Editorial:

Concern for Children In National Health Policy 2015 Towards A Sustainable Developmental Goal By India for 2015 - 2030

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Introduction:

India of course has the technology and know-how to reach the Mars today. Yet, our children continue to remain hungry, malnourished and suffer the brunt of high Infant Mortality (IMR), Neonatal Mortality (NMR) and Maternal Mortality (MMM); much above the Sub-Sahara Africa, thanks to the misplaced priorities and dismal political will in this regard. Now we are considered as the robust emerging economy in the world, empowered with knowledge and advanced technologies, many indigenously developed. Yet the gaps in health outcomes continue to widen. The power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in adequate and equitable manner.

Back-ground:

A comprehensive National Health Policy, particularly targeting expectant mothers and children, is need of the hour. Baring limited success, We have already missed the Millennium Development Goals fixed by ourselves, in the global context of all nations committed to moving towards universal health care. The infant mortality rate (IMR) in India has of course regressed, albeit in a snail pace from 128 in 1970 to 42 per thousand live-births now. Around 3,00,000 children are dying on the very first day of their birth out of 26 million live births per year! The national average of neonatal mortality rate (NMR) stands at 29 per 1000 (Fig. 1), with a wide regional disparity. While Kerala has been able to boast NMR at 7, the rural Madhya Pradesh (42), Odisha (41), UP (40), Rajasthan (39) are the worst examples. However approximately 50% of these figures are reported from the respective urban areas in 2012. The MDG target of under-5mortality rate(U5MR) by 2015 was kept at 42 from a baseline of 126 in 1990 and 52 in 2012 (Fig.1). Our achievements has been credible for having reduced U5MR by 47% from 1990, as against 40% of the international average. 3.3 million children died in this age group in 1990. A this rate, with 48% population rising till 2014, the death of under-5 children would have been rather 3.5 million as against actual death of 1.3 million. It is certainly a success story. However, our ideal target should be rather zero deaths, learning lessons from our past and our mistakes what so ever. If we can bring down our NMR to a single digit fast, like we have achieved in states like Kerala, we would straight away reduce the IMR to below 20. AS regards Maternal Mortality Rate, in every 10 minutes, a young woman is dying during child-birth somewhere in the country. The current MMR is 178 per 1,00,000 live-births in 2012, down from 560 in 1990. It accounts for 0.55% of all deaths and 4% of all female deaths in the 15 to 49 year age group. There are 46,500 maternal deaths, demanding urgent reduction, targeted at 140/1,00,000 by 2015, seen a far cry now. Evidently, we have already missed the boat. The situation is supposed to have improved a bit after implementation of Janani Surakshya Yojana. But its actual application on ground, particularly in rural, remote and hilly areas constituting 80% of rural Bharat is dismal. With the poor infrastructure and half-trained work-force that we have, even the Government admits that only 52% of the TBAs deployed in our primary care facilities have some formal training on safe delivery methods and facility based neonatal care. Several posts are vacant. In reality, they remain too busy in curative and administrative responsibilities to attend each delivery reaching them, mostly in odd hours.

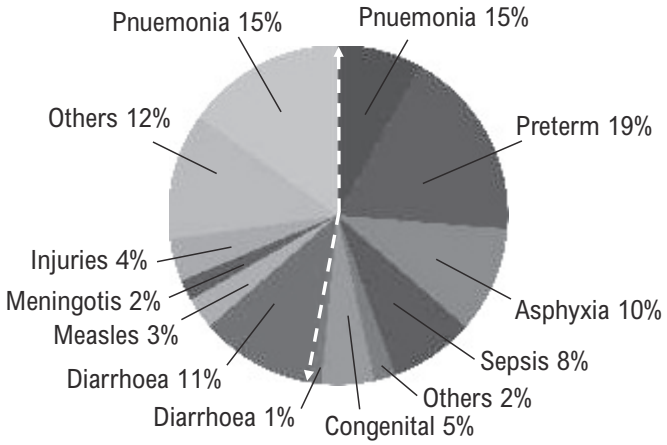

Fig. 1.
Under-5 Vs. Neonatal mortality in India (2012)

Integrated Action Plan:

It is needless to say that in order to reduce IMR, NMR and MMR together, our action plan has to be urgently formulated in an integrated manner, keeping in mind the six pillars of intervention: (1) Pre-conception and antenatal care, (2) Care during labour and child-birth, (3) Immediate new-born care, (4) Care of Health of the new-born, (5) Care of small and sick new-born and (6) Care beyond new-born survival.

The National Rural Health Mission:

The NRHM led to a significant strengthening of public health systems. It brought in a workforce close to 900,000 community health volunteers, the ASHA (Accredited Social Health Activist), who brought the community closer to public services, improving utilization of services and health behaviors. The NRHM deployed over 18,000 ambulances for free emergency response and patient transport services to over a million patients monthly, added over 178,000 health workers to a public system that had depleted its workforce to sub-critical levels over a long period of neglect. It provided cash transfers to over one crore pregnant women annually, empowering and facilitating them to seek free care in the institutions and began to address infrastructure gaps. Of course, there were increase in outpatient attendance, bed occupancy and institutional delivery across states. However such improvements were uneven and more than 80% of increase in services seems to have been contributed by less than 20% of the public health facilities. States with better capacity at baseline were able to take advantage of NRHM financing while high focus States had first to revive or expand their nursing and medical schools and revitalize their management systems. Larger gaps in baselines and more time taken to develop capacity to absorb the funds meant that gaps between the desired norms and actual levels of achievement were worse in high focus states. Inefficiency, low fund utilization, poor governance and leakages have been a greater problem in in several states. Much of the increase in service delivery was related to reproductive and child health services and national disease control programs; and not for the wider range of health care services that were needed. Action on social determinants of health was even weaker.

The **National Urban Health Mission :** It was sanctioned in 2013, to strengthen primary health care through additional ANMs, urban ASHAs, Women's health committees and a network of primary health centres for the marginalized population. It needs substantial expansion on a sustained basis in order to establish and operationalise a well functional primary health care system in rural and urban areas alike. Under NRHM, free care in public hospitals was extended for maternity, newborn and infant care as part of the Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram and other programs, taking district as a unit. The definition of primary care is being extended to include all type of care that district health systems provide, including secondary health care. It implies that specialised skills are made available within the district and important ones, e.g.-Physician, Surgeon, Gynecologist, Paediatrician and Anesthetist are made available at each PHC. It is seen that funds under the scheme

have been diverted by states mostly for constructing building infrastructure of general hospitals, administrative blocks etc which were supposed to have been the states' responsibility. Maximum corruption cases are being encountered misappropriating funds under this grant from centre. At several remote PHC's out of the 5 to 6 specialist doctors posted at PHC, only one managed duty on a particular day in turns and others run their private practice elsewhere.

ASHA volunteers:

An approach to primary care would be possible only where ASHA has been established as an effective bridge between the first tier health facility i.e. PHC and the community. The ASHA would support enrolment of all families with the Health Centers (Sub-centers and PHCs), ensuring that no one is left out and all new entrants are registered constantly. 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 as well as maternal and child health services. Such scheme be extended to all urban areas also under the Urban Health Mission where the population covered per centre would be half (10,000). However, the proportion between number of providers and registered families would remain same.The ASHA worker is supposed to accompany the expectant mother to delivery facility and stay with her till discharge for assistance. She is neither trained nor is it in her domain to assist the nurse / doctor in delivery or immediate neonatal care, although available on the scene. On one hand, we have dire shortage of skilled manpower, on the other hand we fail to optimally utilize the available personnel on the scene such as the ASHA. There is an urgent need to invite Public-Private partnership for motivating, training and empowering them in a time-bound manner and productively engage those in their area of operation may be paying some additional incentive. Among them the trainable ones with right attitude must be identified for hands-on training in a time bound manner.

Disease Burden:

Communicable diseases contribute to 24. 4% of the entire disease burden while maternal and neonatal problems to 13.8%. Non-communicable diseases contribute to 39.1% and injuries to 11.8% of the burden. Our National Health Program must be integrated for care of such conditions as well, under the ongoing NRHM and JSSY. Our public sector hospitals must provide minimum 1 bed per 1000 population with access to free drugs and diagnostics.

Universal Immunization Programme:

The success of polio eradication has raised our hope and confidence on preventive endeavour tremendously. The Universal Immunization Program is poised to benefit the entire community by further increasing immunization coverage with addition of more effective vaccines of high quality and safety. Better adverse event reporting, a good compensation policy and a sound, transparent procurement policy are desirable. While the introduction of new cost effective vaccines is a challenge, these needs to be scaled, simultaneously building institutional capacity to manufacture and deliver vaccines as a complement to our health priorities at primary level. Besides, a strict vigil be kept on the aggressive and manipulative marketing strategies of multi - national to push their products.

Investment in Health Care:

Despite strong economic growth and increased Government health spending during 11th plan, our total spending on healthcare in the country was 4.1% of GDP. Global evidence on health spending shows that unless a country spends at least 5 to 6% of its GDP on health and the major part of it is coming from Government expenditure, basic health-care needs are seldom met. The Government spending on this in India is only 1.04% of GDP

which is about 4 % of total Government expenditure, less than 30% of total spending on health. This translates in absolute terms to INR 957 per capita at current market prices. The Central Government share of this is INR 325 (0.34% GDP) while from State Government it comes to about INR 632 on per capita basis. One important policy decision of the National Health Policy 2002 articulated in the 10th, 11th and 12th Five Year Plans, the NRHM framework was to increase public health expenditure to 2 - 3 % of the GDP. Public health expenditure rose briskly in the first years of NRHM, but its performance started stagnated at 1.04 % of GDP, mainly because of failure to expand workforce, train and retain them. Reluctance to provide regular employment affected service delivery, regulatory functions, management functions and R&D. Corrupt practices restrained spendina.Though there is always space to generate some more value for money, it is unrealistic to expect to achieve key goals in a 5 Year Plan on half of the sanctioned budget. We failed to attain minimum levels of public health expenditure. While it is important to recognise growth potential of a rapidly expanding private sector, international scenario shows that health outcomes and financial protection are closely related to absolute and relative levels of public health spending. Comparison between few BRIC and advanced nations is glaring.

Of the developing countries, Brazil and Thailand are considered to have achieved close to universal health coverage. Thailand has almost the same total health expenditure as India but its proportion of public health expenditure is 77.7% of total health expenditures (3.2 % of GDP). This is spent through a form of strategic purchasing in which 95% is purchased from public sectors. Brazil spends 9% of its GDP on health but of this public health expenditure constitutes 4.1 % of the GDP (45.7% of total expenditure on health). The public health expenditure there accounts for almost 75 % of all health care provision. It would be desirable if India could ensure public health expenditure at 4% of GDP. However, our expert groups have pegged it to 2.5 % as realistic ignoring all justifications. Hence, our "Purchases," must be from state owned industries and exceptionally from private players for supplementation only.

TABLE.1 : Comparision of Health Indicators in BRIC Counrties

Country	Per-Capita Health expenditure ($)	Total exp as % of GDP	Govt exp on health as % total	Life exp at birth
India	62	3.9	30.5	66
Srilanka	93	3.3	42.1	75
Brazil	119	8.9	45.7	74
China	274	5.1	55.9	75
Thailand	214	4.1	77.7	75
UK	3,659	9.4	82.8	81
US$	8,467	17.1	47.8	79

Health-care industry:

The health care industry is growing at 15% compounding annual growth rate. Private health care industry in India is currently valued at $40 billion, projected to grow to $ 280 billion by 2020. Such growth rate is the most rapidly growing area in healthcare industry at 14%, projected to be 21% in next decade. This represents twice the rate of

growth in all services and thrice the national economic growth rate. Unfortunately, this is predominantly in the private corporate sector, with apathetic absence of the public sector. The corporate thrust areas are higher antibiotics and modern vaccines at exorbitant cost, with utter disregard to scientific basis and actual need of common men. Entry of insurance sector and collusion between few unscrupulous hospitals and certain TPAs have pushed the health-care cost beyond reach of the majority. Such catastrophic expenditure on health care cost is thought to be major contributors to poverty, Our planners must keep in mind. The drain on family incomes due to health care costs might cancel the gains in income and Government welfare schemes, aimed to reduce poverty. The country deserves a new health policy, addressing all these. FDI is welcome in an open economy, but not at the cost of our national interest. Raising new regional public sector industries to 'Make In India' in the pattern of IDPL, Hindustan Antibiotics Ltd and Vaccine institute Kasauli etc to manufacture essential drugs, antibiotics and vaccines, strictly on scientific basis, reviewed periodically, is certainly not beyond the capacity of an emerging superpower such as India. We have to counter the multinational giants bleeding our economy constantly with their corporate operational strategy, influencing consumers and doctors alike. Activities and influence of the tobacco and alcohol lobby are every one to see.

The Sustainable Development Goals (SDG 2015 - 30)

Our success in saving lives of children so far, particularly the under-5 group over last 15 years means we have in fact surpassed the UN's MDG goal to some extent on child mortality. The MDG goals are now being replaced by a new set of goals called, "Sustainable Development Goals" from 2015 to 2030. The SDG provide us the opportunity to consolidate all lessons learnt during last 15 years for a suitable but definite course correction. We have to decide the kind of a country we would need and how to get there in a definite time frame.

Conclusion :

The primary aim of the proposed National Health Policy must inform, clarify, strengthen and prioritise in shaping health systems in all dimensions, including investment, organisation and financing, prevention and promotion of good health. Access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, financial protection, regulation and legislation for promotion of health are all-important. No doubt, these need money. But any welfare Government worth its salt must understand that it is not possible to maintain any sound public health system with inadequate financing while checking corruption on in this front. It must be functional and perform at a higher qualitative level in an equitable manner. It is important to create a society where every citizen has easy access to health-care, education, nutrition and clothing for fulfilling own potential. The very political will to ensure universal access to affordable healthcare services in an assured manner must be the catalyst for framing the New Health Policy, viewing 'Health' as a Fundamental Right of every citizen of India under the very 'Right to life'. Hence our Public sector infrastructure must be strengthened to the ideal and maximum extent than surrendering it to the private sector completely. We must drive the health care as a 'Service sector' with due social responsibility at all levels. For children, the intervention package must start from the pre-conceptual stage, not only extending beyond survival of the new-born, but also through adolescence. It is the right investment in right time and in right direction for the future citizen of India. That is what we woe to our children.