National Health Policy - 2001

Legitimising Privatisation

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Draft NHP, 2001 - a Brief Critique

The National Health Policy Draft has finally been released by the Ministry of Health and Family Welfare, early this month. The Draft is available on the website of the ministry, which says that comments on the Draft will be entertained for a month. We would first like to register our protest regarding the arbitrary manner in which this policy is sought to be finalised. The last Health Policy document by the government was released in 1983. We appreciate that in this intervening period developments in the socio-economic and political spheres, both within and outside this country, would necessitate the formulation of a new policy. But one would have assumed that such a process would involve wide ranging discussions at all levels. Moreover, as the Draft itself repeatedly states, Health is a State subject as per our Constitution. From all accounts the State governments have not been involved in the process of drafting, nor has the Central Council of Health and Family Welfare been consulted (which is the apex body that has representatives from all State Health Departments). And now, just one month is being provided to give comments on a policy that is being drafted after 18 years! Moreover, a policy that reportedly has been at the drafting stage for three years!

Eloquent Silence

The Draft is most eloquent where it is silent. It completely omits the very concept of comprehensive and universal health care. In contrast, the NHP 1983 had said: "India is committed to attaining the goal of "Health for All by the Year 2000 A.D." through the universal provision of comprehensive primary health care services". The Draft, thus, departs from the fundamental concept of the NHP 1983 and the Alma Ata declaration. It is also conspicuously silent on the village health worker - the first contact in the primary health care system. By its silence, the Draft provides a framework for the dismantling of the whole concept of primary health care. Significantly, the section on policy prescriptions in the Draft is entirely silent on the content of the primary health care system.

The Draft has nothing substantive to say of the population control programme, which the health movement has long held to constitute a major drain on primary health care. It repeats the usual sophistry that advances in public health have been nullified by increase in population. This refrain contradicts all evidence available across the globe, which show that population stabilisation follows attainment of certain socio-economic standards and do not precede them.

The Draft is practically silent about pharmaceuticals and their impact on health care - thereby accepting that it has no role in formulation of the drug policy. This is even more surprising given the fact that a new Drug Policy is being discussed by the Industry Ministry today, and reports about the policy have been available for some months. The new policy, has reportedly recommended further relaxation of price and production controls. Are we to understand that the NHP

believes that increased drug prices and non-availability of essential drugs have no impact on the health sector?

Important Concerns Ignored

Other important concerns are either ignored or referred to only in passing. The Draft has a four-line section on women's health, without any specific proposals being spelt out. Child health is not even afforded a separate section, and is dealt with through passing references. It is silent on child nutrition in spite of the shameful fact that a half of children below 5 are malnourished in India — a dubious distinction that India shares with only one other country (Bangladesh) in the world.

In the area of medical education the Draft talks of the need to introduce postgraduate courses in "family medicine". The long-standing position of the health movement has been to limit specialisation and reorient undergraduate education to equip doctors in a manner that they are able to better address health needs of the common people. Such a purpose cannot be served by just introducing another specialty called family medicine. The Draft betrays a total lack of understanding regarding the need to create a medical education system oriented to the needs of primary care, and instead is steeped in the bias of urban specialist-based health care. On the other hand it is entirely silent about the bane of private medical colleges and the need to stop the setting up of new private medical colleges and regulate these institutions.

The section on Research harps on "frontier areas" and medical research. There is no understanding of the necessity to initiate and sustain research on public health. There is no mention of the necessity to regulate medical research and to develop ethical criteria in this regard. The impact of TRIPS is discussed in terms of possible impact on drug prices, but there is no mention of the crippling effect of TRIPS on medical research.

Compromise and Contradictions

The Draft appears to be a compromise effort that marries contradictory concerns. Section 2, titled," Present Scenario" analyses many of the present initiatives and their deficiencies. Some of the conclusions drawn in this section are premised on correct assumptions. However, many of these assumptions are ignored or contradicted in the operative part of the Draft, Section 4, titled "policy prescriptions". The Draft makes appropriate references about decentralisation, inadequate funds, non-viability of vertical programmes, inadequate and dysfunctional infrastructure, etc. in Section 2, however, there are either no matching policy prescriptions in section 4 or these prescriptions are expressed in vague generalities. Out of the main policy prescriptions, most relate to encouragement of the private sector and legitimisation of privatisation of the health care delivery system

Increased Fund Allocation — Too Little and Overdue

A further perusal of the Draft throws up many fundamental concerns. The Draft admits that public health investment has been "comparatively low". What it does not admit is the fact that such investment as a percentage of total health expenditure is possibly the lowest in the world; that India has the most privatised health system in the world! The Draft recommends welcome increase in public health expenditure from the present 0.9% of GDP to 2.0% in 2010. However quantum suggested is too little and comes very late. It falls far short of the 5% of GDP that has been a long-standing demand of the health movement and recommended by WHO long back. Moreover the Draft projects that public expenditure in 2010 will be 33% of total health expenditure - up from the present 17%. But even 33% is lower than that of the average of any region in the globe today — India would continue to be one of the most privatised health systems in the world even in 2010! The Draft is eloquent on the inability of states to increase expenditure on health care and laments that the allocation by states has in fact decreased in the past decade. There is a veiled attempt to castigate the states for their inability to increase expenditure. Such insinuations are uncalled for without a detailed analysis of the manner in which the liberalisation process has shattered the financial stability of states.

Top-Down Prescriptions

The Draft, for all the rhetoric on community participation, is replete with "top down" prescriptions. While admitting the wastage involved in running Centrally sponsored and controlled vertical disease control programmes and envisaging their integration in the decentralised primary health care system, it goes on to recommend that we would need to retain many of them! All subsequent formulations in the Draft, especially in the section on policy formulations, assume the continuance of vertical programmes. Moreover the Draft repeatedly asserts that the Centre will continue to plan all public health programmes. The Draft continuously harps on the availability of expertise with the Centre, to justify strong Central control. It is not clear where the basis of such assertions lie. On the other hand the Draft is delightfully vague about actual devolution of responsibility and financial powers to Panchayat Raj Institutions (PRIs) and relocation of accountability to appropriate levels of local self-governments. In the absence of such clarity there is the danger of the primary health care system becoming a Collector driven exercise, which is controlled by the Centre -- thereby defeating the entire effort at decentralisation.

Prescriptions for Further Privatisation

Numerous formulations in the Draft, in various forms, clear the way for even greater privatisation of the health care system. The Draft says, "the NHP will ..... suggest policy instruments for implementation of public health programmes through individuals and institutions of civil society". This constitutes a veiled attempt to clear the way for sub contracting public health to NGOs.

The Draft proposes to employ user fees in public hospital, couched in the usual sugar coating of it being introduced for those who can pay. Global experience of user fees at any level shows that they serve only one purpose -- to drive out the poor and the indigent. Proposal of user fees in a Health Policy Draft is objectionable. The section that suggests targeting of primary health care for resource allocation needs to be read along with this prescription for introduction of user fees. While targeting of primary health care is to be welcomed, this should not constitute an argument for the 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 also hints at "encouraging" the private sector to occupy the space that would be left vacant.

The Draft talks about using Indian health facilities to attract patients from other countries. It also suggests that such incomes can be termed "deemed export" and should be exempt from taxes. This formulation draws from recommendations that the industry has been making and specifically from the "Policy Framework for Reforms in Health Care", drafted by the prime Minister's Advisory Council on Trade and Industry, headed by Mukesh Ambani and Kumaramangalam Birla. Such a proposal, termed by many as "health tourism", will divert our best resources to serve the interests of the global health market and create islands of brain and resource drain within the country. The use of domestic facilities for treating patients from outside the country may be encouraged only if such use is restricted to less than 10% of the facilities of any institution. The Draft also, talks of encouraging "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". Further, there are repeated references in the Draft about "valuable" contributions made by the private sector and the need to "encourage" more such contributions. While the Draft is repeatedly critical of the public health system (justifiably so) there is no criticism of the ills of the unregulated private medical care system, though reference is made to the need to develop regulatory norms.

In brief, the Draft identifies many of the gross deficiencies of the existing health care scenario, proposes a substantial rise in central government expenditure on health care and has some other positive features like the proposed regulation of the Private sector. However, it constitutes an abandonment of the Alma Ata declaration, and legitimises, further privatisation of the health sector.

Jan Swasthya Abhiyan

To

Dr.C.P.Thakur,
Hon.'ble Minister for Health and Family Welfare
Nirman Bhawan,
Maulana Azad Road,
New Delhi

Subject: **Response of the National Coord. Committee, of the Jana Swasthya Abhiyan to Draft NHP-2001**

Honourable Sir,

We the representatives of the National Networks and associated organisations of the **Jana Swasthya Abhiyan**, National Coordination Committee and the state coordinators, of the JSA state coordination committees met at Mumbai on 17th September 2001 to discuss and review the draft National Health Policy - 2001 which had been placed on the website of the Ministry of Health, Government of India to initiate a public dialogue.

We reviewed the document in detail and especially in the context and framework of the Peoples Health Charter that evolved in the first Jana Swasthya Sabha (National, Peoples Health Assembly) which was organised by us in December 2000 at Calcutta as part of our collective commitment to Health for All - Now.

This charter represents the first and only consensus of citizens perspectives in the country, since the Calcutta meeting was preceded by 16 state conventions, around 100 district level conventions, Kalajathas and a peoples block level enquiry process that covered around a 400 blocks. This process was also supported by the evolution of consensus booklets on Health for All issues and covered the present day context of Globalisation; Distortions in Primary Health Care; the need for basic needs approach; the challenges to focus on the marginalised; and the urgent need to confront the commercialisation of medical and health care, all issues that we expect the NHP - 2001 to address as well.

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At the outset we welcome the initiative of the Ministry of Health and Family Welfare, of putting the draft NHP - 2001 on its website for public debate and dialogue though we do feel that for a document of this significance and importance a month is too short a time to do justice to the issues involved.

We welcome the following strengths of the Policy Document:

- The acknowledgement with transparency of:

  1. High levels of morbidity and mortality.
  2. Poor functioning of health services.
  3. Gross Underfunding of health services.

- The acknowledgement of globalisation as a concern with a critical view of TRIPS and its impact.
- The Recommendation for the doubling of Central Government expenditure and the efforts suggested to increase health expenditure by all concerned in general.
- The increased proportion of expenditure on Primary Health Care (55:35:10 formula).
- The envisaged regulation of the private health care sector.
- The concern about public health, capacities ethics, mental health and family medicine.

We are greatly concerned however at the:

- The very vertical, technocentric and fragmented approach to health care.
- The absence of any links to the commitment of NHP - 83 to Alma Ata Declaration and the primary health care approach.
- The complete lack of analysis of why NHP - 1983 goals remained unfulfilled.
- The absence of any linkage of health policy to the determinants of health - water, food, sanitation environment.
- The absence of any recognition of our distorted development process and its relationship to evolving morbidly patterns.
- Total neglect of Nutrition and child health focus with perfunctory reference to women's health.
- The absence of any mention of a rational drug policy and the problems of irrational and unethical prescribing and promotion of medicines.
- A failure to understand the urgent need for decentralisation and strengthening of district and panchayat level mechanism.
- An ambiguity about the urgent need for intersectoral coordination including the links between health, development and poverty alleviation programmes.
- The lack of clarity on the urgent imperative of community mobilization and community participation and a continuation of the benevolent state delivering health to a passive populace.
- The lack of clarity of the real crisis of medical education and the continuing neglect of quality health human power development policies.

- An uncritical look at the commercial vested interest in the private sector in the 'abundance of ill health' with market economics overshadowing peoples needs and patients rights. We believe however that this dialogue process can evolve to debate these issues and look at them with greater policy rigour in the weeks ahead.

As a support to this process of dialogue we are **attaching** the following:

a. A copy of the draft NHP - 2001, redrafted as it were with our own formulations. We have taken the liberty to amend portions of the original draft [crossed out] and add some portions [underlined]. (titled **"Amended Draft NHP-2001").**

b. A copy of the **Peoples Health Charter** adopted at the Peoples Health Assembly in Calcutta on December 1st, 2000. **(Annexure I)**

c. A copy of a comparison between NHP - 2001 formulations and what 'citizens' have expressed as needs and aspirations in the Peoples Health Charter. **(Annexure II)**

We look forward to an opportunity at the earliest for a representative team from the Jana Swasthya Abhiyan to be able to present these endorsements and concerns in person and also discuss our suggestions and the context of the new formulations. **May we take this opportunity to seek and appointment with you where we could present our views.**

We also look forward to a continued dialogue of the JSA -- a network of Networks -- with the Health Ministry for evolving Health policies and programme initiatives of the government in the future towards the Health for All - National Goal.

Thanking You,

Yours Sincerely,

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Attached: 1) Amended Draft NHP-2001
2) Peoples Health Charter (Annexure I)
3) Comparison between NHP - 2001 and Peoples Health Charter. (Annexure II)

Amended 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. It laid out the basic philosophy towards the health sector in the following words: "India is committed to attaining the goal of "Health for All by the Year 2000 A.D." through the universal provision of comprehensive primary health care services". 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~~ moderate drop in the Total Fertility Rate and Infant Mortality Rate, but these are well below the targets set in the 1983 policy. The limited 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-1).). Malnourishment amongst children, or the prevalence of anaemia in women -- as seen in the studies done by the NIN -- has not decreased.

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

Indicator	1951	1981	Target by 2000	2000
Demographic Changes				
Life Expectancy	36.7	54	64	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	21.0	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	9.0	8.7(99 SRS)
IMR	146	110	≤60	70 (99 SRS)
MMR	6-7	4-5	≤2	3-4
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~~ some 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~~ limited 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 -- 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 distorted development leading to 'life-style' diseases -- diabetes, cancer and cardiovascular diseases, vehicular accidents, and suicides & homicides. 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. To address concerns regarding the non-attainment of a large number of goals set out in NHP83 as well as 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~~ one of the lowest in the world. Worse still, during the decade of the nineties, as a percentage of GDP, it 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~~ 14 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. It would not be wrong to say that the system for medical care in the country is the most privatised system anywhere in the world. 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 well 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. In recent years there has been a major squeeze on the fiscal resources of State Governments. ~~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, and a reversal of this above trend. 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)	Under 5 Mortality per 1000 (NFHS II)	Weight For Age- % of Children Under 3 years (<-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 population	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. Even within States, there exist wide disparities because of uneven development. 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, and intra-state disparities imply 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, in backward areas in 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. Vulnerable sections like dalits, tribals, women, children, women, and the disabled are those who have been the most marginalised by the uneven reach of the delivery system ~~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
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.~~ It is envisaged that the States will have the primary responsibility of designing and monitoring their health programmes. The Centre will play a co-ordinating role and provide technical and financial support wherever it is felt necessary.

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, has a low cost-benefit ratio and is difficult to

sustain. In the long run it is a more sustainable option to integrate disease control strategies within the decentralised primary health care network, linked to adequate secondary and tertiary support services. ~~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.~~ Vertical programmes may be considered only as short-term measures, run in a "mission mode" in very exceptional circumstances. 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 or non-existent in a large number of cases. 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. The PHCs have primarily become centres for family planning and immunisation. 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. Further, such shortage is most acute in the case of para-medical manpower like nurses, health workers and technicians. Because of low returns, private medical manpower seldom ventures into underserved areas. Even in the public health sector, it has been difficult to deploy and retain medical manpower in these areas because of the harsh circumstances that obtain here, including lack of access to even very basic facilities. ~~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~~. Only a radical transformation of publicly funded facilities in less developed areas will facilitate the retention of medical humanpower in these areas. Alongside this, a large number of public health functions can be entrusted to adequately trained and suitable remunerated para-medical personnel, including village level health workers. The first contact in the Primary Health Care system, through trained village health workers chosen by the community, as envisaged in the NHP83, needs to be strengthened after analysing the earlier weaknesses in the VHW scheme. To provide immediately accessible first contact care to all villages, there is no

alternative to train a Community Health Worker in every village. ~~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. These practioners will have to be suitably trained, allowed to use limited number of alopathic drugs for primary health care, but strictly forbidden to go beyond the medicines and conditions in which they would be given training.

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 theoretical, 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 also 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.

2.7.3. There has been a mushrooming a private medical colleges in the country. There is a need to standardise minimum norms regarding facilities that should be available at such institutions. There is also the need to standardise fee structures in such institutions. No permision should be given to start new private medical colleges, as such collegs have added to the problems of urban concentration, elitist medical culture, unethical medical practice etc . The NHP2001 issues guidelines 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 more than adequate, the distribution of the disciplines in the postgraduate training facilities is overwhelmingly in favour of clinical specializations. NHP 2001 suggests ways to reorient undergraduate courses in order to equip medical graduates adequately to face the challenges of primary care and family medicine. Such reorientation will seek to ensure that the current craze for specialisation is reversed and more graduates take up primary care as a long term vocation. In order to address possible "academic stagnation" among such graduates and to ensure adequate availability of trained humanpower in "public health" and "family medicine", NHP 2001 makes recommendations for creating and expanding the scope for specialisation in "public health" and "family medicine". ~~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. As recent events have shown, private institutions providing mental health care are grossly negligent and lack basic facilities. The NHP2001 will suggest ways to monitor and regulate such facilities.

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 enhance their ~~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~~ HEALTH RESEARCH

2.12.1 Over the years, ~~medical~~ research activity in the country has been very limited and has been limited to medical research. 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 and modulate the direction of ~~whether the health expenditure in the country is being incurred through optimal applications and appropriate~~ public health strategies. The NHP 2001 will encourage greatly enhanced public investment in research, which, as global experience has shown, is an imperative for giving a thrust to research; while at the same time offering incentives to the private sector to engage in appropriate and relevant research. ~~Medical~~ Health Research in the country needs to be focused, first, on optimisation of public health strategies, and also on therapeutic drugs/vaccines development for tropical diseases, which are normally neglected by international pharmaceutical companies on account of limited profitability potential. The thrust will need to be on, both, research on problems of public health, and basic research on development of medical appliances like drugs, vaccines and diagnostic aids. Research activities will also need to focus on the newly-emerging frontier areas of research based on genetics, genome-based drug and vaccine development, molecular biology, etc. NHP 2001 will also address the issue of ethics in medical research, especially keeping in view recent reports of violation of ethical norms even in public sector research institutions. It shall recommend setting up of suitable mechanisms, institutional and legal, for the regulation and monitoring of medical research in both the public and private sector. 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.~~ At present the private sector is the largest unregulated sector enaged in commercial activities, and the issue of its regulation will be addressed by the NHP2001. 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. Given its large reach and unregulated character, and many reports of substandard, unethical practices on a wide scale, ~~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 technology raises the possibility of its adoption in the health sector. Its role in information dissemination, monitoring and surveillance, which have a bearing on concerns related to public health, will be examined by NHP 2001. ~~NHP-2001 will examine this possibility, especially in the areas of :~~

2.14 ROLE OF THE CIVIL SOCIETY

2.14.1 Historically, the practice has been to implement programmes for primary health care and ~~major national~~ disease control ~~programmes~~ through the public health machinery of the State/Central Governments. It has become increasingly apparent that NGOs and other civil society organisations can play an important role in the monitoring of such programmes and in increasing participation of local communities in planning and implementation of such programmes. They have also played a major role in community mobilisation, that is often a major component of any public health programme. 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 involvement of civil society institutions in the monitoring of public health programmes ~~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 Apart from poverty, due to the patriarchal nature of our society, the triple burden on women of, child -rearing, intensive labour and physical and psychological domestic violence is responsible for the low health status of Indian women. Further, 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 also needs to be recognised. The NHP2001, recognising that issues related to women's health are not confined to their role in child bearing or to problems related to the reproductive tract, sets out policy guidelines that are aimed at enabling women to access the health care system in much larger numbers.

CHILD HEALTH

Children -- who are naturally vulnerable -- face a large brunt of problems that relate to the inadequate reach of public health facilities and services. The are more likely to fall prey to infectious diseases, and infant and child mortality rates continue to be unacceptable high. In fact in the last few years the disturbing trend of stagnation or reversal of fall in such mortality rates have been reported. The problem of under nutrition, further, is a very serious problem among children, given that more than half of children under the age of five are malnourished. This is a shameful statistic and is a record that is the worst in the world with the exception of Bangladesh. The NHP2001, taking serious note of these issues, recommends specific child centred initiatives.

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 uncharted 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.

ENSURING ACCESS TO ESSENTIAL DRUGS, AND RATIONAL DRUG USE

Universal access to life saving medicines is a major imperative for the success of medical interventions. We have had the unfortunate precedent of the National Drug Policy being formulated by the Industry Ministry, with insignificant inputs from the Ministry of Health. The promise in the 1995 Drug policy to set up a National Drug Authority that would, among other things, co-ordinate between the two ministries in formulation and implementation of the country's Drug Policy was never implemented with seriousness. Many elements of the Drug policy like pricing, control on irrational and hazardous drugs, unethical promotion practices by drug companies, self reliance in drug production, etc. have a bearing on access to drugs. Considering these the NHP2001 suggests that the nation's drug policy will reflect adequately concerns related to rational and affordable medical care, and to this end suggest guidelines.

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 Though we very much need a much larger number of different types of paramedics, 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. The medical professionals are not well oriented to deal with this scenario. 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~~ relatively inexpensive prices, largely due to the effect of the Indian Patent Act of 1970. 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 and also obstruct research activities in developing countries like India. NHP-2001 will address itself to the future imperatives of health security in the country, in the post-TRIPS era. It shall also engage in a debate to modify the basic contours of the TRIPS agreement.

2.24 NON – HEALTH DETERMINANTS

(NOTE: This section should be brought in earlier)

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. This is also true for the non communicable diseases like occupational diseases, ' life-style diseases ' etc. since safer working enviroment, better transport- policy, a 'healthy policy' about alcohol and tobacco, -- all such interventions are centrally imp. for controllig the no-communicable diseases. ~~NHP-2001 will not explicitly address itself to all 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.~~ The NHP2001 wil foster an intersectoral approach to all the developmental issues so that health implications of development policies would be explicitly taken into account by the concerned planners. For this purpose it also sets out guidelines for developmental schemes in areas where there is a clear interface between health care and these areas.

2.25 POPULATION GROWTH AND HEALTH STANDARDS

~~2.25.1 Efforts made over the years for improving health standards have been neutralised 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~~. There is a growing global consensus on the futility of running separate programmes aimed at population control; programmes, moreover, that invariably tend to be target oriented and incorporate varying degrees of coercion. The NHP2001 has noted earlier the need to integrate vertical programmes within the decentralised primary health care network. The NHP2001 suggests means by which this can also be done in the case of programmes aimed at population stabilisation. The NHP2001 makes these suggestion while keeping in mind the need to make such a programme entirely free of targets and coercion, and recognising the principle that families and women within families have the right to determine the number of children they want. The contraceptive policy will not target women and injectable contraceptives will not be introduced. There will be no coercion in population stabilisation policies.

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,,. 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 through universal provision of comprehensive primary health care services. This would mean a much more concerted attention for fostering an intersectoral approach towards developmenal programmes so that the basic determinants of health are ensured. The approach about healthcare services 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.~~ Given the situation today it is envisaged that the private sector will continue to play a role in provision of curative services, but such a role will need to be monitored through adequate regulatory mechanisms. 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 • Non communicable diseaseas	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%~~ 5.0%	2010
• Increase share of Central grants to Constitute at least 35% ~~25%~~ of total health spending	2010
• Increase State Sector Health spending from 5.5% to 10% ~~7%~~ of the budget . • Further increase to 15% ~~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~~ bigger 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 in the public sector to 6 5 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~~ 10 percent of the Budget; and, in the second phase, by 2010, to increase it to 8 15 percent of the Budget. With the stepping up of the public health investment, the Central Government's contribution would rise to ~~25~~ 35 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 on a per capita basis. 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. At the same time the increased quantum of toral funds availaible will ensure that secondary and tertiary services are strengthened too and distributed on a per capita basis..

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. All 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~~ would be integrated with the decentralised health care delivery system. 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.~~ National health programmes will be integrated within the Primary Health Care system with decentralised planning, decision-making and implementation. Focus would be shifted from bio-medical and individual based measures to social and community based measures.

The primary medical care institutions including trained village health workers, sub-centres, and the PHCs staffed by doctors and the entire range of community health functionaries will be placed under the direct and administrative control of the relevant level panchayati raj institutions. The overall infrastructure of the primary health care institutions will be under the control of panchayati raj and gram sabhas and provision of free and accessible secondary and tertiary care will be under the control of Zila Parishads, to be accessed primarily through referrals from PHCs. The essential components of primary care would be:

- Village level health care based on Village Health Workers selected by the community and supported by the Gram Sabha/ Panchayat, and the Government health services;
- Primary Health Centres and subcentres with adequate staff and supplies which provides quality curative services at the primary health centre level itself with good support from linkages;
- A comprehensive structure for Primary Health Care in urban areas based on urban PHCs, health posts and Community Health Workers;
- Enhanced content of Primary Care to include all measures which can be provided at the PHC level even for less common or non-communicable diseases (e.g. epilepsy, hypertension, arthritis, pre-eclampsia, skin diseases) and integrated relevant epidemiological & preventive measures;
- Surveillance centres at block level to monitor the local epidemiological situation and tertiary care with all speciality services, available in every district.

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 access the primary health care system that exists today. ~~seek the advice of the medical professionals in the public health system.~~ This results in there being no demand for medical services. This situation is further aggravated because 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 h[illegible]h 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, provided of course the total quantum is above a critical level.

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
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~~. Global experience has shown that levying of user charges, at any level, ultimately leads to the denial of services to the poor, who need them most. The NHP2001 calls for enactment of suitable legislations for raising of resources to support public health investment by taxing people at higher income levels, and also be heavily taxing activities that have an adverse health impact -- like alcohol, tobacco, pan masala, etc.

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.~~

4.5.1. The NHP2001 envisages that a comprehensive need based humanpower plan for the health sector will be formulated that addresses the requirement for creation of a much larger pool of paramedical functionaries and basic doctors in place of the present trend towards over-production of personnel trained in super-specialities.

4.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

4.6.1 NHP-2001 lays great emphasis upon the implementation of the decentralised primary health care programme ~~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~~ under-served 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. There will be no new medical colleges till the backlog of training centres for different types of paramedics is overcome. No new medical colleges in the private sector will be allowed.

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. Major portions of undergraduate

medical education should be imparted in district level medical care institutions, as necessary complement to training provided in medical colleges. At least an year of rural posting for undergraduate students would be made mandatory, without which license to practice would not be issued. Similarly, three years of rural posting after post graduation would be made compulsory.

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.

4.7.4. No more new colleges would be allowed to be opened in the private sector. Steps would be initiated to close down medical colleges in the private sector that charge fees above a defined norm, and those that do not have facilities that shall be laid out as basic necessary standards.

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 a reorientation of the undergraduate medical curriculum so that these disciplines are adequately emphasised. It also 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 ¼th 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~~ three-tiered, one: the primary centre is seen as the first-tier, covering a population of 10,000, with a dispensary providing OPD facility and essential drugs ~~to enable access to all the national health programmes~~; two: a 30 bedded CHC catering to a population of 100,000; and three: a ~~second~~ third-tier of the urban health organisation at the level of the Government general Hospital, where reference is made from the ~~primary centre~~ CHC. 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.

This would include training and creation of dispersed facilities to provide adequate "first aid", as well as equipped secondary and tertiary care centres.

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. The NHP2001 envisages promotion of measures towards mental health that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support and community based management of mental health problems would be promoted. Services for early detection and integrated management of mental health problems would be integrated with Primary Health Care.

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. The policy shall draw up guidelines for minimum standards that need to be adhered to in mental health institutions, and also enact suitable laws to ensure strict adherence to these.

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~~ HEALTH RESEARCH

4.12.1 NHP-2001 envisages the increase in Government-funded medical research to a level of ~~1~~ 2.5 percent of total health spending by 2005; and thereafter, up to ~~2~~ 5 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.~~ NHP 2001 envisages focusing of Health Research in the country, first, on optimisation of public health strategies, and also on therapeutic drugs/vaccines development for tropical diseases, which are normally neglected by international pharmaceutical companies on account of limited profitability potential. Research activities will also need to focus on the newly-emerging frontier areas of research based on genetics, genome-based drug and vaccine development, molecular biology, etc.

4.13 ROLE OF THE PRIVATE SECTOR

4.13.1 NHP2001 will initiate measures to ensure that the unbridled and unchecked growth of the commercial private sector is brought to a halt. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics, standard fee structure, and periodic prescription audit shall be made obligatory. Legal and social mechanisms will be set up to ensure observance of minimum standards by all private hospitals, nursing/maternity homes and medical laboratories. The prevalent practice of offering commissions for referral will be made punishable by law. For this purpose a body with statutory powers will be constituted, which has due representation from peoples organisations and professional organisations. ~~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. However such facilities will be extended only in cases where not more than 10% of the facilities of any institution are put to such use.

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 monitoring public health programmes and in ensuring community mobilisation and participation as regards public health programmes. ~~making available health services to the community~~. NHP2001 envisages the utilisation of NGOs and civil society organisations in the monitoring of public health programmes and in increasing

participation of local communities in planning and implementation of such programmes. They would also have a major role in community mobilisation, and in building the capacities of Panchayati Raj Institutions. ~~In order to utilise 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.

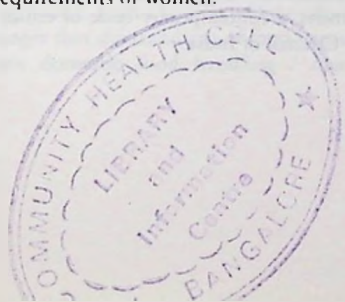
4.16 HEALTH STATISTICS

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.



4.17.2. NHP2001 will set in operation Women-centered health initiatives that include:

- awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in nutrition and health-care;
- preventive and curative measures to deal with health consequences of womens' work and domestic violence;
- complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector;
- special support structures that focus on single, deserted, widowed women and commercial sex workers; gender sensitive services to deal with reproductive health including reproductive system illnesses, maternal health, abortion, and infertility;
- vigorous public campaign accompanied by legal and administrative action against female feticide, infanticide and sex pre-selection.

POPULATION POLICY

All coercive measures including incentives and disincentives for limiting family size would be abolished. The right of families and women within families in determining the number of children they want should be recognised. Concurrently, access to safe and affordable contraceptive measures would be ensured which provides people, especially women, the ability to make an informed choice. All long-term, invasive, systemic hazardous contraceptive technologies such as the injectables (NET-EN, Depo-Provera, etc.), sub-dermal implants (Norplant) and anti fertility vaccines would be banned from both the public and private sector. Urgent measure would be initiated to shift to onus of contraception away from women and ensure at least equal emphasis on men's responsibility for contraception.

CHILD HEALTH

The NHP2001 shall put in operation Child centered health initiatives which include:

- a comprehensive child rights code, adequate budgetary allocation for universalisation of child care services, a expanded and revitalized ICDS programme and ensuring adequate support to working women to facilitate child care, especially breast feeding;
- a comprehensive supplementary feeding programme and nutrition awareness programme that addresses the needs of all undernourished children below the age of 5;
- comprehensive measures to prevent child abuse and sexual abuse;
- educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory elementary education for all children.

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.~~

4.18.2. Ethical guidelines for research involving human subjects shall be drawn up and implemented after an open public debate. No further experimentation, involving human subjects, will be allowed without a proper and legally tenable informed consent and appropriate legal protection. Failure to do so to be punishable by law. All unetical research, especially in the area of contraceptive reseach, would be stopped forthwith. Women (and men) who, without their consent and knowledge, have been subjected to experimentation, especially with hazardous contraceptive technologies will be traced forthwith and appropriately compensated. Exemplary damages shall be awarded against the institutions (public and private sector) involved in such anti-people, unethical and illegal practices in the past.

ENSURING ACCESS TO ESSENTIAL DRUGS, AND RATIONAL DRUG USE

The NHP2001 envisages the formulation of a rational drug policy, under the aegis of the Ministry of Health, that ensures development and growth of a self reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:

- ban all irrational and hazardous drugs;
- introduce production quotas and price ceiling for essential drugs;
- promote compulsory use of generic names;
- regulate advertisements, promotion and marketing of all medications based on ethical criteria;
- formulate guidelines for use of old and new vaccines;
- control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology;
- recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices;
- promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

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.

4.21.2. NHP2001, further, envisages special measures relating to occupational and environmental health which will focus on:

- banning of hazardous technologies in industry and agriculture;
- worker centered monitoring of working conditions with the onus of ensuring a safe workplace on the management;
- reorientation of medical services for early detection of occupational disease;
- special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

~~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 and constraints on medical research. 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.

RESTRICTION ON HAZARDOUS PRACTICES /INDUSTRIES

NNP2001 envisages effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising and sale of their products to the young, and provision of services for de-addiction.

PROMOTION OF HEALTH AMONG PHYSICALLY & MENTALLY CHALLENGED

NHP2001 envisages measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Focus would be on promotion of measures to integrate them in the community with special supports rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

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.

PEOPLE'S HEALTH CHARTER

We the people of India, stand united in our condemnation of an iniquitous global system that, under the garb of "globalisation" seeks to heap unprecedented misery and destitution on the overwhelming majority of the people on this globe. This system has systematically ravaged the economics of poor nations in order to extract profits that nurture a handful of powerful nations and corporations. The poor, across the globe, are being further marginalised as they are displaced from home and hearth and alienated from their sources of livelihood as a result of the forces unleashed by this system. Standing in firm opposition to such a system we reaffirm our inalienable right to comprehensive health care that includes food security; sustainable livelihood options; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum — the right to HEALTH FOR ALL, NOW!

The promises made to us by the international community in the Alma Ata declaration have been systematically repudiated by the World Bank, the IMF, the WTO and its predecessors, the World Health Organization, and by a government that functions under the dictates of international Finance Capital. The forces of "globalization" through measures such as the structural adjustment programme are targeting our resources — built up with our labour, sweat and lives over the last fifty years — and placing them in the service of the global "market" for extraction of super-profits. The benefits of the public sector health care institutions, the public distribution system and other infrastructure – such as they were – have been taken away from us. It is the ultimate irony that we are now blamed for our plight, with the argument that it is our numbers and our propensity to multiply that is responsible for our poverty and deprivation.

We declare health as a justiciable right and demand the provision of basic health care as a fundamental constitutional right of every one of us. We assert our right to take control of our health in our own hands and for this the right to:

- A truly decentralised system of local governance vested with adequate power and responsibilities and provided with adequate finances;
- A sustainable system of agriculture based on the principle of "land to the tiller", linked to a decentralized public distribution system that ensures that no one goes hungry;
- Universal access to education, adequate and safe drinking water, and housing and sanitation facilities;
- A dignified and sustainable livelihood;
- A clean and sustainable environment;
- A drug industry geared to producing epidemiologically essential drugs at affordable cost;
- A health care system which is responsive to the people's needs and whose control is vested in peoples hands;

Further, we declare our firm opposition to:

- Agricultural policies attuned to the needs of the "market" that ignore disaggregated and equitable access to food
- Destruction of our means to livelihood and appropriation, for private profit, of our natural resource bases;
- The conversion of Health to the mere provision of medical facilities and care that are technology intensive, expensive, and accessible to a select few;
- The retreat, by the government, from the principle of providing free medical care, through reduction of public sector expenditure on medical care and introduction of user fees in public sector medical institutions, that place an unacceptable burden on the poor;
- The corporatization of medical care, state subsidies to the corporate sector in medical care, and corporate sector health insurance;
- Coercive population control and promotion of hazardous contraceptive technology;
- The use of patent regimes to steal our traditional knowledge and to put medical technology and drugs beyond our reach;
- Institutionalization of divisive and oppressive forces in society, such as fundamentalism, caste, patriarchy, and the attendant violence, which have destroyed our peace and fragmented our solidarity.

In the light of the above we demand that:

1. The concept of comprehensive primary health care, as envisioned in the Alma Ata Declaration should form the fundamental basis for formulation of all policies related to health care. The trend towards fragmentation of health delivery programmes through conduct of a number of vertical programmes should be reversed. National health programmes be integrated within the Primary Health Care system with decentralized planning, decision-making and implementation. Focus be shifted from bio-medical and individual based measures to social, ecological and community based measures.

2. The primary medical care institutions including trained village health workers, sub-centres, and the PHCs staffed by doctors and the entire range of community health functionaries be placed under the direct administrative and financial control of the relevant level panchayat raj institutions. The overall infrastructure of the primary health care institutions be under the control of panchayati raj and gram sabhas and provision of free and accessible secondary and tertiary level care be under the control of Zilla Parishads, to be accessed primarily through referrals from PHCs. The essential components of primary care should be:

   - Village level health care based on Village Health Workers selected by the community and supported by the Gram Sabha / Panchayat and the Government health services;
   - Primary Health Centers and subcentres with adequate staff and supplies which provides quality curative services at the primary health center level itself with good support from linkages;
   - A comprehensive structure for Primary Health Care in urban areas based on urban PHCs, health posts and Community Health Workers;

- Enhanced content of Primary Health Care to include all measures which can be provided at the PHC level even for less common or non-communicable diseases (e.g. epilepsy, hypertension, arthritis, pre-eclampsia, skin diseases) and integrated relevant epidemiological and preventive measures.
- Surveillance centres at block level to monitor the local epedemiological situation and tertiary care with all speciality services, availaible in every district.

3. A comprehensive medical care programme financed by the government to the extent of at least 5% of our GNP, of which at least half be disbursed to panchayati raj institutions to finance primary level care. This be accompanied by transfer of responsibilities to PRIs to run major parts of such a programme, along with measures to enhance capacities of PRIs to undertake the tasks involved.

4. The policy of gradual privatisation of government medical institutions, through mechanisms such as introduction of user fees even for the poor, allowing private practice by Government Doctors, giving out PHCs on contract, etc. be abandoned forthwith. Failure to provide appropriate medical care to a citizen by public health care institutions be made punishable by law.

5. A comprehensive need-based humanpower plan for the health sector be formulated that addresses the requirement for creation of a much larger pool of paramedical functionaries and basic doctors, in place of the present trend towards over-production of personnel trained in super-specialities. Major portions of undergraduate medical education, nursing as well as other paramedical training be imparted in district level medical care institutions, as a necessary complement to training provided in medical/nursing colleges and other training institutions. No more new medical colleges to be opened in the private sector. Steps be taken forthwith to close down private medical colleges charging fees higher than state colleges or taking any form of donations, and to eliminate illegal private tuition by teachers in medical colleges. At least an year of compulsory rural posting for undergraduate (medical, nursing and paramedical) education be made mandatory, without which license to practice not be issued. Similarly, three years of rural posting after post graduation be made compulsory.

6. The unbridled and unchecked growth of the commercial private sector be brought to a halt. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics, standard fee structure, and periodic prescription audit to be made obligatory. Legal and social mechanisms be set up to ensure observance of minimum standards by all private hospitals, nursing/maternity homes and medical laboratories. Prevalent practice of offering commissions for referral to be made punishable by law. For this purpose a body with statutory powers be constituted, which has due representation from peoples organisations and professional organisations.

7. A rational drug policy be formulated that ensures development and growth of a self reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:

- ban all irrational and hazardous drugs;
- introduce production quotas and price ceiling for essential drugs;
- promote compulsory use of generic names;
- regulate advertisements, promotion and marketing of all medications based on ethical criteria;
- formulate guidelines for use of old and new vaccines;
- control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology;
- recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices;
- promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

8. Medical Reseach priorities be based on morbidity and mortality profile of the country, and details regarding the direction, intent and focus of all research programmes be made entirely transparent. Adequate government funding be provided for such programmes. Ethical guidelines for research involving human subjects be drawn up and implemented after an open public debate. No further experimentation, involving human subjects, be allowed without a proper and legally tenable informed consent and appropriate legal protection. Failure to do so to be punishable by law. All unetical research, especially in the area of contraceptive reseach, be stopped forthwith. Women (and men) who, without their consent and knowledge, have been subjected to experimentation, especially with hazardous contraceptive technologies to be traced forthwith and appropriately compensated. Exemplary damages to be awarded against the institutions (public and private sector) involved in such anti-people, unethical and illegal practices in the past.

9. All coercive measures including incentives and disincentives for limiting family size be abolished. The right of families and women within families in determining the number of children they want should be recognised. Concurrently, access to safe and affordable contraceptive measures be ensured which provides people, especially women, the ability to make an informed choice. All long-term, invasive, systemic hazardous contraceptive technologies such as the injectables (NET-EN, Depo-Provera, etc.), sub-dermal implants (Norplant) and anti fertility vaccines should be banned from both the public and private sector. Urgent measure be initiated to shift to onus of contraception away from women and ensure at least equal emphasis on men's responsibility for contraception.

10. Support be provided to traditional healing systems, including local and home-based healing traditions, for systematic research and community based evaluation with a view to developing the knowledge base and use of these systems along with modern medicine as part of a holistic healing perspective.

11. Promotion of transparency and decentralisation in the decision making process, related to health care, at all levels as well as adherence to the principle of right to information. Changes in health policies to be made only after mandatory wider scientific public debate.

12. Introduction of ecological and social measures to check resurgence of communicable diseases. Such measures should include:

- integration of health impact assessment into all development projects;
- decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners;
- reorientation of measures to check STDs/AIDS through universal sex education, checking social disruption and displacement and commercialisation of sex, generating public awareness to remove stigma and universal availability of preventive and curative services, and special attention to empowering women and availability of gender sensitive services in this regard.

13. Facilities for early detection and treatment of non-communicable diseaseslike diabetes, cancers, heart diseases, etc. to be available to all att appropriate levels of medical care.

14. Women-centered health initiatives that include:

- awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in nutrition and health-care;
- preventive and curative measures to deal with health consequences of womens' work and domestic violence;
- complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector;
- special support structures that focus on single, deserted, widowed women and commercial sex workers; gender sensitive services to deal with reproductive health including reproductive system illnesses, maternal health, abortion, and infertility;
- vigorous public campaign accompanied by legal and administrative action against female feticide, infanticide and sex pre-selection.

15. Child centered health initiatives which include:

- a comprehensive child rights code, adequate budgetary allocation for universalisation of child care services, a expanded and revitalized ICDS programme and ensuring adequate support to working women to facilitate child care, especially breast feeding;
- comprehensive measures to prevent child abuse and sexual abuse;
- educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory elementary education for all children.

16. Special measures relating to occupational and environmental health which focus on:

- banning of hazardous technologies in industry and agriculture;

- worker centered monitoring of working conditions with the onus of ensuring a safe workplace on the management;
- reorientation of medical services for early detection of occupational disease;
- special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

17. Measures towards mental health that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support and community based management of mental health problems be promoted. Services for early detection and integrated management of mental health problems be integrated with Primary Health Care.

18. Measures to promote the health of the elderly by ensuring economic security, opportunities for appropriate employment, sensitive health care facilities and, when necessary, shelter for the elderly.

19. Measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Promotion of measures to integrate them in the community with special support rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

20. Effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising and sale of their products to the young, and provision of services for de-addiction.

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