

DRAFT NATIONAL HEALTH POLICY 2001-II

Resource Generation without Planned Allocation

Unlike the health policy of 1983, this policy attempts to address the problem of poor financial allocations for health care and recommends that it be enhanced considerably. But without a detailed exercise inquiring into the present pattern of allocations, this prescription, overdue as it is, will not serve any purpose. If the additional resources are to make an impact, considerable restructuring of the health system has to be undertaken urgently.

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The NHP 2001 begins with some of the recommendations of the NHP 1983 but all the four recommendations listed in para 1.2, i through iv, in the 2001 policy document are unrealised nearly two decades later – the network of PHCs do not provide comprehensive primary health care but only family planning services, selected immunisation 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 decentralised care does not meet the health care needs of the masses; and even spread specialty 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; targets for achievement that were primarily demographic in nature; and 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 programme of expansion of primary health care facilities was undertaken in the Sixth and Seventh Five-Year Plans to achieve the target of one PHC per 30,000 population and one subcentre per 5,000 population. This period is also the period when public health spending achieved its peak in terms of proportion to the GDP touching 1.26 per cent. The targets of these two plans have more or less been achieved, though a few states still lag behind. However, various studies on 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

programmes and lack of proper monitoring and evaluatory mechanisms. Further, the system being based on the health team concept has 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, various studies have observed that family planning, and more recently immunisation, get not only a large share of public health resources, but also take a disproportionately large share of the health workers' effective work time. [NSS1987; IIM(A) 1985; NCAER 1991; NIRD 1989; Ghosh 1991; ICMR 1989; Gupta and Gupta 1986; Duggal and Amin 1989; Jesani et al 1992; NTI 1988; ICMR 1990.]

Among the other tasks listed by the NHP 1983, decentralisation and de-professionalisation 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 with a tremendous load of out-of-pocket expenditures, and whenever they use public facilities for primary care it is the urban hospital they prefer [NSS 1987, Duggal and 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 programmes continue in their earlier disparate forms, as was observed in the NHP 1983 [MoHFW, 1983: 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 programmes over the last two decades) and those related to national disease programmes 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 1980s and 1990s) 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 and Ananthram 1993]. Various studies show that the private health sector accounts for over 70 per cent of all primary care treatment sought, and over 50 per cent of all hospital care [NSS-1996, Duggal and 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.

Though the NHP 2001 does not even refer to this goal, it 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 outdoor medical facilities in existence, funding is generally insufficient; the presence of medical and paramedical 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 indoor 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 overcrowding, and consequently 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.

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 utilisation of public health facilities from current level of <20 to >75 per cent" is indeed remarkable. What it means is reversal of existing utilisation 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-1980s 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 Fifth Pay Commission. The two NSSO surveys of 1986-87 and 1995-96 clearly show declines in share of public sector utilisation in both OPD and hospitalisation 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 in the new policy can we also talk about global budgeting with assured allocative ratios, that is budgets being distributed on a per capita basis (of course 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 programmes subject to a review based on local epidemiological information and facts.

To illustrate this, taking the community health centre (CHC) area of 150,000 population as a 'health district' at current budgetary levels under global budgeting this 'health district' would get Rs 300 lakh (current resources of state and central governments combined is over Rs 20,000 crore, that is Rs 200 per capita). This could be distributed across this health district as follows: Rs 3,00,000 per bed for the 30-bedded CHC or Rs 90 lakh (Rs 60 lakh for salaries and Rs 30 lakh for consumables, maintenance, POL etc) and Rs 42 lakh per PHC (five PHCs in this area), including its subcentres and CHVs (Rs 32 lakh as salaries and Rs 10 lakh 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 town with 3,00,000 population would get Rs 600 lakh, and assuming Rs 3,00,000 per bed (for instance in Maharashtra the current district hospital expenditure is only Rs 1,50,000 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 per cent of its budget. Of course, 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 recommendations, the per capita funds available would be much higher. Such reorganisation 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 programme 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 department 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, gutkha, 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 department playing a proactive role in drug policy. This is a serious anomaly in the NHP 2001 and the health department must exert its right to determine the drug policy, especially with regard to price control over the WHO list of 300 essential drugs. This is extremely critical in the context of India switching over to the product patent regime under the new arrangement of WTO/TRIPS from 2005. The advantage India has of lowest prices of drugs in the world will be lost if a drug policy favouring public health concerns is not put into place before the above deadline.

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 recognising 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 government 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 licence should be subject to periodic reviews, including continuing medical education and upgradation of knowledge and facilities. Further, to rationalise health resources the state should endeavour to organise the entire health care system, public and private, under a common organised 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 post-natal 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 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.

Further, unlike the 1983 health policy, the new policy at least talks about raising financial allocations. This is a positive sign and needs elaboration. As mentioned above merely raising the overall proportion of expenditure is not adequate. Equal importance has to be given to the way resources are allocated. Adding more resources without reorganising the way they are allocated will not serve any purpose. Hence the new health policy must undertake a detailed exercise in how existing and additional resources will be used. Without doing this, the policy prescriptions will have very little meaning. It would be similar to the panchayat raj initiative – the structure and responsibilities were appropriately amended, elections were held but no financial resources were assigned for carrying out the changes. A suggestion for reallocation of resources has been given above and one can build on this to come up with a definitive plan provided the political will is expressed and enacted.

Reorganising resource allocations in a meaningful way is only the first step. The restructuring of the health care system through a regulatory mechanism, which also organises the entire health care system

should follow. The private sector cannot be left to its own means and ways. It needs to be integrated under a common umbrella along with the public health system. Worldwide the experience shows that if near universal access has to be achieved then an organised public-private mix health care system has to evolve. Apart from regulation, standards, accreditation for the functioning of the health care system one will also need to create a monopoly buyer of health care services and this need not necessarily be the state but some other public arrangement – there is a lot of global experience to learn from. **EPW**

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