

**CUTS Comments on  
National Health Policy (Draft)  
Released by Ministry of Health & Family Welfare, Government of India**

### Public Healthcare Delivery

- Annual family health check-up has to be made compulsory and free of cost so that ailments can be screened at its early stage only. History sheets can be opened for a person who's health condition required more attention and special care. There has to a call center at state level for primary health care services to know the details and for this professional agencies can be hired in a PPP mode.
- Concept of 'Doctor at your Doorstep' in the form of community health checkup camps has to be started and compulsorily two health checkup camps has to be conducted at each revenue village level in collaboration of Gram Panchayats At PHC level a 'Public Private Partnership approach' Document has to prepared to explore the possibility of the local interest people to collaborate in the outreach activities and field camps for health checkups.
- The availability of the primary health services has to be on 24X7 basis.
- To implement such incentive bases service delivery mechanism is never free from corruption and this need strong monitoring mechanism which is online and easy to track will help this scheme to execute there for online monitoring system will have to be created for this.
- Regular capacity building exercise has to happen for ASHA bases new emerged out health challenges and existing local health problems.
- For urban ASHA concept is good but the efficiency and ability and skill of urban ASHA shall be much higher than the ASHA in rural areas and for that trained women shall be hired since in urban areas the awareness of middle class people is a bit higher.
- When integration of all the medical systems including AYUSH was done in some of the states like Rajasthan under NRHM. And AYUSH clinics were merged with health centres. AYUSH doctors were posted in night shifts and it was that these AYUSH doctors never handled cases of delivery in their 20 to 25 years of service along with accident cases and other sort of emergency cases. Then after It is always blamed that AYUSH system is unable to meet the emergency situations and cases of maternity but they can do so if more and more research work is done in all the streams of AYUSH and more and more resource and required infrastructure is provided to AYUSH systems.

- Persons with Disabilities (PWDs) need special attention during emergency situations since they are the persons who are physically challenged therefore less accommodated and equipped to save themselves during these emergencies so PWDs shall be kept in mind while preparing for emergency health care and disaster preparedness in general.

## Healthcare Infrastructure

- Government has recently (December 2014) ordered a US\$ 948 million (20 percent) cut in its 2014-15 healthcare budget due to fiscal constraints. While the total spending on healthcare is estimated at 4.1 percent of GDP, In light of such budget cuts how the government is planning to achieve universal health coverage and right to primary health is not clear
- Public procurement has 25 to 30 % stake in the GDP of India there it becomes very crucial that all the processes of every procurement activity are transparent, accountable and free from all sorts of corruption. At national level there is no public procurement act in place so far so in absence of such legal framework a dedicated portal has to be created to put on all the health related procurements and enabling e procurement, developing management of information system (MIS) and managing entire chain of procurement by using latest ICT tools.
- For strengthening of Infrastructure and development of Human Resources, the financial outlay needs to be enhanced tremendously. Looking at the present resources, government alone may not be available to fulfil the gap. For this PPP (Public Private Partnership) or PPCP (Public Private and Community Partnership) approaches should be adopted. Private players should be invited and supported on cost cum profit sharing method and should be incentivised to operate in the areas and sectors where its difficult and non-remunerative to operate. These approaches should be used not only for creation of infrastructure for health care services but also for preparing human resource development (such as nursing colleges or technical training facilities).
- Most of the private hospitals in urban areas are constructed on the land leased out to them based on certain conditions of serving the poor and marginalised sections of the society. But these norms are widely violated there some mechanism has to be created to monitor these public welfare norms in a foolproof manner.
- On one hand where rate of fertility is high in some states which is resulting in to high rate of population growth while the number of cases of Infertility among couples is growing and as a result thousands of couples remain unblessed with even one child. Therefore Health policy shall well recognize this and give due importance to this growing problem as well.

- Tertiary care services shall be seen from state perspective it is planned in such a way that for super speciality services citizens of one state shall not need to travel to other states and there shall be multiple centre in bigger states like Madhya Pradesh, Rajasthan, Uttar Pradesh and Karnataka.
- Insufficient no of blood banks - Total number of licensed Blood Banks in the Country as on January 2011 is 2,445. This is so insufficient if you compare it with india's 1.2 billion population. The policy should call for establishments of more blood banks and encourage and incentivise private players

### Concerns on Quality of Care

- Absenteeism in the health sector especially in rural areas is a big problem which results in to poor services. This happens due to less human resources and health being an emergency job at 24X7basis.
- The monitoring mechanism for actual implementation of schemes has not been very effective. The same needs to be strengthened along with the accountability at the level of block and district level officials for not achieving the results.
- In terms of achieving access to quality healthcare, government should provide subsidies for target populations and high-impact interventions through subsidised health vouchers particularly to poors and bottom of pyramid as it will increase access to higher quality care for the poor. It will also help create incentives for private providers to serve the poor.

### Healthcare Regulation

- In terms of regulator for private healthcare sector, the draft policy should announce to establish a National Health Regulatory and Development Authority (NHRDA) as discussed during the UPA II regime which is tasked with regulating and monitoring public and private healthcare providers. The authority would also be responsible for developing ethical standards for healthcare delivery and the accreditation of healthcare providers and linked to similar state-level institutions.
- One of the potential measures to check the malpractices of private sector is the Clinical Establishments (registration and regulation) Act of 2010 (CEA), which permits public health authorities to conduct inspections and penalise or cancels the licences of hospital and other clinical establishments that fleece patients. So far only few states have implemented the Act. States need to be encouraged and assisted in the process of enforcement of the CEA. As it stands now, the Clinical Establishment Act 2010 is primarily a licensing legislation – however, with time this should be amended to

incorporate stronger provisions pertaining to quality of service delivery of these institutions. Development of a centralized portal (<http://clinicalestablishments.nic.in/>) is a step in the right direction to ensure transparency and accountability of private clinical establishments across states.

- The NHP should replace the existing CDSCO with a more powerful and independent regulator which should be fair and transparent in its decision making unlike the CDSCO. The new regulator should be given adequate autonomy to discharge its functions and effectively specify regulations and norms for central and state drug licencing authorities and will periodically assess their functioning thus doing away with the current contrast between the Centre and states regulation which is not much effective.
- The regulatory framework in healthcare remains fragmented – and the National health Policy should aim to address this anomaly. There are three main elements that would need to be addressed to ensure that the objects of effective regulatory oversight by the (National and State) government is achieved:
  - (i) Coordination between related organs/Ministries: there is little coordination between the two key Ministries – MoHFW and Department of Pharmaceuticals (a transparent and well laid out process of coordination needs to be institutionalised)
  - (ii) Need for better coordination between national and the state on key matters of healthcare. The government should consider forming a ‘Task Force’ under the NITI Ayog on ‘Healthcare delivery’<sup>1</sup>
  - (iii) Coordination between related organs/Ministries: Provisions in certain legislations (e.g. Dugs and Cosmetics Act) calls for coordination between Department of Pharmaceutical and certain other organs of the government (e.g. Ministry of Env and Forests on GMP related provisions). But there is no perceptible coordination in practice
- No mention has been made of two key roles of the government in healthcare, especially given that there are regulations in place for their implementation:
  - (i) Uniform Code of Pharmaceutical Marketing Practices (UCPMP) which needs to be enforced without further delays (in spite of the fact that it is supposed to come into effect from 1<sup>st</sup> Jan 2015 – there is little information in the public domain)
  - (ii) Price regulation of drugs undertaken by the National Pharmaceutical Pricing Authority – the overall strategy for price regulation should remain clear (provision of good quality drugs at low costs to the poorest sections of the population) and guide the process and practices in price regulation of drugs. All drugs in the National List of Essential Medicines should be price regulated by the government.

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<sup>1</sup> Two such Task Forces are already being planned – one on poverty alleviation and the other on agriculture sector (refer: <http://www.ndtv.com/india-news/niti-ayog-pm-modi-to-form-sub-groups-on-central-schemes-clean-india-737916>)

- Public health system needs to be made accountable and participatory. Institute a mechanism to monitor the clinical effectiveness of quality of services offered at public facilities. How the poor facilities even in large Government institutions compared to other similar corporate hospitals can be improved has no mention in the draft. Policy should push for NABH/NABL certification for public hospitals as well
- The point about the need to address the fragmented regulatory apparatus needs to be reiterated here. The following are key ingredients for effective regulation:
  - Clear institutional mandate (allocation of responsibility)
  - Clearly stated purpose of regulation
  - Mechanism for cooperation/coordination between Ministries/organs of government where necessary
- Draft is silent on provisions regarding regulation on ever expanding private healthcare sector and providers which contributes to 80% of outpatient and 60% inpatient care. One of the potential measures to check the malpractices of private sector is the Clinical Establishments (registration and regulation) Act of 2010 (CEA), which permits public health authorities to conduct inspections and penalise or cancels the licences of hospital and other clinical establishments that fleece patients. So far only few states have implemented the Act. The National health Policy should suggest fast track adoption of the CEA at state level
- The policy should create platforms for mandatory interaction between the stakeholders i.e. industry and regulators, industry and consumers, trade and regulators and medical professional and regulators.
- An variety of secondary and tertiary services are proposed to be bought by the government from private healthcare facilities -- though it is unclear how this differs from the present system of 'empanelled' private hospitals. This system has not proved very effective for various reasons, including delayed and inadequate reimbursement of the costs.
- The section is silent about the effective application of the “Sales Promotion Employees (Condition of Services) Act 1976” – which was brought about to protect the interests of sales promotion employees (including Medical Sales Representatives or MRs as they are popularly referred to). Salaries of MRs are not fixed and linked to ‘sales volume’ , which promotes malpractices.