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STATE HEALTH POLICY MIZORAM 2016

Background and rationale : With specific recommendations given towards the framing of National Health Policy and the current revitalization of Health Services, the following policy has been framed by the State Government to achieve the highest possible level of community health.

Goal :

The attainment of the highest possible level of good health and well-being, through a preventive and promotive health care and universal access to good quality health care services without anyone having to face financial hardship as a consequence.

Key Policy Principles:

Equity: Public expenditure in health care, prioritizing the needs of the most vulnerable, who suffer the largest burden of disease, would mean affirmative action to reach the poorest and minimizing disparity on account of gender, poverty, caste, disability, other forms of social exclusion and geographical barriers.

Universality: Systems and services are designed to cater to the entire population- not only a targeted sub-group.

Quality of Care: Health Care services would be effective, safe, and convenient, provided with dignity and confidentiality with all facilities across all sectors being assessed, certified and incentivized to maintain quality of care.

Inclusive Partnerships: The task of providing health care for all cannot be undertaken by Government, acting alone. It would also require the participation of communities – who view this participation as a means and a goal, as a right and as a duty. It would also require partnerships with academic institutions, NGO,FBO etc.agencies and with the commercial private sector and health care industry to achieve these goals.

Pluralism: Patients who so choose and when appropriate, would have access to AYUSH care providers based on validated local health traditions. These systems would also have Government support and supervision to develop and enrich their contribution to meeting the national health goals and objectives.

Decentralisation: For ensuring responsiveness and greater participation, increasing transfer of decision making to as decentralized a level as is consistent with practical considerations and institutional capacity would be promoted.

Accountability: Financial and performance accountability, transparency in decision making, and elimination of corruption in health care systems, both in the public systems and in the private health care industry, would be essential.

Professionalism, Integrity and Ethics: Healthcare workers and managers shall perform their work with the highest level of professionalism, integrity and trust and be supported by a systems and regulatory enabling environment.

Affordability: As costs of healthcare rises, the policy recommends affordable healthcare cost without compromising quality of care.

Objectives:

(a) Improve population's health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided by the public health sector.

(b) Achieve a significant reduction in out of pocket expenditure due to health care costs and reduction in proportion of households experiencing catastrophic health expenditures.

(c) Assure universal availability of free, comprehensive primary health care services, as an entitlement, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable and non-communicable diseases in the population.

(d) Enable universal access to free essential drugs, diagnostics, emergency ambulance services, and emergency medical and surgical care services in public health facilities, so as to

enhance the financial protection role of public facilities for all sections of the population.

(e) Ensure improved access and affordability of secondary and tertiary care services through a combination of public hospitals and the private health sector.

(f) Influence the growth of the private health care industry and medical technologies to ensure alignment with public health goals, and enable contribution to making health care systems more effective, efficient, rational, safe, affordable and ethical.

Policy Directions:

Investment - Full achievement of the goals and principles as defined would require an increased public health expenditure to 4 to 5% of the GDP, this policy proposes a potentially achievable target of raising public health expenditure to 2.5 % of the GDP. It also notes that 40% of this would need to come from Central expenditures. At current prices, a target of 2.5% of GDP translates to Rs. 3800 per capita, representing an almost four fold increase in five years

Taxation - With the projection of a promising economic growth, the fiscal capacity to provide this level of financing should become available. The Government would explore the creation of a health cess on the lines of the education cess for raising the necessary resources. Other than general taxation, this cess could mobilise contributions from specific commodity taxes- such as the taxes on tobacco, and alcohol, from specific industries and innovative forms of resource mobilization. High public investment in health care is one of the most efficient ways of ameliorating inequities, and for this reason, this commitment to higher public expenditures is essential.

Preventive and Promotive Health:

This Health Policy is based on the goal of attainment of highest level of health, and not merely the absence of disease or disability. To realize this vision, the policy mandates the Department of Health & Family Welfare to provide a roadmap for a series of coordinated policy initiatives and practical actions, to be implemented across all sectors.

Health and happiness is not only a driver of economic growth, it is its very purpose. All sectors would need to be convinced that preventive and promotive health care approaches are not only a health gain but a first order economic gain as well and would be enabled to take ownership of making this health challenge their own challenge. Failure to do so would result in negative impact on workforce participation, economic growth, and societal sense of well-being and achievement. This is a major challenge for the state.

There is much that individuals and families can do to prevent disease and promote good health at their own individual levels. But if the social and economic environment in which they exist – where they work, live and play, where they bring up their families, interact with the community and experience life – is not conducive to good health, the impact of individual behaviours may be severely limited.

Given the multiple determinants of health, it is clear that a prevention agenda that addresses the social and economic environment requires cross-sectoral, multilevel interventions that involve sectors such as food and nutrition, education, safe drinking water and sanitation, housing, employment, industrial and occupational safety, welfare including social protection, family and community services, tribal affairs and communications.

Other than its own policy action and initiatives, the Government has an obligation to build community support and capacity to enjoy good health, particularly among those who are most vulnerable and have the least capacity to make choices and changes in their lifestyle or living conditions that might improve and protect their health: the very young, the marginalized or socially excluded, the poor, the vulnerable to violence, the old, and the disabled. The Village Health Sanitation and Nutrition Committees and its urban equivalents that are a part of Local Government Institutions are a platform that must be strengthened and utilized for this purpose.

Amongst the various possibilities for action, the health policy identifies coordinated action on priority areas for improving the environment for health with measurable achievements through well thought out and financed institutional mechanisms. These include:

(a) The Swachh Bharat Abhiyan, which is already in place, would be supported, and whose success would be measured by the reduction of water and vector borne diseases and declines in improperly managed solid waste.

(b) Balanced and Healthy Diets: This would be promoted through action in Anganwadi centers and schools and would be measured by the reduction of malnutrition, and improved food safety.

(c) Addressing Tobacco, Alcohol and Substance Abuse: Success would be judged in terms of measurable decreases in use of tobacco, alcohol and substance abuse.

(d) Deaths due to road traffic accidents should decline through a combination of response and prevention measures that ensure road safety-. This concept could be expanded to include injuries on account of other causes.

(e) Action against gender violence or sexual violence would be addressed through legal measures, implementation and enforcement of such laws, timely and sensitive health sector responses, and working with young men.

(f) Reduced stress and improved safety in the work place would include action on issues of employment security, preventive measures at the work place including adequate exercise and movement, and occupational health- strengthening understanding of occupational disease epidemiology and demonstrate measurable decreases.

(g) Action would be taken on reducing indoor and outdoor air pollution and measured through decreases in respiratory disease especially in children, and other pollution related illnesses.

The policy explicitly articulates the need for the development of strategies and institutional mechanisms in each of these areas to synergize individual and family level action, with social movements where communities can collectively participate, the use of media to highlight these issues, with appropriate policy interventions that build the social environment under which behavior changes can take place.

The role of the health sector would be to undertake evidence based advocacy within Government and in the media- which highlights the link between these social determinants and disease and the need for collective will to change these determinants. The policy recognizes the need for the holistic approach and cross sectoral convergence in addressing social determinants of health. This would also require the development and use of indicators to measure the determinants and the disease outcomes and systems to measure such indicators. The health sector would have credibility and the administrative and political will to lead these preventive measures, only when it is seen to be completely committed and effective in addressing the health care needs where preventive action fails. Thus a health sector treating severely malnourished children can push for nutrition changes. A good disease surveillance system would pick up outbreaks of water-borne disease and link it to specific sanitation failures. A commitment to provide free care to all victims of gender based violence- be it rape or acid attacks or burns- on a whatever it costs basis, would give it the strength to contribute effectively to the campaigns against gender based violence. Preventive and Promotive Care has a two-way continuity with Curative care- an under recognised reality that this policy recognizes and builds upon. Also the benefits of prevention are most visible when the burden of costs is undertaken by the State. Further a commitment to pay for the costs of care in some of these conditions is a form of accountability of the State for preventive action.

Some aspects of disease prevention and health promotion are specific services that are to be delivered as part of primary health care services. Currently it includes immunization and ante-natal care, school health programmes and some limited health education and health communication efforts. This policy envisages not only extending the coverage and quality of existing services but also extending the package of family and community level preventive and promotive health care services to include early detection and response to early childhood development delays and disability, adolescent and sexual health education, behavior change with

respect to tobacco and alcohol use, screening, counseling for primary prevention and secondary prevention for common chronic illness- both communicable and non- communicable.

Of these programmes, the one that would require much greater emphasis, investment and action is in school health- by incorporating health education as part of the curriculum, by promoting hygiene and safe health practices within the school environs and by acting as a site of primary health care. The school mid day meal programme and the food supplementation at the anganwadi must both be leveraged to achieve the reduction of child malnutrition at an accelerated pace.

ASHAs serving as Community Health Workers in rural and urban areas have significant potential for a critical role in disease prevention and health promotion. The ASHA will be supported to undertake primary prevention for non-communicable diseases, in palliative care and community mental health, through health promotion activities, working with care givers and the Village Health Sanitation and Nutrition Committees, which would include representatives of local government.

Wider involvement of stakeholders includes elected local governments, local communities and community based organisations like self-help groups, students of schools and colleges, non government organizations, professional organizations, and corporate social responsibility mechanisms. Taken together these could constitute a „Social Movement for Health". In this context the use of mass media is important, and a provision can be made for a minimum amount of health messaging from within an agreed menu of priority messages that channels should broadcast.

Public Health Care Delivery objectives

1. In Primary Care: From a Selective Care that is fragmented from secondary/tertiary care to Assured Comprehensive *care* that has continuity with higher levels

2. In Secondary and Tertiary Care: From an input oriented, budget line financing to an output based strategic purchasing.

3. In Public Hospitals: From User Fees & Cost Recovery Based PublicHospitals to Assured Free Drugs, Diagnostic and Emergency Services to all in PublicHealth Facilities

4. In Infrastructure and Human Resource Development: From normative approaches in their development to targeted approaches to reach under-serviced areas.

5. In Urban Health: From token under-financed interventions to on-scale assured interventions that reach the Urban Poor and establish linkages with national programmes: Scaling up of the interventions with focus on the urban poor and achieving convergence among the wider determinants of health.

6. In National Health Programmes- Integration with health systems for effectiveness, and contributing to strengthening health systems for efficiency.

7. In AYUSH services: From Stand-Alone AYUSH to a three dimensional Mainstreaming.

Access to services remains the key issue for most of the poor- with very limited services being available, especially in rural and remote areas. Targeted investment in building health infrastructure and putting in place an adequate number and skill –mix of health human resources and supplies in under-serviced areas where the gaps are the greatest, would remain a major strategy of improving access.

Free Drugs, Free diagnostics and free emergency care services in public hospitals, free emergency response and patient-transport systems would be the norm, thus providing a high degree of access and financial protection at secondary and tertiary care levels.

Urban health is a growing challenge. Despite supposed proximity to health care facilities their access to such facilities is severely limited. The major shift needed therefore is to scale up

this programme to cover the entire urban population within the next five years- and this requires adequate financing on a sustained basis to match the requirement.

Priority setting in health care is a political decision, based on our core values as a nation and informed by technological knowledge of both disease prevalence and feasibility of interventions. The health priorities, which are included in national programmes, have not been included because they are cost-effective. But it will remain the single most important heath indicator for us. Or to take another example, leprosy represents less than one thousandth of all morbidities and has no mortality at all- but it is a core value that as a modern nation we will no longer tolerate the disability and stigma that this disease creates, as we resolved in the case of polio. Whereas markets in health care cannot and do not and perhaps will not address many of these priorities, because they are not value for money propositions in the logic of markets, public health systems must gear up to address these goals. Public health care systems must retain a certain excess in terms of health infrastructure, human resource and advanced technological capacity that can be mobilized in times of crisis. However all national health programmes require, that for effective implementation they are well integrated with state health systems and for efficient functioning must contribute to strengthening state health systems meaningfully.

India has a legacy of pluralism in health care, with many indigenous and alternative approaches to health and medical care also contributing to the health and well-being of its population. In being available at all major public health care facilities so that the population have easy access and can make an informed choice of the system of care they want to follow, to ensure that the considerable existing human resource and infrastructure gets the requisite conditions to provide quality services, which includes medicines and equipment as well as an enabling environment to practice their system with confidence. Supporting validated practices of self-care by communities and households would form the community level component of this mainstreaming and empower people to participate in improving their own health.

1. **Primary Care Services**

Health Care Service delivery would be built on the bedrock of high quality comprehensive primary health care services that are made universally accessible, that are free and that are provided as close to where people live and work as is feasible. Primary Health Care is necessarily comprehensive-addressing primary care for all of reproductive and child health, communicable diseases and non-communicable diseases through appropriate health communication, technologies and care provision. Comprehensive Primary health care is value for money, i.e, higher health outcomes at lower per capita total health expenditure. Such Primary health care would reduce morbidity and mortality greatly at much lower costs to the system and the individual than any other approach, and would significantly reduce the need for secondary and tertiary care. Comprehensive Primary care must be available as the entitlement that we are in a position to assure at this level of social and economic development.

A primary health care team works with communities and therefore understands the needs of its defined community and so is able to provide comprehensive, integrated and patient centered care. It is the focal point for building the trust and credibility of the entire health service. It can be developed to increase the efficiency of the health services as a whole and protect the patient from unnecessary medicalization. The PHC team plays an important role in averting disease, counseling, guiding and educating people and enables them to adopt healthy life styles and make better health and healthcare related choices.

The Organization of Primary care systems depend upon the establishment of a network of primary health facilities, which are adequately staffed, skilled and supported to perform their functions effectively and efficiently. This therefore requires a matching human resource development strategy, a

logistics support system and a referral back up. It involves an up-gradation of the existing *health sub-centres and* orientation of all *primary health centers* to provide this comprehensive set of preventive, promotive, curative and rehabilitative services

Most elements of primary care would be designed such that a nurse or paramedical with suitable training should be able to provide the necessary care. For all chronic illness, a doctor or specialist may have to initiate the treatment and supervise it, but most elements of the continuity of care required for chronic illness can be provided locally by the primary care team, thus preventing overcrowding at the higher and underutilization at the primary level, and saving the family enormous costs and suffering

Such an approach to primary care would be possible only in a context where ASHA has been established as an effective bridge between the first level of health facility and the community. The ASHA would support the enrolment of all families with the Health Centers (Sub-centers and Primary Health Centres providing comprehensive care), ensuring that there are no exclusions and that all new entrants are also registered through regular updations of the registration process. The ASHA will also play a role in secondary prevention by ensuring compliance to treatment and facilitating follow up of those being treated for chronic illnesses. The ASHA has an established and effective role in prevention and management of communicable diseases and in maternal and child health and this will continue to be an important area of focus.

This same concept shall extend to all urban areas also. Though the population per centre ratio would be about half (one for every 10,000 population) the relationship between number of providers and registered families would be the same.- meaning additional human resources and supplies to deliver this larger range of preventive, promotive and curative care services- so that it becomes the first port of call for every individual and family.

Comprehensive Primary Care approaches require reliable and effective referral support with feedback and follow-up mechanisms. Universal coverage with ante-natal care examinations is effective only where we have secondary care facilities which can manage the pregnant woman detected to have complications. Similarly initiation of therapy in most chronic illness may need a medical, even specialist consultation to initiate, but the primary center would be able to provide the necessary regular check-ups needed and ensure medication access and compliance

2. Secondary Care Services

One major strategy to achieving this secondary care capacity is strengthening the **district hospital** and a well-chosen, well located set of sub-district hospitals which could be CHCs or sub-divisional hospitals. Firstly we should have at least 100 beds per one lakh population and they should be distributed such that within what is known as the golden hour- a secondary care facility can be accessed. . There should be efficient emergency transport systems be available. It also implies that the general physician, surgeon, gynecologist, pediatrician and anesthetists are available. . The goal is that all of secondary care, redefined to include a considerable part of what happens currently only in medical college hospitals should now become available within a standard District Hospital. Strategic purchasing by the Government acting as a single payer- purchasing care from public hospitals and private providers as part of a strategic plan for district health systems development. This is one way of improving efficiencies of use of funds Part of the public investment , especially that going to core infrastructure and a part of human resources and supplies would be through budgetary allocation, but an increasing part would be through reimbursement for services provided- or in other words a resource allocation that is responsive to quantity, diversity and quality of caseloads provided care. Development of such secondary care capacity also means certain obligations as regards HR, especially the challenge of finding the necessary specialist skills and in the organization of more comprehensive facility development that can assure at least all common surgical care and emergency medical services. A special scheme to develop this capacity across public and private hospitals that operate in large number of districts where there is currently no capacity at all- would be one important corollary of this scheme.

3. **Re-orienting Public Hospitals:**

An important change in policy mind-set is to move away from imagining public hospitals as social enterprises that ideally must recover the costs of their functioning, to re-imagining them as part of a tax financed single payer health care system in which, what public hospitals deliver is not free care, but rather pre-paid care (like in commercial insurance) and which is cost efficient in addressing health care needs of the population.

The main corollary of this policy statement is that the public hospital must provide universal access to free drugs and diagnostics. In terms of services other than services covered under national health programmes, public health systems should be able to provide all emergency health services. There would be considerable self-selection involved as those who require higher degrees of hospitality arrangements or exclusiveness and can pay for it would prefer to go to private sector- but it is universal in that there is no barrier to the "well to do" also from seeking care in the public hospital.

The other corollary of viewing public services- not as free, but as pre-paid is that quality of care would become an imperative- and all public facilities must have periodic measurements and certification for level of quality and must be financed and incentivized to meet and retain quality standards.

4. **Closing Infrastructure and Human Resource/Skill Gaps:**

In areas where there is high density of population but there are also large gaps in terms of density of facilities and human resources for primary care- the policy would simply be to add on more human resources in the given infrastructure rather than more infrastructure. In urban areas operating the infrastructure in two shifts may also enable higher access- provided the human resources for primary care never falls below the population to provider ratio. In facilities, which have much higher case-loads, the human resources deployed must be proportionately higher to ensure quality of care.

In secondary hospitals the policy approach would be to add more beds and staff to match caseloads if distance is not a barrier to access, rather than fragment the available specialists and medical and nursing staff across several facilities- thus making all of them sub-critical for delivering secondary care services in an assured manner. But where distance is a barrier, new hospitals of the standard CHC model- with 30 beds would have to be strengthened with necessary skilled staff including specialist skills.

Another policy objective would be measurable improvements in quality of care. For public health care facilities, the strategy would be to ensure that every health care facility is measured and scored for quality, and certified and incentivized when it achieves a certain minimum score. Quality measurements would include in the least clinical quality of care, as well as patient safety, comfort and satisfaction. Quality Improvement would require technical support and capacity building as well as institutional arrangements for measurement and certifying

One major area of concern in district health care services is access to blood and blood safety. Currently the network of approved blood banks is not large enough or dispersed enough to ensure safe blood supply across all districts and sub-district hospitals. There are reports that a considerable part of rural blood transfusion requirements are met through unbanked blood transfusions and in some contexts this is the only feasible and safe option. Though blood supply was to be free, in some States commercial transactions around blood have developed. Expanding the network of blood banks and ensuring that there is improved access to safe blood shall be one of the important components of improving service delivery.

5. **Urban Health Care**

The first call of the National Health Policy with respect to urban health would be to address the primary health care needs of the urban population. The National Urban Health Mission(NUHM) would need to be strengthened and adequately financed to achieve this. NUHM would cover all State capitals, District headquarters and cities/towns with more than 50,000 populations. Within this primary care approach there would be a special focus on poor populations living in listed and unlisted slums, other vulnerable populations such as homeless, construction workers, sex workers and temporary migrants.

Since, no comprehensive strategy/ programme had been launched yet to develop an appropriate public health delivery system across cities/ towns, the interventions in urban health must lead to strengthening of the existing primary public health systems & establishing new facilities for the unserved & underserved population. Given the large presence of private sector in urban areas there is considerable scope for developing sustainable models of partnership with for profit and not for profit sector for health care delivery.

Urban health is dependent on the urban environment- and therefore the policy would emphasize measures of reduction of air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress. An important focus area of the urban health policy will be in achieving convergence among the wider determinants of health. The approach to achieving this is both through a major effort at behavior change such as that exemplified by the Swachh Bharat Abhiyan, and supplemented by building modern technological and social approaches to public services and regulatory measures that address each of these urban health determinants.

Addressing the major prevalence of non-communicable diseases such as hypertension and diabetes through planned early detection, and better secondary prevention would be an integral part of urban health strategy. Improved health seeking behavior influenced through capacity building of the community based organizations & establishment of an appropriate referral mechanism would also be important components of this strategy.

6. National Health Programmes:

(a) RCH services:

For further acceleration in the gains made in all Reproductive and Child Health (RCH) programmes, the greatest challenge is to address the social determinants of health. Maternal and perinatal mortality is highest in population sub-groups which are poorer, more malnourished, less educated, have lower age of parity and have too many children or too soon. It is also a reflection of patriarchal mindsets and lack of gender equity which makes women more vulnerable. Thus child and maternal survival is a mirror that reflects the entire spectrum of social development and addressing these social determinants through developmental action of all sectors will remain a priority.

Reduction of Maternal Mortality: Within such a context, the challenge in further reductions in maternal mortality and morbidity lies now in improving the quality of care in health care facilities. In antenatal care this translates to timely detection of complications like hypertension, anemia and diabetes and adequate response to the same. During delivery it means services of a skilled birth attendant, preferably in a facility that is as close to home as possible, which follows all protocols of safe delivery backed up by ready access to emergency obstetric care. An operation theatre that functions only during the occasional sterilization day or emergency obstetric case, or a blood storage unit used only for C-sections would find it more difficult to maintain the quality standards required for safe and effective services, and would have lesser value for money. Even the surgeon requires a regular service for maintaining their skills. Thus a general health systems strengthening would greatly benefit continuity of care and emergency services for maternal health and all strengthening for maternal health would be used to enhance other services as well.

Cash Transfers, Quality of Care Issues: Though there is a persistent level of home delivery in many states improved access and quality of care and ensuring that there are no financial barriers would be adequate to achieve a further shift to safe delivery. Further general increases in cash transfers are not necessary. Improving quality of care at primary level facilities would also limit the load on higher facilities, freeing them to provide secondary and tertiary care of better quality. The existing cash transfer (Janani Suraksha Yojana) however has been effective to cover non- medical costs of care and needs to be retained, and if necessary enhanced in line with the needs of select sub-groups who face a greater financial barrier.

(b)Child and Adolescent Health: The policy‟s commitment to child health begins by endorsing the national consensus on accelerated achievement of single digit neonatal mortality and stillbirth rates through a careful synergy of community based intervention centred around the ASHA and anganwadi worker and improved home based and facility based management of sick newborns. The latter has its own HR and skill requirements as well as increased access to technologies. Developing such high quality facility based care for the sick newborn and child will strengthen and be strengthened by better primary and secondary care facility development. Community based interventions strategies must go beyond immunization to include ready availability and access to ORS and Zinc for diarrhea and appropriate antibiotics for pneumonia, better identification and management of anemia, and screening for developmental defects. The policy affirms commitment to school health programmes as a major focus area and health and hygiene being made as part of the school curriculum. AYUSH doctors supporting healthy local home and community practices and the mainstreaming of AYUSH interventions at primary level will further strengthen primary care. We also need to give special emphasis to the health challenges of adolescents (10 to 19 years) and long term potential of investing in their health care. In this age group there is one section affected by under-nutrition, and there is another section that requires attention to reduction of obesity. Paradoxically both of these can be more common in poorer sections. Adolescent health interventions may not immediately get reflected in reduction in infant mortality rates or other conventional measures of health systems performance but they are nevertheless important.

(c) Universal Immunization Programme: The success of polio eradication has raised the expectations and the Universal Immunization Programme would capitalize on social mobilization and habitation level information base and processes built up in polio eradication to benefit the entire immunization effort. One of the immediate challenges is to further increase immunization coverage with quality and safety. Better adverse event reporting and compensation policies would be built up. While the introduction of new cost effective vaccines is a frontier, these would be introduced and scaled up along with building the institutional capacity to deliver the vaccines and as a complement to other health priorities of primary health care.

(d) Supportive Supervision: The enormous needs and challenges of capacity building and supportive supervision in more vulnerable districts with very weak internal capacity requires a new strategy. One such promising strategy that can be scaled up is where carefully selected and supported nurse-trainers will visit and work with facilities in under-performing and highly vulnerable districts to establish a better quality of facility and community level care.

(e) Population Stabilization including maintaining a gender balance has been and will continue to be one of the main components of national health policy. However the fertility rates is declining rapidly and with improving levels of women‟s education, the demand for contraceptive services is established. Here the policy imperative is to move away from camp based services with all its attendant problems of quality, safety and dignity of women, to a situation where these services are available on any day of the week or at least on a fixed day. The State Health Policy is explicit that coercive methods are not justified nor even effective to meet the goals. Improved access, education and empowerment would be the basis of successful population stabilization.

(f) Women' Health & Gender Mainstreaming: Women‟s health issues and concerns go far beyond maternal health, the ability of the health sector to address these issues needs to be strengthened. Despite the introduction of new technologies access to safe abortion services and for reproductive tract illness remains a major gap that must be seriously addressed. One major concern is the health response to victims of gender violence – ranging from sexual assault to acid attacks on women. While measures to prevent these are the focus, the health system must also bear the costs and undertake whatever it takes to access the appropriate services for these victims. At another level women‟s access to health care needs to be strengthened by making public hospitals more women friendly and ensuring that that the staff have orientation to gender –sensitivity issues.

(g) Communicable Diseases under National Disease control programmes

1.Integrated Disease Surveillance Programme: A comprehensive approach to communicable diseases needs districts to respond to the communicable disease priorities of their locality- and this can only happen in a context where the integrated disease surveillance programme is used to generate a comprehensive understanding of all communicable diseases in the respective areas, as well as respond to localized outbreaks as and when they occur and before they become generalized epidemics. The policy response is to build sufficient public health capacity down to the district level- and this consists of both a network of well-equipped laboratories backed by tertiary care centers and the public health capacity to collect, analyze and respond to the disease outbreaks using the state of the art public health knowledge.

The approach to integration: The communicable diseases that national health programmes address include three chronic diseases- HIV, tuberculosis and leprosy, plus all the vector borne diseases, and the expanded programme of immunization, which has significantly reduced mortality from diseases like diphtheria, pertussis, tetanus, measles and now hepatitis B. Every one of these programmes require on one hand a robust public health system as their core delivery strategy, and on the other they can be considered as opportunities to strengthen health care systems- and designed keeping this goal in mind. Thus blood safety is an important element of HIV control, but the policy imperative is that blood safety measures are designed as part of a universal access to blood transfusion services. Tuberculosis control needs excellent laboratory support for its effectiveness but the programme would be designed to strengthen laboratory services on the whole. The control of malaria requires ASHAs with point of care diagnostics and drugs who can respond in time to every case of malaria, but it would be designed so that it enhances her role, capacity, confidence, and her remuneration for all programmes.

2.Control of Tuberculosis: The current challenges in tuberculosis are persistent high levels of disease transmission, rapid progression of the disease in infected patients and increase in incidence of drug resistant tuberculosis. This calls for more active case detection with a much greater involvement of private sectors in case detection, and adherence to standard treatment protocols. It also requires a choice of strategy with regard to treatment regimes that reflects the changing patterns of microbial sensitivity and medication compliance. In case of drug resistant TB access to free drugs would need to be complemented by affirmative action in the form of investment in enabling access and coping with livelihood issues for that the treatment is carried out, drop-outs reduced and transmission of resistant strains are contained. These treatment based control measures to be most effective in actual reduction of prevalence rates needs supplementation by preventive and promotive action in the workplace and in living conditions.

3.Control of HIV/AIDS The progress in reduction of HIV incidence and HIV related mortality would be sustained and accelerated as greater awareness, enhanced prevention and wider access to ART are put in place. As the programme gets integrated through a well-defined process, care would be taken to ensure that there is no loss of focus on this goal. The achievements in HIV control owe a lot to both its emphasis on prevention, its partnership with active and vibrant communities and civil society, evidence based programming and in the ability to encourage the production of generic anti-retroviral drugs at affordable rates. All these advantages will be sustained and built upon by the policy framework of not only health but other concerned departments and industry. One critical policy concern is to balance the financing strategy so that the current emphasis on prevention continues, while the increasing cost of clinical care and treatment to people living with HIV is also provided for. The private sector would also be included in efforts to provide care, support and treatment to these patients and for help in dealing with stigma and discrimination associated with this disease.

4.Leprosy Elimination: The achievement of „leprosy elimination‟ at the national level i.e. a prevalence rate to less than 1 per 10,000 is an important milestone, but given the epidemiological characteristics of the disease, even in an optimum programme, there would be new cases every year, which would have to detected and managed patiently for the disease to eventually disappear. The thrust of policy is

therefore to build a systems sensitivity to ensure that the small proportion of skin lesions which would be a leprosy case is identified in time, treated and followed up to ensure that not a single extra disability occurs on account of this disease. This can happen only if every provider is sensitized for this, a small proportion of providers remain dedicated to this as resource persons who keep the requisite skills alive within the health system, and further the health system now gears to a better level of dermatological care so that the needle of leprosy lesions in the haystack of skin lesions is not missed. The proportion of grade 2 cases amongst new cases will now become the measure of community awareness and health systems capacity and dedication to this task.

5.Vector Borne Disease Control: The National Vector Borne Disease Control Programme deals with six diseases. Of these, Malaria, Filaria and Kala-azar are on decline because of various interventions in the form of early detection and treatment, integrated vector management and extensive IEC/BCC and the contribution made by ASHA workforce. With malaria there is a growing challenge of drug resistance and the country would have to keep a vigil on the same, changing treatment regimens with logistics support as appropriate Dengue is emerging as the fastest growing infection too faces a challenge. National programme for prevention and control of Japanese Encephalitis (JE)/Acute Encephalitis Syndrome (AES) have been initiated with a strong component of inter-sectoral collaboration, but they require strengthening in many dimensions. Good quality data including entomological information for which a dedicated team of entomologists with support staff is essential in the fight against these diseases. Taken together the battle against vector borne disease is an example of how one needs to be ahead of the problem in biomedical research for understanding of disease and its transmission, in drug innovation and drug discovery and bringing innovations on to the market with very short lag times and in building public health capacity at district levels. Vector borne disease will remain one of the important barometers for how effective public health systems are in integrating preventive and curative care.

(h) Non-Communicable Diseases: Despite a policy intent in the form of a national programme on NCDs, the effort against the growing burden of non-communicable diseases are nascent or initial steps, with considerable distance to traverse before they become universal in outreach. Almost all States have started initiatives to cater to NCD challenges, but a comprehensive learning from various models of implementation is still elusive. This policy will support an integrated approach where screening for the most prevalent NCDs, where secondary prevention would make a significant impact on reduction of morbidity and preventable mortality would be incorporated into the comprehensive primary health care network. This would be firmly linked through continuity of care arrangements with specialist consultations, which can be followed up at the primary care level. Emphasis on medication and access for select chronic illness on a, round the year, basis would be ensured. The National Programme will also ensure that the necessary resource support and capacity building support for such an integrated approach is built up at the district level. This is one area where research and protocol development for mainstreaming AYUSH and developing Integrative Medicine has huge potential for effective prevention and therapy that is also safe and cost-effective, since NCDs often require life-long management. This is one area where research and protocol development for mainstreaming AYUSH and as part of integrated medical care has huge potential for effective prevention and therapy that is safe and cost-effective, since NCDs often require life-long management.

Though CVDs are the major part of NCDs, there are many other health concerns that fall under this category. The National Programme for the prevention of blindness is one such programme, which has made significant progress and achievements in this period. Programmes against deafness and for better oral health have also been initiated. There are also concerns of endemic diseases like sickle cell anemia or thalassemia that cause a preventable load of morbidity and mortality and for which integrated programmes of prevention and management would make for substantial improvements. A number of occupational diseases like silicosis are also in this category and need urgent attention. While some national programmes represent a commitment to central funding for universal free care, others

would be organized in the form of a resource support and would depend largely on State schemes and State health systems to deliver.

Elderly Health : The elderly i.e. the population above 60 years comprise of 8.6% of the population and they are also a vulnerable section. Those above 75 years are most vulnerable and almost 8% of the elderly population is bed ridden or homebound India would need to develop its own cost effective and culturally appropriate approach solution to addressing the health and care needs of the elderly. It would necessarily be a more community-centered approach where care is provided in synergy with family support, with a greater role for community level caregivers with good continuity of care with higher levels. A closely related concern is the growing need for palliative care where in life threatening illness or in end of life contexts there is active measures to relieve pain and suffering and provide support to the patient and the family. Increasing access to palliative care would be an important objective, and in this like for all geriatric illness, continuity of care across levels will play a major role.

Mental Health:

One public health priority that needs urgent attention is the sad state of neglect of mental health issues. The gap between service availability and needs is very wide. Improving this situation requires simultaneous action on several fronts. First an increase in creation of specialists with public financing with special rules to give preference to those willing to work in public systems . Integration with the primary care approach so as to identify those in need of such services and refer them to the appropriate site and follow up with medication and tele-medicine linkages. This would also require specially trained general medical officers and nurses who are able to provide some degree of referral support at the secondary care level in a context where qualified psychiatrists will remain difficult to access for many years. These mid -level psychiatrists would also be enabled by tele-medicine linkages. Supplementing primary level facilities with counselors and psychologists would be useful in several programmes including mental health, such as adolescent and sexual health programmes and HIV control. They could also be charged with creating a network of community members who can provide psycho-social support for such problems. The efforts towards de-stigmatising the psychological disabilities would be further strengthened under this policy. There should be a decreasing need for committing individuals to institutional care and current institutions should have the necessary financial and human resource support and supervision for ensuring humane and caring approaches to the inmates.

Emergency Care and Disaster preparedness:

A district that cannot respond to a poly trauma responding from a single house collapse or a single road accident is in no position to respond to an earthquake or a major train accident or flood. Disasters create maximum load on facilities that are designed to provide minimal package of services. Given the reality that there is a major environment or manmade disaster almost every year, the public health care system has to be designed to respond to such events. This requires a dispersed but effective capacity for routine emergency management and an army of community members trained as first responder for accidents and disasters. This is not only for the surgical emergency- but includes burns, drowning, stampede during fairs and festivals, etc. To support disaster response the policy would call for building earthquake and cyclone resistant infrastructures in vulnerable geographies and develop mass casualty management protocols for CHC and higher facilities and develop emergency response protocols at all levels. Improving capacities of district health systems to cope with the routine emergency is the way to best be prepared for a disaster. A network of emergency care that has an assured provision of life support ambulances linked to trauma management centers, rehabilitative care at community and through the nearest health institutions would be made available as 30% of the injured suffer serious disabilities.

7. Realizing the Potential of AYUSH:

A large part of the population uses AYUSH remedies and prefers to do so, choosing this for reasons that include perceived lower side effects, costs and/or considerations of it being more natural. The first and most important consideration in public policy with respect to AYUSH is ensuring that persons who so choose have access to these remedies. The strategy of co-location in public facilities providing allopathic care as well will continue. Another strategy is investing more on making AYUSH drugs available and standardising drugs and treatment protocols. A third is good propagation of the potential of AYUSH remedies in a number of conditions. Further disciplines like Yoga would be introduced much more widely in the school and in work places as part of promotion of good health. These latter strategies are brought together in the recently adopted National AYUSH Mission.

Tertiary Care Services:

The needs of tertiary care are growing, but the costs are growing even faster and have become prohibitive. Those who can afford do so, have bought private health insurance- but the costs of such insurance are out of the reach of the common man- let alone the poorest. There is need for further expansion of infrastructure for specialty and super specialty services at State level. The challenge with respect to this establishment of medical college is to find the faculty to staff these, to start up advanced tertiary care services as is expected of these centers, and to build them as centers of excellence for research and medical education. Building their capacity as tertiary care institutions of excellence needs exposure and training to the latest skills, a policy of benchmarking with better institutions, enlightened HR policies, and also an emphasis on research This policy would support periodic review and standardization of fee structure and quality of clinical training. The greater the gap between the need and the availability of specialists in a given domain, the greater the likelihood that many may just emigrate, given the need for specialists in developed nations as well. In most private medical colleges and tertiary care hospitals, research is not even seriously on the agenda, though there is a potential for cross-subsidization so that some less affluent sections can be treated. Given that the private sector operates within the logic of the market and that they contribute to the economy through their contribution to the growth rate and by the national earnings from medical tourism, there need not be any major effort to persuade them to care for the poor, as long as their requirements and perceptions do not influence public policy towards universal health care. Where corporate hospitals and medical tourism earnings are through a high degree of associated hospitality arrangements, one could consider forms of taxation/cess, especially for certain procedures and services as a form of resource mobilization towards the health sector.

In addition to expansion of its own provisioning, the Government would purchase select tertiary care services from empaneled private and public sector hospitals to assist the poor. Coverage in terms of population covered and services included will expand gradually. Development of evidence based standard care guidelines of care applicable both to public and private sector and establishing National Healthcare Standards Organization would be a necessary part of this strategy.

Human Resources for Health:

This is a planned human resources that meet the specific requirements for professional and technical skills that are needed most. They key principle around which we build a policy on human resources for health is that workforce performance of the system would be best when we have the most appropriate person , in terms of both skills and motivation, for the right job in the right place, working within the right professional and incentive environment.

A policy framework in human resources for health that is based on the above principle would need to align decisions regarding how and where to encourage growth of professional and technical educational institutions, how to finance professional and technical education, how to define professional boundaries and skill sets, how to shape the pedagogy of professional and technical education, how to frame entry policies into educational institutions, how to define and ensure quality of

education and how to regulate the system so as to generate the right mix of skills at the right place. Similarly public health institutions would need to have enlightened rules – formal and informal- for attracting, retaining and ensuring adequate numbers of persons with the rights skills in the right place. Such policies would have an impact on the growth and work culture of the private sector too. Currently most human resources created, crowds into urban areas, creating a highly competitive market for clients who can pay. Given the information asymmetry that characterizes this sector- such competition leads to considerable degrees of unnecessary and irrational care that regulation alone cannot remove.

To expand the number of specialists and doctors, and to do so with public health needs in mind, the State shall invest with larger human resource deficits by strengthening district hospitals to new medical colleges. Ensuring that doctors are attracted to work in remote areas and that their services can be retained there also requires specific policy measures. Most effective of the various possible approaches is a positive preference given to students from under-serviced areas, who are likely to make a lifelong commitment to go back and serve in these areas. Another positive determinant of voluntary rural location of doctors is a more rural location of medical colleges and a curriculum and pedagogy of medical education which provides exposure and motivation to work with communities. Equally important is to create a positive practice environment where professionals can stay in touch with peers and upgrade their skills and a positive social environment, through better housing, more flexible terms of employment and active measures of community support. Incentives- financial and non-monetary would also be used – and where these are substantial they would make a big difference. Measures of compulsion- whether through mandatory rural postings or mandatory rotational postings are valuable strategies, but these work best in a context where the other strategies are also applied and even then are seldom sustainable. The exact package of policy measures that would successfully address the problem of doctor vacancy would vary from State to State and would change over time, but there is adequate evidence that these can be addressed by the right mix of the strategies articulated above.

Specialist attraction and retention is a much greater challenge, and the public sector has been performing very poorly on this. While partnerships and insurance mechanisms could help improve access in some complex chronic illnesses like cancers where people would go to distant urban centers, most needs for specialist consultation would need to be met within a district. All the measures for retention described with reference to medical doctors would also apply to specialists. The requirement of patient care in super specialty services is very different from the General Specialties with regard to skills required to render effective care. Creating a specialist cadre with suitable pay scales and in addition a performance linked payment would be useful. But most important would be an upgradation of short term training to medical officers who are willing to work in these areas and providing them with a set of basic specialist skills as needed at the block and district level.

Recognizing that Nurses and Health workers form about two-thirds of the health workforce. The policy would strengthen its governance systems so that, nurses are enabled to assume leadership positions, regulation of practice is improved, quality of nursing education is strengthened by training and supporting nurse tutors, establishing cadres like nurse practitioners, and public health nurses. This would increase the total availability of nurses in the areas where they are needed most. There are very few institutions providing specialized nursing courses. It is very important that specialized tertiary level medical care is supported with specialized nursing and Para-medical care. Tertiary care facilities like critical care, cardio-thoracic vascular care, neurological care, trauma care, etc. requires specialized knowledge and skills. The policy recognizes the need for developing training courses and curriculum in these areas.

The community level work force in the form of ASHA created under the National Rural Health Mission, have now creditably established themselves as activists, facilitators and providers of community level care across various contexts. The principles of local selection, experiential training in a set of specific competencies and skills and a field based, hands-on mentoring and supportive supervisory mechanism have enabled them to play a significant role in improved outcomes related to behaviour

change for household behaviours and in improved care seeking. Taking stock of this achievement the policy direction would be to move from treating this cadre as an ad hoc arrangement to visualizing and shaping ASHA as a unique institution with a unique role- such as a community health nurse or Facilitator. One approach has been initiated with the certification programme for ASHA under the National Open School System which will serve as a benchmark, for preferential selection of the ASHA into ANM, nursing and paramedical courses for deployment in Health centres. Similar mechanisms could also be used for certifying additional and more advanced skill sets- including areas like community based geriatric and palliative care. While most ASHAs will remain mainly voluntary, and remunerated for time spent through regular performance incentives and by social recognition, those who obtain qualifications for career opportunities could be given more regular terms of engagement. The policy will enable engagement with NGOs to serve as support and training institutions for ASHA and to serve as learning laboratories on future roles of community health workers as part of the country‟s human resource strategy. Adding a second Community Health Worker would be based on geographic considerations, disease burdens, time required for multiple roles and the establishment of systems to stabilize and support the first ASHA for a set of higher skill levels in which she will be certified. The vision is that eventually every primary care team would have a number of Community Health Nurses as for a defined population certified in a specific set of competencies but with an exclusive focus on meeting community level care needs.

To expand the availability of Nurses and Health Workers, the State would encourage a nursing school and training school in every large district. Building up quality in nursing education would require not only a HR policy for the faculty but peer trainers who would come and work with them for two to three years to build up practice and behavioural norms which are benchmarked with the best nursing schools. Nursing cadre within public service requires both career progression opportunities as well as specialization in areas like public health nursing and clinical specialties.

There is a similar need to have a planned expansion of allied technical skills- radiographers, laboratory technicians, physiotherapists, pharmacists, audiologists, optometrists etc. Here there is much greater opportunity to make use of these needs to provide for local employment without compromising quality. The measures outlined for creating and retaining medical officers for public service are equally applicable but much easier to implement with respect to such skill sets. The policy would allow for multi-skilling with different skill sets so that when posted in more peripheral hospitals there is more efficient use of human resource.

There is a need to create a Public Health Management Cadre which would be based on public health or related disciplines as an entry criteria, an appropriate career structure and recruitment policy to attract young and talented multi-disciplinary professionals committed to prevention and health promotion. Doctors with public health training would form a major part of this, but professionals coming in from diverse backgrounds such as sociology, economics, anthropology, nursing, hospital management, communications, etc. who have since undergone public health management training would also be considered. State could decide whether the medical doctors with public health management training and the non-medical public health managers from other disciplines are in the same cadre stream or in separate streams.

Certain specialized skills which are essential but not limited to public health- like entomology, or communication skills or management of call centers and even ambulance services, need to be nurtured as part of a team that is working on this in a continuous manner. Such skills are better utilized by insourcing through partnership arrangements, than by creating posts, where it is not only difficult to find personnel- but even more difficult to retain their skills. Locale based selection, a special curriculum of training close to the place where they live and work; conditional licensing and a positive practice environment will ensure that this new cadre is preferentially available where they are needed most, i.e. in the under-served areas.Paramedical cadre such as perfusionists, physiotherapists, occupational therapists, radiological technicians, MRI technicians,etc. requires special skills and knowledge. There is

need to develop training courses and curriculum in these areas to efficiently and effectively support the super specialties.

Financing of Health Care & Engaging the Private Sector:

To reduce out of pocket expenditures, catastrophic expenditures and eliminate impoverishment, tax based financing would remain the predominant source of financing for at least 70% of the population who are poor and vulnerable. Free primary care provision by the public sector supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and private sector would be the main financing strategy of assuring health care services. Current publicly financed National Health Insurance schemes would be aligned with this strategy and States would also be encouraged to do the same.

Raising resources for investing in health is one challenge. Spending these resources equitably and efficiently is another. The latter challenge has two constituent parts- improving efficiency of public sector expenditure- and second is the various forms of engagement of private sector. Efficiency of public expenditure co-relate in a major way to the organization of service delivery, efficiency in procurement, the timely recruitment and deployment of the minimum human resources required for service provision and programme management, and ensuring minimum standards of workforce management. Central to improving efficiency in public health expenditure is therefore, clear allocation of powers to specific officers for each of these functions and then holding them accountable for their performance against this work allocation. Inclusion of cost-benefit and cost effectiveness studies in programme design and evaluation would also contribute significantly to increasing efficiency of public expenditure.

Resource allocation/payment mechanisms to public health facilities could also contribute significantly to improving public sector efficiency. A robust State Health Accounts System needs to be operationalised to enable this. Fixed normative allocations that are independent of volume and pattern of services delivered and do not factor in quality of services rendered are inefficient. The policy therefore calls for major reforms in public financing even for public facilities where a significant part of the funds- especially most of those related to operational costs would be in the form of reimbursements for care provision and on a per capita basis for primary care. Fixed costs, which include items like infrastructure development and maintenance, the non-incentive cost of the human resources i.e salaries, much of administrative costs would however continue to flow on a budget basis. While making these changes considerations of equity would be factored in- with higher unit costs for more difficult and vulnerable areas or more supply side investment in infrastructure. These allocations would be made on the basis of differential financial ability, developmental needs and high priority districts to ensure horizontal equity through targeting specific population sub groups, geographical areas, health care services and gender related issues. A risk equilisation formula based on health care needs could be developed. A higher unit cost or some form of financial incentive payable on quarterly or annual basis could be given for facilities providing a measured and certified quality of care. Also considering targeted increase in allocation of public expenditure for curative care, high cost non-communicable diseases, chronic diseases would receive attention in addition to current focus on reproductive, maternal and child health programmes.

Private Sector engagement would largely take the form of purchasing care from private hospitals on a reimbursement basis- against cashless services, which have been provided by them. This payment would be made by the State health assurance agency directly or through an insurance agency. In case the hospital has charged any co-payment for whatsoever reason, this would be mentioned in their claims. Private hospitals would be empanelled for this purpose and would conform to quality norms and standard treatment guidelines. Purchase from private care would be both for secondary care hospitalization and for tertiary care. Such extensive use of purchasing as a means of financing would require the creation of special institutional mechanisms at the State level – in the forms of trusts or registered societies. These agencies would lay down the standards, empanel the providers and process and make payment for the claims. These agencies would also be charged with ensuring that purchasing

is strategic- giving preference to care from public facilities where they are in a position to do so- and encouraging the creation of capacity in services and areas where they are more needed.

Finally private sector engagement need not be necessarily be only through transfer of financial resources. Private providers, especially those working in rural and remote areas, or with under-serviced communities needs to be encouraged. Provision of appropriate skills to meet public health goals, opportunities for skill up-gradation to serve the community better, participation in disease notification and surveillance efforts, sharing and support through provision of certain high value services- like laboratory support for identification of drug resistant tuberculosis or other infections, supply of some restricted medicines needed for special situations, building flexibilities into standards needed for service provision in difficult contexts and even social recognition of their work- would greatly encourage such providers to do better.

Regulatory Framework :

The regulatory role Health and Family Welfare includes regulation of clinical establishments, professional and technical education, food safety, medical technologies and medical products with reference to introduction, manufacture, quality assurance and sales, clinical trials and research, and implementation of other health related laws. Each of these areas needs urgent reforms. This will entail moving away from reactive, voluminous, poorly implemented regulatory regimes, cobbled up in an ad-hoc manner to a more effective, rational, transparent and consistent regime. The regulatory levers need to be wielded, far more consistently and effectively to meet the challenges associated with health care throughout the country, safeguarding the public interest as well as encouraging private initiative. Statutory autonomous bodies regulate Medical Education and Food Safety. The Ministry of Health & Family Welfare directly regulates issues such as drugs, cosmetics, medical devices, other professional education and clinical establishments. The prices and availability of drugs is regulated by the Department of Pharmaceuticals.

The Government of India had enacted the Clinical Establishments Act 2010, after a resolution to that effect was passed by four States and since framed its rules. There are growing concerns regarding costs, unfair practices like kickbacks, irrational and inessential care. Empanelment for insurance and public private partnerships was expected to provide better acceptance for regulation. However the experience is that insurance mechanisms are unable to act against the denial of services, supply driven irrational care, unethical practices, and charging patients for what should be cashless services. It is clear that without a regulatory structure in place, it would be difficult to ensure that public private partnerships or insurance based purchasing would deliver on either health outcomes or financial protection. Much greater emphasis must therefore go into making regulation work. Accreditation of clinical establishments and active promotion and adoption of standard treatment guidelines would be one starting point. Involvement of communities and their representatives in this process- especially in client support for publicly financed health insurance is another.

Regulatory Framework for Professional Education: The four professional councils for medical, nursing, dental and pharmacy council face many challenges in enforcing quality in professional education or professional ethics and good practice. The effectiveness of these councils in regulation of professional education or practice or ethics has been a matter of concern. With respect to the medical council there are also concerns about widespread conflict of interests in professional practice with respect to pharmaceuticals and diagnostic industries and within itself. The policy calls for a major reform and strengthening of these bodies and their accountability. It also emphasizes the Government‟s own accountability in professional education, in ensuring that the process leads to providing professionals who correspond to national needs. One has to build an approach to governance such that there is a balance between autonomy that professional councils require and the good governance, accountability, effectiveness and responsiveness to national priorities and needs.

Availability of safe, wholesome, and healthy foods is an important requirement for health. Microbial contamination of the food contributes to communicable disease burden and the rise in the

Non-Communicable Diseases (NCDs) has links to the consumption of food high in fats, sugars and salts; residues of pesticides, food additives and contaminants. Though enacted in 2006, the Food Safety and Standards (FSS) Act, was operationalized only from late 2011. Implementation of the Act has been far from adequate due to insufficient infrastructure including manpower, budgetary constraints and also the framework of the Act, Regulations and the scope and the degree of enforcement. Since there were few standards in place, science based standard setting has been one of the challenges to its implementation. Harmonization with international standards is also required.

To ensure the safety, efficacy, and quality of drugs and medical devices and cosmetics that are manufactured, imported, or sold in the state, a dynamic regulatory regime would be put in place. This is essential to safeguard the public from sub-standards or unsafe drugs and medical devices and to ensure the Indian pharmaceutical industry‟s global and domestic reputation and leadership. Post market surveillance program for drugs, blood products and medical devices shall be strengthened to ensure high degree of reliability and to prevent adverse outcomes due to low quality and/or refurbished devices/health products.

ICT for Health & Health Information Needs:

Health Information is acknowledged as one of the key dimensions of the health systems. Use of ICT has the potential to reduce frequency of hospital visits & management of chronic diseases. Similarly population level health metrics could guide the development of health policy. E-Health could also facilitate medical consultation with specialists, capacity building of health care workers/ professionals, and improve program monitoring and supervision, and delivery of emergency care. However much of this potential in public health has largely remained under-realized due to a number of policy and operational constraints. This policy will focus on improved deployment of ICT for improving the outcome of the Indian healthcare system.

Governance:

Federal Structure- Role of State and Role of Center: One of the most important strengths and at the same time challenges of governance in health is the distribution of responsibility and accountability between the Center and the States. Though health is a State subject, the Center has accountability to Parliament for central funding – which is about 36% of all public health expenditure and in some states over 50%. Further it has its obligations under a number of international conventions and treaties that is a party to. Further, disease control and family planning are in the Concurrent list and these could be defined very widely. Finally though State ownership has been used by some states to become domain leaders and march ahead setting the example for others, the Center has a responsibility to correct uneven development and provide more resources where vulnerability is more. The way forward is for equity sensitive resource allocation, strengthening institutional mechanisms for consultative

Role of Panchayati Raj Institutions: All elected local bodies- rural and urban would be enabled to provide leadership and participate in the functioning of district and sub-district institutions. Most important of these are the Rogi Kalyan Samitis(RKS) and the Village Health Sanitation and Nutrition Committee (VHSNC). In particular they would be in charge of, and could be financed for implementing a number of preventive and promotive health actions that are to be implemented at the level of the community.

Improving Accountability: The policy would be to increase horizontal accountability, by providing a greater role and participation of local bodies and encouraging community monitoring and better vertical accountability through better monitoring, grievance redressal systems and programme evaluation.

Involving Communities: Communities have a right and duty to participate in their health care and health programmes would be designed to provide the role to do so. The Village Health, Sanitation and Nutrition Committee is one major institutional mechanism for ensuring this and under the leadership of the gram panchayat, it must be strengthened with capacity building and support to pay this role. Involvement of community based organizations and representatives in decision-making in

hospital development societies and district consultative bodies would also be undertaken. A Peoples Health Assembly at the district level, held once in three years to discuss issues of preventive and promotive health and progress made on health plans, and to develop health and health care as a social movement would also be encouraged. In the process of engagement with communities and empowering them to contribute, non-governmental organizations with a tradition of working for community health have an important contribution to make.

Professionalizing Management, Incentivizing Performance: Improved governance must also be reflected in better leadership – which is as much a matter of motivation as of competence. Competence requires formal training for the requisite management and leadership skills. It also requires bringing in at the leadership level, on a regular basis or through consultancies and partnerships, the mix of professional knowledge and skills that are needed. It also needs to build up an environment where good performance is incentivized. Unless the system is able to demonstrate that it is providing more health for the money being allocated to it, it would be unable to sustain its case for more money for the health sector.

Conclusion :

A Policy is only as good as its implementation. The State Health Policy therefore envisages that an implementation framework be put in place to deliver on these policy commitments. Such an implementation framework would specify approved financial allocations and linked to this measurable numerical output targets and time schedules. The implementation framework would also reflect learning from past experience and identify administrative reforms required for more appropriate rules and regulations to governs public financing, institutional design, human resource policies for this sector, re-structuring of institutions required for better governance and management at state and district levels, measures for improving institutional capacity to deliver, and most important the division of powers, functions and accountability between Center and States with respect to health sector performance.