GOVERNMENT OF INDIA
HEALTH AND FAMILY WELFARE
LOK SABHA

STARRED QUESTION NO:116
ANSWERED ON:30.11.2005
REPORT OF NATIONAL COMMISSION ON MACRO ECONOMICS HEALTH
Mahto Shri Tek Lal;Reddy Shri Mekapati Rajamohan

Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether the National Commission on Macro Economics and Health set up by the Government to review the state of country`s health has submitted any report;

(b) if so, the details of the recommendations/findings of the Commission;

(c) whether the Government has examined and accepted the recommendations of the Commission;

(d) if so, the details thereof; and

(e) the time by which the recommendations are likely to be implemented?

Answer

THE MINISTER OF HEALTH AND FAMILY WELFARE (DR. ANBUMANI RAMADOSS)

(a) to (e): A statement is laid on the Table of the House.

STATEMENT REFERRED TO IN REPLY TO LOK SABHA STARRED QUESTION NO. 116 FOR 30TH NOVEMBER , 2005.

(a)to(e): Yes, Sir. The National Commission on Macro Economics and Health has submitted its report. The terms of reference of the Commission included among others, a critical appraisal of the present health system - both in the public and the private sector - and suggesting ways and means of further strengthening it with the specific objective of improving access to a minimum set of essential health interventions to all. It was also intended that the Commission would look into the issue of improving the efficiency of the delivery system and encouraging public-private partnerships in providing comprehensive health care. The conclusions and the recommendations of the Commission are annexed.

As would be evident from the recommendations, these cover a wide range of issues in the health sector. The Commission themselves have recommended that task forces consisting of knowledgeable and eminent people and representatives of stake-holders be constituted to detail out the issues, the operational plans and financial implications. For issues requiring an inter-sectoral perspective, they have recommended constitution of a Group of Ministers.

The recommendations of the Commission are currently under consideration for constitution of appropriate task groups.

ANNEXURE

Conclusions & Recommendations of the National Commission on Macroeconomics and Health

Investing in Health
1. Evidence shows that investment in health can and does contribute to economic growth. Therefore investing in health is investing in economic development and equitable growth.

2. Increase investment in a basket of goods consisting of strategies for poverty alleviation, health, nutrition in particular micronutrients through production incentives, affordable prices and promoting R&D to produce fortified foods; safe drinking water and sanitation, rural road network and female education.

Disease Burden in India
3. India is reeling under a dual burden of disease with unacceptably high levels of communicable and infectious diseases/conditions related to reproductive health, and an emergence of chronic and non-communicable diseases.

4. An exhaustive causal analysis however clearly demonstrates the efficacy of preventive and low-cost solutions to avert disease and death. making a strong case for shifting priority for public investment to focus on prevention of disease and promoting good health values

5. Increase spending on health promotion - at least 10% to 20% of the public sector budget should be earmarked for public health

activities.

Delivery of care

6. Mismatch in goals and strategies and management failure at various levels of decision-making and implementation are reasons for the poor performance of public health systems.

7. The growth of the private sector has been phenomenal due largely to the dysfunctional nature of the public health system. But the private sector has by and large failed to provide quality care at a reasonable cost.

8. By aligning the finances, functions and functionaries with the services to be provided at each of the facilities, efficiencies can be improved. For this, mapping of all facilities should be undertaken and facilities should b relocated based on workload norms, community preferences and distance norms. Thus the access to the first contact for care should be within 30 minutes; inpatient care within 60 minutes; an EmOC facility within 2 hours; and a specialist in 2-4 hours etc

9. Improve efficiencies of public facilities by having utilization norms such as 40 OP per doctor in a PHC/CHC and 75% occupancy rate for IP care, etc.

10. Integrate CHC as the health administrative unit and gatekeeper for referrals to higher facilities and have the PHC focus on health promotion, emergency care and women`s health; and professionalize the management of public facilities by having trained hospital managers.

11. Formulate Public Health Laws for the range of issues in the health sector.

12. Professionalize health management and administration. By an Act of Parliament the following institutions should be established:

(i) Federal Drug Authority
(ii) Indian Medical Devices and Technology Authority
(iii) National Commission for Quality Assurance
(iv) National Commission for Medical and Health Education and
(v) Hospital Financing Corporation.

13. Strengthen the mechanisms for enforcement of laws related to quality assurance, disease surveillance and public health measures, quality of education and drug and food safety.

Human Resources

14. The biggest impediment to achieve health goals will be human resources, both in terms of availability as well as expertise.

15. To meet the growing demand for physicians it is necessary to increase the number of medical colleges and nursing schools. Priority should be given to reducing the existing inequity by establishing 60 medical colleges in the deficit states of UP, MP and Bihar.

16. Establish 6 Schools of Public Health besides upgrading those already in existence in the country - public and private.

17. Likewise an additional estimated 3.25 lakh nurses would be required by 2015. For this it is necessary to establish an additional 225 nursing colleges and upgrade the existing ones.

18. The Medical Council of India and State Medical Councils as also the Nursing Council of India have failed to carry out the mandate provided to them for regulating the profession and raising the standards of medical education and enforcing them. Thus it is essential that the MCI/NCI act be amended to allow for civil society representation in the Council.

19. The MCI should restrict itself to regulating undergraduate education with the postgraduate education being monitored separately by another body. Similar concerns exist for the functioning of the professional councils of the departments of AYUSH.

20. There is a need to establish a Commission for Human Resource Development and Medical and Health Education for promoting excellence in health care and human resources for health.

21. A live register and database needs to be maintained for all categories of medical and paramedical personnel and regularly updated by the respective professional councils. A system of re- registration of doctors and nurses once every five years and linking re-registration with minimum number of hours of continuing medical education (CME) should be introduced.

22. An All India Cadre of Public Health should be established on the lines of the IAS/IPS.

23. Sufficient incentives, financial and non-financial should be given for attracting medical teachers to join and continue in pre - and paramedical specialties in medical colleges. In addition, non - MBBS postgraduate seats may be increased in these specialties. Teachers in medical colleges and nursing training institutions should be provided fellowships foe undertaking higher studies and provided incentives for undertaking research.

24. The number of seats in specialties such as Anesthesiology, Pediatrics, Obstetrics/Gynecology, Psychiatry and Community Medicine should be increased.

25. Multiskilling of MBBS doctors with 9 months post graduate certificate training at the district hospitals in the scarce specialty would enhance availability of the required skills at the community health centers and help bridge the gaps in specialist care in rural areas.

26. There is a need to formulate and implement a national strategic plan for nursing and midwifery development, as done in Bangladesh, Thailand, Indonesia, Myanmar and Sri Lanka etc. For developing leadership skills among nurses the government should invest in multidisciplinary leadership and management development programmes for nurses and midwives.

27. Institute 1000 fellowships for research and higher education in various fields of public health, nursing, medical management etc. for faculty positions in the various schools and autonomous bodies proposed. 25% of these should be earmarked for PhD and post graduate studies and be open to government employees, universities, research institutions and so on.

Integrating the AYUSH system
28. Constitute an independent regulation to assess and monitor quality aspects of AYUSH practice.

29. Amend the Act that defines `medical practitioner` in the Indian Medical Council Act to the MBBS degree holders, disqualifying the 5 lakh degree holders of AYUSH systems registered under the Indian Medicine Central Council Act 1970 and Central Council of Homeopathy Act of 1972 of the Government of India. Suitable changes in the IMC Act will help in the expansion of this resource.

30. A coordinated programme of participatory clinical research should be launched by the ICMR, CSIR to validate the best practices in traditional systems of health care.

31. Functional collaboration of ISM with modern medicine may be facilitated at the PHC level.

32. Formulation of an integrated national approach for the management of HIV/AIDS similar to the model in China and undertaking systematic research on specific aspects related to HIV and the role of ISM are required.

33. The promotion of ISM herbal gardens under the Gram Aushadhi Udyan Cooperative farms and Gram Aushadhi Nirman programmes must be developed in at least 10,000 villages; the village healers identified, skills assessed, enhanced and utilized in the integrative model.

34. Establish a coordinating body for a single window approach to undertake clinical trials under all systems of medicine.

Access to affordable drugs
35. Expand price control of all drugs and mandate use of only generic drugs in all public funded programmes.

36. Weed out irrational drugs and irrational combination drugs to substantially reduce household drug expenditures.

37. A minimum VAT of 1% as against the proposed 4% should be levied for essential drugs.

38. Fix ceilings on trade margins as suggested by the interim report of the Sandhu Committee.

39. Centralized pooled procurement reduce government expenditure by over 30% - 50%. The adoption of the TNMSC model should take place throughout the country.

40. The recommendations of the Mashelkar Committee regarding setting up of the National Drug Authority (NDA) with an autonomous status to take up the functions of drug pricing, quality, clinical trials, etc. need to be implemented. Consequently the present National Pharmaceutical Pricing Authority (NPPA) could be merged with the proposed NDA and Central Government provided assistance to states for strengthening the drug regulatory system.

41. The Patent Act passed recently needs to clarify the scope of patentability; reasonableness of royalty to be paid on the issuance of compulsory licensing; definition of `significant` for the Indian companies manufacturing these drugs, mechanisms for automatic compulsory licensing and strengthening of the regulatory bodies to ensure that drug security is enhanced.

Access to modern technology
42. Regulate the proliferation of technology and reduce the clustering of high-end technology by establishing the norms and requirements of certificate of need by the public health authority.

43. Public sector should shift to contracting the private sector more for diagnostic services as it is more cost effective.

44. Establish the Indian Medical Devices Authority and implement the recommendations of the High Level Committee constituted for the purpose by the ICMR and INSA. The membership should consist of representation from DST, CSIR, INSA, DRDO, IT etc.

45. Introduce and intensively promote use of IT in health care for patient care in 3 areas:
(i) Telemedicine
(ii) Computerized data management and record keeping (3) Training through the Edusat facility.

Financing of health
46. The systems of health financing in India are archaic and need overhauling.

47. Constitute an Expert Group to evaluate the current system of budgeting and harmonize the accounting needs of the Finance Department and the operational requirements of the implementing agencies at all levels.

48. All spending departments must have a budget line with major and minor heads on the nature of health spending.

49. Standardization of treatment protocols and unit cost estimations should be taken up and a schedule of benefits published.

Organizational and financial restructuring.
50. Public spending be increased from the current level of 1.2% to 3% of GDP.

51. Increase public investment to primary health care for providing universal access to a basic package of services at CHCs and facilities below it alongside reorganizing the structure for enhancing accountability and increased sharing of oversight functions by the communities and local bodies.

52. Restructure the financing system to fund packages of health care: core packages, basic health packages and packages for secondary care.

53. Upscale the investment of public health education and information from the current levels to reach 20% of the government health spending. To start with allocate at least Rs 50 per capita per year or 5% of the budget, whichever is more on prevention of disease and promotion of health values.

54. Gradually shift towards a mandatory Universal Health Insurance System for secondary and tertiary care.

55. Merge CGHS and ESIS and re-constitute as a Social health Insurance Corporation of India..

56. Government subsidy for rural communities and urban poor should be 30% of the premium provided as an incentive to those having 70% enrolment.

Increasing accountability and focusing on monitoring
57. Increase performance - based accountability by improving monitoring through concurrent sample surveys, social audit and institutionalizing community management.

58. Shift greater managerial and financial autonomy to provider units which could be formed into Public Trust Hospitals.

Investing in Health: Financing the way forward
59. The amount required for implementing the Way Forward is estimated to be about Rs 74,000 crores of which about Rs 33,000 crores is for capital investment. About Rs 9000 crores is the estimated amount that may be required to be spent towards premium subsidy for the poor.

60. Need for a comprehensive approach to raising resources for increasing the spending on health and related sectors of water, sanitation, nutrition and primary schooling from the current level of 2.7% of GSDP to 9.7% - an increase of 7% of GSDP over the next few years. Way Forward

61. Task Forces consisting of knowledgeable and eminent people and representing all stakeholder groups be constituted to detail out the issues, the operational plans and financial implications.

62. On issues requiring an intersectoral perspective a Group of Ministers may be constituted to deliberate the various policy issues.