2015

National Health Policy 2015
Draft

Placed in Public Domain for Comments, Suggestions, Feedback

Ministry of Health & Family Welfare
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1. *Introduction: Context, Need and Scope*:

1.1. India today, is the world's third largest economy in terms of its Gross National Income (in PPP terms) and has the potential to grow larger and more equitably, and to emerge to be counted as one of the developed nations of the world. India today possesses as never before, a sophisticated arsenal of interventions, technologies and knowledge required for providing health care to her people. Yet the gaps in health outcomes continue to widen. On the face of it, much of the ill health, disease, premature death, and suffering we see on such a large scale is needless, given the availability of effective and affordable interventions for prevention and treatment. "The reality is straightforward. The power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in a comprehensive way, and on an adequate scale".

1.2. This National Health Policy addresses the urgent need to improve the performance of health systems. It is being formulated at the last year of the Millennium Declaration and its Goals, in the global context of all nations committed to moving towards universal health coverage. Given the two-way linkage between economic growth and health status, this National Health Policy is a declaration of the determination of the Government to leverage economic growth to achieve health outcomes and an explicit acknowledgement that better health contributes immensely to improved productivity as well as to equity.

1.3. The National Health Policy of 1983 and the National Health Policy of 2002 have served us well, in guiding the approach for the health sector in the Five-Year Plans and for different schemes, Now 13 years after the last health policy, the context has changed in four major ways. Firstly- Health Priorities are changing. As a result of focused action over the last decade we are projected to attain Millennium Development Goals with respect to maternal and child mortality. Maternal mortality now accounts for 0.55% of all deaths and 4% of all female deaths in the 15 to 49 year age group. This is still 46,500 maternal deaths too many, and demands that the commitments to further reduction must not flag. However it also signifies a rising and unfulfilled expectation of many other health needs that currently receive little public attention. There are many infectious diseases which the system has failed to respond to – either in terms of prevention or access to treatment. Then there is a growing burden of non-communicable disease. The second important change in context is the emergence of a robust health care industry growing at 15% compound annual growth rate (CAGR). This represents twice the rate of growth in all services and thrice the national economic growth rate. Thirdly, incidence of catastrophic expenditure due to health care costs is growing and is now being estimated to be one of the major contributors to poverty. The drain on family incomes due to health care costs can neutralize the gains of income increases and every Government scheme aimed to reduce poverty. The fourth and final change in context is that economic growth has increased the fiscal capacity available. Therefore, the country needs a new health policy that is responsive to these contextual changes. Other than these objective factors, the political will to ensure

universal access to affordable healthcare services in an assured mode – the promise of Health Assurance – is an important catalyst for the framing of a New Health Policy.

1.4. The primary aim of the National Health Policy, 2015, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investment in health, organization and financing of healthcare services, prevention of diseases and promotion of good health through cross sectoral action, access to technologies, developing human resources, encouraging medical pluralism, building the knowledge base required for better health, financial protection strategies and regulation and legislation for health.

2. Situation Analysis

2.1. Achievement of Millennium Development Goals:

India is set to reach the Millennium Development Goals (MDG) with respect to maternal and child survival. The MDG target for Maternal Mortality Ratio (MMR) is 140 per 100,000 live births. From a baseline of 560 in 1990, the nation had achieved 178 by 2010-12, and at this rate of decline is estimated to reach an MMR of 141 by 2015. In the case of under-5 mortality rate (U5MR), the MDG target is 42. From a baseline of 126 in 1990, in 2012 the nation has an U5MR of 52 and an extrapolation of this rate would bring it to 42 by 2015. This is particularly creditable on a global scale where in 1990 India's MMR and U5MR were 47% and 40% above the international average respectively. While the narrowing of these gaps and closure, demonstrate a significant effort we could have done better. Notably, the rate of decline of still-births and neonatal mortality has been lower than the child mortality on the whole. In some states there is stagnation on these two indicators.

2.2. Achievements in Population Stabilization:

India has also shown consistent improvement in population stabilization, with a decrease in decadal growth rates, both as a percentage and in absolute numbers. Twelve of the 21 large States for which recent Total Fertility Rates (TFR) is available, have achieved a TFR of at or below the replacement rate of 2.1 and three are likely to reach this soon. The challenge is now in the remaining six states of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Jharkhand and Chhattisgarh but even here rates are declining. However these six States between them account for 42 % of the national population and 56 % of the annual population increase. In the remaining small States and Union Territories except Meghalaya, the Crude Birth Rate (CBR), is less than 21 per 1000. The national TFR has declined from 2.9 to 2.4. The persistent challenge on this front is the declining sex ratio.

2.3. Inequities in Health Outcomes:

While acknowledging these achievements we need to be mindful and confront the high degree of health inequity in health outcomes and access to health care services as evidenced by indicators disaggregated for vulnerable groups. There are urban-rural inequities and there are

inequities across states. (Table 1). A number of districts, many in tribal areas, perform poorly even in those states where overall averages are improving. Marginalized communities and poorer economic quintiles of the population continue to fare poorly. Outreach and service delivery for the urban poor, even for immunization services has been inadequate.

Table 1 : Disparities in health outcomes:

Indicator	India			
	Total	**Rural**	**Urban**	**% differential**
TFR (2012)	2.4	2.6	1.8	44% difference
IMR (2012)	40	44	27	63% difference

Indicator	States with Good Performance	States with greater challenges
TFR (2012)	HP (1.7), Punjab (1.7), Tamil Nadu (1.7) and West Bengal (1.7)	Bihar (3.5), UP(3.3), Rajasthan (2.9), MP(2.9)
IMR (2010)	Kerala(12), Tamil Nadu(21), Delhi(24), Maharashtra(24)	Madhya Pradesh (54), Assam (54), Orissa (51), Rajasthan (47)
MMR(2010-12)	Kerala (66), Maharashtra (87), Tamil Nadu (90), Andhra Pradesh (110)	Assam (328), Uttar Pradesh /Uttarakhand (292), Rajasthan (255), Odisha (235)

2.4. Concerns on Quality of Care:

The situation in quality of care is also a matter of serious concern and this seriously compromises the effectiveness of care. For example though over 90% of pregnant women receive one antenatal check up and 87 % received full TT immunization, only about 68.7 % of women have received the mandatory three antenatal check-ups. Again whereas most women had received iron and folic acid tablets, only 31% of pregnant women had consumed more than 100 IFA tablets. For institutional delivery standard protocols are often not followed during labour and the postpartum period. Sterilization related deaths a preventable tragedy, are often a direct consequence of poor quality of care. Only 61% of children (12 -23 months) have been fully immunized. There are gaps in access to safe abortion services too, and in care for the sick neonate.

2.5. Performance in Disease Control Programmes:

India's progress on communicable disease control is mixed. The most acclaimed success of this period is the complete elimination of polio. In Leprosy too there have been significant reductions, but after a reduction of an annual incidence of 120,000 cases, there is stagnation, with new infective cases and disabilities being reported. Kala-azar and Lymphatic filariasis are expected to decline below the threshold for certifying by 2015, but as in leprosy there are likely to be Blocks where the prevalence is above this threshold. In many more Blocks, which have

achieved elimination, continuing attention to identifying and managing low levels of disease incidence is required for some time to come. In AIDS control, progress has been good with a decline from a 0.41 % prevalence rate in 2001 to 0.27% in 2011- but this still leaves about 21 lakh persons living with HIV, with about 1.16 lakh new cases and 1.48 deaths in 2011. In tuberculosis the challenge is a prevalence of close to 211 cases and 19 deaths per 100,000 population and rising problems of multi-drug resistant tuberculosis. Though these are significant declines from the MDG baseline, India still contributes to 24% of all global new case detection. In malaria there has been a significant decline, but there are also the challenges, of resistant strains developing and of sustaining the gains, in a disease known for its cyclical reemergence and focal outbreaks. Viral Encephalitis, Dengue and Chikungunya are on the increase, particularly in urban areas and as of now we do not have effective measures to address them. Performance in disease control programmes is largely a function and reflection of the strengths of the public health systems. Where there are sub-critical human resource deployment, weak logistics and inadequate infrastructure, all national health programmes do badly. This was one of the important reasons of the launch of the National Rural Health Mission, which was geared to strengthen health systems.

2.6. Developments under the National Rural Health Mission:

The National Rural Health Mission (NRHM) led to a significant strengthening of public health systems. It brought in a workforce of close to 900,000 community health volunteers, the ASHAs, who brought the community closer to public services, improving utilization of services and health behaviors. The NRHM deployed over 18,000 ambulances for free emergency response and patient transport services to over a million patients monthly, added over 178,000 health workers to a public system that had depleted its workforce to sub-critical levels over a long period of neglect, provided cash transfers to over one crore pregnant women annually, empowering and facilitating them to seek free care in the institutions and began to address infrastructure gaps. Across States, there were major increases in outpatient attendance, bed occupancy and institutional delivery. However these developments were uneven and more than 80% of the increase in services is likely to have been contributed by less than 20% of the public health facilities. Further, States with better capacity at baseline were able to take advantage of NRHM financing sooner, while high focus States had first to revive or expand their nursing and medical schools and revitalize their management systems. Larger gaps in baselines and more time taken to develop capacity to absorb the funds meant that gaps between the desired norms and actual levels of achievement were worse in high focus states. Inefficiencies in fund utilization, poor governance and leakages have been a greater problem in some of the weaker states. Much of the increase in service delivery was related to select reproductive and child health services and to the national disease control programmes, and not to the wider range of health care services that were needed. Action on social determinants of health was even weaker.

2.7. Burden of Disease:

The almost exclusive focus of policy and implementation often masks the fact that all the disease conditions for which national programmes provide universal coverage account for less than 10% of all mortalities and only for about 15% of all morbidities. Over 75% of communicable diseases are not part of existing national programmes. Overall, communicable diseases contribute to 24. 4% of the entire disease burden while maternal and neonatal ailments contribute to 13.8%. Non-communicable diseases (39.1%) and injuries (11.8%) now constitute the bulk of the country's disease burden. National Health Programmes for non-communicable diseases are very limited in coverage and scope, except perhaps in the case of the Blindness control programme.

2.8. NRHM as an instrument for strengthening state health systems:

The National Rural Health Mission was intended to strengthen State health systems to cover all health needs, not just those of the national health programme. In practice, however, it remained confined largely to national programme priorities. While such a limited scope enabled progress in a few indicators, this was a poor strategy. Beyond a point, such selective facility development is neither sustainable nor efficient. For example female sterilization operations or surgery for Emergency Obstetrics Care is safest if performed in an operation theatre, that is functional throughout the year, and undertaken by professional teams with support systems that are in constant use. But if such operations are undertaken on a few days per year, in a camp mode or during an occasional emergency sustaining the quality of care for such sporadic events is much more difficult. Strengthening health systems for providing comprehensive care required higher levels of investment and human resources than were made available. The budget received and the expenditure thereunder was only about 40% of what was envisaged for a full re-vitalization in the NRHM Framework.

2.9. Urban Health:

Rapid and unplanned urbanization has led to massive growth in the number of the urban poor population, especially those living in slums. This section of the population has poorer health outcomes due to adverse social determinants and poor access to health care facilities, despite living in close proximity to many hospitals - public and private. There is almost no arrangement for primary care in many cities and towns. The National Urban Health Mission, sanctioned in 2013 has a strong focus on strengthening primary health care- through additional ANMs, urban ASHAs, women's health committees and a network of primary health centers. A technical resource group has examined the urban health situation at length and suggested measures needed to address the most vulnerable and marginalized sections of the urban poor and the way forward in convergence. NUHM needs substantial expansion of funding on a sustained basis in order to establish and operationalize a well functional primary health care system in the urban areas.

2.10. Cost of Care and Efforts at Financial Protection:

The failure of public investment in health to cover the entire spectrum of health care needs is reflected best in the worsening situation in terms of costs of care and impoverishment due to health care costs. All services available under national programmes are free to all and universally accessed with fairly good rates of coverage. Thus India has one of the largest programmes of publicly financed ART drugs for HIV anywhere in the world. All drugs and diagnostics in all vector borne disease programmes, tuberculosis, leprosy, including rapid diagnostic kits and third generation anti-microbicidals are free and so are insecticide treated bed nets that cover the population of whole geographies. This is also true for all of immunization and much of the pregnancy related care. Private markets have little contribution to make in most of these areas. Yet if health care costs are more impoverishing than ever before, almost all hospitalization even in public hospitals leads to catastrophic health expenditures, and over 63 million persons are faced with poverty every year due to health care costs alone, it is because there is no financial protection for the vast majority of health care needs. In 2011-12, the share of out of pocket expenditure on health care as a proportion of total household monthly per capita expenditure was 6.9% in rural areas and 5.5% in urban areas. This led to an increasing number of households facing catastrophic expenditures due to health costs (18% of all households in 2011-12 as compared to 15% in 2004-05). Under NRHM free care in public hospitals was extended to a select set of conditions – for maternity, newborn and infant care as part of the Janani Suraksha Yojana and, the Janani Shishu Suraksha Karyakram, and for disease control programmes. For all other services, user fees especially for diagnostics and "outside prescriptions" for drugs continued. Also due to the selective approach, several essential services especially for chronic illness was not obtainable or at best only available at overcrowded district and medical college hospitals resulting in physical and financial hardship and poor quality of care.

2.11. Publicly Financed Health Insurance:

A number of publicly financed health insurance schemes were introduced to improve access to hospitalization services and to protect households from high medical expenses. Eight states introduced health insurance programmes for covering tertiary care need and over time as expenditures increased, many of these States (Andhra Pradesh, Karnataka, Tamilnadu, Maharashtra, etc.) moved to direct purchasing of care through Trusts and reserving some services to be delivered only through public hospitals. The Central Government under the Ministry of Labour & Employment, launched the Rashtriya Swasthya Bima Yojana (RSBY) in 2008. The population coverage under these various schemes increased from almost 55 million people in 2003-04 to about 370 million in 2014 (almost one-fourth of the population). Nearly two thirds (180 million) of this population are those in the Below Poverty Line (BPL) category. Evaluations show that schemes such as the RSBY, have improved utilization of hospital services, especially in private sector and among the poorest 20% of households and SC/ST households. However there are other problems. One problem is low awareness among the beneficiaries about the entitlement and how and when to use the RSBY card. Another is related to denial of services by private hospitals for many categories of illnesses, and over supply of some services.

Some hospitals, insurance companies and administrators have also resorted to various fraudulent measures, including charging informal payments. Schemes that are governed and managed by independent bodies have performed better than other schemes that are located in informal cells within existing departments or when managed by insurance companies. The insurance schemes vary widely in terms of benefit packages and have resulted in fragmentation of funds available for health care; especially selective allocation to secondary and tertiary care over primary care services. All National and State health insurance schemes need to be aligned into a single insurance scheme and a single fund pool reducing fragmentation. The RSBY scheme has now been shifted to the Ministry of Health & Family Welfare, helping the State and Central Ministry move to a tax financed single payer system approach. The Ministry could now compare the relative costs per patient for alternative routes of financing viz. purchase through insurance, or direct purchase from private sector and from public sector or free care by public sector as a form of tax based financing, and take the best decision for a given context.

2.12. Healthcare Industry:

Engaging and supporting the growth of the health care industry has been an important element of public policy. The private health care industry is valued at $40 billion and is projected to grow to $ 280 billion by 2020 as per market sources. The current growth rate of this perennially and most rapidly growing area of the economy, the healthcare industry, at 14% is projected to be 21% in the next decade. Even during the global recession of 2008, this sector remained relatively recession-proof. The private health care industry is complex and differentiated. It includes insurance and equipment, which accounts for about 15%, pharmaceuticals which accounts for over 25%, about 10% on diagnostics and about 50% is hospitals and clinical care. The private sector growth cannot be seen merely as a consequence of limited public sector investment. The Government has had an active policy in the last 25 years of building a positive economic climate for the health care industry. Amongst these measures are lower direct taxes; higher depreciation in medical equipment; Income Tax exemptions for 5 years for rural hospitals; custom duty exemptions for imported equipment that are lifesaving; Income Tax exemption for Health Insurance; and active engagement through publicly financed health insurance which now covers almost 27% of the population. Further forms of assistance are preferential and subsidized allocation of land that has been acquired under the public acquisitions Act, and the subsidized education for medical, nursing and other paramedical professional graduating from government institutions and who constitute a significant proportion of the human resources that work for the private sector; and the provision for 100% FDI. Indeed in one year alone 2012-13-as per market sources the private health care industry attracted over 2 billion dollars of FDI much of it as venture capital. For International Finance Corporation, the section of the World Bank investing in private sector, the Indian private health care industry is the second highest destination for its global investments in health. While recognizing that the growth of such industry brings in revenue through medical tourism and that it provides employment, there is a necessity and a rationale for the health Ministry to intervene and to actively shape the growth of this sector for ensuring that it is aligned to its overall health policy goals, especially with regards to access and financial protection. There is also a need to ensure that excessive capitalization and overcrowding in a few cities does not lead to demands on public financing, and that the basic policy structure,

especially as regards costs, standards and regulation is not unduly influenced by the requirements and perceptions of industry.

2.13. Private Sector in Health:

The private sector today provides nearly 80% of outpatient care and about 60% of inpatient care. (The out-patient estimate would be significantly lower if we included only qualified providers. By NSSO estimates as much as 40% of the private care is likely to be by informal unqualified providers). 72% of all private health care enterprises are own-account-enterprises (OAEs), which are household run businesses providing health services without hiring a worker on a fairly regular basis. These are very different in their needs, perceptions and services from both the medical establishments and within the latter from the corporate sector-which represents the health care industry. But over time employment OAEs are declining and the number of medical establishments and corporate hospitals is rising. There are major ongoing efforts to organize such OAEs within the corporate sector and to regulate these by the Government. Regular information about this sector, their differentiation and their practices, problems and needs are essential for the Government to engage with them. Often for OAEs and smaller medical establishments the main grounds for engagement are not financial partnerships with government, but skill up-gradation, referral support, sharing information of public health importance and improved clinical quality for effectiveness in public health priority areas. In terms of comparative efficiency, public sector is value for money as it accounts (based on the NSSO 60th round) for less than 30 % of total expenditure, but provides for about 20% of outpatient care and 40% of in-patient care. This same expenditure also pays for 60% of end-of-life care (RGI estimates on hospital mortality), and almost 100% of preventive and promotive care and a substantial part of medical and nursing education as well.

2.14. Realizing the Potential of AYUSH services:

The National Policy on Indian Systems of Medicine and Homeopathy adopted in 2002, called for a meaningful, phased integration of ISM with health delivery systems which was taken forward both by the AYUSH Department and as part of the mainstreaming component of AYUSH under the National Rural Health Mission. There has been considerable expansion of AYUSH services since then. With this experience a National AYUSH Mission has been launched for overall strengthening of AYUSH network in the public sector with focus on AYUSH services, development of infrastructural facilities of teaching institutions, improving quality control of drugs, capacity building, and community based preventive and promotive interventions. In addition, there is need to recognize the contribution of the large private sector and not-for-profit organizations providing AYUSH services, conducting research for growth of the knowledge base of the AYUSH systems and their services. The contribution of several organizations across the country is also visible in documenting, validating and promoting home and community based traditional practices and practitioners, especially providing recognition to the special knowledge held by various caste groups and adivasis, thereby empowering the marginalized groups. A third development in the past decade globally, has been the emergence of integrative medicine as a frontier and India has the potential to become a world leader in this sphere, given adequate support for research and institution building.

2.15. Human Resource Development:

The last ten years have seen a major expansion of medical, nursing and technical education. In nursing this has led to 1050 ANM courses, 1541 GNM courses, 1160 graduate nursing schools, and 388 post-graduate nursing schools being set up. Similarly there has been an expansion in pharmacy education. The number of medical colleges added and the increase in seats for both undergraduate and post-graduate education has also been high. Though even further expansion is needed and planned for, there is a need to ensure that the outputs of these institutions meet our needs. Currently most have little orientation to rural service or any public services, and the teaching standards are very varied with sub-optimal skill sets requiring extensive in-service training subsequently. The challenge is to guide the expansion of educational institutions to provide skilled health workers to where they are needed most, and with the necessary skills.

2.16. Research and Challenges:

The Department of Health Research was established in 2006 to strengthen Indian efforts in health research. Much of its results are delivered though the research institutions that come under the Indian Council of Medical Research. Simultaneously research support to medical colleges across the country is being strengthened to ensure their engagement in research. Currently over 90% of the research publications from medical colleges come from only nine medical colleges. There have been significant contributions made by the Department, but modest funding of less than 1 % of all public health expenditure has resulted in limited progress. The report of the Committee that examined the functioning of the ICMR in 2012, and the report of the Working Group constituted for the 12th Plan can guide policy in this area. India's strengths in AYUSH can also be leveraged for becoming a world leader in drug discovery as also in integrative medicine and this needs not only research as pure and applied science but also creating institutional structures for documentation, validation and accreditation of community health practices and practitioners.

2.17. Regulatory Role of Government:

The Government's regulatory role extends to the regulation of drugs through the CDSCO, the regulation of food safety through the office of the Food Safety and Standards Authority of India, support to the regulation of professional education through the four professional councils and the regulation of clinical establishments by the National Council for the same. Progress in each of these areas has been challenging. Some of the challenges relate to institutional strengthening and also the mechanisms of institutional governance, and some of the latter require amendments to the laws. Regulation of drug pricing is under the Department of Pharmaceuticals and this has been playing an active and effective role in monitoring prices and taking actions. Reforms in each of these areas, but especially in professional councils and clinical establishments is also facing resistance from certain stakeholders and will require considerable political leadership and public support to implement these reforms. There are also genuine concerns that it would bring back "license raj" the unnecessary and inefficient Government interference in private sector growth. But clearly as private industry grows at a

massive pace, and as this is an area touching upon the lives and health of its population the Government has to find ways to move forward on these responsibilities.

2.18. Investment in Health Care:

Despite years of strong economic growth and increased Government health spending in the 11th Five Year plan period, the total spending on healthcare in 2011 in the country is about 4.1% of GDP. Global evidence on health spending shows that unless a country spends at least 5–6% of its GDP on health and the major part of it is from Government expenditure, basic health care needs are seldom met. The Government spending on healthcare in India is only 1.04% of GDP which is about 4 % of total Government expenditure, less than 30% of total health spending. This translates in absolute terms to Rs. 957 per capita at current market prices. The Central Government share of this is Rs. 325 (0.34% GDP) while State Government share translates to about Rs. 632 on per capita basis at base line scenario. Perhaps the single most important policy pronouncement of the National Health Policy 2002 articulated in the 10th, 11th and 12th Five Year Plans, and the NRHM framework was the decision to increase public health expenditure to 2 to 3 % of the GDP. Public health expenditure rose briskly in the first years of the NRHM, but at the peak of its performance it started stagnating at about 1.04 % of the GDP. The pinch of such stagnation is felt in the failure to expand workforce, even to train and retain them. This reluctance to provide for regular employment affects service delivery, regulatory functions, management functions and research and development functions of the Government. Though there is always space to generate some more value for the money provided, it is unrealistic to expect to achieve key goals in a Five Year Plan on half the estimated and sanctioned budget. The failure to attain minimum levels of public health expenditure remains the single most important constraint. While it is important to recognize the growth and potential of a rapidly expanding private sector, international experience (as evidenced from the table below) shows that health outcomes and financial protection are closely related to absolute and relative levels of public health expenditure.

Country	Total Health Exp per capita (USD) - 2011	Total Health Exp as % of GDP - 2011	Govt. Health Exp as % of Total Health Exp - 2011	Life Expectancy at birth (years) 2012
India	$62	3.9%	30.5%	66
Thailand	$214	4.1%	77.7%	75
Sri Lanka	$ 93	3.3%	42.1%	75
BRIC Countries				
Brazil	$ 1119	8.9%	45.7%	74
China	$ 274	5.1%	55.9%	75
Russia	$803	6.1%	59.8%	69
South Africa	$670	8.7%	47.7%	59
OECD Countries				
USA	$ 8,467	17.7%	47.8%	79
United Kingdom	$ 3,659	9.4%	82.8%	81
Germany	$ 4,996	11.3%	76.5%	81
France	$ 4,968	11.6%	76.8%	82
Norway	$ 9,908	9.9%	85.1%	82
Sweden	$ 5,419	9.5%	81.6%	82
Denmark	$ 6,521	10.9%	85.3%	80
Japan	$ 4,656	10%	82.1%	84

Of the developing countries in the table above, two nations, Brazil and Thailand, are considered to have achieved close to universal health coverage- Thailand has almost the same total health expenditure as India but its proportion of public health expenditure is 77.7% of total health expenditures (which is 3.2 % of the GDP) and this is spent through a form of strategic purchasing in which about 95% is purchased from public health care facilities- which is what gives it such a high efficiency. Brazil spends 9% of its GDP on health but of this public health expenditure constitutes 4.1 % of the GDP (which is 45.7% of total health expenditure). This public health expenditure accounts for almost 75 % of all health care provision. It would be ambitious if India could aspire to a public health expenditure of 4% of the GDP, but most expert groups have estimated 2.5 % as being more realistic. At such levels of expenditure, "purchasing," would have to be mainly from public providers for efficient use of resources with purchasing from private providers only for supplementation.

3. Goal, Principles and Objectives

3.1 Goal:

The attainment of the highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.

3.2. Key Policy Principles:

Equity: Public expenditure in health care, prioritizing the needs of the most vulnerable, who suffer the largest burden of disease, would imply greater investment in access and financial protection measures for the poor. Reducing inequity would also mean affirmative action to reach the poorest and minimizing disparity on account of gender, poverty, caste, disability, other forms of social exclusion and geographical barriers.

Universality: Systems and services are designed to cater to the entire population- not only a targeted sub-group. Care to be taken to prevent exclusions on social or economic grounds.

Patient Centered & Quality of Care: Health Care services would be effective, safe, and convenient, provided with dignity and confidentiality with all facilities across all sectors being assessed, certified and incentivized to maintain quality of care.

Inclusive Partnerships: The task of providing health care for all cannot be undertaken by Government, acting alone. It would also require the participation of communities – who view this participation as a means and a goal, as a right and as a duty. It would also require the widest level of partnerships with academic institutions, not for profit agencies and with the commercial private sector and health care industry to achieve these goals.

Pluralism: Patients who so choose and when appropriate, would have access to AYUSH care providers based on validated local health traditions. These systems would also have

Government support and supervision to develop and enrich their contribution to meeting the national health goals and objectives. Research, development of models of integrative practice, efforts at documentation, validation of traditional practices and engagement with such practitioners would form important elements of enabling medical pluralism.

Subsidiarity: For ensuring responsiveness and greater participation, increasing transfer of decision making to as decentralized a level as is consistent with practical considerations and institutional capacity would be promoted. (Nothing should be done by a larger and more complex organization which can be done as well by a smaller and simpler organization.)

Accountability: Financial and performance accountability, transparency in decision making, and elimination of corruption in health care systems, both in the public systems and in the private health care industry, would be essential.

Professionalism, Integrity and Ethics: Health workers and managers shall perform their work with the highest level of professionalism, integrity and trust and be supported by a systems and regulatory environment that enables this.

Learning and Adaptive System: constantly improving dynamic organization of health care which is knowledge and evidence based, reflective and learning from the communities they serve, the experience of implementation itself, and from national and international knowledge partners.

Affordability: As costs of care rise, affordability, as distinct from equity, requires emphasis. Health care costs of a household exceeding 10% of its total monthly consumption expenditures or 40% of its non-food consumption expenditure- is designated catastrophic health expenditures- and is declared as an unacceptable level of health care costs. Impoverishment due to health care costs is of course, even more unacceptable.

3.3. Objectives:

3.3.1. Improve population health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided by the public health sector.

3.3.2. Achieve a significant reduction in out of pocket expenditure due to health care costs and reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment.

3.3.3. Assure universal availability of free, comprehensive primary health care services, as an entitlement, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable and non-communicable diseases in the population.

3.3.4. Enable universal access to free essential drugs, diagnostics, emergency ambulance services, and emergency medical and surgical care services in public health facilities, so as to enhance the financial protection role of public facilities for all sections of the population.

3.3.5. Ensure improved access and affordability of secondary and tertiary care services through a combination of public hospitals and strategic purchasing of services from the private health sector.

3.3.6. Influence the growth of the private health care industry and medical technologies to ensure alignment with public health goals, and enable contribution to making health care systems more effective, efficient, rational, safe, affordable and ethical.

4. Policy Directions:

4.1. Ensuring Adequate Investment:

4.1.1. The National Health Policy accepts and endorses the understanding that a full achievement of the goals and principles as defined would require an increased public health expenditure to 4 to 5% of the GDP. However, given that the NHP, 2002 target of 2% was not met, and taking into account the financial capacity of the country to provide this amount and the institutional capacity to utilize the increased funding in an effective manner, this policy proposes a potentially achievable target of raising public health expenditure to 2.5 % of the GDP. It also notes that 40% of this would need to come from Central expenditures. At current prices, a target of 2.5% of GDP translates to Rs. 3800 per capita, representing an almost four fold increase in five years. Thus a longer time frame may be appropriate to even reach this modest target.

4.1.2. The major source of financing would remain general taxation. With the projection of a promising economic growth, the fiscal capacity to provide this level of financing should become available. The Government would explore the creation of a health cess on the lines of the education cess for raising the necessary resources. Other than general taxation, this cess could mobilise contributions from specific commodity taxes- such as the taxes on tobacco, and alcohol, from specific industries and innovative forms of resource mobilization. Extractive industries and development projects that result in displacement, or those that have negative impacts on natural habitats or the resource base can be considered for special taxation thereby allowing investment and job opportunities in education and health for affected communities.

4.1.3. Since about 50% of health expenditure goes into human resources for health, an equitous growth of health and education sectors would also lead to increased employment in many areas and communities, which do not otherwise benefit from the economic growth rate, particularly where jobless growth is a phenomenon. High public investment in health care is one of the most efficient ways of ameliorating inequities, and for this reason, this commitment to higher public expenditures is essential.

4.1.4. Corporate social responsibility has now been made mandatory- and this avenue should be maximally leveraged. Though actual CSR flows to health care may be modest in comparison to needs, these could be leveraged for well-focused programmes, communities or geographies with special levels of vulnerability which require special attention.

4.2. **Preventive and Promotive Health:** *addressing the wider social & environmental determinants of health*

4.2.1. This National Health Policy is based on the goal of attainment of highest level of health, and not merely the absence of disease or disability. To realize this vision, the policy mandates the Ministry of Health & Family Welfare to provide a roadmap for a series of coordinated policy initiatives and practical actions, to be implemented across all sectors. This is in line with the emergent international "Health In All" approach as complement to Health For All.

4.2.2. An aspiration to be ranked amongst the most developed and civilized of nations requires a commitment to improving the health and wellbeing of its citizens. Health and happiness is not only a driver of economic growth, it is its very purpose. All sectors would need to be convinced that preventive and promotive health care approaches are not only a health gain but a first order economic gain as well and would be enabled to take ownership of making this health challenge their own challenge. Failure to do so would result in negative impact on workforce participation, economic growth, and societal sense of well-being and achievement. This is a major challenge for the nation.

4.2.3. There is much that individuals and families can do to prevent disease and promote good health at their own individual levels. But if the social and economic environment in which they exist – where they work, live and play, where they bring up their families, interact with the community and experience life – is not conducive to good health, the impact of individual behaviours may be severely limited.

4.2.4. Given the multiple determinants of health, it is clear that a prevention agenda that addresses the social and economic environment requires cross-sectoral, multilevel interventions that involve sectors such as food and nutrition, education, safe drinking water and sanitation, housing, employment, industrial and occupational safety, welfare including social protection, family and community services, tribal affairs and communications.

4.2.5. Other than its own policy action and initiatives, the Government has an obligation to build community support and capacity to enjoy good health, particularly among those who are most vulnerable and have the least capacity to make choices and changes in their lifestyle or living conditions that might improve and protect their health: the very young, the marginalized or socially excluded, the poor, the vulnerable to violence, the old, and the disabled. The Village Health Sanitation and Nutrition Committees and its urban equivalents that are a part of Local Government Institutions are a platform that must be strengthened and utilized for this purpose.

4.2.6. Amongst the various possibilities for action, the health policy identifies coordinated action on seven priority areas for improving the environment for health with measurable achievements through well thought out and financed institutional mechanisms. These include:

4.2.6.1. The Swachh Bharat Abhiyan, which is already in place, would be supported, and whose success would be measured by the reduction of water and vector borne diseases and declines in improperly managed solid waste.

4.2.6.2. Balanced and Healthy Diets: This would be promoted through action in Anganwadi centers and schools and would be measured by the reduction of malnutrition, and improved food safety.

4.2.6.3. Addressing Tobacco, Alcohol and Substance Abuse: (Nasha Mukti Abhiyan) Success would be judged in terms of measurable decreases in use of tobacco, alcohol and substance abuse.

4.2.6.4. Yatri Suraksha: Deaths due to rail and road traffic accidents should decline through a combination of response and prevention measures that ensure road and rail safety-. This concept could be expanded to include injuries on account of other causes.

4.2.6.5. Nirbhaya Nari- Action against gender violence ranging from sex determination, to sexual violence would be addressed through a combination of legal measures, implementation and enforcement of such laws, timely and sensitive health sector responses, and working with young men.

4.2.6.6. Reduced stress and improved safety in the work place would include action on issues of employment security, preventive measures at the work place including adequate exercise and movement, and occupational health- strengthening understanding of occupational disease epidemiology and demonstrate measurable decreases.

4.2.6.7. Action would be taken on reducing indoor and outdoor air pollution and measured through decreases in respiratory disease especially in children, and other pollution related illnesses.

4.2.7. The policy explicitly articulates the need for the development of strategies and institutional mechanisms in each of these seven areas to synergize individual and family level action, with social movements where communities can collectively participate, the use of media to highlight these issues, with appropriate policy interventions that build the social environment under which behavior changes can take place. Taken together, this Health in all approach could be popularized as the Swasth Nagrik Abhiyan- a social movement for health.

4.2.8. The role of the health sector would be to undertake evidence based advocacy within Government and in the media- which highlights the link between these social determinants and

disease and the need for collective will to change these determinants. The policy recognizes the need for the holistic approach and cross sectoral convergence in addressing social determinants of health. This would also require the development and use of indicators to measure the determinants and the disease outcomes and systems to measure such indicators. The health sector would have credibility and the administrative and political will to lead these preventive measures, only when it is seen to be completely committed and effective in addressing the health care needs where preventive action fails. Thus a health sector treating severely malnourished children can push for nutrition changes. A good disease surveillance system would pick up outbreaks of water-borne disease and link it to specific sanitation failures. A commitment to provide free care to all victims of gender based violence- be it rape or acid attacks or burns- on a whatever it costs basis, would give it the strength to contribute effectively to the campaigns against gender based violence. Preventive and Promotive Care has a two-way continuity with Curative care- an under recognised reality that this policy recognizes and builds upon. Also the benefits of prevention are most visible when the burden of costs is undertaken by the State. Further a commitment to pay for the costs of care in some of these conditions is a form of accountability of the State for preventive action.

4.2.9. Some aspects of disease prevention and health promotion are specific services that are to be delivered as part of primary health care services. Currently it includes immunization and ante-natal care, school health programmes and some limited health education and health communication efforts. This policy envisages not only extending the coverage and quality of existing services but also extending the package of family and community level preventive and promotive health care services to include early detection and response to early childhood development delays and disability, adolescent and sexual health education, behavior change with respect to tobacco and alcohol use, screening, counseling for primary prevention and secondary prevention for common chronic illness- both communicable and non-communicable.

4.2.10. Of these programmes, the one that would require much greater emphasis, investment and action is in school health- by incorporating health education as part of the curriculum, by promoting hygiene and safe health practices within the school environs and by acting as a site of primary health care. The school noon meal programme and the food supplementation at the anganwadi must both be leveraged to achieve the reduction of child malnutrition at an accelerated pace.

4.2.11. Occupational Health also requires greater emphasis. Work-sites and institutions must be encouraged and monitored to ensure safe health practices and accident prevention, and provide preventive and promotive services. Diseases that are more prevalent in certain occupational groups must have corresponding preventive action and linkages with primary care facilities which in turn are linked to the specialist services needed. Institutional mechanisms to ensure this is happening must be monitored by city health officers in urban areas and district medical and health officers in rural areas.

4.2.12. Delivery of such an expanded range of services requires firstly moving away from highly selective primary care approaches to a strengthened comprehensive primary care approach (as

outlined in the next section), the strengthening and transformation of the ASHA programme from some sort of stop-gap arrangement to a way of organizing health care and finally it requires a much wider involvement of communities and multiple stakeholders. Skillful and appropriate use of ICT tools would enhance each of these approaches- but would not be a substitute for them.

4.2.13. Nurtured for nearly a decade now, the nearly one million ASHAs serving as Community Health Workers in rural and urban areas have significant potential for a critical role in disease prevention and health promotion. The ASHA will be supported to undertake primary prevention for non-communicable diseases, in palliative care and community mental health, through health promotion activities, working with care givers and the Village Health Sanitation and Nutrition Committees, which would include representatives of local government.

4.2.14. Promotion of Yoga at the work-place, in the schools and in the community would also be an important form of health promotion, that has a special appeal and acceptability in the Indian context.

4.2.15. Wider involvement of stakeholders includes elected local governments, local communities and community based organisations like self-help groups, students of schools and colleges, non-government organizations, professional organizations, and corporate social responsibility mechanisms. Taken together these could constitute a 'Social Movement for Health'. In this context the use of mass media is important, and a provision can be made for a minimum amount of health messaging from within an agreed menu of priority messages that channels should broadcast.

4.2.16. For action on determinants of health, developing capacities and processes for 'Health Impact Assessment' of existing and emerging policies of key non-health departments, directly or indirectly impacting health, and establishing systems that seek concurrence of Department of Health in new policies of key non-health sectors would be prioritized. Convergence with sectors such as nutrition, education, water and sanitation, agriculture, housing, labor etc. across each stage of the planning cycle, and inter- departmental convergence, for synergistic improvement of health status is envisaged.

4.2.17. The policy also recommends the setting up of seven 'Task Forces' for formulation of a detailed 'Preventive and Promotive Care Strategy' in each of the seven priority areas for preventive and promotive action outlined above, and to set the indicators and the targets and mechanisms for achievement in each of these areas.

4.3. Organization of Public Health Care Delivery*:*

Organization of Health Care Services: The 7 Key Policy Shifts:
1. **In Primary Care:** From a *Selective Care* that is fragmented from secondary/tertiary care to *Assured Comprehensive care* that has continuity with higher levels
2. **In Secondary and Tertiary Care:** From an input oriented, budget line financing to an output based strategic purchasing.
3. **In Public Hospitals:** From User Fees & Cost Recovery Based Public Hospitals to Assured Free Drugs, Diagnostic and Emergency Services to all in Public Health Facilities
4. **In Infrastructure and Human Resource Development:** From normative approaches in their development to targeted approaches to reach under-serviced areas.
5. **In Urban Health:** From token under-financed interventions to on-scale assured interventions that reach the Urban Poor and establish linkages with national programmes: Scaling up of the interventions with focus on the urban poor and achieving convergence among the wider determinants of health.
6. **In National Health Programmes-** Integration with health systems for effectiveness, and contributing to strengthening health systems for efficiency.
7. **In AYUSH services:** From Stand-Alone AYUSH to a three dimensional Mainstreaming.

A. The approach to providing assured services is free and universal access to primary care services provided by a network of public primary care health facilities, supplemented by strategic purchase of secondary and tertiary care services – largely from public facilities, supplemented first by purchase from not- for profit private sector and then from the commercial private sector.

B. Access to services remains the key issue for most of India's poor- with very limited services being available, especially in rural and remote areas and urban slums, Targeted investment in building health infrastructure and putting in place an adequate number and skill –mix of health human resources and supplies in under-serviced areas where the gaps are the greatest, would remain a major strategy of improving access.

C. Free Drugs, Free diagnostics and free emergency care services in public hospitals, free emergency response and patient-transport systems would be the norm, thus providing a high degree of access and financial protection at secondary and tertiary care levels. Public Hospitals and the network of public health care facilities are to be perceived as a form of tax based insurance with a single payer, where the public hospitals are providing cashless services in return for pre-payment as happens in any standard insurance package.

D. Urban health is a growing challenge. About 31 % of our population lives in urban areas and 17% of this lives in slums. Despite supposed proximity to health care facilities their access to

such facilities is severely limited. Weak fiscal and management capacity of urban local bodies and inadequate sub-optimal public health facility network have also to be addressed. The major shift needed therefore is to scale up this programme to cover the entire urban population within the next five years- and this requires adequate financing on a sustained basis to match the requirement.

E. Priority setting in health care is a political decision, based on our core values as a nation and informed by technological knowledge of both disease prevalence and feasibility of interventions. The health priorities, which are included in national programmes, have not been included because they are cost-effective, but because they represent important social goals and core values of the nation. Maternal mortality contributes to about 4 % of all mortalities in the 15 to 49 age group of women; and less than 0.55% of all mortalities- across all age groups but it will remain the single most important heath indicator for us. Or to take another example, leprosy represents less than one thousandth of all morbidities and has no mortality at all- but it is a core value that as a modern nation we will no longer tolerate the disability and stigma that this disease creates, as we resolved in the case of polio. Whereas markets in health care cannot and do not and perhaps will not address many of these priorities, because they are not value for money propositions in the logic of markets, public health systems must gear up to address these goals. Even for the health security of the nation, as brought out in our response to disasters and even in our recent preparedness against Ebola virus, public health care systems must retain a certain excess in terms of health infrastructure, human resource and advanced technological capacity that can be mobilized in times of crisis. However all national health programmes require, that for effective implementation they are well integrated with state health systems and for efficient functioning must contribute to strengthening state health systems meaningfully.

F. India has a legacy of pluralism in health care, with many indigenous and alternative approaches to health and medical care also contributing to the health and well-being of its population. This is a legacy that the nation is proud of, and which it will continue to build on and mainstream. Mainstreaming under the NHP 2015, would have three very different dimensions that would run concurrently- firstly at the level of knowledge where increasing validation and evidence and research leads to its growth as part of a common fund of science and technology, secondly in being available at all major public health care facilities so that the population have easy access and can make an informed choice of the system of care they want to follow, and thirdly to ensure that the considerable existing human resource and infrastructure gets the requisite conditions to provide quality services, which includes medicines and equipment as well as an enabling environment to practice their system with confidence, even while recognizing the strengths of other systems and encouraging cross-referral. Supporting validated practices of self-care by communities and households would form the community level component of this mainstreaming and empower people to participate in improving their own health.

4.3.1 Primary Care Services & Continuity of Care

4.3.1.1 Health Care Service delivery would be built on the bedrock of high quality comprehensive primary health care services that are made universally accessible, that are free and that are provided as close to where people live and work as is feasible.

4.3.1.2 Hitherto primary care has been very selective, covering less than 20% of primary health care needs. This has made primary care less responsive to felt health care needs and contributed in no small measure to the image of the under-performing public health care system. Primary care does not merely mean first contact care or symptomatic treatment for simple illness with some elements of care for pregnancy and immunization included. Primary Health Care is necessarily comprehensive- addressing primary care for all of reproductive and child health, communicable diseases and non-communicable diseases through appropriate health communication, technologies and care provision. To denote this important policy change, facilities which start providing the larger package of comprehensive primary health care will be called health and wellness centers.

4.3.1.3 Comprehensive Primary health care is value for money, i.e, higher health outcomes at lower per capita total health expenditure. Such Primary health care would reduce morbidity and mortality greatly at much lower costs to the system and the individual than any other approach, and would significantly reduce the need for secondary and tertiary care.

4.3.1.4 Comprehensive Primary care must be available as the entitlement that we are in a position to assure at this level of social and economic development. To make this entitlement a reality, every family would have a health card that links them to a primary care facility and be eligible for this package of services. Community Participation would be enabled through the Village Health Sanitation and Nutrition Committees, that are supervised by the panchayats and would ensure that there is no exclusion and that locally felt health priorities are included.

4.3.1.5 A primary health care team works with communities and therefore understands the needs of its defined community and so is able to provide comprehensive, integrated and patient centered care. It is the focal point for building the trust and credibility of the entire health service. It can be developed to increase the efficiency of the health services as a whole and protect the patient from unnecessary medicalization. The PHC team plays an important role in averting disease, counseling, guiding and educating people and enables them to adopt healthy life styles and make better health and healthcare related choices.

4.3.1.6 The Organization of Primary care systems depend upon the establishment of a network of primary health facilities, which are adequately staffed, skilled and supported to perform their functions effectively and efficiently. This therefore requires a matching human resource development strategy, a logistics support system and a referral back up. It involves an up-gradation of the existing health sub-centres and orientation of all primary health centers to provide this comprehensive set of preventive, promotive, curative and rehabilitative services. The assured services of this level would include AYUSH elements as appropriate for this level of care as well as support for validated local home and community based practices.

4.3.1.7 Most elements of primary care would be designed such that a nurse or paramedical with suitable training should be able to provide the necessary care. For all chronic illness, a doctor or specialist may have to initiate the treatment and supervise it, but most elements of the continuity of care required for chronic illness can be provided locally by the primary care team, thus preventing overcrowding at the higher and underutilization at the primary level, and saving the family enormous costs and suffering. The use of ICT tools including tele-medicine would support the primary care teams.

4.3.1.8 A system of incentives would support achievement, documentation and verification of many of these population based primary care processes. Completion of registration would earn a team incentive. Completion of the delivery of the core preventive and promotive sub-packages for the population including screening for specific diseases, full treatment compliance and timely referrals for complications, shall also earn team incentives.

4.3.1.9 Such an approach to primary care would be possible only in a context where ASHA has been established as an effective bridge between the first level of health facility and the community. The ASHA would support the enrolment of all families with the Health and Wellness Centers (Sub-centers and Primary Health Centres providing comprehensive care), ensuring that there are no exclusions and that all new entrants are also registered through regular updations of the registration process. The ASHA will also play a role in secondary prevention by ensuring compliance to treatment and facilitating follow up of those being treated for chronic illnesses. The ASHA has an established and effective role in prevention and management of communicable diseases and in maternal and child health and this will continue to be an important area of focus. (The HR implications of this are discussed in section on HR)

4.3.1.10 This same concept shall extend to all urban areas also. Though the population per centre ratio would be about half (one for every 10,000 population) the relationship between number of providers and registered families would be the same.- meaning additional human resources and supplies to deliver this larger range of preventive, promotive and curative care services- so that it becomes the first port of call for every individual and family.

4.3.1.11 Comprehensive Primary Care approaches require reliable and effective referral support with feedback and follow-up mechanisms. Universal coverage with ante-natal care examinations is effective only where we have secondary care facilities which can manage the pregnant woman detected to have complications. Similarly initiation of therapy in most chronic illness may need a medical, even specialist consultation to initiate, but the primary center would be able to provide the necessary regular check-ups needed and ensure medication access and compliance. Careful leveraging of the potential in telemedicine/ICT for two way systemic linkages between primary care on one hand and secondary and tertiary care on the other would ensure continuity of care- which is one of the key process parameters of effective primary health care system.

4.3.2 Secondary Care Services

4.3.2.1 Internationally the definition of primary care is expanding such that it includes all the care that district health systems provide. This implies that what has been categorized hitherto as secondary care should also be assured in much the same way as we are doing for primary health care. Our aspirational goal is that all of secondary care, redefined to include a considerable part of what happens currently only in medical college hospitals should now become available within a standard district- and as a first step to this, within a region or cluster of districts with a population of about 2 to 5 million.

4.3.2.2 There are two corollaries of such an aspiration. Firstly we should have at least 1000 beds per million population (1 per 1000) and they should be distributed such that within what is known as the golden hour- a secondary care facility can be accessed. This implies, as a corollary that efficient emergency transport systems be available as well. It also implies that ten categories of what are currently specialist skills are available within the district and four or five of these- the general physician, surgeon, gynecologist, pediatrician and anesthetists are available with even greater density.

4.3.2.3 One major strategy to achieving this secondary care capacity is strengthening the district hospital and a well-chosen, well located set of sub-district hospitals which could be CHCs or sub-divisional hospitals. Part of the public investment , especially that going to core infrastructure and a part of human resources and supplies would be through budgetary allocation, but an increasing part would be through reimbursement for services provided- or in other words a resource allocation that is responsive to quantity, diversity and quality of caseloads provided care. Another part of this is purchasing care from private hospitals to close critical gaps in public provisioning of services.

4.3.2.4 Strategic purchasing refers to the Government acting as a single payer- purchasing care from public hospitals and private providers as part of a strategic plan for district health systems development. This is one way of improving efficiencies of use of funds- when actual services delivered can be very skewed across facilities and where there are complex local needs of equity and marginalization that would have to be addressed. One element of strategic purchasing is that there is preference to public facilities- justified by the needs of national health programmes, many of which are not and never will be commercially remunerative, by the need to retain adequate reserve capacity for public health emergencies, by the fact that private sector regulation, especially as regards costs remains a challenge and would be possible only in the presence of a vibrant public sector. Even within the private sector a strategic preference for not for profit hospitals which are prepared to work on cost recovery principles and address public health goals in a spirit of service would require to be prioritized.

4.3.2.5 Strategic purchasing is also an opportunity to provide stewardship to the private sector- where purchase by the State would indicate where and what services have critical gaps and encourage growth of the sector in such areas.

4.3.2.6 Development of such secondary care capacity also means certain obligations as regards HR, especially the challenge of finding the necessary specialist skills and in the organization of more comprehensive facility development that can assure at least all common surgical care and emergency medical services. A special scheme to develop this capacity across public and private hospitals that operate in large number of districts where there is currently no capacity at all- would be one important corollary of this scheme. This is discussed further in the section on human resources for health.

4.3.3 Re-orienting Public Hospitals:

4.3.3.1 An important change in policy mind-set is to move away from imagining public hospitals as social enterprises that ideally must recover the costs of their functioning, to re-imagining them as part of a tax financed single payer health care system in which, what public hospitals deliver is not free care, but rather pre-paid care (like in commercial insurance) and which is cost efficient in addressing health care needs of the population.

4.3.3.2 The main corollary of this policy statement is that the public hospital must provide universal access to free drugs and diagnostics. In terms of services other than services covered under national health programmes, public health systems should be able to provide all emergency health services. There would be considerable self-selection involved as those who require higher degrees of hospitality arrangements or exclusiveness and can pay for it would prefer to go to private sector- but it is universal in that there is no barrier to the "well to do" also from seeking care in the public hospital. Affirmative action, in the form of cash transfers, help-desks, rest houses, half way homes, hospices, etc. would in addition be required for ensuring that the poorest two quintiles are proportionately more represented and able to access public health care adequately.

4.3.3.3 The other corollary of viewing public services- not as free, but as pre-paid is that quality of care would become an imperative- and all public facilities must have periodic measurements and certification for level of quality and must be financed and incentivized to meet and retain quality standards.

4.3.4 Closing Infrastructure and Human Resource/Skill Gaps:

4.3.4.1 The main challenge in closing these gaps is in the impermissible level of inequity in the development of infrastructure and the deployment of human resources. There would be a conscious policy to identify districts and blocks which have the larger gaps for development of infrastructure and deployment of additional human resources.

4.3.4.2 In areas where there is high density of population but there are also large gaps in terms of density of facilities and human resources for primary care- the policy would simply be to add on more human resources in the given infrastructure rather than more infrastructure. In urban areas operating the infrastructure in two shifts may also enable higher access- provided the human resources for primary care never falls below the population to provider ratio. In

facilities, which have much higher case-loads, the human resources deployed must be proportionately higher to ensure quality of care.

4.3.4.3 In secondary hospitals the policy approach would be to add more beds and staff to match caseloads if distance is not a barrier to access, rather than fragment the available specialists and medical and nursing staff across several facilities- thus making all of them sub-critical for delivering secondary care services in an assured manner. But where distance is a barrier, new hospitals of the standard CHC model- with 30 beds would have to be strengthened with necessary skilled staff including specialist skills. However if hospitals become very large- then also they could become inefficient and new hospitals would need to be constructed beyond a threshold level of say 1000 beds. A minimum population to bed ratio should be at least 1000 beds per million population- with corresponding human resources and equipment to match. Any additional infrastructure or HR financing would be linked to increases in outpatient and inpatient attendance and utilization of key services in a measurable manner.

4.3.4.4 Another policy objective would be measurable improvements in quality of care. For public health care facilities, the strategy would be to ensure that every health care facility is measured and scored for quality, and certified and incentivized when it achieves a certain minimum score. Quality measurements would include in the least clinical quality of care, as well as patient safety, comfort and satisfaction. Quality Improvement would require technical support and capacity building as well as institutional arrangements for measurement and certifying. In private sector voluntary accreditation with certificates like that of NABH and NABL would predominate. If the private facility is part of a partnership then quality certification either through the NABH/NABL or through the same system as used for public health facilities would be mandatory.

4.3.4.5 One major area of concern in district health care services is access to blood and blood safety. Currently the network of approved blood banks is not large enough or dispersed enough to ensure safe blood supply across all districts and sub-district hospitals. There are reports that a considerable part of rural blood transfusion requirements are met through unbanked blood transfusions and in some contexts this is the only feasible and safe option. Though blood supply was to be free, in some States commercial transactions around blood have developed. Expanding the network of blood banks and ensuring that there is improved access to safe blood shall be one of the important components of improving service delivery.

4.3.5 Urban Health Care

4.3.5.1 The first call of the National Health Policy with respect to urban health would be to address the primary health care needs of the urban population. The National Urban Health Mission(NUHM) would need to be strengthened and adequately financed to achieve this. NUHM would cover all State capitals, District headquarters and cities/towns with more than 50,000 populations. Within this primary care approach there would be a special focus on poor populations living in listed and unlisted slums, other vulnerable populations such as homeless,

rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants.

4.3.5.2 Since, no comprehensive strategy/ programme had been launched yet to develop an appropriate public health delivery system across cities/ towns, the interventions in urban health must lead to strengthening of the existing primary public health systems & establishing new facilities for the unserved & underserved population. Given the large presence of private sector in urban areas there is considerable scope for developing sustainable models of partnership with for profit and not for profit sector for health care delivery.

4.3.5.3 Urban health is dependent on the urban environment- and therefore the policy would emphasize measures of reduction of air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress. An important focus area of the urban health policy will be in achieving convergence among the wider determinants of health. The approach to achieving this is both through a major effort at behavior change such as that exemplified by the Swachh Bharat Abhiyan, and supplemented by building modern technological and social approaches to public services and regulatory measures that address each of these urban health determinants.

4.3.5.4 Addressing the major prevalence of non-communicable diseases such as hypertension and diabetes through planned early detection, and better secondary prevention would be an integral part of urban health strategy. Improved health seeking behavior influenced through capacity building of the community based organizations & establishment of an appropriate referral mechanism would also be important components of this strategy.

National Health Programmes:

4.3.6 RCH services:

4.3.6.1 For further acceleration in the gains made in all Reproductive and Child Health (RCH) programmes, the greatest challenge is to address the social determinants of health. Maternal and perinatal mortality is highest in population sub-groups which are poorer, more malnourished, less educated, have lower age of parity and have too many children or too soon. It is also a reflection of patriarchal mindsets and lack of gender equity which makes women more vulnerable. Thus child and maternal survival is a mirror that reflects the entire spectrum of social development and addressing these social determinants through developmental action of all sectors will remain a priority.

4.3.6.2 **Reduction of Maternal Mortality:** Within such a context, the challenge in further reductions in maternal mortality and morbidity lies now in improving the quality of care in health care facilities. In antenatal care this translates to timely detection of complications like hypertension, anemia and diabetes and adequate response to the same. During delivery it

means services of a skilled birth attendant, preferably in a facility that is as close to home as possible, which follows all protocols of safe delivery backed up by ready access to emergency obstetric care. The latter needs to be addressed through appropriate HR policies that bring in and retain the necessary skills and health care systems, and through regularly functional operation theatres with blood available on a regular basis. An operation theatre that functions only during the occasional sterilization day or emergency obstetric case, or a blood storage unit used only for C-sections would find it more difficult to maintain the quality standards required for safe and effective services, and would have lesser value for money. Even the surgeon requires a regular service for maintaining their skills. Thus a general health systems strengthening would greatly benefit continuity of care and emergency services for maternal health and all strengthening for maternal health would be used to enhance other services as well.

4.3.6.3 Cash Transfers, Quality of Care Issues: Though there is a persistent level of home delivery in many states improved access and quality of care and ensuring that there are no financial barriers would be adequate to achieve a further shift to safe delivery. Further general increases in cash transfers are not necessary. Improving quality of care at primary level facilities would also limit the load on higher facilities, freeing them to provide secondary and tertiary care of better quality. The existing cash transfer (Janani Suraksha Yojana) however has been effective to cover non- medical costs of care and needs to be retained, and if necessary enhanced in line with the needs of select sub-groups who face a greater financial barrier.

4.3.6.4 Child and Adolescent Health: The policy's commitment to child health begins by endorsing the national consensus on accelerated achievement of single digit neonatal mortality and stillbirth rates through a careful synergy of community based intervention centred around the ASHA and anganwadi worker and improved home based and facility based management of sick newborns. The latter has its own HR and skill requirements as well as increased access to technologies. Developing such high quality facility based care for the sick newborn and child will strengthen and be strengthened by better primary and secondary care facility development. Community based interventions strategies must go beyond immunization to include ready availability and access to ORS and Zinc for diarrhea and appropriate antibiotics for pneumonia, better identification and management of anemia, and screening for developmental defects. The policy affirms commitment to school health programmes as a major focus area and health and hygiene being made as part of the school curriculum. AYUSH doctors supporting healthy local home and community practices and the mainstreaming of AYUSH interventions at primary level will further strengthen primary care. We also need to give special emphasis to the health challenges of adolescents (10 to 19 years) and long term potential of investing in their health care. In this age group there is one section affected by under-nutrition, and there is another section that requires attention to reduction of obesity. Paradoxically both of these can be more common in poorer sections. Adolescent health interventions may not immediately get reflected in reduction in infant mortality rates or other conventional measures of health systems performance but they are nevertheless important.

4.3.6.5 Universal Immunization Programme: The success of polio eradication has raised the expectations and the Universal Immunization Programme would capitalize on social

mobilization and habitation level information base and processes built up in polio eradication to benefit the entire immunization effort. One of the immediate challenges is to further increase immunization coverage with quality and safety. Better adverse event reporting and compensation policies would be built up. Vaccine security through encouragement of multiple suppliers and appropriate procurement policies is also a frontier. Health Technology Assessment and building up the national epidemiological information base required for decision making and monitoring would be of immense value for introduction of new vaccines. While the introduction of new cost effective vaccines is a frontier, these would be introduced and scaled up along with building the institutional capacity to deliver the vaccines and as a complement to other health priorities of primary health care.

4.3.6.6 Supportive Supervision: The enormous needs and challenges of capacity building and supportive supervision in more vulnerable districts with very weak internal capacity requires a new strategy. One such promising strategy that can be scaled up is where carefully selected and supported nurse-trainers will visit and work with facilities in under-performing and highly vulnerable districts to establish a better quality of facility and community level care. Such training and support would be enabled by leveraging ICT tools- many of which have been successfully piloted and field-tested.

4.3.6.7 Population Stabilization including maintaining a gender balance has been and will continue to be one of the main components of national health policy. The changed situation however is that 21 States have already achieved replacement levels of fertility rates and in these states the strategic objectives now are better and safer contraceptive choices, with a further push back in age of marriage and improvement in spacing. In all 36 States however the fertility rates are declining rapidly and with improving levels of women's education, the demand for contraceptive services is established. Though declining, fertility rates continue to be unsustainably high in as many as nine States which account for over 35% of the population. Here the policy imperative is to move away from camp based services with all its attendant problems of quality, safety and dignity of women, to a situation where these services are available on any day of the week or at least on a fixed day. Other policy imperatives are to increase the proportion of male sterilization from less than 5% where it is currently, to at least 30 % and if possible much higher. The National Health Policy is explicit that coercive methods are not justified nor even effective to meet the goals. Improved access, education and empowerment would be the basis of successful population stabilization.

4.3.6.8 Women' Health & Gender Mainstreaming: Women's health issues and concerns go far beyond maternal health, the ability of the health sector to address these issues needs to be strengthened. Despite the introduction of new technologies access to safe abortion services and for reproductive tract illness remains a major gap that must be seriously addressed. One major concern is the health response to victims of gender violence – ranging from sexual assault to acid attacks on women. While measures to prevent these are the focus, the health system must also bear the costs and undertake whatever it takes to access the appropriate services for these victims. At another level women's access to health care needs to be

strengthened by making public hospitals more women friendly and ensuring that that the staff have orientation to gender –sensitivity issues.

4.3.7 Communicable Diseases under National Disease control programmes

4.3.7.1 Integrated Disease Surveillance Programme: The National Health Programmes that address communicable diseases (down to every sub-center and PHC) represent less than 6 % of all morbidities and about 25% of all communicable diseases. A comprehensive approach to communicable diseases needs districts to respond to the communicable disease priorities of their locality- and this can only happen in a context where the integrated disease surveillance programme is used to generate a comprehensive understanding of all communicable diseases in the respective areas, as well as respond to localized outbreaks as and when they occur and before they become generalized epidemics. The policy response is to build sufficient public health capacity down to the district level- and this consists of both a network of well-equipped laboratories backed by tertiary care centers and the public health capacity to collect, analyze and respond to the disease outbreaks using the state of the art public health knowledge.

4.3.7.2 The approach to integration: The communicable diseases that national health programmes address include three chronic diseases- HIV, tuberculosis and leprosy, plus all the vector borne diseases, and the expanded programme of immunization, which has significantly reduced mortality from diseases like diphtheria, pertussis, tetanus, measles and now hepatitis B. Every one of these programmes require on one hand a robust public health system as their core delivery strategy, and on the other they can be considered as opportunities to strengthen health care systems- and designed keeping this goal in mind. Thus blood safety is an important element of HIV control, but the policy imperative is that blood safety measures are designed as part of a universal access to blood transfusion services. Tuberculosis control needs excellent laboratory support for its effectiveness but the programme would be designed to strengthen laboratory services on the whole. The control of malaria requires ASHAs with point of care diagnostics and drugs who can respond in time to every case of malaria, but it would be designed so that it enhances her role, capacity, confidence, and her remuneration for all programmes.

4.3.7.3 Control of Tuberculosis: The current challenges in tuberculosis are persistent high levels of disease transmission, rapid progression of the disease in infected patients and increase in incidence of drug resistant tuberculosis. This calls for more active case detection with a much greater involvement of private sectors in case detection, and adherence to standard treatment protocols. It also requires a choice of strategy with regard to treatment regimes that reflects the changing patterns of microbial sensitivity and medication compliance. In case of drug resistant TB access to free drugs would need to be complemented by affirmative action in the form of investment in enabling access and coping with livelihood issues for that the treatment is carried out, drop-outs reduced and transmission of resistant strains are contained. These treatment based control measures to be most effective in actual

reduction of prevalence rates needs supplementation by preventive and promotive action in the workplace and in living conditions.

4.3.7.4 Control of HIV/AIDS: India's progress in reduction of HIV incidence and HIV related mortality would be sustained and accelerated as greater awareness, enhanced prevention and wider access to ART are put in place. As the programme gets integrated through a well-defined process, care would be taken to ensure that there is no loss of focus on this goal. India's achievements in HIV control owe a lot to both its emphasis on prevention, its partnership with active and vibrant communities and civil society, evidence based programming and in the ability to encourage the production of generic anti-retroviral drugs at affordable rates. All these advantages will be sustained and built upon by the policy framework of not only health but other concerned departments and industry. With prevalence rates higher in certain southern and north east States, and with rising trends of HIV in certain pockets in northern States it would be imperative for interventions to be focused on high risk communities and prioritized geographies. One critical policy concern is to balance the financing strategy so that the current emphasis on prevention continues, while the increasing cost of clinical care and treatment to people living with HIV is also provided for. The private sector would also be included in efforts to provide care, support and treatment to these patients and for help in dealing with stigma and discrimination associated with this disease.

4.3.7.5 Leprosy Elimination: The achievement of 'leprosy elimination' at the national level i.e. a prevalence rate to less than 1 per 10,000 is an important milestone, but given the epidemiological characteristics of the disease, even in an optimum programme, there would be new cases every year, which would have to detected and managed patiently for the disease to eventually disappear. The thrust of policy is therefore to build a systems sensitivity to ensure that the small proportion of skin lesions which would be a leprosy case is identified in time, treated and followed up to ensure that not a single extra disability occurs on account of this disease. This can happen only if every provider is sensitized for this, a small proportion of providers remain dedicated to this as resource persons who keep the requisite skills alive within the health system, and further the health system now gears to a better level of dermatological care so that the needle of leprosy lesions in the haystack of skin lesions is not missed. The proportion of grade 2 cases amongst new cases will now become the measure of community awareness and health systems capacity and dedication to this task- and this keeps in mind the global goal of a reduction to grade 2 disability to less than 1 per million by 2020.

4.3.7.6 Vector Borne Disease Control: The National Vector Borne Disease Control Programme deals with six diseases. Of these, Malaria, Filaria and Kala-azar are on decline because of various interventions in the form of early detection and treatment, integrated vector management and extensive IEC/BCC and the contribution made by ASHA workforce. With malaria there is a growing challenge of drug resistance and the country would have to keep a vigil on the same, changing treatment regimens with logistics support as appropriate. Lymphatic filariasis and kala-azar are targeted for elimination by 2015, but even after this surveillance and follow up on localized outbreaks would need to be sustained. Dengue is emerging as the fastest growing infection globally and India too faces a challenge. National programme for prevention and control of Japanese Encephalitis (JE)/Acute Encephalitis

Syndrome (AES) have been initiated with a strong component of inter-sectoral collaboration, but they require strengthening in many dimensions. Good quality data including entomological information for which a dedicated team of entomologists with support staff is essential in the fight against these diseases. Taken together the battle against vector borne disease is an example of how one needs to be ahead of the problem in biomedical research for understanding of disease and its transmission, in drug innovation and drug discovery and bringing innovations on to the market with very short lag times and in building public health capacity at district levels. Vector borne disease will remain one of the important barometers for how effective public health systems are in integrating preventive and curative care.

4.3.7.7 Non-Communicable Diseases: Despite a policy intent in the form of a national programme on NCDs, the effort against the growing burden of non-communicable diseases are nascent or initial steps, with considerable distance to traverse before they become universal in outreach. Almost all States have started initiatives to cater to NCD challenges, but a comprehensive learning from various models of implementation is still elusive. This policy will support an integrated approach where screening for the most prevalent NCDs, where secondary prevention would make a significant impact on reduction of morbidity and preventable mortality would be incorporated into the comprehensive primary health care network. This would be firmly linked through continuity of care arrangements with specialist consultations, which can be followed up at the primary care level. Emphasis on medication and access for select chronic illness on a, round the year, basis would be ensured. The National Programme will also ensure that the necessary resource support and capacity building support for such an integrated approach is built up at the district level. This is one area where research and protocol development for mainstreaming AYUSH and developing Integrative Medicine has huge potential for effective prevention and therapy that is also safe and cost-effective, since NCDs often require life-long management. This is one area where research and protocol development for mainstreaming AYUSH and as part of integrated medical care has huge potential for effective prevention and therapy that is safe and cost-effective, since NCDs often require life-long management.

4.3.7.8 Though CVDs are the major part of NCDs, there are many other health concerns that fall under this category. The National Programme for the prevention of blindness is one such programme, which has made significant progress and achievements in this period. Programmes against deafness and for better oral health have also been initiated. There are also concerns of endemic diseases like fluorosis and sickle cell anemia or thalassemia that cause a preventable load of morbidity and mortality and for which integrated programmes of prevention and management would make for substantial improvements. A number of occupational diseases like silicosis are also in this category and need urgent attention. While some national programmes represent a commitment to central funding for universal free care, others would be organized in the form of a resource support and would depend largely on State schemes and State health systems to deliver.

4.3.7.9 The elderly i.e. the population above 60 years comprise of 8.6% of the population (103.8 million) and they are also a vulnerable section. Those above 75 years (20.52

million) are most vulnerable and almost 8% of the elderly population is bed ridden or homebound (NSSO). India would need to develop its own cost effective and culturally appropriate approach solution to addressing the health and care needs of the elderly. It would necessarily be a more community-centered approach where care is provided in synergy with family support, with a greater role for community level caregivers with good continuity of care with higher levels. A closely related concern is the growing need for palliative care where in life threatening illness or in end of life contexts there is active measures to relieve pain and suffering and provide support to the patient and the family. Increasing access to palliative care would be an important objective, and in this like for all geriatric illness, continuity of care across levels will play a major role.

4.3.8 Mental Health:

One public health priority that needs urgent attention is the sad state of neglect of mental health issues. The gap between service availability and needs is widest here- 43 facilities in the nation with a 0.47 psychologists per million people. Improving this situation requires simultaneous action on several fronts. First an increase in creation of specialists with public financing with special rules to give preference to those willing to work in public systems and to limit emigration, which is a major problems in this sector. Integration with the primary care approach so as to identify those in need of such services and refer them to the appropriate site and follow up with medication and tele-medicine linkages. This would also require specially trained general medical officers and nurses who are able to provide some degree of referral support at the secondary care level in a context where qualified psychiatrists will remain difficult to access for many years. These mid -level psychiatrists would also be enabled by tele-medicine linkages. Supplementing primary level facilities with counselors and psychologists would be useful in several programmes including mental health, such as adolescent and sexual health programmes and HIV control. They could also be charged with creating a network of community members who can provide psycho-social support for such problems. The efforts towards de-stigmatising the psychological disabilities would be further strengthened under this policy. There should be a decreasing need for committing individuals to institutional care and current institutions should have the necessary financial and human resource support and supervision for ensuring humane and caring approaches to the inmates.

4.3.9 Emergency Care and Disaster preparedness:

A district that cannot respond to a poly trauma responding from a single house collapse or a single road accident is in no position to respond to an earthquake or a major train accident or flood. Disasters create maximum load on facilities that are designed to provide minimal package of services. Given the reality that there is a major environment or manmade disaster almost every year, the public health care system has to be designed to respond to such events. This requires a dispersed but effective capacity for routine emergency management and an army of community members trained as first responder for accidents and disasters. This is not only for the surgical emergency- but includes burns, drowning, stampede during fairs and festivals, etc. To support disaster response the policy would call for building earthquake and cyclone resistant infrastructures in vulnerable geographies and develop mass casualty

management protocols for CHC and higher facilities and develop emergency response protocols at all levels. Improving capacities of district health systems to cope with the routine emergency is the way to best be prepared for a disaster. A network of emergency care that has an assured provision of life support ambulances linked to trauma management centers- one per 30 lakh population in urban and one for every 10 lakh population in rural areas will form the key to a trauma care policy. Rehabilitative care at community and through the nearest health institutions would be made available as 30% of the injured suffer serious disabilities.

4.3.10 Realizing the Potential of AYUSH:

4.3.10.1 A large part of the population uses AYUSH remedies and prefers to do so, choosing this for reasons that include perceived lower side effects, costs and/or considerations of it being more natural. The first and most important consideration in public policy with respect to AYUSH is ensuring that persons who so choose have access to these remedies. The strategy of co-location in public facilities providing allopathic care as well will continue. Another strategy is investing more on making AYUSH drugs available and standardising drugs and treatment protocols. A third is good propagation of the potential of AYUSH remedies in a number of conditions. Further disciplines like Yoga would be introduced much more widely in the school and in work places as part of promotion of good health. These latter strategies are brought together in the recently adopted National AYUSH Mission.

4.3.10.2 This policy recognizes that principles of care differ for AYUSH systems of medicines and mainstreaming would involve 'nurturing' these individual system of medicines through development of infrastructural facilities of teaching institutions, improving quality control of drugs, capacity building of institutions & professionals, building research and public health skills of practical utility and initiating community-based AYUSH interventions for preventive & promotive healthcare. Initiating community-based AYUSH interventions for preventive & promotive healthcare, and linking them with the ASHAs and VHSNCs would be an important plank of this policy.

4.3.10.3 The second important meaning of mainstreaming, which was accelerated with NRHM, was training of AYUSH professionals to help them perform 'national program' functions. In many primary health centers however they are the only medical professionals available and therefore take care of both ayush and allopathic curative care. Given human resource constraints, the National Health Policy would continue with this but with the addition of a mandatory bridge course that gives them at least the competencies of mid-level care provider with respect to allopathic remedies. Simultaneously, continuing education for upgrading of knowledge and skills in their own systems as regular in-service capacity strengthening would be instituted, just as for the modern medical system doctors.

4.3.10.4 This policy further support the integration of AYUSH systems at the level of knowledge systems by validating processes of health care promotion and cure and sensitizing practitioners of each system (Allopathic and AYUSH) to the strengths of the others. Such validation would lead to greater acceptability and even use of AYUSH remedies by all practitioners- and there is potential for such use in NCDs care and geriatric care and promotive

health. This is also needed for integration across the different streams within AYUSH and for cross-referrals as appropriate across systems. This is also required for systemic validation evidence pertaining to safety, efficacy and quality of AYUSH drugs and therapies. Promotion of further research in this field will be actively pursued, and application of available integrative knowledge through development of appropriate clinical protocols for primary, secondary and tertiary levels will be part of this approach. The policy recognizes the need to standardize and validate Ayurvedic medicines.

4.3.10.5 To better regulate the AYUSH drugs market the policy would also support establishment of separate Central Drug Controller for AYUSH drugs and strengthening of quality enforcement mechanism in the States for application to mass manufactured drugs. Prescriptions compounded individually by providers themselves are on another footing, and seen as part of development of standard treatment guidelines.

4.3.10.6 The development of sustainable livelihood systems through involving local communities and establishing forward and backward market linkages in processing of medicinal plants will also be supported by this policy. The policy would also strengthen steps for farming of herbal plants. Developing mechanisms for certification of 'prior knowledge' of traditional community health care providers and involving them in this process, engaging them in the conservation and generation of the raw materials required, as well as creating opportunities for enhancing their skills are part of this policy. Following on pilots already conducted, documentation, validation, certification and skill enhancement mechanisms would be undertaken.

4.3.11. Tertiary Care Services:

4.3.11.1. There has been a considerable expansion in tertiary care services in recent years- most of it in the private sector. The needs of tertiary care are growing, but the costs are growing even faster and have become prohibitive. Those who can afford do so, have bought private health insurance- but the costs of such insurance are out of the reach of the common man- let alone the poorest. One of the Government responses to this challenge is to expand its own capacity to provide tertiary care services consisting of strengthening 58 medical colleges in the first three phases, upgrading 58 district hospitals to become medical colleges and building up close to 15 more new AIIMS. In addition the center has six AIIMS which will soon be functioning at full capacity and a number of national tertiary care hospitals ,which are declared national centers of excellence in tertiary health care. There is need for further expansion of infrastructure for specialty and super specialty services at State level.

4.3.11.2. The challenge with respect to this expansion of medical colleges and AIIMS is to find the faculty to staff these, to start up advanced tertiary care services as is expected of these centers, and to build them as centers of excellence for research and medical education. Building their capacity as tertiary care institutions of excellence needs exposure and training to the latest skills, a policy of benchmarking with better institutions, enlightened HR policies, and also an emphasis on research.

4.3.11.3. The challenge with respect to expansion of medical colleges in the private sector is the high cost they charge for clinical care and professional education. The fees and the orientation make it less likely for graduates to take up public sector services or even serve in towns and cities outside the main metropolis. This policy would support periodic review and standardization of fee structure and quality of clinical training. The greater the gap between the need and the availability of specialists in a given domain, the greater the likelihood that many may just emigrate, given the need for specialists in developed nations as well. In most private medical colleges and tertiary care hospitals, research is not even seriously on the agenda, though there is a potential for cross-subsidization so that some less affluent sections can be treated. Though there is an obligation imposed by their access to considerable tax exemptions and public acquisition of land, - it is only a rare private commercially run hospital that meets these obligations. A number of not- for- profit hospitals however offer this, but these are few. Given that the private sector operates within the logic of the market and that they contribute to the economy through their contribution to the growth rate and by the national earnings from medical tourism, there need not be any major effort to persuade them to care for the poor, as long as their requirements and perceptions do not influence public policy towards universal health care. Where corporate hospitals and medical tourism earnings are through a high degree of associated hospitality arrangements, one could consider forms of taxation/cess, especially for certain procedures and services as a form of resource mobilization towards the health sector.

4.3.11.4. Going by the experience of the family medicine training that some of these hospitals provide, one should be cautious of a general policy of using tertiary care private facilities as training centers for specialists. On the other a number of leading corporate or not for profit hospitals like Aravind Eye Hospitals, or the Christian Medical College Hospitals, or Tata Cancer Hospitals, or the Sai Hospitals, have made remarkable contributions to training appropriate specialists and super-specialists and this should be strengthened and leveraged. Developing criteria to empanel these socially motivated and committed tertiary care centers into the Government effort and developing partnerships with them to close the specialist gaps would be a way forward.

4.3.11.5. In addition to expansion of its own provisioning, the Government would purchase select tertiary care services from empaneled private and public sector hospitals to assist the poor. Coverage in terms of population covered and services included will expand gradually. Development of evidence based standard care guidelines of care applicable both to public and private sector and establishing National Healthcare Standards Organization would be a necessary part of this strategy.

5 Human Resources for Health:

5.1. The need of the day is not a headlong (market-driven) expansion of the pool of professional and technical human resources for health, but a planned increase that creates human resources that meet the specific requirements for professional and technical skills that are needed most. They key principle around which we build a policy on human resources for health is that

workforce performance of the system would be best when we have the most appropriate person , in terms of both skills and motivation, for the right job in the right place, working within the right professional and incentive environment.

5.2. A policy framework in human resources for health that is based on the above principle would need to align decisions regarding how and where to encourage growth of professional and technical educational institutions, how to finance professional and technical education, how to define professional boundaries and skill sets, how to shape the pedagogy of professional and technical education, how to frame entry policies into educational institutions, how to define and ensure quality of education and how to regulate the system so as to generate the right mix of skills at the right place. Similarly public health institutions would need to have enlightened rules – formal and informal- for attracting, retaining and ensuring adequate numbers of persons with the rights skills in the right place. Such policies would have an impact on the growth and work culture of the private sector too. Currently most human resources created, crowds into urban areas, creating a highly competitive market for clients who can pay. Given the information asymmetry that characterizes this sector- such competition leads to considerable degrees of unnecessary and irrational care that regulation alone cannot remove.

5.3. To expand the number of specialists and doctors, and to do so with public health needs in mind, the Government shall invest in States with larger human resource deficits by strengthening 58 existing medical colleges and further converting 58 district hospitals to new medical colleges. To build up a continuous flow of faculty for the over 600 medical colleges that would be in existence and to provide centers of excellence in biomedical and clinical research, the center shall also expand the number of AIIMS like centers of medical education and research from 9 to 15. The ownership and burden of financing this would be shared between the Central and State/UT Governments. The rules regarding setting up of medical colleges and the entire system of regulation of medical education would also be informed and guided by the needs of correcting the current distortions of medical educational policy that have led to this mismatch between needs and skills. Connectivity provided by National Knowledge Network shall be networked for tele-education, tele-CME, tele-consultations and access to digital library.

5.4. Ensuring that doctors are attracted to work in remote areas and that their services can be retained there also requires specific policy measures. Most effective of the various possible approaches is a positive preference given to students from under-serviced areas, who are likely to make a lifelong commitment to go back and serve in these areas. Another positive determinant of voluntary rural location of doctors is a more rural location of medical colleges and a curriculum and pedagogy of medical education which provides exposure and motivation to work with communities. Equally important is to create a positive practice environment where professionals can stay in touch with peers and upgrade their skills and a positive social environment, through better housing, more flexible terms of employment and active measures of community support. Incentives- financial and non-monetary would also be used – and where these are substantial they would make a big difference. Measures of compulsion- whether through mandatory rural postings or mandatory rotational postings are valuable strategies, but these work best in a context where the other strategies are also applied and even

then are seldom sustainable. The exact package of policy measures that would successfully address the problem of doctor vacancy would vary from State to State and would change over time, but there is adequate evidence that these can be addressed by the right mix of the strategies articulated above.

5.5. Specialist attraction and retention is a much greater challenge, and the public sector has been performing very poorly on this. While partnerships and insurance mechanisms could help improve access in some complex chronic illnesses like cancers where people would go to distant urban centers, most needs for specialist consultation would need to be met within a district. Measures to address this would include the expansion of specialist education both of the mainstream MCI registered courses and educational options linked to the National Board of Examinations and College of Physicians and Surgeons. All the measures for retention described with reference to medical doctors would also apply to specialists. The requirement of patient care in super specialty services is very different from the General Specialties with regard to skills required to render effective care. This calls for developing human resources for super specialty care, which would entail developing training centres for the same. Creating a specialist cadre with suitable pay scales and in addition a performance linked payment would be useful. But most important would be an upgradation of short term training to medical officers who are willing to work in these areas and providing them with a set of basic specialist skills as needed at the block and district level. In many nations these take the form of MD courses in family medicine or general practice. These courses have started up here, but despite being highlighted in the 2002 National Health Policy operate on a sporadic basis and on a scale too small, and without the necessary support to make an impact. Supplemental policy initiatives to make this post interchangeable with the post of any of the basic specialists sanctioned for CHC would also expedite the rolling out of this strategy. Another essential policy initiative to realize such re-definitions of professional boundaries, not only for family medicine courses but for many other specialist needs, is to convert National Board of Examinations as a statutory body to innovate new education and training models to train appropriate specialists. Technological innovations coupled with advances in cellular biology knowledge are influencing therapeutic interventions. Hence, developing teams comprising of clinicians, cellular biologists, researchers, academicians, etc. in each specialty who can deliver holistic care becomes pertinent.

5.6. Given the changing professional norms, non-specialists tend to refer away far too many cases to specialists, undermining general practice. For a number of conditions general practice is as good as or even better than specialists in that domain. A large number of distance and continuing education options by which general practitioners in both the private sector and the public sector who work in such areas and with under-served communities can upgrade their skills in what would otherwise have to be referred away, would be used to address this problem- so that general practitioners at all levels can resolve more problems and refer less.

5.7. The expansion of primary care from selective care to comprehensive care requires a complementary human resource strategy. One important element of this strategy is the development of a cadre of mid-level care providers through a B.Sc in community health. Another option is to develop such mid-level providers and through bridge courses and short courses by which graduates from different clinical and paramedical backgrounds, like AYUSH

Doctors, Pharmacists, BSc Nurses, GNMs, etc., would be able to provide these services at what is now known as the sub-center level. This will not only improve availability of manpower with appropriate skills in public health system in remote areas but will also provide additional promotional avenues to many cadres and attract them to work in remote areas. Locale based selection, a special curriculum of training close to the place where they live and work; conditional licensing and a positive practice environment will ensure that this new cadre is preferentially available where they are needed most, i.e. in the under-served areas. Paramedical cadre such as perfusionists, physiotherapists, occupational therapists, radiological technicians, MRI technicians,etc. requires special skills and knowledge. There is need to develop training courses and curriculum in these areas to efficiently and effectively support the super specialties.

5.8. Recognizing that nurses form about two-thirds of the health workforce in India, the policy would strengthen its governance systems so that, nurses are enabled to assume leadership positions, regulation of practice is improved, quality of nursing education is strengthened by training and supporting nurse tutors, establishing cadres like nurse practitioners, and public health nurses. This would increase the total availability of nurses in the areas where they are needed most. There are very few institutions providing specialized nursing courses. It is very important that specialized tertiary level medical care is supported with specialized nursing and Para-medical care. Tertiary care facilities like critical care, cardio-thoracic vascular care, neurological care, trauma care, etc. requires specialized knowledge and skills. The policy recognizes the need for developing training courses and curriculum in these areas.

5.9. The nearly one million community level work force in the form of ASHA created under the National Rural Health Mission, have now creditably established themselves as activists, facilitators and providers of community level care across various contexts. The principles of local selection, experiential training in a set of specific competencies and skills and a field based, hands-on mentoring and supportive supervisory mechanism have enabled them to play a significant role in improved outcomes related to behaviour change for household behaviours and in improved care seeking. Taking stock of this achievement the policy direction would be to move from treating this cadre as an ad hoc arrangement to visualizing and shaping ASHA as a unique institution with a unique role- such as a community health nurse or Facilitator. One approach has been initiated with the certification programme for ASHA under the National Open School System which will serve as a benchmark, for preferential selection of the ASHA into ANM, nursing and paramedical courses for deployment in Health and Wellness centres. Similar mechanisms could also be used for certifying additional and more advanced skill sets- including areas like community based geriatric and palliative care. While most ASHAs will remain mainly voluntary, and remunerated for time spent through regular performance incentives and by social recognition, those who obtain qualifications for career opportunities could be given more regular terms of engagement. The policy will enable engagement with NGOs to serve as support and training institutions for ASHA and to serve as learning laboratories on future roles of community health workers as part of the country's human resource strategy. Adding a second Community Health Worker would be based on geographic considerations, disease burdens, time required for multiple roles and the establishment of systems to stabilize and support the first ASHA for a set of higher skill levels in which she will be certified. The vision is that eventually every primary care team would have a number of

Community Health Nurses as for a defined population certified in a specific set of competencies but with an exclusive focus on meeting community level care needs.

5.10. To expand the availability of nurses the Ministry would encourage a nursing school in every large district or cluster of districts of about 20 to 30 lakh population. Building up quality in nursing education would require not only a HR policy for the faculty but peer trainers who would come and work with them for two to three years to build up practice and behavioural norms which are benchmarked with the best nursing schools. Centers of Excellence for Nursing and Allied Health Sciences would also be established in each State. Nursing cadre within public service requires both career progression opportunities as well as specialization in areas like public health nursing and clinical specialties. States which have adequate nursing institutions may explore gradually shifting to three year nurses even at the sub-center level to support the implementation of the comprehensive primary health care agenda.

5.11. There is a similar need to have a planned expansion of allied technical skills- radiographers, laboratory technicians, physiotherapists, pharmacists, audiologists, optometrists etc. Here there is much greater opportunity to make use of these needs to provide for local employment without compromising quality. The measures outlined for creating and retaining medical officers for public service are equally applicable but much easier to implement with respect to such skill sets. The policy would allow for multi-skilling with different skill sets so that when posted in more peripheral hospitals there is more efficient use of human resource.

5.12. The last seven years have seen a major inculcation of public health management skills of different backgrounds into the public health systems and they have performed well in improving programme effectiveness. The nation has also seen a major expansion of public health and public health management education from two or three courses in 2004 to over 30 such courses across the nation. However in the absence of a public health cadre this inculcation of public health skills remains an ad hoc arrangement, which is inadequate for building long term systems. There is a need to create a Public Health Management Cadre in all States which would be based on public health or related disciplines as an entry criteria, an appropriate career structure and recruitment policy to attract young and talented multi-disciplinary professionals committed to prevention and health promotion. Doctors with public health training would form a major part of this, but professionals coming in from diverse backgrounds such as sociology, economics, anthropology, nursing, hospital management, communications, etc. who have since undergone public health management training would also be considered. States could decide whether the medical doctors with public health management training and the non-medical public health managers from other disciplines are in the same cadre stream or in separate streams and whether they would be part of the formal directorates of health.

5.13. Certain specialized skills which are essential but not limited to public health- like entomology, or communication skills or management of call centers and even ambulance services, need to be nurtured as part of a team that is working on this in a continuous manner and in touch with their national and international peers. Such skills are better utilized by insourcing through partnership arrangements, than by creating posts, where it is not only difficult to find personnel- but even more difficult to retain their skills.

5.14. To ensure quality of Medical Education, a common entrance exam on the pattern of NEET for UG entrance at All India level needs to be enforced. A Licentiate Exam will be introduced for all medical graduates with a regular renewal at periodic intervals with CME credits accrued. All Indian students studying medicine abroad should undertake a screening test to obtain registration with the regulatory body and the same should be applicable for Indian colleges as well to ensure the quality of medical graduates. The policy recognizes the need to revise the under graduate and post graduate medical curriculum keeping in view the changing needs, technology and the newer emerging disease trends. Development of research centers would be a focus area.

5.15. The policy also envisages the use of telemedicine, online training, etc. to support continuing medical and nursing education and on the job support to providers, especially those working in professional isolation in rural areas. The strengthening of in-service training and training institutions remains one of the important challenges in strengthening health delivery- both in the public and in the private sector.

6. Financing of Health Care & Engaging the Private Sector:

6.1. To reduce out of pocket expenditures, catastrophic expenditures and eliminate impoverishment, tax based financing would remain the predominant source of financing for at least 70% of the population who are poor and vulnerable (Whose per capita monthly consumption expenditure is less than Rs. 1640 in Rural and Rs. 2500 in urban areas at current prices). Free primary care provision by the public sector supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and private sector would be the main financing strategy of assuring health care services. Current publicly financed National Health Insurance schemes would be aligned with this strategy and States would also be encouraged to do the same.

6.2. Raising resources for investing in health is one challenge (which was discussed in section 4.1.) Spending these resources equitably and efficiently is another. The latter challenge has two constituent parts- improving efficiency of public sector expenditure- and second is the various forms of engagement of private sector. Issues relating to governance straddle both public sector engagement and purchase from private sector and are discussed in the section on governance. Efficiency of public expenditure co-relate in a major way to the organization of service delivery, efficiency in procurement, the timely recruitment and deployment of the minimum human resources required for service provision and programme management, (including financial management), and ensuring minimum standards of workforce management. Central to improving efficiency in public health expenditure is therefore clear allocation of powers to specific officers for each of these functions and then holding them accountable for their performance against this work allocation. Inclusion of cost-benefit and cost effectiveness studies in programme design and evaluation would also contribute significantly to increasing efficiency of public expenditure.

6.3. Resource allocation/payment mechanisms to public health facilities could also contribute significantly to improving public sector efficiency. A robust National Health Accounts System needs to be operationalised to enable this. Fixed normative allocations that are independent of volume and pattern of services delivered and do not factor in quality of services rendered are inefficient. The policy therefore calls for major reforms in public financing even for public facilities where a significant part of the funds- especially most of those related to operational costs would be in the form of reimbursements for care provision and on a per capita basis for primary care. Fixed costs, which include items like infrastructure development and maintenance, the non-incentive cost of the human resources i.e salaries, much of administrative costs would however continue to flow on a budget basis. While making these changes considerations of equity would be factored in- with higher unit costs for more difficult and vulnerable areas or more supply side investment in infrastructure. These allocations would be made on the basis of differential financial ability, developmental needs and high priority districts to ensure horizontal equity through targeting specific population sub groups, geographical areas, health care services and gender related issues. A risk equilisation formula based on health care needs could be developed. A higher unit cost or some form of financial incentive payable on quarterly or annual basis could be given for facilities providing a measured and certified quality of care. Also considering targeted increase in allocation of public expenditure for curative care, high cost non-communicable diseases, chronic diseases would receive attention in addition to current focus on reproductive, maternal and child health programmes.

6.4. Private Sector engagement would largely take the form of purchasing care from private hospitals on a reimbursement basis- against cashless services, which have been provided by them. This payment would be made by the State health assurance agency directly or through an insurance agency. In case the hospital has charged any co-payment for whatsoever reason, this would be mentioned in their claims. Private hospitals would be empanelled for this purpose and would conform to quality norms and standard treatment guidelines. Purchase from private care would be both for secondary care hospitalization and for tertiary care.

6.5. Such extensive use of purchasing as a means of financing would require the creation of special institutional mechanisms at the National and State level – in the forms of trusts or registered societies. These agencies would lay down the standards, empanel the providers and process and make payment for the claims. They would be under the Ministry of Health & Family Welfare at center and in States, but with institutional autonomy. These agencies would also be charged with ensuring that purchasing is strategic- giving preference to care from public facilities where they are in a position to do so- and encouraging the creation of capacity in services and areas where they are more needed. The policy should aim to bring about complementarity in the role played by private and public institutions, and not encourage competition between them. This recognizes that there are certain public health functions, even in curative care for which a robust public health system must remain. Private sector has grown passively and continues to evolve with very little, if any, policy guidance and regulatory mechanism. As a result, they are not oriented to public health goals and are not available for many public health interventions. The aim is to enhance investment in the sector- not merely substitute public by private services.

6.6. Private sector engagement could also take other forms. One form is contracting out of primary care facilities to not-for-profit organizations with a known tradition of public services, in areas where Government has limitations in organizing services. Other is contracting out certain services where a team of specialized human resources and a domain specific organizational experience is required- like in the case of contracting out of ambulance services, or advanced diagnostics, or imaging services are required. This is often more needed and easier to implement in non-medical services in hospital settings- like in laundry, catering, housekeeping, security services etc. though in such outsourcing the care should be that efficiency is not at the cost of basic labour conditions.

6.7. Finally private sector engagement need not be necessarily be only through transfer of financial resources. Private providers, especially those working in rural and remote areas, or with under-serviced communities needs to be encouraged. Provision of appropriate skills to meet public health goals, opportunities for skill up-gradation to serve the community better, participation in disease notification and surveillance efforts, sharing and support through provision of certain high value services- like laboratory support for identification of drug resistant tuberculosis or other infections, supply of some restricted medicines needed for special situations, building flexibilities into standards needed for service provision in difficult contexts and even social recognition of their work- would greatly encourage such providers to do better.

7. Regulatory Framework :

7.1. The regulatory role of the Ministry of Health and Family Welfare includes regulation of clinical establishments, professional and technical education, food safety, medical technologies and medical products with reference to introduction, manufacture, quality assurance and sales, clinical trials and research, and implementation of other health related laws. Each of these areas needs urgent reforms. This will entail moving away from reactive, voluminous, poorly implemented regulatory regimes, cobbled up in an ad-hoc manner to a more effective, rational, transparent and consistent regime. The regulatory levers need to be wielded, far more consistently and effectively to meet the challenges associated with health care throughout the country, safeguarding the public interest as well as encouraging private initiative. Statutory autonomous bodies regulate Medical Education and Food Safety. The Ministry of Health & Family Welfare directly regulates issues such as drugs, cosmetics, medical devices, other professional education and clinical establishments. The prices and availability of drugs is regulated by the Department of Pharmaceuticals.

7.2. The Government of India had enacted the Clinical Establishments Act 2010, after a resolution to that effect was passed by four States and since framed its rules. However it has not been possible to make substantial progress in implementation with many States and the Indian Medical Association still not being on board. Only nine States and Union Territories have adopted the Act so far. A few States have enacted their own State laws. On one hand

some stakeholders consider the Act as intrusive, having ambiguity in many aspects including management of emergency stabilization and who would bear the costs, and place greater reliance on self-regulation with transparency as effective levers of regulation. On the other hand are growing concerns regarding costs, unfair practices like kickbacks, irrational and inessential care. Empanelment for insurance and public private partnerships was expected to provide better acceptance for regulation. However the experience is that insurance mechanisms are unable to act against the denial of services, supply driven irrational care, unethical practices, and charging patients for what should be cashless services. It is clear that without a regulatory structure in place, it would be difficult to ensure that public private partnerships or insurance based purchasing would deliver on either health outcomes or financial protection. Much greater emphasis must therefore go into making regulation work. Accreditation of clinical establishments and active promotion and adoption of standard treatment guidelines would be one starting point. Involvement of communities and their representatives in this process- especially in client support for publicly financed health insurance is another. Further discussion, dialogue and persuasion, and a better consensus to find a workable solution would be the way forward.

7.3. Regulatory Framework for Professional Education: The four professional councils for medical, nursing, dental and pharmacy council face many challenges in enforcing quality in professional education or professional ethics and good practice. The effectiveness of these councils in regulation of professional education or practice or ethics has been a matter of concern. With respect to the medical council there are also concerns about widespread conflict of interests in professional practice with respect to pharmaceuticals and diagnostic industries and within itself. The policy calls for a major reform and strengthening of these bodies and their accountability. It also emphasizes the Government's own accountability in professional education, in ensuring that the process leads to providing professionals who correspond to national needs. One has to build an approach to governance such that there is a balance between autonomy that professional councils require and the good governance, accountability, effectiveness and responsiveness to national priorities and needs.

7.4. Availability of safe, wholesome, and healthy foods is an important requirement for health. Microbial contamination of the food contributes to communicable disease burden and the rise in the Non-Communicable Diseases (NCDs) has links to the consumption of food high in fats, sugars and salts; residues of pesticides, food additives and contaminants. Though enacted in 2006, the Food Safety and Standards (FSS) Act, was operationalized only from late 2011. Implementation of the Act has been far from adequate due to insufficient infrastructure including manpower, budgetary constraints and also the framework of the Act, Regulations and the scope and the degree of enforcement. Since there were few standards in place, science based standard setting has been one of the challenges to its implementation. Harmonization with international standards is also required. The experience gained during implementation and various court judgments and views of stakeholders have all pointed to areas in the law that require amendment and this will be taken up. Simultaneously the Government will strengthen and put in place the necessary network of offices, laboratories, e-governance structures and human resources needed for the enforcement.

7.5. India is known as the manufacturing hub and pharmacy of the world with exports to over 200 nations. To ensure the safety, efficacy, and quality of drugs and medical devices and cosmetics that are manufactured, imported, or sold in the country, a dynamic regulatory regime would be put in place. This is essential to safeguard the public from sub-standards or unsafe drugs and medical devices and to ensure the Indian pharmaceutical industry's global and domestic reputation and leadership. Regulation systems have to be on par with international standards and aligned with WHO and other relevant international guidelines. Post market surveillance program for drugs, blood products and medical devices shall be strengthened to ensure high degree of reliability and to prevent adverse outcomes due to low quality and/or refurbished devices/health products. The Drugs and Cosmetics Act would be amended to incorporate chapters on medical devices-which is essential to unleash innovation and the entrepreneurial spirit for manufacture of medical device in India. Strengthening testing and surveillance capacities in Center and States, a national data bank of all regulatory actions, and e-governance tools would strengthen and speed up regulatory processes. Building capacities in line with international practices in our regulatory personnel and institutions would have the highest priority.

7.6. Clinical trials are essential for new product discovery and development. But these have great risks for the human volunteers. With the objective of ensuring the rights, safety and well-being of clinical trial participants, while facilitating such trials as are essential a separate chapter is being included in the Drugs and Cosmetic Act for its regulation, transparent and objective procedures shall be specified, and functioning of ethics and review committees strengthened. The Global Good Clinical Practice Guidelines, which specifies standards, roles and responsibilities of sponsors, investigators and participants would be adhered to. Further accreditation of sites, investigators and ethics committees and formula for payment of compensations shall be laid down and compliance with it monitored.

7.7. Vaccine safety and security requires development of a rational vaccine policy and effective regulation. It will encompass commissioning more research and development for manufacturing new vaccines, including against locally prevalent diseases; to build more manufacturing units to generate healthy competition; and to guard against the risks of batch failure; and to develop innovative financing and assured supply mechanisms with built in flexibility. In this context units such as the integrated vaccine complex at Chengalpattu would be set up and vaccine, anti-sera manufacturing units in the public sector upgraded with rise in their installed capacity. The challenge lies in taking timely steps to ensure sufficient availability of quality vaccines at affordable prices.

8. Medical Technologies:

8.1. India is the pharmacy of the developing world; but about half of its population does not have access to essential lifesaving medicines and the situation is worse when it comes to

medical devices and in-vitro diagnostics. India has a great tradition and capacity for innovation in most areas, but despite having the technical capacity to manufacture any drug, its role in new drug discovery and drug innovation including in bio-pharmaceuticals and biosimilar, even for its own health priorities is limited. India has a public health system with a stated commitment to providing universal access to free care, but out of pocket expenditures as a proportion on account of access to drugs and diagnostics is prohibitively high, one of the highest in the world. These are the paradoxes that the national health policy addresses.

8.2. Learning from experience and the consensus amongst expert groups that have examined the issue of progress to universal health care, making available good quality, free essential and generic drugs and diagnostics, at public health care facilities is the most effective way at this present juncture. The drugs and diagnostics available free would include all that is needed for comprehensive primary care including all chronic illnesses in the assured set of services. At the tertiary care level too, at least for in-patients and out-patients in geriatric and chronic care segments, most drugs and diagnostics should be free or subsidised with fair price selling mechanisms for most and some co-payments for the "well to do".

8.3. One of the challenges to ensuring access to free drugs and diagnostics though public services is the quality of public procurement and logistics. Public procurement and distribution when well done, as Tamilnadu and more recently Rajasthan has shown, reduces out of pocket expenditures on account of drugs and diagnostics considerably and increases access while limiting irrational prescription practices. Quality assurance of a very high order has also been demonstrated to be possible in such systems. To provide leadership in this area, the center is also setting up a central procurement agency which shall be charged with the procurement and distribution of vaccines and a number of key drugs, and which shall use a state of the art IT platform for inventory management and logistics, and ensure quality and timeliness of central drug supplies.

8.4. Pricing of drugs, medical devices and equipment: The regulatory environment around pricing of drugs, medical devices and equipment requires a balance between the patient's concern for affordability and the industry's concern for adequate returns on investment for growth and sustainability. Pricing for drugs shall continue to be regulated for an increasing range of essential drugs via notifications released by National Pharmaceutical Pricing Authority (NPPA) under National Essential List of Medicines (NELM). Both the list and the cap on prices shall be periodically revised. Timely revision of NELM along with appropriate price control mechanisms for generic drugs shall remain a key strategy for decreasing costs of care for all those patients seeking care in the private sector. An approach on the same lines but suiting specific requirements of the sectors would be considered for price control with regard to a list of essential diagnostics and equipment.

8.5. Availability of drugs and medical devices also requires corresponding industrial growth and trade policies. The Indian pharmaceutical industry has already established itself as a leader in the production of generic drugs- and indeed a large part of the drugs used not only in third world, but also in the developed world are Indian generics. National Health Policy requires the need to strengthen and sustain this not only as part of its economic growth strategy but also as

an imperative for the health security of the nation. Special focus on production of Active Pharmaceutical Ingredient (API) which is the back-bone of the generic formulations industry must be provided. In medical devices and equipment over 80% is imported. The goal with respect to medical devices shall be to encourage domestic production, in consonance with the "Make in India" national agenda, and such a development would ensure more affordable prices as well as increased access to life saving technologies.

8.6. Drug Innovation and New Drug Discovery are important aspects of access. One aspect of this is access to drugs for neglected diseases, diseases which are our public health priority- but are not viable commercial propositions to discover and bring to the market because only the poorest need them or the numbers requiring them are small. Another aspect of this is affordable access to the new drugs that would come into the market tomorrow- the next generation of drugs. In certain areas this link is obvious- the most well-known being anti-HIV drugs, drugs for multi-drug resistant tuberculosis, drugs against hepatitis, and against vector borne diseases, drugs for new and emerging infections, and anti-cancer drugs. However in many other non-communicable diseases also there is a potential for improving available therapies with better medicines and diagnostics. Government policy would be to both stimulate innovation and new drug discovery as required to meet health needs as well as ensure that new drugs discovered and brought into the market are affordable to those who need them most. The main constraints to innovation are : funding, the inadequate structure and functioning of regulatory institutional mechanisms, barriers to clinical and animal research and problems of sustaining an innovation ecosystem even if one is developed. Public procurement policies and public investment in priority research areas must also be aligned to drug discovery in areas which are our priority. Similar policies are required for discovering more affordable, more frugal and appropriate point of care diagnostics and robust medical equipment for use in our rural and remote areas.

8.7. There is a need to align our policies in trade, commerce, industry and science and technology and external affairs policies so that they are in consonance with the public health goals of access to new drugs at affordable rates and sustaining our advantage in generics. For medical devices and equipment trade barriers such as inverted duty structures would be corrected for facilitating cross border trade and indigenous development. Establishing sufficient labeling and packaging requirements on part of industry and effective port - clearance mechanisms for required medical products on part of authority shall be an immediate priority. Such alignment requires that Ministry of Health and Family Welfare takes a more pro-active and informed role in this area and institutional mechanisms of coordination are established.

8.8. A public sector capacity in manufacture of certain essential drugs and vaccines is also essential to retain in the larger long term understanding of health security and to address some needs which are not attractive commercial propositions. Institutions like CRI, Kasauli, the BCG Institute, Chennai, the Institute of Serology, Kolkata, the National Biological Institute, Noida, and Indian Pharmacopeia Commission play vital roles in production of biologicals and vaccines and in quality assurance and testing mechanisms. Most of these institutions perform functions that none in the private sector can or would take up. Though for the developing world, these are unique achievements, these institutions need more investment and appropriate

HR policies and governance initiatives to enable them to become comparable with their benchmarks in the developed world.

8.9. One special problem area is anti-microbial resistance and the failure of the pharmaceutical industry to keep pace with the increased resistance shown by organisms, by developing new antibiotics. Microbial resistance is being seen even among the most common organisms, largely due to antibiotic misuse by physicians in the country. This calls for a rapid standardization of guidelines, regarding antibiotic use, limiting the use of antibiotics as Over-the -Counter medication (but permitting certain antibiotics to front line paramedics), banning or restricting the use of antibiotics as growth promoters in animal livestock and hospital infection control guidelines a mandatory part of all hospital quality guidelines. Pharmaco-vigilance regarding antibiotic usage in the hospital and community is a must, in order to enforce change in existing practices.

8.10. One important capacity with respect to introduction of new technologies and their uptake into public health programmes is health technology assessment. This new multi-disciplinary domain, modeled on the work of the National Institute of Clinical Excellence in the UK, is required to ensure that technology choice is participatory and is guided by considerations of scientific evidence, safety, cost effectiveness considerations and social values. This approach is extended also to technology choice involved in the development of standard treatment guidelines and in public health programmes. The National Health Policy commits to the development of capacity in this areas and the use of this approach for making technology choices that impact on public health.

9. ICT for Health & Health Information Needs:

9.1 Health Information is acknowledged as one of the key dimensions of the health systems. Use of ICT has the potential to reduce frequency of hospital visits & management of chronic diseases. Similarly population level health metrics could guide the development of health policy. E-Health could also facilitate medical consultation with specialists, capacity building of health care workers/ professionals, and improve program monitoring and supervision, and delivery of emergency care. However much of this potential in public health has largely remained under-realized due to a number of policy and operational constraints. This policy will focus on improved deployment of ICT for improving the outcome of the Indian healthcare system.

9.2 An integrated health information system which serves the needs of all stake-holders and improves efficiency, transparency, citizen experience, and delivery of better health outcomes in terms of access, quality, affordability and lowering of disease burden and facilitates monitoring of health entitlements to citizens is the goal. This integrated health information architecture will stand on five pillars- first, the systems for increasing public access to information of community health and the individual's access to her/his own health records, secondly the tools required for public health providers- at the periphery and at mid-level management, thirdly systems for support to providers and hospital managers for a measurable improvement in

quality and efficiency of care, fourth, an IT enabled supply chain management systems and finally, systems for better monitoring, planning and governance.

9.3 A caution that the policy takes note of is that such digitization of all health events and processes should be firmly embedded in a modern understanding of civil liberties and therefore safeguard patient privacy and autonomy and ownership over information that concerns them. Such aspects pertaining to data privacy & security, etc. will be addressed through appropriate regulatory and statutory framework. National e-Health Authority (NeHA) will be set up to provide leadership in implementation of the integrated health information system, to promote adoption of standards and facilitate exchange of patients health records across facilities in a secure way.

9.4 The transformation of primary care in the larger understanding of district health systems is linked to many steps. One step is every individual and family is issued a health card which entitles them to a range of preventive and promotive services from the primary care team. Another is digitizing the functions of recording service delivery, enabling follow up, reporting on services delivered and analytics of local public health situation, while measurably reducing the time the peripheral provider spends on register and data work. The third step is a feature which enables continuity of care with higher levels. And finally building district and sub-district capacity for management including appropriate payment gateways to facilities and to individual beneficiaries as required. Functions like appointment scheduling, effective grievance redressal, case record maintenance which have never happened earlier at primary care levels can now be enabled by ICT.

9.5 A robust growth of ICT to meet various needs of health care system requires a national health information architecture where States and facilities can develop systems to suit their needs and priorities as long as they are consistent with Electronic Health Record Standards and Data and Metadata Standards and inter-operability guidelines as laid down and enforced by the National eHealth Authority (NeHA).

9.6 The integrated health information system will be based on key principles and strategies like (a) adoption of National Electronic Health Record Standards (announced by the Ministry in 2013) and Metadata and Data Standards; (b) federated architecture to roll-out and link systems at State level and national level; (c) progressive use of "Aadhaar" (Unique ID) for identification (in case UID is not available, then other ID would be created as per the standards notified by the Ministry) and issue of a unique Health Card to every citizen; (d) creation of health information exchange platform and national health information network; (e) use of existing/planned national & state level IT infrastructures such as the National Optical Fiber Network, Meghraj (cloud), (f) smartphones/tablets for capturing real-time data; and (h) setting-up of dedicated governance structures.

9.7 The National Health Policy also sees tremendous potential for the application of Tele-medicine systems and M-Health. These have applications in ensuring continuity of care across

levels of care and for reaching out to rural and remote areas. It also has great scope along with other communication channels like the internet for creation of online clinical and non-clinical learning materials that can transform systems of training and distance education for both in-service needs and for the private sector partners. All these growing needs will require the creation of a new discipline and the building of capacity within public systems for health informatics - which itself emerges from the combination of public health, information sciences, information technology and understanding of social contexts and institutions in the application of technology. The policy is, on scaling of various initiatives in the area of tele-consultation which will entail linking tertiary care institutions (medical colleges) to District and Sub-district hospitals which provide secondary care facilities, for the purpose of specialist consultations.

9.8 ICT would similarly be used for generation and sharing of information about AYUSH services and AYUSH practitioners, the traditional community level healthcare providers, and household level preventive, promotive and curative practices. This will strengthen the management and quality of AYUSH services in the public system and also provide an outreach component for prevention and promotion of health.

9.9 Demographic and health surveys will continue to play a major role in policy formulation- partly as a validation of data from routine systems, partly because it would take time to establish routine reporting into the system by private health care facilities and partly because some types of information are better captured through surveys. The scope of surveys would also need to be extended to capture information regarding costs of care and financial protection provided by different forms of financing and provisioning. Such information is vital for measuring progress towards the national health policy objectives and improving upon the mix of strategies used in different contexts. In addition to the NFHS surveys, a sample of districts done every year for morbidity and cost of care analyses modeled on the 71st round of the NSSO surveys would build on the baseline provided by the 71st round with a moving average and a real-time situation analysis on cost of care.

9.10 One other important source of information is vital events reporting, especially cause of death reporting. Today we have reliable medically certified causes for only about 28% of deaths. Careful deployment of ICT tools, improvement of work processes, and innovative capacity building has to come together to make this fundamental tool of decentralized and disaggregated burden of disease measure reliable enough for health planning and health outcome measurements at all levels.

10. Knowledge for Health:

10.1 The National Health Policy recognizes the key role that health research plays in the development of a nation's health. Health research internationally incorporates two approaches (i) research on country specific health problems necessary to formulate sound policies and plans for field action; and (ii) contributions to global health research aimed at developing new

knowledge and technologies to solve health problems of general significance, which are also relevant to the population of the country. In a knowledge based sector like health, where advances happen daily it is important to invest at least 5 % of all health expenditure on health research. The establishment of a Department of Health Research (DHR) in the Ministry of Health & Family Welfare was in recognition of the key role that health research would play for the nation.

10.2 The health policy envisages strengthening the 32 publicly funded health research institutes under the Department of Health Research, the 15 apex public health institutions under the Department of Health & Family Welfare, and research activity in the over 143 Government and over 150 private medical colleges in the nation. The fact is that in 2007, 96% of the research publications in India emanated from as little as 9 medical colleges that reflect how little most of them are geared to the challenges of health research. Further much of this published research is not on priority health concerns and the translation of key research findings into policy, which could improve the health of the people, is very limited and needs to be enhanced. The health policy also notes the need for partnerships with the growing presence in research of universities, and privately owned research institutes and research laboratories.

10.3 Health research in India needs to advance on three fronts. One front is to generate the evidence base required for decision making in Health Systems and Services. This requires establishing linkages between health research and national health programs to identify key operational issues and to ensure uptake of research findings into decision making in public health. The second front is in medical product innovation and discovery as required for our public health needs and to sustain a vibrant Indian pharmaceutical and medical device industry on par with global standards. The third front is to encourage the development of fundamental research in all areas relevant to Health, such as Physiology, Biochemistry, Pharmacology, Microbiology, Pathology, Molecular Sciences and Cell Sciences, to ensure that a national critical mass of scientists who can contribute the benefits of modern technology to health research is developed. Each of these three fronts of advance needs their own distinct strategies, and institutional and governance mechanisms.

10.4 For health systems and operational research, at least half of it should come from research that is commissioned by programme managers in charge of implementing programmes as formative research, problem solving or evaluation. This research is by nature very inter-disciplinary with the social science and uptake of research findings requires engagement with the health systems. The human resources in this research need to have interaction and even mobility between implementers, researchers and administrators. Coordinating committees led by implementing agencies would be essential.

10.5 For drug and devices discovery and innovation, Steering Committees that bring together the Department of Pharmaceuticals, the Department of Biotechnology, the regulatory bodies, the Department of Industrial Policy and Promotion, the Departments of Science and Technology with the Health Ministry are important. A common sector innovation council for the Health Ministry should be strengthened and made functional to play this role with its leadership shared between the Department of Health & Family Welfare and Department of

Health Research. Here the challenges are not only in discovery, but in managing intellectual property rights, testing of products especially clinical trials, health technology assessment, and managing the transition from laboratory to the market. Here innovative strategies of public financing and careful leveraging of public procurement can help generate the sort of innovations that are required for Indian public health priorities.

10.6 Strengthening publicly financed research institutions requires first and foremost to be inspired by the founding vision of many of these - at around the time when the nation woke to independence, institution building was seen as the core of nation building. To re-claim such a vision some of the research institutions, which lag behind, would be benchmarked with the best institutions in their domain nationally and internationally and supported by financing and partnerships to achieve such levels of performance. It would also require appropriate HT policies, a considerable degree of autonomy without compromising on responsiveness to policy priorities and systems of constantly upgrading the knowledge base, capacity and skills. A good permeability across institutional boundaries through networking and collaborations with multiple partners is also essential.

10.7 For making full use of all research capacity in the nation, grant in aid mechanisms which provide extramural funding to research efforts would be scaled up so that potentially every research institutions in the nation is engaged- even if it requires considerable efforts in capacity building in many of these. Grant-in-aid mechanisms would also enable a large and active number of health NGOs to participate in the generation of knowledge and it would be able to engage and get desirable outputs from private institutions.

10.8 One area of growing concern in health research is in the ethical dimensions, especially with reference to clinical trials and conflict of interest situations. The clinical trials registry established by ICMR and DST is a good start but would need to be implemented well. However if India has to get into drug and device discovery , it would need to ensure that while there is no relaxation of ethics and safeguards in trials, delays in approvals and a blanket fear of any trials would be most unhelpful. Clear and transparent guidelines, with independent monitoring mechanisms are the way forward.

10.9 In order to develop a strong base of data and information, academia, public policymakers, private sector and industry need to come together in the form of information sharing partnerships and research collaborations.

10.10 There is also the need to develop information data-bases that researchers can share on a wide variety of areas. This includes ensuring that all unit data of major publicly funded surveys related to health are available in the net in a suitable format- like is done with NFHS and NSSO data. It includes disease registries, data from National Anti-Microbial Resistance Surveillance and other surveillance programmes, microbial, viral bio-banks, and so on.

10.11 International aid agencies were once important sources of financing of public health programmes, but today their entire contribution is less than 1% of public health expenditure. In recent years their role therefore has been largely been focused on technical assistance and

capacity building where they are making substantial contributions, especially in states like Uttar Pradesh, Bihar, Jharkhand where much greater investment is needed to build up organizational capacity. International Partnerships will continue to play an important in developing national capacity. This could be done though technical assistance and through provision of access to the latest in knowledge and skills from across all nations, by sharing best practices, and by setting standards and benchmarks.

10.12 India needs to also develop its own new policy towards international health and health diplomacy. Such a policy should leverage our strengths in frugal innovation in the area of pharmaceuticals, medical devices, health care delivery and information technology- to assist all nations in improved access to essential health commodities at much lower costs. It should learn from other nations and bring in their strengths and best practices with respect to generating new knowledge and technologies needed to address health priorities of the developing world, for improving quality of care, for better regulation of private sector and as advocacy for increasing public investment in health. It should leverage international cooperation, especially involving nations of the Global South, to build our own institutional capacity in green-field innovation, and for knowledge and skill generation. It could build alliances with nations in similar situations, like the BRICS nations to develop terms of trade and intellectual property rights regimes that are supportive of national economic growth and health policies. And finally it needs to protect Indian population from health risks due to new pandemics and maintain credibility of nation in terms of countering the negative stereotyping of India as a source of health risks for the world.

10.13 In the context of India being an emerging developed nation, Indian policy must move towards repositioning India from being a recipient of aid and technical assistance to an equal partner in international technical cooperation and the pace-setter in setting international norms and standards that prioritize people's health as the central consideration. In partnership with other BRIC nations, it must build up multilateral institutions like WHO, strengthening their democratic and representative structure, and reducing conflicts of interests that flow from their financing.

11 Governance:

11.1 **Federal Structure- Role of State and Role of Center**: One of the most important strengths and at the same time challenges of governance in health is the distribution of responsibility and accountability between the Center and the States. Though health is a State subject, the Center has accountability to Parliament for central funding – which is about 36% of all public health expenditure and in some states over 50%. Further it has its obligations under a number of international conventions and treaties that is a party to. Further, disease control and family planning are in the Concurrent list and these could be defined very widely. Finally though State ownership has been used by some states to become domain leaders and march ahead setting the example for others, the Center has a responsibility to correct uneven development and provide more resources where vulnerability is more. The way forward is for equity sensitive resource allocation, strengthening institutional mechanisms for consultative

decision-making and coordinated implementation, better management of fiduciary risks, and provision of capacity building and technical assistance to States.

11.2 The Institutional Framework: The main challenge at both Center and the States is strengthening the synergistic functioning of the directorate as the technical leadership and the civil services as the administrative leadership and coordinating both of these with the increasing number of State owned or fully state financed corporations, and registered societies and autonomous or semi-autonomous institutions. Directorates need to be strengthened by HR policies, central to which is that, those from a public health management cadre must hold senior positions in public health. In all directorates, senior personnel need to have been groomed into leadership roles by experience of policy and administrative work, before they come to occupy key positions. Civil servants too should have clear induction and orientation programmes in the domain as also general understanding of institutional processes that they need to put in place so that the directorates and various state owned institutions in a knowledge based sector are able to perform optimally.

11.3 State Owned, Guided and Financed Institutions: Examples of State owned, financed and guided institutions include State health societies and programme management units, medical services corporation that look after procurement and logistics, in some states infrastructure and transport management bodies, State institutes of health and family welfare and state health systems resource centers, state agencies for management of emergency response services, and state agencies or trusts for managing purchasing of care from private sector and a number of large tertiary care centres which have autonomous status. These are becoming essential either because they require very specialized skill sets that general human resource policies cannot bring together and sustain, and/or because a financial autonomy is essential for carrying out a set of complex operations in an accountable and time bound manner. A systematic study of best practices in such institutions across States, as was done for the apex public health institutions can inform us of the most appropriate institutional design and mechanisms for such institutions. General guidelines in the form of minimum governance standards for such state owned or state financed corporations and trusts and societies within which one can have flexibility to frame rules and incur expenditure without referral for approvals at each step would be put in place for ensuring optimal functioning. These would include in the least, clear terms of reference for the organization, a board where both the chairperson and members have their accountability as much as the CEO as his, and clear statement of measures of performance and performance reviews.

11.4 Role of Panchayati Raj Institutions: All elected local bodies- rural and urban would be enabled to provide leadership and participate in the functioning of district and sub-district institutions. Most important of these are the Rogi Kalyan Samitis(RKS) and the Village Health Sanitation and Nutrition Committee (VHSNC). In particular they would be in charge of, and could be financed for implementing a number of preventive and promotive health actions that are to be implemented at the level of the community.

11.5 Addressing Fiduciary Risks: One of the key problems of the Central government's financing of the States relates to fiduciary risks. This is only one part of improving accountability, but mis-management of funds is what brings the programme the most dis-repute. While routine systems of audit would continue to be strengthened- the center as funding agency can insist on some key institutional mechanisms that reduce this risk and monitor whether these are in place, at least with respect to its funds. The four most important processes where the State should be asked to create rules that conform to good governance standards as laid out by the Center and then comply with them would be a) procurement and logistics for drugs and devices b) transfers and postings c) appointment of a regular district chief health and medical officer or equivalent by due process – since most funds are given to or spent by district health society d) selection of partners and timely payments to them in public private partnerships and similarly grant-in-aid mechanisms for NGOs.

11.6 Improving Accountability: The policy would be to increase horizontal accountability, by providing a greater role and participation of local bodies and encouraging community monitoring and better vertical accountability through better monitoring, grievance redressal systems and programme evaluation.

11.7 Involving Communities: Communities have a right and duty to participate in their health care and health programmes would be designed to provide the role to do so. The Village Health, Sanitation and Nutrition Committee is one major institutional mechanism for ensuring this and under the leadership of the gram panchayat, it must be strengthened with capacity building and support to pay this role. Involvement of community based organizations and representatives in decision-making in hospital development societies and district consultative bodies would also be undertaken. A Peoples Health Assembly at the district level, held once in three years to discuss issues of preventive and promotive health and progress made on health plans, and to develop health and health care as a social movement would also be encouraged. In the process of engagement with communities and empowering them to contribute, non-governmental organizations with a tradition of working for community health have an important contribution to make.

11.8 Professionalizing Management, Incentivizing Performance: Improved governance must also be reflected in better leadership – which is as much a matter of motivation as of competence. Competence requires formal training for the requisite management and leadership skills. It also requires bringing in at the leadership level, on a regular basis or through consultancies and partnerships, the mix of professional knowledge and skills that are needed. It also needs to build up an environment where good performance is incentivized. Unless the system is able to demonstrate that it is providing more health for the money being allocated to it, it would be unable to sustain its case for more money for the health sector.

12 Legal Framework for Health Care and the Right to Health:

12.1 There are a large number of laws that govern health policy and implementation in a number of areas- and health policy has not only to be compliant with these laws but also contribute to strengthening implementation. There are unfortunately a number of laws that have over time developed inadequacies due to changed contexts and a number of newly emerged services and technologies where laws are needed. Laws under review include the Mental Health Bill, the Medical Termination of Pregnancy Act, the bill regulating surrogate pregnancy and assisted reproductive technologies, Food Safety Act, Drugs and Cosmetics Act and the Clinical Establishments Act. The process of aligning many of these laws to meet our needs and changed circumstances and understanding becomes one of the urgent tasks in the coming years.

12.2 One of the fundamental policy questions of our times is whether to pass a health rights bill making health a fundamental right- in the way that was done for education. Many industrialized nations have laws that do so. Many of the developing nations that have made significant progress towards universal health coverage like Brazil and Thailand have done so and the presence of such a law was a major contributory factor. A number of international covenants to which we are joint signatories give us such a mandate- and this could be used to make a national law. Courts have also rulings that in effect see health care as a fundamental right- and a constitutional obligation flowing out of the right to life. There has been a ten-year long discussion over this without a final resolution. The policy question is whether we have reached the level of economic and health systems development as to make this a justiciable right- implying that its denial is an offense. And whether when health care is a State subject, it is desirable or useful to make a central law? And whether such a law should mainly focus on the enforcement of public health standards on water, sanitation, food safety, air pollution etc, or on health rights- access to health care and quality of health care – i.e on what the state enforces on citizens or on what the citizen demands of the state? Or does the health policy take the position that given the existence of a large number of laws including the clinical establishments Act, and the track record on adopting them and implementing them, a Central law is neither essential nor feasible. To break the deadlock and this vacillation and move forwards with determination- the draft national health policy proposes the following formulation- "the Center shall enact, after due discussion and on the request of three or more States (using the same legal clause as used for the Clinical Establishments Bill) a National Health Rights Act, which will ensure health as a fundamental right, whose denial will be justiciable. States would voluntarily opt to adopt this by a resolution of their Legislative Assembly. States which have achieved a per capita public health expenditure rate of over Rs 3800 per capita (at current prices) should be in a position to deliver on this- and though many States are some distance away- there are states which are approaching or have even reached this target." Such a policy formulation/resolution we feel would be the right signal to give a push for more public health expenditure as well as for the recognition of health as a basic human right, and its realization as goal that the nation must set itself.

13. Concluding Note: Implementation Framework and the Way Forward.

A Policy is only as good as its implementation. Past policies, have faced innumerable constraints in implementation. The National Health Policy therefore envisages that an implementation framework be put in place to deliver on these policy commitments. Such an implementation framework would specify approved financial allocations and linked to this measurable numerical output targets and time schedules. The implementation framework would also reflect learning from past experience and identify administrative reforms required for more appropriate rules and regulations to governs public financing, institutional design, human resource policies for this sector, re-structuring of institutions required for better governance and management at national, state and district levels, measures for improving institutional capacity to deliver, and most important the division of powers, functions and accountability between Center and States with respect to health sector performance

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