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Posted 19 September 2011

The Planning Commission, Govt. of India, has recently released the Draft Approach Paper to the 12th Five Year Plan. The paper recognizes that a larger allocation of resources for Health is needed in the Twelfth plan and suggests increasing the total health expenditure as percentage of GDP to 2.5 percent by the end of the Twelfth Plan. The paper focuses on Universal Health Coverage and proposes that the healthcare delivery must be made more consultative and inclusive through strengthening PRIs, increasing user participation and conducting bi-annual evaluations of the processes. It further acknowledges the gross shortage of health professionals as a serious impediment to achieve an expansion in the public provision of health services.

Wada Na Todo Abhiyan had actively participated in providing civil society inputs to the Approach Paper in the stages when it was being developed. The resultant document entitled "Approaching Equity" was published and presented to the Planning Commission. Continuing in the same vein, Wada Na Todo Abhiyan along with UNICEF would like to consult with various stakeholders on the contents of the Approach Paper.

The draft approach paper to the Twelfth Five Year Plan is available at http://planningcommission.nic.in/plans/planrel/12appdrft/appraoch_12plan.pdf (PDF, 2.5 MB). The section on health (Chapter 9) has the following components:

- Towards Comprehensive Health Care
- Health Infrastructure
- Human Resources for Health
- Publicly Financed Healthcare
- Child Nutrition and Re-structuring ICDS

We believe that the final plan will benefit from a wider critique of the approach paper. Please download the paper from the link above, review it critically and send in your comments. Since the final plan is in the process of being formulated, it would be useful for the Civil Society in India to review the approach paper and give in your comments. Your inputs will help us prepare a set of suggestions for the Government based on an assessment of the issues that have not been adequately addressed in the Approach Paper.

R.K. Baxi, Government Medical College, Baroda

Thanks for sharing the draft approach paper. The paper tries to address current scenario. However, we need a well-defined HRH policy, which does not appear to be in place. Contractual and ad-hoc appointees at less than minimum wage can not deliver quality and cannot be expected to have loyalty to program performance. This flexibility has proved to be too costly. Tight monitoring and watch on performance indicators with some seriousness about accountability will do the trick. PPP models which have worked should be scaled up/replicated.

Mismatch of training and other logistic support to the trained staff needs to be addressed in the right earnest. Rural postings of doctors should be made compulsory for everyone without favours/fears - before their post graduation starts. Bonds/raising bond amounts punishes the parents and has so far not served the intended purpose. Medical education is costly; hence we should desist from making it of poor quality. As I see, there is a scope of raising educational fee, tuition fee etc by atleast 200%. Those who come from modest economic or socio-cultural background should be given scholarship with a higher bond or longer commitment to the benefactor. Why not be realistic in that? This will help equip our public health care systems better and will help generate confidence among users by providing quality health care. Similarly, a fraction of "cost to client" must be recovered from clients who are not BPL. All issues in the draft have been identified well with some reference to general direction to take. (9.3 of draft and onwards)

I remain thankful to you for sharing the draft and for motivating to think about it.

Summary of Responses

Comments on the chapter on health of the draft approach paper to the 12th five year plan were invited. The chapter on health is forward looking and progressive in approach and delves upon critical areas hitherto inadequately addressed or neglected. The most important direction set out in the chapter is achievement of Universal Health Care. However, the paper also needs to focus on increasing spread, expansion of services and integration of services. The priority for inter-sectoral convergence of health programmes must not get underscored as against the comprehensive health care approach. Additionally, the coordination of ICDS and Health at the grass root level under the Panchayati Raj Institutions (PRI) is a welcome step but its operationalization remains to be seen. In the introductory points and elsewhere, Nutrition requires a specific mention so as to keep the focus and the nutrition related goals must be emphasized specifically in the entire chapter.

The section wise comments on the health chapter of draft approach paper are as follows –

Towards Comprehensive Health Care - Points 9.4 to 9.16

Members appreciated the mention of comprehensive primary health care, which is efficient, effective and accountable. This will require structural changes in the way primary health care is organized in the country and redefine role of institutions from sub- center to district hospital in rural areas and proposed primary health care institutions in urban areas; design and equip these institutions appropriately for delivering comprehensive health care following life cycle approach. It entails re-skilling all health professionals including paramedics, doctors, and specialists accordingly and examining staffing patterns. Effective supportive supervision is a key for any functional primary health care model hence efforts towards a functional supervision system will be required. Also, members said that the Comprehensive Healthcare approach is good for the States who have nearly achieved the NRHM goals. However, for States who are way behind to achieve NRHM goals, will need to prioritize focus areas.

The chapter doesn't state anything on Governance and Accountability in the health sector and there is no articulation of solutions to existing problems of corruption, lack of accountability and lack of grievance

redress mechanisms. A Citizen's charter could be suggested. Further, members commented that there needs to be transparent mechanism for periodic review of how the plans are put into action so that the review can feed into gaps for mid-course corrections. This is because the Government of India cannot leave implementation of plans entirely onto States. There has to be mechanism to review how decentralized plans get dovetailed with the top driven plan and agenda resulting in budget outlays on activities which are not in the priority list of the decentralized plan.

In Point 9.5, emphasis on determinants of maternal health is required i.e anaemia, undernutrition, early age of childbearing, gender issues, social exclusion and not only on prenatal and intra-natal care. Further, there is no mention of urban health at all and while mentioning the convergence of all national health programmes, vector borne diseases program needs inclusion.

Point 9.6 mentions promotion of a public health cadre on the lines of Tamil Nadu intervention. However, how to encourage states to have such a cadre is the key issue. The concept of public health cadre can be promoted by putting conditionality's on release of funds from central grants to the states especially those meant for supporting human resources. A **Public Health Council** could be proposed to set up standards for various types of health workers, and standards for health institutions of various types in the country.

Point 9.10 could also mention incentives for higher education of girls to delay age at marriage and child bearing. A focused intervention for married adolescents could address two MDG goals very efficaciously as maternal and neonatal mortality in this target population is much higher as compared to women over 20 years.

9.11 mentions the Twelfth Plan must make children an urgent priority. Maternal health also need to be included as "Maternal and child health as an urgent priority". This will involve *convergence* of Health and Maternal and Child Care services. The lifecycle approach concept evolved under RCH II needs to be sustained.

It is mentioned that high rate of growth of population will be addressed. However, the detail of how this will be achieved is not given along without any mention of addressing quality and access issues in contraceptive services.

Another important direction mentioned is to encourage states to enact a Public Health Act. It is important to have a Public Health Act which has provisions for safe guarding or protecting health of individuals and communities. This act must specify healthy living and working conditions which state must ensure for its citizens to make **right to health** a reality. However, the document does not mention that to promote public health - **Health-in-All-Policies Approach** is needed, hence, a mechanism needs to be set up for example Inter-Ministerial Group to do **Health Impact Assessment of all public policies**. The Government can go further and devise a National Public Health Act which can be a framework law on which state acts can be modeled.

Health Infrastructure – Points 9.17 to 9.24

Document refers to improving health infrastructure and suggests fulfilling the gaps in number of health institutions. The gaps are based on base population of 2001, however, ideally the number of health institutions required should be estimated based on projected population of 2017/2021. The rationale of

population based norms for deciding number of health institutions also requires careful reconsiderations. Population based norms are not useful in areas with low population densities, difficult terrain and disadvantaged social groups. Ensuring that all health institutions conform to IPHS standards in terms of infrastructure, equipment, drugs and human resources should be a short term goal. Also while discussing the infrastructural development, the document must also consider strategies to prevent leakages and ensure good quality of construction while upgrading PHCs and CHCs.

The document in point 9.19 mentions that the new medical and nursing colleges should be linked to district hospitals. However, given the current situation and with the majority of private medical colleges in the country, it is very difficult to introduce new regulations in this regard. Additionally, opening of new private medical colleges should be restricted to small/ backward/ remote districts so as to bring health facilities and economic growth in these areas. Government could also have a policy to finance these private medical colleges to keep medical education affordable.

Point 9.21 mentions that urban slums and settlements are to be covered with sub-centres, ICDS centres and PHCs, through NUHM. However, members said that instead of setting up local service centres to improve coverage in urban areas, there is a need to build up an **urban health care system** in urban areas.

Drug management including logistics is an important neglected area that deserves correction in 12th plan. Ideally all drugs should be dispensed from the health facility of Jan Aushadhi stores. In point 9.23, safe drug components need a specific mention for the planning and management of prophylactic drug like IFA and SC level kits for uninterrupted well planned logistics.

Active involvement of MCI representatives in National program planning and implementation is a need of the time and need to be placed in the 12th plan. This is supposed to structure; revise medical education as per the larger need of the national health programs. The plan also needs to project a need for a process towards long term human resource planning for at least next 20 years including existing cadres; new cadres to be introduced like district health managers, hospital managers, community nutritionists at district level.

Similarly other important functions like management of drugs, diagnostics, hospital waste management, infection prevention, record keeping, community participation, HIMS and information and communication will require **standardization, proper infrastructure and professionally trained human resource**. It is needless to mention that these important functions have not received adequate attention from policy planners in the past.

Human Resources for Health – Points 9.25 to 9.32

Twelfth five year plan must recognize that time has come to **move from ad hoc management practices to professional management** in areas of public health and hospital management. The contractual and ad-hoc appointees at less than minimum wage can not deliver quality and can not be expected to have loyalty to program performance. This flexibility has proved to be too costly. It is crucial to plan specific processes to address the alarming shortage in human resources. Further, it was said that coercion and compulsion will not tackle the root cause and it needs different strategies in different situation and as per the severity of the human resource deficit.

A **concrete HR policy** is required to be in place with emphasis on the following –

- Attracting talent through good compensation packages and allowances
- Giving incentives for working in HR deficit areas
- Administrative accountability for unfilled vacancies at state and district level
- Special recruitment drives and campaigns with decentralized recruitments and recruiting local persons for local vacancies
- Increasing transparency and addressing the corruption issues related to appointments, place of posting and transfers.
- Revising service rules related to transfers and postings to remove scope of corruption
- Creating new posts to share doctor's work load and delinking doctors from responsibilities like sanitation work, data compilation etc

The HR policy also needs to spell out mechanisms to deal with gender issues in human resource management example life stage needs of the women health work force, career advancement possibilities without penalising women for their reproductive responsibilities etc.

Further, observations so far have revealed that privatization of medical/nursing/medical technology has not contributed in filling up the void of health workforce in public sector. Medical education institutions have flourished in the country over last few decades particularly in private sector and have created a new challenge to uphold the standards of quality and regulation. Medical education thus requires a critical review of curricula and obligatory adherence to quality standards.

Priority for well trained cadre of various paramedic cadres for peripheral health services needs to be projected strongly due to their crucial role in primary health care. To bring uniformity in training of these crucial cadres, to increase their number, skill base and to award a respectable degree as a motivation, there is a need to develop Community Health and Nutrition University at state level exclusively focusing on need based cadre and skill development of paramedics. For example, to address the skill scarcity in terms of obstetrician, anesthesiologist and neonatologist, multi-skill diploma and certificate courses can be introduced.

Also, Allied Health Personnel have been totally left out except for the Laboratory Technicians. This cadre forms a large chunk of the workforce and their contribution is unrecognized. Increasing the numbers of the Allied Health personnel, developing their skills and regulating the professions can also go a long way in fulfilling the shortage of doctors and nurses.

Health systems research capabilities are low and needs strengthening. Currently private health sector is un-regulated and as a result very little information is available on morbidity profiles and case fatality rates. It is desirable to regulate private health care sector to ensure that it conforms to standard treatment protocols, provides ethical care and participates in national health programmes.

Publicly Financed Healthcare – Points 9.33 to 9.37

In the light of the high out of pocket expenditure on health care in India, and the rapidly growing share of private sector in providing health care services, a phased and planned approach to universalize public funded health care is essential at this point.

A basic package of health care to all citizens (right to health care) will require enhancement of public financing to upto 3-5% of GDP. A mechanism to set up a **District Health Fund** needs to be worked out. Equally important is that the District Health Fund Manager plans a mechanism of funding public/private health institutions for delivery of basic package of health care. This will also need strengthening of the Health Information System with bi-annual audit by stakeholders. One solution may not fit all states/districts, hence, the example provided in the documents - social health insurance such as Rashtriya Swathya Bima Yojna need to be looked at more carefully before adoption.

Also, there is a need to target the migrant populations, which remain largely untargeted by the health system and is never on the priority list.

Child Nutrition and Re-structuring ICDS – Points 9.38 to 9.42

It is important to overcome the ambiguities under the sub-head of "Child Nutrition and Restructuring ICDS". This approach paper must take in cognizance the output/outcome of several interventions implemented by 'Women and Child Development' sector which were expected to yield a positive/catalytic influence on health status of women in particular.

Also, with ASHAs in place to support the health system, the challenge for the AWWs is even greater today. Under a new format, the incentive based system could be used for the AWW too, to make their contribution more meaningful at the community level. It could be in the form of targeting the urban/ rural underserved pockets where the unmet needs related to the family spacing and limiting still exists. There is also mention of an innovative health and nutrition monitoring and surveillance system to be put in place. The operationalising of such a system will be a big challenge, but involving the ICDS supervisors meaningfully could go a long way to make it feasible.

Further, there is no emphasis given to monitoring aspect in the document. It is important to monitor to ensure accountability. Internal as well as external monitoring and evaluation should be performed regularly.

Overall, the chapter on health in the draft approach paper of the 12th plan sets out a vision/goal and some broad directions to achieve these goals. However, it does not spell out adequately how this vision/goal would be achieved. There is a need for greater detailing of operational strategies and how will this approach in the health sector be evaluated.

You can also view this update at: ftp://ftp.solutionexchange.net.in/public/mch/comm_update/mch-update-62-311011.pdf (PDF, Size: 270 KB)

Health

Maternal and Child Health Community

Community Update
No. 62: November 11, 2011

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From the Resource team

Dear members,

Greetings from Solution Exchange!

The Global Human Development Report was launched last week. The report explores the integral links between environmental sustainability and equity and shows that these are critical to expanding human freedoms for people today and in generations to come. It offers important new contributions to the global dialogue showing how sustainability is inextricably linked to basic questions of equity – that is, of fairness and social justice and of greater access to a better quality of life. Click here for the report.

UNDP India and Wada Na Todo Abhiyan have come out with a publication entitled “Equity Unaddressed”- A Civil Society Response to the Draft Approach Paper - 12th Five Year Plan. I am glad to share with you that the inputs given by members of the MCH Community on the Health chapter of the Draft Approach Paper have been included in the publication. It was presented to Planning Commission members in a workshop organized by Wada Na Todo Abhiyan in New Delhi last month. A copy of the publication is available on UNDP India website. Click here for the report.

Coming to the community activities, the community started a new discussion last week on Injection Practices and Promoting Injection Safety. We await your inputs on the query.

The MCH Community is now on Facebook. I invite you all to become part of the MCH Community Facebook Page. Looking forward to see you there.

Regards,

Meenakshi Aggarwal
MCH Community
Solution Exchange