mechanisms for programme implementation. India must act immediately and vigorously to control the level of HIV infection so that it does not grow beyond 3% of the population.

3. Future Challenges

As if present and emerging problems do not present enough of a challenge to a resource-hungry and weak health system, there are also the challenges of the future for which provisions must be made. Projections of population increase indicate a changing demographic profile with profound implications for health planners and economists. The next two decades will see a significant increase in the 15-59 age group; the increase in longevity will almost double the population of the elderly (> 60 years). As more individuals survive to middle age, the years of exposure to the risk factors of chronic disease increase. Non-communicable diseases (NCDs) will gradually become the dominant contributors to the burden of disease – their share increasing from an estimated 33% in 1998 to 57% in 2020. In fact, even at the present stage of health transition, India contributes substantially to the global burden of NCDs. In 1990, India accounted for 19% of all deaths, 16% of all NCD deaths and 17% of all CVD

deaths in the world. CVD in India alone accounted for around 2.4 million deaths, in contrast to nearly 3.2 million CVD deaths in all the industrialized countries put together. In addition, recent evidence suggests that impaired fetal nutrition, reflected in small birth size, results in programmed susceptibility to adult cardiovascular disease, diabetes and some cancers. With NCDs positioned as a major public health challenge, the existing health systems will need to be reorganized and reoriented to deliver the expanded mandate of healthcare – involving the prevention, surveillance and management of chronic diseases along with primary and secondary healthcare. The emerging burden of NCDs poses a special threat to the poor due to the often prolonged and expensive treatment required for these conditions, as well as much greater exposure to risk factors like tobacco and alcohol.

The management of NCDs is often technology-intensive and expensive. Individual as well as societal resources are already being drained at a disproportionately high level by the tertiary care management of NCD, drawing scarce resources away from the unfinished agenda of infectious disease and maternal and child health. Though NCD epidemics usually originate in the upper socioeconomic strata, they diffuse across the social spectrum, with the social gradient ultimately reversing and the poor becoming the most afflicted.

The exorbitant costs of treating chronic diseases make prevention the most suitable option for India. Traditionally, public health approaches to NCD control has consisted of a high-risk strategy, targeting those with high levels of risk factors and employing interventions to reduce them, usually with drugs; and a population strategy that attempts to reduce risk factor levels in the whole community, usually through lifestyle-related measures. Along with these approaches, effective low-cost case-management strategies are required for those who manifest disease. Such technologies are available, but they await widespread dissemination and application. Tobacco control is a major public health imperative providing the largest benefit for NCD prevention. Tobacco-related cancers, CVD and chronic obstructive airway disease can be effectively prevented if the tobacco habit is discouraged and overcome among the population. At present, programmes for NCD control are either non-existent or functioning at a low level in India. The National Cancer Control Programme involves cancer registries at selected sites and strengthening of facilities for clinical care (such as radiotherapy). Pilot studies for the control of CVD and diabetes have been initiated but have not had an impact on policy and programme development. Tobacco control has received greater attention, but it still awaits the passage of proposed legislation as well as a vigorous public education campaign.

Taken together, what do the present, emerging and future challenges imply? To begin with, they call for the high-priority control of communicable diseases to avoid the double burden of communicable and non-communicable diseases. They call for appropriate public health interventions to control the risk factors of NCDs such as tobacco and unhealthy lifestyles, emphasize preventive strategies, and set up arrangements for the early detection and cost-effective treatment of NCDs at the primary and secondary levels.

4. Finance

The recurring refrain in any discussion of the Indian health system is finance, a refrain that grows more shrill and urgent because of policy failures and State neglect. The crux of the problem is abysmally low public health expenditure – around 0.9% of GDP, below the average of low-income countries and even Sub-Saharan Africa. Despite the increasing urgency of problems in the health sector, public health expenditure as a proportion of total government expenditure has in fact *declined* over the years. This has to be seen against a background of fiscal deficits: the combined fiscal deficits of the centre and the states are estimated at 10% of GDP. Following a temporary stabilization in the early nineties, the fiscal situation has deteriorated, so that government ability to increase investments in health has been eroded further. Since the states typically account for about 75% of public health expenditure, their financial health is crucial for both general development and specific health outlays. But the combined gross fiscal deficits of the states, which ranged between 2.4-2.9% between 1993-94 and 1997-98, increased to 4.2% in 1998-99 and to 4.9% in 1999-2000. Fiscal crises have meant sharp reductions in the non-salary recurring expenditure in public health facilities, leading to further deterioration of quality. In addition, the increase in salary and pension liabilities after the Fifth Pay Commission has aggravated the resource crunch.

The share of health expenditure in the major states, in the range of 6-7% up to the 1980s, has come down to just over 5% in the 1990s. This is a significant decline in the proportion of health expenditure to the total expenditure in the states in over two decades. As far as the real per capita public spending on health is concerned, the evidence of 11 states at 1980-81 constant prices shows a steady increase, though in varying degrees. The sole exception is Uttar Pradesh, the most populous state; the declining per capita public spending in this state with very poor health outcomes is indeed a disturbing trend. Moreover, trends of the real per capita public spending on health of selected major states, and their distribution among primary, secondary and tertiary healthcare, show that between the period 1985-86 and 1998-99, per capita public spending increased at the

primary and secondary levels by about 50%, while spending levels increased by more than 100% in the tertiary sector. This has grave implications for both the equity and efficiency of the health system.

The declared policy was for the State to provide free universal healthcare to the entire population, but this policy objective has been totally divorced from the reality on the ground. In fact, India has one of the highest levels of private financing (87%), with out-of-pocket expenses estimated to be as high as 84.6%. The highly skewed pattern of health finance in India is a major contributor to the perpetuation of poverty. Indeed, the greatest failure of the Indian health system is its inability to develop a financing mechanism for the healthcare of the poor. It is clear then that the foremost objective of the Indian health finance system is financial risk protection for the poorer and weaker sections of the population. Access to health services should depend on individual need, not on ability to pay. The most efficient way of providing financial protection is to pool the risk between the rich and the poor, the young and the old, and the employed and the unemployed, to enable cross subsidization. At the international level, the main instrument used to achieve this objective is health insurance, but this has remained relatively undeveloped in India.

That there is a strong case for increasing the share of health in resource allocation is by now self-evident. But the extent to which tax revenues can be reallocated to the health sector would depend not only on political will, but also on the fiscal situation. In a poor country with a low tax base, mounting debt liabilities, undeniable security concerns and a legacy of poorly targeted subsidies, we cannot rest content with merely advocating reallocation of resources for larger investment in health. Generally speaking, the available tax resources should be used primarily for provision of public goods, the healthcare of the poor – particularly those in the informal sector outside the reach of insurance mechanisms, and for community financing. To the extent possible, resources should be raised from dedicated sources to eliminate competition, and to provide stable and growing sources of revenue. At the same time, there must be improvement in the targeting of public subsidies towards the healthcare of the poor. This implies taking three steps:

- Increase allocation for public health and primary and secondary healthcare, which is better utilized by low-income families.
- Utilize user fees at secondary and tertiary levels to reduce the price advantage of public services, reducing their attractiveness to the well off and simultaneously making arrangements for exemptions of the poor.
- Improve the efficiency of public services to encourage their greater utilization.

Various options for different categories of the population in different income groups need to be considered in the course of developing a framework. As far as the rich are concerned, voluntary private health insurance deserves government encouragement, but there is no justification for public subsidies such as the recent tax concessions. Increased competition would automatically spread the coverage of voluntary health insurance, leading to improved products and services. The State's role is essentially to develop an appropriate legislative framework, and to appoint a dedicated and independent regulatory authority that will monitor the insurance sector, and formulate procedures and regulations to help avoid well-documented market failures. But even in the absence of voluntary health insurance, the rich, given their financial resilience, could continue to depend on out-of-pocket expenses.

The objective for the middle income section is to cover all the employees in the formal sector via social insurance, primarily financed by employer and employee contributions. State participation should at best be nominal. People in the informal sector could join either voluntary health insurance schemes or community finance schemes wherever feasible. If none of these options is chosen, they could continue to rely on out-of-pocket expenses.

Schemes such as ESIS, CGHS, and employer-based schemes already cover the low-income formal sector, though ESIS and CGHS have demonstrated deficiencies of coverage and quality, as well as high administrative costs. These schemes could be replaced by social insurance, with the government playing facilitator and financier, but not necessarily provider of services. The services for social insurance could be contracted out; this would enhance efficiency and reduce costs. The manufacturing and services sector would grow with economic growth and industrialization, so that social insurance could play an increasingly important role. At present, approximately 10% of the population are covered by social insurance and employer-based schemes: this can be increased to around 21% of households, including all income groups, wherever social insurance is feasible.

An estimated 46.6% of the poor population is in the informal sector, and they deserve maximum State assistance since they are beyond the reach of social insurance. The preferred option is Community Financing Schemes. However, such schemes require strong local leadership and organizational capabilities, often provided by NGOs. Most current schemes do not receive any government support, but state governments could design a package of incentives that will encourage NGOs to develop such schemes in designated areas, with the government contributing a fixed premium for every below-

- Timely release of funds allowing advance preparatory action for procurement against the next year's allocation.
- Sufficient provision for maintenance of facilities created for the project.
- Identification, training and positioning of the project team before the project begins, and not shifting them during the project period.
- At least one year's preparatory time for all major projects to complete formalities such as land acquisition, preparation of building plans, finalization of technical specifications and development of training modules.
- Improvement of monitoring mechanisms.
- Simplification of procurement procedures, avoiding multiple references to, and approvals from, donor agencies.

Other ideas from our study on EAPs

Tax on Tobacco: This tax has two main components -- the basic excise duty, a central levy; and additional excise duty in lieu of sales tax, which is levied and collected by the central government on behalf of the states. This is a buoyant source of revenue with a mechanism already in place for the imposition of a cess. The linkage between tobacco and disease is well established, and taxation serves the dual purpose of reducing consumption and yielding resources. There is a strong case for dedicating at least part of the revenue to preventive and promotive health, particularly to controlling the risk factors for NCDs. Even a 15% cess could contribute at least Rs.1,000 crores to the health sector without disturbing existing sources of revenue.

Revenues from Disinvestment: The government's ambitious programme of disinvestment in public sector enterprises has had a slow start because of political pressures, resistance from trade unions and procedural difficulties. But the establishment of a separate ministry for disinvestment, and the successful privatization of BALCO despite political opposition, augurs well for rapid progress. The Budget for 2001-02 set a target of Rs.12,000 crores from this source. Out of this Rs.7,000 crores is earmarked for restructuring public sector enterprises, and the balance of Rs.5,000 crores for investment in infrastructure and social sectors. Although infrastructure is a high priority, there are many other sources to support it, including the cess on petroleum products and private investment. It is in this context that we urge earmarking at least Rs.2,000 crores annually from disinvestment revenue for additional investment in the health sector.

State Levies:

Levy on Excise: The rationale behind a dedicated levy on tobacco for health applies equally to a cess on state excise duties, which predominantly relate to taxes on alcohol consumption. Again, this is a buoyant source of revenue with an annual yield of about 15,000

poverty-line (BPL) family covered by such schemes. Also, all donations to genuine community finance organizations should be exempted from tax. But most of the population would still need health cover by the State, calling for a more efficient primary and secondary healthcare system with a strong referral link. Moreover, even community financing schemes and access to public primary and secondary facilities do not provide financial risk protection to the poor against costs of hospitalization and serious illness. This requires the setting up of Sickness Funds in each district to directly reimburse such costs to the public or designated private facility. On current estimates, a fund to .cover an approximate 300 million BPL population would require Rs.2,500 to Rs.4,000 crores annually.

The total health spending in 1998-99 is estimated at Rs.161 billion or Rs.16100 crores. This means the level of public investment will have to be more than doubled to reach the average of lower middle-income countries, or 2.2% of GDP. The strategy is to develop dedicated levies that provide a sustained source of finance to strengthen the health sector and insulate it, at least partially, from fiscal crises, emergencies and political upheavals.

Central Level:

Reallocation from General Revenues: Considering the tight fiscal position and the competing claims of different sectors, diverting significant resources from other sectors to health does not seem feasible. But a 50% increase, or roughly an additional Rs.2000 crores, can be made available -- partly from General Revenues and partly by reallocation from other programmes that have failed to make the desired impact.

nor health Which ones?

Increased External Assistance: From 1990 to 1995, the average disbursement of external assistance to the health sector has been 216 million dollars or Rs.1000 crores – around Rs.10 per capita. Considering the Indian context – population size, levels of income and the burden of disease – the quantum of this assistance is woefully inadequate. But despite this, external assistance has played a key role in directing resources to priority areas. Meanwhile, in view of a better absorptive capacity, it would not be unrealistic to expect assistance to increase to at least three times in the coming years. The resulting yield would mean an additional Rs.2000 crores a year.

who sets priority?

The performance of externally aided schemes could be greatly enhanced by reforms at both donor and recipient levels:

- Better project preparations involving full consultation with all stakeholders.

crores -- and a 33% surcharge on existing excise revenue could yield 5,000 crores annually.

Property Taxes: There are three categories of property-related taxes. The first one, registration and stamps, is a tax on transfer of property, and yields an annual Rs.10,000 crores. A 20% surcharge could yield 2,000 crores annually. The second source is urban property tax, collected by local bodies. The estimated income, based on 1997-98 per capita estimates, works out to around 2,300 crores. This is a rapidly growing source and the present yield would exceed 2,700 crores. A 33% cess could provide Rs.900 crores per year for Sickness Funds and other healthcare services for the urban poor. The third source is land revenue, which yields around 1,500 crores a year; a 33% surcharge could yield 500 crores a year. Property taxes are currently both low and progressive, and could make a significant contribution towards the new mechanism of Sickness Funds. These funds could be created by a suitable cess on both rural and urban property as well as on their transfers, so that it takes into account both equity considerations and ease of administration and collection. The collections could be pooled state-wise, then allocated to district-level societies proportionate to the number of BPL families. The identified BPL family member would be given free treatment in public facilities and designated private facilities, and the costs charged directly to the Fund. These sources of earmarked levies could yield around 3,500 crores a year, sufficient to support Sickness Funds.

User Fees: This levy cannot be perceived only as a revenue raising mechanism. It discourages the overuse of public facilities by the affluent while correcting some distortions in the use of public facilities. Revenues generated from this source can be used to improve quality of care, in turn improving the utilization of these facilities. User fees can also involve the local community in managing public healthcare facilities, so that a sense of participation and ownership is fostered. The present yield from this source is small, but it is capable of considerable expansion, as indicated by new initiatives in MP and Rajasthan. There are, however, hurdles to a major expansion, and these include the lack of appropriate mechanisms to review user charges; the minimal level of cost recovery caused by low fee structure; the absence of mechanisms to exempt the poor; and the lack of adequate arrangements to ensure fund utilization at the point of collection. But again, recent state initiatives provide lessons that can be applied to overcome these weaknesses:

- The income from user fees should be credited to a hospital-based fund managed at the local level with the authority to review the charges.

- The income from user fees should be additional to the budget allocations for the medical facility.
- Use of the fund should be exclusively for improvements in the relevant medical facility by the local fund management committee, in accordance with state government guidelines.
- All BPL families should have identification cards to secure automatic exemption. Mechanisms should also be in place to consider the exemption of other indigent families at the discretion of the local committee.

In sum, while resources must be mobilized to change the health system through measures such as dedicated taxes, particularly property taxes, the critical guideline for mobilization is that the resources must be stable as well as sustainable. Since the object of the entire exercise is to provide financial risk protection, insurance as a mechanism must be promoted wherever feasible. So should community finance, which calls, however, for strong leadership from NGOs and local bodies. What happens then to those who do not have access to insurance or community finance schemes? It is for these weaker and disadvantaged sections that mechanisms such as Sickness Funds are necessary; and most of all, an improved primary and secondary health system that delivers care to those who need it most.

5. Health Systems

A. Public:

Our vast rural health infrastructure received substantial financial support during the 1980s, or the Sixth and Seventh Five Year Plan periods. But this substantial investment has not yielded optimal benefits: many institutions are not fully functional as a result of staff shortage and the lack of drugs and consumables. One of the major and persistent causes of a malfunctioning healthcare infrastructure in the rural areas is a critical shortage of key health manpower, particularly of doctors in public facilities. This is partly due to inadequate incentives and poor working conditions, and partly because the posting of doctors in rural areas suffers from a lack of transparency. The result is that the under-served areas, where even private sector facilities are not available, are completely deprived of any healthcare facilities.

The non-availability of key personnel in public health facilities is often cited as the main reason for under-utilization of public health facilities. But an analysis of manpower shortage at the primary level suggests that more than shortfalls of personnel, it is the organization and management of existing human resources that is the key to better performance. The lesson is clear: efficiency in the use of

existing resources should take precedence over mobilizing additional resources.

The deteriorating environment, the lack of safe drinking water and poor nutritional status, all conditions that affect disease burden and health outcomes, are poverty-related. These health hazards threaten the growing slum population in cities – as much as 30-50% of the total urban population. But in the absence of functioning institutional mechanisms, it is difficult to put the required coordinated and integrated action into practice. Divisions within the MHFW have also aggravated compartmentalization. The Ministry is now divided into three independent departments of health, family welfare and ISM. Since population control was considered a priority, an independent department of family planning was created even though public health and family planning services had to be delivered through the common rural health infrastructure. The emphasis on family planning targets transferred the entire rural health portfolio to that department, divorcing it from other health programmes. The result was poor utilization; the PHC, in many states, was in the public eye, only a family planning facility.

An analysis of disparities in health outcomes shows that certain states in India have consistently worse health outcomes. A cross-sectional regression analysis was carried out for 25 states to assess whether differentials in health service delivery capacity have a significant association with health outcomes. The analysis was based on three independent variables, namely female literacy, immunizations and use of ORT therapy in diarrhea episodes. Since MCH preventive services are mostly delivered in the public sector, it was concluded that public sector capacity is considered a relevant and critical determinant of health outcomes. Jean Dreze and Haris Gazdar advance the same hypothesis in an analysis of development experiences in Uttar Pradesh, Kerala and the southern states. The authors argue that the relevant determinant of the development status of these states is the reach and functioning of public services, and support this argument with a comparative picture of select public services. This reinforces our hypothesis that public health sector capacity in terms of provisioning of services is a critical determinant for improved health outcomes.

That access to health services is a key mechanism for better health outcomes is also indicated by utilization data: states that have high utilization rates reveal lower mortality rates. NSS data shows that the percentage of people who did not access healthcare for reasons of location is higher in the poor performing states. The analysis indicates a strong association between health outcomes and equity in the public financing of healthcare. Health outcomes appear to be strongly associated with higher per capita public health spending,

and with higher allocations to the secondary sector. Scarce financial resources are being inefficiently used, not only in terms of allocative patterns, but also in the management of fund flow and monitoring. Several of the problems confronting public health service delivery call for the reorganization and better management of existing resources. Access to healthcare is hindered not only by geographic, social and cost barriers, but also by inherent systemic and structural weaknesses of the public healthcare system:

- compartmentalized structures and inadequate definition of roles at all levels of care; inefficient distribution, use and management of human resources so that people have to contend with lack of key personnel, unmotivated staff, absenteeism, long waiting times, inconvenient clinic hours/outreach, service times, unauthorized patient charging;
- inadequate planning, management and monitoring of services/facilities; displaying insensitivity to local/community needs; ineffective or non-existent referral systems, resulting in under-utilization of PHCs, over-utilization of hospital services, duplication of services and cost-ineffective provision of services; inadequate systems to enforce accountability and assure quality;
- inefficient systems for purchasing drugs, supplies and services, which fail to ensure quality and value for money;
- inadequate attention to health education and public disclosure.

Setting priorities in health sector policy and planning is a matter of intense debate. International opinion emphasizes the bias in favour of hospital care and the need to reform health systems in favour of primary care. Our analyses suggest that the state must focus on both primary and secondary sectors simultaneously, linked as they are for the delivery of basic health services. The focus on secondary care in the context of referral linkages with the primary sector, and the welfare objective of insuring the poor against costs of illness, is considered as essential as the focus on primary care. Most important is reforming administrative structures to integrate primary and secondary levels through administrative and technical controls at the referral hospital level.

The capacity of the public health system to monitor morbidity, and to respond to changes in disease patterns, is greatly hampered by the lack of reliable epidemiological data. The current reporting systems are confined only to public facilities that deal with barely one-fifth of the illness episodes. Hence the huge under reporting, generating a sense of complacency. The model developed by the Christian Medical College, Vellore, and implemented in Kottayam District, Kerala, needs to be replicated as soon as possible all over the country to improve the quality of epidemiological data.

Another important area that has suffered neglect is public health as a discipline. Even the highest technical positions in public health, whether at central or state level, do not require a public health background; specialized institutions as well as faculties of Preventive and Social (Community) Medicine remain in an equally sad state of neglect. Unless public health as a field gets the recognition and importance it deserves, the planning of health systems will continue to over-emphasize curative services.

The foremost problem in designing an efficient health system is the top-down approach with negligible community participation and ownership. Is it possible, for instance, to conceive of bioenvironmental control of vectors, or improvement in sanitation and hygiene, without the active participation of the people making up the community? Similarly, the monitoring and supervision of peripheral health services from state and district headquarters has invariably failed, underscoring the need for active local involvement.

One of the ways to address this deficiency is decentralization of authority to local bodies (Panchayati Raj institutions). But the fact is that decentralization could have conflicting results without sufficient preparation of local bodies to take on this expanded role. The Kerala experience indicates that decentralization has to be preceded by a long period of planning, defining and clarifying responsibilities, capacity building and advocacy. Capacity building of local bodies as well as the community is an essential prerequisite to reap the full benefits of decentralization. It is evident that such devolution encourages local bodies to consider health as integral to other development activities, facilitating coordinated action on other determinants of health such as water and sanitation.

The states provide several examples linking the issue of community participation with institutional autonomy and delegation of powers to local committees to raise and use resources for improvements in medical facilities. The experiences of Madhya Pradesh and Rajasthan, for instance, show a marked improvement in the quality of services, availability of drugs and consumables as well as patient satisfaction. These are welcome initiatives; but they are yet to be converted into a comprehensive policy to secure community participation in all health programmes.

B. Private:

Without in any way underestimating the importance of the public health system, it must be recognized that the private sector has grown to be the main provider of curative healthcare. At the all-India level, the private sector currently dominates both outpatient and inpatient care: 82% of all outpatient visits take place in the private

sector. An important dimension to the utilization of in-patient care in the public and private health sector is the share between the rich and the poor. Overall for India, the percentage of the poorest quintile using private sector hospitalization facilities is, at 39%, almost half that of the richest at 77%. Tertiary care institutions, providing specialized and super-specialized care in the private sector, constitute only 1-2% of the total number of private institutions; and corporate hospitals, which have in recent times gained in visibility and publicity, actually constitute less than 1%.

The evidence is that the people of India, including the poor, make considerable use of the private health sector. But at what cost? This is a crucial dimension of the private health sector in India, unfortunately under-researched. NSS data reveals that the average cost of treatment in the private sector for rural inpatients is 2.1 times higher, and for urban inpatients 2.4 times higher, than in the public sector during 1995-96. Technology advances are usually associated with a decrease in costs, but the reverse holds true for the medical sector, where technological developments have been capital-intensive, making the provision of healthcare increasingly expensive. A proliferation of medical equipment and technologies in urban areas has led to excess capacities, and the consequent unnecessary and irrational use of these technologies.

In sum, rather than private providers developing into partners with the State in the achievement of national health goals, the technical quality of care provided in the private sector is often poor – ranging from poor infrastructure to inappropriate and unethical treatment practices, to over-provision of services and exorbitant costs, to delivery by unqualified providers. Information asymmetry among users, arising out of a lack of information and an inability to make sound judgements about available types of healthcare, compounds the problem. The natural corollary to the concentration of qualified practitioners and facilities in urban areas, and the limited spread of the voluntary sector, has been the rise of unqualified, rural medical practitioners. The estimated one million illegal practitioners are said to be managing 50-70% of primary consultations, mostly for minor illnesses, and, in this sense, form the *de facto* primary curative healthcare system of rural India. A clear policy promoting private health facilities in the under-served areas, along with a set of clearly defined incentives, would correct these imbalances.

Given the extent of private sector dominance in the healthcare system, any significant improvement in healthcare is inconceivable without the active involvement and cooperation of the private sector, particularly the voluntary sector. According to a rough estimate, the number of voluntary organizations working in healthcare areas is more than 7000. Despite the lack of comprehensive documentation

on the contribution of NGOs, there is no disputing the fact that NGOs have the potential to improve access, quality and equity of services, either through direct provision or through advocacy and other action. This potential to contribute substantially to public health goals has not been realized due to several reasons. Their limited size and spatial distribution is a major cause. That they are missing where they are most needed hinders effective partnerships with the public health system. The challenge is to find strategies that will facilitate a far more substantial participation by NGOs in the health sector, particularly in backward states and remote areas, and to ensure systems that will keep such participation accountable and transparent.

Public-private partnership would make a considerable contribution to the successful implementation of public health programmes. Also necessary are continuing medical education, and the active involvement of professional bodies – to disseminate standard treatment protocols for diseases such as TB and malaria, to check the irrational use of drugs, and to regulate unethical practices.

Equally important is the task of developing appropriate independent mechanisms for the regulation of the private sector – mechanisms that involve all stakeholders, set up and enforce standards, ensure quality control, transparency of charges, control unethical practices and promote accreditation systems. The challenge is to devise innovative mechanisms that address the acknowledged distortions and malpractices, yet do not stifle private initiative – so important for the expansion of healthcare facilities to meet growing demand. The legislations under consideration in Andhra Pradesh and Karnataka, and the initiative taken by Maharashtra in developing accreditation mechanisms, deserve commendation.

Anti Quackery Bill?

Finally, each state needs to work out the problem of unqualified practitioners with a view to their eventual elimination. The ban could be enforced straightaway in well-served areas; in the under-served areas, they will be gradually eliminated as alternative facilities get established. In the interim, the registration and training of such practitioners, limiting the scope of their use of allopathic drugs for treating minor ailments, needs to be attempted as a temporary measure.

6. Drug Policy and Regulations

The Indian pharmaceutical industry is already feeling the impact of globalization, even though the WTO mandated legislation to recognize product patents is to be brought into force only in the year 2005. The agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) came into force with the formation of the

World Trade Organization (WTO) in January 1995. TRIPS obliges all developing countries to make available 20 year patent protection for novel, non-obvious and useful inventions, whether products or processes, in all fields of technology including pharmaceuticals. Violations of TRIPS obligations can lead to trade retaliation or compensation to affected WTO members. India has so far recognized only process patents in pharmaceuticals, and legislation for compliance with WTO obligations is pending passage in Parliament. As of December 1999, only 16 WTO countries, including India, continued to exclude pharmaceuticals from product patent protection. India has no option but to fall in line; but the government should actively explore ways in which the advantages of the new regime can be maximized and the disadvantages minimized.

The public policy question will have to be resolved in such a way that a balance is maintained between the need to keep new drugs affordable to those who need them, while retaining strong incentives for the invention of new drugs and the development of new and better treatments. The selective use of compulsory licensing provisions for the manufacture of generic substitutes for patented drugs having major public health significance has to be explored with international cooperation. So far, the Indian pharmaceutical industry has paid scant attention to research because of the absence of product patent protection, and concentrated its energies on producing generic substitutes for foreign patented and branded products. But the Intellectual Property Rights Regime (IPR) is set to change with the introduction of product patents in conformity with WTO mandated regulations. The Indian pharmaceutical industry already commands a major advantage over its rivals in the West since the cost of bringing a new chemical entity into the market is estimated at $250-500 million in the US, but only $90-100 million in India. According to a recent study by the Administrative Staff College of India (*The Indian Pharmaceutical Industry*, May 2000), "India has the potential to become the hub of pharmaceutical research." In order to harness the resources and skills of the Indian pharmaceutical industry towards the neglected diseases of the poor, the government needs to develop an appropriate incentive framework.

At present, the administration of drugs and pharmaceuticals is divided between the Ministry of Chemicals and Fertilizers (MCF) that is responsible for drug policy; and the Ministry of Health and Family Welfare (MHFW) that sets standards and deals with quality control, the introduction of new drugs and the enforcement of relevant laws and regulations. This arrangement prevents the government from taking a holistic view that includes the interests of both the industry and the consumer. Often, the policy of one ministry is at cross-purposes with that of the other. As early as 1975, the J. L. Hathi

Committee recognized this dichotomy and suggested that an independent National Drug Agency be set up to take over all the drug-related functions performed by the two Ministries. The proposed NDA could be supported by a small cess on the manufacture and import of pharmaceuticals, conveniently collected along with excise and customs duties. Significant public sector support would be necessary to motivate the pharmaceutical industry to invest in R&D in diseases of the poor such as TB and malaria, and the proposed National Drug Fund could provide one such avenue of support. The current situation is unlikely to improve merely by tinkering with the existing system. The only option that would make a noticeable difference is an independent National Drug Authority, supported by adequate financial resources from the National Drug Fund.

Elsewhere in the Report, we have recommended greater decentralization and devolution of powers to the states. However, the indiscriminate licensing of drugs by the states, the poor enforcement of quality standards, and the open violation of laws regarding sale of prescription of drugs, compels us to suggest an enlarged role for the central authority. The proposed NDA, armed by a new law that provides for more stringent scrutiny before licensing, could weed out irrational combinations and ensure stricter enforcement. The National Drug Fund should be used primarily to support the NDA, upgrade public health laboratories, and strengthen the enforcement machinery. The unauthorized and irrational use of anti-microbials by unqualified practitioners and registered practitioners of other systems of medicine, a situation encouraged by the free sale of prescription drugs across the counter, has been a major factor in the development of drug-resistant bacteria. Similarly, the proliferation of over 20,000 manufacturers without the requisite infrastructure to monitor GMP, and the large-scale manufacture and sale of sub-standard and spurious drugs. pose a major health hazard. Only stringent laws that are effectively enforced can check these problems.

7. Health Research

India has great potential and unique capabilities in health research. Its acknowledged strengths in all knowledge-based activities, its infrastructure and trained manpower, its vast clinical material, rich bio-diversity, unparalleled heritage of traditional systems of medicine and a dynamic and technologically capable pharmaceutical industry all add up to this potential. But only a national health research policy that creates an incentive environment for both public and private sectors will help the country realize this potential to the fullest. Timely enactment of IPR related legislation would bring the present phase of uncertainty to an end. Next, a substantial increase of public investment in basic and strategic research is required, with a specific

focus on the neglected diseases of the poor. The international support for health research has so far been nominal – the estimate is 5% of the total health R&D expenditure in 1992-93. Indian potential in this area justifies a major increase in external assistance. A priority should be health policy and systems research, to date a neglected area except for the recent interest shown by the World Bank and some bilateral donors.

The lack of available expertise in disciplines such as health economics, health finance and epidemiology is a major constraint on health policy and systems research, and special efforts need to be made to train researchers in these fields. Research capacity should be strengthened – with the improvement of infrastructure, the training of scientists, and through new collaborations with institutions in the North and the South. In particular, capacity needs to be developed quickly to undertake clinical trials for new molecules likely to be introduced for the various communicable diseases. Existing public sector institutions could produce higher quality of research with more appropriate management structures. Most important, for both public and private sectors, is a network of alliances among academia, research institutions and industry. The utilization of basic and strategic research outputs by industry to take the process further toward product development should be the goal of such an alliance. The ICMR should develop suitable mechanisms to facilitate such an alliance, and the inter-mediation between research outputs from academia and research institutions, and the pharmaceutical industry along the lines of TDR in WHO. It is also essential to establish institutional mechanisms that will promote interaction between policymakers and programme managers on the one hand, and researchers on the other, for setting the research agenda and for utilization of research outputs.

8. Indian Systems of Medicine (ISM)

The term ISM comprises six different systems – ayurveda, siddha, unani, yoga, naturopathy and homeopathy – out of which only ayurveda, siddha and yoga are entirely indigenous. India has a rich heritage in ancient systems of medicine that make up a veritable treasure house of knowledge, and these systems can make a significant contribution to the healthcare of the population. But despite a vast parallel infrastructure of hospitals, dispensaries and teaching institutions, and over 6,00,000 registered practitioners, this potential has not been realized. Over 90% of illness episodes are treated by allopathy. Even registered practitioners of ISM treat patients with modern drugs though they are not authorized to do so, often with undesirable consequences. The failure to evolve the synthesized national system recommended by the ICSSR/ICMR Committee has prevented the use of even proven ISM remedies in

- Vigorous and sustained efforts to prevent the spread of HIV/AIDS, with focus on IEC and interventions involving high risk population following the example of Tamilnadu; simultaneously, arrangements for medical care of AIDS patients through clinical training in treatment protocols and sensitization of health workers on HIV/AIDS patients.
- Strengthening of the health system in high malariogenic areas, particularly tribal regions, for early detection and prompt radical treatment to reduce the reservoir of infection.
- Development of treatment protocols and regulations for co-opting the private sector in communicable disease programmes; this may include continuing medical education and active participation of professional bodies like the IMA.

2. Facing the Rising Threat of NCDs:

- Identification of a menu of core components to provide an 'essential package' of chronic care with possible extension to an 'optimal package'
- Integration of these services into various levels of healthcare.
- Development of evidence-based, context-specific and resource-sensitive clinical practice guidelines that can be integrated into various levels of healthcare to facilitate the use of low-cost, high-impact interventions.
- Modification of the training of healthcare providers of diverse categories to enhance skills relevant to chronic disease prevention, surveillance and management.
- Sequential prioritization of 'essential' elements for early implementation and 'optimal' elements for later integration.
- Vigorous efforts to control risk factors by sustained health education, community participation and legal action with regard to tobacco and alcohol.

3. Reduction of Infant and Maternal Mortality:

- Targeting of high IMR states first, and within states, high IMR districts and regions; all CHCs and 24-hour PHCs in high IMR districts and regions to be fully equipped to handle basic newborn care and referral.
- Focus on the disadvantaged and poorest groups; trained CHWs to be located in identified remote regions with a large proportion of disadvantaged groups such as Scheduled Tribes for the delivery of essential MCH services.
- Arrangements to effectively screen and identify all high risk cases, and ensure their deliveries in appropriately equipped health facilities; in general, promotion of institutional deliveries by providing appropriate facilities and incentives including emergency transportation.

public healthcare facilities. Also, the vast army of ISM manpower has rarely been utilized for public health programmes. The failure to evaluate traditional remedies scientifically has prevented their wider acceptance in India as well as abroad. What is most important is for ISM to develop its strengths in providing relief in apparently incurable chronic ailments such as digestive disorders, asthma and arthritis. At the same time, ISM needs to popularize preventive practices such as yoga, which could be an important element in the strategies being evolved to cope with the threat of NCDs. Some recent initiatives of the new Department of ISM seem to address these deficiencies; but on the whole, this area requires priority attention to explore and realize its full range of possibilities.

9. Conclusion :

The above analysis clearly underscores the need for a quantum jump in the public investment for health, accompanied by wide-ranging reforms at every level. This can be achieved only with strong political will and commitment, which can in turn be generated only through a strong people's movement cutting across party affiliations. The first step is better awareness and the widest possible dissemination of information on health issues. It is only vigorous informed debate on health issues – in Parliament, in the state legislatures, in the media, and in various public forums – that will eventually grow and gel into a broader people's movement. It is in the context of this long and complex process that this Report seeks to identify, describe and analyze the current issues in Indian health and the future directions of change.

III. Future Directions: Summary of Recommendations

1. Communicable Disease Control:

- Acceleration of India's epidemiological transition by vigorous public policy to control communicable diseases; malaria control to focus on those areas with an API above 2; rapid expansion of DOTS so that the entire country is covered for TB control.
- Substantial increase of central funding without stipulation of matching contribution by the states.
- The central government to consider a more direct intervention in actual implementation, if necessary through trained personnel on contract in weak performing states; in well performing states, release of block grants against certain clearly defined deliverables to provide greater flexibility in the implementations of the programmes.
- Establishment of a comprehensive disease surveillance system in all districts with central funding for a period of ten years.

- Strengthening antenatal care by screening every pregnant woman for anemia, hypertension, diabetes, urinary and reproductive tract infections, malaria, and TB.
- Convergent action at the cutting edge level between health personnel and anganwadi workers for ensuring full coverage of child health services.

4. Finance:

- Public health expenditure to be more than doubled to raise the level of public investment from the present 0.9% of GDP to at least the level of the average of lower middle-income countries (2.2% GDP); additional resources to be mobilized largely through dedicated levies to avoid competition from other sectors and to provide increasing and sustainable funding.
- Increase of allocation for public health and primary and secondary healthcare that is better utilized by low-income families.
- Differential planning and deployment of budgets in line with the extent of disease burden, economic backwardness of the state/region and poverty levels; the government to bear a special responsibility to ensure good quality care through appropriate incentives and strengthening of facilities in backward and poorly developed areas/states, since public sector facilities may be the only facilities available.
- Utilization of user fees at secondary and tertiary levels to reduce the price advantage of public services, reducing their attractiveness to the affluent and simultaneously making arrangements for exemptions of the poor.
- Setting up of systems of social insurance such as Sickness Funds to provide financial risk protection to the poor against serious illness and hospitalization.
- Coverage of employees in the formal sector with social insurance primarily financed by employer and employee contributions; social insurance to replace low coverage existing schemes, especially in the low-income formal sector, with services contracted out to enhance efficiency and reduce costs.
- Package of incentives to encourage NGOs to develop community finance schemes in designated areas, with the government contributing a fixed premium for every BPL family covered by the scheme.

5. Health Systems:

- Restructuring of Central Ministry of Health and Family Welfare so that it withdraws from day-to-day management and concentrates on its stewardship role by strengthening its planning, analytical and public health expertise.

- Restructuring of the health systems of the states based on three principles: (i) decentralized authority, responsibility and decision-making; (ii) integration of preventive, promotive and curative services; and (iii) local community participation.
- Removal of identified constraints and inadequacies at the primary healthcare level to improve their efficiency and utilization, and reducing the load on over-utilized hospital services by providing essential drugs, consumables and diagnostics, making arrangements for proper maintenance of facilities, and removing constraints on mobility of health personnel.
- Addressing manpower shortages by an appropriate combination of incentives, legislative measures, and management reforms: reservation of PG seats for those candidates in service with a record of rural service; making rural service compulsory for admission to PG courses; contractual appointments to fill vacancies; a transparent transfer policy that requires every doctor to work in rural areas by rotation for a prescribed period; preference for foreign training given to doctors with rural service records; better residential facilities, rural service allowance; allowing private practice only in under-developed areas where even private facilities are inadequate.
- Mapping the availability of health facilities in hilly regions and areas inhabited by tribal populations; the provision of mobile health teams and community health workers to cover identified gaps.
- Decentralization and devolution of powers to local authorities after careful preparation and adequate training.
- Delegation of administrative and financial powers to medical facilities to be exercised through local committees to promote efficiency, accountability and mobilization of resources.
- Institutionalization of coordination arrangements at different levels.
- Involvement of community self help groups and women's groups for people's participation in health programmes.
- Institutional arrangements for regulating the private sector with the participation of all stakeholders to set and enforce standards, control unethical practices, and ensure transparency of charges and non-denial of emergency care.
- Development of capacities for contracting out services to the private sector; promoting new partnering initiatives with the private sector for service delivery and management of public institutions.
- Development of an incentive package for the voluntary sector to set up facilities in the identified under-served areas.
- Promotion of accreditation networks for identified services through voluntary organizations/professional bodies.

- Elimination of unqualified practitioners in a phased manner, beginning with well-served areas.

6. Drug Policy and Regulations:

- Creation of an independent National Drug Agency to take over all drug-related functions, supported by a National Drug Fund financed by a small cess on the manufacture and import of pharmaceuticals; institution of a more stringent law to deal with the proliferation of sub-standard manufacturing units and irrational fixed dose combinations, poor laboratory facilities, sub-standard and spurious drugs, weak enforcement machinery, and open violation of law by chemists selling prescription drugs over the counter.
- Selective use of compulsory licensing to produce generic substitutes for patented drugs of public health significance, and to provide the necessary incentives and financial support to pharmaceutical companies for the same.

7. Health Research:

- Development of a health research policy to create an incentive framework to promote research, particularly on the diseases of the poor.
- Higher investment in development of infrastructure for basic and strategic research in the public sector, with changes in the management structures to promote quality research outputs.
- Development of alliances among academia, research institutions and the pharmaceutical industry to promote the utilization of research leads by the industry for product development; ICMR to develop capacities for such inter-mediation on the lines of TDR in WHO.
- Emphasis on health policy and systems research and reducing the deficiency of researchers by providing training avenues in epidemiology, health finance and health economics.
- Creation of an incentive environment for the pharmaceutical industry to invest in research through tax concessions, pricing incentives for new molecules, facilitating clinical trials and regulatory approvals, and supporting promising products for the neglected diseases of the poor with financial support from the National Drug Fund.

8. Indian Systems of Medicine:

- Development of a national health system incorporating the best of all systems; including proven remedies of ISM as first drugs of choice in the public healthcare system.
- Encouraging scientific evaluation of traditional remedies.
- Utilization of ISM manpower in public health programmes.
- Emphasis on the special strengths of ISM in treating chronic ailments such as digestive disorders, asthma and arthritis.
- Popularizing ISM practices such as yoga to prevent and treat NCDs.

		Health expenditures		Health expenditures by source (%)		
Region (N)	N	Total per capita (US$)	As % of GDP	Public	Private	Aid flows
Established market economies	25	1675.2	7.73	77.0	23.0	-
Middle Eastern Crescent	32	189.1	4.27	55.0	42.9	2.9
Economies in transition	19	150.3	4.27	72.7	27.3	-
Latin America and Caribbean	33	118.1	5.30	54.9	37.4	7.6
Asia and Pacific islands	33	60.2	4.01	40.9	48.1	11.0
Sub-Saharan Africa	47	35.7	4.86	33.4	37.6	28.8

Source: WHO, 1997

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DRAFT NATIONAL HEALTH POLICY

I. INTRODUCTION

1. As a consequence of the rapid advances in science and technology, the country's health system is faced with a range of threats, opportunities, and challenges, for never before have people, ideas, goods or infections traveled across nations with such speed. Globally, the increased access to knowledge and information has profoundly enhanced our capabilities to live healthy and productive lives.

2. Given the modest resources, health gains, over the last fifty years, have been remarkable for their depth and expanse. The first three decades after Independence were marked by sustained efforts to control disease, resulting in the eradication of small pox and plague, the effective containment of malaria, a dramatic reduction in leprosy and a positive trend towards a drop in fertility and mortality. Due to expansion in access to water, sanitation, nutrition, better housing and higher incomes, people are healthier, live longer and a larger number of children survive their fifth year growing into young adults. These gains were the result of the overall development in the country but in no small measure, also on account of the increased investments in expanding access to basic health services in the remotest corners of this vast country.

Box 1 : Achievements Through The Years - 1951-2000

INDICATOR	1951	1981	2000
DEMOGRAPHIC CHANGES			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	119	70 (99 SRS)
EPIDEMIOLOGICAL SHIFTS			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no of cases)	>44,887	Eradicated	
Guineaworm (no. of cases)		>39,792	Eradicated
Polio		29709	265
INFRASTRUCTURE			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries &Hospitals(all)	9209	23,555	43,322 (95-96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors(Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

3. The 1983 National Health Policy had advocated a comprehensive approach to medical education, research and health services that would be relevant to the country's needs and priorities; involvement of the civil society and inter sectoral coordination as cornerstones for achieving specific targets related to diseases affecting the poor . However, since then , the health system has become extraordinarily complex, as it seeks to address the demands of a wide variety of pre and post transition diseases. Due to demographic changes there is a larger population of the young and the aged entailing, health implications of increasing vulnerability to sexual infections and demand for chronic and geriatric care. Children and young adults continue to die prematurely on account of simple, low cost and easy to treat diseases, namely, diarrhoea, TB, respiratory infections and maternal causes, as also cancer, cardiovascular diseases, and injuries, which are expensive and difficult to cure. Corporate hospitals offering state of the art treatment coexist with unqualified practitioners dispensing modern drugs for minor ailments reflecting the wide differentials in the needs, demands and expectations of health care services among the people.

4. Societal averages hide the diversity that characterises this large country, with people all at once, living in different time periods. Not only do the poor have higher levels of mortality compared to the rich, but also suffer disproportionately more on account of communicable diseases. Due to the gradual decline in the functioning of public hospitals the poor are being forced to go to the private sector at great financial risk, the other option being not availing of any treatment at all, making policies directed to addressing equity central to the achievement of public health goals. . Similarly, the lesser-endowed states have worse health outcomes compared to the better off, indicating the great amount of unevenness that exists among states in their ability to provide health care services to their people. The vast differentials in health status among states is depicted below in Box 2 :

Box 2 : Differentials in Health Status Among States

Indicator	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mortality per 1000 (NFHS II)	Weight For Age Children Under 3 % <-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 population	Mala-ria +ve Cases 2000 (in '000)
INDIA	26.1	70	94.9	47	408	3.7	2200
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharastra	25.02	48	58.1	50	135	3.1	138
TN	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

5. Mindful of the problems and constraints that plagues the health system, but conscious of the opportunities available for corrective action, the National Health Policy, 2001 renews its commitment to expeditiously control communicable diseases, eliminating a few and containing the rest in a time bound manner. The rapid spread of sexual infections and the emerging epidemic of non-communicable diseases, particularly among the productive age groups is a matter of concern and will receive priority attention. The NHP also aims to initiate affirmative action to protect the poor from further impoverishment or social exclusion on account of ill health, by formulating policies and action plans directed to addressing inequity. Based on the need to restrategise and retool for meeting the challenges of an increasingly technology driven, interdependent world, the Policy will seek to strengthen research. Finally, it will also facilitate the restructuring of the present health care system to work together in partnership with all stakeholders, namely, the civil society, NGOs' and the private sector providers for realizing the goals and aspirations as articulated in the NHP,2001.

II. OBJECTIVES

6. The main objective of the NHP, 2001 is to achieve a standard of good health that is acceptable, affordable and sustainable. It will aim to develop a health system that is appropriate to our needs, has the requisite capacity to effectively reduce disease burden and arrest any further increase on account of environmental and behavioral factors. To lend sustainability the rational use of drugs alongside the tried and tested systems of traditional medicine will be assiduously promoted. As no health system can sustain the high costs of modern day treatment, advocacy for adopting healthy lifestyles and preventive health care through community-based strategies will be our focus.

7. The most immediate objective of NHP, 2001, will however, be two :1) the overall reduction in morbidity and the reduction of mortality by over three quarters on account of communicable diseases, maternal and infectious diseases; and 2) to improve the functioning of the existing public health system to be assessed in terms of the utilization, particularly by the poor. To realize the immediate and medium term objectives the NHP is committed to achieve the following goals during the period 2001-2015.

Box 3: Goals to be achieved by 2000-2015

➢ Eradicate Polio and Yaws	2005
➢ Eliminate Kala Azar and Leprosy	2010
➢ Eliminate Lymphatic Filariasis	2015
➢ Achieve Zero level growth of HIV/AIDS	2010
➢ Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
➢ Reduce Prevalence of Blindness to 0.5%	2010
➢ Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
➢ Improve nutrition and reduce proportion of LBW Babies from 30% to 10%	2010
➢ Increase utilisation of public health facilities from current Level of <20 to >75%	2010
➢ Establish an integrated system of surveillance, National Health	2005

Accounts and Health Statistics.	
➢ Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
➢ Increase share of Central grants to Constitute at least 25% of total health spending	2010

8. Realization of the above goals will be contingent upon the full implementation of various components of public policy, many of which fall outside the domain of the health sector. Adequate levels of public health spending, female literacy, universal access to nutrition, safe water and sanitation, reduction in environmental pollution, planned urbanisation, macroeconomic policies related to technological self reliance, mass media and information, reduction in poverty and finally a strong political support are some of the factors that are outside the health sector but profoundly influence its ability to fulfill its mandate.

9. There are ten determinants that have been identified for concerted action and focused policy attention. These determinants fundamentally impact upon our ability to achieve the goals. The current status and measures proposed to be taken under each determinant is detailed below.

III. FUNDAMENTAL DETERMINANTS

1. HEALTH FINANCING

The most fundamental determinant to the achievement of health goals is the provisioning of adequate funds for public health. Of the total estimated amount of 4.5% of GDP spent on health, government's share is about 20% accounting for 0.9% of the GDP, the rest being expenditures incurred by individual households. India is one of the 20 lowest public health spenders in the world:

Box-4 : % Public Health Spending in select Countries

Indicator	%Population with income of <$1 day	Infant Mortality Rate/1000	%Health Expenditure to GDP	%Public Expenditure on Health to Total Health
India	44.2	72	5.2	13
China	18.5	31	2.7	24.9
Sri Lanka	6.6	16	3	45.4
UK	-	6	5.8	96.9
USA	-	7	13.7	44.1

Source : WHR 2000

10. In the past 15 years, health expenditures by government as share of GDP has been declining from 1.3 in1990 to 0.9% in 1999, while per capita private household spending has doubled to Rs. 165.The proportion of central budget allocations for

health to the total central budget has also been stagnant at about 1.3%, while declining in the states from about 7% to 5.5% Central share in total health spending by states is about 15%. Of this 15% about 40% is for disease control programmes, the rest being for family welfare. There has been a significant shift in resource allocations within the central health budgets which have shown a decline in the proportion of the budget earmarked for communicable disease control from 58.7% during 1986-87 to 47.1 in 2001-2002, the shift being towards non communicable disease control and Medical Education and Research. Similarly, in the states also while there has been an increase by about 50% in the allocations for primary and secondary care, it has doubled for tertiary care. Overall, states spend on an average about 40% on primary health care, 30% on secondary and about 10% on tertiary hospitals and medical colleges. With more than three quarters of the money for salaries and wages, there is little money for procurement of drugs, equipment or improvement of infrastructure, resulting in the gradual decline in the quality of services being provided in public facilities.

11. The amounts spent by government determines the quality and reach of the public health system. Low expenditures by government either mean the partial or the non-implementation of an activity of public health importance or the deficit being made up by patients from out of their pocket. Not unexpectedly, the low performing states spend half of what the better performing states are spending with predictably poor er health outcomes.

12. The weak financial health of the states, competing demands, a low political support and an insufficient understanding of the nexus between poverty and ill health and the consequent social costs are the main contributory factors for the continued under funding of the health sector. In view of the criticality of adequate resources the NHP will seek to :

- Double the Health Budgets across the board to constitute at least 2.5% of the GDP by 2010;
- 50% of the budgets be earmarked for Primary Health Care and communicable disease control programmes, 30% for secondary and 10% for tertiary care;
- Increase share of central grants to constitute at least 25% of total state health spending for the next 10 years till the states fiscal situation improve;
- Initiate mechanisms for resource generation for sustaining the investments and meeting recurring costs at least partially in all institutions such as increased student fees in all medical colleges and other training institutions or charging user fees in hospitals for those belonging to a high income level groups , subject to guidelines;
- Provide financial incentives for the non private charitable sector to set up secondary and tertiary facilities subject to conditions;
- Formulate social insurance packages or establish sickness funds to cover the hospital expenses of all the poor below a certain income level and thereby reduce the share of out of pocket expenditures to total health financing.

2. EQUITY

13. Benefits arising from the social and economic development of the country have not been spread in an equitable manner resulting in wide differentials between rural and urban, men and women, rich and poor. These differentials have a direct impact

on the capability of those sections of society who bear the double burden of poverty and social discrimination, the aged and women, to access public services in accordance with their needs.

Box 5: Differentials among States

Indicator	Population BPL % (Planning Commission, Government of India)			IMR Per 100 Live Births (1999-SRS)			<5 Mortality per 1000 (NFHS II)			Weight For Age % OF Children Under 3 <-2SD (NFHS II)		
	Rur	Urb	Total	Rur	Urb	Tot	Rur	Urb	Tot	Rur	Urb	Tot
India	27.09	23.62	26.10	75	44	70	103.7	63.1	94.9	49.6	38.4	47
Better Performing States												
Kerala	9.38	20.27	12.72	14	16	14	43*	32.7*	18.8	30.6*	22.9*	26.9
Maharashtra	23.72	26.81	25.02	58	31	48	85.5*	60.5*	58.1	57.5*	45.5*	49.6
Tamil Nadu	20.55	22.11	21.12	58	39	52	105.5*	74.2*	63.3	52.1*	37.3*	36.7
Low Performing States												
Orissa	48.01	42.83	47.15	100	65	97	104.8	102.0	104.4	55.5	45.3	54.4
Bihar	44.30	32.91	42.60	64	55	63	108.6	68.3	105.1	55.1	47.4	54.4
Rajasthan	13.74	19.85	15.28	85	59	81	120.6	92.3	114.9	51.9	46.0	50.6
UP	31.22	30.89	31.15	88	66	84	129.5	85.8	122.5	53.6	42.6	51.7
MP	37.06	38.44	37.43	96	55	90	152.2	82.9	137.6	58.44	44.3	55.1

*NFHS I (1992-93)

14. The most reliable form of insurance cover to the poor is a well performing public health system. However, to address the needs of vulnerable target groups, specific interventions will be designed such as

- providing transportation facilities to the health center, ensuring access to female providers by earmarking one medical post in all the Community Health Centers;
- training of medical and non medical personnel in geriatric care;
- ensuring suitable timings and the regular availability of services, drugs and medicines needed for diseases suffered by women and the old ,
- establishment of health posts in urban slums,
- mobile vans with expanded functions and diet for inpatients in the tribal areas.
- Regular monitoring of data covering the vulnerable groups will be institutionalised.

15. It is estimated that of those poor who receive hospital care, several are pushed below the poverty line on account of the economic burden of illness. Evidence also indicates that cost of hospitalisation has increased threefold in the last decade. Nearly a quarter of the poor are unable to take treatment for lack of money. This being an unacceptable situation, the NHP will promote social insurance schemes and encourage states to establish sickness funds for covering the entire cost of treatment for families below a certain income level.

3. RESTRUCTURING THE PUBLIC HEALTH DELIVERY SYSTEM

16. The 1983 National Health Policy triggered a process of major expansion of primary health care infrastructure in the rural areas. Based on population norms, health institutions were established at every five, thirty and hundred thousand population, providing at each level the technical expertise appropriate for the functions to be performed. Yet, in large parts of the country, optimal utilization of this infrastructure remained unrealized on account of a set of multiple factors such as, under funding and the thin spread of resources; inconvenient siting of facilities; vacancies of critical staff; absenteeism due to poor supervision; inadequate and irregular supply of inputs; and an unresponsive environment. In the case of public hospitals, inadequate investment over a period of time resulted in the lowering of the quality of care due to overcrowding, long wait, overworked and underpaid personnel, obsolescent equipment and the routine stock outs of essential drugs. In view of these factors, there has been a steady decline in the utilization of public health facilities. Less than 20% seek treatment in primary health facilities and not more than 45% go to public hospitals for inpatient care. The cumulative fall out of these developments has been the sharp increase in the out of pocket expenditures being incurred for treatment, particularly by the poor for whom even one episode of hospitalization is catastrophic resulting in a lifetime of indebtedness.

17. Addressing the distortions and shortcomings in the public health system will be the major focus of National Health Policy. Priority attention will be on

- Consolidating the gains by filling up gaps in infrastructure and the availability of critically needed personnel, if necessary on contractual basis;
- At appropriate levels, establishing transparent and administratively simple mechanisms for efficient and timely procurement of inputs and logistics management;
- Encouraging states to undertake a review of the existing facility norms and an audit of the health institutions in the public and private sector. Such an exercise will enable a more cost effective distribution of resources and a more rational sitting of facilities, aimed to ensure effective access to the poor;
- Initiating steps to ensure the proper functioning of the primary health centers affected by the absenteeism of doctors at the peripheral institutions by exploring other alternatives, namely, the promotion of a cadre of trained Licentiates of Medical Practitioners (LMP) and the more intensive use of the trained practitioners of Indian Systems of Medicine. By upgrading the training and competency levels, the paramedical staff, particularly nurses, can be yet another option to complement or substitute the medical doctor in the PHC's located in remote areas; .
- In view of the overall inability of the states to deploy specialists at the CHC's in accordance with the GOI guidelines, the states will be free to consider other options, such as, posting of medical graduates after 6-9 month rigorous training in anesthesiology, gynecology, surgery a pediatric care which are the skills required to address major morbidity in rural areas.

18. The NHP will develop appropriate financial packages and programme strategies to correct imbalances among the states. The low performing states, districts and areas will be provided funds by the center for meeting the recurring and non recurring costs of critical gaps for satisfactorily implementing the priority programmes in

accordance with the technical guidelines. The center will also intensify its monitoring to ensure proper and timely utilisation of these funds. Incentives will also be extended to personnel working in these hardship areas to motivate them to achieve the goals in a time bound manner.

19. Policies will also be constituted to strengthen the health infrastructure in rural areas by expanding the State Health Systems Projects to cover all the states, but appropriately modified to ensure that investments are for the strengthening of the primary and community health centers, which are used more and have greater relevance to the poor. Besides, center will also provide financial support for filling critical infrastructure gaps in public hospitals at district level besides providing financial and non financial incentives to charitable and non profit organisations to motivate them to set up facilities in underserved areas.

20. Given the growing complexities in administering modern day hospitals, professional managers will be inducted to improve the functioning of hospitals. This measure will also free the critically required medical manpower from routine administrative work and attend to patient care. Delegation of financial and administrative powers and imparting an overall sense of accountability will be ensured by gradually converting hospitals into autonomous entities under Trust Managements. The principal objective of these measures would be to improve efficiency, reduce costs and improve the utilisation of these public facilities by the poor. Therefore, performance indicators will be aimed at evaluating not only quality of the outcomes but also utilization.

Box 6 : Milestones for System Strengthening

- Ensure filling up of critical gaps, of resources, personnel and inputs under priority programmes by rationalizing existing norms and administrative systems ;
- Develop managerial and technical capacity in the State and District Health Societies to gradually take over functions being performed at the center and state levels and for developing District Health Plans based on local epidemiology for securing central grants ;
- Intensify monitoring at center, state and district level by increased use of IT and trained personnel dedicated to the task of concurrent evaluation ;
- Establish in all Districts, Disease Surveillance Units to be centrally funded for the next ten years ;
- Review norms to facilitate re - locationing of facilities and redeployment of personnel for ensuring access, efficiency and close supervision ;
- Develop performance indicators and incentives for enforcing the referral system ;
- Ensure all PHC's , CHC's and District Hospitals have modern communications and transport facilities, adequate delegation of powers and funds to meet local needs ;
- Earmark one out of the four posts of doctor in the CHC for women;
- Integrate health education and early screening of diabetes, cancer, cardiovascular disease, mental health and eye care in the primary health care system by appropriate training to health functionaries and provisioning of equipment and drugs ;

4. ROLE OF THE CENTER AND THE STATES

21. Over the years, there has been a paradigm shift in the technical capacity of states to design, formulate and implement public health programmes in an effective manner, justifying a review of the role of the center. In keeping with the changed situation and to address the more important issues of governance, role of the center will

- continue to be directly involved with the implementation of disease control programmes by enhancing assistance to all low performing states and districts to strengthen and speed up the epidemiological transition ;
- Monitor the centrally funded programmes in the low performing states in a mission mode ;
- Gradually decentralise many of its current responsibilities and functions to states and institutions having the requisite capability. To such states / institutions, center will provide assistance to strengthen managerial and technical capacity and thereafter release bulk funds on a per capita basis, further releases being subject to achieving certain outcomes ;
- Redirect its energies and capacity to focus on providing leadership in setting technical standards and the strict enforcement of quality; ensuring universal access to health care; containing costs through medical audit and other policy instruments; enforcing compliance to regulations regarding the private sector, drugs, prevention of food adulteration; implementation of insurance programmes for the poor and eligible target groups; closely monitoring and keeping a strict vigilance through a well knit surveillance system to ensure no resurgence of diseases that have been controlled; development of health statistics; advocacy and motivation of NGOs'; and social mobilisation for health through health education campaigns etc.

The center will also actively consider either making the CGHS and MSD into professionally managed concerns with appropriate managerial autonomy or close them down altogether and look at other options;

- The states will likewise be motivated to devolve their functions and funds to district levels, Hospital Trust Committees and locally elected bodies in similar fashion. The priority attention at the center and state levels will be to improve the overall governance regarding health programmes;
- The Districts will be administrative units for health programmes while the villages will be the units for health action. Every village will have Village Health, Nutrition and Population Committees consisting of 6-10 members, trained to discharge health functions and ensuring every home with access to sanitation, safe water and health facilities. They will also be trained to do simple tests such as a urine test, taking blood pressure, dispensary medicines for treating minor ailments, particularly, traditional medicines and those modern medicines, which have no side effects and referral. States will be encouraged to decentralise several health related duties and responsibilities to the locally elected bodies along with a reasonable budget;

5. PRIVATE SECTOR

The private sector is the dominant provider of health services with a substantial share of 80% outpatient treatment and 55% of inpatient care. Rising incomes and demand for improved care stimulated the growth of the private sector. However, due to the absence of a regulatory environment, the spread has been uneven, quality of services mixed, range of services narrow with a high propensity for over diagnosis and costly.

For harnessing the available potential the NHP will seek to involve the private sector in the implementation of all national programmes and also in providing good quality health services to the people, subject to fair pricing and an accountability to patient satisfaction. Financial incentives will be extended to the non profit charitable institutions willing to set up hospitals, medical or dental colleges in the poorer states and poorer regions as identified by the government but subject to free care to the poor through referral by public health institutions. Regulations to ensure adherence to standards and quality will be formulated on priority. Finally, the requisite capacity for monitoring the enforcement of regulations will be developed at the central and state level. An autonomous body will be established for accreditation of private hospitals.

Partnering with the private sector will be encouraged, particularly for providing support services in all hospitals such as security, laundry, sanitation maintenance, laboratory support, including fee per service contracts for specialized services Government will also extend financial assistance and encourage establishment of consumer forums and enforce a patient charter in all hospitals, public and private.

6. HUMAN RESOURCE DEVELOPMENT - FOR A BALANCED MIX

22. The present health system is highly skewed in favor of medically trained doctors to the near exclusion of other paramedical and non-medical disciplines. The imbalanced mix of skills and the virtual non availability of some of the sorely required manpower and specialists such as pediatricians, anesthetists, ophthalmologists, surgeons, epidemiologists, entomologists, microbiologists, nurses, laboratory technicians, ophthalmic assistants etc. in the low performing

states is one of the reasons for their low achievement. Besides, quality of training and standards in instruction have also been affected due to obsolescent equipment, run down facilities for want of capital investment and the policy of permitting teaching faculty to do private practice.

23. The NHP will aim to

- restore teaching standards and ensure quality. For this, reform in the examination and evaluation systems will be initiated;
- A corpus for providing interest free loans to government medical colleges for improving the infrastructure and procurement of equipment will be set up;
- States will be encouraged to establish Universities of Health Sciences for better integration and standardization of training quality;
- High priority will be accorded to increasing the number of nursing colleges and gradually phasing out / or drastically upgrading the old ANM schools to meet the emerging challenges and requirements;
- Curriculum will be suitably restructured to allow for the development of the community health stream and the clinical stream. This will be an important step. Bifurcating the doctors at the graduate level, will enable a more efficient deployment of personnel. Those taking up community medicine will be posted in the PHC/CHCs' and later as managers in charge of public health programmes, while those specialising in clinical disciplines will work in hospitals and medical colleges. Such development of a cadre of Public Health oriented doctors and nurses is required to meet the challenges of the dual burden of disease, where containment of non communicable diseases will have to rest on community based strategies with focus on prevention and behavioral change.

  The 10+2 vocational stream will be integrated to the production of required number of laboratory technicians ophthalmic assistants and other para medical staff;
- In recognition of the extreme importance of public health to the country, the three premier public health institutions, namely AIIHPH , NICD and NIHFW will be made autonomous and upgraded into Institutes of Excellence. Action will also be taken to encourage states to strengthen existing infrastructure to upgrade public health training.

Box 7 : <u>Important Initiatives for Improving Training and Medical Education</u>

- Establish an Autonomous Medical Grants Commission provided with a corpus fund for improving the infrastructure of government medical colleges and adherence to teaching standards and giving accreditation to colleges ;
- Ban private practice by teaching faculty and provide incentives ;
- Revise curriculum to suit the health needs of the country and introduce credits for integrated medicine;
- Identify scarce disciplines and provide incentives to attract students ;
- Gradually make all medical colleges autonomous institutions with Government providing block grants subject to meeting laid down social objectives and standards;
- Establish a National Examination to be cleared for obtaining a license to practice and provide for mandatory examination every five years for renewal of license;
- Encourage private investment in the establishment of medical colleges and nursing school subject to equitable distribution of these colleges for ensuring a more balanced growth of medical infrastructure, tight control on quality and fees to be charged;
- Develop a Cadre of Public Health specialists

- Bring about necessary amendments to the legal provisions to check commercialization of medical education and also removing discretionary powers of state and central governments
- Enforce a rule that all graduates shall be required to do two years of compulsory rural service at the PHC and CHC to be eligible for PG degree. This shall be a conditionality in the case of all students who get tuition waivers, fellowships or subsidized education.

7. IMPACT OF GLOBALIZATION

India is a substantial contributor to the global disease burden, which needs to be reversed.

Box 8 : Indias' Share of the World's Health Problems (in %)

Popul-ation TB Cases	Poverty Leprosy cases	Total Deaths	Child Deaths	Mat-ernal Deaths	Persons with HIV	TB Cases	Lepr-osy cases
17	36	17	23	20	14	30	68

24. Indias' high disease burden also makes it more vulnerable to changes in global arrangements. The introduction of new rules and the entry of new participants and markets have to be responded in a suitable manner so as to maximize benefits and minimize losses. Important Agreements such as the TRIPS, SPS, and GATS, will impact upon and influence India's ability to access essential drugs at affordable prices; food and nutrition security and safety; quality of pharmaceuticals; and cross border movement of consumers and critical health personnel with potential to deplete critically required resources and sharpen existing inequities.

25. The NHP will ensure developing appropriate safeguards and strategies for coping with new order as detailed below :

Box – 9 Actions for Maximizing Opportunity and Reducing Negative Consequences

TRIPS

- Promote National Essential Drugs List which largely consisting of generic products;
- Initiate action to motivate practitioners in the public and private sector to prescribe drugs from the NEDL;
- Increase investment in Research relevant to India's needs
- Focus on disease prevention;
- Improve quality of generic drug manufacture by upgrading and enforcing quality standards by strengthening supervision for which a FDA to be established. Guidelines regarding sale by prescription and by licensed pharmacists will be enforced.

SPS

- Establish food standards and strengthen the system of enforcement to promote food safety and quality in order to reduce incidence of food borne diseases and emergence of vibrant pathogens as a result of contaminated foods at home and imported from abroad;
- Strengthen existing laboratories and establish one comprehensive laboratory with capacity to undertake all forms of testing as required for quality assurance;
- Strengthen capacity of regulators of imported foods for timely testing without sacrificing speed or quality;
- Strengthen monitoring and surveillance in the Departments of Health at central and state levels to work in partnerships with private industry, consumer groups, International organisations etc.

GATS

- Develop an Action Plan with the objective of ensuring no depletion of critically required expertise and personnel from the public sector on account or migration to private facilities or abroad; maximising the comparative advantage India has in skilled human resources; and ensuring existing inequities do not widen while at the same time increase foreign exchange earnings;
- Accord high priority to quickly upgrade and improve quality and standards of medical education and paramedical training;
- Establish quality assurance mechanisms and standards of care;
- Expand the number of institutions, particularly nursing;
- Encourage investment, including from the public sector, to establish high quality care hospitals and medical colleges and nursing schools etc. at designated areas for attracting foreign clientele at home and establishing centers abroad.

8. RESEARCH

For various reasons, research on tropical diseases that are of most concern to us has attracted a low priority, globally. Besides, combined with the imperative need to reduce risks that arise from imbalanced dependence on external knowledge, there is an urgent need to invest on promoting indigenous research by having a National Health Research Policy. The salient features of such policy will be to encourage the development of fundamental research in areas relevant to health and develop over time a critical mass of scientists engaged in futuristic areas such as biotechnology, genomics based drug development, optimal utilization of molecular biologic developments for diagnosis, therapy and prevention etc. Establishment of appropriate infrastructure and microbial containment facilities, gene and tissue banks etc. will be pursued. Optimal utilization for Information Technology will be given high priority. Greater collaboration between Research Institutions on areas of national priority will be encouraged and a system of dissemination of research results set up under a National Research Forum. Most importantly, financial incentives will be provided to encourage research devoted to HIV/AIDS, MDR TB and other drug and pesticide resistance under the malaria programme.

IV. POPULATION STABILIZATION

The effective implementation of population control policies will help reduce disease burden, improve quality of life and general health of the people. In the context of decreasing future burden of non communicable diseases which are expensive to treat, the reduction of low birth weight babies by improving the nutritional status of the mother and spacing of pregnancies is critical as, recent findings suggest that impaired foetal nutrition results in susceptibility to adult cardiovascular disease, diabetes and some cancers. Besides, propagation of safe sex also has the double benefit of reducing disease transmission on account of HIV/AIDS in the general community. In view of these linkages to health status, population control measures will be integrated with the promotion and delivery of health services by the private and public sector.

V RESTRUCTURING OF THE ADMINISTRATIVE SETUP FOR COORDINATED IMPLEMENTATION

In most states, work distribution in the health departments at the state and district levels have been divided in accordance with funding pattern of national programmes resulting in a clear separation between family welfare and communicable diseases and health infrastructure. To bring about better synergy, more effective coordination and reduce overlap states will be encouraged to reconstitute the departments and directorates on a functional basis that will enable integration of all areas and programmes pertaining to primary health care involving facilities and activities implemented at CHC and below under one head and hospital services, manpower planning and regulatory aspects under another.

VI LEGISLATION

The NHP will seek to review all the legal enactments in force and take action to amend and enact legislation for establishing the new innovations that have been incorporated herein, particularly related to the amendment of the MCI, Regulation of the Private Sector, Consumer protection laws etc.

VII NEW STRUCTURES

The health conditions are changing. Technologies to manage new conditions are changing. This makes it necessary to come up with new institutional frameworks for addressing the new challenges. Accordingly, under the NHP 2001 action will be taken to establish over the next few years, new structures, namely the Medical Education Commission, FDA, National Accreditation Commissions for Quality Assurance, Hospital Committees, District Surveillance Units, Coordination Committees for Intersectoral Coordination particularly for water and sanitation, Village Health, Nutrition and Population Committees, Autonomous Units and Insurance Regulators and Sickness Funds Authorities etc.

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NATIONAL HEALTH POLICY - BACKGROUND PAPER FOR DISCUSSION

Objectives

The main objective of the NHP-2001 is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be by increasing to the access the decentralised public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. A central objective would be to ensure more equitable access to health services across the expanse of the country. Emphasis will be given to increasing the public health investment through substantially increased contribution by the Central Government. The contribution of the private and NGO sector in providing health services would be much more, particularly for the group which can afford to pay for services. Increased sectoral share of allocation will be provided for preventive and curative initiatives at the primary health level. Emphasis will be laid on use of rational drugs within the allopathic system, appropriately supplemented with tried and tested systems of traditional medicine. Within these broad objectives, NHP-2001 will endeavour to achieve the time-bound goals mentioned in Box-1.

Fundamental Determinants which impact on the goals of Health Policy

Financial Resources

A progressive increase in the public health spending of which a substantial part has to come in from the Central Government is a key factor is achieving the public health goals set in the NHP 2001. It is noticed that the proportion of Central Government budgetary allocation for Health of the total budget remains stagnant at 1.3 per cent. In the States this proportion progressively declined from 7.00 to 5.5%. The Central share in total Health spending of States is about 15%. The poor financial health of State Governments and their inability to spend adequate resources for social infrastructure like health has contributed to overall decline in public spending on health care infrastructure in the country. Taking

this into consideration, it is planned to increase health sector expenditure to 5.0% of GDP with 2.0% of GDP being appropriated to public health investment by the year 2010. The States should not only try to arrest the declining trend in public health expenditure but should restore it to 7% by 2005 and progressively increase it to 8% by 2010.

The provisioning of higher public health investment will also be dependent upon the increased absorptive capacity of health administration to gainfully utilise the funds in the States. In order to ensure that the access to primary health care is maximised, at least 55% of the public health investment should be appropriated to primary health care, the remaining going to secondary health care (33%) and the balance to tertiary health care. The Central grants in total health care spending by the States should also be increased from the present 15% to 25% by 2010.

Equity

While inadequate resource allocation led to sub-optimal performance in public health in the country as a whole, there are wide variations in performance between better performing and lower performing States, between rural and urban areas, between rich and poor and men and women. These differentials impact directly on those sections of the society who bear the double burden of poverty and social discrimination. Box 2 shows the differentials in health status acro States.

To ensure equity in allocation of resources and to minimise the differentials in health status, the following measures are proposed:

i. Increased public spending on health at the grass roots level to strengthen the primary health care system

ii. Special needs of socially vulnerable sections like Scheduled Tribes, nomadic communities, urban slum dwellers, need targetted programmes for improving their health status.

iii. There should be provision for social security for poor and vulnerable sections who lose their life's savings in attending to care and support of members of their families. NHP 2001 will promote social insurance schemes and encourage States to establish a sickness fund for covering the cost of treatment for families below a certain income level.

iv. Strengthening the public health delivery system: The serious gaps in infrastructure act as a big determinant in delivering health care to people living in rural and remote areas in the country. Increased commitment of resources for primary health care is of prime necessity in strengthening the delivery system. Shortage of doctors in primary health care institutions can be met by organising a cadre of Licentiates of Medical Practitioners (LMPs) and more intensive use of trained practitioners of Indian system of medicine. The States should liberalize the process of recruitment and encourage trained professionals to be employed on contractual basis through simplified administrative procedures.

v. A big disincentive for people in the rural areas to access primary health care is the absence of drugs and other consumables in many of these centres. Drugs and consumables are important components of public health care delivery system. To set this right, NHP 2001 would commit financial resources from the Central Government for funding of the drug and equipment costs of primary health care centres through a simplified procedure. The procurement procedure for these drugs and consumables should be as simple and decentralised as possible.

vi. There are impediments in the flow of resources from the Central Government to programmes operated at the field level like the national

disease control programmes. There should be a proper arrangement to streamline resource-flow to priority programmes. Formation of Health Societies at the State and district level wold facilitate direct transfer of funds from the Central Government to the operating units at the field level without the usual budgetary constraints. The Society model which has initially been experimented in some States has proved to be an effective delivery system for implementation of targetted public health programmes and should be adopted by all the States at the State and district level.

Role of States

States have the primary constitutional responsibility to provide health care to its people. However, the health care delivery system in many States remain largely centralised at the Departmental level inspite of the strong and effective presence of institutions of local self-government at village, block and district levels. Decentralised management of health institutions especially those at the primary level through Panchayati Raj institutions is strongly advocated in the NHP 2001. Flow of Central funds to States for public health programmes should be effectively linked to the performance of the States in the area of decentralisation of programme management to the PRIs.

Decentralisation of programme management should also be reinforced by convergence of all vertical public health programmes at district level and below. This will lead to economy of scale and avoid duplication of effort on areas like IEC, training, etc.

The health care functionaries at the field level now operate under various Departmental authorities with control at the State level. There is need to bring in convergence in their work even though it may not be possible to bring them under one administrative umbrella. Personnel like Anganwadi workers, ANMs,

male health workers, link volunteers, etc. can be brought on a common platform for effective delivery of health care at the primary level.

States should also accord priority to school health programmes aiming at preventive health education, regular health check-ups and promotion of health seeking behaviour among school children. Investment of resources in school health programmes would have a long term impact on the general health status of the people may reduce the requirement of public health spending substantially.

The States should actively involve the private sector in public health programmes. Medical practitioners in the private sector can be effective implementers of national programmes for reduction/control of communicable diseases, spreading awareness about non-communicable diseases and promote healthy life styles among the people. NGOs and community-based organisations should find an increasingly important role in the public health programmes for social mobilisation through health education campaigns.

The States should also try to bring in effective linkages with other social sectors like education, water supply, sanitation and nutrition which are also contributory factors to improving the general health status of the community. Convergence of socially-relevant programmes in these sectors with the health sector would bring in greater effectiveness in implementation.

Private Sector

Private sector is the dominant provider of health care services with a substantial share of 80 per cent in outpatient treatment and 55% in inpatient care. But due to the absence of a regulatory environment, the quality of service suffered leading to lack of accountability among the private sector health care providers. NHP 2001 envisages a strong and effective regulatory mechanism for private sector health care institutions and diagnostic facilities by enactment of a statute. The law will spell out the minimum statutory requirement for setting up a

health care institution and establish qualitative standards to bring in accountability. With this effective control, tertiary health care can largely be left to the private sector. With proper financial incentives, the private sector can be helped in channelising the resources to priority areas of clinical care and management at the tertiary level.

Human Resource Development

As in other areas, there is serious regional imbalance in availability of qualified medical practitioners and nursing and para-medical personnel across the country. NHP 2001 envisages financial support to under-served States in th country for providing medical education through establishment of medical/dental colleges, nursing colleges and other health care institutions. The Central Government should be able to provide adequate resources to these States for promoting centres of medical education.

The present educational system is heavily accented towards clinical care at the expense of public health. NHP 2001 will try to give primacy to public health in medical education. Adequate incentives will be provided for young medical aspirants to choose public health as a career. The experience in other countries, especially in the developed world, shows that public health needs qualified managers and not merely clinicians. There is therefore a strong case to open public health to non-medical professionals which will substantially improve the quality of the public health cadre in the country.

Even in postgraduate medical education, there is wide disparity across disciplines which led to neglect of public health-related specialities. The Policy would actively try to bring down this disparity and give greater encouragement for postgraduate medical education in public health-related subjects.

Non-determinant issues

Research: Biomedical research in India has not kept pace with fundamental and applied research in other scientific and technological fields. The Policy will aim at encouraging development of fundamental research in areas relevant to health. There should be investments in futuristic areas like biotechnology, genomic-based drug development, molecular biology, etc. Research in vaccines and therapeutic drugs for important diseases like HIV/AIDS, cancer, MDR TB, would be actively promoted by the Government. The Indian Council of Medical Research will play an increasingly vital role in promoting biomedical research and transfer of technology to the manufacturing sector. The country should also develop technical competence in the area of Patent Regimes and in filing Product Patents for inventions. The scientific institutions should gather adequate expertise in patents and in understanding the global implications of a patent regime.

Disease Surveillance and Response: Even though vast sums of money have been spent on control of communicable diseases, they continue to take their toll through outbreaks in various parts of the country. In most of these cases, lives could be saved if the response were to be quick and effective. In the absence of a proper surveillance and reporting system, valuable lives are lost in outbreaks of even curable diseases like malaria, GE, cholera, JE, etc. Building an effective surveillance system was accorded a very low priority in the country till recently. The surveillance system on polio and HIV/AIDS have demonstrated that the Centre and the States can build an effective response to control of diseases by getting critical and timely information. NHP 2001 would strive to build an integrated disease surveillance system for the entire country initially for communicable diseases which will later be expanded to include non-communicable diseases also. An effective networking of public health laboratories with health care institutions to provide results of samples is an important component of an effective surveillance system.

The country also does not have a proper national health accounts which acts as a handicap in planning and management of public health programmes. Development of a proper health management information system would lead to establishment of a reliable national health accounts which will be one of the priorities of NHP 2001.

Information, Education and Communication: Public health programmes need strong visibility. In a country with around 35% illiterate population, effective communication of public health-related issues is a big challenge. The NHP 2001 would strive to develop a national IEC strategy for health communication, health educational programmes, specially tailor-made to rural and illiterate populace. A the national health programmes should have a very strong component of IEC which should be implemented not only through Governmental media but through NGOs and community-based organisations. Promotion of a healthy life style is incumbent upon provision of health messages targetted at different groups like women, students, youth, migrant workers, etc.

Population Stabilisation: The Population Policy 2000 has certain immediate, mid-term and long term objectives. The long term objective is to achieve a stable population by 2045. The Policy sets certain socio-demographic goals for 2010 which are also relevant to the National Health Policy - 2001. Prevention and control of communicable diseases, containing the spread of HIV/AIDS, universal immunisation of children against all preventable diseases, addressing the unmet need for basic, reproductive and other health services, supplies and infrastructure are goals which run like a common thread in both the Policies. The objective of NHP 2001 to achieve an acceptable standard of good health among the general population of the country can be attained through these socio-demographic goals set in the Population Policy. Improving the general health status of the populace in our country will in itself be a contributory factor to faster population stabilisation.

Box I.: Goals to be achieved by 2000-2015

➢ Eradicate Polio and Yaws	2005
➢ Eliminate Kala Azar and Leprosy	2010
➢ Eliminate Lymphatic Filariasis	2015
➢ Achieve Zero level growth of HIV/AIDS	2010
➢ Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
➢ Reduce Prevalence of Blindness to 0.5%	2010
➢ Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
➢ Improve nutrition and reduce proportion of LBW Babies from 30% to 10%	2010
➢ Increase utilisation of public health facilities from current Level of <20 to >75%	2010
➢ Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
➢ Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
➢ Increase share of Central grants to Constitute at least 25% of total health spending	2010

Box 2 : Differentials in Health Status Among States

Indicator	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mortality per 1000 (NFHS II)	Weight For Age Children Under 3 % <-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 population	Malaria +ve Cases 2000 (in '000)
INDIA	26.1	70	94.9	47	408	3.7	2200
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharastra	25.02	48	58.1	50	135	3.1	138
TN	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

Box 3 : Achievements Through The Years - 1951-2000

INDICATOR	1951	1981	2000
DEMOGRAPHIC CHANGES			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	119	70 (99 SRS)
EPIDEMIOLOGICAL SHIFTS			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no of cases)	>44,887	Eradicated	
Guineaworm (no. of cases)		>39,792	Eradicated
Polio		29709	265
INFRASTRUCTURE			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries &Hospitals(all)	9209	23,555	43,322 (95-96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors(Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

Box-4 : % Public Health Spending in select Countries

Indicator	%Population with Income of <$1 day	Infant Mortality Rate/1000	%Health Expenditure to GDP	%Public Expenditure on Health to Total Health
India	44.2	72	5.2	13
China	18.5	31	2.7	24.9
Sri Lanka	6.6	16	3	45.4
UK	-	6	5.8	96.9
USA	-	7	13.7	44.1

Source : WHR 2000

Campaign on Access to Essential Medicines

A National Convention, jointly organised by the Jana Swasthya Abhiyan (Campaign for Peoples Health) and the Federation of Medical Representatives of India (FMRAI) was held in New Delhi on 14th June, 2001. The Convention was addressed by leading public health experts, academics, leaders of trade unions, women's organisations, farmer's organisations, peoples' science organisations, as well as representatives from FMRAI and JSA. The Convention adopted the attached Charter on Access to Essential Medicines. It also resolved to launch a nationwide campaign based on the charter, the salient targets of which would be:

- Setting up campaign committees in all States of the country
- Carry out mass demonstrative actions in State and District centres across the country in the form of rallies, convention, and other protest actions.
- Collect 10 million signatures supporting the Charter by September 2001.
- Organise a mass protest rally in New Delhi in November 2001.

Peoples Charter for Access to Essential Medicines

1. No privatisation of the public healthcare system.
2. More per capita budgetary expenditure on healthcare.
3. Increase the number of National Diseases Eradication Programmes and enhanced budgetary support to each programme.
4. Revitalise public sector drug companies.
5. Develop a public distribution system for cheaper essential drugs.
6. Formulate a rational drug under the aegis of the Health Ministry.
7. Ensure production and availability of all drugs in the national Essential Drug List.
8. Control import of bulk drugs and finished formulations and rationalise duties on imports. Restrict import keeping in view the needs of domestic producers.
9. All drugs should be assessed periodically, in order to ban hazardous and irrational drugs.
10. Formulate a new Drug Prices Control Order to bring all drugs under price control and to reduce prices of essential drugs.
11. No change in the fundamentals of the Indian Patents Act,1970, that allow domestic manufacture of patented drugs to counter monopoly, high prices and imports.
12. Utilisation of third party licensing by big companies to evade taxes, reduce employment and utilise cheap labour should be stopped.
13. Uniform tax structure for all drugs, maximum retail price should be inclusive of all taxes.
14. Strengthen quality control mechanisms to stop proliferation of spurious and sub-standard drugs.
15. Enquire into corrupt practices by drug companies involving tax and duty evasion.
16. All government purchases should be made through a central procurement system, based on the list of essential drugs.
17. No Foreign Direct Investment (FDI) be allowed in the pharmaceutical sector, except where there is clear indication that such investment will be accompanied by transfer of technology not available in the country.

Explanatory note on Peoples Charter for Access to Essential Medicines

Withdrawal of the Government from Health Care

A series of policy changes by the government -- including some that are on the anvil -- will have a direct effect on access to medical care in the country. The Insurance Regulatory Authority Act, for example, is designed to facilitate the introduction of private health insurance, and also to allow entry to MNCs in the health sector. It, moreover, allows the government to legitimise its withdrawal from investing in health care.

Public expenditure on health care has been a major casualty of the process of economic liberalisation and structural adjustment policies. Central allocation to State governments for health has declined, thereby forcing many States to procure loans from lending agencies such as the World Bank. Such loans are invariably associated with conditionalities that are directed at a transformation of the public health system. Such a transformation is sought to be achieved through mecahisms such as introduction of user charges, purchase of medicines through global tenders, farming out of primary health care centres to NGOs -- in others words, mechanisms for privatisation of the public health infrastructure and delivery system.

In many States we already witness the shift of administrative responsibilities in health care delivery to NGOs and other private organisation, thus minimising the role of elected representatives. This will further facilitate the privatisation of the health infrastructure. Implementation of such prescriptions, put forward by the World Bank, has led to utter chaos in the public health infrastructure in countries in S.America and Africa -- a fact that is admitted to even by the World Bank.

Investment by the government on health care (less than two percent of the budget) in India is one of the lowest in the world. Per capita investment in health is only Rs.57 a year and 87% of health care costs are paid for privately. Notwithstanding this the government has not only reduced expenditure on disease eradication programmes, it has also reduced the number of programmes covered. We see today a resurgence of communicable diseases, and while old diseases like tuberculosis, malaria, kalaazar flourish anew, newer diseases have started manifesting themselves -- including the looming threat of an AIDS epidemic. What is urgently required is not a cutback on existing programmes but a major expansion of disease control programmes.

Abandonment of Price Controls

While access to drugs constitutes only a part of measures required to confront a major public health crisis, it is still a necessary part. Recent policies that have been announced by the government are poised to further cut access to essential medicines, especially for the poor. In the recent budget the government has announced its intention to slash the number of drugs under price control. Moreover, such changes are being mooted not by the Ministry of Health or even the Ministry of Chemicals, but by the Finance Ministry.

The move to further reduce the span of price control is directed at improving the health of the industry and not the Indian people. Since the introduction of the first comprehensive drug policy in 1978, all subsequent policies have pandered to the needs of the industry. While the 1978 policy had 343 drugs under price control, this was reduced to 166 in 1987 and further to just 73 in 1994. Profitability allowed in controlled categories was increased in this period from 40-75% in 1978, to 75-100% in 1987 and finally to 150% in 1994. It is now proposed that just 15-20 drugs will be kept under price control -- thereby virtually making the whole policy of price control redundant. We already have a situation where the prices of essential drugs like anti-TB, anti-leprotics, cardiovascular drugs, etc. are rising at a significantly higher rate than the rate of inflation, and the situation can only worsen as price control is further relaxed. Many drug companies are known to openly flout the existing DPCO by not submitting cost-data to the National Pharmaceutical Pricing

Authority (NPPA). The pharmaceutical industry has openly expressed its displeasure over the NPPA (constituted about 5 years ago) and the new pricing policy might decide to scrap the NPPA. A new Drug Price Control Order, in fact, needs to do quite the opposite of what is being proposed -- increase the span of price controls, so that all essential drugs are put under price control.

Skewed R&D Policy

Almost two years back the Govt. had appointed two committees -- one to prepare policy guidelines towards R&D and the other to review the existing Drug Price Control Order (DPCO). The committee on R&D, among other recommendations, proposed the setting up of a corpus fund of Rs.150 crores for the pharmaceutical industry. In India the private sector had done little R&D for drug development, while major R&D work has been largely done in public funded institutions like CSIR laboratories. While the specific mechanisms for setting up the corpus fund are awaited, it is apprehended that this fund would be created by imposing higher taxes on drugs. Thus the private sector, in spite of its poor record in R&D, will be allowed another largesse by the government. Instead it would make much better sense for the government to invest in strengthening public funded R&D.

Revitalise the Public Sector

Even today there is a large infrastructure for manufacture of drugs in the public sector. Of these, the production units of Hindustan Antibiotics Ltd. have been rented out to private enterprises, who are making profit out of it. The Indian Drugs and Pharmaceuticals Ltd. (IDPL), once the largest company in the pharmaceutical sector in India, has been lying idle since 1996 and the Bureau of Industrial Finance and Restructuring (BIFR) has recommended that the company be wound up. HAL and IDPL, in the formative years of the drug industry in India, were the largest manufacturing units in the country and played a major role in helping the country become self reliant in the area of production of essential drugs. Moreover these two companies pioneered production of drugs from the basic stage in the country, and were the first to challenge the monopoly of MNCs. Unfortunately the same conditions which led to these companies becoming sick still exist -- corrupt and inept management at the highest levels coupled with a lack of direction. Today, faced with a change in the patent system and a renewed challenge from the Multinational Sector, these public sector units (IDPL, HAL as well as Bengal Chemical, Bengal Immunity and Smith Stanistreet) still have a major role to play. Given the will and the vision these public sector units can be revitalised and can play an important role in making available life saving and essential drugs at cheaper prices.

Public Distribution System

It is estimated that 60-70% of the Indian people have little or no access to medicines, primarily because they cannot afford such medicines and the public health system is woefully adequate. In such a situation the government needs to establish a public distribution system for drugs, through which all essential drugs at subsidised prices (where necessary) should be distributed.

Ensure Rational Drug Use

A large number of hazardous and irrational drugs are sold in the market. Sale of such drugs is not only a major health hazard, but also deflects scarce resources away from essential medicines. Such a situation has been made possible because there is no real drug policy in existence -- merely a pricing and licensing policy. Companies, as a consequence, are able to sell these medicines with the help of their high-pressure unethical marketing. A rational drug policy under the aegis of the Health Ministry (and not the Industry Ministry) is the first necessary step to remedy this situation. Such a policy needs to prioritise drug needs of the country on the basis of a list of essential drugs, ensure production of quality drugs at cheaper prices and minimise import. The policy should also devise means to ensure rational drug production and usage.

Stop Unethical Promotion

Steps are required to put a check on the unethical promotion of drugs. In spite of repeated assurances the government is yet to enforce the 'Criteria of Ethical Promotion of Pharmaceuticals' prepared by the WHO. In recent years there is a noticeable tendency towards marketing of expensive new drugs, most of which have little or no advantage over older and cheaper drugs. These drugs, many of them being imported, are marketed with the help of lucrative inducements offered to a section of the medical profession and chemists. Therefore a rational drug policy should include mechanisms to ensure ethical drug promotion and prevent the import of non-essential drugs.

Reverse Import Liberalisation

Following the liberalisation of imports, multinational drug companies are closing down their production units in the country. They are either importing their products from their parent companies or getting them manufactured in the small scale sector. This has led to a sharp increase in imports in the last two years, while closure of large production units has caused unemployment of thousands of workers. While mergers, acquisitions and brand selling has flourished, there is no significant investment in the industry. All these have led to increasing unemployment and loss of job security in the pharmaceutical sector. Liberalised imports have also forced the closure of many medium scale bulk drug companies who face competition from cheaper imported bulk drugs. Urgent measures are required to stop unrestricted import of bulk drugs through appropriate duty structures that favour domestic manufacturers.

Save the Indian Patents Act, 1970

The Indian Patents Act of 1970 was instrumental in helping the country achieve self reliance in the production of drugs. It helped Indian companies introduce new drugs within 2-3 years of their introduction in the global market, that too at prices that were one-tenth or less of global prices. It also encouraged the development of process technologies for a large majority of essential drugs, principally in public funded institutions. Today the government is poised to change the Indian Patents Act in order to "honour" its obligations at the WTO. Changes envisaged will reverse most of the benefits of the earlier Act. It is of vital importance that the new Act retain licensing provisions that allow domestic manufacturers to manufacture patented drugs if monopolies are created, if prices are high, or if domestic manufacture is not done by the original patentee. Various other safegaurds need to be built in to see that all the gains of the 1970 Patents Act are not frittered away. Today many developing countries, who amended their Patent Acts in accordance with the TRIPS accord are faced with exorbitant prices for new drugs -- a situation that has brought the whole continent of Africa, reeling under the onslaught of an AIDS epidemic, to the brink of a disaster. Many of these countries are today prepared to come together and unitedly demand a revision of the TRIPS accord. The issue has also led to the building of an unparallelled global coalition that is prepared to question the TRIPS accord. India has, arguably, the most developed pharmaceutical industry in the developing world. Instead of rushing in to amend its Patents Act in a foolhardy manner, India needs to provide leadership to the rising tide of discontent all over the globe, against the TRIPS accord.

Stop Third Party Manufacture

The government allows large companies to get their drugs manufactured in the small scale sector, even if they have the capacity to manufacture such drugs. This opportunity is being misused by many large companies, some of whom have even closed down their factories. This facility for "third party manufacturing" allows big companies to utilise exemptions provided to the small scale sector and also to reap the benefits of cheap labour costs in the small scale sector. Moreover, such manufacturing leads to poor quality control and increases the presence of sub-standard and spurious drugs in the market. Many large companies, however, are content to reap profits as mere traders, leaving the manufacturing to the large, unorganised and poorly monitored small scale sector.

- **Stop Tax and Duty Evasion, Rationalise Taxes**

Unregulated manufacturing also allows large scale defaults in the payments of taxes and duties. This leads to crores of revenue being lost by the government. While the practice is widely known, the government has refused to act till date. Because the tax structure varies in among different states, it too promotes illegal trade in drugs across state borders. Moreover, in the absence of a clear tax structure, consumers are charged in accordance with the arbitrary whims of retail chemists. This situation can be remedied by having an uniform tax structure, and by clearly printing the price of drugs on packages, inclusive of all taxes.

Centralised Drug Procurement

The government is a major purchaser of drugs and if government purchases are co-ordinated it can provide it with a major bargaining handle to push down drug costs. Such a procedure is in place in many countries, including many developed countries, and should be introduced in India too.

International symposium on
TRIPS and Access to Medicines

An International symposium on TRIPS and access to medicines was organised by the National Working Group on Patent Laws and Medecins Sans Frontieres (doctors Without Borders) on 4th June. This was followed by a Working Group Meeting on "Intellectual Property and Access to Drugs" in New Delhi India, on 5th and 6th June, 2001. The meeting was held in the background of MSF's ongoing "Access to Essential Medicines" campaign and the upcoming WTO Ministerial Conference. This working Group, constituted of 25 international experts, has been set up by MSF to advise it in its campaign.

Background to the Symposium

The widely evocative issue of access to anti-retrovirals, i.e. drugs that are used to treat AIDS patients, has played a major role in the way the international community today sees the pharmaceutical industry. Treatment of AIDS with a combination of drugs -- called Highly Active Anti-retroviral Treatment (HAART) -- has decreased mortality from AIDS by 84% in developing countries. Unfortunately less than 5% of AIDS infected people across the globe have access to such treatment currently, because the estimated cost of treatment by HAART is about $12,000 per person per year. At present rates, Zimbabwe, Uganda and Ivory Coast would require to spend 265%, 172% and 84% of their respective Gross National Products, just to buy drugs to treat all their AIDS patients! This issue has been the rallying point of a major global campaign that today is demanding a closer, critical look at the TRIPS agreement.

Condemnation of the role of pharmaceutical companies reached a crescendo due to the lawsuit brought against the South African government in Pretoria's High Court by 39 pharmaceutical companies. The lawsuit targeted a legislation by South Africa -- the Medicines and Related Substances Control Amendment Act, No. 90 of 1997 -- which allowed the country access to cheaper anti-AIDS drugs. The 1998 lawsuit was supported by the US Government, which placed South Africa on the Special 301 Watch List, and the European Union, which wrote to then Vice President of South Africa, Mbeki, to express its concern about the legislation. This move by the pharma majors evoked a massive counter-response across the globe, led by MSF. The companies suffered a major defeat when, in April, 2001 the companies capitulated to mounting anger and disgust over their conduct and agreed to withdraw the case unconditionally. About two months back Brazil moved a resolution at the UN Human Rights Commission, which was approved by 52 votes in favor, 0 against and 1 abstention (USA). The resolution, among other things, called upon States, at the international level, to ensure that "the application of international agreements is supportive of public health policies which promote broad access to safe, efficient and affordable preventive, curative or palliative pharmaceuticals and medical technologies..." Today many national governments in third world countries are backing protests and demonstrations against the WTO in general and the TRIPS regime in particular.

Countries in Africa, Latin America and Asia, as well as organisations campaigning for access to cheap anti-AIDS drugs see India as a potential source of cheap drugs. In March 2001, an Indian company, Cipla, announced that it would offer the combination of anti-AIDS drugs at a cost of $600 per patient per year, and later announce that they could bring down costs to $350. Cipla's offer was matched within weeks by two other companies, Hetero Drugs and Ranbaxy. These offers are, till date, by far the cheapest that have been made anywhere in the world. In other words, Indian companies are now offering drugs to treat AIDS at prices that are one fortieth of global prices! Such a precipitous fall in prices can revolutionise AIDS treatment in developing countries, and save millions of lives.

The defeat for the 39 pharmaceutical companies in South Africa is not the end of the battle. Every country that has tried to interpret the TRIPS Agreement in a manner that allows access to cheaper drugs for its people is faced with a hostile reaction from the US. But it has led to the building of an unprecedented global coalition against the use of TRIPS to deny the poor access to drugs.

Summary of Deliberations at the Symposium

Participants at the symposium expressed concern at the trend in Intellectual Property protection, that is increasingly skewing the balance of the rights of patent holders and consumers, in favour of the former. Speakers noted that the TRIPS agreement marks a fundamental shift in this balance, as well as a shift in global attitudes where private profits are put ahead of social benefits. This is further fueled by dependence of economies in the developed world on industries that require strong IP protection. Of the 15 most profitable industries today, 6 are from the pharmaceutical sector and 5 from the IT sector. It was also pointed out that IP protection allows such industries to create monopolies, not only over production, but also in the control of knowledge.

The net result of this trend, in the pharmaceutical sector, has been high cost of medicines and the consequent denial of access to medicines by the income poor across the globe. Further, it has also led to a situation where medicines required to treat disease that predominantly occur among the poor are not researched at all. Instead drugs that are being researched are drugs used for "lifestyle" diseases like baldness, impotence, obesity, etc. It was underlined that while the pharmaceutical industry claims that high prices are explained by the massive expenditure on R&D, the truth is that drugs they actually research have little relevance to real medical needs. Moreover, the kind of profits that big pharmaceutical MNCs generate are an indication of profiteering and not just legitimate profit making.

Speakers at the symposium also stressed on the need to utilise provisions available in the TRIPS agreement to ensure production of cheap drugs by domestic manufacturers in developing countries. For this, legislations in developing countries need to have licensing and other provisions that prevent abuse of monopoly positions by MNCs and also allow imports of drugs from the global market at lower prices. It was also pointed out that the next few years are going to be crucial, as developed countries challenge laws enacted by developing countries like Brazil in the WTO dispute settlement mechanism. The resolution in WTO of the complaint made by the US against Brazil for violation of the TRIPS agreement because the former has included provisions that allow it to produce cheap ant-AIDS drugs by licensing domestic manufacturers, is being seen as crucial in this context.

Speakers also commented on the adverse effect that TRIPS has on R&D and technology dissemination in developing countries. It was pointed out that such capabilities, built up in countries like India, Brazil and Argentine are under serious threat. The need to organise public funded research in these countries was stressed. Representatives from the Indian Drug Manufacturers Association and the Indian Pharmaceutical alliance spoke of the need to tailor the Indian Patent ACT - still at the drafting board -- to the needs of domestic industry, and domestic consumers. Speakers also expressed concern that there are already are signs that the Indian pharmaceutical industry is moving from a position of self reliance and relatively stable prices to a situation of import dependence and high prices.

Those who spoke at the Symposium include Mr. S.P. Shukla, formerly India's chief negotiator at GATT; Ms.Ellen 't Hoen, Co-ordinator of MSF's Access campaign; Prof. Prabhat Patnaik and Prof. Ashok Parthasarathy from JNU; Dr James Orbinski, Director MSF Working Group on Drugs for Neglected Diseases; Dr. Pushpa M. Bhargava, Founder Director, CCMB; Dr. Nitya Nand, Chairman, NWGPL and Former Director, Central Drug Research Instt.; Dr. Arun Ghosh, Former Member Planning Commission; and Mr.James Love, Director, Consumer Project on Technology (USA), Mr.B.K. Keayla, Convenor, NWGPL, Dr. Amit Sen Gupta, NWGPL, Prof. Fredrick M. Abbott, Florida State University; Prof. Jerome H. Reichnmn, Prof. of Law, Duke University; Mr.Dinesh Abrol, Co-convenor, NWGPL; Dr. Biswajit Dhar, NWGPL; Dr. Vandana Shiva, RFSTE; Dr. Gopakumar Nair, Indian Drug Manufacturer's Association; Mr. Dilip G. Shah, Indian Pharmaceutical Alliance; Dr. D.B.A. Narayana, Director, Dabur Research Foundation; Dr. Graham Dukes, Universities of Groningen and Oslo; Mr. Balraj Mehta, NWGPL; Dr.Mira Shiva, Co-ordinator All India Drug Action Network; Dr. N.N. Mehrotra, CDRI; Mr Amitava Guha, Federation of Medical Representatives' Assn. of India, Dr.Zafar Mirza, Health Action International; Mr.Prabir Purakayastha, Delhi Science Forum; and Ms. Pascale Boulet, MSF.

Padmini Alumni — points for HNP Ad. Com. Meeting — Mon 22/10/01

1. Workshop on sustainability ← Grants from GOI / Have own budgets - either panch. resources / 18% allocated for women

what will happen after the project period

salary, etc.

2. Prioritise + focus

what are things that project can continue

3. Disc' c departmental officers. — giving them a copy of report

letter re all — informing about the project + CHC role.

4. Sustainability from panchayats. ← Kanbay study, intervention study, c partnership

Infighting d/o lack of communic' + understanding

Non credit sustainability — human commitment

Padma — available after 3rd Nov — for the entire month

28th / 29th for Calany.

Agenda for 22/10 meeting

1. Review of HNP.
2. Planning — Time frame, responsibility — work backward from Nov 15th
3. Workshop — on sustainability, integr" — the hows, + disease surveillance
4. Pictorial/graphical presentation of key project interventions in the context of what is primary health care + public health.

Avoid short termism / bureaucratic way of ideas — colour code for strategy + impl

allowance for AWW

DRAFT NATIONAL HEALTH POLICY - 2001

1. INTRODUCTORY

1.1 A National Health Policy was last formulated in 1983 and since then, there have been very marked changes in the determinant factors relating to the health sector. Some of the policy initiatives outlined in the NHP-1983 have yielded results, while in several other areas, the outcome has not been as expected.

1.2 The NHP-1983 gave a general exposition of the recommended policies required in the circumstances then prevailing in the health sector. The noteworthy initiatives under that policy were :-

i. A phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves;
ii. Intermediation through 'Health volunteers' having appropriate knowledge, simple skills and requisite technologies;
iii. Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level;
iv. An integrated net-work of evenly spread speciality and super-speciality services; encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government's facilities is limited to those entitled to free use.

1.3 Government initiatives in the pubic health sector have recorded some noteworthy successes over time. Smallpox and Guinea Worm Disease have been eradicated from the country; Polio is on the verge of being eradicated; Leprosy, Kala Azar, and Filariasis can be expected to be eliminated in the foreseeable future. There has been a substantial drop in the Total Fertility Rate and Infant Mortality Rate. The success of the initiatives taken in the public health field are reflected in the progressive improvement of many demographic / epidemiological / infrastructural indicators over time – (Box-I).

Box-1 : Through The Years - 1951-2000Achievements

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	110	70 (99 SRS)

Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no of cases)	>44,887	Eradicated	
Guineaworm (no. of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries &Hospitals(all)	9209	23,555	43,322 (95–96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors(Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

1.4 While noting that the public health initiatives over the years have contributed significantly to the improvement of these health indicators, it is to be acknowledged that public health indicators / disease-burden statistics are the outcome of several complementary initiatives under the wider umbrella of the developmental sector, covering Rural Development, Agriculture, Food Production, Sanitation, Drinking Water Supply, Education, etc. Despite the impressive public health gains as revealed in the statistics in Box-I, there is no gainsaying the fact that the morbidity and mortality levels in the country are still unacceptably high. These unsatisfactory health indices are, in turn, an indication of the limited success of the public health system to meet the preventive and curative requirements of the general population.

1.5 Out of the communicable diseases, which have persisted over history, incidence of Malaria has staged a resurgence in the1980s before stabilising at a fairly high prevalence level during the 1990s. Over the years, an increasing level of insecticide-resistance has developed in the malarial vectors in many parts of the country, while the incidence of the more deadly P-Falciparum Malaria has risen to about 50 percent in the country as a

whole. In respect of TB, the public health scenario has not shown any significant decline in the pool of infection amongst the community, and, there has been a distressing trend in increase of drug resistance in the type of infection prevailing in the country. A new and extremely virulent communicable disease – HIV/AIDS - has emerged on the health scene since the declaration of the NHP-1983. As there is no existing therapeutic cure or vaccine for this infection, the disease constitutes a serious threat, not merely to public health but to economic development in the country. The common water-borne infections – Gastroenteritis, Cholera, and some forms of Hepatitis – continue to contribute to a high level of morbidity in the population, even though the mortality rate may have been somewhat moderated. The period after the announcement of NHP-83 has also seen an increase in mortality through 'life-style' diseases- diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem. The changed circumstances relating to the health sector of the country since 1983 have generated a situation in which it is now necessary to review the field, and to formulate a new policy framework as the National Health Policy-2001.

1.6 NHP-2001 will attempt to set out a new policy framework for the accelerated achievement of Public health goals in the socio-economic circumstances currently prevailing in the country.

2. CURRENT SCENARIO

2.1 FINANCIAL RESOURCES

The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 20 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual per capita public health expenditure in the country is no more than Rs.160. Given these statistics, it is no surprise that the reach and quality of public health services has been below the desirable standard. Under the constitutional structure, public health is the responsibility of the States. In this framework, it has been the expectation that the principal contribution for the funding of public health services will be from States' resources, with some supplementary input from Central resources. In this backdrop, the contribution of Central resources to the overall public health funding has been limited to about 15 percent. The fiscal resources of the State Governments are known to be very inelastic. This itself is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget. If the decentralized pubic health services in the country are to improve significantly, there is a need for injection of substantial resources into the health sector from the Central Government Budget. This approach, despite the formal Constitutional provision in regard to public health, is a necessity if the State public health services - a major component of the initiatives in the social sector - are not to become entirely moribund. The NHP-2001 has been formulated taking into consideration these ground realities in regard to the availability of resources.

2.2 EQUITY

2.2.1 In the period when centralized planning was accepted as a key instrument of development in the country, the attainment of an equitable regional distribution was considered one of its major objectives. Despite this conscious focus in the development process, the statistics given in Box-II clearly indicate that attainment of health indices have been very uneven across the rural – urban divide.

Box II : Differentials in Health Status Among States

Sector	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mort-ality per 1000 (NFHS II)	Weight For Age- % of Children Under 3 years (<-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 popula-tion	Malaria +ve Cases in year 2000 (in thousands)
India	**26.1**	**70**	**94.9**	**47**	**408**	**3.7**	**2200**
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharastra	25.02	48	58.1	50	135	3.1	138
TN	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

Also, the statistics bring out the wide differences between the attainments of health goals in the better- performing States as compared to the low-performing States. It is clear that national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country. Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide

inter-State disparity implies that, for vulnerable sections of society in several States. access to public health services is nominal and health standards are grossly inadequate. Despite a thrust in the NHP-1983 for making good the unmet needs of public health services by establishing more public health institutions at a decentralized level, a large gap in facilities still persists. Applying current norms to the population projected for the year 2000, it is estimated that the shortfall in the number of SCs/PHCs/CHCs is of the order of 16 percent. However, this shortage is as high as 58 percent when disaggregated for CHCs only. The NHP-2001 will need to address itself to making good these deficiencies so as to narrow the gap between the various States. as also the gap across the rural-urban divide.

2.2.2 Access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially disadvantaged sections of society. The statistics given in Box-III highlight the handicap suffered in the health sector on account of socio-economic inequity.

Box-III : Differentials in Health status Among Socio-Economic Groups

Indicator	Infant Mortality/1000	Under 5 Mortality/1000	% Children Underweight
India	70	94.9	47
Social Inequity			
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

2.2.3 It is a principal objective of NHP-2001 to evolve a policy structure which reduces these inequities and allows the disadvantaged sections of society a fairer access to public health services.

2.3 DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES

2.3.1 It is self-evident that in a country as large as India, which has a wide variety of socio-economic settings, national health programmes have to be designed with enough flexibility to permit the State public health administrations to craft their own programme package according to their needs. Also, the implementation of the national health programme can only be carried out through the State Governments' decentralized public health machinery. Since, for various considerations, the responsibility of the Central Government in funding additional public health services will continue over a period of time, the role of the Central Government in designing broad-based public health initiatives will inevitably continue. Moreover, it has been observed that the technical and managerial expertise for designing large-span public health programmes exists with the

Central Government in a considerable degree; this expertise can be gainfully utilized in designing national health programmes for implementation in varying socio-economic settings in the states.

2.3.2 Over the last decade or so, the Government has relied upon a 'vertical' implementational structure for the major disease control programmes. Through this, the system has been able to make a substantial dent in reducing the burden of specific diseases. However, such an organizational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain. Over a long time-range, 'vertical' structures may only be affordable for diseases, which offer a reasonable possibility of elimination or eradication in a foreseeable time-span. In this background, the NHP-2001 attempts to define the role of the Central Government and the State Governments in the public health sector of the country.

2.4 THE STATE OF PUBLIC HEALTH INFRA-STRUCTURE

2.4.1 The delineation of NHP-2001 would be required to be based on an objective assessment of the quality and efficiency of the existing public health machinery in the field. It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services. As a result of such inadequate public health facilities, it has been estimated that less than 20 percent of the population seeks the OPD services and less than 45 percent avails of the facilities for in-door treatment in public hospitals. This is despite the fact that most of these patients do not have the means to make out-of-pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition.

2.5 EXTENDING PUBLIC HEALTH SERVICES

2.5.1 While in the country generally there is a shortage of medical manpower, this shortfall is disproportionately impacted on the less-developed and rural areas. No incentive system attempted so far, has induced private medical manpower to go to such areas; and, even in the public health sector it has usually been a losing battle to deploy medical manpower in such under-served areas. In such a situation, the possibility needs to be examined for entrusting some limited public health functions to nurses, paramedics and other personnel from the extended health sector after imparting adequate training to them.

2.5.2 India has a vast reservoir of practitioners in the Indian Systems of Medicine and Homoeopathy, who have undergone formal training in their own disciplines. The possibility of using such practitioners in the implementation of State/Central Government public health Programmes, in order to increase the reach of basic health

care in the country, is addressed in the NHP-2001.

2.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

2.6.1 Some States have adopted a policy of devolving programmes and funds in the health sector through different levels of the Panchayati Raj Institutions. Generally, the experience has been a favourable one. The adoption of such an organisational structure has enabled need-based allocation of resources and closer supervision through the elected representatives. NHP- 2001 examines the need for a wider adoption of this mode of delivery of health services, in rural as well as urban areas, in other parts of the country.

2.7 MEDICAL EDUCATION

2.7.1 Medical Colleges are not evenly spread across various parts of the country. Apart from the uneven geographical distribution of medical institutions, ,the quality of education is highly uneven and in several instances even sub-standard. It is a common perception that the syllabus is excessively theoritical, making it difficult for the fresh graduate to effectively meet even the primary health care needs of the population. There is an understandable reluctance on the part of graduate doctors to serve in areas distant from their native place. NHP-2001 will suggest policy initiatives to rectify these disparities.

2.7.2 Certain medical discipline, such as, molecular biology and gene-manipulation, have become relevant in the period after the formulation of the previous National Health Policy. Also, certain speciality disciplines – Anesthesiology, Radiology and Forensic Medicines – are currently very scarce, resulting in critical deficiencies in the package of available public health services. The components of medical research in the recent years have changed radically. In the foreseeable future such research will rely increasingly on such new disciplines. It is observed that the current under-graduate medical syllabus does not cover such emerging subjects. NHP-2001 will make appropriate recommendations in this regard.

2.8 NEED FOR SPECIALISTS IN 'PUBLIC HEALTH' AND 'FAMILY MEDICINE'

2.8.1 In any developing country with inadequate availability of health services, the requirement of expertise in the areas of 'public health' and 'family medicine' is very much more than the expertise required for other specialized clinical disciplines. In India, the situation is that public health expertise is non-existent in the private health sector, and far short of requirement in the public health sector. Also, the current curriculum in the graduate / post-graduate courses is outdated and unrelated to contemporary community needs. In respect of 'family medicine', it needs to be noted that the more talented medical graduates generally seek specialization in clinical disciplines, while the remaining go into general practice. While the availability of postgraduate educational facilities is 50 percent of the total number of the qualifying graduates each year, and can be considered adequate, the distribution of the disciplines in the postgraduate training facilities is overwhelmingly in favour of clinical specializations. NHP-2001 examines the need for ensuring adequate availability of personnel with specialization in the 'public health' and 'family medicine' disciplines, to discharge the public health responsibilities in the country.

2.9 URBAN HEALTH

2.9.1 In most urban areas, public health services are very meagre. To the extent that such services exist, there is no uniform organisational structure. The urban population in the country is presently as high as 30 percent and is likely to go up to around 33 percent by 2010. The bulk of the increase is likely to take place through migration, resulting in slums without any infrastructure support. Even the meagre public health services available do not percolate to such unplanned habitations, forcing people to avail of private health care through out-of-pocket expenditure. The rising vehicle density in large urban agglomerations has also led to an increased number of serious accidents requiring treatment in well-equipped trauma centres. NHP-2001 will address itself to the need for providing this unserved population a minimum standard of health care facilities.

2.10 MENTAL HEALTH

2.10.1 Mental health disorders are actually much more prevalent than are visible on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families. Serious cases of mental disorder require hospitalization and treatment under trained supervision. Mental health institutions are perceived to be woefully deficient in physical infrastructure and trained manpower. NHP-2001 will address itself to these deficiencies in the public health sector.

2.11 INFORMATION, EDUCATION AND COMMUNICATION

2.11.1 A substantial component of primary health care consists of initiatives for disseminating, to the citizenry, public health-related information. Public health programmes, particularly, need high visibility at the decentralized level in order to have any impact. This task is particularly difficult as 35 percent of our country's population is illiterate. The present IEC strategy is too fragmented, relies heavily on mass media and does not address the needs of this segment of the population. It is often felt that the effectiveness of IEC programmes is difficult to judge; and consequently, it is often asserted that accountability, in regard to the productive use of such funds, is doubtful. NHP-2001, while projecting an IEC strategy, will fully address the inherent problems encountered in any IEC programme designed for improving awareness in order to bring about behavioural change in the general population.

2.11.2 It is widely accepted that school and college students are the most receptive targets for imparting information relating to basic principles of preventive health care. NHP-2001 will attempt to target this group to improve the general level of health awareness.

2.12 MEDICAL RESEARCH

2.12.1 Over the years, medical research activity in the country has been very limited. In the Government, such research has been confined to the research institutions under the Indian Council of Medical Research, and other institutions funded by the States/Central Government. Research in the private sector has assumed some significance only in the last decade. In our country, where the aggregate annual health expenditure is of the order

of Rs. 80,000 crores, the expenditure in 1998-99 on research, both public and private sectors, was only of the order of Rs. 1150 crores. It would be reasonable to infer that with such low research expenditure, it would be virtually impossible to make any dramatic break-through within the country, by way of new molecules and vaccines: also, without a minimal back-up of applied and operational research, it would be difficult to assess whether the health expenditure in the country is being incurred through optimal applications and appropriate public health strategies. Medical Research in the country needs to be focused on therapeutic drugs/vaccines for tropical diseases, which are normally neglected by international pharmaceutical companies on account of limited profitability potential. The thrust will need to be in the newly-emerging frontier areas of research based on genetics, genome-based drug and vaccine development, molecular biology, etc. NHP-2001 will address these inadequacies and spell out a minimal quantum of expenditure for the coming decade, looking to the national needs and the capacity of the research institutions to absorb the funds.

2.13 ROLE OF THE PRIVATE SECTOR

2.13.1 Considering the economic restructuring underway in the country, and over the globe, since the last decade, the changing role of the private sector in providing health care will also have to be addressed in NHP 2001. Currently, the contribution of private health care is principally through independent practitioners. Also, the private sector contributes significantly to secondary-level care and some tertiary care. With the increasing role of private health care, the need for statutory licensing and monitoring of minimum standards of diagnostic centres / medical institutions becomes imperative. NHP-2001 will address the issues regarding the establishment of a regulatory mechanism to ensure adequate standards of diagnostic centres / medical institutions, conduct of clinical practice and delivery of medical services.

2.13.2 Currently, non-Governmental service providers are treating a large number of patients at the primary level for major diseases. However, the treatment regimens followed are diverse and not scientifically optimal, leading to an increase in the incidence of drug resistance. NHP-2001 will address itself to recommending arrangements, which will eliminate the risks arising from inappropriate treatment.

2.13.3 The increasing spread of information technologt raises the possibility of its adoption in the health sector. NHP-2001 will examine this possibility.

2.14 ROLE OF THE CIVIL SOCIETY

2.14.1 Historically, the practice has been to implement major national disease control programmes through the public health machinery of the State/Central Governments. It has become increasingly apparent that certain components of such programmes cannot be efficiently implemented merely through government functionaries. A considerable change in the mode of implementation has come about in the last two decades, with an increasing involvement of NGOs and other institutions of civil society. It is to be recognized that widespread debate on various public health issues have, in fact, been initiated and sustained by NGOs and other members of the civil society. Also, an increasing contribution is being made by such institutions, in the delivery of different components of public health services. Certain disease control programmes require close

inter-action with the beneficiaries for regular administration of drugs: periodic carrying out of the pathological tests; dissemination of information regarding disease control and other general health information. NHP-2001 will address such issues and suggest policy instruments for implementation of public health programmes through individuals and institutions of civil society.

2.15 NATIONAL DISEASE SURVEILLANCE NETWORK

2.15.1 The technical network available in the country for disease surveillance is extremely rudimentary and to the extent that the system exists, it extends only up to the district level. Disease statistics are not flowing through an integrated network from the decentralized public health facilities to the State/Central Government health administration. Such an arrangement only provides belated information, which, at best, serves a limited statistical purpose. The absence of an efficient disease surveillance network is a major handicap in providing a prompt and cost effective health care system. The efficient disease surveillance network set up for Polio and HIV/AIDS has demonstrated the enormous value of such a public health instrument. Real-time information of focal outbreaks of common communicable diseases – Malaria, GE, Cholera and JE – and other seasonal trends of diseases, would enable timely intervention, resulting in the containment of any possible epidemic. In order to be able to use an integrated disease surveillance network, for operational purposes, real-time information is necessary at all levels of the health administration. NHP-2001 would address itself to this major systemic shortcoming in the administration.

2.16 HEALTH STATISTICS

2.16.1 The absence of a systematic and scientific health statistics data-base is a major deficiency in the current scenario. The health statistics collected are not the product of a rigorous methodology. Statistics available from different parts of the country, in respect of major diseases, are often not obtained in a manner which make aggregation possible, or meaningful.

2.16.2 Further, absence of proper and systematic documentation of the various financial resources used in the health sector is another lacunae witnessed in the existing scenario. This makes it difficult to understand trends and levels of health spending by private and public providers of health care in the country, and to address related policy issues and formulate future investment policies.

2.16.3 NHP-2001 will address itself to the programme for putting in place a modern and scientific health statistics database as well as a system of national health accounts.

2.17 WOMEN'S HEALTH

2.17.1 Social, cultural and economic factors continue to inhibit women from gaining adequate access to even the existing public health facilities. This handicap does not just affect women as individuals; it also has an adverse impact on the health, general well-being and development of the entire family, particularly children. NHP 2001 recognises the catalytic role of empowered women in improving the overall health standards of the community.

2.18 MEDICAL ETHICS

2.18.1 Professional medical ethics in the health sector is an area, which has not received much attention in the past. Also, the new frontier areas of research – involving gene manipulation, organ human cloning and stem cell research _ impinge on visceral issues relating to the sanctity of human life and the moral dilemma of human intervention in the designing of life forms. Besides these, in the emerging areas of research, there is an un-charted risk of creating new life forms, which may irreversibly damage the environment, as it exists today. NHP – 2001 recognises that moral and religious dilemma of this nature, which was not relevant even two years ago, now pervades mainstream health sector issues.

2.19 ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS

2.19.1 There is an increasing expectation and need of the citizenry for efficient enforcement of reasonable quality standards for food and drugs. Recognizing this need, NHP – 2001 makes an appropriate policy recommendation.

2.20 REGULATION OF STANDARDS IN PARA MEDICAL DISCIPLINES

2.20.1 It has been observed that a large number of training institutions have mushroomed particularly in the private sector, for several para medical disciplines – Lab Technicians, Radio Diagnosis Technicians, Physiotherapists, etc. Currently, there is no regulation/monitoring of the curriculum, or the performance of the practitioners in these disciplines. NHP-2001 will make recommendations to ensure standardization of training and monitoring of performance.

2.21 OCCUPATIONAL HEALTH

2.21.1 Work conditions in several sectors of employment in the country are sub-standard. As a result of this, workers engaged in such activities become particularly prone to occupation-linked ailments. The long-term risk of chronic morbidity is particularly marked in the case of child labour. NHP-2001 will address the risk faced by this particularly vulnerable section of the society.

2.22 PROVIDING MEDICAL FACILITIES TO USERS FROM OVERSEAS

2.22.1 The secondary and tertiary facilities available in the country are of good quality and cost-effective compared to international medical facilities. This is true not only of facilities in the allopathic disciplines, but also to those belonging to the alternative systems of medicine, particularly Ayurveda. NHP-2001 will assess the possibilities of encouraging commercial medical services for patients from overseas.

2.23 IMPACT OF GLOBALIZATION ON THE HEALTH SECTOR

2.23.1 There are some apprehensions about the possible adverse impact of economic globalisation on the health sector. Pharmaceutical drugs and other health services have always been available in the country at extremely inexpensive prices. India has established a reputation for itself around the globe for innovative development of original process patents for the manufacture of a wide-range of drugs and vaccines within the ambit of the existing patent laws. With the adoption of Trade Related

Intellectual Property (TRIPS), and the subsequent alignment of domestic patent laws consistent with the commitments under TRIPS. there will be a significant shift in the scope of the parameters regulating the manufacture of new drugs/vaccines. Global experience has shown that the introduction of a TRIPS-consistent patent regime for drugs in a developing country, would result in an increase in the cost of drugs and medical services. NHP-2001 will address itself to the future imperatives of health security in the country, in the post-TRIPS era.

2.24 NON – HEALTH DETERMINANTS

2.24.1 Improved health standards are closely dependent on major non-health determinants such as safe drinking water supply, basic sanitation, adequate nutrition, clean environment and primary education, especially of the girl child. NHP-2001 will not explicitly address itself to the initiatives in these areas, which although crucial, fall outside the domain of the health sector. However, the attainment of the various targets set in NHP 2001 assumes a reasonable performance in these allied sectors.

2.25 POPULATION GROWTH AND HEALTH STANDARDS

2.25.1 Efforts made over the years for improving health standards have been neutralized by the rapid growth of the population. Unless the Population stabilization goals are achieved, no amount of effort in the other components of the public health sector can bring about significantly better national health standards. Government has separately announced the 'National Population Policy – 2000'. The principal common features covered under the National Population Policy-2000 and NHP-2001, relate to the prevention and control of communicable diseases; priority to containment of HIV/AIDS infection; universal immunization of children against all major preventable diseases; addressing the unmet needs for basic and reproductive health services; and supplementation of infrastructure. The synchronized implementation of these two Policies – National Population Policy – 2000 and National Health Policy-2001 – will be the very cornerstone of any national structural plan to improve the health standards in the country.

2.26 ALTERNATIVE SYSTEMS OF MEDICINE

2.26.1 Alternative Systems of Medicine – Ayurveda, Unani, Sidha and Homoeopathy – provide a significant supplemental contribution to the health care services in the country, particularly in the underserved, remote and tribal areeas. The main components of NHP-2001 apply equally to the alternative systems of medicine. However, the policy features specific to the alternative systems of medicine will be presented as a separate document.

3. OBJECTIVES

3.1 The main objective of NHP-2001 is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country. Emphasis will be given to increasing

the aggregate public health investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the State level to render effective service delivery. The contribution of the private sector in providing health services would be much enhanced, particularly for the population group, which can afford to pay for services. Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation. Emphasis will be laid on rational use of drugs within the allopathic system. Increased access to tried and tested systems of traditional medicine will be ensured. Within these broad objectives, NHP-2001 will endeavour to achieve the time-bound goals mentioned in Box-IV.

Box-IV: Goals to be achieved by 2000-2015

• Eradicate Polio and Yaws	2005
• Eliminate Leprosy	2005
• Eliminate Kala Azar	2010
• Eliminate Lymphatic Filariasis	2015
• Achieve Zero level growth of HIV/AIDS	2007
• Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
• Reduce Prevalence of Blindness to 0.5%	2010
• Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
• Improve nutrition and reduce proportion of LBW Babies from 30% to 10%	2010
• Increase utilisation of public health facilities from current Level of <20 to >75%	2010
• Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
• Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
• Increase share of Central grants to Constitute at least 25% of total health spending	2010
• Increase State Sector Health spending from 5.5% to 7% of the budget Further increase to 8%	2005 2010

4. NHP-2001 - POLICY PRESCRIPTIONS

4.1 FINANCIAL RESOURCES

The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, the Central Government will have to play a key role in augmenting public health investments. Taking into account the gap in health care facilities under NHP-2001 it is planned to increase health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010. The State Governments would also need to increase the commitment to the health sector. In the first phase, by 2005, they would be expected to increase the commitment of their resources to 7 percent of the Budget; and, in the second phase, by 2010, to increase it to 8 percent of the Budget. With the stepping up of the public health investment, the Central Government's contribution would rise to 25 percent from the existing 15 percent, by 2010. The provisioning of higher public health investments will also be contingent upon the increase in absorptive capacity of the public health administration so as to gainfully utilize the funds.

4.2 EQUITY

4.2.1 To meet the objective of reducing various types of inequities and imbalances – inter-regional; across the rural – urban divide; and between economic classes – the most cost effective method would be to increase the sectoral outlay in the primary health sector. Such outlets give access to a vast number of individuals, and also facilitate preventive and early stage curative initiative, which are cost effective. In recognition of this public health principle, NHP-2001 envisages an increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targetted for 35 percent and 10 percent respectively. NHP-2001 projects that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms for such facilities.

4.3 DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES

4.3.1 NHP-2001, envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, NHP-2001 envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, Malaria and HIV/AIDS would need to be continued till moderate levels of prevalence are reached. The integration of the programmes will bring about a desirable optimisation of outcomes through a convergence of all public health inputs. The policy also envisages that programme implementation be effected through autonomous bodies at State and district levels. State Health Departments' interventions may be limited to the overall monitoring of the achievement of programme targets and other technical aspects. The relative distancing of the programme implementation from the State Health Departments will give the project team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-informed

decision-making.

4.4 THE STATE OF PUBLIC HEALTH INFRASTRUCTURE

4.4.1 As has been highlighted in the earlier part of the Policy, the decentralized Public health service outlets have become practically dysfunctional over large parts of the country. On account of resource constraint, the supply of drugs by the State Governments is grossly inadequate. The patients at the decentralized level have little use for diagnostic services, which in any case would still require them to purchase therapeutic drugs privately. In a situation in which the patient is not getting any therapeutic drugs, there is little incentive for the potential beneficiaries to seek the advice of the medical professionals in the public health system. This results in there being no demand for medical services, and medical professionals, and paramedics often absent themselves from their place of duty. It is also observed that the functioning of the public health service outlets in the four Southern States – Kerala, Andhra Pradesh, Tamil Nadu and Karnataka – is relatively better, because some quantum of drugs is distributed through the primary health system network, and the patients have a stake in approaching the Public health facilities. In this backdrop, NHP-2001 envisages the kick-starting of the revival of the Primary Health System by providing some essential drugs under Central Government funding through the decentralized health system. It is expected that the provisioning of essential drugs at the public health service centres will create a demand for other professional services from the local population, which, in turn, will boost the general revival of activities in these service centres. In sum, this initiative under NHP-2001 is launched in the belief that the creation of a beneficiary interest in the public health system, will ensure a more effective supervision of the public health personnel, through community monitoring, than has been achieved through the regular administrative line of control.

4.4.2 Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment through public funding in the primary health sector. Box-V gives statistics which show clearly that the standards of health are more a function of accurate targeting of expenditure on the decentralised primary sector (as observed in China and Sri Lanka), than a function of the aggregate health expenditure.

Box-V: Public Health Spending in select Countries

Indicator	%Population with income of <$1 day	Infant Mortality Rate/1000	%Health Expenditure to GDP	%Public Expenditure on Health to Total Health Expenditure
India	44.2	70	5.2	17.3
China	18.5	31	2.7	24.9
Sri Lanka	6.6	16	3	45.4
UK	-	6	5.8	96.9
USA	-	7	13.7	44.1

Therefore, NHP-2001, while committing additional aggregate financial resources, places strong reliance on the strengthening of the primary health structure, with which to attain improved public health outcomes on an equitable basis. Further, it also recognizes the practical need for levying reasonable user-charges for certain secondary and tertiary public health care services, for those who can afford to pay.

4.5 EXTENDING PUBLIC HEALTH SERVICES

4.5.1 NHP-2001 envisages that, in the context of the availability and spread of allopathic graduates in their jurisdiction, State Governments would consider the need for expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Systems of Medicine and Homoeopathy. Simple services/procedures can be provided by such practitioners even outside their disciplines, as part of the basic primary health services in under-served areas. Also, NHP-2001 envisages that the scope of use of paramedical manpower of allopathic disciplines, in a prescribed functional area adjunct to their current functions, would also be examined for meeting simple public health requirements. These extended areas of functioning of different categories of medical manpower can be permitted, after adequate training and subject to the monitoring of their performance through professional councils.

4.5.2 NHP-2001 also recognizes the need for States to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in under-served areas.

4.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

4.6.1 NHP-2001 lays great emphasis upon the implementation of public health programmes through local self Government institutions. The structure of the national disease control programmes will have specific components for implementation through such entities. The Policy urges all State Governments to consider decentralizing implementation of the programmes to such Institutions by 2005. In order to achieve this, financial incentives, over and above the resources allocated for disease control programmes, will be provided by the Central Government.

4.7 MEDICAL EDUCATION

4.7.1 In order to ameliorate the problems being faced on account of the uneven spread of medical colleges in various parts of the country, NHP-2001. envisages the setting up of a Medical Grants Commission for funding new Government Medical Colleges in different parts of the country. Also, the Medical Grants Commission is envisaged to fund the upgradation of the existing Government Medical Colleges of the country, so as to ensure an improved standard of medical education in the country.

4.7.2 To enable fresh graduates to effectively contribute to the providing of primary health services. NHP-2001 identifies a significant need to modify the existing curriculum. A need based, skill-oriented syllabus, with a more significant component of practical training, would make fresh doctors useful immediately after graduation.

4.7.3 The policy emphasises the need to expose medical students, through the undergraduate syllabus, to the emerging concerns for geriatric disorders, as also to the cutting edge disciplines of contemporary medical research. The policy also envisages that the creation of additional seats for post-graduate courses should reflect the need for more manpower in the deficient specialities.

4.8 NEED FOR SPECIALISTS IN 'PUBLIC HEALTH' AND 'FAMILY MEDICINE'

4.8.1 In order to alleviate the acute shortage of medical personnel with specialization in 'public health' and 'family medicine' disciplines, NHP-2001 envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these discipline in medical training institutions, to reach a stage wherein ¼ th of the seats are earmarked for these disciplines. It is envisaged that in the sanctioning of post-graduate seats in future, it shall be insisted upon that a certain reasonable number of seats be allocated to `public health' and `family medicine' disciplines. Since, the `public health` discipline has an interface with many other developmental sectors, specialization in Public health may be encouraged not only for medical doctors but also for non-medical graduates from the allied fields of public health engineering, microbiology and other natural sciences.

4.9 URBAN HEALTH

4.9.1 NHP-2001, envisages the setting up of an organised urban primary health care structure. Since the physical features of an urban setting are different from those in the rural areas, the policy envisages the adoption of appropriate population norms for the urban public health infrastructure. The structure conceived under NHP-2001 is a two-tiered one: the primary centre is seen as the first-tier, covering a population of one lakh, with a dispensary providing OPD facility and essential drugs to enable access to all the national health programmes; and a second-tier of the urban health organisation at the level of the Government general Hospital, where reference is made from the primary centre. The Policy envisages that the funding for the urban primary health system will be jointly borne by the local self-Government institutions and State and Central Governments.

4.9.2 The National Health Policy also envisages the establishment of fully-equipped 'hub-spoke' trauma care networks in large urban agglomerations to reduce accident mortality.

4.10 MENTAL HEALTH

4.10.1 NHP – 2001 envisages a network of decentralised mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would envisage diagnosis of common disorders by general duty medical staff and prescription of common therapeutic drugs.

4.10.2 In regard to mental health institutions for in-door treatment of patients, the policy envisages the upgrading of the physical infrastructure of such institutions at Central Government expense so as to secure the human rights of this vulnerable segment of society.

4.11 INFORMATION, EDUCATION AND COMMUNICATION

4.11.1 NHP-2001 envisages an IEC policy, which maximizes the dissemination of information to those population groups, which cannot be effectively approached through the mass media only. The focus would therefore, be on inter-personal communication of information and reliance on folk and other traditional media. The IEC programme would set specific targets for the association of PRIs/NGOs/Trusts in such activities. The programme will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programmes on the targeted groups. The Central/State Government initiative will also focus on the development of modules for information dissemination in such population groups who normally, do not benefit from the more common media forms.

4.11.2. NHP-2001 envisages priority to school health programmes aiming at preventive health education, regular health check-ups and promotion of health seeking behaviour among children. The school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'. This is expected to be the most cost-effective intervention as it improves the level of awareness not only of the extended family, but the future generation as well.

4.12 MEDICAL RESEARCH

4.12.1 NHP-2001 envisages the increase in Government-funded medical research to a level of 1 percent of total health spending by 2005; and thereafter, up to 2 percent by 2010. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and Malaria, as also the Sub-types of HIV/AIDS prevalent in the country. Research programmes taken up by the Government in these priority areas would be conducted in a mission mode. Emphasis would also be paid to time-bound applied research for developing operational applications. This would ensure cost effective dissemination of existing / future therapeutic drugs/vaccines in the general population. Private entrepreneurship will be encouraged in the field of medical research for new molecules / vaccines.

4.13 ROLE OF THE PRIVATE SECTOR

4.13.1 NHP-2001 envisages the enactment of suitable legislations for regulating minimum infrastructure and quality standards by 2005, in clinical establishments/medical institutions; also, statutory guidelines for the conduct of clinical practice and delivery of medical services are to be developed over the same period. The policy also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages.

4.13.2 To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as 'deemed exports' and will be made eligible for all fiscal incentives extended to export earnings.

4.13.3 NHP-2001 envisages the co-option of the non-governmental practitioners in the national disease control programmes so as to ensure that standard treatment protocols are followed in their day-to-day practice.

4.13.4 NHP-2001 recognizes the immense potential of use of information technology applications in the area of tele-medicine in the tertiary health care sector. The use of this technical aid will greatly enhance the capacity for the professionals to pool their clinical experience.

4.14 ROLE OF THE CIVIL SOCIETY

4.14.1 NHP-2001 recognizes the significant contribution made by NGOs and other institutions of the civil society in making available health services to the community. In order to utilize on an increasing scale, their high motivational skills, NHP-2001 envisages that the disease control programmes should earmark a definite portion of the budget in respect of identified programme components, to be exclusively implemented through these institutions.

4.15 NATIONAL DISEASE SURVEILLANCE NETWORK

4.15.1 NHP-2001 envisages the full operationalization of an integrated disease control network from the lowest rung of public health administration to the Central Government, by 2005. The programme for setting up this network will include components relating to installation of data-base handling hardware; IT inter-connectivity between different tiers of the network; and, in-house training for data collection and interpretation for undertaking timely and effective response.

4.16 HEALTH STATISTICS

4.16.1 NHP-2001 envisages the completion of baseline estimates for the incidence of the common diseases – TB, Malaria, Blindness – by 2005. The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology. The policy also recognizes the need to establish in a longer time frame, baseline estimates for : the non-communicable diseases, like CVD, Cancer, Diabetes; accidental

injuries; and other communicable diseases, like Hepatitis and JE. NHP-2001 envisages that, with access to such reliable data on the incidence of various diseases, the public health system would move closer to the objective of evidence-based policy making.

4.16.2 In an attempt at consolidating the data base and graduating from a mere estimation of annual health expenditure, NHP-2001 emphasis on the needs to establish national health accounts, conforming to the 'source-to-users' matrix structure. Improved and comprehensive information through national health accounts and accounting systems would pave the way for decision makers to focus on relative priorities, keeping in view the limited financial resources in the health sector.

4.17 WOMEN'S HEALTH

4.17.1 NHP-2001 envisages the identification of specific programmes targeted at women's health. The policy notes that women, along with other under privileged groups are significantly handicapped due to a disproportionately low access to health care. The various Policy recommendations of NHP-2001, in regard to the expansion of primary health sector infrastructure, will facilitate the increased access of women to basic health care. NHP-2001 commits the highest priority of the Central Government to the funding of the identified programmes relating to woman's health. Also, the policy recognizes the need to review the staffing norms of the public health administration to more comprehensively meet the specific requirements of women.

4.18 MEDICAL ETHICS

4.18.1 NHP – 2001 envisages that, in order to ensurethat the common patient is not subjected to irrational or profit-driven medical regimens, a contemporary code of ethics be notified and rigorously implemented by the Medical Council of India.

4.18.2 NHP – 2001 does not offer any policy prescription at this stage relating to ethics in the conduct of medical research. By and large medical research within the country is limited in these frontier disciplines of gene manipulation and stem cell research. However, the policy recognises that a vigilant watch will have to be kept so that appropriate guidelines and statutory provisions are put in place when medical research in the country reaches the stage to make such issues relevant.

4.19 ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS

4.19.1 NHP – 2001 envisages that the food and drug administration will be progressively strengthened, both in terms of laboratory facilities and technical expertise. Also, the policy envisages that the standards of food items will be progressively tightened at a pace which will permit domestic food handling / manufacturing facilities to undertake the necessary upgradation of technology so as not to be shut out of this production sector. The policy envisages that, ultimately food standards will be close, if not equivalent, to codex specifications; and drug standards will be at par with the most rigorous ones adopted elsewhere.

4.20 REGULATION OF STANDARDS IN PARAMEDICAL DISCIPLINES

4.20.1 NHP-2001 recognises the need for the establishment of statutory professional

councils for paramedical disciplines to register practitioners, maintain standards of training, as well as to monitor their performance.

4.21 OCCUPATIONAL HEALTH

4.21.1 NHP-2001 envisages the periodic screening of the health conditions of the workers, particularly for high risk health disorders associated with their occupation.

4.22 PROVIDING MEDICAL FACILITIES TO USERS FROM OVERSEAS

4.22.1 NHP-2001 strongly encourages the providing of health services on a commercial basis to service seekers from overseas. The providers of such services to patients from overseas will be encouraged by extending to their earnings in foreign exchange, all fiscal incentives available to other exporters of goods and services.

4.23 IMPACT OF GLOBALISATION ON THE HEALTH SECTOR

4.23.1 NHP-2001 takes into account the serious apprehension expressed by several health experts, of the possible threat to the health security, in the post TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines. To protect the citizens of the country from such a threat, NHP-2001 envisages a national patent regime for the future which, while being consistent with TRIPS, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries. The Policy also sets out that the Government will bring to bear its full influence in all international fora – UN, WHO, WTO, etc. – to secure commitments on the part of the Nations of the Globe, to lighten the restrictive features of TRIPS in its application to the health care sector.

5. SUMMATION

5.1 The crafting of a National Health Policy is a rare occasion in public affairs when it would be legitimate, indeed valuable, to allow our dreams to mingle with our understanding of ground realities. Based purely on the clinical facts defining the current status of the health sector, we would have arrived at a certain policy formulation; but, buoyed by our dreams, we have ventured slightly beyond that in the shape of NHP-2001 which, in fact, defines a vision for the future.

5.2 The health needs of the country are enormous and the financial resources and managerial capacity available to meet it, even on the most optimistic projections, fall somewhat short. In this situation, NHP-2001 has had to make hard choices between various priorities and operational options. NHP-2001 does not claim to be a road-map for meeting all the health needs of the populace of the country. Further, it has to be recognized that such health needs are also dynamic as threats in the area of public health keep changing over time. The Policy, while being holistic, undertakes the necessary risk of recommending differing emphasis on different policy components. Broadly speaking, NHP – 2001 focuses on the need for enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also, the policy is focused on those diseases which are principally contributing to the disease burden – TB, Malaria and Blindness from the category of historical diseases; and HIV/AIDS from the category of 'newly emerging

diseases'. This is not to say that other items contributing to the disease burden of the country will be ignored; but only that, resources as also the principal focus of the public health administration, will recognize certain relative priorities.

5.3 One nagging imperative, which has influenced every aspect of NHP-2001, is the need to ensure that 'equity' in the health sector stands as an independent goal. In any future evaluation of its success or failure, NHP-2001 would like to be measured against this equity norm, rather than any other aggregated financial norm for the health sector. Consistent with the primacy given to 'equity', a marked emphasis has been provided in the policy for expanding and improving the primary health facilities, including the new concept of provisioning of essential drugs through Central funding. The Policy also commits the Central Government to increased under-writing of the resources for meeting the minimum health needs of the citizenry. Thus, the Policy attempts to provide guidance for prioritizing expenditure, thereby, facilitating rational resource allocation.

5.4 NHP-2001 highlights the expected roles of different participating group in the health sector. Further, it recognizes the fact that, despite all that may be guaranteed by the Central Government for assisting public health programmes, public health services would actually need to be delivered by the State administration, NGOs and other institutions of civil society. The attainment of improved health indices would be significantly dependent on population stabilisation, as also on complementary efforts from other areas of the social sectors – like improved drinking water supply, basic sanitation, minimum nutrition, etc. - to ensure that the exposure of the populace to health risks is minimized.

Suggestions on the draft policy are welcome. Kindly mail your suggestions to aeabop@nb.nic.in within 30 days.

In Sickness and in Wealth

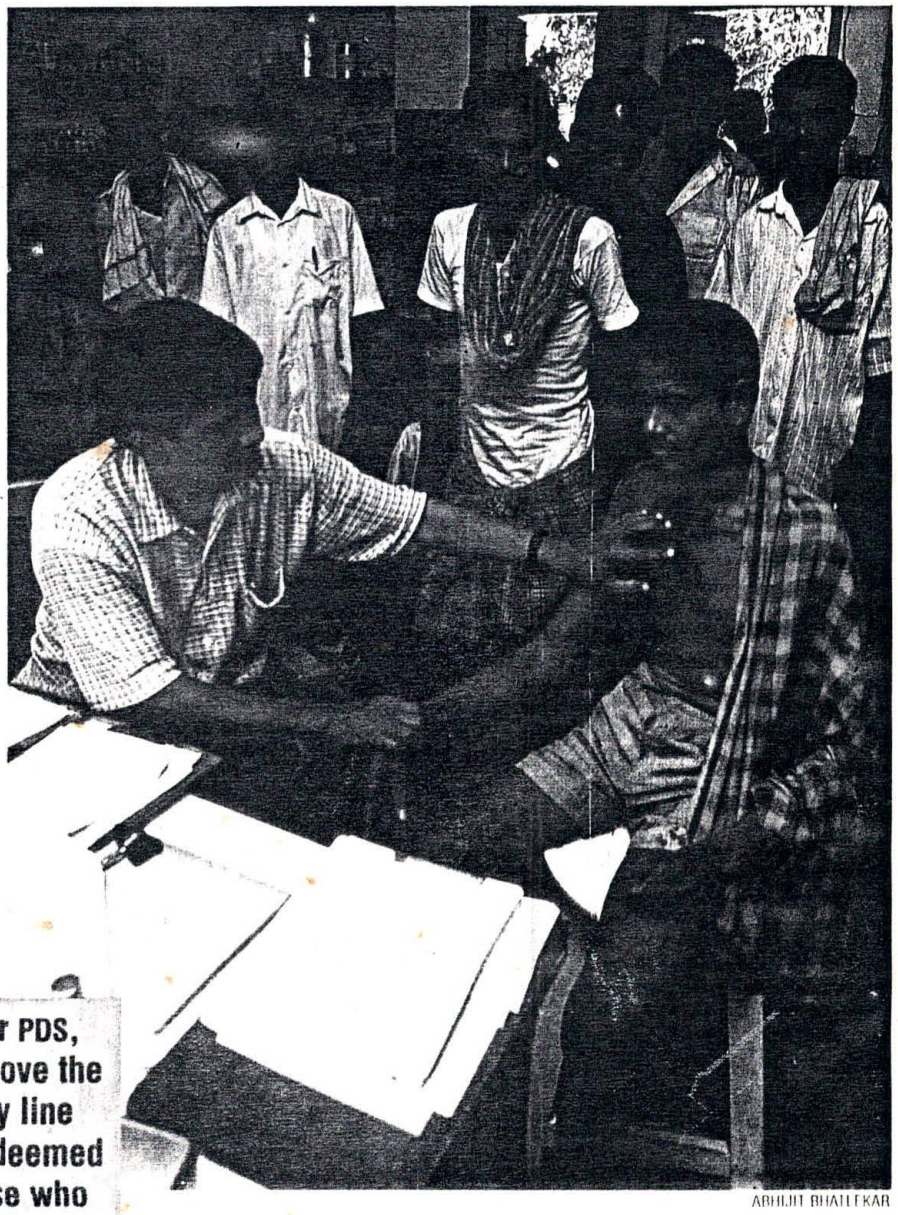
A likely switchover to a 'pay-and-be-treated' regime can only compound the misery of the poor

By **DAVINDER KUMAR**

IT'S a 'revamp' of the healthcare system one should well be wary of. Free or subsidised medicare at public hospitals and medical centres could well become a thing of the past as the government puts the final touches to its National Health Policy (NHP), 2001. Similar to the strategy adopted by the food ministry for the Public Distribution System (PDS), those above the poverty line may now find themselves bracketed as "those who can afford to pay" and be asked "reasonable user charges" to avail secondary and tertiary healthcare facilities.

The switchover to the 'pay and be treated' mode in a country which has a sizeable population living below the poverty line has understandably caused concern to those monitoring public health. Says Robert J. Kim-Farley, the World Health Organisation (WHO) representative in India: "It must be ensured that there is total access to healthcare and that such services are affordable. Sometimes the costs of hospitalisation are so high that it alone can push one below the poverty line. These points need to be considered while finalising the policy."

This is just one of the contentious issues in the draft NHP due to be finalised in a fortnight. Coming as it does after a gap of nearly two decades, it has angered several organisations working in the health sector who have alleged that it is anti-people, lacking in vision and a total 'sell-out' to transnational forces eying the huge health market.



ABHIJIT BHATLEKAR

Like for PDS, those above the poverty line may be deemed as 'those who can pay' and be charged user fees.

Over 1,000 countrywide organisations associated with healthcare and health policy have come together under the banner of the Jan Swasthya Abhiyan (JSA) and are contesting several points in the policy. In its critique, the JSA says: "The draft introduces the concept of user fees, albeit couched in the usual sugar-coating of 'those who can pay'. Global experience of user fees at any level shows that they serve only one purpose—to drive out the poor. While the targeting of primary healthcare is to be welcomed, this should not constitute an argument for legitimisation of the government's retreat from providing comprehensive and quality secondary and tertiary care. The draft hints at this possibility in different sections and at encouraging the private sector to occupy the space that would be left vacant."

The policy draft does admit grave deficiencies in the health sector and notes how only 20 per cent of the population seeks OPD services and is forced to turn to private clinics. It also admits the collapse of the primary healthcare system and acknowledges the poor coverage of women's health and prevention of infant mortality. Ironically, its prescriptions fail to address the problems or offer solutions.

The draft policy, for instance, admits that public health investment has been 'comparatively low' and plans to raise it from 0.9 per cent to 2 per cent of the GDP by 2010. But experts say it's still well below the WHO-recommended share of 5 per cent. "The policy does not admit that public health investment in India has been abysmally low. In fact, considered as a percentage of total health expenditure, it is perhaps the lowest in the world, making it the most privatised health system in the world," says B. Ekbal, vice-chancellor of Kerala University and chairman of the health subcommittee of the Kerala Sastra Sahithya Parishad.

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Draft NHP Comments RN 31/1/02

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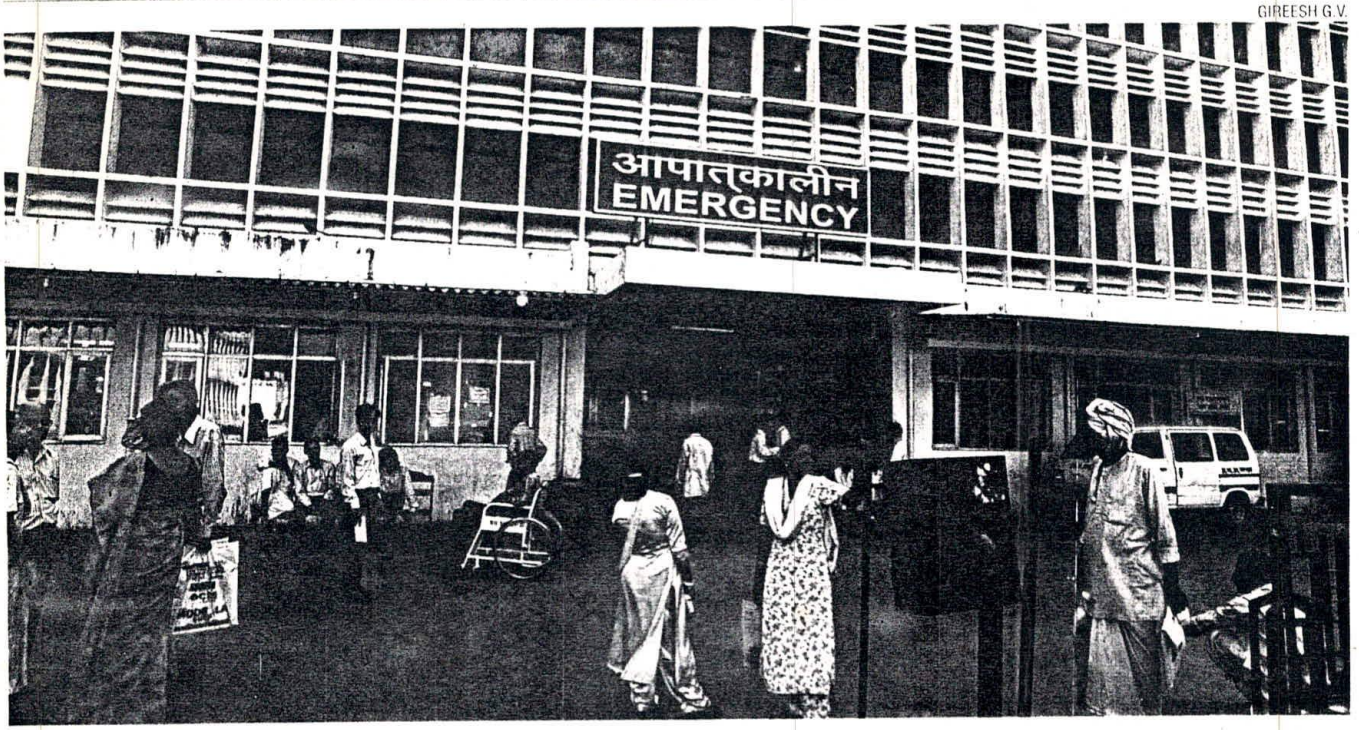

Rather than OPDs (left) of public hospitals (above), most have to go to private clinics

What makes this pill even more bitter is the strong influence of MNC forces in drafting the health policy. "Nearly 80 per cent of the health services in India is already controlled by the private sector. The policy provides further space for it without putting any defined mechanisms of keeping a check," says Pune-based community health expert Anant Phadke, associated with the Medico Friend Circle.

Phadke has a point. The policy calls for providing incentives to the private sector to move to the primary healthcare system. However, the experience in urban centres has been discouraging. The incentives in terms of subsidised land, water, electricity and duty-free import facility doled out to high-profile private medical centres and hospitals in the urban areas has seen little benefit for the poor. Very few of these hospitals conform to the mandatory provision of free medical care to the population below the poverty line or the reservation of a certain percentage of their beds for the poor.

THE government is being accused of shirking its responsibility of improving public health services. The policy has dropped the earlier much-publicised goal of universal healthcare. Says Mira Shiva of the Delhi-based Voluntary Health Association of India (VHAI): "After wrapping up the PDS, the government is trying to wash its hands of the healthcare services. How can the healthcare services be left to the private sector when there is absolutely no regulatory or social control over it? At this rate, profit maximisation, irrational healthcare, irrational use of medical technology will proliferate. Entry of large corporations into basic needs with the backing of the international trade regime will become a very dangerous situation for India."

ISSUES OF CONTENTION

- **Free public health services to be restricted**
- **Incentives to private sector to enter the primary healthcare system**
- **Universal healthcare goal dropped**
- **No integration of associated sectors like food, water or sanitation**
- **No effective regulatory mechanism suggested for the private sector**
- **No clear safeguards to meet WTO/TRIPS challenges**

The health ministry counters this by saying that the new policy proposes to regulate the private sector with the enactment of suitable legislations by 2003 and also evolving guidelines for the conduct of clinical practice and delivery of medical services. Experts take this with a pinch of salt. Observes Shiva: "Despite all the rules in place, sex-determination is still so rampant."

The policy is also being criticised for a diffused focus. It is being said that the issue of health has been discussed in isolation without even considering the associated and vital areas of nutrition, food security, water, sanitation and even population control.

In fact, the advisory note by the WHO country team has suggested that "the vision for health needs to be strengthened". It has also touched upon women's health which, as also pointed out by several NGOs, has been dismissed with a vague mention in the policy. According to the WHO suggestion, "the final NHP may more clearly spell out strategies, interventions and targets for improving maternal health". It has also pointed out the need to focus on food safety, lack of which results in starvation deaths.

Ravi Duggal, director of Cehat, a prominent Mumbai-based healthcare NGO, points to the absence of a focused drug policy in the NHP. "This a serious anomaly and the health department must exert its right to determine the drug policy, especially with regard to price control over the WHO list of 300 essential drugs. This is extremely critical in the context of India switching over to the product patent regime under the new WTO/TRIPS arrangement from 2005. The advantage India has of lowest prices of drugs in the world will be lost if a drug policy favouring public health concerns is not put in place before the 2005 deadline."

Interestingly, the policy also has plans to attract overseas patients for comparatively low-cost treatment as a means of generating foreign exchange. To which S. Srinivasan of Low Cost, an NGO that manufactures low-priced drugs for the poor, says: "First, let us manage our staggering health system rather than look for foreign currency."

Undeterred, the officials at the health and family welfare ministry are busy finalising the policy. One thing they say with certainty is that the PDS formula will definitely make its way to the health sector. ■