CHAPTER – 4

HEALTH FOR ALL INTERNATIONAL AND NATIONAL POLICY

4.1. International Policy

Health for all is internationally accepted goal. The entire community of the world is called for the protection, improvement and promotion of the health of all people on the globe.

4.1.1. International Treaties and Conventions Ratified by India

Alma Ata Declaration

The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC), Almaty (Kazakhstan) in September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health for All".

The conference was called for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urged governments, the WHO, UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the world
community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The conference called on the afore mentioned was to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of the declaration. The declaration has 10 points and is non-binding on member states.

The declaration reaffirms the WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The definition seeks to include social and economic sectors within the scope of attaining health and reaffirms health as a human right.

Equity

The declaration highlighted the inequity between the developed and the developing countries and termed it politically, socially and economically unacceptable. ▪ Health as a Socio-Economic Issue and As a Human Right The declaration called for economic and social development as a pre-requisite to the attainment of health for all. It also declared positive effects on economic and social development and on world peace through promotion and protection of health of the people. Participation of people as a group or individually in planning and implementing their health care was declared as a human right and duty.

Role of the State

It emphasized on the role of the state in providing adequate health and social measures. It defined ‘Health for All’ as the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. The declaration urged governments, international organizations and the whole world community to take this up as a main social target in the spirit of social justice.
Primary Health Care and Components

It urged signatories to incorporate all components of the primary health care in their health systems as the most efficient and cost-effective way to organize a health system and urged international cooperation in better use of the world's resources towards achievement of the goal “Health for All. Primary health care has since been adopted by many member nations.

4.1.2. International Conference on Population & Development (ICPD) Cairo, 1994

It was a milestone in the history of population policy and in the history of women’s rights. ICPD programme of action was signed by 179 nations. Consensus was reached on ‘women’s equality and empowerment’ as global priority. This was recognized not only as universal human right but as an essential step towards eradicating poverty and stabilizing population growth. Women’s ability to access reproductive health and rights is recognized as the cornerstone of her empowerment. ICPD programme of action emphasizes

- Providing universal access to family planning & sexual and reproductive health services
- Gender equality, women’s empowerment & equal access to education for girls
- Addressing the individual, social & economic impact of urbanization and migration
- Addressing environmental issues associated with population changes with focus on sustainable development
- Partnership with Non-govt. sector

Adoption of this approach led to the formulation of a truly comprehensive population policy for India in 2000. Replacement of MCH approach by RCH approach, target free approach to family planning, identifying 12 strategic themes beyond family planning as mentioned earlier were the key features of this policy. Later ICPD + 5 reviews led to formulation of Millennium Development Goals.
4.1.3. United Nations Millennium Declaration, 2000

The **Millennium Development Goals** (MDGs) are eight international development goals that were established following the Millennium Summit of the United Nations in 2000, following the adoption of the United Nations Millennium Declaration. All 189 United Nations member states at the time (there are 193 currently) and at least 23 international organizations committed to help achieve the Millennium Development Goals by 2015, the goals follow:

**Goal I:** To eradicate extreme poverty and hunger - Halve between 1990 & 2015 the proportion of poor people

**Goal II:** Universal primary education - 100% primary completion rate for all children by 2015

**Goal III:** Promote gender equality and empower women - Eliminate gender disparity in primary & secondary education by 2005 and at all levels by 2015

**Goal IV:** Reduce child mortality by 2/3rds between 1990 and 2005

**Goal V:** Improve maternal health – Reduce 1990 maternal mortality levels by 3/4ths by 2015

**Goal VI:** Combat HIV+ and related diseases – To halt them by 2015 and reverse their spread

**Goal VII:** Ensure environmental sustainability

**Goal VIII:** Develop a global partnership for development

To accelerate progress, the G8 Finance Ministers agreed in June 2005 to provide enough funds to the World Bank, the International Monetary Fund (IMF) and the African Development Bank (AfDB) to cancel $40 to $55 billion in debt owed by members of the Heavily Indebted Poor Countries (HIPC) to allow them to redirect resources to programs for improving health and education and for alleviating poverty.


Following the framework adopted in WHO convention, Government of India enacted
Cigarettes & Other Tobacco Products ( Prohibition & Advertisement ) Act 2003(COTPA) with a view to achieve improvement of public health in general and to prohibit advertisement of and to provide for regulation of trade, commerce, production, supply and distribution of cigarettes and other tobacco products in the country. Act is enforced since May 2004. Important features of COTPA

1. Ban on smoking in public places (including work places after 2008)
2. Ban on advertising of tobacco products
3. Ban on sale of tobacco products to minors & within 100 yards from educational institutions
4. Mandatory display of pictorial health warning on all tobacco product packages

4.1.5. The Declaration of Helsinki

The Declaration is a set of ethical principles regarding human experimentation developed for the medical community by the World Medical Association (WMA). It is widely regarded as the cornerstone document on human research ethics.

It is not a legally binding instrument under the international law, but instead draws its authority from the degree to which it has been codified in, or influenced, national or regional legislation and regulations. Its role was described by a Brazilian forum in 2000 in these words "Even though the Declaration of Helsinki is the responsibility of the World Medical Association, the document should be considered the property of all humanity".

The Declaration was originally adopted on June 1964 in Helsinki, Finland, and has since undergone seven revisions (the most recent at the General Assembly in October 2013) and two clarifications, growing considerably in length from 11 paragraphs in 1964 to 37 in the 2013 version. The Declaration is an important document in the history of research ethics as it is the first significant effort of the medical community to regulate research itself, and forms the basis of most subsequent documents.

Prior to the 1947 Nuremberg Code there was no generally accepted code of conduct governing the ethical aspects of human research, although some countries, notably
Germany and Russia, had national policies [3a]. The Declaration developed the ten principles first stated in the Nuremberg Code, and tied them to the Declaration of Geneva (1948), a statement of physicians' ethical duties. The Declaration more specifically addressed clinical research, reflecting changes in medical practice from the term 'Human Experimentation' used in the Nuremberg Code. A notable change from the Nuremberg Code was a relaxation of the conditions of consent, which was 'absolutely essential' under Nuremberg. Now doctors were asked to obtain consent 'if at all possible' and research was allowed without consent where a proxy consent, such as a legal guardian, was available (Article II.1).

**Principles**

The Declaration is morally binding on physicians, and that obligation overrides any national or local laws or regulations, if the Declaration provides for a higher standard of protection of humans than the latter. Investigators still have to abide by local legislation but will be held to the higher standard.

**Basic principles**

The fundamental principle is respect for the individual (Article 8), their right to self-determination and the right to make informed decisions (Articles 20, 21 and 22) regarding participation in research, both initially and during the course of the research. The investigator's duty is solely to the patient (Articles 2, 3 and 10) or volunteer (Articles 16, 18), and while there is always a need for research (Article 6), the subject's welfare must always take precedence over the interests of science and society (Article 5), and ethical considerations must always take precedence over laws and regulations (Article 9).

The recognition of the increased vulnerability of individuals and groups calls for special vigilance (Article 8). It is recognised that when the research participant is incompetent, physically or mentally incapable of giving consent, or is a minor (Articles 23, 24), then allowance should be considered for surrogate consent by an individual acting in the
subjects best interest. In which case their consent should still be obtained if at all possible (Article 25).

**Operational principles**

Research should be based on a thorough knowledge of the scientific background (Article 11), a careful assessment of risks and benefits (Articles 16, 17), have a reasonable likelihood of benefit to the population studied (Article 19) and be conducted by suitably trained investigators (Article 15) using approved protocols, subject to independent ethical review and oversight by a properly convened committee (Article 13). The protocol should address the ethical issues and indicate that it is in compliance with the Declaration (Article 14). Studies should be discontinued if the available information indicates that the original considerations are no longer satisfied (Article 17). Information regarding the study should be publicly available (Article 16). Ethical publications extend to publication of the results and consideration of any potential conflict of interest (Article 27). Experimental investigations should always be compared against the best methods, but under certain circumstances a placebo or no treatment group may be utilised (Article 29). The interests of the subject after the study is completed should be part of the overall ethical assessment, including assuring their access to the best proven care (Article 30). Wherever possible unproven methods should be tested in the context of research where there is reasonable belief of possible benefit (Article 32).

**Additional guidelines or regulations**

Investigators often find themselves in the position of having to follow several different codes or guidelines, and are therefore required to understand the differences between them. One of these is Good Clinical Practice (GCP), an international guide, while each country may also have local regulations such as the Common Rule in the US, in addition to the requirements of the FDA and Office for Human Research Protections (OHRP) in that country. There are a number of available tools which compare these. Other countries have guides with similar roles, such as the Tri-Council Policy Statement in Canada.
Additional international guidelines include those of the CIOMS, Nuffield Council and UNESCO.

4.1.6. Nuremberg Code

The **Nuremberg Code** is a set of research ethics principles for human experimentation set as a result of the Subsequent Nuremberg Trials at the end of the Second World War.

On August 20, 1947, the judges delivered their verdict in the "Doctors' Trial" against Karl Brandt and 22 others. These trials focused on doctors involved in the human experiments in concentration camps. The suspects were involved in over 3,500,000 sterilizations of German citizens. The trials began on December 9, 1946 in Nuremberg, Germany and were led exclusively by the United States. Harry Truman approved these trials in January 1946. Most of the suspects escaped punishment for their crimes. Several of the accused argued that their experiments differed little from pre-war ones and that there was no law that differentiated between legal and illegal experiments.

In May of the same year, Dr. Leo Alexander had submitted to the Counsel for War Crimes six points defining legitimate medical research. The trial verdict adopted these points and added an extra four. The ten points constituted the "Nuremberg Code". Although the legal force of the document was not established and it was not incorporated directly into either the American or German law, the Nuremberg Code and the related Declaration of Helsinki are the basis for the Code of Federal Regulations Title 45 Part 46, which are the regulations issued by the United States Department of Health and Human Services governing federally funded human subjects research in the United States.

The Nuremberg code includes such principles as informed consent and absence of coercion; properly formulated scientific experimentation; and beneficence towards experiment participants.
The ten points of the Nuremberg Code

These are:

1. Required is the voluntary, well-informed, understanding consent of the human subject in a full legal capacity.
2. The experiment should aim at positive results for society that cannot be procured in some other way.
3. It should be based on previous knowledge (like, an expectation derived from animal experiments) that justifies the experiment.
4. The experiment should be set up in a way that avoids unnecessary physical and mental suffering and injuries.
5. It should not be conducted when there is any reason to believe that it implies a risk of death or disabling injury.
6. The risks of the experiment should be in proportion to (that is, not exceed) the expected humanitarian benefits.
7. Preparations and facilities must be provided that adequately protect the subjects against the experiment’s risks.
8. The staff who conduct or take part in the experiment must be fully trained and scientifically qualified.
9. The human subjects must be free to immediately quit the experiment at any point when they feel physically or mentally unable to go on.
10. Likewise, the medical staff must stop the experiment at any point when they observe that continuation would be dangerous.

There are strong linkages between population, health and development. India’s health challenges are not only huge in magnitude due to its large population but they are complex due to its diversity and the chronic poverty and inequality. There are extreme inter-state variations, caused by not only the cultural diversity but because the states are at different stages of demographic transition, epidemiological transition and
socioeconomic development. Along with the old problems like persistence of communicable diseases and high maternal mortality in some parts, there is an urgent need to address the emerging issues like the threat of non-communicable diseases, HIV AIDS and health problems of the growing aged population. Accelerating demographic transition is not only necessary for the population stabilisation but it is closely related to health goals.

Mortality reduction obviously depends on the morbidity reduction and is closely linked with the success of the health programmes. Contraceptive use and fertility reduction, though finally result into slower population growth, are very important for reduction in maternal mortality, infant and child mortality and thus lead to improvement in the health of women and children. Government of India is committed to the goal of ‘Health for All’. The obligation of the Government to ensure the highest possible health status of India's population and access to quality health care has been recognized by a number of key policy documents.

4.2. National Policy

The policy directions of the "Health for All" declaration became the policy of government of India with the adoption of the National Health Policy Statement of 1983. Driven by this declaration there was some expansion of primary healthcare in the eighties. Further, the National Health Policy of 2002 and the Report of the Macro Economic Commission on Health and Development (2005) emphasized the need to increase the total public health expenditure from 2 to 3 percent of the GDP. They also stressed the need to strengthen the role of public sector in social protection against the rising costs of health care and the need to provide a comprehensive package of services without reducing the prioritization given to women and children's health. This section on Policy Instruments gives the salient features of the National Population Policy, 2000 and National Health Policy, 2002 describing the broad objectives, overall approach, time bound goals, policy prescriptions
for achieving them and the important features of the strategy envisaged by the policy regarding the delivery of National Health Programmes.

The section also covers the relevant health-related features of other policies (e.g. policies for children, youth, elderly, and women) because different age groups as well as men and women have different health needs. Besides, health is a multidimensional subject apart from access to health services; it depends on other dimensions like nutritional status, availability of and access to pure drinking water, free from environmental pollution etc. Hence, it is a matter of multi-sectoral co-ordination. Hence relevant features of important policies like water policy, environmental policy are also given.

4.2.1. National Health Policies and their Immediate Objectives were as follows:

(a) National Population Policy, 2000(Health related components)

To address the unmet needs for contraception, health care infrastructure & health personnel and to provide integrated service delivery for basic reproductive and child health care.

Medium Term Objective:

To bring Total Fertility Rate to replacement level by 2010 through vigorous implementation of inter-sectoral operational strategies

Long Term Objective:

To achieve a stable population by 2045 at a level consistent with requirements of sustainable economic growth, social development & environmental protection
(b) Health–related Goals for 2010

Reduce IMR to below 30 per 1000 live births
Reduce MMR below 100 per 100,000 live births
Achieve universal immunisation of children against all vaccine preventable diseases
Achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained personnel
Achieve universal access to information/counselling & services for fertility regulation and contraception with wide choice
Achieve 100 per cent registration of births, deaths, marriages & pregnancies
Contain the spread of AIDS, promote integration between management of RTI, STI & NACO

Prevent and control communicable diseases
Integrate ISM in the provision of RCH services
Bring about convergence of the implementation of related social sector programmes to make family welfare people centred programme for the achievement of these goals, the policy identified the following 12 strategic themes which are to be pursued by adopting the operational strategies given in the action plan in the policy document Decentralised planning & implementation

Convergence of service delivery at village level
Empowering women for health & nutrition
Child health & survival
Meeting unmet need for family welfare services
Focus on underserved groups (like urban slums, tribals, migrants, displaced persons, adolescents)

Increased participation of men in planned parenthood
Diversifying categories of RCH health care providers by including private practitioners and reviving system of licensed medical practitioners
Collaboration with NGOs & private sector
Legislation, New Structures & Funding

The policy the government to implement the action plan, the policy recommended creation of National & State/UT Commissions on Population, creation of the coordination cell in the planning commission and doubling of the annual budget of the Dept. of Family Welfare. It also suggested some motivational measures to promote small family.

4.2.2. National Health Policy (NHP), 2002 Objectives & Approach
To achieve an acceptable standard of good health amongst the general population of the country by adopting the following approach

- Increasing the access to the decentralized public health system
- Establishing new infrastructure in deficient areas,
- Upgrading the infrastructure in the existing institutions.
- Ensuring a more equitable access to health services across the social and geographical expanse of the country.
- Increasing the aggregate public health investment through a substantially increased contribution by the Central Government
- Strengthening the capacity of the public health administration at the State level to render effective service delivery.
- Enhancing the private sector contribution to providing health services, particularly for the population group which can afford to pay for services.
- Giving primacy to preventive and frontline curative initiatives at the primary health level through increased sectoral share of allocation
- Emphasising rational use of drugs within the allopathic system.
- Ensuring Increased access to tried and tested systems of traditional medicine
Goals to be achieved by 2000-2015

- Eradicate Polio and Yaws by 2005
- Eliminate Kala Azar by 2010
- Eliminate Lymphatic Filariasis by 2015
- Achieve Zero level growth of HIV/AIDS by 2007
- Reduce Mortality by 50% on account of TB, Malaria & other Vector and Water borne diseases by 2010
- Reduce Prevalence of Blindness to 0.5% by 2010
- Reduce IMR to 30/1000 & MMR to 100/Lakh by 2010
- Increase utilization of public health
- Establish an integrated system of facilities from current level of less than 20 to more than 75 by 2010
- surveillance & National Health Accounts and Health Statistics 2005
- Increase health expenditure by Government as a % of GDP from existing 0.9 to 2% by 2010
- Increase share of Central grants to Constitute at least 25% of total health spending by 2010
- Increase State Sector Health spending from 5.5% to 7% of the budget 2005 investment
- Further increase to 8% by 2010

Policy Prescriptions

Financial Resources

It is planned, under the policy to increase health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health, by the year 2010. In the first phase, by 2005, states would be expected to increase the commitment of their resources to 7 percent of the Budget and, by 2010, to increase it to 8 percent of the Budget. Central Government’s contribution would rise to 25 percent from the existing 15 percent by 2010.
For reducing various types of inequities and imbalances NHP2002 sets out an increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targeted for 35 percent and 10 percent respectively.

4.2.3. Delivery of National Public Health Programmes

NHP envisages --

Key role for the Central Government in designing national programmes, provisioning of financial resources & technical support, monitoring and evaluation

Gradual convergence of all health programmes under a single field administration to bring about a desirable optimisation of outcomes through a convergence of all public health inputs.

Programme implementation be effected through autonomous bodies at State and district levels, having State Government officials, social activists, private health professionals and MLAs/MPs on their management board to ensure greater operational flexibility & well informed decision making

Kickstarting the revival of the Primary Health System by providing some essential drugs under Central Government funding through the decentralized health system

Great reliance on the strengthening of the primary health structure for the attaining of improved public health outcomes on an equitable basis

Expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Systems of Medicine and Homoeopathy

NHP recognizes the need for States to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in underserved areas.

Urges all State Governments to consider decentralizing the implementation of the programmes to local self govt. Institutions by 2005.

Emphasises the need to introduce urgently under the provisions of the Indian Medical Council Act and Indian Nursing Council Act minimal statutory norms for the deployment of doctors and nurses.
Envisages the setting up of a Medical Grants Commission for funding new Government Medical and Dental Colleges in different parts of the country.

NHP identifies the need-based, skill-oriented syllabus, with a more significant component of practical training, in order to make fresh doctors useful immediately after graduation.

Recognises the need to expose medical students, through the undergraduate syllabus, to the emerging concerns for geriatric disorders and to raise the proportion of postgraduate seats in the disciplines of ‘public health’ and ‘family medicine’ in medical training institutions, to reach a stage wherein ¼ th of the seats are earmarked for these disciplines.

Emphasizes the need for an improvement in the ratio of nurse’s vis-à-vis doctors/bed and for establishing training courses for super-speciality nurses required for tertiary care institutions.

Emphasizes the need for basing treatment regimens, in both the public and private domain, on a limited number of essential drugs of a generic nature

Envisages that not less than 50% of the requirement of vaccines/sera is sourced from public sector institutions.

Envisages a two-tiered urban health structure (to be funded jointly by the local self government institutions and State and Central Govts.) - primary centre as the first tier, covering a population of one lakh with a dispensary providing an OPD facility and essential drugs, and a Government general hospital, where reference is made from the primary centre as the second tier.

Envisages a network of decentralised mental health services for ameliorating the more common categories of disorders.

Envisages an IEC policy, with focus on the dissemination of information using not only the mass media but he inter-personal communication, folk and other traditional media to bring about behavioural change

Envisages giving priority to school health programmes which aim at preventive health education, providing regular health check-ups, and promotion of health seeking behaviour among children.
Envisages an increase in Government-funded health research to a level of 1 percent of the total health spending by 2005; and thereafter, up to 2 percent by 2010 focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and Malaria, as also on the sub-types of HIV/AIDS

Commits higher priority to central govt. funding of programmes related to women’s health

Envisages implementation of a code of ethics to avoid irrational or profit driven medical regimen

Strengthening technical expertise and laboratory facilities in food & drug administration

Periodic screening of health condition of workers for high risk disorders associated with their occupation

Envisages provision of medical facilities to overseas users on payment basis

**4.2.4. Other Policies which have Health related Component**

i. National AIDS Prevention & Control Policy, 1992

**Goal: Zero level of new infections by 2007 Objectives & Strategies**

1. Providing care & support to people living with HIV AIDS
2. Overcoming stigmatisation, discrimination & seclusion associated with HIV/AIDS
3. Preventing women, children & socially weak groups from becoming vulnerable to HIV AIDS
4. Controlling STDs among vulnerable sections
5. Promoting condom use
6. Reinforcing traditional Indian values
7. Emphasis on HIV testing, counselling, strong surveillance system
8. Implementation through NACO & State AIDS cells
9. Ensuring availability of adequate safe blood & blood products by (Budget allocation by NACO to National Blood Transfusion Council & making latest transfusion technology available to them, encouraging blood donation, creating awareness about blood banking
services through NGOs, taking steps for the legislation to eliminate profiteering in blood banks)

**ii. National Blood Policy, 2002**

Government of India published in the year 2002 the National Blood Policy. The objective of the policy is to provide safe, adequate quantity of blood, blood components and products. The main aim of the policy is to procure non remunerated regular blood donors by the blood banks. The policy also addresses various issues with regard to technical personnel, research, and development and to eliminate profiteering by the blood banks by selling blood. The policy also envisages that fresh licences to stand alone blood banks in private sector shall not be granted and renewal of such blood banks shall be subjected to thorough scrutiny.

**iii. National Nutrition Policy, 1993**

It was adopted by the Government of India in 1993 under the aegis of the Department of Women and Child Development. It advocated a multi-sectoral strategy for eradicating malnutrition and achieving optimum nutrition for all. The policy advocates the monitoring the nutrition levels across the country and sensitizing government machinery on the need for good nutrition and prevention of malnutrition. The National Nutrition Policy also includes the Food and Nutrition Board, which develops posters, audio jingles and video spots for disseminating correct facts about breastfeeding and complementary feeding.

**Goals**

- Reduction in the incidence of moderate and severe anaemia
- Reduction in the incidence of low birth weight to less than 10%
- Elimination of blindness due to Vitamin A deficiency
- Reduction in iron deficiency anaemia among pregnant women to 25%
Universal iodisation of salt to reduce iodine deficiency
Emphasis on geriatric nutrition

**Direct Interventions**
ICDS, fortification of essential foods - salt with iodine, bread with iron, popularization of low cost, nutritious food, Vitamin A deficiency prophylaxis programme, Nutritional Anaemia Prophylaxis programme. National Plan of Action on Nutrition (NPAN) was formulated in 1995, with commitments from 14 related ministries. National Nutrition Mission was set up in 2002.

**4.2.5. National Policy for Empowerment of Women, 2001**
It reiterates NHP’s demographic goal regarding IMR & MMR to be achieved by
- Ensuring equal access to comprehensive, affordable quality health care
- Eliminating all forms of violence against women & girls
- Safeguarding reproductive rights of women
- Ensuring access to safe, effective & affordable family planning methods of their choice
- Making special efforts to address the problem of nutrient deficiencies among women especially pregnant women provision of safe drinking water, toilet facilities and sanitation within accessible reach of households

**4.2.6. National Policy for Children 2013**
Earlier, the NPC 1974 recognised the need for national programmes for children so that they grow to become ‘robust citizens, physically fit, mentally alert and morally healthy’
Further, National Charter of Children adopted by India in 2004 underlined the intent to secure for every child right to enjoy a healthy and happy childhood and all root causes that negate the healthy growth of children To affirm this commitment, Government of India adopted in the NPC 2013, a long term, sustainable, multi-sectoral, inclusive and integrated approach for the development and protection of children i.e. 0 -18 age group.
Survival, health, nutrition, development, education, protection and participation are the key priorities of the policy. It reiterates the State’s commitment to ensure equitable access to essential, preventive, promotive, curative and rehabilitative health care for all children. Towards this goal, NPC envisages that state shall take measures to

- Improve maternal health care (pre-natal, natal, post-natal)
- Provide universal access to services for informed choices related to births and spacing
- Address key causes of child mortality through appropriate interventions including access to safe drinking water and sanitation
- To improve new born and child care practices
- To protect children from water borne, blood borne, vector borne, communicable and other childhood diseases by providing universal and affordable access to appropriate services
- Prevent disabilities, physical and mental through timely measures to take pre-natal, natal, peri-natal and post-natal care of mother and child
- Ensure availability of services, support and provisions for nutritive attainment in a life cycle approach with focus on infant and young child feeding (IYCF) practices and on the health and nutrition needs of adolescent girls and other vulnerable groups
- Prevent HIV infections at birth and ensure proper treatment to infected children
- Provide the adolescents access to information regarding ill effects of alcohol and substance use and support for the choice of healthy lifestyles

The state commits to allocate the required financial, material and human resources for the implementation of NPC 2013. The Ministry of Women & Child Development is the nodal ministry for implementation of NPC.

4.2.6. National Youth Policy, 2014

National Youth Policy 2014, provides a holistic vision for the youth (Age 15-29) in India which is to empower the youth to achieve their full potential and through them enable India to find its rightful place in the community of nations. One of the 5 key objectives of the policy is to develop a strong and healthy generation to take on future challenges. Among the 11 priority areas to achieve 5 key objectives two refer to health viz. I) Health
& Healthy Lifestyle, II) Sports. Future imperatives towards the health objectives in NYP are as follows-
- Improve service delivery
- Awareness about health, nutrition and preventive health care
- Targeted disease control programme for the youth
- Increased access to sports facilities and training, promotion of sports culture among youth & support to talented sports persons.

The NYP discusses the need to review the efficiency of the primary health care and implement correction mechanisms where existing strategies are proved to be ineffective. It also envisages creation of large pool of trained doctors, nurses, health workers, to incentivise them to work in remote areas and to develop Anganwadi centres as hubs in rural areas. Active participation of the private sector in setting up the training institutions is expected to support the over-burdened government machinery. For women youth, greater natal and pre-natal care for vulnerable age group 14-18 years, campaign against female feticide will be implemented. Awareness programme for youth about nutrition choices, ill-effects of drugs/substance use and inclusion of health and nutrition in the curriculum of schools and colleges are the other initiatives mentioned in NYP. As under ‘Saksham Scheme, progressive adolescents and youth volunteers from NSS and NYKS are envisaged to play important role in this. Under the targeted disease control programme for the youth, NRHM, NACP and on-going NGO programmes are to be leveraged for awareness, early detection and treatment programme for control of HIV / AIDS, STD and TB among youth.

4.2.7. National Policy on Older Persons, 1999

It envisages state support to ensure health care of older persons, protection against abuse and exploitation, development of social support system, strengthening of the capacity of families to take care of old persons, provision of health care facilities in hospitals to handle geriatric cases, mobile medicare units, Jan Arogya scheme to provide cover up to Rs. 5000/- for to70+ persons who can’t afford high cost of medical care.
4.2.8. National Pharmaceutical Policy

Independent body National Pharmaceutical Pricing Authority- is entrusted with the task for price fixation and revision of essential drugs and blood products.

Foreign investment permitted to give impetus to R&D in Drug sector


Objectives:

To promote good health through outreach through preventive, promotive, curative interventions through ISM & H and integrate ISM & H with health care delivery system

To improve the quality of teachers & clinics in ISM & H

To reorient research in ISM & H.

4.2.10. National Water Policy, 2012

The objective of National Water Policy, 2012 is

i) to spread cognizance of the existing situation regarding water resources-the scarcity, availability, wastage, mismanagement, pollution and its inefficient use taking into account the needs of growing population and the impact of climate change

ii) to propose a framework for creation of system of laws and institutions and a plan of action for efficient management of water resources with a unified national perspective. As far as health is concerned, the policy emphasises needs to address the problems of environmental and health hazards. a) Industrial effluents affecting the availability of safe drinking water, b) Inadequate sanitation and c) Lack of sewage treatment which results in water pollution. NWP lays down those public policies on water resources which need to be governed by the following principles—

Equity and social justice
Planning, development and management of water resources needs to be governed by common integrated perspective considering local, regional, state and national context; keeping in view the human, environmental, social and economic needs.

Water needs to be managed as a common pool community resource through a National level legal framework, under public trust doctrine to achieve food security, livelihood, and equitable and sustainable development for all.

Existing water Acts may have to be modified accordingly. The policy recognises the need to optimise the utilisation of water for diverse uses such as domestic, agricultural, industrial, navigation, recreation, hydro-power, thermal power but emphasises that the centre, states and local bodies must ensure access to a minimum quantity of potable water for essential health and hygiene to all its citizens, within easy reach of the household.

The policy emphasises the need for i) rainwater harvesting and de-salinisation of water in urban and industrial areas, ii) integration of urban water supply and sewage treatment schemes and iii) provision of improved water supply and proper sewerage facilities in rural areas. After discussing the supply & demand aspects and suggesting appropriate institutional framework for efficient management of water resources, it recommends that a National Water Informatics Centre should be established to collect, collate and process data on water.

4.2.11. National Environment Policy, 2006

NEP deals with adverse effects on health air pollution, water pollution and noise pollution. It emphasises use of solar energy, promotion of low cost strategy of sewage treatment, public/private partnership in setting up and operation of sewage treatment plans, formulation of urban transport strategy to reduce air pollution, formulation and implementation of noise emission norms appropriate to various activities.
4.3. Administrative Structure of MOHFW

At the Centre, MOHFW is headed by the Union Cabinet Minister and a State Minister. The Ministry of Health & Family Welfare comprises the following four departments, each of which is headed by a Secretary to the Government of India, assisted by joint, Deputy and undersecretaries

1. Department of Health & Family Welfare
2. Department of Health Research
3. Department of AIDS Control

Department of AYUSH has been separated from the Ministry of Health & Family Welfare and now is a separate ministry.

Organisational Charts of the Department of Health & Family Welfare are given in the Annexure.

Directorate General of Health Services (DGHS) is an attached office of the Department of Health & Family Welfare and has subordinate offices spread all over the country. The DGHS renders technical advice on all medical and public health matters and is involved in the implementation of various health schemes.

The administrative structure of public health services in India is ‘two-winged’. First, there is the secretariat of the health ministry and second there is the technical wing, which is called the directorate of health services. Both these wings are under the Ministry of health, the former under the Secretary of the Ministry and the latter under the Director General (Director in States). For some of the programs/schemes, there are directors, advisors and commissioners and their deputies and assistants.

This elaborate structure at the Central government level shows the extent of involvement of the centre in the implementation of various health programmes in the States. The same elaborate administrative structure (more or less) is repeated at the state level.
There is a minister, secretary and a Director of Health with their deputies, assistants etc. in each state. To facilitate interaction between the central government and state governments there is central Council of Health and Family Welfare, which comprise the health ministers and secretaries from all states and a few nominated members. This council is also the primary advisory and policy-making body for health care in the country.

The Planning Commission also has a health cell that supports this advisory and policymaking function besides preparing detailed plans for the health sector of the country. Health is a matter of inter-sectoral co-ordination. Many diseases are water-borne or somare related to pollution. Similarly different age-groups have different health needs as seen in the policy instruments section. Hence though Health is primarily the responsibility of MOHFW, other ministries such as Ministries of women & child development, environment, water resources, rural development, urban development, human resources, have strong linkages with public health and sanitation. Hence they also have an indirect role in the health related activities. Besides, increasingly, there is a trend of public –private partnership to involve NGOs and private sector functionaries and institutions in the implementation of the government programmes.

**Role & Functions of Central and State Governments in the Implementation of Health Policy & Programmes**

Private sector is mainly concerned with curative aspect while government health facilities are responsible for public health i.e. disease prevention & control as well as sanitation. As far as public health is concerned, areas of operation have been divided between Union Government and State Governments in view of the federal nature of the Constitution. As discussed earlier, Seventh Schedule of Constitution describes three exhaustive lists of items, namely, Union list, State list and Concurrent list. Though some items like public health, hospitals, sanitation etc. fall in the State list, the items having wider ramification at the national level like Family Welfare and Population Control,
Medical Education, Prevention of Food Adulteration, Quality Control in manufacture of Drugs etc. have been included in the Concurrent list. The health policy and planning framework has been provided by the central government. The central government has also provided to the States funding as well as the design and components of various national programs such as vertical programs for leprosy, tuberculosis, blindness, malaria, smallpox, diarrhea, filarial, goiter and now HIV/AIDS. These programs are implemented uniformly across the length and breadth of the country. The states also implement the centrally funded and designed programs of family planning and universal immunisation.

The Union Ministry of Health & Family Welfare is instrumental and responsible for implementation of various programmes on a national scale in the areas of health and family welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines. In addition, the Ministry also assists states in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance. Expenditure is incurred by Ministry of Health & Family Welfare either directly under Central Schemes or by way of grants-in-aids to the autonomous/statutory bodies’ and NGOs. In addition to the centrally sponsored family welfare programmes, the Ministry is implementing several World Bank assisted programmes for control of AIDS, Malaria, and Tuberculosis in designated areas. Besides, State Health Systems Development Projects with World Bank assistance are under implementation in various states. The projects are implemented by the respective State Governments and the Department of Health & Family Welfare only facilitates the States in availing of external assistance. All these schemes aim at fulfilling the national commitment to improve access to Primary Health Care facilities keeping in view the needs of rural areas and where the incidence of disease is high.
Government Health Infrastructure in Rural & Urban Areas For the Delivery of Health Services--Roles & Functions of Different Health Facilities

The large cities, depending on their population have a few state run hospitals (including teaching hospitals. At the district level on an average there is a 150 bedded Civil General Hospital in the main district town and a few smaller hospitals and dispensaries spread over the other towns in the district and sometimes in large villages. In the rural areas of the district there are rural hospitals, Community health centres, primary health centres and sub-centres that provide various health services and outreach services.

Sub-centre

One per 5000 population in plain area & 3000 population in hilly/tribal area, is the first peripheral contact point between Primary Health Care system and the community. It is manned by at least one Female (Auxiliary Nurse Midwife) and also one Male Health Worker, One Lady Health Visitor (LHV) is provided for six such Sub-Centres. Subcentres are assigned task relating to Maternal and Child Health, Family Welfare, Nutrition, immunization, Diarrhea and Pneumonia Control and control of Communicable Diseases. ANMs and also provided drugs for minor ailments and for essential material and child health care. ANMs also provide Family Planning counseling and supplies.

Primary Health Centre

One per 30,000 populations in plain area & 20,000 populations in hilly/tribal area, PHC is the first contact point between village community and the Medical Officer. It is manned by a Medical Officer and other support staff. It acts as a referral Unit for 6 Sub-Centres and many PHCs as 4-6 beds for patients. It provides curative, preventive, promotive and Family Welfare services. The PHCs are being strengthened under NRHM to provide a package of essential public health services, and support for outreach services including
for regular supplies of essential drugs and equipment, upgrading single doctor PHC to 2 doctors PHC by posting AYUSH practitioners at PHC level, provision of 3 Staff Nurses in a phased manner based on patient load and delivery load. The States/UTs have to incorporate their proposals and requirement of funds in their Programme Implementation Plans under NRHM.

**Community Health Centre**

one per 1,20,000 population in plain area & 80,000 population in hilly/tribal area, CHC is established and maintained by the State Governments and as per standards it is supposed to be manned by four Medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It normally has 30 indoor beds with one OT, X-ray, and Labour room and Laboratory facilities and serves as a referral centre for 4 PHCs. It provides facilities for emergency obstetrics are and specialist consultations. Indian Public Health standards lays down that this CHC should be manned by 6 Medical Specialists including an Anesthesics and Gynecologist supported by 24 paramedical and other staff with inclusion of two nurse midwives in the present system of seven nurse midwives

With efforts to decentralise governance many of the functions are being transferred to the district level under the Panchayat Raj Acts in various states These large beaurocracies at the centre and state level and in a few states even at the district level “direct and administer” the various health programs through officials and medical personnel at the district and lower levels and in metropolitan city hospitals.

The city hospitals and the civil hospitals are basically curative centres providing outpatient and in-patient services for primary, secondary and tertiary care. In contrast the rural institutions provide mainly preventive and promotive services like communicable disease control programs, family planning services and immunization services, in addition to curative services.
4.4. Some Important Public Institutions under Ministry of Health and Family Welfare

These institutions are either under the MOHFW or are autonomous bodies fully or partly funded by MOHFW and they play important role in India’s pursuit for ‘Health for All’

i. Central Research Institute
ii. All India Institute of Hygiene and Public Health
iii. National Centre for Diseases Control
iv. Central Drugs Laboratory
v. Central Institute of Psychiatry
vi. Dr. Ram Manohar Lohia Hospital,
vii. Safdarjang Hospital,
viii. Medical Stores Organisation
ix. B.C.G. Vaccine Laboratory
x. Central Food and Standardisation Laboratory
xi. All India Institute of Physical Medicine and Rehabilitation.

xii. National Tuberculosis Institute.

xiii. Central Leprosy Teaching and Research Institute.
xiv. Port Quarantine (sea and air) seamen's and marine hospitals.

xv. Dental Council of India.

xvi. Indian Nursing Council

xvii. Pharmacy Council of India

xviii. National Cancer Research Centre.

xix. All India Institute of Medical Sciences.

xx. All India Institute of Speech and Hearing.

xxi. National Institute of Mental Health and Neuro-Science


xxiv. National Institute of Health & Family Welfare
4.5. Major Health Initiatives of MOHFW & Important Health Programmes

The Ministry of Health & Family Welfare is implementing various schemes, programmes and national initiatives to provide universal access to quality healthcare. The approach is to increase access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions.

4.5.1. National Health Mission (NHM)

The National Health Mission (NHM) has time-bound quantifiable goals to be achieved through specific road maps with appropriate linkages and financial allocations for strengthening the health infrastructure. A continuous flow of good quality information on inputs, outputs and outcome indicators, is essential for monitoring the progress of NHM at closer intervals. Integral to this process is using information for decentralised planning where the States prepare Integrated District Health Action Plans (IDHAP) culminating to the State Health Action Plans or Programme Implementation Plans (PIP) through which resource mobilization takes place. At the national level, various steps have been taken to improve the Monitoring & Evaluation system by strengthening support systems for an effective MIS system in terms of dedicated manpower, their training, IT interventions and dedicated funds.

Nodal Information Officer has been identified at various levels - the State, District, and facility levels so that she/he functions as the focal point for submission and Dissemination of information. The States have been requested to synergise the monitoring and IT infrastructure across health programmes to minimise redundancy. As a part of the plan process, many different programmes have been brought together under the overarching umbrella of the National Health Mission (NHM) with National Rural
Health Mission (NRHM) and National Urban Health Mission (NUHM) as its two Sub-Missions. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs. The main programmatic components of NHM include Health System Strengthening in rural and urban areas- Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases.

4.5.2. National Rural Health Mission (NRHM):

NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

4.5.3. Major Initiatives under NRHM

1. ASHAs – About 9 lakh volunteers called Accredited Social Health Activists have been engaged under the mission to work as a link between the community and the public health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas

2. Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society is a simple yet effective management structure. This committee is a registered society whose members act as trustees to manage the affairs of the hospital and is responsible for upkeep of the facilities and ensure provision of better facilities to the
patients in the hospital. Financial assistance is provided to these Committees through untied fund to undertake activities for patient welfare. So far 31,109 Rogi Kalyan Samitis (RKS) have been set up involving the community members in almost all District Hospitals (DHs), Sub-District Hospitals (SDHs), Community Health Centres (CHCs) and Primary Health Centres (PHCs) till date.

3. The Untied Grants to Sub-Centres (SCs) for better equipment e.g. Blood Pressure measuring equipment, Haemoglobin (Hb) measuring equipment, stethoscope, weighing machine etc giving more confidence to ANMs

4. The Village Health Sanitation and Nutrition Committee (VHSNC) Untied grants of Rs. 10,000 are provided annually to each VHSNC under NRHM, which are utilized through involvement of Panchayati Raj representatives and other community members in many states. Till date, 5.12 lakh. VHSNCs have been set up across the country

5. Janani Suraksha Yojana (JSY) aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme, cash assistance is provided to eligible pregnant women for giving birth in a government health facility. Since the inception of NRHM, 7.04 crore women have benefited under this scheme

6. Janani Shishu Suraksha Karyakarm (JSSK): Launched on 1st June, 2011, JSSK entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. This marks a shift to an entitlement based approach. The free entitlements include free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, and free transport
7. **Mother and Child Tracking System (MCTS):** MoHFW has introduced web based name based tracking system called Mother & Child Tracking System (MCTS) across all the States & UTs to facilitate timely delivery of antenatal and postnatal care services to all the pregnant women and immunization to all the children. MCTS is an innovative IT system providing alerts to health service providers about the services due list and service delivery gaps. Furthermore, the system also provides ready reference about the status of services / vaccination delivered to pregnant women and children. Under MCTS, appropriate health promotion messages to beneficiaries that are relevant according to the month of pregnancy or date of birth of the child are being sent on mobiles of beneficiaries. MCTS is also being used for transfer of JSY benefits to pregnant women after delivery as is presently being done in over 120 districts.

The data collection formats of MCTS have been revised so that more comprehensive RCH related information may be captured. Unstructured Supplementary Services Data (USSD) based solution has been introduced for real time updation of MCTS database by ANMs using their existing mobile phones. Efforts are being made to develop tablet based applications which will allow health workers to register and update service delivery information from tablets, resulting in timely registration and updation of information and better micro-planning.

8. Other initiatives such as **National Medical, Mobile Unit (NMMU), National Ambulance Services, Mainstreaming of AYUSH facilities.**

4.6. **New Initiatives of NRHM**

1. **Rashtriya Bal Swasthya Karyakram (RBSK):** This initiative was launched in February 2013 and provides for Child Health Screening and Early Intervention Services through early detection and management of 4 Ds i.e. Defects at birth, Diseases, Deficiencies, Development delays including disability.

2. **Rashtriya Kishor Swasthya Karyakram (RKS):** Launched in January 2014 to Reach out to 253 million adolescents in the country in their own spaces and introduces
Peer-led interventions at the community level, supported by augmentation of facility based services. This initiative broadens the focus of the adolescent health programme Beyond reproductive and sexual health and brings in focus on life skills, nutrition, Injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

3. **Mother and Child Health Wings (MCH Wings):** 100,50,30 bedded Maternal and Child Health(MCH) Wings have been sanctioned in public health facilities with high bed occupancy to cater to the increased demand for services.

4. **Free Drugs and Free Diagnostic Service:** To address the issue of high out of pocket expenditure, Ministry introduced an incentive to the extent of 5% of the state's Resource Envelope under NRHM for those states that implemented free essential drugs scheme for all patients accessing public health facilities.

5. **National Iron+ Initiative** Besides pregnant women and lactating mothers, it aims to provide IFA supplementation for children, adolescents and women in reproductive age group. Weekly Iron and Folic Acid Supplementation

6. **Reproductive, Maternal, Newborn, Child and adolescent Health Services (RMNCH+A):** A continuum of care approach has now been adopted under NRHM with the articulation of strategic approach to Reproductive Maternal, Newborn, Child and Adolescent health (RMNCH+A) in India. This approach brings focus on adolescents as a critical life stage and linkages between child survival, maternal health and family planning efforts.

7. **Identifying “Delivery Points”** with the objective of providing comprehensive reproductive, maternal, new-born, child and adolescent health services (RMNCH+A) services at the facilities identified as high demand, high performance facilities.
8. **Universal Health Coverage (UHC):** A key goal of the 12th Plan. The National Health Mission is the primary vehicle to move towards UHC. India has charted a path that depends largely on provision of affordable, quality health care by the public health system as its main form of social protection, with supplementation from the private sector to close gaps. UHC pilot projects would be supported in at least one district of each state.

9. **Mother and Child Tracking Facilitation Centre (MCTFC):** MCTFC has been operationalized from National Institute of Health and Family Welfare (NIHFW). It is being operated by 80Helpdesk Agents (HAs). It will validate the data entered in MCTS in addition to guiding and helping both the beneficiaries and service providers with up to date information on Mother and Child Care services through phone calls and Interactive Voice Response System (IVRS).

10. **Quality Assurance (QA):** The present strategy is a shift in focus from fragmented approach of different quality systems to one comprehensive approach of Quality Assurance. Based on best practices of existing quality system and on the scientific literature, a comprehensive operational guideline on Quality assurance has been launched wherein National Quality Assurance standards have been published.

11. **ASHA Certification:** Certification of ASHAs to enhance competency and professional credibility of ASHAs by knowledge and skill assessment would be done by National Institute of Open Schooling.

12. **NGO Guidelines:** Guidelines for NGO involvement under NHM during Twelfth Five-year Plan have been issued recently. to envisage greater state ownership for NGO led programmes and are intended to provide a broad framework to the States to partner with NGOs and facilitate their participation in capacity building, support for community processes service delivery, develop innovations through research and documentation, advocacy, and for supplementing capacities in key areas of the public health system to improve health care service delivery.
4.7. National Programmes under NRHM

National Vector Borne Disease Control Programme (NVBDCP), which includes Malaria, Lymphatic Filariasis, Kala Azar, Japanese Encephalitis, Dengue fever and Chikungunya

- National Leprosy Eradication Programme (NLEP)
- Revised National TB Control Programme (RNTCP),
- National Programme for Control of Blindness (NPCB),
- National Iodine Deficiency Disorders Control Programme (NIDDCP)

4.7.1. National Urban Health Mission (NUHM):

The National Urban Health Mission (NUHM) as a submission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013. NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development. NUHM would endeavour to achieve its goal through:

- Need based city specific urban health care system to meet the diverse health care needs of the urban poor and other vulnerable sections.
- Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.
- Partnership with community and local bodies for a more proactive involvement in planning, implementation, and monitoring of health activities.
• Availability of resources for providing essential primary health care to urban poor.
• Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

NUHM would cover all State capitals, district headquarters and cities/towns with a population of more than 50000. It would primarily focus on slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers. The centre-state funding pattern will be 75:25 for all the States except North-Eastern states including Sikkim and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the centre-state funding pattern will be 90:10. The Programme Implementation Plan (PIPs) sent by the states are appraised and approved by the Ministry. In the 12th Plan an allocation of Rs. 15,143 crores has been made for National Urban Health Mission.

Other Major National Health Programmes

National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Strokes (NPCDCS)
National Tobacco Control Programme
National Mental Health Programme (NMHP),
National Programme for the Prevention and Control of Deafness (NPPCD)
• National Programme for Prevention & Control of Fluorosis (NPPCF)
National Programme for Health Care of the Elderly (NPHCE)
National STD Control Programme

Other Important Programmes - Old & New

Some aspects of some of these programmes are covered in NHM strategies
1. **Maternal Health Programme** to reduce maternal mortality and ensure maternal health. The strategies include schemes under NHM & other schemes such as, demand promotion under schemes like JSSK, essential emergency & Obstetric care, comprehensive abortion care services, Management of RTI & STI, iron supplementation, Maternal death review, village health & Nutrition Days, mother and child tracking, capacity building through training programmes, Menstrual hygiene scheme.

2. **Child Health Programme** to reduce infant and child mortality through strategies like interventions for new-born care (facility based and home based), interventions for infant & young child feeding, Nutritional Rehabilitation Centres, Initiatives for Integrated management of neo-natal and childhood diseases (Acute Respiratory Infections, Diarrhea, Rashtriya Bal Swasthya Karyakram (RBSK), Universal Immunisation Programme (UIP) for children and pregnant women.

3. **Pulse Polio Immunisation programme** launched in India in 1995, following WHO resolution for Polio Eradication in 1988 was a part of the Global Initiative Children age 0-5 were administered polio drops during National and Sub-national rounds every year. About 172 million children were immunised during each National Immunisation Day. On 27th March 2014, WHO regional Certification Commission certified India as Polio Free Nation.

4. **Family Planning Programme**- Since its inception in 1952 as the first govt. family planning programmes in the world it has undergone many transformations. It is a big transition from the simple clinical approach in the early fifties. To MCH and CSSM approach and then to the present holistic RCH approach. From the earlier target bound programme to the present target free approach it is a paradigm shift after ICPD, Cairo. The comprehensive approach is reflected in the 12 strategic themes identified in the National Population Policy 2000. In the present programme there is emphasis on spacing methods, IUD and male sterilisation while Minilap and Laparoscopy are promoted as terminal female methods. Present strategies include emphasis on quality assurance, home
delivery of contraceptives, and easy availability of Pregnancy testing kits. Post-partum family planning services, emergency contraceptive pills, public private partnership for increasing the access to FP services and social marketing of condoms.

5. **Integrated Disease Surveillance Project/ Programme (IDSP)** was launched with World Bank assistance in November 2004 to detect and respond to disease outbreaks quickly. The project was extended for 2 years in March 2010. From April 2010 to March 2012, World Bank funds were available for Central Surveillance Unit (CSU) at NCDC & 9 identified states (Uttarakhand, Rajasthan, Punjab, Maharashtra, Gujarat, Tamil Nadu, Karnataka, Andhra Pradesh and West Bengal) and the rest 26 states/UTs were funded from domestic budget. The Programme continues during 12th Plan under NRHM with outlay of Rs. 640 Crore from domestic budget only. Surveillance units have been established in all states/districts (SSU/DSU). Central Surveillance Unit (CSU) established and integrated in the National Centre for Disease Control, Delhi. Training of State/District Surveillance Teams and Rapid Response Teams (RRT) has been completed for all 35 States/UTs. IT network connecting 776 sites in States/District HQ and premier institutes has been established with the help of National Informatics Centre (NIC) and Indian Space Research Organization (ISRO) for data entry, training, video conferencing and outbreak discussion. Under the project weekly disease surveillance data on epidemic prone disease are being collected from reporting units such as sub centres, primary health centres, community health centres, hospitals including government and private sector hospitals and medical colleges. States/districts have been asked to notify the outbreaks immediately to the system. On an average, 30-40 outbreaks are reported every week by the States. 553 outbreaks were reported and responded to by states in 2008, 799 outbreaks in 2009, 990 in 2010, 1675 outbreaks in 2011, 1584 outbreaks in 2012 and in 2013, 1898 outbreaks have been reported till 8th December.

6. **Drug De addiction Programme (DDAP):** The Drug De addiction Programme in the Ministry of Health & Family Welfare was started in the year 1987-88 which was later modified in 1992-93. The programme was initiated as a scheme with funding from the
central government and implementation through the states. Under the scheme, a one-time grant in aid of Rs.8.00 lakhs was given to states for construction of each Drug De addiction Centre and a recurring grant of Rs.2.00 lakhs was given to Drug De addiction Centres established in North Eastern Regions to meet the expenses on medications and other requirements. At present 122 such Centres have been established across the country including centres in Central Government hospitals and institutions of which 43 centres have been established in the North Eastern Region. Under this programme, a national nodal centre, the “National Drug Dependence Treatment Centre”, has been established under the All India Institute of Medical Sciences (AIIMS), New Delhi which is located in Ghaziabad while two centres i.e. NIMHANS, Bangalore and PGI, Chandigarh have also been upgraded by this Ministry. The purpose of these centres was to provide de-addiction and rehabilitation services to the patients and to conduct research and provide training to medical and paramedical staff in the area of drug de addiction. *(Substance use Disorders: A Manual for paramedical Staff, Rakesh Laland Atul Ambekar, 2009)*

7. **National AIDS Control Programme (NACP)** India has the third highest number of estimated people living with HIV in the world. According to the HIV Estimations 2012, the estimated number of people living with HIV/AIDS in India was 20.89 lakh, with an estimated adult (15-49 age group) HIV prevalence of 0.27% in 2011. India has demonstrated an overall reduction of 57% in the annual new HIV infections among adult population from 2.74 lakh in 2000 to 1.16 lakh in 2011, reflecting the impact of various interventions and scaled-up prevention strategies under the National AIDS Control...The first phase of was launched by the Government of India in 1992 to combat the HIV infection and AIDS in the initial stage itself. However, with the evolving trends of the HIV/AIDS epidemic, the focus of the subsequent phases of the programme (NACP-II in 1999 and NACP-III in 2007) shifted from raising HIV/AIDS awareness to behaviour change, from a national response to a more decentralised response and to increasing involvement of NGOs and networks of People Living with HIV (PLHIV).
**Preventive strategies**

Targeted Interventions for High Risk Groups (Female Sex Workers, Men who have Sex with Men, Transgender/ Hijras, Injecting Drug Users) and Bridge Population (Truckers & Migrants)

- Needle Syringe Exchange Programme and Opioid Substitution Therapy for IDUs
- Prevention Interventions for Migrant population at source, transit and destination
- Link Worker Scheme for HRGs and vulnerable population in rural areas
- Prevention & Control of Sexually Transmitted Infections/Reproductive Tract Infections
- Blood Safety
- HIV Counselling & Testing Services
- Prevention of Parent to Child Transmission
- Condom promotion
- Information, Education & Communication and Behaviour Change Communication (BCC).
- Social Mobilisation, Youth Interventions and Adolescence Education Programme
- Mainstreaming HIV/AIDS response
- Work Place Interventions

**Care, Support & Treatment Services**

- Laboratory services for CD4 Testing and other investigations
- Free First line & Second-line Anti-Retroviral Therapy (ART) through ART centres and Link ART Centres (LACs), Centres of Excellence (CoE) & ART plus centres.
- Paediatric ART for children
- Early Infant Diagnosis for HIV exposed infants and children below 18 months
- Nutritional and Psychosocial support through Care and Support Centres (CSC)
- HIV/TB Coordination (Cross referral, detection and treatment of co-infections)
- Treatment of Opportunistic Infections
Drop in Centres for PLHIV networks

For prevention and control of HIV/AIDS the Department of AIDS Control has formulated policies and developed standards, guidelines norms. Strategies developed for programme implementation include finalisation of State action plans, financial planning & management, budgeting, release of funds and monitoring expenditures at National and State levels, strategic information management including programme monitoring, surveillance and research, institutional strengthening, human resource management, capacity building, technical and administrative support as well as guidance to State AIDS Control Societies.

8. Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) aims at correcting the imbalances in the availability of affordable healthcare facilities in the different parts of the country in general, and augmenting facilities for quality medical education in the under-served States in particular. The scheme was approved in March 2006. The first phase in the PMSSY has two components - setting up of six institutions in the line of AIIMS; and upgradation of 13 existing Government medical college institutions.

Spread over 10 states In the second phase of PMSSY, the Government has approved the setting up of two more AIIMS-like institutions, one each in the States of West Bengal and Uttar Pradesh and upgradation of six medical college institutions. In the third phase of PMSSY, it is proposed to upgrade seven existing medical college institutions from 5 states.

Data Requirements & Availability

In a vast country like India, full of diversity and disparities, it is a big challenge to implement the various programmes in the health sector following the policy guidelines within the constitutional and legal framework and to achieve the desired impact on all sections of the population, especially the deprived ones. In order to plan, design, implement and monitor these programs and to evaluate their performance and impact,
statistical data on a large number of indicators are required. Data on these indicators are required not only at All India level but also for the state/UT and district level. It is also essential to have the indicators by the background characteristics particularly by economic status (income or expenditure class or standard of living Index), by sex, by education, by caste (SC/ST/ OBC) because it is important to see that the programmes have reached the poor and the deprived. Indicators required can be classified as , Background Variables,, Impact indicators (fertility Indicators, Mortality Indicators, Morbidity Indicators ,Nutrition Indicators),Programme Performance Indicators, Health Infrastructure Indicators, Accessibility Indicators, Amenities indicators, Financial Indicators. Data on most of the above indicators is available in successive rounds of the Census of India, Sample Registration System, National Family Health Survey, District level Household & Facility Survey, National Sample Survey, and Official Statistics available in Health & Family Welfare Yearbooks and other publications of govt. of India. Comparability of data over the period and between the sources, however, needs to be taken into account. Indicators &data sources are discussed in detail in other chapters.

**HMIS - Use of Health Management Information System in Monitoring and Evaluation of Health Programmes**

There has been a growing emphasis in India on Health Management Information System (HMIS) as a part of the National Rural Health Mission (NRHM) initiative to enable capturing of public health data from both public and private institutions in rural and urban areas across the country in order to strengthen the evidence based planning of health programmes. Hence, one of the core strategies of NRHM in achieving its goals is to strengthen capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

Management Information System is designed to collect and report information on a programme, which allows managers at all levels to plan, monitor, and evaluate the operations and the performance of the whole programme. HMIS is a systematic process
of collection, compilation, reporting, analysis and use of information on health care services. The information is generally helpful in planning, problem solving and decision making in health care service provisioning. Health management information incorporates all the data needed by policy makers, service providers/clinicians and health service users to improve and protect population health. Any user, who has a password to login HMIS web portal, can generate the customised HMIS reports as per his/her requirement based on information on a given item 1. Across States & Periods 2. Across Districts and Periods Proper use of HMIS is expected to contribute significantly to improve the health program performance and ultimately achieving its stipulated goals.

4.8. Health Sector in India - Structure, Roles & Functions

Public & Private Sector

Private health sector in India consists of dispensaries, clinics, nursing homes and hospitals (practicing Allopathic, /Ayurvedic, /Homeopathic, / Unani systems) owned and run by individuals or by groups of Individuals. They are to some extent registered under and regulated by the organisations like Medical Council and now will be registered under and regulated by the National/State Councils constituted under the Clinical Establishment Act as described earlier. Public Sector consists of (a) dispensaries, clinics, nursing homes and hospitals (practicing Allopathic,/Ayurvedic,/ Homeopathic,/ Unani systems ) owned and run by charitable institutions, religious organisations like churches and NGOs (b) Countrywide network of government health facilities i.e. sub-centres, primary health centres, Community Health Centres And rural hospitalising rural areas and in urban areas, urban health centres, Municipal & other government hospitals. These come under the Ministry of Health & Family Welfare (MOHFW). (c) In addition there are dispensaries, clinics & hospitals specifically for the employees of other public sector bodies such as Atomic Energy, Railways, Port Trust, Reserve Bank, Armed Forces, which come under the respective ministries. In addition Pharmaceutical companies, chemist shops, research organisations, medical colleges and other health related training and research institutes;
laboratories are also a part of the health sector, private or public according to their ownership.

**4.9. Health care system Public and private sector**

As discussed earlier in major urban areas, healthcare is of adequate quality, approaching and occasionally meeting Western standards. However, access to quality medical care is limited or unavailable in most rural areas, although rural medical practitioners are highly sought after by residents of rural areas as they are more financially affordable and geographically accessible than practitioners working in the formal public health care sector.

According to National Family Health Survey-3, the private medical sector remains the primary source of health care for 70% of households in urban areas and 63% of households in rural areas.\(^1\) Reliance on public and private health care sector varies significantly between states. Several reasons are cited for relying on private rather than public sector; the main reason at the national level is poor quality of care in the public sector, with more than 57% of households pointing to this as the reason for a preference for private health care. Other major reasons are distance of the public sector facility, long wait times, and inconvenient hours of operation. The study conducted by IMS Institute for Healthcare Informatics in 2013, across 12 states in over 14,000 households indicated a steady increase in the usage of private healthcare facilities over the last 25 years for both Out Patient and In Patient services, across rural and urban areas.\(^2\)

The National Rural Health Mission (NRHM) was launched in April 2005 by the Government of India. The goal of the NRHM was to provide effective healthcare to rural

---

people with a focus on 18 states which have poor public health indicators and/or weak infrastructure.\(^3\)

### 4.10. Twelfth Five Year Plan

12\(^{th}\) Five Year Plan is based on the recommendation of High Level Experts Group (HLEG) and other stakeholder consultations, the key elements and strategy is outlined. The long term objective of this strategy is to establish a system of Universal Health Coverage (UHC) in the country. Following are the 12th plan period strategy:\(^4\)

1. Substantial expansion and strengthening of public sector health care system, freeing the vulnerable population from dependence on high cost and often unreachable private sector health care system.
2. Health sector expenditure by central government and state government, both plan and non-plan will have to be substantially increased by the twelfth five year plan. It was increased from 0.94 per cent of GDP in tenth plan to 1.04 per cent in eleventh plan. The provision of clean drinking water and sanitation as one of the principal factors in control of diseases is well established from the history of industrialized countries and it should have high priority in health related resource allocation. The expenditure on health should increase to 2.5 per cent of GDP by the end of Twelfth Five Year Plan.
3. Financial and managerial system will be redesigned to ensure efficient utilization of available resources and achieve better health outcome. Coordinated delivery of services within and across sectors, delegation matched with accountability, fostering a spirit of innovation is some of the measures proposed.
4. Increasing the cooperation between private and public sector health care providers to achieve health goals. This will include contracting in of services for gap filling, and various forms of effectively regulated and managed Public-Private


Partnership, while also ensuring that there is no compromise in terms of standards of delivery and that the incentive structure does not undermine health care objectives.

5. The present Rashtriya Swasthya Bima Yojana (RSBY) which provides cash less in-patient treatment through an insurance based system should be reformed to enable access to a continuum of comprehensive primary, secondary and tertiary care. In twelfth plan period entire Below Poverty Line (BPL) population will be covered through RSBY scheme. In planning health care structure for the future, it is desirable to move from a 'fee-for-service' mechanism, to address the issue of fragmentation of services that works to the detriment of preventive and primary care and also to reduce the scope of fraud and induced demand.

6. In order to increase the availability of skilled human resources, a large expansion of medical schools, nursing colleges, and so on, is therefore is necessary and public sector medical schools must play a major role in the process. Special effort will be made to expand medical education in states which are under-served. In addition, a massive effort will be made to recruit and train paramedical and community level health workers.

7. The multiplicity of Central sector or Centrally Sponsored Schemes has constrained the flexibility of states to make need based plans or deploy their resources in the most efficient manner. The way forward is to focus on strengthening the pillars of the health system, so that it can prevent, detect and manage each of the unique challenges that different parts of the country face.

8. A series of prescription drugs reforms, promotion of essential, generic medicine and making these universally available free of cost to all patients in public facilities as a part of the Essential Health Package will be a priority.

9. Effective regulation in medical practice, public health, food and drugs is essential to safeguard people against risks and unethical practices. This is especially so given the information gaps in the health sector which make it difficult for individual to make reasoned choices.
10. The health system in the Twelfth Plan will continue to have a mix of public and private service providers. The public sector health services need to be strengthened to deliver both public health related and clinical services. The public and private sectors also need to coordinate for the delivery of a continuum of care. A strong regulatory system would supervise the quality of services delivered. Standard treatment guidelines should form the basis of clinical care across public and private sectors, with the adequate monitoring by the regulatory bodies to improve the quality and control the cost of care.

Indian Health care system is just a nominal health care system; there are not enough hospitals, doctors, medical staff, medicines or ambulance services available in the system. Quality of care and accessibility is very poor. Most people depend on private hospitals for health care except very poor people, who depend on government hospitals because they can't afford private out of pocket health care. This system can't be called a health care system from a Western perceptive. This is not an organized or functional system but a collection of government hospitals in different parts of the country to serve a huge population. India ranks last in healthcare compared to OECD or BRICS countries. The 12th five year plan document on health has received a lot of criticism for its limited understanding of universal health care and failure to increase public expenditure on health. While the HLEG report recommends an increase in public expenditure on health from 1.58 per cent of GDP currently to 2.1 per cent of GDP by the end of 12th five year plan it is far lower than the global median of 5 per cent. The lack of extensive and adequately funded public health services pushes large numbers of people to incur heavy out of pocket expenditures on services purchased from the private sector. Out of pocket expenditures arise even in public sector hospitals, since lack of medicines means that patients have to buy them. This results in a very high financial burden on families in case of severe illness. Though, the 12th plan document express concern over high out-of-pocket (OOP) expenditure, it does not give any target or time frame for reducing this expense. OOP can be reduced only by increasing public expenditure on health and by setting up widespread public health service providers. But the planning commission is planning to do this by regulating private health care providers. It takes solace from the
HLEG report which admits that, "the transformation of India’s health system to become an effective platform for UHC is an evolutionary process that will span several years".

Instead of developing a better public health system with enhanced health budget, 12th five year plan document plans to hand over health care system to private institutions. The 12th plan document causes concern over Rashtriya Swasthya Bima Yojana being used as a medium to hand over public funds to the private sector through an insurance route. This has also incentivized unnecessary treatment which in due course will increase costs and premiums. There has being complaints about high transaction cost for this scheme due to insurance intermediaries. RSBY does not take into consideration state specific variation in disease profiles and health needs. Even though these things are acknowledged in the report, no alternative remedy is given. There is no reference to nutrition as key component of health and for universal Public Distribution System (PDS) in the plan document or HLEG recommendation. In the section of National Rural Health Mission (NRHM) in the document, the commitment to provide 30- to 50-bed Community Health Centres (CHC) per lakh population is missing from the main text. It was easy for the government to recruit poor women as ASHA (Accredited Social Health Activist) workers but it has failed to bring doctors, nurses and specialist in this area. The ASHA workers who are coming from a poor background are given incentive based on performance. These people lose many days job undertaking their task as ASHA worker which is not incentivized properly. Even the 12th plan doesn't give any solace.

4.10. Status of Private Health Care Sector in India

The character of health care as a service is getting eroded rapidly from the Indian society. It has become fully commercialized and is the dominant provider of health care nationally and globally. Commercialization of the healthcare has brought in more problems than benefits. Pharmaceutical industry and the medical equipment industry both have eroded the ethics of medical profession. Their marketing practices have lured majority of medical professionals (plus unqualified quacks too) to increasingly resort to unnecessary and irrational prescriptions of drugs, overuse of diagnostic tests like
CAT/MRI scan, ultrasound/echo and other radiological/laboratory investigations plus ECG & unnecessary references to specialists and super-specialists. Here, a well-organized kickback system operates: they call it commission! Private health sector dominance has flourished due to state's support for it to grow and flourish and out of specific policies favoring privatization under the new economic regime of liberalization and globalization.

Indian Medical education is almost wholly state-financed; major beneficiary is the doctor who sets up private practice after his / her training. More than three-fourths of medial graduates trained with public funds either work in the private sector or migrate abroad. Their contribution to society is very little because they have to engage in health care as a business activity. So many tax non-tax benefits are provided to the medical professional from the public funds, viz., econcessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals, incentives, tax holidays, and subsidies to private pharmaceutical and medical equipment industry, raw materials (bulk drugs) to private formulation units at subsidies rate / low cost, exemptions in taxes and duties in importing medical equipment and drugs, especially the highly expensive new medical technologies.

The government has allowed the highly profitable private hospital sector to function as trusts, which are exempt from taxes. Hence they don't contribute to the state exchequer even when they charge patients exorbitantly. Government has been contracting out its programs and health services selectively to NGOs in rural areas where its own services are ineffective: further discredit to public health services and way for further privatization. PHCs introduce the local population to modern health care but also provide the private sector an entry point to set them up. Development of drugs and medical and surgical techniques (R & D) are pioneered in public institutions but commercialization, marketing and profit appropriation is left with the private sector.

The government has allowed the private health sector to proliferate uncontrolled. Neither the government nor the Medical Council of India has any control over medical practice,
its ethics, its rationality, its profiteering etc. There is no regulation of quality of practice and standards in hospital care of any kind whatsoever. New Indian economic policy has also given boost to private health care sector to flourish. The core of our macro-economy is poverty and anti-poverty programs are a big business and crucial for political survival in India. Health care is a very crucial part of this poverty syndrome because unlike education we cannot avoid it. Government investment in the health sector is declining; social sectors are the first to suffer; Expenditures on health care have been affected both in quantitative terms (real expenditures reduced) and qualitative terms (increasing % of establishment costs and decreasing % on medicines, equipment, maintenance and new investments). The cost of medicines is rapidly rising. The drug price control is on its way out and India having signed the WTO treaty on IPR is moving closer to international prices of drugs. The combined effect of all these facts resulted in reduced access for the poor to health care.

Private medical practice flourishes almost everywhere. Medical practice in India is a multi-system discipline e.g. allopathy or modern medicine, homoeopathy, ayurveda, unani, and siddha; naturopathy, yoga, chiropractic; large number of modern unqualified or quasi-qualified 'quack' practitioners; herbal and witch doctors. Complexity and diversity making information management, recording, monitoring etc. is a very tough task. This is partly responsible for the chaos and lack of regulation and quality control.

Persons qualified in modern medicine tend to locate themselves in urban areas, whereas those with non-allopathic qualifications are located in equal numbers in both urban and rural areas. In 1981 urban allopaths were 3 times more in number than in rural areas.

4.11. Attracting Factors for Corporate sector to the Healthcare Sector

1. Locational Factors

The major factors in deciding the location of the hospital are:

- A central place having easy accessibility
Space around the hospital for future expansion
Space to make provision for residential quarters for the staff
Hostel facility, if there is to be college on campus
It is beneficial if no other hospital is around
Disease that could be a characteristic of a certain region, could affect the location
Super-specialty hospitals make most business sense in metro cities where space is a problem and a lot of hospitals are already present

2. Marketing Strategies

As hospitals spend millions of rupees in technology and infrastructure, it becomes necessary, that they attract patients and generate funds.

Various marketing and brand building exercises are as under;
Many hospitals have eminent personalities from the industry in their Board of trustees. This indirectly leads to increased inflow of patients. Presence of eminent personalities creates a sense of confidence in the minds of people.
Private hospitals attract their shareholders by offering discounts. For example, a special discount of 20% on all preventive health checks is offered to all shareholders of Apollo Hospitals Enterprise Limited.
Hospitals have long-term understanding with PPO's (Preferred Provider Organization), which further have understanding with corporates.
The success rate of crucial operations and surgeries, reflect the technological and knowledge based edge of the hospital over the competitors. Such successes are discussed in health magazines and newspapers, which becomes a natural advantage for the hospital.
Some hospitals by means of their past track record have created a niche market for themselves. For example, Hinduja Hospital is known for its high-quality healthcare at reasonable rates, whereas Lilavati Hospital is known for its five-star services.
• Hospitals hold seminars and conferences relating to specific diseases, where they invite the doctors from all round the country, for detailed discussion. This makes the hospital well known amongst the doctors, who could in future refer complicated cases to the hospital.

• Hospitals also promote medical colleges. This helps them to generate extra resources in form of fees, using the same infrastructure with consistently good pool of human resources.

3. Sources of Revenue

• “Large hospitals, with high bed-occupancy rate are profitable” this is misleading statement.

• Global experience shows that hospitals with more than 250 beds don’t do well. Many Indian hospitals are following the US healthcare industry, by decreasing the average length of stay of patients and increasing patient turnover.

• 80% of the revenues from a patient come in the first 72 hours post-admission. Hospitals generate a lot of revenues from General Inspection, because the patient turnover is very high.

• Many corporate plan small 100 bedded specialized hospitals, which cater to specific diseases like cardiac, cosmetic surgery, neurology etc.

• Super-specialty hospitals with 100-150 beds generate revenue equivalent to large 500 bedded general hospitals.

• Large hospitals with approximately 500-bed capacity take about 9-10 years to break even whereas super-specialty hospitals with about 100 beds take about 6-7 years to break even.

• General room to ICU/ICCU room ratio in general hospitals is 8:2; while in super specialty hospitals it is 6:4.

• The visiting doctors contribute approx. 15% of their billings to the hospital revenues.
• Hospitals generate revenues from in-house supply of medicines. Some hospitals make it mandatory for the patients to buy medicines from the hospital's chemist shop. A margin of >15-20% is charged for such medicinal supplies.
• Many Trust Hospitals also earn this way. New entrants or corporates for whom private healthcare sector is a direct extension of their line of business (e.g. Pharma companies), generate good returns from medicine supply.
• Hospitals promoting medical studies generate extra resources in form of fees, using the same infrastructure. E.g. Fee charged to foreign students at Manipal Hospital is US $ 20000 annually.
• Indian doctors are amongst the best of the world. Overseas Indians get world-class treatment at a fraction of the cost they would have to pay abroad. They prefer to consult these doctors for their chronic diseases such as high blood pressure, diabetes, neurological problems and even dentistry.
• Medical charges in India are between one-tenth and one-thirtieth those of the US. For example, a bypass surgery which costs $3000 in US, costs only Rs. 35000-40000 in India, with the same technologies and facilities.
• Health Plan packages provided by hospitals to family and corporate. Family Health Plan (FHP), a subsidiary of Apollo Hospitals does health management of employees of its clients. With a wide network of hospitals and healthcare providers countrywide, and a tie-up with General Insurance Corporation of India, FHP offers a range of services to employees and dependants, such as Preventive Healthcare, Corporate Counseling, Welfare Programmes, Claims Administration, Patient-care Coordination and so on. So FHP's healthcare packages, optimize the benefits while keeping the cost under control.
• 'Effective Stress Management Programme' offered by Wockhard Hospital
• Third Party Administrators (TPA) negotiate better deals for the customers and sort out their medical claims for a fee.
• Preferred Provider Organization (PPO), can manage almost all the healthcare needs of their customers. PPOs can't provide insurance cover, as they don't assume the risk of their clients.
• With private insurance, most PPOs and TPAs will turn into Health Maintenance Organizations (HMO). Here they link their products with insurance companies, or hospitals. (As of today, HMOs aren't allowed in India).
• HMOs carry the risk of their customers. So, they want to know the bio informatics and the epidemiological data of their clients. Understanding disease trends helps in knowing which risk to carry and at what price.
• Hospitals can become integrated healthcare systems i.e. when medicines, food services, laundry and linen etc will become "purchased" services. These third-party operations will increase the profit margins.

4. The Future

• By 2005 world-wide Healthcare industry is stated to be a $4 trillion market. It is the largest service sector in US.
• World Bank Report in November 1999 pointed at the emergence of large-scale, investor-owned hospitals in the country as a "dramatic" development. The corporate hospitals playing a positive role in the healthcare sector by taking the load off government hospitals with poor performance.

5. Merger and Acquisition

• Strength of ties with individual hospitals and physicians, Relative sizes of the hospitals, their geographical proximity are key factors to be considered before going for mergers.
• Major advantages of merger are, more integrated health-care systems that can achieve economies of scale, by rationalizing capacity and amalgamating functions as Information Technology, Consultants, Emergency Transport, Database and Research and Development.
• Merged hospitals in narrowly defined geographic areas with few or no competitors exert favorable influence on the services.
Key to success is strong orientation to performance, standardizing and integrating work processes, functions, suppliers and investments - but not necessarily on a centralized basis.

Some mergers are synergy of skills - i.e. merged organizations benefit from one another's individual strengths by applying them across the board, make joint investments in branding or information technology and also to react effectively to the changed market forces. Alternatively hospitals go in for Group Purchases, as in USA.

6. **Role of Technology**

Healthcare provider agencies opt for leading–edge, high-tech, automated technologies e.g. telecommunications technology to help transfer of electronic medical data, including high resolution images, sounds, live video and patient records from one location to another through telephone lines, ISDN, modem, Internet, satellites, video-conferencing etc.

Diagnosing and monitoring severe asthma and cardiac patients; portable monitoring device to record their breathing patterns and sent via a modem or a telephone line to a central management system to be processed and results sent directly to the patient's consultant. The system records the date, time, temperature and humidity conditions critical to analyze the health of asthma patients. *Apollo hospitals and Escorts Heart Research already have tele-cardiology systems.*

7. **Major Corporate Players**

**The Apollo Group of Hospitals:**

One of Asia's largest healthcare players with more than 2600 beds; planning to invest more than Rs.2000 crore, to build around 15 new hospitals in India, Sri Lanka, Nepal and Malaysia.
• **Fortis Healthcare:**

With more than 250 crore investment, more than 200 bedded cardiac hospital (increased to 375), located in the town of Mohali; 12 cardiac and information centers in and around the town, to arrange travel and stay for patients and family; tie up with an overseas partner.

• **Max India:**

After selling of his stake in Hutchison Max Telecom, Analjit Singh has decided to invest around 200 crores, for setting up world class healthcare services in India. Max India plans a three tier structure of medical services - Max Consultation and Diagnostic Clinics, Max Med, a 150 bed multi-speciality hospital and Max General, a 400 bed hospital. The company has already tied up with Harvard Medical International, to undertake clinical trials for drugs, under research abroad and setting up of Max University, for education and research.

• **Escorts:**

• EHIRC located in New Delhi has more than 220 beds. The hospital has a total 77 Critical Care beds to provide intensive care to patients after surgery or angioplasty, emergency admissions or other patients needing highly specialized management including Tele cardiology (ECG transmission through telephone). The EHIRC is unique in the field of Preventive Cardiology with a fully developed programme of Monitored Exercise, Yoga and Meditation for Life style management.
• **Wockhardt & Duncans Gleneagles International** also have major expansion plans.

8. **Demographic Details**

- National average % households in low-income group (with annual income less than Rs. 25000) has declined from 58.84% in 1990 to 49% in 1996; middle and higher middle income group (annual income more than Rs. 50000) has increased from 14% to 20%.
- We have 35-38 million households or 200 million insurable lives.

9. **Factors which have influenced the globalization of health services**

- Decline in public sector expenditures
- Rise in private sector participation in health care
- Liberalization of related sectors such as insurance and telecommunications
- Fast mobility of consumers and health service providers
- Technological advances making the across the border delivery of many health services possible; especially tertiary healthcare services
- Differences in costs, availability, and quality of health care
- Emergence of investment opportunities in the health care sector with the liberalization of investment regulations
- General increase in demand for health services arising from rising income levels and aging populations

4.12. **Health Insurance (Medi-Claim Policy)**

- Medi-claim is the HEALTH INSURANCE cover - Mediclaim Policy has become synonymous with health insurance.
- When the health care costs have become more and more expensive, it is felt necessary to have a health insurance.
Health Insurance is a contract of Indemnity in which the insurer promises to indemnify the loss occurred to the insured, through treatment of diseases, against the premium paid and acceptance of the proposal form.

It creates the fiduciary relations i.e. the insured cannot conceal any fact relevant to the subject matter of the contract.

**Features of the Proposal Form consists mainly:**

- It gives details of cover, inclusion and exclusion of benefits;

- The insured consents and authorizes the insurer to seek any medical information about himself from hospital or medical practitioner;

- The insured confirms his consent to the terms and conditions of the contract/policy;

- The insured confirms that the questions that he has answered about his state of health are true and can form the basis of the contract;

- In case of adverse medical history the insured has to complete a detailed questionnaire related to diabetes, hypertension, chest pain or coronary insufficiency or myocardial infarction;

- Any detailed medical answers have to be completed by a consulting physician etc.

**Conditions Applicable**

- Medi claim is available to persons between 5-80 years of age;

- Children bellow 5 years can be covered only if one of the parents is covered concurrently;

- A 10% discount is available if the entire family avails the cover at the same time. Family includes spouse, dependent children and dependent parent;
The sum assured is increased by 5% for each year of claim free insurance, subject to a maximum accumulation of 10 years;

The insured is permitted on health check for every four years of coverage, the cost of which should not exceed 1% of sum assured;

The cover could be extended to Nepal and Bhutan as well;

In claim proceeding, the first intimation of claim must be given to the company with the relevant details within 7 days of the date of hospitalization;

Final claim should be filed within 30 days of completion of treatment;

The premium qualifies for a tax benefit under the Income Tax Act

Health insurance Cover

In health insurance the underlying contractual relationship takes within its fold the explicitly contemplated risk in the form of envisaged illness.

The policy covers the hospitalization and domiciliary hospitalization expenses for diseases suffered during the policy period.

It also covers hospitalization for injuries caused during an accident.

Hospitalization:

The policy usually covers the following expenses:

- Boarding expenses in a hospital or in nursing home as per the description provided in the policy;

- Surgical, anesthetist’s, medical practitioners, specialist’s, consultant’s etc. fees;

- Nursing expenses;

- Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicine and drugs, diagnostic reports, dialysis, chemotherapy, prosthetic limbs etc.

The total liability covered does not exceed the total sum assured under such policy.
- It includes expenses incurred for a period up to 30 days prior and 60 days after hospitalization.
- 24 hours of hospitalization is a condition precedent in such claim.
- This could be waived if insured is discharged before the prescribed hours by the doctor for certain treatment like eye surgery, dental surgery, chemotherapy, kidney-stone removal, dialysis etc.
- Domiciliary Hospitalization is a medical treatment carried out by professional doctors at home when the patient cannot be moved to a hospital due to the condition or lack of facility/accommodation.
  - It covers all the normal hospitalization expenses except pre and post hospitalization treatment expenses;
  - It does not cover the expenses incurred for the treatment of Asthma, Chronic Nephritis, Diarrhea, Bronchitis, Diabetes, Epilepsy, Hypertension, Influenza, Psychiatric disorders, Pyrexia, Tonsillitis, Laryngitis and Pharyngitis, Arthritis, Gout and Rheumatism;
  - It does not cover the period of treatment for first three days and relapse within 45 days.

**Excluded Claims**

- No claim/expenses is payable under this policy for the treatment of following diseases:
- Pre-existing diseases at the time of policy;
- Any disease contracted by the insured within 30 days of taking out the policy,
  - but this condition will not apply to a case where the medical practitioner is of opinion that it could not have been traced by the insured;
  - This condition will also not apply, if the policy is continued from the previous year without any break i.e. renewed without break;
- During the first year of operation of the policy, the expenses incurred for the treatment of disease like cataract, Hysterectomy, Hernia, Fistula, Piles, Hydrocele, Sinusitis etc;
- Vaccination or inoculation/immunization of any kind;
- Circumcision, unless necessary for the treatment of a disease not excluded in the policy;
- Cosmetic surgery or aesthetic treatment other than that which is necessitated due to accident or part of any illness;
- Convalescence, general debility, run down condition or rest-cure, congenital disease or defects, sterility, venereal disease, self injury or use of intoxicating drugs;
- Various conditions commonly referred to as AIDS;
- Expenses on vitamins and Tonics unless forming part of a treatment;
- Treatment arising from childbirth;
- Voluntary medical termination of pregnancy;
- Naturopathy treatment;
- Cost of spectacles, contact lenses, hearing aids;
- Dental treatment or dental surgery of any kind unless requiring hospitalization.

**Settlement of claims and TPAs (Third Party Administrators)**

- Settlement of claims
  - Depending upon the cover, the insured may get a facility of cashless services. Or the insured is entitled to reimbursement, subject to terms and conditions of the policy.

- TPAs (Third Party Administrators)

- Earlier, the responsibility as to claims processing was handled by the insurance company itself.

- Now because of the introduction of TPAs (Third Party Administrators), this task is outsourced to the concerned TPA.
TPAs shoulder the responsibility of liasoning between the insurance company and the consumer i.e. insured.

Speaking in our context it is a significant relief to the consumers.

Who can be a TPA?

The necessary regulations introduced in the IRDA may be called the Insurance Regulatory and Development Authority (Third Party Administrators – Health Service) Regulations, 2001.

Only a company with share capital, registered under the Companies Act, 1956 can function as TPA.

The main object of the co. is to carry on business in India as a TPA in the health service.

On being licensed by the IRDA, the co. can not engage itself in any other business.

The minimum paid up capital of the co. shall be in equity shares amounting to Rs. 1 crore. At no time less than the same.

At least one of the directors of the TPA shall be a qualified medical doctor registered with the Medical Council of India.

A license granted can be revoked after due notice for sufficient reasons.

Every policy holder will be allotted to a particular TPA.

Such TPA must shoulder the responsibility of rendering services to the policy holder.

Hospitals and TPA will be the contractual partner for this specific purpose.

As a result, subject to overall terms and conditions of the policy, every person is entitled to claim either cashless facility or claim reimbursement.

Legal issues

Life insurance is for life, while the health insurance is for healthy life.

The health insurance is a contract.

It is an annual contract with an irrevocable offer to renew upon payment of the agreed renewal premium.
In an existing contract where it is specifically provided that the insurer is not bound to give notice when the policy is due for renewal and
the insured remits the renewal premium in time, the insurer cannot invoke the cancellation clause for refusing renewal,

Unless any one of the contingences permitting cancellation has occurred.

There is already a standing offer seeking renewal and that is why Clause 5.9 stipulates that notice of renewal need not be given by the insurer.

The moment insured pays the premium in time the acceptance of that offer is complete,

It creates a binding contract and there would be no option with the insurer to deny renewal.

Insurance is a -

Contract of utmost good faith. (uberrime fidie)

Contract of Indemnity.

Risk is illness/disease, a consideration.

Payment of Premium is an essential element. (consideration)

Insurable interest – necessary element, without which, it becomes a wagering contract – a void contract.

Insurance Cos. are State within the meaning of Article 12 of the Constitution of India,

Notwithstanding the entry of private companies in the field of general insurance, ending their monopoly by virtue of insertion of Sec.24A in the Act of 1972, are enjoined with the obligations to act with fairness.

Arbitrariness should not appear in their actions or decisions.

Any tendency to undertake risk selection so as to insure low-risk individuals

and exclude the high-risk ones from insurance via exclusion conditions

would impose a heavy financial burden on the people who are prone to get sick and most in need of risk protection,

Obviously works against the constitutional perspective.
Public Health Insurance Scheme have, therefore, to be safeguarded against such
tendencies that may be disguised under a refined argument of business or
commercial prudence.

A bare reading of the exclusionary provisions in the policy shows that only in
respect of the disease/injuries which are pre-existing

“When cover incepts for the first time”, the liability of the company will be
excluded.

This would mean that the liability in respect of the disease/injury occurring during
the continuance of the cover without break will remain.

A party cannot be absolved from liability to perform a contract merely because
the performance becomes more onerous. (M/s Alopi Prasad and Sons Ltd. v.
U.O.I., AIR 1960 SC 588)

Refusal, however, be justified on the grounds such as fraud, misrepresentation,
non-fulfillment of the obligations by the insured.

It is settled legal position that where after every effort to reconcile more than two
clauses of contract of insurance appear plainly in conflict,

it is necessary to consider the comparative weight to be given to each of them.

In such case, one of the rules applicable to determine which clause shall prevail is
that the policy should be construed strongly against the insurers.

In case of ambiguities in a policy,

the rule is that the policy being drafted in a language chosen by the insurers,

Must be taken most strongly against them. (Verba chartarum fortius accipiuntur
contra profrentem i.e. words are to be interpreted most strongly against him who
uses them)

Health Care, Insurance and the State

u/a 47 of the Constitution of India, protecting health of the citizens against
infectious diseases, promoting better standards of healthcare and ensuring that
there are adequate safeguards against financial risks connected with severe
ailments would constitute key objectives of the public health policy in a Welfare
State.
The socially and economically marginal groups in the society can hardly afford the financial burden involved in treatment of disease.

This calls for an equitable distribution of the financial burden of ill-health.

Such disproportionate economic burden on the poor sections demands State intervention to ensure that private health insurance is regulated in a manner that would promote the goals of the national health policy in the context of the directive principles of securing high standards of living of the people, to improve public health and to secure that the operation of the economic system does not result in the concentration of wealth and means of production to the detriment, as mandated by the Articles 39 and 47 of the Constitution.