

A RESPONSE TO THE DRAFT NATIONAL HEALTH POLICY 2001

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1. INTRODUCTORY / CURRENT SCENARIO

The NHP 2001 begins with some of the recommendations of the NHP 1983 but all the 4 recommendations listed in para 1.2, i thru iv, in the 2001 policy document are unrealized nearly two decades later – the network of PHCs do not provide comprehensive primary health care but only family planning services, selected immunization services and selected disease surveillance; health volunteers started in 1977 have now disappeared in most states; there is no organised referral system for the hospitals because the decentralized care does not meet the health care needs of the masses; and evenly spread speciality and super-specialty services do not exist, whether public or private they are located mostly in metro cities or other large cities.

The NHP 1983 had other critical recommendations which the NHP 2001 does not refer to :

- ✓ the establishment of a nationwide network of epidemiological stations that would facilitate the integration of various health interventions, and
- ✓ targets for achievement that were primarily demographic in nature.
- ✓ an expansion of the private curative sector which would help reduce the government's burden,

During the decade following NHP 1983 rural health care received special attention and a massive program of expansion of primary health care facilities was undertaken in the 6th and 7th Five Year Plans to achieve the target of one PHC per 30,000 population and one subcentre per 5000 population. This target has more or less been achieved, though a few states still lag behind. However, various studies looking into rural primary health care have observed that, though the infrastructure is in place in most areas, they are grossly underutilised because of poor facilities, inadequate supplies, insufficient effective person-hours, poor managerial skills of doctors, faulty planning of the mix of health programs and lack of proper monitoring and evaluatory mechanisms. Further, the system being based on the health team concept failed to work because of the mismatch of training and the work allocated to health workers, inadequate transport facilities, non-availability of appropriate accommodation for the health team and an unbalanced distribution of work-time for various activities. In fact, all studies have observed that family planning, and more recently immunisation, get a disproportionately large share of the health workers' effective work-time. (NSS,1987, IIM(A),1985, NCAER,1991, NIRD,1989, Ghosh,1991, ICMR,1989, Gupta&Gupta,1986, Duggal&Amin,1989, Jesani et.al,1992, NTI,1988, ICMR,1990)

Among the other tasks listed by the NHP 1983, decentralisation and deprofessionalisation have taken place in a limited context but there has been no community participation. The entire burden of whatever care PHCs and SCs provide falls on the shoulders of the ANM – the male health worker is being phased out and the health volunteers are vanishing in most states. This model of primary health care being implemented in the rural areas has not been acceptable to the people as evidenced by their health care seeking behaviour. The rural population continues to use private care and whenever they use public facilities for primary care it is the urban hospital they prefer (NSS-1987, Duggal & Amin,1989, Kannan et.al.,1991, NCAER,1991, NCAER,1992, George et.al.,1992). Let alone provision of primary medical care, the rural health care system has not been able to provide for even the epidemiological base that the NHP of 1983 had recommended. Hence, the various national health programs continue in their earlier disparate forms, as was observed in the NHP 1983 (MoHFW,1983, p 6).

As regards the demographic and other targets set in the NHP 1983, only crude death rate and life expectancy have been on schedule. The others, especially fertility and immunisation related targets are much below expectation (despite special initiatives and resources for these programs over the last two decades), and those related to national disease programs are also much below the expected level of achievement. In fact, we are seeing a resurgence of communicable diseases.

However, where the expansion of the private health sector is concerned the growth has been phenomenal thanks to state subsidies in the form of medical education, soft loans to set up medical practice etc... The private health sector's mainstay is curative care and this is growing over the years (especially during the eighties and nineties) at a rapid pace largely due to a lack of interest of the state sector in non-hospital medical care services, especially in rural areas (Jesani&Ananthram,1993). Various studies show that the private health sector accounts for over 70% of all primary care treatment sought, and over 50% of all hospital care (NSS-1996, Duggal&Amin,1989, Kannan et.al.,1991, NCAER,1991, George et.al.,1992). This is not a very healthy sign for a country where over two-thirds of the population lives either at or below subsistence levels.

The above analysis clearly indicates that NHP 1983 did not reflect the ground realities adequately. The tasks enunciated in the policy were not sufficient to meet the demands of the masses, especially those residing in rural areas. "Universal, comprehensive, primary health care services", the NHP 1983 goal, is far from being achieved.

The NHP 2001 does not even refer to this goal but clearly acknowledges that the public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continues to be unacceptably high, and resource allocations generally insufficient - *"It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the*

equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services.”(para 2.4.1 NHP 2001).

The NHP 2001 needs to be lauded for its concern for regulating the private health sector through statutory licensing and monitoring of minimum standards by creating a regulatory mechanism. This has been an important struggle of health researchers and activists to build accountability within the private health sector and we hope the new policy addresses this issue rigorously. Also the express concern for improving health statistics, including national accounts, is welcome. A mechanism of assuring statutory reporting not only by the public system but also the private sector is an urgent requirement so that health information systems provide complete and meaningful data.

2. NHP 2001 POLICY PRESCRIPTIONS

The main **objective** of NHP 2001 is to achieve an acceptable standard of good health amongst the general population of the country (para 3.1). The goals given in Box IV of the policy document are laudable but how their achievement in the specified time frame will happen has not been supported adequately in the policy document. Goal number 10 “Increase utilization of public health facilities from current level of <20 to >75%” is indeed remarkable. What it means is reversal of existing utilization patterns which favour the private sector. While we support this goal to the hilt we are worried that many prescriptions of the policy favour strengthening of the private health sector and hence is contrary to this goal. Hence, all such prescriptions relating to a larger role of the private health sector must be removed from the policy and instead regulation of the practice and growth of the private health sector must be an important concern for this policy.

We support larger **allocation of resources** by the Centre and larger allocations being recommended for state governments but the states must be given autonomy to use these resources as per their own needs and for this the Centre must insist that states formulate their own health policies.

While much more resources need to be allocated for the public health sector, it is also clear that allocative efficiencies have to be looked into. Since the mid-eighties the proportion of consumables and maintenance costs and capital costs in the health budget have been declining and this decline got further hastened after the 5th pay Commission. The two NSSO surveys of 1986-87 and 1995-96 clearly show declines in share of public sector utilization in both OPD and hospitalization services between the two periods and this correlates very well with reductions seen in expenditures on the non-salary components of the health budgets. Instead of only talking about proportionate allocations to the primary, secondary and tertiary sectors can we also talk about global budgeting with assured allocative ratios, that is budgets being distributed on a per capita basis (ofcourse with appropriate weightages for sparse and hilly areas) and with clearly worked out ratios for line items. Moreover there should be autonomy to local governments to make their own health programs subject to a review based on local epidemiological information and facts.

To illustrate this, taking the CHC area of 150,000 population as a “health district” at current budgetary levels under global budgeting this “health district” would get Rs. 300 lakhs (current resources of state and central govt. combined is over Rs.20,000 crores, that is Rs. 200 per capita). This could be distributed across this health district as follows : Rs 300,000 per bed for the 30 bedded CHC or Rs. 90 lakhs (Rs.60 lakhs for salaries and Rs. 30 lakhs for consumables, maintenance, POL etc..) and Rs. 42 lakhs per PHC (5 PHCs in this area), including its sub-centres and CHVs (Rs. 32 lakhs as salaries and Rs. 10 lakhs for consumables etc..). This would mean that each PHC would get Rs. 140 per capita as against less than Rs. 50 per capita currently. In contrast a district headquarter with 300,000 population would get Rs. 600 lakhs, and assuming Rs. 300,000 per bed (for instance in Maharashtra the current district hospital expenditure is Rs. 150,000 per bed) the district hospital too would get much larger resources. To support health administration, monitoring, audit, statistics etc, each unit would have to contribute 5% of its budget. Ofcourse, these figures have been worked out with existing budgetary levels and excluding local government spending which is quite high in larger urban areas. Given larger resource allocations as per the NHP 2001, the per capita funds available would be much higher. Such reorganization of fund allocations will remove the inadequacies of the public health system as highlighted in the policy in paras 2.4.1 and 4.4.1.

In para 4.3.1, the NHP 2001 talks about **program implementation** through autonomous bodies. The “health district” mentioned above could become the basic unit with a health committee constituting elected (Panchayat), professional (doctors, nurses etc.) and consumer representatives into the governing body. This would also mean substantial pruning of the existing health bureaucracy as the control will now vest with the local authority and the role of the state health dept. would be overall monitoring and audit as indicated in the NHP 2001.

In para 4.4.2 the NHP 2001 expresses the practical need to levy reasonable **user charges** for certain secondary and tertiary health care services. User-charges is a regressive means of recovering costs and given the overall conditions of poverty it is also not an appropriate means of collecting revenues. Those who have the capacity to pay must be made to pay through other means. All persons having regular wages/salaries or business incomes must contribute through payroll taxes for health, perhaps something similar to the profession tax charged in some states. Other ways of generating revenues need to be considered, such as proportion of turnover of health degrading products like cigarettes, alcohol, guthka, pan masalas etc.. as a health levy earmarked for the Ministry of Health. A health cess could be charged on items such as personal vehicles, air-conditioners, mobile phones and other luxury products, owned houses of a certain type/dimensions, on land revenues, on polluting industries etc..

While the NHP 2001 does mention the need to make more provisions for medicines and other consumables, there is no mention of the Health Dept. playing a proactive role in the **drug policy**. This is a serious anomaly in the NHP 2001 and the Health dept must exert its right to determine the drug policy, especially with regard to price control over the WHO list of 300 essential drugs.

In reference to para 4.5.1 with regard to expanding the pool of medical practitioners instead of creating licenciates, qualified practitioners of other systems, nurses, pharmacists and other paramedics with certain years (say 8-10) of experience should be allowed to complete the MBBS course by recognizing their existing skills for which they could be given credits and would have to do a shorter course to complete the MBBS degree.

With regard to **regulation of the private health sector** the concern expressed in the NHP 2001 is welcome (para 4.13.1). There is an urgent need to have a comprehensive legislation on clinical establishments and medical institutions which specifies minimum standards, good medical practice standards, a mechanism for accreditation, a system of licensing where the local govt. should have the authority to decide how many practitioners, hospitals/hospital beds, diagnostic facilities etc.. it needs under its jurisdiction. Further renewal of doctors/ hospitals/ diagnostic centres etc.. registration and license should be subject to periodic reviews, including continuing medical education and upgradation of knowledge and facilities. Further, to rationalize health resources the state should endeavour to organize the entire health care system, public and private, under a common organized structure through which a regulated public-private mix system can be evolved, similar to most countries, which have near universal access health care systems. Such restructuring of the health care system will lead to genuine reforms and establish greater equity in access to health care.

Finally, the **primary health care package** needs to be clearly defined. A suggestion of what this should comprise is given below:

- General practitioner/family physician services for personal health care, including support of paramedics and health volunteers for preventive and promotive care.
- First level referral hospital care and basic specialty (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic) services, including dental and ophthalmic services.
- Immunisation services against vaccine preventable diseases.
- Maternity services for safe pregnancy, safe abortion, safe delivery and postnatal care.
- Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.
- Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- Ambulance services.
- Contraceptive services.
- Health education.

To conclude it is important to emphasise that a health policy, like any other policy, must make a political statement and give evidence of the backing of a political will. There must of necessity be a preamble, which makes this expression of a political commitment and in this case it must be in the context of health and health care as a right. In the absence of expression of such a political will there cannot be a policy but only a statement of intent.

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