Ensuring a Healthy Future

NCMP Commitments – Agenda for Action

The challenge of providing affordable, available, accessible, acceptable and appropriate healthcare to over a billion people of India is daunting. The problems are many: limited resources, poor governance, skewed manpower, inadequate infrastructure, lack of accountability, misdirected investments, mounting hospital costs, monumental corruption, ignorance, and illiteracy. But happily, India has many unique advantages too. How do we leverage our strengths and achieve minimum acceptable levels of health compatible with modern civilization?

The National Health Policy 2002 – (NHP) set the goal of increasing public health expenditure from 0.9 percent of GDP to 2% of GDP by 2010. This calls for enhancement of states' health expenditure from 5.5% of total budget to 8% by 2010; and union expenditure from 1.3% of total budget to about 7% – almost six-fold increase. The National Common Minimum Programme 2004 (NCMP) set the target of raising public spending on health care to at least 2-3 percent of GDP by 2009, with focus on primary health care. The NCMP among other things, promises the following:

- A national cooked nutritious mid-day meal scheme, funded mainly by the central government, will be introduced in primary and secondary schools. An appropriate mechanism for quality checks will also be set up. The UPA will also universalise the Integrated Child Development Services (ICDS) scheme to provide a functional anganwadi in every settlement and ensure full coverage for all children. Proper infrastructure will be created in schools for NCC, NSS, physical development, sports and cultural development of all students.
- The UPA government will raise public spending on health to at least 2-3% of the GDP over the next five years, with focus on primary healthcare. A national scheme for health insurance for poor families will be introduced. The UPA will step up public investment in programmes to control all communicable disease and also provide leadership to national AIDS control effort.
- The UPA government will take all steps to ensure availability of life-saving drugs at reasonable prices. Special attention will be paid to the poorer sections in the matter of health care. The feasibility of reviving Public Sector Units set up for the manufacture of critical bulk drugs will be re-examined so as to bring down and keep a check on prices of drugs.

While the goals set out in the NHP are admirable, mere good intentions are not sufficient. The NHP-2002 rightly points out the failure of decentralized public health system, but does not identify specific measures to revive public health system at the grass roots. The NHP merely states that primary health system can be kick-started by providing some essential drugs by the union government. However we need to break free from piecemeal approach and attempts to reinvent public health system. One of the key deficiencies in our PHC-based delivery system is its lack of credibility, as PHCs failed to be centers for curative medicine. Therefore, we need to create a Taluk / Block level referral facility for every 100,000 population. We must also make a departure from the NHP-2002 by clearly specifying the functional delineation among various tiers of public health care system. We need to recognize an urgent need to address the

preventable and avoidable suffering due to ineffective public health care system. We need to revisit the necessity of campaign mode to tackle select diseases to reduce the levels of morbidity as a stop-gap measure. Such campaign mode has severe limitations, and it cannot be a substitute to proper primary health care delivery. While it has application in select situations, it must be integrated fully with the system of primary health care. However, a conscious and concerted effort is needed to revamp public health delivery simultaneously.

NHP-2002 again rightly emphasizes the necessity of an Information, Education and Communication (IEC) policy to usher in healthy behavioral changes. While the intent is valid, there is a necessity to institutionalize any such effort, and to empower citizens to enable them to change their behaviour, as well as to hold public functionaries to account. An army of health volunteers would be an appropriate mechanism for such an effort. NHP-2002 treats local governments as mere implementation agencies of various health programmes. However, in consonance with the spirit of 73rd and 74th amendments and with an intention to empower the local communities, we need to transfer functions, funds and functionaries to local governments to ensure efficiency and accountability in the delivery of health care services. We also need to create District Health Boards with local governments, professionals and civil society representatives for effective decentralization and delivery of services.

In any intervention in health care at the national level, there are two severe limitations which ought to inform our advocacy.

- Health is a state subject and as such the levers available with the union government are minimal.
- The union government can only influence the state governments through persuasion, financial incentives and public pressure.

The interventions proposed therefore have to be limited in nature, keeping in view these political and administrative realities.

Lessons of Past Experience

The measures suggested in the NCMP are laudable and require clear, well-designed, cost-effective, implementable programmes. In order to accomplish these goals, the following lessons of past experience should be internalized:

- Our public health expenditure is only around 1 percent of GDP, which is one of the lowest in the world. Out of the total health expenditure in India, only 17% is the public share, and the rest comes from citizens, most of it is out-of-pocket from the poor and middle classes.
- Given the perilous state of our public health system, and the extremely low public expenditure on health, there must be a quantum jump in public health sector resource allocation. This allocation must be judiciously combined with mechanisms to improve the service delivery. These resources can be indigenously raised by innovative financing mechanisms.
- Mere allocations will not guarantee outcomes. Effective utilization of resources is critical.
- Disease burden and epidemiology must guide the prioritization and budget allocations among health problems. Low-cost, high-impact solutions ought to be explored first. Unnecessary expenditure on irrational and wasteful interventions should be avoided.

- The programmes designed must suit Indian conditions.
- Special efforts must be made to reach the vulnerable sections, and rural and urban poor.
- Even now, most disease burden in India is on account of preventable diseases. Therefore the greatest accent must be on preventive and primary health. We need to recognize that our primary health system has been inadequate and weak. In addition to improving infrastructure and bridging gaps, we need to focus on issues of access, equity and accountability.
- Communities' ownership, decentralization and accountability are the keys to successful implementation**.** Accountability must be institutionalized for both public and private health care systems through local administrative, professional and political mechanisms.
- Massive employment generation must be linked to fight against poverty and improvement of the vital services for the poor – education and health care.
- Many "non-health" developmental efforts have enormous impact on health status of the community. In fact, about 80% of the health improvement in the West resulted over a century ago from improvements in nutrition, sanitation, hygiene and housing. The next great improvement in the form of life-expectancy increase (20 years) came in the first half of the 20^{th} century by the conquest of infectious diseases through mass immunization programmes and antibiotics. After 1950, with the introduction of NHS, life expectancy increased in Britain only by 10 years. Generating effective public demand and creating instruments of accountability are as important as efforts to improve supply.
- There must be an integrated policy and implementation of various strands which together constitute good health – nutrition, water supply, sanitation, reproductive and child health, family welfare, medical education, health manpower development and rational drug policy.
- Health care delivery works best when clubbed with other successful community-based initiatives like micro-finance, thrift societies, cooperative and non-profit organizations.
- Certain easily controllable, highly prevalent diseases should be attacked on priority basis through massive national campaigns. These are the low-hanging fruit waiting to be plucked. However, vertical programmes must be the exception and not the norm. Real benefits flow from improving the foundations of primary health delivery system. Therefore vertical programmes must be horizontally integrated at the local level. Care must be exercised to ensure that vertical programmes and campaigns do not dislocate the functioning and effectiveness of primary health delivery and normal operations of health workers.
- Our impressive medical training and hospital infrastructure needs to be revamped to suit our needs, restore the trust of the community and improve efficacy. Public sector services must perform the role of setting optimal standards and benchmarks for quality care.
- Lessons of past experience must be internalized in future development of health services. Vast amount of experience has been gained from several projects launched by government, non-profit organizations and local communities over the years. Any agenda for action to be sustainable should be locally contextualized, relevant and effective to suit the local requirements.
- As health is a state subject, any serious interventions in health care need to be state-specific, and should be discussed and debated in the states widely among different stakeholders. Finally, the state governments and legislatures must adopt and 'own' them, so that long-term commitment and sustainability are assured.

National Health Mission

We understand that the government is contemplating a Rural Health Care Mission for selected states. Undoubtedly, the health care crisis is more acute in Uttar Pradesh, Bihar, Uttaranchal, Jarkhand, Madhya Pradesh, Chattisgarh, Rajasthan, Orissa, Assam, Jammu and Kashmir, and the North-Eastern states. Therefore special attention needs to be focused on those regions. However, we must recognize that poor health delivery is endemic in most of India. Sickness and the consequent financial burden are the largest contributors to impoverishment and indebtedness all over India. Even in the otherwise better-served Kerala about 15 percent of people hospitalized fall below poverty line only on account of sickness. In Bihar this percentage is 35, and all over India it is 25 percent. One episode of hospitalization – whether in public hospitals or private facilities – imposes a cost burden of 60 percent of the annual income for an Indian on an average. As the rich spend only a small fraction of their income on health and sickness, the poor bear a disproportionate burden all over India. Given the appalling state of public health systems in most of India, rural population, and urban poor and middle classes all over the country are in dire need of significant improvement in health delivery and risk-pooling. Therefore, it is vital that a National Health Mission is launched to cover the whole country – rural and urban. The Mission design should be flexible in order to meet the special needs of underserved regions. Also focused attention is needed on the issues of reproductive and child health, nutrition, water and family welfare in certain pockets in order to reduce disparity among regions. While more resources should flow into vulnerable regions and specialized programmes must be launched, the Health Mission must remain national in scope, and must address the public health needs – primary and preventive, as well as risk-pooling and curative – across the whole country.

Figure 7

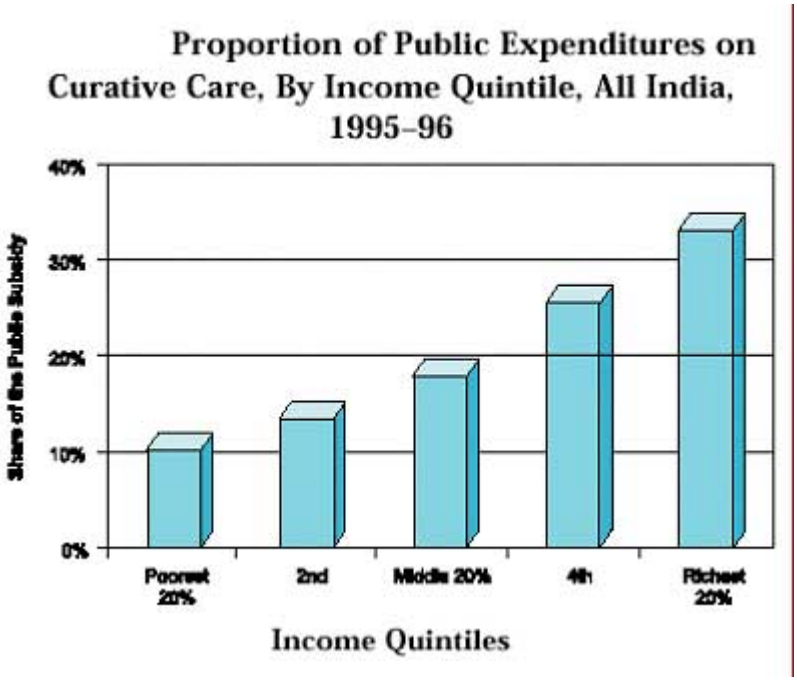


Figure 8

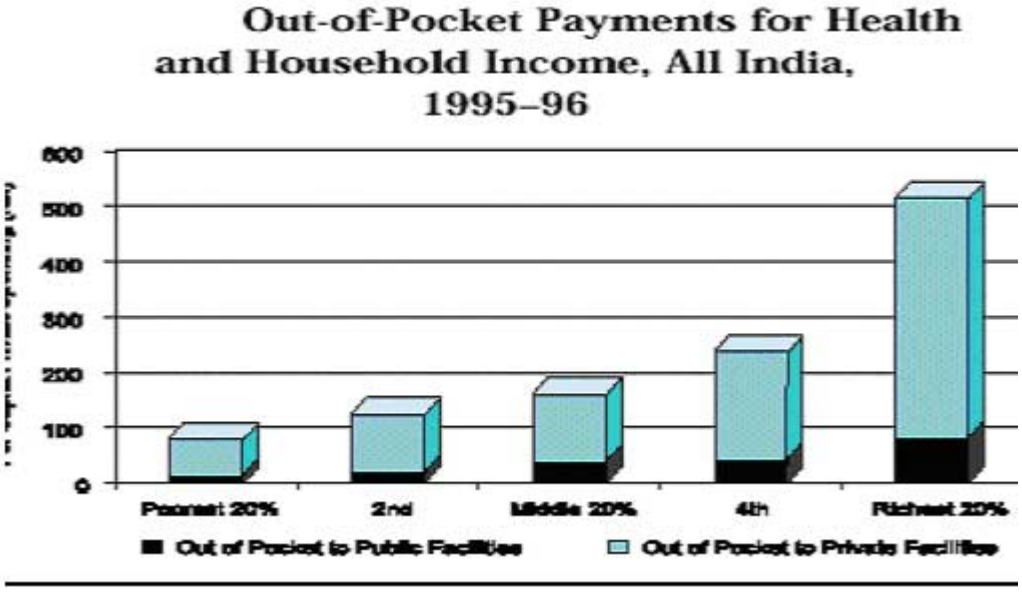
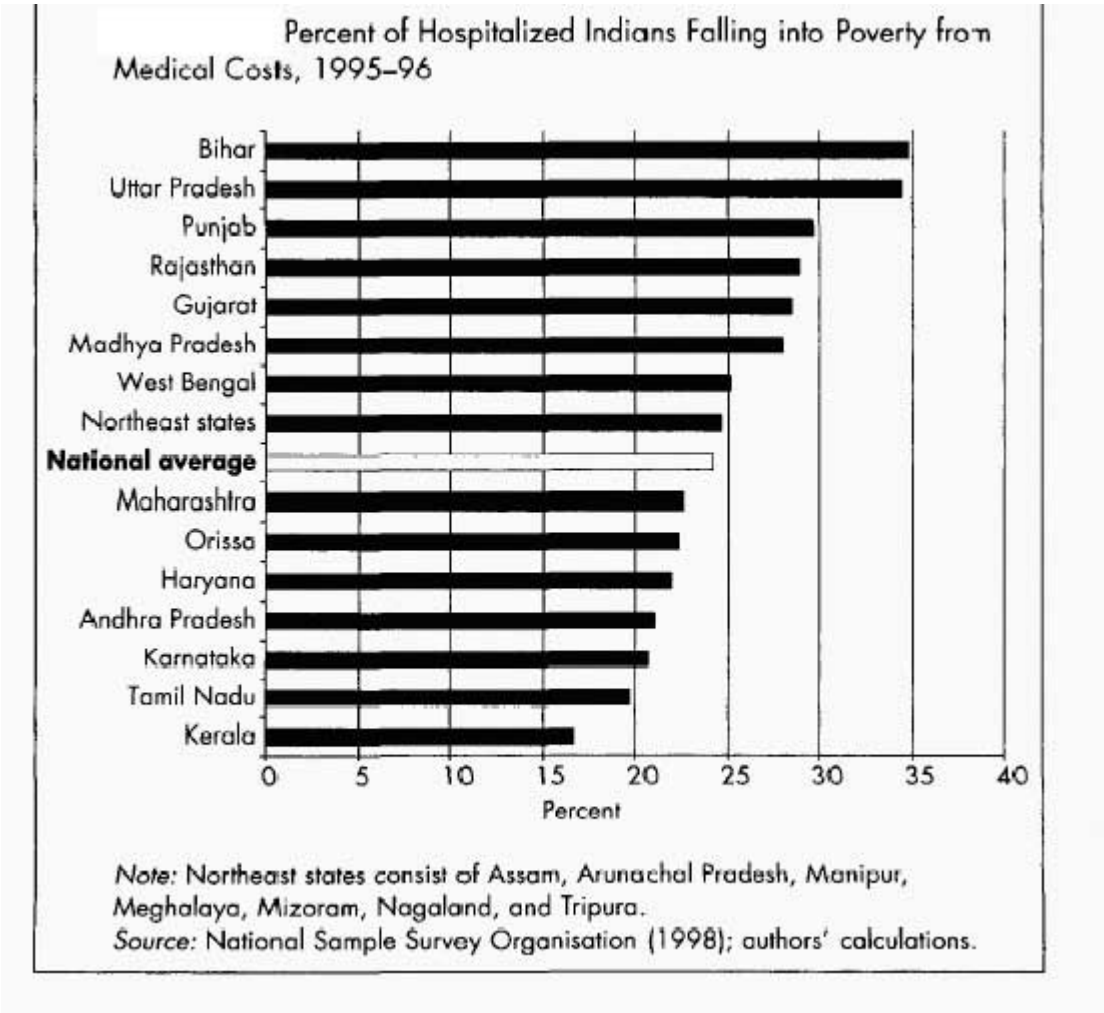


Figure 9



**

Health is a very acutely perceived need among the poor and illiterate sections of population. Therefore, sensible health interventions and improvement of public health delivery will impact the lives of the poorer and disadvantaged sections in particular. As the gestation period between health interventions and better outcomes is relatively short, and as every family is deeply conscious of the dangers of sickness of its members, there is much greater political return on health investments both in the short-term and in the long-term than in almost any other sector. Therefore National Health Mission must be taken up as a truly national movement and massive public participation must be encouraged. The design of the programmes must incorporate public participation, local accountability and self-correcting institutional framework.

Finally, the National Health Mission will be successful and effective only if its implementation is decentralized and it is community-owned. The operation of such a decentralized system can only be under the umbrella of local governments. The programme has to be implemented in a phased manner for transfer of the resources and

funds from the public sector to the people at the grass roots level. Genuine community health care has to fulfil several prerequisites. Health care must be fully integrated with all other related programmes including nutrition, immunization, ICDS, water supply, family welfare, and sanitation from district to village and town level. It must be an integral part of the local self-governing institutions. Strong political will with the support and monitoring of the community yields best results. Effective training and capacity building to the village health functionaries, imparted in a flexible, non-formal, field-oriented manner is vital for efficacy, participation and people's ownership. All vertical programmes must be integrated with primary health delivery. Suitable and flexible institutional mechanisms need to be designed and standardized to train health personnel including multipurpose health workers, nurses, and rural medical practitioners. The decentralized, people-based and community-oriented health care cannot be implemented as a quick-fix 'military' style programme like other vertical programmes. It must be integrated with great care and deliberation into the panchayati raj and municipal governance as well as credible civil society, non-profit and community based health initiatives. Only then can the public health initiatives yield desired results.

Based on these principles, insights and lessons, five practical programmes and approaches are suggested below for adoption with such modifications as are necessary. Where possible, tentative budgetary requirements and time-lines are indicated. This agenda is not a substitute to the health policy, nor is it comprehensive. It is in fact limited in scope, only aimed at filling the gaps. The Agenda for action proposed is based on the following assumptions:

- There will be a National Health Mission covering all the states and union territories, and both rural and urban areas. The pattern of union assistance, however, can be need-based, and variable across states.
- The ongoing programmes of the union and state governments will continue
- The strategic interventions contemplated here are complementary and add-ons to the ongoing programmes aimed at creating a significant impact
- The Tenth-plan commitments will be fully honoured in health sector. These allocations proposed are in addition to the Tenth Plan allocations.

1. Raising an Army of Community Health Volunteers

The experience of several pioneering and successful healthcare initiatives clearly establishes the need for bridging the gap between the formal health institutions and the people. The salient features of the proposal are as follows:

- There will be a female Village Health Worker (VHW) on an average for every 1000 population. The VHWs shall be selected by the community from among the educated women from the village. A million VHWs are needed for India.
- The habitation will be the unit for VHW. Each habitat, even with population less than 1000, will have a VHW. In larger villages, the population served by a VHW may be more than 1000. On an average, it is expected that there will be one VHW per 1000 populations.
- There will be Urban Health Workers (UHW) in urban areas inhabited by low-income and poor populations.
- Wherever possible, the functions of ICDS or Anganwadi personnel in the village can be integrated with the VHWs. This will have the additional benefit of improving the quality of nutrition for children by emphasizing the fortification of diet through Vitamin A, Iodine, etc. This will also facilitate universalization of ICDS.
- The VHWs / UHWs shall be given a three-month training programme. Estimated cost will be Rs 6000/ trainee – training of all VHWs / UHWs may be spread over three years. Several non-profits – Voluntary Health Association of India (VHAI), Jana Swastha Abhiyan (JSA), Foundation for Research in Community Helath (FRCH), Comprehensive Rural Health Care Project, Jamhked (CRHP), Tribhuvandas Foundation, many other charitable foundations, healthcare providers, and government should work in partnership in this training and capacity building programme. This training will be imparted at the district and sub-district level, and monitored by the Panchayats, with technical support from the 30 – 50 bedded Community Health Centre covering the area.
- The training schedule and methodology need to be standardized, and manuals produced in each regional language to suit local requirements. However, actual imparting of training can be flexible, and left to the local communities, panchayats, municipalities, civil society partners and public health experts. Where necessary, training can be split in to several short phases.
- VHWs will be purely voluntary workers who are paid an honorarium of, say Rs 1000/month. The budget can be allocated by the union government and states on cost sharing basis (50:50). The amount will be kept at the disposal of village Panchayat; the selection of VHW, and payment of honorarium will be determined by the panchayat. If the VHW's functions are integrated with the ICDS / Anganwadi worker, the honorarium will be in addition to the benefits that they are receiving under universalization of ICDS programme.
- VHWs may collect a user fee as determined by the village community. This will serve as an incentive for the VHWs to deliver better quality services, and the community can also hold them accountable.

- VHWs will primarily focus on preventive care, health education, immunization, maternal and child care, home delivery of babies, family planning services, and early diagnosis and control of major preventable illnesses.
- VHWs/ UHWs may also be provided performance-linked additional incentives based on immunization, institutional deliveries when required, referral of patients to PHC or Community Health Centre etc.
- The VHWs / UHWs will never be government employees. They should be volunteers recruited, appointed and held accountable by the community. Their honororium shall be paid by the village community through the Panchyat, the funds for this will be transferred by the union and state governments to the Panchayats.
- The VHWs shall be supervised and supported in all technical matters by the ANM available for every 5000 population, and the Primary Health Centre.
- All the vertical programmes for disease control and birth control shall be integrated at the village, sub-centre, PHC and district level. The VHW / UHW and other health care delivery agencies will be fully involved in all those programmes.
- Each VHW / UHW shall be given a health kit including first-aid tools, a few generic drugs, and a supply of simple, relevant literature in local language. This kit shall be replenished on a periodic basis, or as often as required.
- For all preventive care, reproductive and child health care, health education, counseling, family planning services and simple ailments, the VHW / UHW drawn from the community and living in its midst must be the first point of contact.
- The VHWs will pay special attention to counseling and prevention of female foeticide and gender violence
- Apart from preventive care, VHW / UHW must be capable of managing childhood diarrhoeas, simple wounds, worm infestations, skin infections like scabies, and malaria. There must also be capability to suspect tuberculosis, leprosy and other communicable diseases, and once they are diagnosed and drugs are prescribed by the PHC or Community Health Centre, all follow up and supply of medicines should be at the level of VHW / UHW.
- Broadly, the functional classification in the accompanying table must be the guide for curative care at the VHW / UHW and other levels. The ailments in categories A and B must be handled by the VHW / UHW. Category C (except malaria and measles) require referral by VHW / UHW to the CHC. Category D will have to be handled by CHC, district hospital and tertiary hospitals depending on the severity and complexity of the disease.
- A District Health Board (DHB) needs to be constituted to supervise, monitor and fund all the primary health and curative care delivery programmes in the district. This DHB shall comprise of the elected local governments (Zilla Parishad, Municipalities and Municipal Corporation), the health department officials, credible non-profit and civil society initiatives, consumer groups, experts and representatives of health care providers at village, PHC, CHC, district hospital and teaching hospital levels. DHB will be a legally constituted authority with complete responsibility for programmes, personnel, budgets, health plan preparations at village, block and district level and funding and reimbursements. All vertical programmes, if any, shall be fully integrated at the level of District Health Board and below.

- There shall also be full integration of all related programmes including nutrition, ICDS, immunization, drinking water, sanitation, and family welfare services at the DHB level. Appropriate technical and managerial support will be available to the DHB along with funds. DHB shall have mechanisms to facilitate local decision making from village to district level, involving all key stake-holders and the local communities.
- Village Health Plans must be prepared by the VHW / UHW in consultation with the community. Similarly at the PHC / Block level, and District level, Health Plans must be prepared annually. DHB will monitor their preparation and will be responsible for implementation.

Fund Requirements

Training	:	Rs. 200 crores per year for training of VHWs / UHWs spread over three years – borne by the union.
Honorarium	:	Rs. 1200 crore per annum towards honorarium (shared equally by union and states)
Health kits	:	Rs. 100 crore per annum – health kit, a few generic drugs etc. (shared equally by union and states)
Refresher workshop	:	Rs. 50 crore per annum – 2 refresher workshops – 3 days each (shared equally by union and states)

Timeline

- One year for scheme preparation, training module, identification of institutions and organizations
- Training spread over three years

2. Strengthening the Primary Health Care Delivery System

The heart of the public health system should be the preventive and primary health care. Empirical evidence shows that preventive health care usually favours the poor, while curative care favours the rich. Even in public expenditure on curative care, the poorest quintile population shares only 10% of the resources, while the richest quintile share nearly 33%. In other words, for every Re 1 spent for curative care on the poorest 20 percent of population, Rs 3 is spent on the richest 20 percent population. Therefore strengthening the primary health system and preventive care is vital to improve the health of the poor.

At present, 60 percent of all public health expenditure goes in salaries and wages, and only 35 percent goes for materials and supplies, drugs and transport. Even as the public health budget is limited, curative services including hospitals and dispensaries, insurance schemes, and medical education account for 60 percent of the expenditure. Only 26 percent goes to preventive health and family welfare, and 14 percent is spent on administration and miscellaneous services.

On paper, an impressive primary health infrastructure exists in India. We have over 3100 community health centres, which are 30 – 50 bedded hospitals. There are nearly 23000 primary health centres (PHC) with 4 – 6 beds each, serving a population of 30,000 in plains areas, and 20,000 in hill areas. A PHC is supposed to have one or two medical officers and 14 paramedical staff. The PHC is the first contact point between the community and a trained physician. It is expected to provide promotive, preventive, curative and family welfare services. There are usually 6 sub centres in a PHC area, each serving about 5000 population. Each sub-centre is expected to have a male and a female multipurpose worker (MPW). There are over 137,000 sub-centres in India.

While this infrastructure seems impressive, in reality there are many lacunae. And there are more deficiencies in poorer and poorly served states. For instance, while there is a surplus of physicians in PHCs overall, in 8 states there is a shortage of 1779 doctors. 1186 PHCs are without a physician. There is a shortage of about 6,500 Female MPWs (4.8%), and 81,000 male MPWs (58%). There is also shortage of Male Health Assistants (25000), lab technicians (5221 – 23%) and pharmacists (2102 – 9.2%). More important, even when the staff is in place, the supplies of drugs and consumables is inadequate.

A massive national effort is therefore required to fill these gaps and make our primary health care delivery institutions at PHC and sub centre level effective. While health is a state subject, the poorer states are also poorly served by public health institutions. Given the fiscal constraints facing most states, union assistance is required to overcome the deficiencies in primary health care. However, the formula of sharing the burden between the union and states can vary, based on a combination of per capita income of the state, health indicators like infant mortality rate, and demographic indicators like birth rate, and fertility rate. These allocations will have to be in addition to the current level of expenditure by the union and states. Also, first, the government commitments of allocations in health sector under the Tenth five-year plan must be honoured. Subject to

these provisos, the tentative budgetary requirements to fill these gaps as part of the National Health Mission are given below.

Direct union financing of Male MPWs: 80,600 of them – mostly in the poor states with the highest disease burden:

Fund requirement: Rs. 828 cr/year

Provisioning of 35 drugs listed in the Essential Drugs List (EDL) to all PHCs: At present the utilization of PHCs is abysmally low. Most of the beds are unoccupied, and patients have no confidence in the primary health care system meeting even the most rudimentary requirements. There is very little money available for drugs at PHC and sub centre level. The additional infusion of resources for supply of drugs will substantially improve utilization of services of PHCs.

Fund requirement: Rs. 500 cores / year

Intensification of ongoing communicable disease control programmes: Vertical programmes must be integrated at the district level and become part of the unified, horizontal primary health care delivery system. However, programmes for the control of malaria, TB, HIV / AIDS, blindness related to infections and childhood heart disease need to be strengthened.

Fund requirement: Rs 500 crores / year.

Urban Health Posts: Much of the emphasis in primary health care has rightly been on rural areas. But the urban poor and lower middle classes suffer no less than their rural counterparts on account of poor health care delivery. With increasing urbanization, we have to strengthen the urban primary health care delivery too. A large number of health workers and other personnel need to be financed.

Fund requirement: Rs. 200 crores/year

New programmes for the control of non-communicable diseases (NCD): As the prosperity levels rise and health indicators improve, there is an increasing burden of non-communicable diseases. Diabetes, hypertension, respiratory ailments, preventable blindness, injuries and accidents, cancer, coronary artery disease and other vascular diseases are gaining in prominence. They all can be better managed by proper counseling, better life styles, early diagnosis and certain preventive measures. The morbidity and mortality, and health care costs on account of these NCDs are dramatically increasing. As communicable diseases are brought under control, most of the future health care costs will be on account of NCDs. Therefore a new programme needs to be initiated for control of NCDs.

Fund requirement: Rs. 260 crores/year

Upgradation of PHCs: The facilities at PHCs need to be upgraded in order to provide 24-hour delivery services, and care of the new-borns.

Fund requirement: Rs 480 crores / year

Supply of Auto-destruct Syringes: Poor sterilization and reuse of injection needles are common causes of spread of infections, including intractable hospital infections and HIV virus. Therefore introduction of auto-destruct syringes for routine immunization is necessary

Fund requirement: Rs 60 crores / year

Total fund requirements for strengthening the primary health care delivery system

Male MPWs	:	Rs. 828 crores/year
• Supply of listed drugs	:	Rs. 500 crores/year
• Intensification of ongoing disease control programmes	:	Rs. 500 crores/year
Urban health posts	:	Rs. 200 crores/year
Control of non-communicable diseases	:	Rs. 260 crores/year
Upgradation of PHCs for 24-hour delivery	:	Rs 480 crores /year
Supply of auto-destruct syringes	:	Rs 60 crores / year
Total	:	Rs. 2828 crores/year

Note: This projection is contingent upon continuance of all the current health care programmes, and full allocation as per Tenth plan projections. These are additional fund requirements over and above current non-plan and plan allocations.

3. National Mission for Sanitation

It is well recognized that safe drinking water and sanitation are two vital requirements for good health. Governments have been paying serious attention to drinking water problem, and 88 percent of Indians have access to improved water sources. Drinking water supply is an intensely political issue, and parties and governments are responding to people's urges. Several schemes and programmes are being implemented to provide safe drinking water in rural and urban areas. But the condition of sanitation is appalling. Only 31 percent people have access to a safe, hygienic toilet. 69 percent of Indians are forced to defecate in public, with grievous consequences to health, hygiene and human dignity. No serious efforts are made to combat this problem, which causes severe inconvenience particularly to women, children, the aged and the disabled.

The cost of a modern, scientifically designed, hygienic toilet is no more than Rs 3000. Sulabh International and many other organizations demonstrated the efficacy of low-cost household toilets. The problem is one of ignorance, habit, poverty and at the local level, unavailability of the material to build the toilet. Habits change with time and persuasion, and people always prefer better lifestyles. Ignorance can be overcome by a massive public education campaign. Government needs to come forward with a programme for a toilet for every household. Once materials are mass-produced and available at low cost in the market with government initiative, most people can afford to build toilets at their own expense. All it requires is a short-term national campaign to promote hygiene and sanitation. About 20 – 25 percent of the population may need subsidies. Assuming 20% labour component, each toilet needs a subsidy of Rs 2400 per family. Such subsidy will amount to Rs 12,000 crores for the whole country. Spread over a five-year period, it will cost no more than Rs 2400 crores per year. With political will, it is possible to extend sanitation facilities to the whole population in five years.

A National Mission for Sanitation needs to be launched with an objective of building a safe, hygienic toilet in every household and propagating the message of hygiene and health. With the vast majority of people not having access to hygienic toilets, public defecation is one of the greatest scourges of modern India. Most water-borne diseases, childhood diarrheas and infections through faeco-oral transmission are directly a result of lack of hygiene and sanitation.

- 120 million households have no access to hygienic toilets. A five-year programme should be taken up to build a safe hygienic toilet in every household.
- In reality, the problem is linked to housing and water availability. But every household of a permanent nature (including thatched huts) can have a toilet. In areas of extreme water scarcity where septic tanks are not feasible, other viable models can be adopted. But 80% of the households – or about 100 million hygienic toilets can, and must, be built.
- These can be funded by household savings, and government subsidies. Roughly, 50% of the needy households can build the toilets from private resources, provided they are motivated, and the technology and material are readily available and accessible. What is needed is a massive national campaign and precise public education.

- About 50 million households may therefore require government support. The unit cost will be about Rs 3000. While 20% can be household contribution (Rs. 600) in the form of labour, 80% can be government contribution (Rs. 2400). Government contribution can be shared by the union and states in the ratio of 2:1.

A task force must go into design aspects of the safe household toilets. The terrain, water availability, housing availability, proximity to a ground water source contaminating it – all these determine the design. There are also technologies for dry toilets where water is scarce. Even where water is available, sparing use of scarce water for flushing is a critical requirement. Considering all these circumstances, a variety of technically sound designs must be prepared and propagated. Also follow up steps are required for mass manufacturing of the materials required. Similarly, there must be follow up on education and propagation of technology for converting night soil into compost, and for use of septic tanks alternately,

Fund Requirements

The total, one-time allocation by union and states for 50 million toilets will be of the order of Rs. 12000 crore. The union's share will be Rs 8000 crore. Spread over 5 years at 10 million toilets a year, this will mean an allocation of Rs 1600 crore per year for the union and Rs 800 crore per year for all states put together.

Annual fund requirement for 5 years: Rs. 2400 crore.

In addition, a national public health education programme and propagation of technology may cost Rs 100 crores per year. The union may take up this campaign.

Annual fund requirement for 5 years : Rs. 100 crore

Timeline

This can be implemented over a period of 5 years, covering 50 million households with government support, and 50 million households with private savings.

Other Spin-offs

Apart from the obvious health benefits, this will help stimulate the economy by creating a demand for Rs 30,000 crores of material, simple technology and labour.

4. Taluk / Block Level Referral Hospitals for Curative Care

Even though the primary healthcare centers (PHCs) are originally designed to deliver both preventive and curative healthcare services, over the years they have failed largely on both fronts. As a result, the feeling of increasing number of people is that PHCs are not there to serve the people, and are there only as an extended arm of government. There are three principal reasons for this:

- Doctors posted in PHCs rarely serve there. The PHCs and their staff are not accountable to the community or local government.
- Owing to the gradual decline in quality of services, the PHCs are not equipped to deliver curative services. It is the curative services which bring the people to a health center. As the evidence shows, 81 % of outpatient (OP) care, and 56 % of inpatient (IP) care are provided by private sector (1996). Even the limited services (OP and IP) offered in public sector are almost always in hospitals other than PHCs.
- The facilities and location of the PHC in most cases are not conducive for it to act as a referral center. The facilities and staffing are inadequate to provide reliable curative care. And the location is often away from the nearest urban center, and even more remote than the habitat from which patients seek help. The natural tendency of people seeking curative care is to go to a more central location, and not to a more remote location.

Typically, the credibility of a healthcare institution and the public perception are shaped by the quality of curative services. It is unlikely that the PHCs can even be sufficiently improved to provide effective curative services. The PHC should function as the nodal agency for all preventive services, national programmes, monitoring of VHWs and ANMs, and reproductive and child healthcare services including birth control and institutional deliveries where required. PHCs can also attend to life threatening emergencies and simple ailments. However, once the preventive and primary health care system is rejuvenated through voluntary health workers and other steps envisaged under NCMP, they will be fully preoccupied with these services. Integration of vertical programmes, creation of a District Health Board and strengthening of sub-centres will make PHCs far more effective and accountable.

PHCs will be able to handle a small proportion of curative services. But we need a full-fledged, accessible, credible, effective, accountable first referral hospital which will function as the apex of preventive and primary health care delivery system providing technical and training support. This referral hospital will also be the first serious curative service provider, addressing 70 to 80 percent of all ailments requiring physician's intervention and / or hospitalization.

The preventive health care system will be trusted by the people only when the hospital system supporting it is accessible and effective. No matter how good the preventive health system is, there will always be disease burden and morbidity in society. Most people think of health care only when they are sick. Given the fact that out-of-pocket payments are staggering in India, and sickness is the largest contributor of poverty and

indebtedness, a good quality, efficient and effective public hospital network with close linkages with the PHCs, sub-centres and voluntary health workers is critical. It is a fact that most curative expenditure tends to favour the better off sections of the population. But that is largely because public hospitals are mostly concentrated in big cities and district towns. Only one Community Health Centre (CHC) or Area hospital exists per 350,000 population. Over crowding and lack of accountability in CHCs repels most of the people, and forces them to seek private health care at huge out-of-pocket expense. Therefore it is essential to create new institutions or strengthen existing institutions to serve as credible and effective referral centers to offer curative services. The referral centers must be designed based on the following guidelines:

- One 30-50 bed referral hospital for every 100,000 population with a full complement of staff and infrastructure including one Civil Surgeon, 3 or 4 Civil Assistant Surgeons, a dentist, 7 or 8 staff nurses and two paramedical personnel.
- This hospital should be controlled by the local government (district panchayat or town/city government) and District Health Board. The staff should be recruited, appointed and controlled by the District Health Board and financial provisioning for the hospital should be made by the Board, with full assistance from state and union governments in the form of grants.

While redesigning the primary and curative institutions, the following broad principles should be adhered to:

- 80 % of all cases can be handled by the VHW, ANM or PHC through prevention. About 15 % of patients need to go to a referral center and 5 % to the tertiary level.
- Out of the total public healthcare budget, at least 50 % should be for preventive care, and no more than 35 % for referral care and 15% for tertiary care.
- The preventive care budget should be supplemented by additional funds to meet cost of drugs for common ailments such as Malaria, Diaorrhea, TB, Leprosy etc.
- Functional classification of diseases and jurisdiction among different service providers will be adhered to, not according to medical pathology, but according to the varying levels of knowledge, skills and facilities needed for diagnosis, management and care. (See Table)

We need to remember that when the PHCs were conceived, the communication and transport network were very weak in this country. Though there is a lot more to be done to improve communication/transport networks, the current situation is far better than in 1950's and 1960's. The experience of the past few decades demonstrates that the location of PHC has been determined by various extraneous factors such as political compulsions and availability of free land. Further, people tend to visit closest neighboring towns, semi urban and urban centers as they provide choice in terms of medical shops, transport facilities, lodges and food joints. If we factor all these and the success of several health care projects, establishment of referral centers would clearly ensure better delivery of health services

There are over 3100 community health centres (30-50 bedded) and Area hospitals (50-100 bedded) all over India. In order to serve the whole country, at one hospital per 100,000 population, we need a total of about 10,000 such facilities. Even in urban areas we need these small hospitals, failing which the second referral and tertiary care hospitals will be overcrowded. The failure of primary health and first referral system converted even our teaching and super-specialty hospitals into overcrowded primary health centres and nursing homes. Therefore 7000 new community health centres need to be built, furnished and equipped.

Fund Requirements

Capital cost of 7000 CHCs at Rs. 1 crore each = Rs. 7000 crores.

Annual cost (spread over five years) = Rs. 1400 crores.

Note: Maintenance cost is dealt with separately in the next section relating to risk-pooling and financing mechanism for curative care.

Table 12				
Data at the Community Health Center (CHC) Level				
State	**Total**	**CHCs**	**CHCs**	**New CHCs to be built**
	Population	**Available**	**Required**	
AP	75,727,541	219	757	538
A & N Islands	356,265	4	4	0
Arunachal Pradesh	1,091,117	20	20	0
Assam	26,638,407	100	266	166
Bihar	82,878,796	148	829	681
Chandigarh	900,914	1	9	8
Chattisgarh	20,795,956	0	208	208
Dadra & Nagar Haveli	220,451	1	2	1
Daman & Diu	158,059	1	2	1
Delhi	13,782,976	0	138	138
Goa	1,343,998	5	13	8
Gujarat	50,596,992	242	506	264
Haryana	21,082,989	64	211	147
Himachal Pradesh	6,077,248	65	65	0
Jammu & Kashmir	10,069,917	53	101	48
Jharkand	26,909,428	0	269	269
Karnataka	52,733,958	249	527	278
Kerala	31,838,619	105	318	213
Lakshadweep	60,595	3	3	0
Maharashtra	96,752,247	351	968	617
Manipur	2,388,634	16	24	8
Meghalaya	2,306,069	13	23	10
Mizoram	891,058	9	9	0
Madhya Pradesh	60,385,118	342	604	262
Nagaland	1,988,636	9	20	11
Orissa	36,706,920	157	367	210
Pondicherry	973,829	4	10	6
Punjab	24,289,296	105	243	138
Rajasthan	56,473,122	263	565	302
Sikkim	540,493	2	5	3
Tamil Nadu	62,110,839	**239**	621	382
Tripura	3,191,168	11	32	21
Uttar Pradesh	166,052,859	310	1661	1351
Uttaranchal	8,479,562	0	85	85
West Bengal	80,221,171	99	802	703
Total Of States & UTs	**1,027,015,247**	**3210**	**10286**	**7076**
Annual Recurring cost of maintaining CHC = Rs 50 lakhs.				
Stipulated Ratio: One 30-50 bed referral hospital for every 100,000 population.				

Table 13
Functional Classification of Diseases

Category A – These comprise of simple, self-limiting diseases which can be adequately handled by the individual and the family e.g. minor coughs, colds, diarrhea's, body aches, cuts, bruises, boils, minor allergies and a host of everyday conditions. Both the diagnostic as well as the treatment skills are a part of the tradition of most families and communities and are managed by utilizing home and folk remedies and/or safe and cheap over-the-counter drugs. The role of these as a placebo should also not be underestimated.

Category B – These are diseases which are not life-threatening but are nevertheless responsible for a substantial part of the community morbidity load. These include scabies, worms, moderately severe cuts, bruises, abdominal colic, osteoarthritis, chronic dermatitis, common fevers and chronic obstructive pulmonary disease. They can be adequately diagnosed and looked after with the help of a properly trained local health functionary with a modest repertoire of safe but effective drugs. Advice for management of the disease by methods such as Oral Rehydration Therapy (ORT), steam inhalation or application of sulphur ointment or benzyl benzoate, would be even more appropriate than unnecessary investigations and medication with antibiotics and corticosteroids, which is now common practice, often by injection.

Category C – This category comprises diseases like severe gastroenteritis, dysentery, acute respiratory infections, tuberculosis, tetanus, leprosy, malaria, poliomyelitis, measles, pneumonia, rheumatic heart diseases and sexually transmitted diseases. These diseases can be most effectively tackled by the people themselves in conjunction with their better trained paramedical workers, if access is available to professional support.

Category D – This group comprises high profile but relatively few conditions which need knowledge, skills and facilities that can only be provided by the trained medical or nursing professionals at a hospital. These include major medical and surgical problems and emergencies which are beyond the scope of the paramedical worker who can nevertheless be taught to provide first aid before referral as well as to undertake follow-up and after-care. The *block/taluka* Hospital can meet this requirement more effectively and humanely, at far lower cost. This would also reduce dependency on unnecessarily costly care in a private hospital.

It is realized that while utilizing such a classification, in a few instances, the severity of the disease may increase and upgrade to the next higher category or categories. A holding period of 48 to 72 hours is generally indicated following which the persistence or exaggeration of symptoms indicates referral to the next level of care. The paramedical workers can be taught the signs and symptoms of common emergencies like meningitis, abdominal pain or injury where immediate referral is necessary when in doubt. Adequate communication and transport is an important aspect of such a decentralized system of health and medical care so lacking in the existing system.

Source: Antia NH, Dutta GP, Kasbekar AB, "*Health and Medical Care : A People's Movement*", (Pune: FRCH, 2001)

5. Risk-Pooling and Hospital Care Financing

NCMP – 2004 has set the ambitious target of a national health insurance scheme covering the poor families. However, available evidence and past experience indicate that such a scheme has to be introduced in phases with careful sequencing.

Experience of many projects run by civil society initiatives and non-profit foundations indicates that the average actuarial costs for even a modest health insurance coverage comes to about Rs.200 per capita per annum. Even if only the 30 crore poor people are targeted, the total costs come to about Rs. 6000 crores per annum. If we assume that the lower middle classes will get 50% subsidy on insurance premium, a further amount of Rs. 4000 crores per annum would be needed (to cover 40 crore population). Thus, any credible national insurance programme, even with modest and limited risk coverage will cost about Rs. 10,000 crores per annum.

The total per capita expenditure on public health care now is only about Rs. 200. At a time when the public health system and preventive care are in disarray, a national health insurance will end up subsidizing private hospitals and drive investment into curative medicine, sophisticated diagnostics, and heroic interventions. This will further diminish resources for preventive and public health, and lead to escalation of demand for high cost curative medicine, in the fond hope that more hospitals will ensure better health.

Moreover, most of the disease burden is a consequence of failure of primary care. The need of the hour is clearly to strengthen preventive and public health systems in order to give best value for the money spent, reduce disease burden and promote the health status of the community. In this context, excessive reliance on health insurance, as a means of health care delivery, is clearly neither prudent nor cost-effective. Health insurance will only address the symptoms of failure of public health, without reducing the disease burden. This will only lead to spiraling health care costs as witnessed in many advanced countries. The evidence in the OECD countries shows that healthcare costs are growing much faster than GDP. The total healthcare costs in rich countries are now estimated at an astronomical $ 3 trillion. India should do everything possible to limit these costs of healthcare, even as everything possible is done to improve the health status of the community.

However, the disease spectrum is undergoing rapid changes with enhanced prosperity and better preventive health care. The average life span also is increasing significantly. Therefore, India should move towards risk pooling options in case of hospitalization. But this has to be treated as a lower order priority compared to improvement in public health delivery system.

But a comprehensive National Health Insurance scheme faces formidable obstacles. The union government announced in the budget of 2003-04 the launching of a community based universal health insurance scheme for low-income population. This scheme envisaged Re 1/day premium for individuals, Rs.1.5/- per day for families of up to 5 members, and Rs.2/-day for families of up to 7 members, and provides a risk cover of up

to Rs.30000 per family, compensation for loss of livelihood for 15 days at Rs.50/- per day, and in case of death of the earning head of family due to personal accident, Rs.25,000/- insurance coverage. The government's subsidy is Rs.100/- per year in respect of below poverty line (BPL) families, and the scheme covers groups of at least 100 families. The scheme was expected to cover 10 million BPL families during the first year, and Rs.100 crore was allocated as government subsidy. There is no data on the actual implementation of the scheme. But the available indications are that the scheme has not taken off. The scheme does not cover primary health and out-patient care. Identification of BPL families eligible for subsidy, collection of premium, management of the scheme, and settlement of claims pose formidable obstacles.

From this analysis, it is clear that credible, trustworthy public providers are necessary to improve hospital care. Otherwise, health insurance will only further strengthen private providers at the cost of public exchequer. Such a policy will be neither sound nor economical. However, the mounting cost of hospital care, increasing out-of-pocket expenditure for hospitalization, and their catastrophic impact on personal and family finances demand an innovative and flexible risk-pooling mechanism to provide a security net for the poor and low income groups. Where necessary, we must be able to involve private providers also, but with strict control of costs and standards of care. But the primary goal should be to strengthen public health system, even as families are protected from financial ruin in case of sickness.

Certain Approaches to Risk-pooling

Such risk-pooling mechanism should meet the following tests:

- Linking risk-pooling with strengthening of public health care providers.
- Recognize the magnitude and importance of small, low-cost private providers as a national resource, and integrate them in health care system when necessary and feasible.
- Ensuring decentralized, local control and flexibility.
- Create incentives and risk-reward system to promote quality health service delivery.
- Raise resources innovatively and make the programme sustainable.
- Promote greater accountability and cost control in curative services.
- Ensure choice to patients among multiple service providers.
- Encourage competition among health care providers
- Ensure access and quality of service to those with no influence or voice.
- Focus must be on optimal care for all at low cost, and not ideal care for a few at exorbitant cost.

Given these objectives the following model substantially meets most of the above requirements cost.

- An amount of Rs 90 per capita will be raised every year for risk-pooling of hospital care costs as follows:
    - Rs 30 per capita will come from the union government

    - Rs 30 per capita will come from the state government
    - Rs 50 per capita will be raised as a local tax collected by the local government along with property tax and other local taxes. This tax will be levied and collected only from above-poverty line people. Assuming that 40% of people are exempted on account of poverty, the final realization will be Rs 30 per capita. Alternatively, Rs 30 per capita can be raised from all those above poverty line, and the balance will be reimbursed by the union and state.
- A total of Rs 9000 crores will thus be raised annually.
- This hospital care fund will be disaggregated for every district on population basis. The amount will be kept at the disposal of the District Health Board (DHB) constituted in each district, or for every 3 million population. For instance, for a DHB serving 3 million people, Rs 27 crores will be allotted.
- While public hospitals are built at government cost, no other maintenance budget will be allotted to them except through the District Health Fund (DHF)
- Every patient will have a choice to approach any one of the public hospitals within the area of DHB, in case of sickness.
- All primary health care services will be provided by PHCs, sub-centres and VHWs / UHWs free of cost, for which separate budget allocations are made.
- CHCs will be the first referral hospitals. Only when CHCs cannot deal with a patient on account of need for highly specialized services can patients be referred to the district and teaching hospitals.
- All these hospitals will be funded only by way of reimbursement of costs for services rendered. Both salary costs and maintenance costs will be recovered only by way of services.
- The DHB will manage the DHF. **Funds credited to DHF shall be non-lapsable.**
- Reimbursements will be based on standard costs decided by experts periodically. There will be flexibility to suit local conditions. For instance, a cataract surgery costs may be reimbursed at Rs.600 to Rs.1000.
- Standards of care and protocols will be prescribed.
- If the local public hospitals are not able to handle the case-load, the patients can go to approved non-profit hospitals or private doctors and small nursing homes. Private providers too will be reimbursed in the same manner as public hospitals.
- The discretion of involving private providers will be exercised by the DHB depending on local requirements.
- There will be appropriate accreditation procedures for all such private providers intending to participate in the hospital care programme.

Such a risk-pooling mechanism as outlined above meets all the tests for a viable, sustainable and effective curative care system. However, in order for such risk pooling to work, the following support systems are required.

- DHB must have the legal status to control funds, health care services and personnel in public hospitals.
- An effective, functioning and accessible primary and preventive health care system is the necessary prerequisite for successful hospital care risk-pooling.

- A proper health accounting system must be put into place to constantly monitor, study and analyse how resources are deployed and costs are incurred, and to establish the link between disease burden and costs. Such constant evaluation is necessary to make adjustments regularly, and ensure optimal care at the lowest cost possible.
- Any risk-pooling system is prone to leakages, false claims and public fraud. Therefore a strong, independent ombudsmen system must be institutionalized at the district, state and national levels, with adequate capacity and powers to check all abuses and malpractices.
- Cost of services must be evaluated regularly and standardized with sufficient flexibility. Costs allowed must be high enough to give incentive to the provider to attract patients, and low enough to be economical and save public money.
- Standards of care should be clearly defined for each intervention, procedure and treatment.
- District, teaching and super-specialty hospitals must be allowed to have special paid beds with added comforts and facilities. They can be free to collect user costs at market rates. However, standards of care for the same intervention must be identical for all patients. This will raise additional resources from those who can afford, and at the same time there will be pressure to maintain high quality services.
- Criteria for prioritization of care must be fixed so that the greatest benefit accrues at the least cost and effort to most people.
- A patients' bill of rights or patients' charter must be evolved with appropriate safeguards, and made applicable to all public and private providers.

Apart from the above National Health Insurance Schemes (NHIS), those who wish to go in for private health insurance would be free to join such schemes. However, contribution to NHIS shall be mandatory for all, except those who are below poverty line.

In addition, government may encourage community-based health insurance initiatives. In such cases, people covered by such schemes may be exempted from paying the premium (Rs.30 or 50 per capita). A scheme can be launched by the government to support such existing or future initiatives on the following lines:

- Link health insurance to existing, successful, credible institutions like credit cooperatives, thrift societies, self-employed groups, non-profit healthcare providers, and dairy cooperatives.
- There must be an effective healthcare infrastructure – primary as well as hospital care – supporting the health insurance scheme.
- Wherever there are such groups operating health risk-pooling schemes, government will match the premium amounts raised in respect of BPL families.
- Insurance Regulatory and Development Authority Act needs to be amended to remove entry barriers into health insurance for non-profits and cooperatives.
- A whole population of a geographic area, or a whole group of people in a sector (eg: members of cooperatives) must be covered on a large enough scale for the scheme to be viable and effective. The scheme cannot be for self-selecting beneficiaries alone.
- The best practices should be meticulously documented for wide propagation and designing of a comprehensive scheme in future.

- A modest sum of Rs 100 crore can be allocated and utilized per annum initially. As demand picks up, the schemes can be expanded to cover larger populations and government subsidies can be tapered off.
    - After 5 years, a review may be undertaken to decide on future course of action.

Funding Requirements

Risk-pooling: from union and states	:	Rs. 6000 crore per annum
Less current maintenance cost of public hospitals (estimated)	:	Rs. 3500 crores / annum
		---
Additional Requirement	:	Rs. 2500 crores / annum
Community Based Health Insurance	:	Rs. 100 crores / annum

Total	:	Rs. 2600 crores /annum

Total Funding Requirement for Health Care Interventions

The above five recommendations of the NAC are in line with the commitments made under the NCMP in health sector. As stated earlier, they are in addition to the on-going programmes and the Tenth Plan commitments.

The total estimated financial outlay of these proposals is as follows:

Community Health Workers (Recurrent cost)	Rs. 1550 crores/year
Strengthening Primary Health care (Recurrent cost)	Rs. 2828 crores/year
National Sanitation Mission (Capital cost)	Rs. 2500 crores/year
First Referral Hospitals (Capital cost)	Rs. 1400 crores/year
Risk-pooling and Hospital care financing (Recurring cost)	Rs. 2600 crores/year
Total	Rs.10878 crores/year

Note: Capital cost for National Sanitation Mission (2500 crores / year), and first referral hospitals (Rs. 1400 crores / year), and training cost of community health workers (Rs. 200 crores / year) are only one time costs extending for three to five years. The permanent recurring burden on the exchequer on account of these proposals will be of the order of Rs 6770 crores per annum

As discussed earlier, the proposed National Health Mission would best serve the goals if it is made applicable for the whole country – all states, and rural and urban areas. However, the union support can be on preferential basis to backward states and districts. If the five broad proposals outlined above are integrated with the National Health Mission, it will result in radical restructuring of the health care delivery system in India. However, this transition will take time, enormous political will, considerable skill, painstaking attention to detail and domain expertise. Local innovations should be encouraged, and programmes should be designed based on past experiences of various civil society initiatives, non-profit organizations and government schemes.

Task Forces

In order to achieve this transition, and address the many related issues in health care, several task forces need to be appointed with health officials, professionals, experts, policy analysts and civil society representatives. These Task Forces must give time-bound reports – say within 60 days, after due deliberation and wide consultation. Their recommendations must be specific, lucid, and be amenable to immediate implementation. The suggested task forces are as follows:

1. Reproductive and Child Health (RCH) and Birth Control in High Fertility States

We should recognize that there is great demand for effective reproductive health and birth control services. This demand cuts across the religious and caste divide, and rich-poor and urban-rural barriers. Most people recognize the need to adopt small family norm for their own economic and physical well-being. However, we have not created the infrastructure to meet such demand with sensitivity, while preserving the dignity of these families. People are often treated as cattle to be ferried on trucks to family planning camps.

If citizens are treated with sensitivity and empathy, and if they feel that they get the dignity they deserve, the response will be electrifying. There is anecdotal evidence that even now, the limited incentives offered for adopting small family norm are often appropriated by the public health staff, and the poor people are often treated with utmost callousness. It should be possible to create a congenial climate at least in respect of reproductive health as a special campaign, as States like Tamil Nadu, Andhra Pradesh and Karnataka have amply demonstrated.

The Task Force will identify the best practices in other countries and within our own states, and devise mechanisms for their integration in the health care delivery and National Health Mission, particularly in the regions where birth rates and fertility rates are high. The initiatives must be combined with strategies for empowerment of women, and prevention of female foeticide and gender violence.

Extension of family planning services or addressing the reproductive health needs of women must take place within the context and framework of a comprehensive community health programme. Therefore, filling the gaps in primary and preventive health care delivery system, creation of community health volunteers (VHWs and UHWs), and ensuring accountability and community ownership are the essential prerequisites for successful spread of family planning and birth control measures.

There is a great demand for spacing methods and sterilization for women. Family planning camps will remain an important mechanism for reaching these services to women. However, the Task Force should specify the protocols for the camps, and have in place a system of monitoring the functioning of the camps. Also detailed guidelines for spacing methods – IUDs and pills need to be evolved, with clear lines of responsibility among health personnel. Assurance of good quality service and treatment with dignity,

and access to reliable preventive and curative health care facilities are the best incentives for birth control. The Task Force may design appropriate programmes based on these criteria for the rapid promotion of family planning and birth control in states where fertility rates are high.

2. Convergence and Integration of Services

Mechanisms need to be evolved to integrate preventive and primary health with nutrition (Mid-day meals), child care including ICDS, water supply, sanitation, maternal care and family welfare and birth control services. The Task Force will identify institutional mechanisms and practices for such convergence at national and state level, and total integration at the level of DHB and its health delivery arms – preventive and curative.

3. Medical Education and Medical Grants Commission

We need special measures to overhaul medical education, and make it more relevant to our needs.

a. Emphasis on nutrition, infection and tropical diseases.
b. Greater exposure to patient care during student days – with beds being allotted to students.
c. Emphasis on life-saving procedures
d. Mandatory exposure to PHCs and rural and community hospitals.
e. Better integration of non-allopathic systems and indigenous systems in the curriculum – particularly in dealing with non-infectious, chronic, degenerative diseases, allergic disorders and life style diseases.
f. Involvement of private hospitals in medical education.
g. Involvement of leading private consultants in medical teaching.
h. Emphasis on gender-sensitivity, and public-health and preventive perspective.
i. Exposure to rights, laws and medical ethics.

A Task Force should go into all these issues and finalise an action plan to reform medical education. Possible creation of a Medical Grants Commission for accrediting teaching and training institutions, and funding them must be part of the Task Force's charter. Medical education should include training of paramedics, nurses and other health personnel. Also short-term courses to meet our health needs must be designed by the task force.

4. Training of Voluntary Health Workers

An expert group must finalize the details of VHW training and produce appropriate manuals in various languages. Also the details of annual refresher courses and the medical kits to be supplied must be finalized.

5. Regulation of Medical Care and Medical Ethics

Indian medical care – public and private – is largely unregulated. A Task Force must study the best practices and identify mechanisms, including drafting appropriate legislation, to effectively regulate medical care. The following measures need to be pursued rigorously:

- Strict limits on use of drugs and formulations, and use of generic drugs as far as possible. The government needs to adapt the Bangladesh model.
- Standardizing medical care and determination of standards/protocols and costs for investigations, procedures, and surgeries.
- Strict regulatory control to prevent inflated billing and malpraxis.
- Encouragement to civil society initiatives which bring healthcare professionals, providers and public on one platform in an institutionalized manner.
- Mandatory independent Ombudsmen to be appointed by the corporate hospitals and health service providers to investigate complaints and order redressal.
- Innovative tools like False Claims Act to combat inflated billing (US model).
- Incentives to promote independent rating of hospitals and nursing homes.
- Transparency laws to make hospital information available in public domain, without violating patient privacy.
- All other steps to promote spread of information and true competition, and to inform the citizen-customers.

6. Regulation of Medical Profession

It is commonly acknowledged that the Indian Medical Council Act has largely failed in its main purpose. A new regulatory mechanism is required to bring greater transparency, accountability and participation of prominent citizens and jurists.

7. Accreditation and Integration of Rural Medical Practitioners (RMPs) into Health System

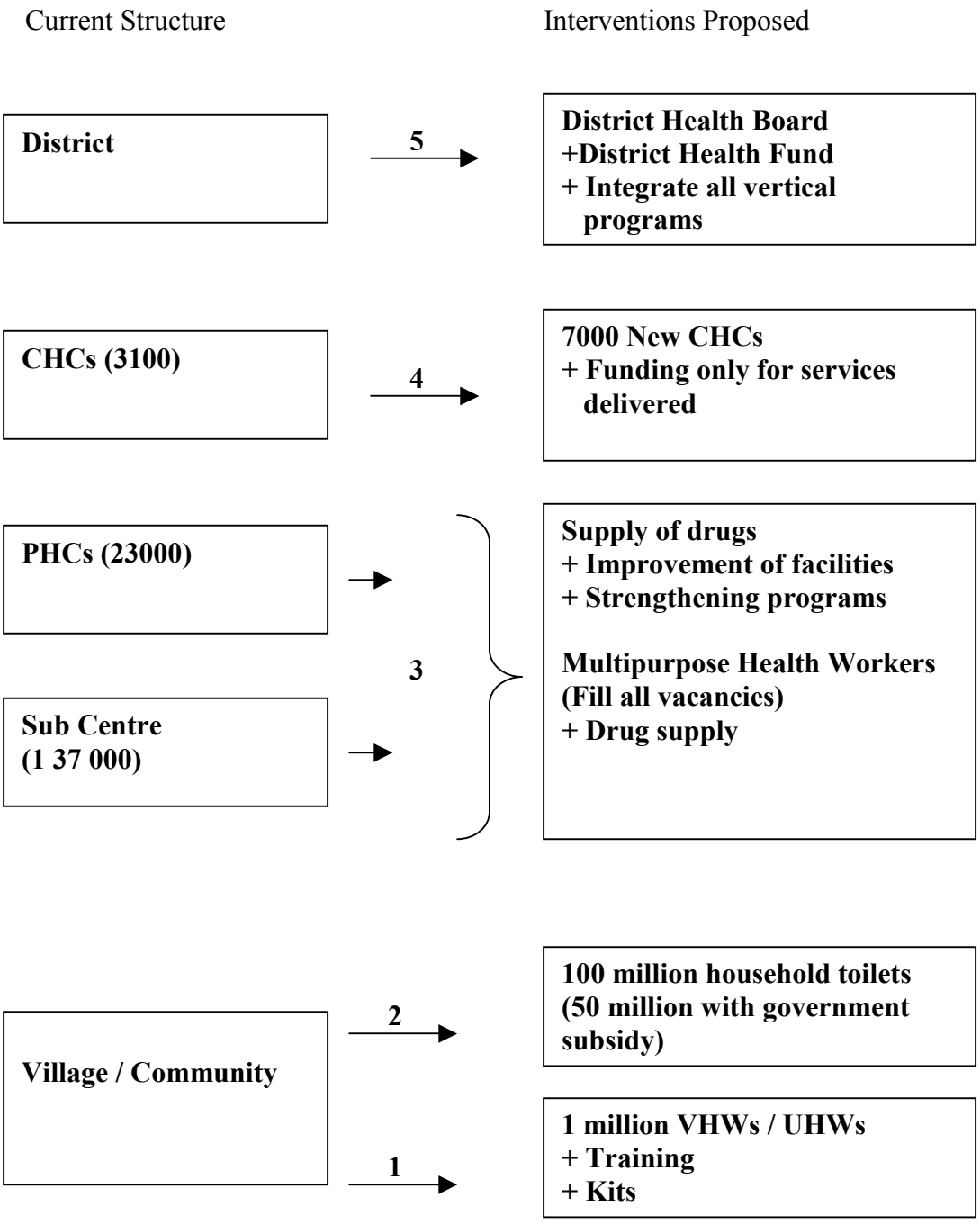
There are 500,000 RMPs – often with no formal qualifications or training - providing health care all over rural India. In most cases, they are the first point of contact for the patients, and they also act as agents to refer patients to private nursing homes and corporate hospitals. Though the law does not recognize them, we cannot wish them away. The Task Force must design mechanisms for testing and accreditation of those qualified, so that they can practice rural medicine within prescribed limits. Training programmes can be devised to help those who wish to hone or upgrade their skills. They can thus act as private health care providers in areas where specialized knowledge and skills are not needed. The Task Force must also identify ways of making them partners in public health delivery at the grassroots level.

8. Health Financing Mechanisms

Revamping of our health care costs money. If our public health expenditure is to be enhanced to 2 - 3/ of GDP, the union expenditure must increase from 1.3% to at least 7% of the total budget, and states' budget must rise from 5.5% to 8% or more. Given the fiscal compulsions, such increases in allocations are not easy. A Task Force must study innovative and feasible financing mechanisms. Several proposals have been made by citizens' groups, including a health cess; higher taxes on tobacco, ghutka, alcohol and other stimulants, which will be directly routed to public health; earmarking of a share of union grants to states for health care purposes; reducing the interest rates on external funding to states with the condition that the savings will be directed to public health; a cess on petrol and diesel and motor vehicles tax which will be dedicated to accident prevention etc. The Task Force needs to study these and other proposals and give specific, practical recommendations, estimating the sums which could be raised for public health financing.

Figure 10

Ensuring a Healthy Future



Conclusion

Politics, Governance and Health

In a democratic society all roads lead to politics. True politics is about promotion of human happiness. Health is a key ingredient of happiness. And governance is about reconciling conflicting demands, and allocation of limited resources to meet the unlimited needs through proper prioritization. And finally the art of governance lies in efficiently managing institutions to give the best value for the money spent, and to create systems of accountability and people's participation.

It is well recognized that India is facing a fiscal crisis, with the combined expenditure of union and states exceeding revenues by about 10 percent of the GDP. Given the systemic rigidities and prior commitments without reference to returns to society, there are very few possibilities of significant increases in budgetary allocations to the social sector. Mere tinkering here and there will not release the much needed resources for healthcare. And people who are helpless victims of corruption, mal administration and poor quality of services are not going to meekly accept higher taxation. More borrowings are not sustainable, and will lead us into vicious debt trap. In any case, more resources without better utilization will only encourage profligacy and does not guarantee results. It is this vicious cycle that the political process has to reverse.

Government in India has accepted too many responsibilities without building the institutional capacity to deliver. A more critical failure has been in the neglect of vital functions of state. In a modern civilized society, apart from the sovereign functions of security, public order, rule of law and justice, the most vital requirements for fulfillment of human potential and creation of opportunities for vertical mobility are healthcare and education. The fact that India ranks with five countries, all of which are ravaged by civil war or collapse of institutions, in its share of public health expenditure as a proportion of total health expenditure is testimony to this complete perversion of state's role. If the Indian State has to act as a facilitator to release human potential and promote prosperity, then government needs to be reinvented. We need to first focus our energies and resources on those areas which promote happiness, facilitate growth and create opportunities to break out of shackles imposed by social hierarchies and poverty. Political reform to make elections free and fair, and to facilitate changes in the rules of the game instead of mere periodic change of players are the first step. This should be followed by redefining the role of government and reassigning priorities and allocating resources in substantial measure for health and education.

Mere allocation of resources in a centralized, unaccountable, rigid governance structure will not yield results. Nor will people accept higher burdens without commensurate services of quality. We need to empower local governments in order to establish clear links between vote and public good, taxes and services, and authority and accountability. Only then can good leadership emerge, resources be raised in adequate measure, and public servants become accountable to their masters, the citizens. In an iniquitous society with a small segment of educated, skilled population engaged in organized sector in government with colonial legacy, the bulk of the people are at the mercy of the mighty state functionaries, and the roles between citizen and

public servants are reversed. The true sovereign in a democracy becomes a humble subject, and the servant becomes the master. Mere formal political equality in the form of universal franchise and lofty constitutional precepts are not enough to make popular sovereignty real, and public services accountable to people. Governance must be decentralized and institutions must be built on the basis of principle of subsidiarity with the citizen as the centre, and most functions entrusted to the stakeholders and local government closest to people.

Finally all power is mere responsibility to serve. The ultimate objective of all governance is to provide quality services to citizens. The satisfaction of the citizen is the true measure of performance. In such a scheme of things, public sector and private sector become meaningless, and collaboration and convergence become inevitable. Public provisioning and monitoring will be combined with private services, and private funds can augment public services. New and innovative methods of financing and service delivery will become a reality once citizens get good value for their money, and accountability is enforced.

In mature democracies not a day passes without public attention being focused on health and education policies or the State of those services. Most elections are fought on education and healthcare issues. In India much of our political process is divorced from real issues of life and death, and empowerment. Health and education are relegated to the background, and politics has been reduced to a game of private power for personal aggrandizement. In the ultimate sense quality healthcare and citizen-centred democracy go together. The struggle for better health, the fight for accountable democracy, the quest for people's sovereignty and the urge for best value for public money spent are all inseparable. We have the strength and resilience as a society; our workers have skills and enterprise; and our people have good sense and ambition. We are privileged to live in the 21st century, when most human predicaments have practical solutions, and avoidable suffering can be prevented as never before. We have the cumulative experience in our own country and throughout the world to guide us.

If we internalize those lessons and strive to build and sustain a viable healthcare system, we will surely attain a State of health and happiness in keeping with our full potential.

References

Reports and Surveys

‘A Decade of Challenges & Achievements’ – A Report Towards a Healthy Society’ , AIDS Prevention Education, Deepam Educational Society for Health, 1997.

‘Agenda for Revitalization of Indian Medical Heritage’, From the detailed report of The Independent Commission on Health, 2001.

‘AIDS, Youth and Women: a dance ballet to commemorate A Decade of Challenges and Achievements’ – Deepam Educaional Society for Health (DESH).

‘Annual Report 2003-2004’, Indian Institute of Health and Family Welfare, Hyderabad.

APVVP Patient Satisfaction Survey', Mahapatra Prasanta Dr, Sarikonda Sreenivasa, Hyderabad: Institute of Health Systems; December 2000.

APVVP Patient Satisfaction Survey, Mahapatra Prasanta Dr, Gop Bhagirath, , Hyderabad: Institute of Health Systems; June 2001.

'Creating a model for delivering healthcare for our villages' Note received from Charutar Arogya Mandal

'Development of Mental Health Care in India 1947 – 1995' – From the detailed report of The Independent Commisssion on Health in India, 2000.

'Environmental Sanitation and Communty Water Supply', Country situation Analysis, From the detailed Report of The Independent Commission on Health in India, 2000.

'Health and Medical Care: A People's Movement', NH. Anita, GP Dutta and AB Kasbekar, Foundation for Research in Community Health, 2000.

'Health Situation India: 2001', With special reference to the control of communicable diseases. From the detailed report of The Independent Commission on Health in India, 2001.

Human Development Report 2002: Deepening Democracy in a Fragmented World, United Nations Development Programme, New Delhi: OUP; 2002.

'India New Directions in Health Sector Development at the state Level: An Operational Perspective', The World Bank, Washington (DC): World Bank; 1997.

'India Raising the Sights: Better Health System for India's Poor, Overview', The World Bank, Washington (DC): World Bank; 2001.

"Insurance", note received from Narayana Hrudayalaya Foundation

Macroeconomics and Health: Investing in Health for Economic Development, World Health Organisation, Report of Commission on Macroeconomics and Health, Geneva: World Health Organisation, 2001.

'Medical Ethics For Self Regulation of Medical Profession and Practice', From the detail Report of The Independent Commission on Health in India, 2000.

'Medicines, Medical Practice and Health Care India in the Era of Globalisation: Political Economy Perspectives', Amit. S. Ray, The Independent Commission on Development and Health in India, 2004.

'National Family Health Survey 1992 – 1993', International Institute for Population Sciences, 1995.

‘National Family Health Survey 1998 – 1999’, International Institute for Population Sciences, October, 2000.

‘National Health Policy – 2002’, http://www.techno-preneur.net/timeis/updated11.htm

‘National Human Development Report 2001’, Planning Commission of India, New Delhi: OUP; 2002

‘Regulating Medicine and Ethics’, From the Detail Report of The Independent Commission on Health in India, 2001.

‘Report of The Independent Commission on Health in India’, Voluntary Health Association of India, 1997.

‘RCGP Information Series No.5: Health Service Expenditure’, Royal College of General Practitioners, London: RCGP; 2001.

‘State of India’s Health’, Voluntary Health Association of India, 1992.

‘Strengthening Public Health Systems’, Executive Summary Report, State Health Resource Centre, 2003.

‘Strengthening Public Health Systems’, Report of a Study of Issues of Workforce Management, Nationalisation of Services and Human Resource Development in the Public Health Systems of Chattisgarh State, State Health Resources Centre, 2003.

‘Statement on the Health of the Indian People’, The Indian Council of Social Science Research, New Delhi: ICSSR; 2001.

‘Techincal Report – Migration of Physicians and Nurses Geneva’, World Health Organisation, World Health Organisation, 1979.

‘The Cancer Education, Awareness and Early Detection Programme’ –note received from NDDB

‘The Private Health Sector in India, Nature, Trends and Critique’, From the detailed Report of The Independent Commission on Health in India, 2000.

‘The State of India’s Public Services: Benchmarks for the New Millennium’, Public Affairs Centre, Bangalore: Public Affairs Centre, 2002.

‘The World Health Report 2000, Health Systems: Improving Performance’, World Health Organisation, Geneva: World Health Organisation, 2000.

‘World Development Report 1993, Investing in Health’, The World Bank, New York:OUP, 1993.

‘You could be facing a major takeover bid’ – Deepam Educational Society for Health, DESH.

Books/Articles/Papers

Adema Willem, *Net Total Social Expenditure*, OECD Paris, www.oecd.org/els/social/nse.

“A Dose of History,” *The Economist*, December 23, 1999.

“A Review and Consultation Report on JSR Yojana of MP”, July – Nov, 2001

Ahuja, Rajeev, “Health Insurance for the Poor”, available at http://www.epw.org.in/showArticles.php?root=2004&leaf=07&filename=7412&filetype=html

Antia NH, Dutta GP, Kasbekar AB, “*Health and Medical Care: A People’s Movement*”, (Pune: FRCH, 2001)

Arun Gupta, “Why ensure exclusive breast feeding for all babies?” Visit http://southasia.oneworld.net/article/view/91300/1/

Ashtekar Shyam, "China Reforms and Healthcare," *Economic and Political Weekly,* Vol.XXXIV, No. 41, October 9, 1999, p.2908-2911.

“Asking For Trouble,” *The Economist,* August 7, 1997.

“A New Prescription,” *The Economist*, September 12, 2002.

Bennett Sara, MuraleedharanV.R, "New Public Management and Healthcare in Third World," *Economic and Political Weekly*, Vol.XXXV, No;1&2, January 8, 2000, p.59-68

Bose Ashish, "Health For All By 2000: Broken Promises," *Economic and Political Weekly*, Vol.XXXVI, No.11, March 17, 2001, p.905-907.

Bose, Ashish and Research Team, ‘Vulnerability Health Index in States, Health for the Millions’ April-May&June-July 2004, Vol: 30, No: 1&2, pages 4,.5 and 25 (Published by Voluntary Health Association of India)

Chen Lincoln C, *In Pursuit of Health Equity: The Kerala-Global Connections*, TN Krishnan Memorial Lecture, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, 2001.

Comprehensive Rural Health Project, Jamkhed; www.jamkhed.org

"Confronting the Commercialization of Health Care" *People's Health Resource Bo*ok by JSA.

CM Francis, *"Medical Ethics"*- Jay Pee Publications

Das Veena, Das RK, Coutinho Lester, "Disease Control and Immunisation, A Sociological Enquiry," *Economic and Political Weekly*, Vol.XXXV, No.8&9, February 19-26, 2000, p.625-632.

"Don't Fall Sick on the Prairie," *The Economist*, October 28, 1999.

Drug Policy in India, www.medindia.net/buy_n_sell/pharm_industry/ph_drugpolicy.htm.

Ellis Randall P, Alam Moneer, and Gupta Indrani, "Health Insurance in India, Prognosis and Prospectus," *Economic and Political Weekly*, Vol. XXXV, No.4, January 22, 2000, p.207-217,

"For 80 Cents More," *The Economist,* August 15, 2002.

Garg.Charu.C, *Equity of Health Sector Financing and Delivery,* Boston (MA): Harvard School of Public Health; 1998.

"Get Rich Soon," *The Economist*, October 2, 1997.

Gill Sucha Singh, Guhman Ranjit Singh, "Punjab: Rural Health-Proactive Role for the State," *Economic and Political Weekly*, Vol. XXXV, No.51, December 16, 2000, p.4474-4477.

Govindaraj Ramesh, Chawla Mukesh, *Recent Experiences with Hospital Autonomy in Developing Countries - What Can We Learn?* Boston (MA): Harvard School of Public Health; 1996.

Gumber Anil, Kulkarni Veena, "Health Insurance for Informal Sector, Case Study for Gujarat," *Economic and Political Weekly*, Vol. XXXV, No.40, September 30, 2000, p. 3607-3613.

Gupta Devender B, Gumber Anil, "Decentralisation: Some Initiatives in Health Sector," *Economic and Political Weekly,* February 6, 1999.

Hanson Kara, Berman Peter, *Private Healthcare Provision in Developing Countries: A Preliminary Analysis of Levels and Composition,*
http://www.hsph.harvard.edu/ihsg/publications/pdf/No-76.PDF

"Health International," *The Economist,* June 22, 2000.

"Health Spending," *The Economist,* June 27, 2002.

"Health of Nation" *The Economist*, June 17, 2004.

"India Claims Herbal Malaria Cure", BBC News, available at http://news.bbc.co.uk/i/hi/world/south_asia/988316.stm

Jutting, Johannes P, " Do Community-based Health Insurance Schemes Improve Poor People's Access to Healthcare ? Evidence From Rural Senegal", *World Development, Vol32, No:2* 2003*, pp27-288*

Lim Edwin, *A Vision for India's Health System,* Washington (DC): The World Bank; 2001.

LV Prasad Eye Institute, Hyderabad; www.lvpeye.stph.net

Mahavir Hospital, Hyderabad

Michael Kent Ranson, *Reduction of Catastrophic Healthcare Expenditures by a Community-Based Health Insurance Scheme in Gujarat, India: Current Experiences and Challenges,* Geneva: World Health Organisation, 2002.

Mukhopadhyay Alok, *Public-Private Partnership in the Health Sector in India*, Tokyo: ADBI, 2000.

Nayar K.R, "Decline of Co-operative Medical Services in Kerala," *Economic and Political Weekly*, Vol.XXXV, No. 7, February 12, 2000, p.519-521.

Padmavati.S, "Rheumatic Fever and Rheumatic Heart Disease in India at the Turn of the Century," *India Heart*, Vol.53. 2001, p. 35-37.

Peters DH, Yazbeck AS, Sharma RP, Ramana GNV, Pritchett LH, Wagstaff A, *Better Health Systems for India's Poor: Findings, Analysis and Options*, Washington (DC): World Bank; 2002.

Prasad Purendra, "Healthcare Access and Marginalised Social Spaces, Leptospirosis in South Gujarat," *Economic and Political Weekly*, Vol. XXXV, No.41, October 7, 2000, p.3688-3694

"Pharmaceuticals: Vitamin Conspiracy," *Economic and Political Weekly*, Vol.XXXIV, No.29, July 17-23, 1999.

Ram, Mohan M, 'Iodation of Common Salt for Control of IDD', *Indian Institute of Health and Family Welfare*

Rane Wishvas, "Continuing Rise in Drug Prices, Brand Leaders Show the Way," *Economic and Political Weekly*, Vol.XXXIV, No.30, July 24, 1999, p. 2057-2060.

"Reaching Health to the Grassroots" - 1997

Reddy.K.N nd Selvaraju.V, Healthcare Expenditure by Government of India 1974-75 to 1990-91, New Delhi: Seven Hills Publications; 1994.

"Reducing Maternal Deaths: Evidence and Action" – *DFID's position papers*

Sadanandan Rajeev, "Government Health Services in Kerala," Who Benefits, *Economic and Political Weekly,* Vol.XXXVI, No.32, August 11, 2001, p.3071-3077

Sen Gita, Iyer Aditi, George Asha, "Structural Reforms and Health Equity, A Comparison of NSS Surveys, 1986-87 and 1995-96," *Economic and Political Weekly*, April 6, 2002, p. 1342-1352.

'Sexual and Reproductive Health and Rights" - *DFID's position papers*

Shukla Abhay, Phadke Anant, "Putting Heath on People's Agenda," *Economic and Political Weekly*, Vol. XXXV, No.33, August 12, 2000, p. 2911-2912

"Terrorism is not the Only Scourge," *The Economist*, December 20, 2001.

"Theatre of Discontent," *The Economist*, October 3, 2002.

"The Health of Nations," *The Economist,* June 22, 2000.
"The health of nations", The Economist, July 17, 2004

"Towards an alternative approach to Malaria Control" - VHAI

Velkoff Victoria A, Adlakha Arjun, *Women's Health in India*, Washington (DC): U.S.Department of Commerce; 1998.

Udwadia, Tehemton.E, "Surgical Care for the Poor," *Indian Journal of Surgery*, Vol : 65, Issue 6, November-December, 2003
Voluntary Health Services, Chennai

Zhang Kaining, *"The Impact of Socio-Economic Reform in rural China on Reproductive Health Services,";*www.ksg.harvard.edu/cbg/Conferences/financial_sector/ImpactofSocio-economicReforminRuralChina.pdf

-

** Raising the Sights: Better Health System for India's Poor , The World Bank, November 3, 2001, Washington. p.3.*

** David.H.Peters, Abdo.S.Yazbeck, Rashmi R. Sharma, G.N.V. Ramana, Lant H. Pritchett, Adam Wagstaff, Better Health System For India's Poor: Findings Analysis and Options, The World Bank, 2002, Washington. p.5