Internal Document
HEALTH FIRST CAMPAIGN
BY INDIAN MEDICAL ASSOCIATION
OBJECTIVE

The health sector in India has never been given the priority it deserves, leading to grossly inadequate services at levels. The allocation of meager 1.1% of GDP for health services speaks volumes about the apathy of successive governments towards this most important determinant of social and economical progress of a nation. Health sector being one of the largest employer of the population and "the" largest employer of the female population certainly deserves more attention from policy makers.

Indian Medical Association, the national association of more than 3 lakh modern medicine doctors as direct members across the country ***and another 5 lakh indirect members through its wings such as junior doctor network, medical students network, federation of medical association , women's wing etc proposes*** to launch a **HEALTH FIRST** initiative. The aim of the **HEALTH FIRST** initiative is to provide a holistic approach to health care sectors, having **common man as focal point.**

Through this initiative ,we wish to offer our services as *a* think-tank, *support and pressure group* to the government both at national and state leve*l* so as to bring health *at the* forefront on the agenda of political parties.

After exhaustive discussions and deliberations with multiple stake holders and experts ,**Indian Medical Association** have prepared a document of health issues which need urgent attention of the government & political parties.

Here are some of the points presented as **"MAGNA CARTA FOR HEALTH"** ie, the **Health Manifesto** for our country.

MAGNA CARTA FOR HEALTH

1. Increased public expenditure in Health Care.

2. Universal Health Coverage through government funding

3. Private Public Partnership facilitated by not for profit institutions.

4. Emphasis on Primary Care and Rural Health Care

5. Structured Universal three tier reference system.-- Primary, Secondary & Tertiary care

6. No Criminalization of Medical Profession.

7. Quality public funded medical education governed by autonomous democratic regulation.

CHARTER

1. GDP share in health care

Increase GDP *share* in health care from 1.2 % to 5%. Prioritize primary & preventive health, social determinants of health, medical education and research for fund distribution. Fund allotment has to be as per the percentage of patients seeking treatment in any particular system. Bring mechanism to ensure utilization & outcome.

3.3% of Indian population is pushed below poverty line every year due to increased out of pocket expenditure for their disease burden. Main limitation for decreasing the out of pocket expenditure in healthcare is very low allocation to health care which is remaining static at 1.2% for years together. The out of pocket expenditure in health care as per the NSSO statistics is 80% in India, which is one of the highest in the world. Many of the developing countries like Srilanka and Malasia have reduced it to 60% or less. In developed countries it is below 30%. the required boost in health care can be achieved only by increased allocation and it should be ideally 5%.

2. Universal health coverage- to all irrespective of socioeconomic group or geographical location.

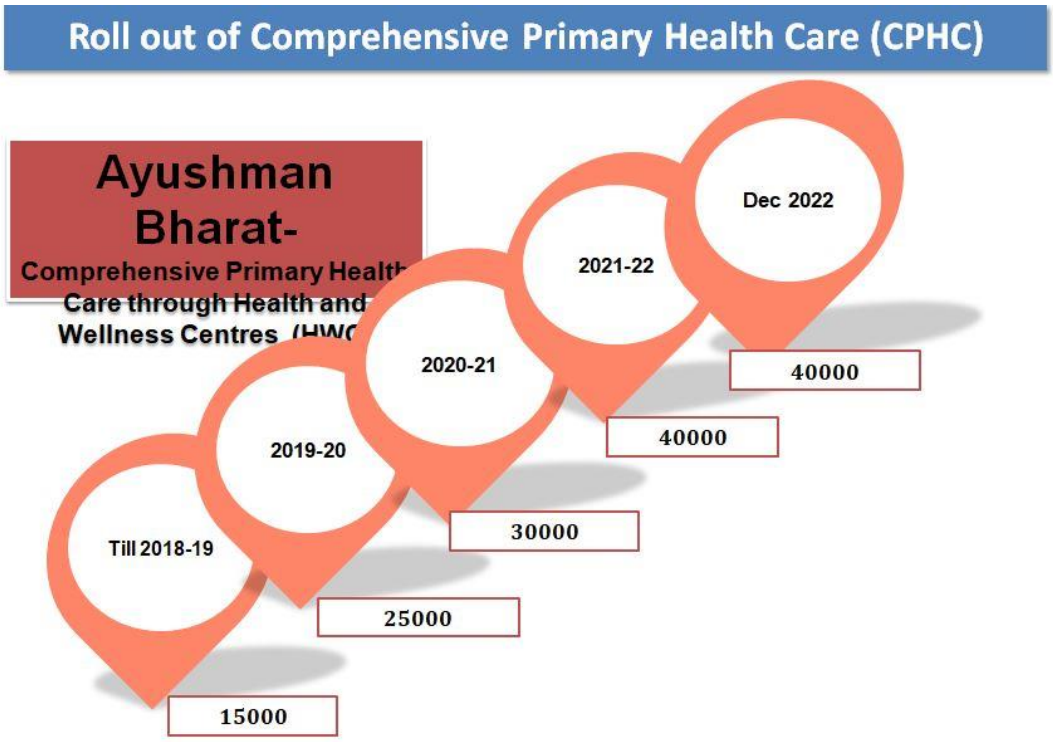
Attainment of universal health coverage and Sustainable Development Goals by 2025. Direct public funding for improving access , increasing infra structure and man power. Insurance based public funded programs have to be abandoned and direct government funding to be introduced. Right to health has to be embedded in the constitution.

Universal health coverage was a part of Millennium Development goals which should have attained by 2015, but at least by 2020. But the present proposals of Universal health coverage target only some socio economic groups and geographical areas. The proposed Ayushman Bharath program is planning to cover only 40% of the population. As all the public funded health programs are proposed to be integrated into that platform, it is obvious that instaed of Universal health coverage, only a section of the population will be covered. Appropriate program has to be devised to cover the whole population especially regarding preventive and primary health care. The targets of Sustainable development goals can never be met without a comprehensive program

Even the public funded health programs that cover weaker sections of the population do so by insurance based systems. The various stipulations and conditions inherent to such insurance based systems make it difficult for the people to obtain the promised coverage. Health should be become constitutional right of citizens and the funding, delivery mechanism and accessibility should be hassle free. This calls for necessity of direct funding. In the insurance based system when government is saying that they are giving Rs.5 lakh worth health care to each citizen, the actual amount spent is less than Rs.1000, which is too meager to attain the proposed goal. More over the insurance model is increasingly proven to be a failure in developed nations as a sole model for health care.

3. Primary health care and rural health care Increase number of Primary Health Centers to focus on preventive and primary health care. One sub center for every 10000 population in

urban and semi urban areas, 5000 in rural areas and 3000 in hilly and tribal areas. Improve infrastructure and total manpower in subcentres. Reconcieve wellness centre concept. Wellness centers, if at all established to be manned by MBBS graduates.



There is a definite need for more primary health centers and subcentres which should focus on primary care and preventive health. The wellness centre concept of providing specialty care in primary care centres will dilute the primary and preventive health care and bring in catastrophic results. And even the roll out proposal of wellness clinics is so slow that the target will not be achieved in another 25 years. This will bring in a huge gap in primary care scenario. Hence there should be a focussed approach to increase the number of Primary Health Centres and Subcentres. MBBS graduates to be posted in these centres to supervise the activities.

4. Co ordinated approach for improving *Social determinants of health*

Focus on **preventive and *public* health care**

Improve sanitation ensure safe drinking water , adequate ,nutritious & hygienic food. Ensure safe and healthy food policy by implementing stringent measures on adulteration, health tax on junk food, tobacco, alcohol etc, scientific slaughter houses, regulation of use of preservatives and pesticides, encourage safe transport and storage of food etc. Health impact assessment before starting industries and enterprises.

The impediments in attaining health goals in our country is not only due to lacunae in health infrastructure and manpower, but also due to lack of attention on social determinants of health. There should be strong policy directed to improving social determinants of health. This will require co ordination between various ministries and departments.

5. Medical education

To start more number of medical colleges in the government sector in states lacking in medical manpower.

Capping of fees of private medical colleges to make them affordable to all.

State based health manpower assessment to ensure equitable distribution of teaching centers.

No dilution of scientific concepts in curriculum and no traditional system of treatment should be main streamed.

Maintain autonomy, democratic nature & federal structure of regulatory bodies and academic institutions.

Self governance of medical and allied professionals to be ensured and representation of all States in decision making. Restore democratically elected Medical Council of India. The concept of National medical commission is unacceptable.

Continuous quality improvement and advancement in knowledge to be provided to all health providers.

Blatant privatization of medical education sector to be restricted. Government cannot withdraw from the responsibility of imparting education and as a part medical education also. Now the medical colleges are allotted haphazardly without a scientific state based assessment of need. This has brought in a gross mal distribution of institutions in the country. As per PSC for health report 60% of the medical colleges are located in areas inhabited by 30% of the population. The mechanism of fee regulation in medical college is also inefficient. Hence meritorious students find it difficult to pursue medical education. There should be adequate steps to increase the number of government medical colleges.

There are attempts to include modern medical curriculum in the courses for traditional and alternate systems of medicine. Such an unscientific approach is dangerous to public health at large. more over mainstreaming of traditional methods is not being attempted in any other fields of science like space, aviation, IT etc.

The regulation of medical and allied systems as any other profession is based on the principle of self governance. But recently there were proposal like NMC bill to curtail self governance, limit state representation etc. These moves had attracted lot of resistance from the medical community and opposition from the public. Even the democratically elected MCI was replaced by Government nominated Board of Governors.

6. Medical research

Medical grants commission to be set up for funding medical education , co-coordinating medical universities and ensuring advanced research in medicine.

7. Shortage of Medical Manpower

Addressing the perceived issue of **shortage of MBBS doctors** in rural, tribal and hilly areas *through* incentive based approach *with* improved *administration and infrastructure.*

Appropriate mechanism to address medical manpower shortage in some states has to be addressed.

Govt should ensure policy initiatives to increase qualified nurses and para medical staff.

There are surplus roll out doctors and allied health professionals in some states while some states lack sufficient manpower. Central recruitment of manpower to be deployed in backward areas and other solutions have to be considered. Creation of Indian medical service has to be definitely considered. The system of contract based appointments in health sector has to be done away with

8. Reducing the Out of Pocket Health Expenditure for common man-

Regulating the prices and quality of drugs, implants, equipments and consumables.
Restructuring taxes ,import duties by proper implementation of laws to aid price regulation.

One drug, One Price policy should be followed.

Quality control mechanism of drugs, consumables and implants is inefficient. There is gross overlap of various stake holders like petroleum ministry, health ministry, central government and state government. The onus of varying price of medicines and varying quality is purel on the government. Government should bring in uniform pricing of drugs and consumables by legislation assuring quality.

9.. Safe environment for doctors

Strong Central **act to prevent violence** against health care providers- National Health Care Establishment Protection Act *under IPC.*
Better working environment for **service and resident doctors** to reduce present high level of stress by Good Governance policies *& implementation of service rules and rights provided in the constitution*.

No Criminal liability in Medical Practice.

SITUATION

For the past two decades medical professionals in India have been facing medical malpractice litigation in an unprecedented scale. however the most disturbing development has been trial under criminal law for medical negligence and other laws. This legal threat has lead to severe anguish within medical fraternity, turmoil among legal professionals and shock ,anger and distrust of the common man for medical professionals

COMPONENTS

SECTIONS UNDER INDIAN PENAL CODE*The criminal liability of medical negligence is an extremely controversial issue. In order to establish criminal liability, it is important to ascertain whether intent to harm (MENS REA) was present or not. but in criminal negligence cases intent to harm has been replaced by gross negligence. Gross negligence itself is not defined in IPC. Moreover criminal law punishes only affirmative harm. But in medical negligence failure to act in a prudent manner also is a crime.*

> *It should not be forgotten that medicine, especially emergency medicine is inherently risky. Bad outcomes or mistakes do not necessarily mean that care was negligent or that health care providers are criminally at fault*

MTP act, PCPNDT act, POCSO act etc are also being applied against medical practitioners for technical reasons and medical professionals are prosecuted. The health laws like MTP,POSCO & PCPNDT act were enacted during various periods to address some social maladies prevalent in the country. Necessity of highly ethical and moral behaviour from the part of modern medical practitioners in the area of abortions, sex selection and female foeticide, examination of child sex abuse victims etc were emphasised by duties enforced by law in the respective acts. consequently inadequacies in these laws or its implementation often brought in certain difficulties in medical practice.

MTP ACT

The indications, social outlook and techniques have change but the act remain the same. Now the act is incapable of adressing the social issues

- *(i) MTP is allowed only upto 20 weeks. now the routine anomaly scans to diagnose congenital anomalies is being done at 20 weeks and if gross congenital anomalies are diagnosed, there is only limited scope for MTP. Hence the period should be extended to 24 weeks.*
- *(ii)Now the techniques available for MTP by administration of oral medications demands that some clauses of MTP act to be modified accordingly.*
- *(iii) The act should be modified to allow termination of any unwanted pregnancy, if the woman wants (before 24 weeks). The clause of contraceptive failure in married couples to be changed and marriage should not be precondition for MTP.*
- *(iv) in case of MTP in minors, the ascent of the child also to be considered if the child is of 12-18 yrs of age.*

PC PNDT ACT

- *After 14 years of enactment and implementation, if we have a relook it is evident that the act failed to improve the child sex ratio of the country which worsened from 2001 to 2011 census values. the act itself has lot of inconsistencies and as such does not prescribe any solid mechanism to prevent sex selection. without considering the bigger social issues and responsibility of the society and family members, the act focussed on medical profession. As such only few cases of true sex selection were booked under the act, most of the cases of arrests, remand etc were for technical reasons like late submission of forms etc. restriction of procurement of tools as mentioned in the act also is ineffective as more sophisticated, small hand held tools are available to do a pelvis scan. The fate of unwanted girl children is also grim as underfive mortality of girl children is more and the issue requires further study.*

POCSO ACT

- *There is lack of awareness regarding the provisions of the act and responsibility of various stake holders. This lack of awareness extends to medical practitioners, public, family members, and even police personnel.*
- *Timely reporting and timely examination of a child sex abuse victim is a must.*
- *The responsibilities of stakeholders and the procedures to be followed in cases of child sex abuse should be specified. One government hospital in each district should be named as a centre for examination of victims under POCSO act and facilities for examination as mentioned in the act to be provided. The reporting authority in the hospital to be specified.*

- *Data analysis of POCSO cases, conviction rate, progress of trial etc to be done and published.*

To treat a patient the medical professionals often have to take a calculated risk and take decisions, if fail may further complicate the situation. So it becomes difficult to define gross negligence.

Besides this one has to consider section 88 of IPC which saves medical professionals from criminal liability when the act is done in good faith. hence section 304 A and similar sections of IPC should only be considered along with section 88.

In this context there is a definite need for appropriate legislation to exclude medical profession from criminal liability.

10. *Steps to improve health care delivery*

Proper public private partnership in health care. Private sector should play collaborative and complementary role in health care delivery rather than those sectors play parallel role.

Restructure Ayushman Bharat program with realistic package rates and ensure timely disbursal of funds. Eliminate middlemen and avoid leakage of funds from public exchequer. Primary Care Access in Insurance.

	Public (percentage)			**Private (percentage)**	
	Health sub center / front line worker	PHC or CHC	Public hospital	Private doctor	Private hospital
Gujarat	2.5	6.4	10.5	52.9	27.5
Kerala	0.6	10.2	23	35.4	30.6
Maharashtra	2.1	5.4	10.3	62	20
Uttar Pradesh	2.2	2.7	11.8	72.4	10.8
Bihar	0.6	5	8	76.3	9.8
Rajasthan	1.5	11.4	22.5	48.4	16

All India	**1.9**	**6.5**	**17**	**50.3**	**24.1**

11. *Ensure scientific and authorized health care to people*

No unscientific mixing of treatment systems.

Abolish bridge course to prevent creating separate class of doctors for underprivileged part of society.

No Crossopathy.

Strong policy and legislation regarding unauthorized treatments, advertising and quackery.

The practice of Modern Medicine in India and the rules and regulations governing the practice of Modern n India, are settled positions of law in India. The Supreme Court of

India in (1) ***Poonam verma v/s Aswin*** *Pattel and others reported in 1996 (4) SCC 332, (2)* ***Dr. Muktiar Chand and others v/s State of Punjab and others reported in AIR 1999 (SC) 468 , (3) Medical council of India and another v/s State of Rajasthan reported in AIR 1996 (S.C) 2073,*** *has clearly held that, only a person holding a registration with the Medical Council of India or its state Medical Council is entitled to practice Modern System of Medicine.*

12. Protection of Small & Medium Nursing Homes

Single window clearance for Laws & Regulations for Healthcare establishments.
Better policies to ensure viability & smooth functioning of small healthcare establishments which provide 24*7 affordable, accessible, ethical and accountable health services and are backbone in providing secondary health care.
Providing incentives to small and medium scale hospitals through concessional land allotment , tax sops and other benefits as provided for IT sector and small and medium scale industries.

The small and medium hospital sector in the country is faced by innumerable problems

DWINDLING PATIENT BASE
INCREASING EXPENDITURE
LACK OF SUPPORT
UNFAVOURABLE LEGISLATIONS
CORPORATISATION
PUBLIC FUNDED HEALTH PROGRAMS & PRIMARY CARE

INSURANCE & PRIMARY CARE
LITIGATIONS
THREAT OF HOSPITAL VIOLENCE
ALTERNATIVE SYSTEMS
QUACKERY
LESS TAKERS
But as per NSSO data 70% of the health care is provided by these institutions. Programs to support such hospitals is the need of the hour. Government can entrust such hospitals for providing designated services on partnership basis

13. Exemption *of* medical profession from **Consumer Protection Act**, capping of compensation in medical accidents*/ negligence* , fixing of premium of indemnity insurance for doctors specialty wise as in third party insurance for vehicles.

Indian Medical Association*, the umbrella organisation of all modern medical practitioners in the country representing 8.5lakhs modern medical practitioners is very much concerned about many of the provisions of Consumer Protection act. We feel that this will cause further increase in treatment cost, make health care unaffordable and inaccessible to weaker sections of the society, promote corporatization of health care make small and medium hospitals unviable and will make implementation of public funded health programs difficult. On one hand Government is concerned about the catastrophic Health care cost and on the other hand the same Government indirectly changes the rules of the game. What has to be realised is that such moves hit people directly. More and more people will go below the poverty line every year. Apart from the adverse impact on the small and medium hospitals, all small entrepreneurs across the spectrum will also be hit.*

As regards the quantum of compensation, own Supreme Court in the case of ***Sarla Verma vs. Delhi Transport Corporation (2009) 6 SCC 121., notes as-***
"The lack of uniformity and consistency in awarding compensation has been a matter of grave concern… If different tribunals calculate compensation differently on the same facts, the claimant, the litigant, the common man will be confused, perplexed, and bewildered. If there is significant divergence among tribunals in determining the quantum of compensation on similar facts, it will lead to dissatisfaction and distrust in the system.

However, the dilemma that judges face while awarding compensation in medical negligence cases is largely due to the following: (a) The law is required to protect a patient's rights and (b) the law also needs to provide due autonomy to a profession that by all definitions are an inexact science.

A doctor in our country generally works in an atmosphere replete with constraints such as poor infrastructure, overcrowding of patients, lack of human resources (both medical and nonmedical), violence against medical personnel, non availability of essential drugs and investigations, irregular/erratic supply of medicines, poor quality of supplied medicines, deplorable state of maintenance of medical equipment, administrative work, deadlines and targets to increase the patient turn over, all while receiving inadequate remuneration for their demanding work. In light of the above, it is worth asking whether a medical practitioner can be held liable for medical negligence arising from an inability to diagnose due to the absence of required investigative facilities, poor quality of supplied medicines, or non maintenance of equipment and poor infrastructure. Hence, the court should take into account, the exact circumstances the practitioners working and the specific situations that led to the negative outcome so that justice is served."

Glaring example of high compensation can be seen in Dr. Kunal Saha vs Dr. Sukumar Mukherjee And Ors. on 1 June, 2006Equivalent citations: III (2006) CPJ 142 NCBench: M Shah, K G Member, R Rao, where Justice Shah opined that "Disease suffered by the wife of the Complainant was also - Rare - TEN (Toxic Epidermal Necrolysis) which affects only 1 or 1.3 persons, out of 10 lakhs. Diagnosis of such disease is difficult and not simple and depends upon expertise of the medical practitioner, particularly, a Dermatologist. In such a case, can a patient or his relative expect from the medical practitioner that the patient in all cases should be cured?

Repercussions and Impact of the** Dr. Kunal Saha vs Dr. Sukumar Mukherjee And Ors. Case/ **Judgment:

i) Since the Consumer Protection Act is largely tilted towards in the interests of consumers alone, there are plethora of false and frivolous cases by the extortionist population to earn unjust compensation without any fear of Law as there is no equitable penalty involved.

ii) Doctors now are forced to resort to defensive medical practice and despite a measure to tackle it, they prefer to be safe to leave a critically ill patient to his/her fate.

iii) In absence of check and balances, there is multifold increase in the false and frivolous cases with impunity.

iv) The cost of medical treatment soared high to such an extent that the innocent population at large now feeling the heat. Clearly a disservice to the ailing society.

India, unlike the USA, does not have a jury system that determines culpability or quantum of compensation. In India, the judge in the consumer court, or the civil court, has complete discretion over the compensation amount and hence is bound to consider the impact of the judgment because he/she sets a precedent even in the manner and quantum of damages awarded.

How the patients/community by large will be adversely affected if this Bill is approved by the upper house (Rajya Sabha) of the parliament:

1. *Medical professionals will have to enhance their medical indemnity insurance protection by minimum 200% from the present level, for their protection against litigations if any. This will entail increase by 200% their annual subscription. They will then have no options left than to increase their professional charges of managing patients. Ultimately this burden will fall upon the poor and needy patients.*
2. *Medical professionals will have no alternatives left than to move away to a very defensive practice, and of not talking any risk to manage emergency and complicated cases. This would again adversely affect the positive health out come of patients.*
3. *Because of ensuing defensive practice, quantum of laboratory investigations will increase to multi-fold. This will again have an adverse implications on patients increasing their out of pocket expenses.*
4. *Around 60% of primary and secondary health care services are provided across the country by solo medical practitioners and/or by small nursing homes/hospitals. With such draconian provisions in the Bill, they will have no alternatives left than to close down their practices. Considering lack of these facilities available in public health centers and institutions, ultimately the sufferers would be the poor and marginalized patients.*
5. *This Bill more than draconian for the medical practitioners, have not considered these humanitarian issues, adversely affecting availability of these services at affordable cost provided by small nursing homes.*
6. *Health and welfare of an individual being the constitutional right of each citizen of the country, this Bill if passed and made as an Act, will impinge upon the constitutional rights.*

7. *And as a welfare state and a welfare federal government, this Bill will unfortunately will be against the spirit of a welfare state.*

In this back ground Indian Medical Association had placed certain suggestions for the draft bill 2015 which were put in public domain but have not been considered in the 2018 Bill.

SUGGESTED SPECIAL PROVISIONS FOR NEGLIGENCE IN HEALTHCARE

1. *A "**Medical Negligence Act**" should be enacted by our parliament solely for dealing with the medical negligence cases where both medical practitioners and patients are made accountable."*

2. *In the case of a complaint against medical negligence, the complainant shall be asked to deposit a sum of not less than 10 % of value of services/compensation claimed into the receipt Account of the State Government/Consumer Welfare Fund. If the allegation at any stage found to be false and frivolous, the amount shall be forfeited.* ***(under rule 9A of 1987) or rules to be made U/S. 35 of Consumer protection Bill-2018).***

3. *Whenever a complaint is received against a doctor or hospital by the Consumer Fora (whether District, State or National), then before issuing notice to doctor or hospital against whom the complaint was made, the respective Consumer Forum shall first refer the matter to the concerned State Medical council to arrange for expert opinion(with a time limit tag) and only after the receipt of the reports that there is a prima facie case of medical negligence, shall issue notice to the concerned doctor/hospital. It will be necessary to avoid harassment to doctors who may not be ultimately found to be negligent and also to prevent false and frivolous cases. If the patient is not satisfied with the decision of the council,* ***he or she can again appeal to the Medical council of India.****(may be inserted under* ***clause (vi) of sub-section (4) of section 13) or (under Section 36(2)and104(2)(a) of Consumer protection Bill-2018).***

4. *The Medical Council shall judge the complaint of medical negligence on three grounds-*
   i) Whether the complaint is fit to proceed by a court of Law;
   ii) If the complaint is false and frivolous;
   iii) If there is anything against the norms that favours action by the ethics committee.

5. *To avoid the lack of uniformity and consistency in awarding compensation a suitable formula is being proposed, hereby* ***(Under Section 14(d) of Consumer Protection Act 1986) or (under Section 39(1)(m)and under Section 106 of Consumer protection Bill-2018)*** *as -*

$$\text{Compensation} = \frac{B \times F \times R}{99.37}$$

Where,

B = Base amount (the actual cost of treatment, as prescribed in Jan Arogya Yojna, for the specified ailment or procedure).

F = Factor depending on ***the age*** *of the participant (based on Workmen's Compensation Act, 1923).Where* ***99.37*** *is the risk factor at the age of 65 or above, as specified in the said act.*

R = Risk factor depending on the ***seriousness and severity of the disease, presence of co-morbidity, and duration of disease*** *of the participant at the time of admission in the hospital/clinic between a scale of 0.5 and 3 as under:*

   i. 0.50: Critically ill patient (expected survival not more than 6 months)
   ii. 1.0: High-risk patient (survival expected between 6 and 24 months)

iii. *2.0: Moderate-risk patient*
iv. *3.0: Mild-risk patient*

14. *Involvement of stake holders*

Involvement of Indian Medical association in formulation and implementation of Health policies by Central and state govt.

15. *Social justice and elderly care*

More policy initiatives for ensuring safe and comfortable living of elderly & marginalised population (tribal, costal, women, children, disabled, mentally challenged, etc)