A REPORT OF

HIGH LEVEL GROUP ON HEALTH SECTOR

2019

Submitted to

Fifteenth Finance Commission of India

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*"Attainment of highest possible Level of **Health** and **Well being** for all, through a **preventive** and **promotive** health care and **universal access** to good quality health services without anyone having to face financial hardship as a consequence"*

National Health Policy 2017

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13. Dr. Anoop Singh, Member
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Officers of XV-Finance Commission

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18. Dr. Ravi Kota, Joint Secretary
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20. Ms. Maushumi Chakravarty, Media Adviser
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22. Shri. Jasvinder Singh, Director
23. Ms. Sweta Satya, Joint Director
24. Other officers of XV-FC

TABLE OF CONTENTS

INDEX OF TABLES

INDEX OF FIGURES

EXECUTIVE SUMMARY

The Fifteenth Finance Commission had constituted a High-Level Group on Health consisting of eminent experts from across the country in health sector. The role and functions of the High Level Group (HLG) on Health Sector was to evaluate the existing regulatory framework in the health sector for enabling a balanced yet faster expansion of the health sector; suggest ways to optimize the use of existing financial resources and to incentivize the state governments' effort on fulfilment of well-defined health parameters in India; and to holistically examine best international practices for the health sector and seek to benchmark our frameworks to these practices for optimizing benefits keeping in mind our local issues.

HLG including representatives from Niti Ayog, Board of Governor, MCI and Ministry of Health & Family Welfare met on various occasions and deliberated at length over the various issues, challenges faced by the healthcare delivery system in India and suggested remedial measures for the same. Proposals were also invited from Ministry of AYUSH and National Health Authority in light of the terms of reference of HLG on Health.

HLG recommended that public health and hospitals may be brought under the concurrent list of seventh schedule of Constitution of India from the existing assignment under state list. It is also recommended that right to health may be declared as fundamental right on 75th Independence Day of India in year 2021. HLG recommended various measures for human resource for health viz. need to restructure the MBBS curriculum to make it competency based, introducing certain degree of specialization in MBBS curriculum and MCI/NMC to develop small courses on wellness clinic, basic surgical procedures, anaesthesia, obstetrics and gynaecology, eye, ENT etc. for MBBS doctors and encourage AYUSH as an elective subject for medicine undergraduates for increasing awareness towards AYUSH.

HLG emphasised that undergraduate medical teaching should only be imparted in medical college with residential campuses with amenities for

student development. It is also clarified that same is not required for post graduate medical teaching, which can be imparted in public and private sector hospitals not having attached medical college and residential campus. Private medical colleges and hospitals having DNB programme may be given tax incentives under Section 80JJA of income tax of India or any other tax incentives as deemed appropriate, which should be linked to the outcome.

There is need to separate medical training for those who will provide healthcare services from those who will render medical teaching. It is suggested that service providers can also assume the role of a medical teacher but in a cadre separate from medical college teachers. Those who desire to acquire academic designations have to demonstrate required research experience and publications as mandated by the Medical Council of India. The enabling provisions for the same may be explored by MCI/ National Medical Commission. Faculty in medical colleges should not be allowed to do private practice as it compromises teaching and research. They should be compensated adequately in commensuration with their ability to earn rationalised to the cost of living. The issues like optimum compensation, working conditions, promotional avenues, transfer policies etc. have to be clearly laid out. Finance Commission of India is requested to constitute a high level committee to address these issues.

It is suggested that there should be one common exit exam for the undergraduate medical students qualifying from both public and private sector medical colleges. The performance of the UG students from the medical colleges in common exit exam will determine affiliation and number of seats for undergraduate medical teaching in the respective medical colleges in the coming years, thereby improving the quality of medical education. On the similar lines specialty boards may be constituted under the Medical Council of India/ National Medical Commission, which will have representation of eminent professionals from the concerned field and various members from the well-established and recognized scientific societies.

Gaps in human resource for health can be filled with availability of multilayered and multi-skilled human resources in allied healthcare manpower, nursing, and employed community workers. MBBS doctors and specialists also requires augmentation. By Year 2025, government should be able to strengthen medical infrastructure so that each medicine undergraduate should have the option of pursuing post graduate medical education. It is strongly recommended that regulatory bodies viz. MCI/NMC/DNB should restore the post graduate diplomas in specific areas such as paediatrics, obstetrics and gynaecology, anaesthesia, orthopaedics, family medicine, ophthalmology etc. and majority of the seat share should go to in-service candidates. Family medicine physicians are required in India, hence, MOHFW may be requested to create suitable ecosystem for family medicine specialists. Finance Commission is requested to give impetus to the infrastructure strengthening so as to reach the intended objective. In addition, the government should enhance the involvement of private practitioner in public sector hospitals for healthcare delivery.

The asymmetric distribution of medical colleges needs to be corrected as most of the medical colleges are situated in western and southern part of India. All the public health facilities including district hospitals, private sector facilities and corporate hospitals should be utilised for starting specialists DNB courses which will not only enhance the service provisioning but will also ensure the availability of trained human resource. It is suggested that allied healthcare professionals can be accredited with skill India. The concept of nurse practitioner, three years trained community health assistant and physician assistants should be promoted, their training be standardized and utilised accordingly.

Finance Commission can strengthen National Health Mission with additional allocation for creating short service commission where doctors can be employed for different states to correct the asymmetry in distribution of human resource. There is need for revamping and reviewing the functioning of Nursing Council through Nursing Council Act. It is recommended that nursing college teachers should be involved in hospital

services rather than being limited to nursing colleges. There is need for larger role to be played by nursing professionals and the concept of nurse practitioner, physician assistant, nurse anaesthetist etc. should be introduced for better utilization of Nursing Professionals.

There is a need for larger allocation of funds for the health sector in general to meet the ambitious targets of public health expenditure on Health and raise it to 2.5% of GDP, as envisaged in the National Health Policy 2017. Both central and state government should be nudged to substantially increase the spending on healthcare. A performance-based framework for incentivising various state governments with additional allocation of resources by Finance Commission of India is recommended which consists of four indicators namely state health budget as a proportion of total state budget (40%), health system performance (30%), public health system and management cadre (20%) and stunting decline rate (10%). HLG unanimously agreed upon the larger investment in primary healthcare almost to the tune of two third of the total budgetary allocation. Various state governments should earmark at least 2% of their health budget for health research activities.

Primary health care should be the number one fundamental commitment of each and every state. MoHFW is carrying out strengthening of public healthcare delivery system by making community health centres, primary health centres, sub-centres, wellness centres as per the 2011 population figures, which will entail an expenditure of two lakh nineteen thousand crores. Data availability on routine medical activities like collection of blood, transfusion, surgeries conducted, dialysis done on daily basis etc., across the community health care centres of the states should be ensured. In coming five years, 3000 to 5000 small hospitals (200 beds each) may be created close to the community, which necessitates the participation of private sector in achieving the same. Government can work out the various modalities of incentivising the investment by private sector so as to attract the equity required to develop this infrastructure in tier II and tier III cities.

Development of infrastructure under AYUSH would entail additional financial burden on States/ UTs, the finance commission award may provide corresponding state share of Rs. 2192.69 crores out of total financial implication of Rs. 5960.98 crores to implement this scheme based exclusively on AYUSH Wellness model.

National Health Authority under the ambit of Ayushman Bharat Scheme may devise a comprehensive health insurance scheme for people having formal employment to overcome the financial challenge faced in availing health services. National Health Authority can also act as the strategic purchaser and collective negotiator for negotiating rates of medical supplies and medical devices, which can bring down the cost of healthcare delivery.

TERMS OF REFERENCE OF HIGH-LEVEL COMMITTEE ON HEALTH

The Fifteenth Finance Commission had constituted a high-level group consisting of eminent experts from across the country in health sector, with Prof. Randeep Guleria, Director, AIIMS, New Delhi being the convenor.

The role and functions of the High Level Group on Health Sector were:

1. To evaluate the existing regulatory framework in the health sector and examine its strength and weaknesses for enabling a balanced yet faster expansion of the health sector keeping in view India's demographic profile;

2. To suggest ways and means to optimize the use of existing financial resources and to incentivize the state governments' effort on fulfillment of well-defined health parameters in India; and

3. To holistically examine best international practices for the health sector and seek to benchmark our frameworks to these practices for optimizing benefits keeping in mind our local issues.

DELIBERATIONS & DISCUSSIONS

The High-Level Group on Health met on various occasions (minutes of the meetings annexed) and had intense deliberation at length over the various issues, challenges faced by the healthcare delivery system in India and suggested the remedial measures for the same.

During the meetings, High Level Group on Health had also invited members from Niti Ayog; Board of Governors, Medical Council of India and Ministry of Health Family Welfare, Government of India to share their expertise on various issues being discussed as per the terms of reference of High Level Group on Health.

The fifteenth Finance Commission also had detailed interaction with the Ministry of Health and Family Welfare, Government of India and Department of Health Research, Indian Council of Medical Research on various issues pertaining to the respective institutions and healthcare delivery system in India. Ministry of AYUSH and National Health Authority also submitted their proposals in reference to the terms of reference of the High-Level Group on Health Sector

EXISTING HEALTHCARE SCENARIO OF INDIA

REGULATORY FRAMEWORK

For improving regulatory environment in medical sector, the Medical Council of India (MCI), which was the regulatory body for medical education in the country, was superseded by a Board of Governors. The Board of Governors comprise of eminent doctors from premier healthcare Institutions of the country. The Board of Governors is focusing on reforms to enhance the ease of setting up new medical colleges in order to increase the number of seats. The National Medical Commission Bill to replace MCI has been passed by the Parliament.

To regulate and maintain standards of 15 broad categories of allied health professionals, covering 53 types of professionals, Allied and Healthcare Professionals Bill, 2018 was approved by cabinet in November 2018, and has been introduced in Rajya Sabha on 31st December 2018. It will lead to standardization of curriculum and various other aspects related to allied health sector. It will lead to creation of 1.5 million jobs nationally and internationally. MCI Board of Governor order has been re-promulgated.

PUBLIC HEALTH EXPENDITURE:

To meet the ambitious targets of improvement in health services, there is a need for larger allocation of funds for the health sector in general. Not only is this a necessity because good health as a key enabler to a happy life is a goal in itself, but this is an imperative for sustained economic development. Equally important is to have more health for the money, for which States need to be nudged for improved performance on key indicators and parameters. Public expenditure on health essentially comprises of union health expenditure and health expenditure by States/UTs (contribution of local bodies is negligible). Among various countries India is among the low performing when it comes to public health expenditure. (Figure 1)

Figure 1 ***Health Expenditure in Total Government Expenditure (%) (2014)*** *(Source –MOHFW)*

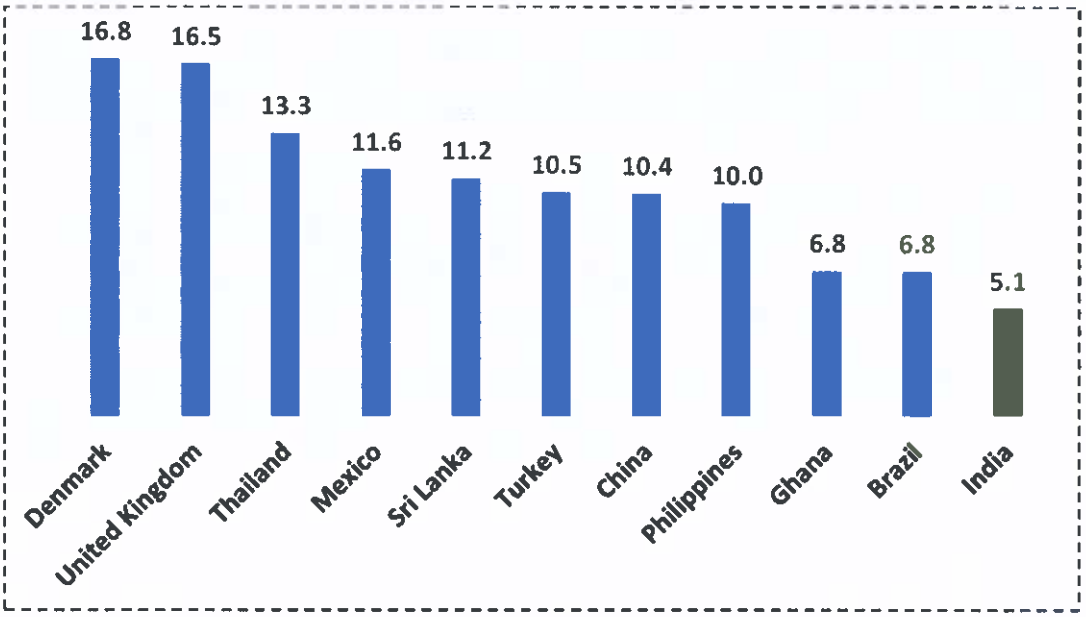
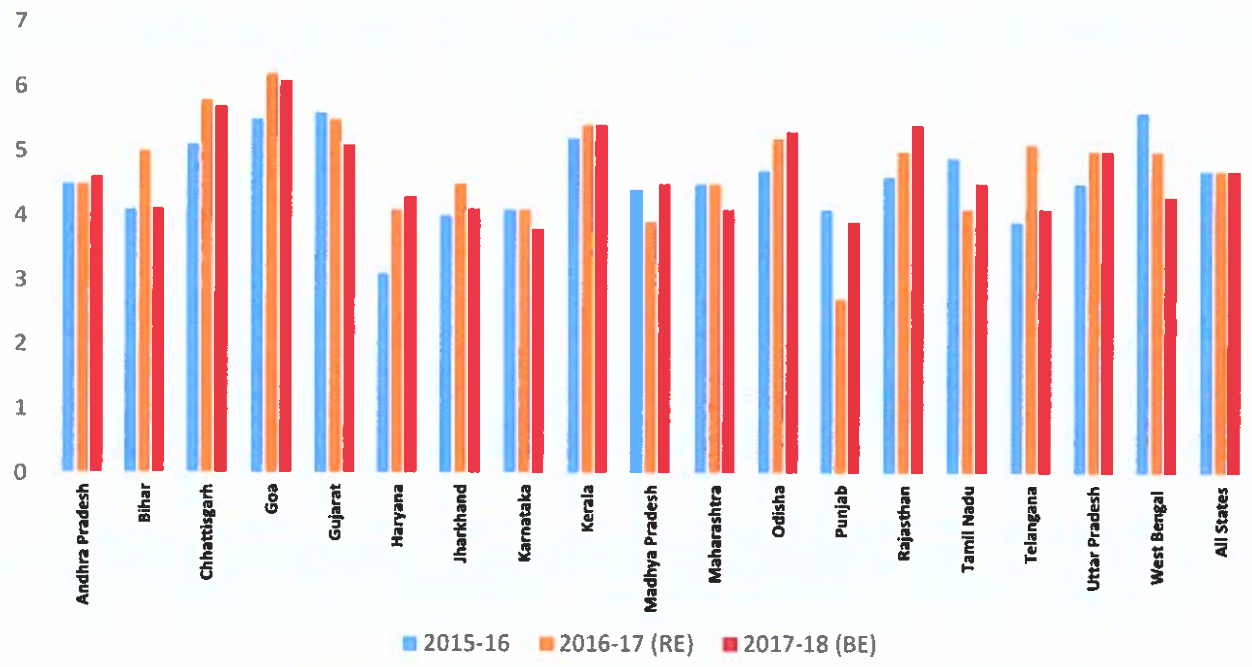


Table 1 ***Healthcare expenditure made by Union and State Government (In Rs Crores)*** *(Source –Niti Ayog Presentation)*

	2018-19 BE	2018-19 RE	2019-20 BE	
Union budget Incl AYUSH, DHR, and health in other ministries	66226.37	68738	77137.88	1,900,000
State budgets (with assumptions)	170390	177205.6	177205.6*	2,15,000
Total (Union + State)	**236616.37**	**245943.6**	**254343.48**	**3,35,000**
GDP	18841000	18841000	20197552	
Health Exp as % of GDP	**1.25**	**1.30**	**1.26**	

Figure 2 ***Expenditure on Medical, Public Health and Family Welfare - As ratio to Aggregate Expenditure***
(Source –Niti Ayog Presentation)

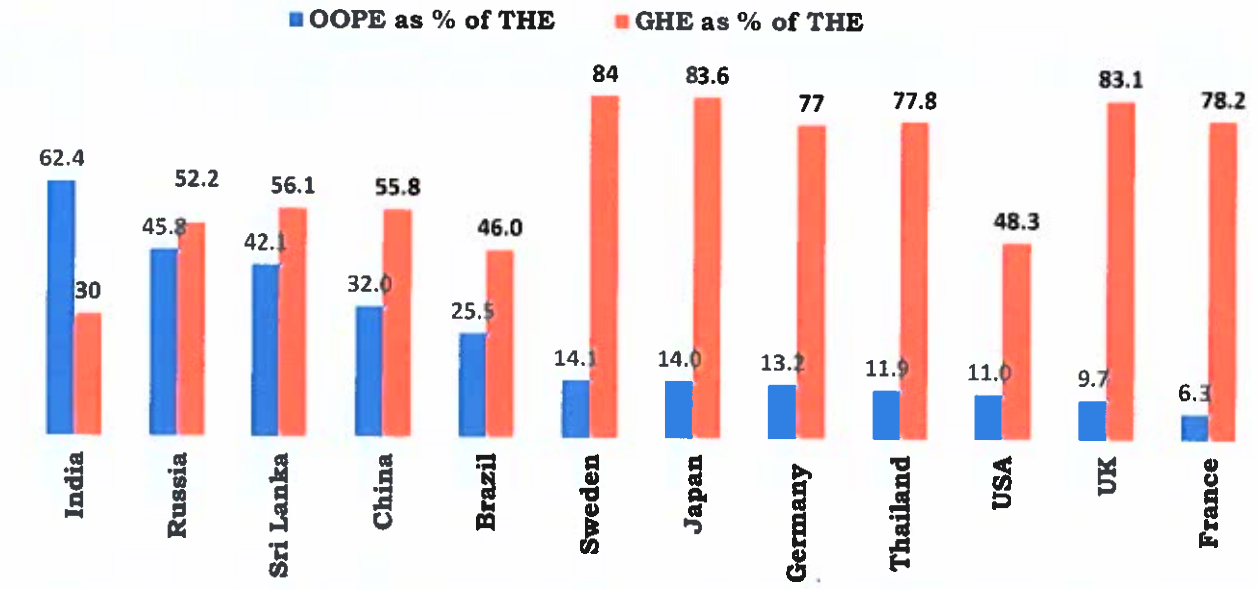


In order to reach the target of 2.5 % of GDP by 2025 as envisioned in National Health Policy 2017, the commitment will have to come from both the Union Government and States. In so far as the Union Govt. is concerned, budgetary support from the general pool would be the pre-dominant source of funding. Additionally, education and health Cess (4%) has been introduced in the Union Budget of 2018-19, in place of education cess of 3%. Further, there is now a provision for sourcing funds for medical education and research including for new AIIMS from the Higher Education Financing Agency (HEFA).

On the State side, there is a constant push from the health ministry to the states to increase the outlay on health. The National Health Policy advocates that the states should spend 8% of their budget on health, which is currently 4.7% as per the figure of RBI. In addition, the National Health Mission stipulates at least 10% increase in health outlay every year or average for three years. Furthermore, programmes such as the Ayushman Bharat with its twin pillars of health & wellness centres and Pradhan Mantri Jan Arogya Yojana (PMJAY) will also nudge states to spend more on health as state share contribution. However, suitable recommendations from the XVth Finance Commission will be necessary to nudge the States to increase their budget outlays for health, particularly primary health.

India ranks 176 out of 191 countries when it comes to government expenditure on health, while it is ranked 182 out of 191 countries in terms of out of pocket expenditure on health.

Figure 3 Government Health Expenditure versus Out of Pocket Expenditure among various countries (Source – MOHFW)



HUMAN RESOURCE FOR HEALTH

There are serious concerns with regards to the shortfall/gap in the human resource required for health. Currently, doctor-population ratio is 1:1511. This has been calculated assuming availability of 80% of 11.15 lakh registered doctors in the country. The current intake capacity of MBBS is 70,000. At this rate, more than 3 lakh doctors will be added to the pool in the next 4-5 years. Besides, there are 7.63 lakh ayurveda, unani and homeopathy (AUH) doctors and around 2.5 lakh registered dentists.

Table 2 Doctor and nurse population ratio *(Source –MOHFW)*

	WHO norm	**Current position in India**
Doctors	**1:1000**	**1:1511 (Additionally, there are 7.9 lakh AYUSH practitioners registered in the country)**
Nurses	**1:300**	**1:670**

In year 2011, a high level group on healthcare was constituted by Govt. of India where it was discussed that 1,88,000 specialists are required. The Lancet Commission describes that India requires 65 million surgeries; however, only 27 million surgeries are being conducted. Hence, in order to meet the shortfall of 40 million surgeries, 18000 surgeons are required.

Table 3 Current human resource supply in health *(Source –MOHFW)*

	Medical	**Nursing**
Total Colleges	499	1936
Government colleges	245	143
Private colleges	254	1793
UG Seats	33,472 (Govt.) 36,540 (Pvt.) 70,012 (Total)	7,830 (Govt.) 88,645 (Pvt.) 96,475 (Total)
PG seats	45000 (approx.)	12617

The Government has taken various steps to further increase the availability of human resource in the country which includes:

a. During the last five years 118 new medical colleges have been established in the country thereby increasing intake capacity by 18,835 seats.

b. The Government is implementing a centrally sponsored scheme for establishment of new medical colleges attached with district/referral hospitals in 82 districts in under-served areas of the country. 74 such colleges have been approved and 22 colleges have become functional.

c. There are other centrally sponsored schemes for increasing UG seats and PG seats in existing government medical colleges.

d. The Ministry is also implementing a scheme for expanding tertiary healthcare setup by establishing new AIIMS. Cabinet has approved 20 new AIIMS to enhance tertiary healthcare in the country.

e. Minimum standard requirements for medical colleges including requirement of land, faculty, staff, bed/ bed strength and other infrastructure has been rationalized to facilitate setting up of new colleges.

f. The ratio of teachers to students has been revised from 1:1 to 1:2 for all MD/MS disciplines and 1:1 to 1:3 in subjects of anaesthesiology, forensic medicine, radiotherapy, medical oncology, surgical oncology and psychiatry. Further, teacher student ratio in public funded government medical colleges for Professor has been increased from 1:2 to 1:3 in all clinical subjects and for Associate Professor from 1:1 to 1:2 if the Associate Professor is a unit head. The same has also been extended to the private medical colleges with certain conditions. This would result in increase in number of PG seats in the country.

g. Diplomate of National Board (DNB) qualification has been recognized for appointment as faculty to take care of shortage of faculty.

h. Enhancement of maximum intake capacity at MBBS level from 150 to 250.

i. Relaxation in the norms of setting up of medical college in terms of requirement for faculty, staff, bed strength and other infrastructure.

j. Requirement of land for establishment of medical college in metropolitan cities as notified under Article 243P (c) of the Constitution of India has been dispensed with.

k. Support for strengthening/up-gradation of state government medical colleges for starting new PG courses/increase of PG seats.

l. Support for establishment of new medical colleges by upgrading district/referral hospitals preferably in underserved districts of the country.

m. Support for strengthening/ up gradation of existing state government/central government medical colleges to, increase MBBS seats and super-speciality seats.

n. Enhancement of age limit for appointment/ extension/ re-employment against posts of teachers/dean/principal/ director in medical colleges from 65 to 70 years.

o. Under the centrally sponsored scheme of strengthening /up gradation of nursing services (Auxiliary Nurses Midwives [ANM] /General Nurse Midwives [GNM], the government has approved 128 ANM and 137 GNM schools to be set up in the country.

p. Training of community health workers is being done and short-term training is being provided in OBG and anesthesia to overcome the shortage of human resource for health.

NURSING PROFESSION

As per Indian Nursing Council records, there are around 29 lakh nursing personnel registered in the country as on 31-12-2017. It is estimated around 19.1 lakh nursing personnel are available for active services, which gives a nurse- population ratio of about 1: 670 (Population taken as 128 Crores) There are around 8000 nursing institutes in the country producing about 3 lakh nursing personnel annually to meet the requirement of nursing personnel in the country.

To regulate nursing education, Indian Nursing Council (INC) had set uniform standards for training of nurses, midwives and health visitors. It also prescribes minimum standards of education and training of nurses and promotes research in the field of nursing. Some of the steps taken by the government to strengthen the nursing profession are as under:

- Financial support has been provided to establish Nursing Cells/Directorate in states to strengthen the management and leadership capacity of nurses.
- Funds are being given for training of nurses as well as for up gradation of schools of nursing into college of nursing under the scheme for development of nursing.
- Funds are also provided for establishment of ANM/ GNM schools in the country under the centrally sponsored scheme of up-gradation/ strengthening of nursing services.
- Guidelines for midwifery services in the country have been rolled out which will create a cadre of nurse practitioner in midwifery.
- In-service training to nursing personnel is provided under the scheme training of nurses-development of nursing services. An assistance of Rs. 1,65,300/- per course of 7 days duration for 30 participants is provided.

- Continuing Nursing Education (CNE) has been started to improve of quality of nursing education. Renewal of license once in five years has also been linked with 150 hours of CNE.
- Registration tracking system-live register of nurses has been launched which will be of great help to government for planning and policy decisions. Around 4.7 lakh nurses have been enrolled in the live-register.
- A curriculum for nurse practitioner in critical care (Post Graduate-Residency Program) has been launched to meet the challenges and demands of tertiary health care services in India.
- Process to phase out GNM course by March, 2022 to implement single entry level for nursing has been initiated.
- Registered nurses are given additional six months course to function as middle level health worker at health and wellness centre under Ayushman Bharat.
- Post basic specialty courses in ten areas like critical care nursing, neonatal nursing, psychiatric nursing, operation room nursing, emergency and disaster nursing etc are prepared for training nurses to function effectively in health care team and to provide specialized nursing care to the patients in the hospital and community.

REFORM AGENDA BEING PURSUED BY MEDICAL COUNCIL OF INDIA

Board of Governor is running the Medical Council of India (MCI) and is actively pursuing the reform agenda. Reform work on 15 regulations is being carried out/completed. The following measures are being undertaken by Board of Governors, MCI as a part of reform agenda.

- Intensive care unit beds were earlier not being accounted for assigning Post Graduate (PG) seats. The same is being modified with a

promulgation of regulation, which will immediately add 1300 PG seats. It is yet to be notified.

- Board of Governor is also examining the issue of co-sharing of casualty / emergency beds by various specialties.
- The requirement of training in concerned super-specialty where such a course does not exist for starting a new specialty/super-specialty is unnecessary and is being done away with. Now, it would require demonstration of work experience in that super-specialty in the form of clinical, academic and training.
- To promote ease of doing business, various punitive clauses are being repealed.
- Various penalty clauses are being introduced to issue show cause notices to hospitals providing false information with regards to faculty strength.
- Earlier while assessing, medical colleges were declared either fit or not fit for affiliation by MCI but currently same has been modified. For e.g. if a medical college can attain 75% parameters set by MCI, then it is being recommended for affiliation.
- Issue of predatory journals is being taken up MCI and only those journals which are indexed with pubmed will be taken as selection/promotion criteria for the faculty members in medical colleges. Process for the same is underway.
- MCI is closely monitoring the availability of Medical teachers.
- MCI is working towards strengthening the MBBS internship programme.
- DNB has been made equivalent to MD/MS and immense efforts are being made to increase the footprint of DNB. Various healthcare organizations in Army Medical Corps, Indian Railways, Coal India Limited, Steel Authority of India Limited, Employees State Insurance and state govts. are coming up with DNB programmes. The DNB

program can be easily started with existing infrastructure and requires minimum increment in infrastructure/resources.

- MCI is exploring the possibilities of scholarships under CSR.
- MCI is actively engaging with National Board of Examinations (NBE) to reserve some of the seats for state governments.
- Star rating system will be introduced for medical colleges

HEALTH CARE DELIVERY SYSTEM

As per the World Bank report, India stands 114 in terms of human capital strength while countries like Vietnam stands at 7th place. The panel stated the importance of primary health in building human capital strength. Healthcare delivery system is driver of growth and 10% of population in India is children which should be imparted health education, ways to improve preventive and promotive health to gain advantage of demographic dividend.

Public health facilities

There have been several steps taken to strengthen the facilities at the level of Sub-Centre (SC), Primary Health Centre (PHCs), Community Health Centres (CHCs), and District Hospitals (DH) at infrastructure and service delivery level.

Table 4 Current status of public health infrastructure

Type of health facility	In position	Shortfall (as against population norms)	% Shortfall	States with severe shortfall
Sub Centre	1,56,231	34,946	19	47%- Bihar 37% Jharkhand
Primary Health Centre(PHC)	25,650	6,409	22	69% Jharkhand 58% W Bengal 39% Bihar

Community Health Centre (CHC)	5,624	2,168	30	81% Bihar

MOHFW has prepared technical and operational guidelines for strengthening district hospitals for multi-speciality care and as a site for training. The guidelines envisage increasing the number of speciality services being offered at DH level, improving the quality of existing clinical specialist services by adding additional human resources (specialists), developing district hospitals as training sites for medical, paramedical and nursing courses. District and sub-district hospitals are being used as a platform for imparting trainings like DNB/CPS/Nursing/Allied Health professionals training /Mid-Level Health Provider (MLHP) training etc. This will help in developing district hospital as a knowledge hub. Indian Public Health Standards (IPHS) were revised in 2012 for all levels of public healthcare facilities to improve public health infrastructure, planning, and up-gradation of multi-specialty services. A district hospital would thus move towards provision of all basic speciality services and also take up super-speciality services gradually.

A cadre of Public Health and Primary Care Practitioner which will act as a bridge between Medical Officer and ANM worker is being created by providing six months training in primary care and public health to BAMS and nursing professionals. In this system, treatment initiation would be done by doctor and follow up will be at the level of community practitioner. Under NMC Bill provision for nurse practitioner has also been made in certain areas.

Strengthening Monitoring System

Currently the following measures are being taken by Ministry of Health & Family Welfare to monitor the delivery of health services at public health facilities level:

- Health Management Information System (HMIS), which is a web-based monitoring system that captures facility-wise data on services delivered including the outpatient department (OPD), In patient department (IPD), laboratory and radiological investigations undertaken every month from all the public health facilities. The provision for entering data on a daily basis is being considered in the upgraded version of HMIS.

- In addition, name-based tracking of delivery of services is also undertaken for delivery of services for pregnant women and children through the Reproductive and Child Health (RCH) portal, for TB patients through the NIKSHAY and for the patients of non-communicable diseases through the NCD App.

- Further, States have been advised to follow Indian Public Health Standards (IPHS) norms for manpower recruitment. Support for manpower recruitment agencies and skills based competency assessment is being undertaken to screen the suitable candidates being recruited under the NHM. Incentives under the NHM are provided to the states to implement comprehensive health Human Resources Information Systems (HRIS) to ensure rational deployment of health human resources and holding them to account for performance.

- National Quality Assurance Program (NQAP) is being implemented with an aim at integrating quality as a dimension in healthcare services with a uniform measurement system. Quality standards have been laid down for all levels of public health facilities. Performance of each level of facility is envisaged to be monitored through key performance indicators. Facilities are incentivized on attainment of National Quality Assurance Standards (NQAS) certified status and maintain it. An institutional framework has been set up at all levels to oversee quality assurance activities.

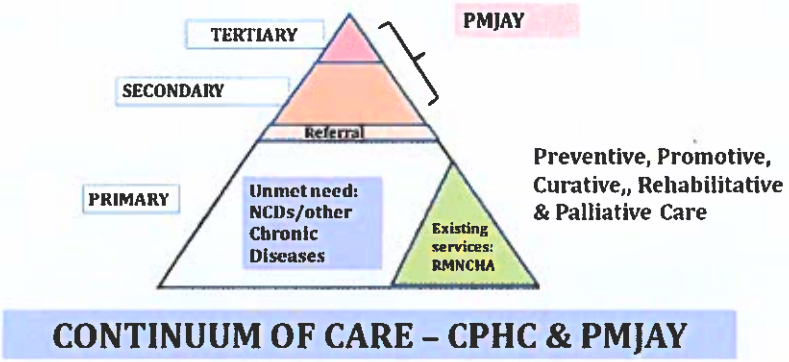
- Under the Ayushman Bharat, daily progress report of number of patients hospitalized, claims submitted and paid is captured which is also being monitored.

  Ministry has devised a robust system to monitor the progress of HWCs on real time basis on indicators related to human resources training, drugs, diagnostics, community outreach, infrastructure, branding, yoga sessions, and IT applications. In addition, NCD application, a cloud-based mobile, web and analytics solution has been developed to digitize health records to aid the population-based screening program, to bring quality health services at door step, to serve as job-aid to enhance productivity of health workers & doctors, and to facilitate monitoring of delivery of services by state and district administrators.

AYUSHMAN BHARAT SCHEME

Ayushman Bharat Scheme aims to provide holistic care comprising of primary, secondary & tertiary care in an integrated manner. It will provide financial protection for secondary and tertiary care hospitalization through Pradhan Mantri Jan Arogya Yojana (PMJAY). The scheme will operationalize 1.5 lakh Health and Wellness Centres to deliver comprehensive primary health care services including prevention and health promotion.

Figure 4 Rationale behind Ayushman Bharat Scheme



Under Ayushman Bharat, it is proposed to transform the existing 1.5 lakh SHCs and PHCs in the Country as Health and Wellness Centres (HWCs) by December 2022. The sub-centre level HWCs will be led by a Mid-Level Healthcare Provider (MLHP)/ Community Health Officer. The MLHP will be a B.Sc Nursing/GNM or Ayurveda Practitioner who has successfully passed the six months certificate course in community health.

AYUSH

The main thrust of the Ministry of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa Rigpa and Homoeopathy) is to popularize AYUSH systems of medicine through effective human resource development, provision of quality AYUSH services, information, education and communication, quality research and growth of the medicinal plants sector. In the recent past, there is a paradigm shift in the approach from disease management towards achieving wellness. AYUSH systems have their holistic healthcare approaches to achieve health and wellbeing.

The National Health Policy, 2017 categorically recognizes the important role of AYUSH systems in promotion of healthy living and prevention strategies that are safe as well as cost-effective. Policy encourages medical pluralism and ensures access to AYUSH through co-location in public facilities, Mainstreaming AYUSH as an integrated medical care, improving quality control of AYUSH medicines, yoga at the work-place, in the schools, in the community and capacity building of institutions and AYUSH professionals.

AYUSH Infrastructure at a glance

The existing infrastructure of AYUSH consist of 7,73,668 registered AYUSH practitioners, 4035 AYUSH hospitals, 27951 AYUSH dispensaries, 702 under graduate, 212 post graduate education institutions, 8954 AYUSH manufacturing units, 55 private owned and 27 state owned drug testing laboratories.

Considerable efforts are being put by the Ministry of AYUSH for overall growth of AYUSH systems in the country. Role of yoga for achieving health &

wellness is widely recognized after the declaration by U.N. of 21st June as International Day of Yoga. Increasing role of AYUSH in medical tourism and wellness industry is also emphasized resulting in the growth of Indian medical tourism sector including AYUSH sector from USD 21.07 billion in 2015 to USD 22.92 billion in 2016.

RECOMMENDATIONS

RECOMMENDATIONS MADE BY EARLIER FINANCE COMMISSIONS

12th Finance Commission

- Grants to 7 states - Rs. 5887.08 crore for health infrastructure development - Assam, MP, Odisha, UP, Uttaranchal, Jharkhand and Bihar

13th Finance Commission

- Grant to 15 States - Rs. 2539 crores for health - Andhra Pradesh, Arunachal Pradesh, Chhattisgarh, Gujarat, Haryana, Kerala, Madhya Pradesh, Maharashtra, Mizoram, Nagaland, Orissa, Rajasthan, Tamil Nadu, Uttarakhand, West Bengal)
- Grants for new PHCs, CHCs & SCs - to improve physical infrastructure of Public Hospitals and Nursing Colleges

14th Finance Commission

- No sectoral allocations made

SECTION 1 REGULATORY FRAMEWORK

1.1 *Health as a subject may be assigned under Concurrent List of Seventh Schedule of Constitution*

According to the Seventh Schedule of the Constitution 'Health' is a State list item. However, it is seen that a large number of programmes have been initiated/sponsored by the central government. Considering this 'Health' as a subject may be transferred from state list to concurrent list.

Public Health and Hospitals may be brought under the Concurrent List of Seventh Schedule of Constitution of India from the existing assignment under State List.

As per the present constitutional arrangement, Public Health and Hospitals are under the State List. Subjects like population control and family planning, adulteration of food stuff, medical education, and prevention of the extension from one state to another of infectious or contagious diseases are under concurrent list. The proposal to bring Public Health and Hospitals under concurrent list deserves wider consultation and deliberation. NITI Aayog may be requested to hold wider consultations in this regard and then put up the matter to Inter State Council.

1.2 *Right to Health*

"The right to health can be understood as the right to effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system."

The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable physical and mental health (2006)

India has made huge progress over years in all the fields globally and now it's the right time to declare Right to Health as Fundamental Right, which emanates from the Right to Life guaranteed under Article 21 of Constitution of India.

Ministry of Health and Family Welfare is also contemplating a rights-based approach to health as is the case with employment, food and education. With regard to the Right to Health, the NHP 2017 advocates a progressively incremental assurance-based approach with assured funding to create an enabling environment for realizing health as a right in the future. Any rights-based approach on health would need to look at availability of infrastructure, health human resources and state's capacities to provide basic preventive, curative and rehabilitative healthcare services across rural and urban areas.

Right to Health may be declared as Fundamental Right on 75th Independence Day of India in Year 2021

The issues of health also extend beyond health sector to other social determinants of health like poverty, equity, literacy, sanitation, nutrition, drinking water availability etc. Therefore, any rights-based approach should be preceded by an enabling environment.

The Constitution incorporates provisions guaranteeing everyone's right to the highest attainable standard of physical and mental health. Article 21 of the Constitution guarantees protection of life and personal liberty to every citizen. The Supreme Court has held that the right to live with human dignity, enshrined in Article 21, derives from the directive principles of state policy and therefore includes protection of health. Further, it has also been held that the right to health is integral to the right to life and the government has a constitutional obligation to provide health facilities. The Constitution of India may be amended suitably to provide free and quality healthcare to all its citizens as a fundamental right in such a manner as the state may, by law, determine.

SECTION 2 HUMAN RESOURCE FOR HEALTH

2.1 Strengthening Medical Teaching Programme

Serious concerns were expressed by High Level group on Health on the limited role of a MBBS doctors in current scheme of things in healthcare delivery system as they cannot conduct basic surgical procedures and administer anaesthesia or perform ultrasonography at community health centre level. MBBS training is not adequate enough to practice medicine and surgery.

2.1.1 There is a need to restructure the MBBS curriculum to make it competency based. Certain degree of specialization may be included in MBBS curriculum for which MCI can be asked to develop small courses on wellness clinic, basic surgical procedures, anaesthesia, obstetrics and gynaecology, eye, ENT etc. and encourage AYUSH as an elective subject for generating awareness towards AYUSH.

Medical teaching should only be imparted in medical colleges with residential campuses having amenities for student development. Undergraduate teaching not only involves imparting of medical education but also involves developing human qualities, value system and character building.

Undergraduate medical teaching is being imparted in medical college while postgraduate medical teaching is being imparted in medical colleges as well as tertiary care hospitals including private hospitals. It is emphasised that undergraduate medical teaching should only be imparted in medical colleges with residential campuses having amenities for student development. Undergraduate teaching not only involves imparting of medical education but also involves developing human qualities, value system and character building, which is unlike other professional education. Also, the undergraduate

medical teaching entails acquisition of clinical skills which happens in hospitals usually in evening hours, hence, necessitates safe and secure residential campus near to the teaching hospital. It is also clarified that same is not required for post graduate medical teaching, which can be imparted in public and private hospitals not having attached medical college and residential campus.

Service providers can also assume the role of a medical teacher but in a cadre separate from medical college teachers.

Medical Council of India has come out with a model to encourage participation of private sector in undergraduate medical teaching. Consortium model/joint venture model brings together two/three partners, who can develop various facilities required for opening of a medical college i.e. medical college, teaching hospital and residential campus. Corporate hospitals and various other hospitals can adopt this model to start a medical college.

2.1.2 Private medical colleges may be given tax incentives under Section 80JJA of Income Tax of India or any other tax incentives as deemed appropriate. Further these tax incentives should be linked to the outcome evaluation as mentioned subsequently.

2.1.3 There is a need to separate medical training for those who will provide healthcare services from those who will render medical teaching. Service providers can also assume the role of a medical teacher but in a cadre separate from medical college teachers. Clinicians practising in private hospitals can assume the role of the medical teachers for undergraduate medical teaching. They can also get empanelled as visiting faculty in medical colleges and healthcare institutions. Those desirous to

acquire academic designations viz. Assistant Professor, Assoc. Prof, Professor etc. must demonstrate required research experience and publications as mandated by the Medical Council of India. The enabling provisions for the same may be explored by the Medical Council of India/ National Medical Commission. However, it is clarified that clinical teachers desirous of acquiring academic designations must start at the level of assistant professor irrespective of their length of clinical experience and will move up the ladder as per the eligibility criteria prescribed by the regulatory authority. They must engage in research, publications and have to mandatorily undertake online courses including research methodology, ethics, GMP etc. There should be no direct entry at various levels of academic designation and should be only at the level of Assistant Professor. In addition, they have to forego their private practice and can only work on salary basis.

Faculty in medical colleges should not be allowed to do private practice as it compromises teaching and research. They should be compensated adequately in commensuration with their ability to earn rationalised with cost of living

2.1.4 Creation of an environment for medical teaching entails significant time; hence, it is strongly recommended that the teaching faculties engaged in medical colleges should not be allowed to do private practice. Allowing private practice will certainly compromise the medical teaching. However, the medical teachers should be adequately compensated, and their salary structures should not be compared with the corresponding officers in other departments and Institutions.

2.1.5 The issues like optimum compensation, working conditions, promotional avenues, transfer policies etc. have to be clearly laid out. Finance Commission of India is requested to constitute a high-level committee to address all these issues.

2.1.6 Post graduate residents in hospitals are contributing towards the hospital services and should be paid stipend/ compensation in lieu of the same. However, medical doctors desirous of pursuing post-graduation in private sector medical colleges are being charged exorbitant amount of tuition/ capitation fees. The charging of exorbitant amount of tuition fees/ capitation fees by the medical colleges is irrational and against human values due to which deserving meritorious candidates are devoid of opportunity from attaining higher education. The regulatory authorities should take a note of this and bring about necessary regulation to control this menace.

2.2 Evaluation of Medical Education on Outcome Basis

2.2.1 Current regulatory framework of MCI focuses on entry point / infrastructure rather than outcome or end product, hence, requires modification. It is suggested that there should be one common exit exam for the undergraduate medical students qualifying from both public and private sector medical colleges. Performance of the MBBS students in common exit

Single common exit exam for the undergraduate/ post graduate/ super speciality medical education is recommended to ensure the quality of medical education. The performance of UG students/ residents in common exit exam will determine the affiliation and number of seats for medical teaching in the respective medical institutes in the coming years. A system of speciality and super-speciality boards needs to be developed under the regulatory authority.

exam will determine affiliation and number of seats for undergraduate medical teaching in the respective medical colleges in the coming years. Indirectly, both public sector and private sector medical colleges have to continuously strive to improve the quality of medical education, thereby addressing the question of poor quality of medical education being raised from time to time. The modality of the common exit exam may be decided by the Medical Council of India/ National Medical Commission.

2.2.2 On the similar lines Specialty Boards may be constituted under the Medical Council of India/ National Medical Commission. These specialty boards will have representation of eminent professionals from the concerned field and various members from the well-established and recognized scientific societies in the respective field. These specialty boards will decide upon the curriculum for respective field and will also decide upon the structure of the common exit exam.

2.3 Filling up the gap in Human Resource for Health

Gaps in human resource for health can be filled with availability of multilayered and multi-skilled human resources in allied healthcare manpower, nursing, and employed community workers. Gap filling is also required for MBBS doctors and specialists.

By Year 2025, government should be able to strengthen medical infrastructure so that each medicine undergraduate should have the option of pursuing post graduate medical education. Regulatory bodies should restore the post graduate diploma program and majority of the seat share should go to in-service candidates.

2.3.1 Almost one third of MBBS graduate are engaged in preparing for PG entrance exams and not contributing to health delivery system. It is suggested that number of undergraduate (UG) and

postgraduate (PG) medical seats may be made equal by Year 2025. It is recommended that, government should strengthen medical infrastructure in order to develop absorption capacity so that each and every medicine undergraduate should have the option of pursuing post graduate medical education (MD/MS/PG Diploma) within India depending upon his/ her performance in the entrance examination conducted by the regulatory authorities.

2.3.2 It is strongly recommended that regulatory bodies viz. MCI/NMC/DNB should restore the post graduate diplomas in specific areas such as paediatrics, obstetrics and gynaecology, anaesthesia, orthopaedics, family medicine, ophthalmology etc. and majority of the seat share should go to in-service candidates. These two year post graduate diploma program candidates would primarily serve the purpose of service provisioning. These PG diplomas should be provided in affiliated hospital of college granting their MBBS or in District hospital under supervision of medical college UG teachers. Professionals graduating after this post graduate diploma program can practice specialty in primary and secondary care settings only. Finance Commission is requested to give impetus to the infrastructure strengthening to reach the intended objective.

2.3.3 In addition, the government should enhance the involvement of private practitioner in public sector hospitals for healthcare delivery.

2.3.4 Medical colleges should be created at the regional levels within the state thereby catering to adjoining districts and these medical colleges can optimally utilize the resources (human resource for health and infrastructure) available with district hospitals in the region, which will in turn aid in capacity

building of the same. Also, the asymmetric distribution of medical college needs to be corrected as most of the medical colleges are situated in western and southern part of India.

2.3.5 ***Need for Family Medicine Specialists:***

2.3.5.1 Family medicine physicians are required in India; however, there are not enough opportunities for family medicine specialists. There is a need for good family medicine programme at district level and proper cadre need to be in place.

2.3.5.2 MOHFW may be requested to create suitable ecosystem for family medicine specialists. There should be proper family medicine department in medical colleges with full time faculty and efforts should be made to increase the opportunities after pursuing family medicine.

MOHFW may be requested to create suitable ecosystem for Family Medicine Specialists. There is a need for good family medicine programs at District level and proper cadre structure need to be in place.

2.3.5.3 A model Centre for Family Medicine needs to be created at AIIMS, New Delhi to guide the other healthcare institutions in developing the speciality.

2.3.6 Public opinion may be floated on how to attract foreign doctors with repute and creating a pool of retired army doctors.

2.3.7 All the public health facilities including district hospitals, private sector facilities and corporate hospitals should be utilised for starting specialists DNB courses which will not only

enhance the service provisioning but will also ensure the availability of trained human resource.

2.3.8 It is suggested that allied healthcare professionals can be accredited with skill India.

2.3.9 Finance Commission can strengthen National Health Mission, with additional financial allocation for creating short service commission where doctors can be employed and deputed to different states to correct the asymmetry in distribution of human resource.

Finance Commission can strengthen National Health Mission with additional allocation for creating short service commission where doctors can be employed and deputed to different states to correct the asymmetry in distribution of Human Resource.

2.3.10 It is also suggested that Nurse Practitioner, three years trained Community Health Assistant and Physician Assistants should be promoted, their training should be standardized and properly utilised.

2.3.11 The training and delivery of healthcare services should be technology enabled to reduce the asymmetry in skill set of healthcare workers and creating synergistic environment among public health workers at primary and secondary healthcare level.

2.4 Role of DNB in Healthcare Delivery

2.4.1 DNB route may be adopted by the private sector to unleash the medical education capability.

2.4.2 Hospitals providing DNB courses may be given tax incentives under Section 80JJA of Income Tax of India or any other tax incentives as deemed appropriate. Further these tax incentives

should be linked to the outcome evaluation as mentioned in earlier recommendation.

2.4.3 All the public hospitals can be utilized for starting DNB programme. Govt. institutes running MD/MS program may be allowed to run the DNB programme.

All the Hospital, public and Private should be utilised for delivering DNB courses. Hospitals providing DNB courses may be given tax incentives under Section 80JJA of Income tax of India

2.4.4 Proposals may be invited from corporate and private sector hospitals so that every bed in private sector hospitals can be utilized for medical education, to fill the gap between required and available number of specialists.

2.4.5 DNB providing hospitals have to undergo NAAC like rating system.

2.5 Strengthening Nursing Profession

2.5.1 There is a need for revamping and reviewing the functioning of Nursing Council through Nursing Council Act. It is the need of the hour to standardize and improve the quality of nursing education. The revamping should specifically look into the ease of starting nursing colleges.

There is need for revamping and reviewing the functioning of Nursing Council through Nursing Council Act.

2.5.2 There is a need for larger role to be played by nursing professionals. The concept of nurse practitioner, physician assistant, nurse anesthetist etc. may be introduced for better utilization of nursing professionals. Nurse Practitioners in at least few specialties are urgently required.

2.5.3 In the recent past there has been proliferation of nursing colleges in private sector with quality of nursing education being in question, especially in terms of practical training which

leaves much to be desired. The practical training lacks specialization and does not incorporate global advances.

2.5.4 It is recommended that nursing college teachers should be involved in hospital services rather than being limited to nursing colleges.

2.5.5 Well defined career progression needs to be put in place for nursing professional. There is need for Nursing Council, State Government and Central Government to act in this direction.

SECTION 3 PUBLIC HEALTH EXPENDITURE

3.1 Health Expenditure

India ranks 183 among 194 countries in terms of per capita government spending on healthcare, which is abysmally low. It is suggested that investment in healthcare is required to bring about an improvement in healthcare scenario. It has been established that public investment has brought down MMR, IMR, TB, HIV, Malaria etc. Human resource for health is a major blockade in improving the healthcare delivery system in India. Expenditure on primary healthcare should be two third and on tertiary care should be one third, which will require the restructuring of public health expenditure.

As per National Health Account (NHA) Estimates for 2015-16, Union Government expenditure on healthcare was 35.4% of total public health expenditure and state government share was 64.6%. As per the National Health Policy 2017, the government had made a commitment for public expenditure on health to be 2.5% of GDP by 2025. Currently, the share of state and central govt. is in the ratio of 65: 35.

The expenditure made by central government has remained same over past few years, which is low. There is a gap in expenditure on health required to be done to achieve goal of public health expenditure set under National Health Policy, as the expenditure on health for past few years by Govt. of India has remained the same. It is less likely that the public health expenditure would increase to 2.5% of GDP, if the similar trend continues.

3.1.1 Budgetary allocation by state government on health sector as per the RBI figures is 4.7% of the total budget which has to increase to 8% to reach the goal envisioned under National Health Policy.

3.1.2 To address equity and to ensure that no one is left behind, the states with health lag in terms of facilities, infrastructure, and manpower are provided more resources to catch up.

3.1.3 The requirement of funds by the MOHFW in order to achieve the goal of reaching public health expenditure of 2.5% of GDP by 2025 is given in Table 5. The estimations have been made assuming an annual growth rate in GDP of 7.5% and Inflation of 4%. The % GDP at base line is taken as 1.35 for the year 2017-18 based on economic survey data (2017-18).

3.1.4 There is need to optimally utilize the existing resources in addition to pumping more resources for provisioning of healthcare services. It is suggested that monitoring and accountability measures needs to be put in place for optimal utilization of resources. It is also suggested that financing mechanisms may be linked with human resource in place for public sector hospitals.

Table 5 Funding requirements for reaching 2.5% of GDP on expenditure on health (Rs. In Lakh Crore)

Year	GDP assuming 7.5% growth rate	GDP assuming 4% inflation	% GDP allocation for health	Overall EXP. On health	Union Share (35.6%)	States Share (64.4%)
2017-18 (Baseline)		166.28	1.35	2.24	0.80	1.45
2018-19	178.75	185.90	1.47	2.74	0.98	1.76
2019-20	199.84	207.84	1.61	3.35	1.19	2.15
2020-21	223.43	232.36	1.76	4.08	1.45	2.63
2021-22	249.79	259.78	1.92	4.99	1.78	3.21
2022-23	279.26	290.44	2.10	6.09	2.17	3.92
2023-24	312.22	324.71	2.29	7.43	2.65	4.79
2024-25	349.06	363.02	2.50	9.07	3.23	5.84

Source: GDP of 2017-18, as per Economic Survey, Vol.II for the year 2017-18 .

3.2 Financial allocation

3.2.1 Under untied funds, 10% of the funds given to the States may be earmarked for the health sector with at least two third being reserved for the primary health.

Ten percent of the untied funds given to the States may be earmarked for the health sector with at least two third being reserved for the primary health.

3.2.2 Health infrastructure status of the States should also be used as criteria for allocation of resources. This will help States with significant infrastructure deficit and health lag to get more funds.

3.3 Proposed expenditure

Enhanced allocation from centre and state budgets are proposed to be spent on the following, as there is considerable potential/ demand in these areas and the states have improved absorptive capacity:

- **Ayushman Bharat**
  - Operationalizing 1.5 lakh Health and Wellness Centres
  - Financial protection for secondary and tertiary care hospitalization through PMJAY to cover 10.77 Crore poor and vulnerable families.
- Expanding basket of vaccines and their coverage
- Revised National Tuberculosis Control Programme (RNTCP) and National Viral Hepatitis Control Programme (NVHCP)
- Free essential drugs and essential diagnostics in public sector health facilities
- Establishing health facilities as per population norms
- Strengthening facilities as per the Indian Public Health Standards (IPHS)

- Expanding/strengthening the All India Institutes of Medical Sciences (AIIMS) and up-gradation of district hospitals to medical colleges.

3.4 *Sector Specific Treatment to Health*

Finance Commission may accord Sector Specific Treatment to Health based on a framework. The following framework (Table 6) as recommended by Niti Ayog and MOHFW may be used for financial allocation by Finance Commission of India based on the performance in addition to routine allocation done by Central Government.

Health may be accorded Framework Enabled Sector Specific treatment for additional funds allocation to various state governments as performance incentive

3.5 *Health expenditure on research*

International Commission on Health Research and Development (1990) recommended that at least 2% of national health expenditure should be invested in ENHR [Essential National Health Research]. However, the figure is far less if total national expenditure of about Rs.180657.00 crores on healthcare (including states)is taken into consideration. There is practically no investment by the State governments for health research. Hence, it should be made incumbent upon the states to earmark at least 2% of their health budget for health research activities. Health research cells may be constituted within the State Health & Family Welfare Departments for medical/bio-medical/health research. Two percent of the budget allocated to the National Programmes should be spent on research

States should earmark at least 2% of their health budget for Health Research activities.

Table 6 Framework for Sector Specific Treatment to Health Sector

Indicator	Weightage	Indicators	Points

State health budget as a proportion of total State budget	**40% = 40 points**	• Each State to raise proportion of the health budget to 8% by 2025
		• Each year in the XV FC period should see an incremental change in that direction
		• Baseline will be 2019-20 (n%)
		8%-n%=delta H. Each year percentage increase target should be deltaH/5
		• Weightage score
		• Increase as a proportion of the target
		  • 90% or more = 50 points
		  • 70-89% = 40 Points
		  • 50-69% = 30 Points
		  • 30-49% = 20 Points
		  • <30% = 10 Points
		  • No increase = Nil	

Health system performance	**30% i.e. 30 points**	Operationalization of health and wellness centres	15
		Specialist/medical officer/nurses/MLHPs/ANMs in govt./Govt. aided institution per 10,000 population	15
		Case Notification rate for TB	10
		Screening of 30+ population for common NCDs	10
		Proportion of Sub-district and district hospitals as per IPHS as prescribed	15
		Proportion of medical college hospitals as per NABH	15
		No. of hospital beds per 1000 population	10
		Full Immunization Coverage	10

	Total	100
Public health system and management cadre	**20% i.e. 20 points (5 per year) Earned if all the milestones for the year are achieved**	**Year 1 (2020)** 1. GO/Circular from General Administration to Department of Health for putting up a proposal for creation/ reconstitution of the Public Health System's and Management cadre. 2. Constitution of Task force/ Committee. 3. Draft report of the Task Force. 4. Public/ Stakeholder comments on Draft report. 5. Final report of the Task Force. **Year 2 (2021)** 6. Proposal to Government and approval of the report 7. Cabinet Note 8. Cabinet approval/ State Assembly 9. Gazette notification of Cadre and Recruitment Rules. **Year 3 (2022)** 10. Oversight committee for implementation. 11. Implementation Year 4 Implementation
Stunting decline rate	**10% i.e. 10 points**	Rate of decline More than 2% = 10 points 1 to 2% = 03 points Less than 1% = nil points

3.6 Incentives and Subsidy in Healthcare

3.6.1 Cross subsiding the delivery of healthcare services.

3.6.2 Finance commission should explore ways to incentivize medical education.

3.6.3 Cross subsiding medical education can be made mandatory for all the hospitals and suggested performance grant system may be institutionalized.

3.6.4 Incentive structure may be created in entire healthcare delivery system after doing proper ground work.

SECTION 4 STRENGTHENING PUBLIC HEALTHCARE DELIVERY SYSTEM

4.1 Strengthening Public Health Facilities

4.1.1 As per Ministry of Health & Family Welfare proposal for strengthening of districts hospital, having 250 or more hospitals beds, by converting them to medical colleges is in process; District hospitals with 100 – 200 beds would be strengthened. District hospital not upgraded as medical colleges will be used as sites for DNB, CPS courses and allied health professional courses and would be used for scaling up NHM programme.

4.1.2 Strengthening of public healthcare delivery system by making Community Health Centres, Primary Health Centres, Sub-centres, Health and Wellness centres as per 2011 population norms is being carried out. It will entail an expenditure of two lakh nineteen thousand crores.

Primary health care should be the number one fundamental commitment of each and every state. MOHFW is carrying out strengthening of public healthcare delivery system by making Community Health Centres, Primary Health Centre, Sub-centres, wellness centres as per the 2011 population, which will entail an expenditure of two lakh nineteen thousand crores.

4.1.3 Primary health care should be the number one fundamental commitment of each and every state. Finance Commission is requested to increase the healthcare expenditure in line with the National Health policy. It is also suggested that central funding be spent on adequately equipping and providing human resource for health and wellness centres.

4.1.4 Training of doctors needs to be devolved at the level of district and sub-district level, so these specialists have the ability to work in rural areas.

4.1.5 Role of ASHA should be upgraded in delivery of healthcare services.

4.1.6 Ensuring availability of data on routine medical activities like collection of blood, transfusion, surgeries conducted, dialysis conducted etc., across the community health care centres of the states. Compulsory daily audit of utilisation of health facilities cover the main components like number of patients, nature of illness, total number of ECG taken, radiological investigations conducted, the number of laboratory tests undertaken etc. It is also proposed that a daily audit may be sent on whats App or any other technology. Thereafter, an external audit at state level on a monthly basis could be conducted. Further, the state government may keep the Ministry of Health informed at the beginning of each month.

4.2 Creating 3000 to 5000 hospitals in next 5 years

Currently, India is having a hospital bed – population ratio of 1 hospital bed per 1000 population, and National Heath Policy envisages increasing it to 2 hospital bed per 1000 population. This doubling up of hospital beds is not possible from the contribution by public sector hospitals alone, hence, necessitates the participation of private sector to augment the existing hospital bed population ratio.

Creating 3000 to 5000 hospitals (200 beds each) in next five years with participation of private sector.

4.2.1 In coming five years, 3000 to 5000 small hospitals (200beds) may be created close to the community and the role of private sector may be explored in achieving the same.

4.2.2 The government can work out the various modalities of incentivising the investment by private sector so as to attract the equity required to develop this infrastructure in tier II and tier III cities, which can be in the form of viability gap funding, allocation of resources, tax breaks/ incentives, soft loans etc.

4.2.3 Participation of private sector should be encouraged by adopting various innovative approaches in service delivery mechanisms and adoption of health technology. Corporate Social Responsibility scheme may be leveraged to enhance participation of private sector for e.g. adoption of health and wellness centres by private sector hospitals/organisations, implementation of various health programmes by private sector hospitals etc.

4.3 National Health Authority

4.3.1 National Health Authority under the ambit of Ayushman Bharat Scheme may devise a comprehensive health insurance scheme for people employed in formal sector to overcome the financial challenge faced in availing health services. It is recommended that scheme may be devised on no profit

Comprehensive Health Insurance Scheme for the people employed in formal sector may be introduced under the Ayushman Bharat Scheme.
Electronic Medical records for all the healthcare facilities may be developed

no loss basis and can be administered by institution as identified by the competent authority.

4.3.2 National Health Authority can also act as the strategic purchaser and collective negotiator for negotiating rates of medical supplies and medical devices, which can bring down the cost of healthcare delivery.

4.3.3 NHA through Ayushman Bharat Scheme can also assume the role of gatekeeping for patient referrals among various levels of healthcare.

4.4 Electronic Medical Records

The government of India should come up with electronic medical record for all the health care facilities in India include private sector hospitals, which can be accessed across the country by concerned stakeholders. This EMR should have same platform for interoperability so as to facilitate the healthcare delivery irrespective of the type and level of healthcare facility.

SECTION 5 AYUSH – INTEGRATIVE MEDICINE

5.1 Up-gradation of Sub-Centres (SC) as Health & Wellness Centres by the Department of AYUSH in States /UTs under Ayushman Bharat:

The decision has been taken by Central Government that 10 % of all Sub-Centers to be developed in the country will be operationalized by the Ministry of AYUSH under Ayushman Bharat in centrally sponsored scheme mode. Therefore, the Ministry of AYUSH has to operationalize 12500 HWCs in a period of three years, through States/ UT Governments. The main objectives are to establish a holistic wellness model based on AYUSH principles and practices, to empower masses for "self-care" to reduce the disease burden & out of pocket expenditure. Since, this component would entail additional financial burden on States/ UTs, the finance commission award may provide corresponding State share of Rs. 2192.69 crores out of total financial implication of Rs. 5960.98 crores to implement this scheme based exclusively on AYUSH Wellness model.

Development of Infrastructure under AYUSH would entail additional financial burden on States/ UTs, the finance commission award may provide corresponding State share of Rs. 2192.69 crores out of total financial implication of Rs. 5960.98 crores to implement this scheme based exclusively on AYUSH Wellness model.

5.2 Establishing additional HWCs in under-served / un-served areas:

Department of Health has proposed to develop 32,900 Sub-Centres out of which the Ministry of AYUSH proposes to develop 1/3rd of proposed sub-centres i.e. approximately 10935 Sub-Centres in relatively underserved and far flung areas of the country where the particular AYUSH system is popularly accepted and traditionally

practised by the masses in those areas. The existing schematic provisions do not have provision for accommodating this component, therefore finance commission package may be useful for creating infrastructure for delivery of quality AYUSH services through these sub-centres to be designated as AYUSH health and wellness centres. The AYUSH HWCs would serve as the first point of contact for primary healthcare services in these uncovered rural areas.

5.3 *Setting up of Integrated AYUSH Hospitals in all Districts*

Establishment of Integrated AYUSH hospitals with in-patient facilities at every district is taken as one of the milestones to enable the states to provide the population with referral services in AYUSH systems of medicine. In this regard, central government through centrally sponsored scheme of National AYUSH Mission (NAM) has provided grant-in aid to States/UTs for setting up of 85 integrated AYUSH hospitals in last 5 years. However, considering the need to expand this activity in all districts of the country, where such hospitals are not available, 15th Finance Commission may award additional resources to the states so that health care continuum with AYUSH services can be accomplished. The States / UTs would take up the establishment of district level Integrated AYUSH hospitals with facilities under different systems of AYUSH including Yoga & Naturopathy services for strengthening promotive and preventive healthcare at community level along with curative services and in-patient care. The financial requirement to the tune of 9711.38 crores is required for establishing such integrated AYUSH hospitals in 402 districts where such hospitals are not available at present.

(Detailed proposal is attached at annexure IV)

ANNEXURES

Fifteenth Finance Commission

(Union Finance and Coordination)

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Minutes of the Meeting of the XVFC with the High Level Group on Health Sector held on 20th August, 2018 from 3:00 PM onwards at Commission's office, K.C. Neogy Conference Room, 22nd Floor, Jawahar Vyapar Bhawan, New Delhi

List of the participants is at Annexure

The key highlights of the meeting are as follows:

A. Chairman, FC

In his opening remarks, the Chairman welcomed the Members of the High Level Group (HLG) on Health Sector. Chairman stressed that the Planning Commission (PC) has been abolished and though the NITI Aayog had been established, the XV Finance Commission had an added responsibility. Further, he stated that, 'Health' as per the Seventh Schedule of the Constitution is a State list item but a large number of programmes have been initiated by the Central Government. He sought the HLG's views on reducing the Doctor-Patient Ratio and also improvement in the regulatory environment in the medical sector.

B. Dr. Devi Shetty, Member HLG

He made a presentation on the Public Health needs with an emphasis on Manpower and Monitoring ***(Copy of the presentation enclosed at F/B)***. He stated that skilled manpower and conditional financial allocation are the two main challenges of the Health Sector today. He also stated that in the contemporary scenario, the disease spectrum has changed from infectious diseases to degenerative diseases. He emphasised the need to strengthen the Community Health Centres and District Hospitals in the States. He stressed that the health sector could be a key driver of the 21st Century economy on account of its employment potential. He also made some key suggestions on improving the medical education in the country.

C. Dr. Naresh Trehan, Member HLG

He emphasised the need to create 'Cooperative Model' rather than a 'Competitive Model' between Public and Private Hospitals. He also laid emphasis on integration of the few initiatives taken by the Government by citing the example of 'Ayushman Bharat' and 'Swachh Bharat Mission'. He stated that the key components of the two Govt. initiatives could be better delivered if they work in close cooperation with each other as more than 50% of the issues related to disposal of medical wastes pertain to Swachh Bharat Mission.

D. Dr. Deelip Govind Mhaisekar, Member HLG

He supported Dr. Reddy for having a comprehensive ban of private practice by Government Doctors. Secondly, he reiterated the need to increase the post graduate doctors in the country.

E. Dr. Bhabatosh Biswas, Member HLG

He stated that the Government is the custodian of health care and hence, it should intervene to utilize the capacities of Doctors particularly in the public sector and also pay/reward them accordingly. He further stated that the capacity of the public hospital could be utilised fully to produce both the doctors as well as the supporting staff without diluting quality.

F. Dr. Aarti Vij on behalf of Dr. Randeep Guleria, Convenor HLG

The suggestion made by her included the need for discussion on the following:

(i) Optimum utilisation of the funds allocated by the Centre to the States on Public Health;

(ii) Need to open more Medical Colleges and Hospitals, for training more manpower which could enable to build the gap between doctor-patient ratios;

(iii) Need to think in the lines of the price control mechanism in the pharmacy and drugs market and thereby bring uniformity in the Health Care facility;

(iv) Proposal to include officials from National Health Accounts Division in Ministry of Health which is monitoring the funds allocated to the States. They could be asked to provide data on funds allocated to the States and their optimum utilisation and outcomes. Also, NITI Aayog could be requested to provide data pertaining to the health sector;

(v) Proposal to include the discussion with officials from Resource Centre at the Ministry of Health which is the unit under the Department of Planning charged with Health Information Management Systems (HMIS) for the sector; and

(vi) Representatives from WHO and Dr.V.K.Paul from NITI Aayog could be included for the discussion on the issues pertaining to Health Sector.

G. Prof. K.Srinath Reddy, Member HLG

He flagged that a number of issues of the Health Sector were identified in the 11th and 12th Five Year Plan documents, but remained unresolved. He referred to the Bill on National Commission for Health, Education and Research, which never saw the light of the day. He cited the examples of Philippines, Cuba and U.S.A. as countries were health care practices could be examined in the context of India.

H. **Member (SKD)**

He broadly agreed with the suggestions flagged by Dr. Aarti Vij during the meeting.

I. **Member (AS)**

He raised two issues: (i) 'Can Technology be an enabler or a replacement in the Health Sector? (ii) Can Tele-Medicine create an impact in the Health Sector?'

J. **Member (AL)**

He emphasised that there is a need to focus on human resource development. He stated that the public-private partnership is an old term rather he prefers competition for better utilisation of resources.

K. **Secretary**

He stated that the Commission could have one session with Skill Development Ministry and understand how the Ministry is working on providing skills to paramedics and the nurses working in the health sector. He further stated that the state specific requirements may be included in the report.

L. **Chairman – concluding remarks**

The Chairman requested the HLG to provide the first cut of the High Level Group by the end of February, 2019. The first draft shall be based on the defined role and function of the HLG circulated through Commission's OM dated 1.5.2018 ***(F/A)***. He also stated that, the Commission would conduct two more meetings to discuss and deliberate on the key issues pertaining to the Health Sector. Also, the Secretary, Ministry of Health could be called upon separately to discuss the key issues. He also requested Dr. Devi Shetty to give the list of questions on Health in form of questionnaire that could be asked by the Commission during their visits to the States.

The meeting ended with vote of thanks to the Chair.

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Annexure

List of Participants

S.No.	Name & Designation
	Fifteenth Finance Commission (XV-FC)
1.	Shri N.K.Singh, Chairman
2.	Shri Shaktikanta Das, Member
3.	Shri Anoop Singh, Member
4.	Dr. Ashok Lahiri, Member
5.	Dr. Ramesh Chand, Member
6.	Shri Arvind Mehta, Secretary
	High Level Group on Health Sector
7.	Dr. Devi Shetty , Chairman, Narayana Health City, Bangalore
8.	Dr. Deelip Govind Mhaisekar, Vice Chancellor, Maharashtra University of Health Science, Pune
9.	Dr. Naresh Trehan, Medanta City, Gurgaon
10.	Dr. Aarti Vij, AIIMS, New Delhi on behalf of Dr. Randeep Guleria, Director , AIIMS
11.	Dr. Bhabatosh Biswas, Prof & HOD of Cardio Thoracic Surgery, R.G.Kar Medical College, Kolkata
12.	Prof. K. Srinath Reddy, President of Public Health Foundation of India.
	Other officers of XV-FC in attendance
13.	Shri Mukhmeet S. Bhatia, Joint Secretary
14.	Dr. Ravi Kota, Joint Secretary
15.	Shri Antony Cyriac, Economic Adviser
16.	Shri Jasvinder Singh, Director
17.	Shri Gopal Prasad, Director
18.	Shri Bharat Garg, Director & OSD to Chairman
19.	Ms. Sweta Satya, Deputy Director
20.	Shri Anshuman Mishra, Deputy Director

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आचार्य रणदीप गुलेरिया
निदेशक

PROF. RANDEEP GULERIA
MD, DM (Pulmonary Medicine), FAMS, FIMSA
DIRECTOR

Dated: 25th April, 2019

Sub: Minutes of the 2nd meeting of High Level group on Health Sector Constituted under Fifteen Finance Commission, Govt. of India.

Dear Sir,

This is in reference to the High Level Group on Health Sector Constituted under Fifteen Finance Commission, 2nd meeting of which was held at 11 am on 8th February 2019 in Ramalingaswami Board Room of AIIMS, New Delhi.

Please find enclosed the minutes of meeting of High Level Group on Health Sector for your perusal.

Kind Regards

With regards.

Yours sincerely

(Prof. Randeep Guleria)

Sh. N. K. Singh
Chairman
Fifteenth Finance Commission
Govt. of India

HIGH LEVEL FROUP ON HEALTH SECTOR
Under Fifteenth Finance Commission of India

Sub: Minutes of the 2nd Meeting of High Level Committee on Health constituted under the 15th Finance Committee Commission, Govt. of India.

The 2nd Meeting of the High Level Committee on Health constituted under the 15th Finance Commission of India was held at 11:00am on 8th February 2019 in Ramalingaswami Board Room of All India Institute of Medical Sciences, New Delhi. It was attended by the following officials:

1. Sh. N.K. Singh
   Chairman, Fifteenth Finance Commission, Govt. of India
2. Prof. Randeep Guleria
   Director, AIIMS, New Delhi
3. Dr. Naresh Trehan
   Chairman & Managing Director of Medanta- The Medicity
4. Dr. Devi Shetty
   Chairman, Narayana Health City
5. Prof. K. Srinath Reddy
   President, Public Health Foundation of India
6. Dr. Deelip Govind Mhaiskar
   Vice Chancellor, Maharashtra University of Health Sciences
7. Prof. Bhabatosh Biswas
   HOD, C.T.V.S, R.G. K. Medical College
8. Dr. V.K. Paul
   Member, Niti Ayog
9. Dr. Aarti Vij
   Prof. Hospital Administration
   Prof. In-charge (ORBO), Chairperson, Media & Protocol Division
10. Dr. Ashok Lahiri
    Member, Fifteenth Finance Commission

11. Dr. Ramesh Chand
Member, Fifteenth Finance Commission

12. Sh. Arvind Mehta
Secretary, Fifteenth Finance Commission

13. Sh. Mukhmeet S. Bhatia
Joint Secretary

14. Dr. Rajeev Kumar
Prof. Urology & Associate Dean, AIIMS New Delhi

15. Dr. Vijaydeep Siddharth
Asstt. Prof. Hospital Administration

16. MS. Maushumi Chakravarty
Media Adviser

17. Sh. Antony Cyriac
Adviser

18. Ms. Sweta Satya
Joint Director, Fifteenth Finance Commission

19. Sh. Bharat Bhushan Garg
Director (OSD to Chairman), Fifteenth Finance Commission

At the outset, Chairman, 15th Finance Commission of India welcomed and praised all the members of the High Level committee on Health for their commitment towards the agenda of Health. He appraised the house that each year Finance Commission of India comes out with a theme or an area of focus and this year Finance Commission desires to devote attention towards health. He also appraised that following the 1st meeting of High of Level Committee on Health, productive discussions were held with the Ministry of Health & Family Welfare (MoHFW), Govt. of India, where presentation was made by MoHFW and a set of questions were handed over to which the replies have already been received and shared with all the committee members. In today's meeting, he would like the committee to take the discussion forward and come out with

some recommendations on health sector, which may form part of core recommendations to be made by the committee.

Prof. Randeep Guleria, Convener, High Level Committee on Health welcomed all the members and special invitees to the 2nd Meeting of High Level Committee on Health. He re-emphasized the roles and responsibilities of High Level Committee on Health. He also mentioned that the response submitted by MoHFW touches upon various issues, which were raised in first meeting of the committee i.e. increase in public expenditure on health, implementation of education & health cess, Higher Education Financing Agency (HEFA), composite health index under Ayushman Bharat Scheme etc.

The following issues were deliberated by the committee:

1. **Regulatory Framework:** Sh. N.K. Singh requested the house to apprise regarding the status of legislations/ordinance pertaining to healthcare i.e. National Medical Commission Bill, Allied Health Sectors bill, MCI ordinance etc. and also suggested to obtain the status report on the same from MoHFW. It was informed that bill on allied healthcare providers has been passed by Rajya Sabha and is in public domain for seeking public opinion. It was informed by Dr. K. Srinath Reddy that NMC bill has been introduced in Lok Sabha but yet to be taken to Rajya Sabha. Prof. Randeep Guleria apprised that MCI ordinance has lapsed and is likely to re promulgated again.

2. **Reform agenda pursued by Medical Council of India:** Prof. V. K. Paul, Niti Ayog informed that currently the Board of Governor is running the Medical Council of India (MCI) and is actively pursuing the reform agenda. He also informed that reform work on 15 regulations is being carried out/completed. It was informed by him that various agendas are being prioritized as per the discussions held in previous meeting. He appraised the house about the following measures which are being undertaken by Board of Governors, MCI as a part of reform agenda.

- **Intensive Care Unit beds** were earlier not being accounted **for assigning Post Graduate (PG) seats**. The same is being modified with a promulgation of regulation, which will immediately add 1300 PG seats. It is yet to be notified.
- Board of Governor is also examining the issue of **co-sharing of casualty / emergency beds** by various specialties.
- The requirement of training in concerned super-specialty where such a course does not exist for starting a new specialty/super-specialty is unnecessary and is being done away with. Now it would require demonstration of work experience in that super-specialty in the form of clinical, academic and training.
- To promote **ease of doing business**, various punitive clauses are being repealed.
- Various **penalty clauses** are being introduced to issue show cause notices to hospitals providing false information with regards to faculty strength.
- Previously while **assessing the medical colleges**, outcome was in terms of fit or not fit for affiliation by MCI but currently same has been modified. For e.g. if a medical college can attain 75% parameters set by MCI, then it is being recommended for affiliation.
- Issue of **predatory journals** is being taken up and only those journals which are indexed with Pubmed will be taken as selection/promotion criteria for the faculty members in medical colleges. Process for the same is underway.
- MCI is closely monitoring the **availability of Medical teachers**.
- MCI is working towards **strengthening the MBBS internship programme**.

- **DNB has been made equivalent to MD/MS** and immense efforts are being made to **increase the footprint of DNB**. Various healthcare organizations in Army Medical Corps, Indian Railways, Coal India Limited, Steel Authority of India Limited, Employees State Insurance and state govts. are coming up with DNB programmes. The DNB program can be easily started with existing infrastructure and requires minimum increment in infrastructure/resources.
- Under section **80 JJA of Income Tax of India**, 100% rebate is being extended to various healthcare organizations on amount spent in distributing stipends for DNB candidates.
- MCI is exploring the possibilities of **scholarships under CSR**.
- MCI is actively engaging with National Board of Examinations (NBE) to reserve some of the seats for state governments.

3. **Shortage of Human Resource for Health:** Dr. Devi Shetty expressed serious concerns over the shortfall/gap in the Human Resource required for health. He appraised that in year 2011, a high level group on healthcare was constituted by Govt. of India where it was discussed that 1,88,000 specialists are required. To fill the shortage of human resource for health, he gave an example of Maharashtra state, where College of Physicians and Surgeons, are actively involved in delivery of healthcare services, which has not only filled the gap in human resource for health but has also improved the Maternal Mortality ratio (MMR) in the state. The various fellowships and diplomas awarded by the College of Physicians and Surgeons have been de-recognized by MCI. The doctors produced by College of Physicians and Surgeons can be an asset in filling the gap in Human Resource required for health. They can act as intermediate specialists. He also emphasized that it should be made permissible that procedures can be performed by person without requiring degree but having the experience in the concerned field. Dr. Naresh Trehan agreed with above and also opined that the concept of

specialized program should be encouraged. For example: A PGDCC in cardiology was started in collaboration with IGNOU was shut down by MCI these individuals were acting as rural cardiologists. Prof. V.K. Paul requested Dr. Naresh Trehan to float a note on the same, which shall be duly considered by the MCI.

It was informed by Prof. V.K. Paul, that to address the shortage of human resources for health, public opinion is floated on how to attract foreign doctors, creating a pool of retired army doctors and discussion on College of Physicians and Surgeons are still on.

Sh. Arvind Mehta suggested that Government of India should do shadow budgeting and address supply chain issues in human resource for health, further district hospitals may be converted to medical colleges.

Dr. Devi Shetty cited the example at healthcare delivery system of Cuba and Philippines and suggested that the strategy of imparting medical education may be modified to fill the gap between required and available doctors.

4. **Medical Education:**

- Dr. Devi Shetty quoted the Lancet Commission, where India requires 65 million surgeries, however, only 27 million surgeries are being conducted, which means government hospitals are doing lesser number of surgeries. He further emphasized that to meet the shortfall of 40 million surgeries, 18000 surgeons are required, which is only possible if medical education is reformed. He recommended **equalizing the number of undergraduate (UG) and postgraduate (PG) medical seats.**
- Dr. Naresh Trehan expressed concerns over the **quality of Medical Education** especially on the MBBS training from private Medical Colleges. Dr. Naresh Trehan requested Prof. V.K. Paul to clarify whether medical teaching /training can only be conducted on hospital beds providing free of cost treatment. Prof. V.K. Paul assured him to get it examined.

- Dr. Devi Shetty opined that **restriction of Medical Education to be only imparted in Medical College should be done away with**, as it is getting very costly to pursue medical education. He was of the opinion that higher medical education can also take place in hospitals and suggested structural changes in the manner in which medical education is being imparted currently. He raised concerns over the **stringent definition of Medical teacher and suggested if same can be modified**.

- Prof. V. K. Paul suggested that **MBBS can be made equal to post graduate degree**, can be the way forward as almost one third of MBBS graduate are busy preparing for PG entrance exams and not contributing to health delivery system. He also expressed concerns over the quality of medical education being imparted in private medical colleges. Dr. Bhabatosh Biswas also suggested that **regulatory framework needs to be amended** so that number at PG seat can be increased to becomes equivalent to UG seat.

- Prof. V. K. Paul informed that **star rating system** will be introduced for medical colleges and private practice by medical college faculty will be prohibited.

- Dr. K. Srinath Reddy suggested that a **system of specialty Boards** may be introduced in line with the U.S system of medical education, which shall be responsible for empanelling the medical practitioners and monitoring the standards of medical education.

- Dr. Aarti Vij recommended that there is need for **creation of medical colleges at regional levels within the state thereby catering to adjoining districts** and these medical colleges can optimally utilize the resources (human resource for health and infrastructure) available with district hospitals in the region, which will in turn aid in capacity building of the same. Sh. Arvind Mehta suggested that Central Government can

bear the capital expenditure in bringing up these medical colleges while state government can be asked to bear the recurring expenditure.

- Dr. Devi Shetty stated that **number of faculty members** per medical college in India are more than what has been observed in western countries. He also suggested that some departments like Forensic Medicine, Community Medicine may not be required at the medical college level.
- Dr. Bhabatosh Biswas also suggested that **current regulatory framework of MCI focus on entry / infrastructure** rather than outcome or end product, hence, requires modification.

5. **Incentives and Subsidy in Healthcare**: Dr. Randeep Guleria stated that there are not enough incentives in government sector for people to come on board, and also suggested that private practice by faculty members of medical college shall be prohibited. Dr. K. Srinath Reddy also agreed that under paid doctor is a major issue in government sector. The Doctor's should be well paid and people should demand services accordingly. Sh. N.K. Singh stressed upon the importance of cross subsiding the delivery of healthcare services.

   Prof. V.K Paul requested Finance commission to explore ways to incentivize medical education.

   Dr. Ashok Lahiri suggested cross subsiding medical education can be made mandatory for all the hospitals and suggested performance grant system may be institutionalized.

   Chairperson 15th Finance Commission suggested that incentives structure may be created in entire healthcare delivery system after doing proper ground work.

6. **Better Utilization of existing MBBS doctors & Rural Medicine:** Dr. Devi Shetty expressed concern on the limited role of a MBBS doctors in current

scheme of things in healthcare delivery system as they cannot conduct basic surgical procedures and administer anesthesia or perform ultrasonography at Community Health Centre level.

Prof. Randeep Guleria opined that current training in MBBS is inadequate to perform procedure and family physicians are needed in our country. MCI was asked if it can develop small courses on wellness clinic, basic surgical procedures, Anesthesia, Obstetrics and Gynecology, Eye, ENT etc.

Dr. Rajeev Kumar opined that the MBBS training is not adequate enough to practice medicine and surgery and there is need to restructure the MBBS curriculum to make it competency based. He also suggested that certain degree of specialization may be included in MBBS curriculum.

Dr. K. Srinath Reddy suggested that a MBBS course for rural areas may be started which may be called as MBBS Rural Medicine, as MBBS trained in urban environment are culturally challenged to work in rural areas.

7. **Role of DNB in Healthcare Delivery:** Prof. V.K. Paul suggested that the DNB route may be adopted by the private sector to unleash the medical education capability. He informed that number of DNB seats are going to be increased from 7000 to 22000 by 2020. He invited ideas for all out adoption of DNB by various healthcare institutes. Dr. Anoop Singh also opined the same.

Dr. Bhabatosh Biswas informed that DNB started with private hospitals, however, in year 2013 it was for the first time introduced in District hospital of West Bengal. He suggested that all the public hospitals can be utilized for starting DNB programme. He also brought it to the notice of the house that Govt. institutes running MD/MS program has been denied permission to run DNB programme.

Prof. V.K Paul urged Dr. Devi Shetty and Dr. Naresh Trehan to come out with proposals to National Board of Examination, so that each and every bed in private sector hospitals can be utilized for medical education, so as to fill the gap between required and available number of specialists.

8. **Need for Family Medicine Specialists:** Prof. V.K. Paul stated that Family Medicine Physicians are required in India, however, there are not enough opportunities for Family Medicine Specialists in India and Secretary, MoHFW may be requested to create suitable ecosystem for Family Medicine Specialists.

   Dr. K Srinath Reddy also suggested that there is a need for good family medicine programs at District level and proper cadre structure need to be in place, otherwise Family Physicians will end up being glorified observers and will not be treated as regular medical students.

   Dr. Bhabatosh Biswas, also suggested that there should be proper Family Medicine Department with full time faculty and consultant and efforts should be made to increase the opportunities after Family Medicine.

9. **Role of Nursing Professionals in Healthcare Delivery:** Dr. Devi Shetty stressed upon the need for larger role to be played by nursing professionals and suggested that the concept of Nurse Practitioner, Physician Assistant, Nurse Anaesthetist etc. may be introduced for better utilization of Nursing Professionals. He also suggested that a well defined career profession needs to be put in place for Nursing Professional. Dr. Randeep Guleria also agreed that Nurse Practitioners in at least few specialties are urgently required.

10. **Ayushman Bharat Scheme:** Dr. Naresh Trehan suggested that entire health sector can be stacked upon the Ayushman Bharat Scheme and suggested that the scheme can be broken up into various components and same can be worked upon to establish a continuum. He also suggested that the scheme like CGHS & ECHS also needs assessment in view of the Ayushman Bharat Scheme.

    Prof. V. K Paul appraised that Ayushman Bharat is incentivizing medical education by providing 10% more reimbursement to healthcare facilities having DNB.

11. **Strengthening Primary Health Care:** Dr. V.K. Paul opined that healthcare delivery system is driver of growth and 10% of population in India is children which have to be utilized properly to gain advantage of Demographic dividend. Dr. Anoop Singh also cited the World Bank report where India stands 114 in terms of Human capital strength while county like Vietnam stands at 7th place. The Panel stated the importance of primary health in building human capital strength.

    Dr. K. Srinath Reddy recommended that primary health care should be the number one fundamental commitment of each and every state and people should be given freedom of choice. Dr. V.K. Paul urged the Finance Commission to increase the healthcare expenditure in line with the National Health policy. It was also discussed to upgrade the role of ASHA in delivery of healthcare services.

Dr. N. K. Singh desired to hold the meeting of the committee after couple of month in late April or early May and invite Secretary, Health and Family Welfare, Govt. of India as special invitee for the next meeting.

Meeting ended with thanks to the chair.

(Prof. Randeep Guleria)
Convener

Distribution as above & copy to:

Secretary, Health & Family Welfare, Govt. of India

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आचार्य रणदीप गुलेरिया
निदेशक

Dr. Randeep Guleria
MD, DM, (Pulmonary Medicine), FAMS, FIMSA
Director

संख्या/No.....

दिनांक/Date.....

Dated: 1st July, 2019

Sub: Minutes of the 3rd meeting of High-level Group on health constituted under 15th Finance Commission of India.

Dear Sir,

This is in reference to the High Level Group on Health Sector Constituted under Fifteenth Finance commission, 3rd meeting of which was held at 3:00 pm on 23rd May, 2019 in Board Room of Finance Commission of India.

Please find enclosed the minutes of 3rd meeting of High Level Group on Health Sector for your perusal.

Kind regards

Yours sincerely

(Prof. Randeep Guleria)

Sh. N.K. Singh
Chairman
Fifteenth Finance commission
Govt. of India

HIGH LEVEL FROUP ON HEALTH SECTOR
Under Fifteenth Finance Commission of India

Sub: **Minutes of the 3rdmeeting of High-level Group on health constituted under 15th Finance Commission of India.**

3rd Meeting of the High-level Group on Health Constituted under 15th Finance Commission of India was held at 3:00 pm on 23rd may 2019 in Board Room of Finance Commission of India. It was attended by the following officials:

High level group on Health:

1. Prof. Randeep Guleria, Director, AIIMS, New Delhi
2. Dr. Devi Shetty, Chairman, Narayana Health City, Bangalore
3. Dr. Deelip Govind Mhaiskar, Vice Chancellor, Maharashtra University of Health Sciences, Pune
4. Dr. Bhabatosh Biswas, Prof. & Head, CTVS, R. G Kar Medical College, Kolkata
5. Prof. K. Srinath Reddy, President, Public Health Foundation of India

Ministry of Health & Family Welfare, NITI Aayog & AIIMS, New Delhi:

6. Dr. V. K. Paul, Member, NITI Aayog
7. Shri Manoj Jhalani, AS & MD (NHM), M/o Health and Family Welfare
8. Dr. Dharmendra Singh Gangwar, Addl. Sec. & Fin. Adv., MOHFW
9. Shri Roshan Jaggi, Joint Secretary, Ministry of Ayush
10. Ms. Preeti Nath, Economic Advisor, MOHFW.
11. Dr. Sriramappa. V, Deputy Director, MOHFW.
12. Dr. K. R. Rajeshwari, Assistant Director, MOHFW
13. Prof. Aarti Vij, Hospital Administration, AIIMS, New Delhi
14. Prof. Rajeev Kumar, Addl. Dean, Academics, AIMS, New Delhi
15. Dr. Vijaydeep Siddharth, Asstt. Prof., Hosp. Admin., AIMS, New Delhi

Fifteenth Finance Commission

16. Shri N.K. Singh, Chairman
17. Shri. A.N. Jha, Member
18. Dr. Anoop Singh, Member
19. Dr. Ashok Lahiri, Member
20. Dr. Ramesh Chand, Member
21. Shri. Arvind Mehta, Secretary

Officers of XV-FC

22. Shri. Mukhmeet S. Bhatia, Additional Secretary
23. Dr. Ravi Kota, Joint Secretary
24. Shri. Antony Cyriac, Economic Adviser
25. Ms. Maushumi Chakravarty, Media Adviser
26. Shri. Bharat Bhushan Garg, Director & OSD to Chairman
27. Shri. Jasvinder Singh, Director
28. Ms. Sweta Satya, Joint Directors
29. Other officers of XV-FC

Chairperson, Fifteenth Finance Commission of India welcomed all the committee members and officials. He suggested that the recommendations including the key points/ suggestions made during interaction with the Hon'ble Minister of Health & Family Welfare, Government of India particularly the changes in regulatory framework are to be incorporated in the report to be submitted by High-level group on Health which will subsequently be incorporated in Chapter on Healthcare in the Finance Commission Report to be submitted to the Government of India. The report to be submitted may comprise of recommendations part and sector specific treatment/ Intervention. He suggested that a financial framework consisting of certain parameters may be recommended and resources may be made available based on the compliance of same. These resources which will be allocated based on the compliance to the framework would be in addition to the budgetary allocation made by Central Government for Health as a part of Sector Specific Intervention.

Dr. Randeep Guleria requested the expert comments of all the committee members on up scaling of suggested interventions at a faster rate in a holistic manner.

1. **EXPENDITURE ON HEALTHCARE:**

Prof. V.K. Paul made a presentation on public health expenditure, in which the following key points were highlighted:

- As per the National Health Policy 2017, the Government had made a commitment for Public Expenditure on Health to be 2.5% of GDP by 2025.
- Currently, the share of State and Central Govt. is in the ratio of 65: 35.

- Budgetary Allocation by State Government on Health Sector as per the RBI figures is 4.7% of the total budget which has to increase to 8% to reach the goal envisioned in National Health Policy.
- The expenditure made by Central Government has remained same over past few years, which is low.
- As of now, there is a gap in expenditure on health required to be done to achieve the public health expenditure set in National Health Policy and expenditure which needs to be done, as the expenditure on health for part few years by Govt. of India has remained the same. It is less likely the public health expenditure would increase to 2.5% of GDP, if the similar trend continues.

Dr. Devi Shetty opined that there is need to optimally utilize the existing resources rather than pumping more resources for provisioning of healthcare services. He suggested that monitoring and accountability measures needs to be put in place for optimal utilization of resources. It was also suggested that financing mechanisms may be linked with human resource in place in public sector hospital.

Dr. KS Reddy suggested public health spending needs to be increased enhancing absorption capacity and utilization of resources.

AS & MD (NHM) stated that India ranks 183 among 194 countries in terms of per capita government spending on healthcare, which is abysmally low. He also opined that investment in healthcare is required to bring about an improvement in healthcare scenario. It has been established that public investment has brought down MMR, IMR, TB, HIV, Malaria etc. and human resource for health is a major blockade in improving the same. Two third investments must go in primary healthcare to yield better result.

Dr. Ashok Lahiri, emphasized that expenditure on primary healthcare should be two third and on tertiary care should be one third, which will require the restructuring of Public Health Expenditure. The private sector spending compared to public sector spending on healthcare is 2.5 times and the balance needs to be reached. Various models would be required for various states or straight jacket approach would work needs to be decided.

2. **FRAMEWORK ENABLED HEALTH SPECIFIC TREATMENT:**

Prof. V.K. Paul requested that Finance Commission may accord Sector Specific Treatment to Health based on a framework. He suggested the framework to be in place for healthcare intervention and should comprise of following:

a) **Reforms in Healthcare system:** A reform package needs to be developed which will include various reforms required in healthcare system for e.g. creation of public health cadre to manage our services in a scientific and effective manner on the lines of what Government of Kerala & Tamil Nadu has done; strengthening the nursing cadre and their career progression; deployment and transparent transfer policy of human resource etc.

b) **Investment by state in Human Resource Development:** Capital investment by state governments is required in establishing medical colleges and efforts also need to be made in improving the quality of education in medicine, nursing and allied healthcare. In past few years, the entire investment in starting new medical colleges has come from the Central Government.

c) State governments expenditure on health sector needs to be increased to 8% for achieving the public health expenditure goal as envisioned in National Health Policy.

AS & MD (NHM) opined that indicators needs to be developed for institutionalizing financial incentives and these indicators should be measurable, controlled and can be easily monitored as well as motivates the healthcare workers. Indicators should be implementable and should ensure easy allocation of resources. He suggested that incentive framework to be developed should be aligned with Sustainable Development Goals.

3. **REGULATORY FRAMEWORK:**

a. **Constitutional assignments:** Committee was apprised that Public Health and Hospital falls under the state list, while Medical Education and Medicine Profession are under the concurrent list of the seventh schedule of Constitution of India. Chairperson, Finance Commission of India suggested that reform package may have components pertaining to regulatory framework governing the same.

b. **Healthcare legislations:** AS & MD (NHM) appraised on the current status of important legislation. It was informed that Allied Healthcare Professional Bill for transforming the regulation, management and employment of allied healthcare professionals is pending with Upper House i.e Rajya Sabha. It will lead to standardization of curriculum and various other aspects related to allied health sector. It will lead to creation of 1.5 million jobs nationally and internationally. It was informed that NMC Bill has lapsed and has to be reintroduced, while MCI Board of Governor order has been re-promulgated. He also informed that District Hospital not upgraded as Medical Colleges will be used as sites for DNB, CPS courses and allied health professional courses and would be used for scaling up NHM programme.

c. **Regulatory Reforms in Medical Education:** Dr. Devi Shetty suggested that overcoming the shortage of human resource requires change in regulatory framework by making number of UG seats equivalent to PG seats. In addition, training of diploma holders needs to be done to enhance their skill set. He also opined that a regulatory amendment is required so that state government can grant approvals for starting the medical college.

Dr. Devi Shetty informed that huge amount to the tune of Rs 450 Crores is required to start a medical college and further 150 Crores is required to maintain it. He suggested that regulatory framework needs to be modified so that more medical colleges may be created with lesser investments. It was suggested that the existing private hospitals with 300 beds and above may be upgraded to medical colleges which will add immediately 300 medical colleges with 30,000 seats with allocation of seat belonging to state government. It needs redefining the definition of Medical College Hospital and Teacher/Trainer in regulatory framework i.e. Indian Medical Council Act.

Dr. B Biswas recommended that for faster reform &up-scaling of intervention, all healthcare facilities should be utilized for training purpose, as dependency on Govt. Medical College will not suffice the HR requirement. It was suggested that the definition of medical teacher needs amendments and there is need to have uniform policy for management of Human Resources. He also suggested that emphasis should be laid on assessing the quality of outcome of medical education rather than

focusing on inputs (HR, building, equipment etc.) as being currently done by MCI in assessing the fitness/suitability for starting a medical college.

Dr. Randeep Guleria suggested that all public sector hospitals including District Hospitals should be utilized for starting DNB programme.

4. **PUBLIC PRIVATE PARTNERSHIP:**

Dr. Randeep Guleria suggested that there is need for public private partnership (PPP) in a more inclusive manner as private sector contributes in a major way in healthcare delivery.

5. **NITI AYOG:**

Dr. Randeep Guleria suggested that there are two major challenges that are being addressed through Niti Ayog, one is the cost of tertiary care through Ayushman Bhaarat Scheme and improving public sector especially at the primary level. He also mentioned that there is significant out of pocket expenditure involved in availing medical care and also the efficiency of provisioning of healthcare services is an area of concern. The care provided should be value for money when it comes to common man.

Dr. V.K. Paul suggested that collaboration with private sector is required and Human Resource reforms should be incentivized which needs governance reforms.

6. **HUMAN RESOURCE FOR HEALTH:**

Dr. Devi Shetty reiterated his concern over the shortage of human resource for health and suggested that College of Physician and Surgeons (CPS) may be given accreditation by Medical Council of India. He cited the example of state of Maharashtra and Karnataka where model of CPS has been quite successful in bringing down the maternal and infant mortality. AS & MD(NHM) that there is list of courses of College of Physicians and Surgeons which are recognized by MOHFW and MOHFW is planning to expand the list of courses.

Dr. KS Reddy recommended that the gaps in human resource for health can be filled with availability of multilayered and multi-skilled human resources in allied healthcare manpower, nursing, and employed community workers.

Gap filling is also required for MBBS doctors and specialists. He also suggested that allied healthcare professionals can be accredited with skill India. Also, the asymmetric distribution of Medical College needs to be corrected as most of the medical colleges are situated in Western and Southern part of India. He suggested that Finance Commission can strengthen National Health Mission with additional allocation for creating short service commission where doctors can be employed and deputed to different states to correct the asymmetry in distribution of Human Resource. He further stated that Nurse Practitioner, there years trained Community Health Assistant and Physician Assistants should be promoted, standardized and utilised. They should be technology enabled to reduce the asymmetry in skill set of healthcare workers and creating synergistic environment among public health workers at primary and secondary healthcare level.

Dr. Deelip Govind Mhaisekar suggested that all the public health facilities including district hospitals, private sector facilities and corporate hospitals should be utilised for starting specialists DNB courses which will not only enhance the service provisioning but will also ensure the availability of trained human resource. Dr. B. Biswas also suggested that District Hospital should start more specialist courses.

AS & MD (NHM) apprised that training of community health workers is being done and short-term training is being provided in OBG and anesthesia to overcome the shortage of human resource for health.

7. **STRENGTHENING OF PUBLIC HEALTHCARE DELIVERY SYSTEM:**

AS & MD (NHM) informed that proposal for strengthening of Districts hospital, having 250 or more hospitals beds, by converting them to medical colleges is in process, district hospitals with 100 – 200 beds would be strengthened. Also, strengthening of public healthcare delivery system by making Community Health Centers, Primary Health Center, Sub-centers, wellness centers as per the 2011 population norms is being carried out. It will entail an expenditure of two lakh nineteen thousand crores.

Dr. Ashok Lahiri suggested that there should be incentive for state governments on expanding medical education infrastructure. Human resource for health is a major blockade in strengthening healthcare delivery

system; hence, it was suggested that augmentation should mainly focus on medical education.

AS & MD (NHM) appraised that a cadre of Public Health and Primary Care Practitioner which will act as a bridge between Medical Officer and ANM worker is being created by providing six months training in Primary Care & Public Health to BAMS and Nursing professionals. In this system, treatment initiation would be done by doctor and follow up will be at the level of community practitioner. He also appraised that under NMC Bill provision for nurse practitioner has also been made in certain areas.

Dr. KS Reddy suggested that more medical colleges are required for training of doctors in specialty courses. He also suggested that training of doctors needs to be devolved at the level of District and sub-district level, so these specialists have the ability to work in rural areas. It was also suggested that central funding be spent on adequately equipping Health and Wellness Centre Human Resource.

Mr. N.K. Singh suggested that MoHFW needs to work in close co-ordination with Niti Ayog, if state specific data can be made available to that necessary recommendations can be made accordingly.

Meeting ended with thanks to the chair.

(Prof. Randeep Guleria)
Convener

Distribution as above & copy to:

Secretary, Health & Family Welfare, Govt. of India

Proposal by
Ministry of AYUSH
to
High Level Group on Health Sector
(Constituted by 15th Finance Commission)
for
Strengthening AYUSH Systems to improve Health Care Delivery System in the Country

सत्यमेव जयते

Ministry of AYUSH
Government of India

CONTENTS

553

EXECUTIVE SUMMARY

The Hon'ble PM's Vision of New India includes the attainment of National Goal of Health & Wellness for All. The aim of National Health Policy, 2017 is to achieve the highest possible level of Health & Well-being for all through preventive and promotive healthcare.

The NHP-2017 envisages mainstreaming the potential of AYUSH within a pluralistic system of integrative healthcare. The policy envisages following thrust areas for development and promotion of our traditional system of healthcare viz. Ayurved, Yog & Naturopathy, Unani, Siddha & Homoeopathy: -

i. Development of infrastructure for quality AYUSH healthcare services and AYUSH Education,
ii. Strengthening the regulatory framework for assuring quality AYUSH health services and AYUSH Education,
iii. To promote Yoga at workplaces, schools and community level,
iv. Promotion of Medicinal Plant sector for supply of quality herbal raw material to AYUSH drug & allied industry.

Ministry of AYUSH has initiated series of actions to ensure scientific development and expand outreach of the traditional systems of healthcare towards the achievement of **Universal Health Coverage at affordable costs. Promotion of healthy living and preventive strategies from AYUSH systems including Yoga, promoting the concept of medical pluralism by affording availability of Allopathic and AYUSH health services at one location and assuring supply of quality AYUSH medicines** through **scientifically** validated **research and** high quality **control mechanism has been the focussed areas of work for Ministry of AYUSH in partnership with States and Union Territories.**

In different States and UTS, there exist 31986 stand-alone AYUSH health facilities in the form of Dispensaries and District hospitals. 13,000 Allopathic Health facilities have co-located AYUSH services. 8954 AYUSH pharmacies and 82 Drug Testing laboratories exist in States / UTs. 912 UG / PG level AYUSH colleges with about 47,200 annual intake capacity are imparting education to produce qualified human resource. 7.70 lakhs AYUSH practitioners are available in the country as qualified manpower, whose services can be productively utilized. 11 National level Institutes and 5 Research Councils under different streams of AYUSH work under Ministry to promote Education, Research, Drug development and public healthcare.

Various activities of AYUSH public Healthcare are also supported through States and UTs under Centrally Sponsored Scheme of **National AYUSH Mission (NAM)** which works on the analogy of National Health Mission (NHM). States and UTs in last 5 years, have been able to develop good infrastructure utilizing central grant-in-aid. Third Party Evaluation of

NAM report received in November, 2018 recommends for continuation of NAM with enhanced financial support.

Requirement of States / UTs for promotion of AYUSH System

I. Improvement of infrastructure & positioning of manpower at AYUSH Health facilities and AYUSH Education Institutions.

- AYUSH health facilities in States/UTs are insufficient and inadequate.
- There is need to develop AYUSH health facilities in under-served/un-served areas at primary and secondary level.
- For quality AYUSH education, Educational Institutes need to be strengthened through infrastructure and qualified teaching faculty
- Under NAM, limited central assistance is provided for strengthening infrastructure viz building, equipments, other logistics.
- However States/UTs in many cases are not able to position required manpower viz Doctors, Para Medics, trained professionals for pharmacies & DTLs, drug inspectors.
- Infrastructure created remains unutilized or under utilized.

II. Strengthening of Administrative set up in States / UTs.

Most States / UTs have inadequate administrative set- up which affects planning, implementation, monitoring, reporting and overall functional capacity

- Half of the States /UTs do not have district level administrative setup to supervise & monitor Primary Health Services.
- 10 States/UTs do not have full time Head of Department (HoD) for AYUSH.

Inadequate budget availability to States / UTs

AYUSH Ministry's budgetary allocation is quite meager and is roughly 3-4% of total budget allocation of Ministry of Health & Family Welfare. The budgetary allocations of States and UTs are also in the same range. State AYUSH Departments do not receive any financial support from sources like Finance Commission Awards, external funding and thus lack of adequate budgetary provisions comes in the way of speedy and timely execution of schemes aimed at infrastructure development, improving public healthcare delivery services,

Research activities and strengthening of Regulatory institutional frameworks. States and UTs have not been able to productively utilize the Central grants due to non-availability of matching States share required under Centrally Sponsored Scheme. The administrative set ups in States and UTs in AYUSH Departments are grossly inadequate and there is heavy shortage of trained manpower. There are instances where infrastructure created through central aid remains partially or completely unutilized due to non-positioning of manpower. Positions in health facilities and related institutions remain vacant due to non-availability of financial resources with States to pay their salaries.

It is in this backdrop that Ministry has proposed before the Fifteenth Finance Commission that there is a strong need to earmark exclusive funds for State AYUSH Departments to take up activities aimed at promotion of AYUSH healthcare system especially comprehensive primary healthcare / related activities so that potential of AYUSH systems is harnessed for the benefit and welfare of the people of this country.

Proposal by Ministry of AYUSH to High Level Group on Health Sector (Constituted by 15th Finance Commission) for Strengthening AYUSH Systems to improve Health Care Delivery System in the Country

1. Background:

The main thrust of the Ministry of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa Rigpa and Homoeopathy) is to popularize AYUSH systems of medicine through effective human resource development, provision of quality AYUSH services, information, education and communication, quality research and growth of the medicinal plants sector. In the recent past, there is a paradigm shift in the approach from disease management towards achieving wellness and AYUSH systems have their holistic healthcare approaches to achieve health & wellbeing.

2. National Health Policy, 2017:

Attainment of the highest possible level of Health and well being for old through preventive and promotive health care is one of the important goal of National Health Policy, 2017. The National Health Policy, 2017 categorically recognizes the important role of AYUSH systems in promotion of healthy living and prevention strategies that are safe and cost-effective. Policy encourages medical pluralism and ensures access to AYUSH through co-location in public facilities, Mainstreaming AYUSH as an integrated medical care, improving quality control of AYUSH medicines, Yoga at the work-place, in the schools and in the community and capacity building of institutions and AYUSH professionals.

3. AYUSH Infrastructure at a glance:

The existing infrastructure of AYUSH consist of **7,73,668** registered AYUSH Practitioners, **4035** AYUSH Hospitals, **27951** AYUSH Dispensaries, **702** under Graduate & **212** Post Graduate Education Institutions, **8954** AYUSH Manufacturing units and **55** Private owned and **27** State owned Drug Testing Laboratories.

Considerable efforts are being put by the Ministry of AYUSH for overall growth of AYUSH systems in the country. Role of Yoga for achieving Health & Wellness is widely recognized after the declaration of U.N. 21st June as International Day of Yoga. Increasing role of AYUSH in Medical Tourism & Wellness industry is also emphasized resulting in the growth of Indian Medical Tourism sector including AYUSH sector from USD 21.07 Billion in 2015 to USD 22.92 Billion in 2016.

4. Regulatory framework in AYUSH sector:

The regulation and Quality control of Ayurveda, Siddha, Unani and Homoeopathy drugs is administered under Drugs and Cosmetics Act, 1940 and Rules there under. Ministry of AYUSH coordinates with the State Licensing Authorities and Drug Controllers to achieve uniform administration of the Act. Good Manufacturing Practices (GMP) for ASU medicines is required to be enforced by the State licensing authorities. However, due to limited Laboratory infrastructure, enforcement mechanism & technical manpower in the States enforcement of regulations is required to achieve its stated objectives.

The Regulations in Human Resource Development for AYHUSH Sector is a priority area to the Central Government. Two Statutory bodies i.e **Central Council of Indian Medicines** and **Central Council of Homeopathy** are mandated for prescribing minimum standards of education in AYUSH system, to advice Central Govt. matters relating to recognition of medical qualifications, to make a recommendation to Govt. of India under proposal receipt for establishment of new AYUSH colleges, to increase in take capacity in under Graduate and Post Graduate Degrees and also to prescribe standards of professional contact, etiquette and code of esthetics by the practitioners. However, Ministry is trying for enhancing the coverage of availability of quality educational institutional in various parts of the country.

- There is also a need to leverage the reform measures in education like networking through IT Grid, patient data documentation, modernization of teaching hospitals for which states have to shelve out more funds and attention.

- Besides regulations, in order to facilitate the paradigm shift proposed for financing and organizing the AYUSH health system, there is a need to establish complementary mechanisms to develop capacity for enforcement of regulations;

- Further, there is a need to evolve flexible and innovative approaches, and institutional capacity to provide policy-makers with a critical mass of multivariate skills. As factors impacting upon health are never static, there is a need for continued vigil and a system with the ability to synthesize information from various sources and assess health implications at present and in the future. The assistance for the institutional infrastructure as proposed in this document is a bare minimum and there is a need to establish it on priority.

5. Need for AYUSH services:

There is a highly receptive environment prevalent in the country where the value of AYUSH systems in healthcare is widely recognized. Their holistic approach, strength in disease prevention, management of Non-communicable disease, socio-cultural acceptability, evidence base, availability of talented human resource and national priorities have brought the traditional systems to the forefront.

- The basic prerequisites for health, sanitation and hygiene require special attention in underserved areas such as urban slums and distant rural far flung areas.

- Major challenge is reluctant Health care personnel to go and serve in these underserved and inconvenient areas. It is a fact that AYUSH doctors has already been serving in such areas. The AYUSH sector has more than 7 lakh registered practitioners who are qualified to efficiently manage Primary Health Care.

- AYUSH, apart from providing healthcare services, can play a major role in inter-sectoral cross-cutting issues such as environmental issues, occupational health, safe water and sanitation, gender violence, road safety etc. in an effective manner.

6. Constraints of the States/UTs for AYUSH promotion:

While Ministry of AYUSH through National AYUSH Mission (NAM) and other central sector schemes put its efforts in rolling out action plans envisaged in National policies including NHP 2017, budgetary constraints in the states/UTs make them difficult to prioritize this sector. National AYUSH Mission (NAM) is a centrally sponsored scheme where Center

and States have fund share like 60% and 40%. Many States/ UTs express their inability to contribute their share. Further, the financial flow from State treasuries to State implementing agencies under Centrally Sponsored Scheme of NAM is considerably delayed affecting time bound implementation of the envisaged activities under the mission. The Ministry is facing huge financial crunch in translating schematic provisions into actions. Due to the resource crunch the Mission is not effective in achieving goals. Under the NAM, infrastructure upgradation such as building of integrated AYUSH hospitals, Drug testing Laboratories, State AYUSH Pharmacies has been taken place to limited extend but they are not fully functional due to unavailability of funds for deploying adequate manpower.

7. Meeting the targets through enhanced allocation of budget:

The budget allocation to AYUSH sector is roughly around 3-4% of entire health sector which is grossly insignificant considering the role these medical systems are required to play in primary health care focusing on holistic wellness model based principles of prevention and promotion. Enhanced investment in this sector will yield reduced disease burden and resultant reduction in the over-crowding of tertiary health care facilities. This will in turn reduce the out of pocket expenditure and financial burden on the population in developing country like India.

Given the Center's own limitations in increasing resource transfers to states through Centrally Sponsored Schemes, mobilizing the additional resources would require adoption of a comprehensive approach including Finance Commission awards rather than making incremental increases to the annual plans year after every year.

In this regard, Ministry of AYUSH submitted its Approach Paper to Finance Commission through nodal Ministry of Health & Family Welfare. Ministry projected its demand for allocation of minimum 10% of grant earmarked for Health sector.

8. Aim:

The proposal seeks to enhance the coverage of AYUSH services particularly in far flung and un-served areas of the country and to put in place a robust regulatory enforcement mechanism in order to provide holistic health to the population.

9. Objective:

- To make provision for AYUSH services at three levels of comprehensive Primary, Secondary and Tertiary through holistic wellness model based on AYUSH principles and practices
- To develop a robust regulatory and administrative framework in AYUSH Health System for assured quality.
- To empower masses for "self care" based on life style modifications and thus to reduce the disease burden &out of pocket expenditure
- To provide informed choice for pluralistic model of healthcare to the needy public.

10. Action plan:

1.1 Upgradation of Sub-Centres (SC) as Health & Wellness Centres by the Department of AYUSH in States /UTs under Ayushman Bharat:

The decision has been taken by Central Government that 10 % of all Sub-Centres to be developed in the country will be operationalised by the Ministry of AYUSH under Ayushman Bharat in Centrally Sponsored Scheme mode. Therefore the Ministry of

AYUSH has to operationalise 12500 HWCs in a period of three years, through States/ UT Governments. The main objectives are to establish a holistic wellness model based on AYUSH principles and practices, to empower masses for "self care" for reducing the disease burden & out of pocket expenditure and to provide informed choice to the needy public. Since this component would entail additional financial burden on States/ UTs, the finance commission award may provide corresponding State share of Rs. 2192.69 crores out of total financial implication of Rs. 5960.98 crores to implement this scheme based exclusively on AYUSH Wellness model.

Demonstration Model of HWC to be established by AYUSH under Ayushman Bharat programme

1.2 Establishing additional 10,935 HWCs in under-served / un-served areas: The Department of health has proposed to develop 32,900 Sub-Centres and the Ministry of AYUSH proposes to develop 1/3rd of 32,900 proposed sub-centres i.e. approximately 10935 SCs in relatively underserved and far flung areas of the Country where the particular AYUSH system is popularly accepted by the masses and traditionally practised in those areas. The existing schematic provisions do not have provision for accommodating this component, therefore finance commission package may, in particular, be useful for creating infrastructure for delivery of quality AYUSH services through these sub-centres to be designated as AYUSH health and wellness

centers. The AYUSH HWCs would serve as the first point of contact for primary healthcare services in these uncovered rural areas.

1.3 Setting up of Integrated AYUSH Hospitals in all Districts:

Hon'ble PM has expressed in his long term visionary goal for AYUSH that each district of the country should have one District level integrated AYUSH hospital which would provide AYUSh healthcare services under different systems and also would promote Yoga interventions at community level.

Therefore, establishment of Integrated AYUSH hospitals with in-patient facilities at every district is taken as one of the milestone to enable the states to provide the population the referral services in AYUSH systems of medicine. In this regard, Central Government through Centrally Sponsored Scheme of National AYUSH Mission (NAM) has provided Grant-in Aid to States/UTs for setting up of 85 integrated AYUSH hospitals in last 5 years. However, considering the need to expand this activity in all Districts of the country, where such hospitals are not available, 15th Finance Commission awards to the States would be highly essential so that health care continuum with AYUSH services can be accomplished. The States / UTs would take up the establishment of District level Integrated AYUSH hospitals with facilities under different systems of AYUSH including Yoga & Naturopathy services for strengthening promotive and preventive healthcare at community level alongwith curative services and in-patient care.

The financial requirement is 9711.38 Crores to establish such integrated AYUSH hospitals in 402 districts where such hospitals are not available at present.

1.4 Strengthening Drug Regulatory and administrative frame work:

Drugs under different AYUSH systems are regulated under Drugs & Cosmetics Act, 1940 and Drugs & Magic Remedies (Objectionable Adv.) Act, 1954. Provisions of these Acts are enforced by State / UTs Governments through framework of qualified professionals viz. Drug inspectors, Analysts, Licensing Authorities and Other Regulatory Staff. Due to inadequate Regulatory framework in States / UTs, this vital area is grossly ignored. It also affects the quality aspects of medicines manufactured in Pharmacies, regulation on sale and dispensation resulting in potential of marketing in foreign countries. Keeping in view, it is proposed to have the components of State pharmacies, State Drug Testing Laboratories and Drug Regulatory Enforcement Mechanism in the States / UTs.

11. Timeline

The above facilities will be established within 5 years, that is by 31st March 2025.

12. Details of the proposal:

The proposal seeks both onetime support and recurring expenditure during Fifteenth Finance Commission period.

- Onetime cost includes infrastructure and equipments including IT establishments.
- Recurring expenses include HR cost and medicines.

13. Financial requirement:

13.1 Sub-Centre to be developed as AYUSH Health & Wellness Centres by upgrading the existing facilities:

Cost Breakup for one Unit of HWC (Rs. in lakhs)			
Recurring Component (per annum)		**Non-Recurring Component**	
Manpower	7.876	Civil Works, equipments, fixtures, furniture, Lab	8.00
Medicines	2.00		
Contingency	0.50		
Training	0.3		
Laboratory	0.3		1.03
IT	0.05	Training	0.7
IEC	0.25	IT	0.63
		Monitoring	
Total	11.28		10.36
Grand Total	21.64		

13.2: Additional AYUSH HWCs to be developed in under served / un-served areas as <u>Fresh facilities</u>:

Cost Breakup (Rs. in lakhs)	
Recurring Component (per annum)	Non-Recurring Component

Manpower	**7.876**	**Infrastructure ,**	**61.77**
Medicines	**3.00**	**equipments,**	**3.91**
Contingency	**0.50**	**fixtures, furniture,**	
Training	**0.3**	**Lab**	
Laboratory	**0.3**		**0.8**
IT	**0.05**	**Training**	**0.84**
IEC	**0.25**	**IT**	**2.46**
		Monitoring	
Total	**12.276**		**69.78**
Grand Total	**82.056**		

13.3 Setting up of Integrated AYUSH Hospitals:

Cost Breakup			**(Rs. in lakhs)**
Recurring Component (per annum)		**Non-Recurring Component**	
Manpower	**120.00**	**Civil Works,**	**1500.00**
Medicines	**30.00**	**equipments,**	
Contingency		**fixtures, furniture**	
Total	**150.00**		**1500.00**
Grand Total	**1650.00**		

13.4 **Unit Cost of AYUSH Pharmacy, Drug Testing Laboratory (DTL) and Drug Control Administrative Framework**

Amount (Rs in Crore)

Sl.No	**Activity**	**State AYUSH Pharmacy**	**State DTL**	**Drug Control Framework**
	Non-Recurring			
1	Infrastructure (Building/ capital works)	4.50	2.50	-
2	Equipments/Machineries	4.00	2.00	1.00
3	IT Equipment	0.50	0.50	0.50
	Recurring			
4	Manpower	0.89	1.13	0.77
5	Raw Material & Consumables	0.65	0.40	-
6	Survey Sample etc.	-	-	0.10
	Total	**10.54**	**6.53**	**2.37**

State wise financial requirement for setting up of 12500 HWCs (upgradation of existing facilities)

Rs. in Crore

S.N.	State/UT	No. of HWCs	Unit cost		Total cost for 3 years	Central share	State share
			Non-recurring @10,36,430	Recurring for 3 Years			
1.	Andhra Pradesh	600	62.186	223.941	286.127	171.676	114.451
2.	Arunachal Pradesh	30	3.109	11.197	14.306	12.876	1.431
3.	Assam	400	41.457	149.294	190.751	171.676	19.075
4.	Bihar	800	82.914	298.588	381.503	228.902	152.601
5.	Chhatisgarh	450	46.639	167.956	214.595	128.757	85.838
6.	Goa	20	2.073	7.465	9.538	5.723	3.815
7.	Gujarat	750	77.732	279.927	357.659	214.595	143.064
8.	Haryana	200	20.729	74.647	95.376	57.225	38.15
9.	Himachal Pradesh	200	20.729	74.647	95.376	85.838	9.538
10.	Jammu & Kashmir	250	25.911	93.309	119.22	107.298	11.922
11.	Jharkhand	250	25.911	93.309	119.22	71.532	47.688
12.	Karnataka	750	77.732	279.927	357.659	214.595	143.064
13.	Kerala	450	46.639	167.956	214.595	128.757	85.838

S.N.	State/UT	No. of HWCs	Unit cost		Total cost for 3 years	Central share	State share
			Non-recurring @10,36,430	Recurring for 3 Years			
							Rs. in Crore
14.	Madhya Pradesh	900	93.279	335.912	429.191	257.514	171.676
15.	Maharashtra	850	88.097	317.25	405.347	243.208	162.139
16.	Manipur	40	4.146	14.929	19.075	17.168	1.908
17.	Mehgalaya	40	4.146	14.929	19.075	17.168	1.908
18.	Mizoram	35	3.628	13.063	16.691	15.022	1.669
19.	Nagaland	40	4.146	14.929	19.075	17.168	1.908
20.	Odisha	600	62.186	223.941	286.127	171.676	114.451
21.	Punjab	200	20.729	74.647	95.376	57.225	38.15
22.	Rajasthan	1,100	114.007	410.559	524.566	314.74	209.827
23.	Sikkim	15	1.555	5.599	7.153	6.438	0.715
24.	Tamil Nadu	650	67.368	242.603	309.971	185.983	123.988
25.	Telangana	400	41.457	149.294	190.751	114.451	76.301
26.	Tripura	100	10.364	37.324	47.688	42.919	4.769
27.	Uttarakhand	150	15.546	55.985	71.532	64.379	7.153

S.N.	State/UT	No. of HWCs	Unit cost		Total cost for 3 years	Central share	State share
			Non-recurring @10,36,430	Recurring for 3 Years			
							Rs. in Crore
28.	Uttar Pradesh	1,500	155.465	559.853	715.318	429.191	286.127
29.	West Bengal	700	72.55	261.265	333.815	200.289	133.526
30.	A&N Islands	11	1.14	4.106	5.246	5.246	0
31.	Chandigarh	2	0.207	0.746	0.954	0.954	0
32.	D&N Haveli	7	0.726	2.613	3.338	3.338	0
33.	Daman & Diu	3	0.311	1.12	1.431	1.431	0
34.	Delhi	1	0.104	0.373	0.477	0.477	0
35.	Lakshadweep	1	0.104	0.373	0.477	0.477	0
36.	Puducherry	5	0.518	1.866	2.384	2.384	0
TOTAL		**12,500**	**1295.540**	**4665.442**	**5960.986**	**3768.296**	**2192.690**

Establishment of AYUSH HWCs to be developed in States/UTs (to be developed as fresh facilities)

S.No:	State/UT	New Sub-Centres to be developed as AYUSH wellness Centres (in Nos.)	Cost of Sub-Centres to be developed as AYUSH wellness centres (Rs. in Crore)	Central Share (Rs. in Crore)	40% /10% State Share (Rs. in Crore)
1.	Andhra Pradesh	-	-	-	-
2.	Arunachal Pradesh	2	1.823	1.641	0.182
3.	Assam	402	366.517	329.865	36.652
4.	Bihar	2,896	3,960.57	2,376.342	1,584.228
5.	Chhattisgarh	-	-	-	-
6.	Goa	-	-	-	-
7.	Gujarat	-	-	-	-
8.	Haryana	238	325.488	195.293	130.195
9.	Himachal Pradesh	-	-	-	-
10.	Jammu & Kashmir	-	-	-	-
11.	Jharkhand	737	1007.922	604.753	403.169
12.	Karnataka	-	-	-	-
13.	Kerala	-	-	-	-
14.	Madhya Pradesh	374	511.482	306.889	204.593

S.No:	State/UT	New Sub-Centres to be developed as AYUSH wellness Centres (in Nos.)	Cost of Sub-Centres to be developed as AYUSH wellness centres (Rs. in Crore)	Central Share (Rs. in Crore)	40% /10% State Share (Rs. in Crore)
15.	Maharashtra	958	1310.16	786.096	524.064
16.	Manipur	27	24.617	22.155	2.462
17.	Meghalaya	105	95.732	86.159	9.573
18.	Mizoram	-	-	-	-
19.	Nagaland	20	18.234	16.411	1.823
20.	Odisha	502	686.535	411.921	274.614
21.	Punjab	173	236.595	141.957	94.638
22.	Rajasthan	-	-	-	-
23.	Sikkim	-	-	-	-
24.	Tamil Nadu	-	-	-	-
25.	Telangana	-	-	-	-
26.	Tripura	-	-	-	-
27.	Uttarakhand	-	-	-	-
28.	Uttar Pradesh	3,560	4,868.657	2,921.194	1,947.463
29.	West Bengal	909	1243.148	745.889	497.259
30.	A & N Islands	-	-	-	-
31.	Chandigarh	-	-	-	-

S.No:	State/UT	New Sub-Centres to be developed as AYUSH wellness Centres (in Nos.)	Cost of Sub-Centres to be developed as AYUSH wellness centres (Rs. in Crore)	Central Share (Rs. in Crore)	40% /10% State Share (Rs. in Crore)
32.	D & N Haveli	-	-	-	-
33.	Daman & Diu	-	-	-	-
34.	Delhi	24	19.693	19.693	-
35.	Lakshadweep	-	-	-	-
36.	Puducherry	8	6.564	6.564	-
Total		**10935**	**14683.737**	**8,972.822**	**5,710.915**

Establishment of District level Integrated AYUSH Hospitals in States / UTs

Sr. No.	Name of State/UT	Number Of the District	Number of Districts where AYUSH Hospital is available / under-establishment	Integrated AYUSH hospital to be established in Districts	Financial assistance required by States / UTs (Rs. in Crores)		
					Non-recurring	Recurring	Total
1	Andaman & Nicobar Islands	3	1	2	30.00	18.32	48.32
2	Andhra Pradesh	13	6	7	105.00	64.10	169.10
3	Arunachal Pradesh	25	1	24	360.00	219.78	579.78
4	Assam	33	2	31	465.00	283.89	748.89
5	Bihar	38	6	32	480.00	293.04	773.04
6	Chandigarh	1	1	0	0.00	0.00	0.00
7	Chhattisgarh	27	19	8	120.00	73.26	193.26
8	Daman & Diu	2	2	0	0.00	0.00	0.00
9	Dadar& Nagar Haveli	1	1	0	0.00	0.00	0.00
10	Delhi	11	0	11	165.00	100.73	265.73
11	Gujarat	33	23	10	150.00	91.58	241.58
12	Goa	2	2	0	0.00	0.00	0.00
13	Haryana	22	4	18	270.00	164.84	434.84
14	Himachal Pradesh	12	12	0	0.00	0.00	0.00

539

Sr. No.	Name of State/UT	Number Of the District	Number of Districts where AYUSH Hospital is available / under-establishment	Integrated AYUSH hospital to be established in Districts	Financial assistance required by States / UTs (Rs. in Crores)		
					Non-recurring	Recurring	Total
15	Jammu & Kashmir	22	6	16	240.00	146.52	386.52
16	Jharkhand	24	0	24	360.00	219.78	579.78
17	Kerala	14	14	0	0.00	0.00	0.00
18	Karnataka	30	30	0	0.00	0.00	0.00
19	Lakshdweep	1	1	0	0.00	0.00	0.00
20	Manipur	16	5	11	165.00	100.73	265.73
21	Mizoram	8	8	0	0.00	0.00	0.00
22	Madhya Pradesh	51	24	27	405.00	247.26	652.26
23	Maharashtra	36	4	32	480.00	293.04	773.04
24	Meghalya	11	2	9	135.00	82.42	217.42
25	Nagaland	11	4	7	105.00	64.10	169.10
26	Odisha	30	4	26	390.00	238.10	628.10
27	Puducherry	4	2	2	30.00	18.32	48.32
28	Punjab	22	5	17	255.00	155.68	410.68
29	Rajasthan	33	33	0	0.00	0.00	0.00
30	Sikkim	4	3	1	15.00	9.16	24.16
31	Tamil Nadu	32	4	28	420.00	256.41	676.41

Sr. No.	Name of State/UT	Number Of the District	Number of Districts where AYUSH Hospital is available / under-establishment	Integrated AYUSH hospital to be established in Districts	Financial assistance required by States / UTs (Rs. in Crores)		
					Non-recurring	Recurring	Total
32	Telangana	31	8	23	345.00	210.63	555.63
33	Tripura	8	4	4	60.00	36.63	96.63
34	Uttar Pradesh	75	67	8	120.00	73.26	193.26
35	Uttrakhand	13	10	3	45.00	27.47	72.47
36	West Bengal	23	2	21	315.00	192.31	507.31
		722	**320**	**402**	**6030.00**	**3681.38**	**9711.38**

025

Strengthening AYUSH Drug Regulatory Framework in States / UTs - State-wise Requirements

(Rs. in Crore)

S. No	States/Uts	State AYUSH Pharmacies			State Drug Testing Laboratory			State ASU&H Drug Control Framework		
		Number of Units	Non Recurring	Recurring	Number of Units	Non Recurring	Recurring	Number of Units	Non Recurring	Recurring
1	Andaman & Nicobar	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
2	Andhra Pradesh	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
3	Arunachal Pradesh	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
4	Assam	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
5	Bihar	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
6	Chandigarh	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
7	Chhattisgarh	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
8	D&N Haveli	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
9	Daman & Diu	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
10	Delhi	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
11	Goa	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
12	Gujarat	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870

(Rs. in Crore)

S. No	States/Uts	State AYUSH Pharmacies			State Drug Testing Laboratory			State ASU&H Drug Control Framework		
		Number of Units	Non Recurring	Recurring	Number of Units	Non Recurring	Recurring	Number of Units	Non Recurring	Recurring
13	Haryana	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
14	Himachal Pradesh	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
15	Jammu & Kashmir	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
16	Jharkhand	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
17	Karnataka	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
18	Kerala	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
19	Lakashdeep	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
20	Madhya Pradesh	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
21	Maharashtra	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
22	Manipur	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870

(Rs. in Crore)

S. No	States/Uts	State AYUSH Pharmacies			State Drug Testing Laboratory			State ASU&H Drug Control Framework		
		Number of Units	Non Recurring	Recurring	Number of Units	Non Recurring	Recurring	Number of Units	Non Recurring	Recurring
23	Meghalaya	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
24	Mizoram	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
25	Nagaland	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
26	Orissa	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
27	Puducherry	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
28	Punjab	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
29	Rajasthan	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
30	Sikkim	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
31	Tamil Nadu	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
32	Tripura	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
33	Uttar Pradesh	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
34	Uttarakhand	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870

(Rs. in Crore)

S. No	States/Uts	State AYUSH Pharmacies			State Drug Testing Laboratory			State ASU&H Drug Control Framework		
		Number of Units	Non Recurring	Recurring	Number of Units	Non Recurring	Recurring	Number of Units	Non Recurring	Recurring
35	West Bengal	1	9.000	1.540	1	5.000	1.530	1	1.500	0.870
Total		**35**	**315.000**	**53.900**	**35**	**175.000**	**53.550**	**35**	**52.500**	**30.450**

Grand Total **680.40** **Crore**

14. Cumulative Financial Projections

Rs. in Crore

S.No.	Service Area	Total Financial Implication	Requirement from Fifteenth Finance Commission	Remarks
1	Development of AYUSH Health & Wellness Centres -12500	5,960.98	2,192.69	State share to be met from Finance Commission Award
2	Development of New Sub Centers in unserved and under-served Areas - 10935	14,683.74	5,710.92	
3	Integrated District Hospitals	9,711.00	9711.00	States / UTs to be provided 100% financial support under this head.
4	Strengthening Drug Regulatory Framework	680.40	680.40	
5	Strengthening Administrative Framework	762.29	762.29	Administrative requirement is 4% of total financial requirement from Fifteenth Finance Commission.
	TOTAL	**31,798.41**	**19,057.30**	