2nd National Consultation on the Draft Public Health Bill, 2015

Minutes

The 2nd National consultation on Public Health Bill was organised by NHSRC at New Delhi on 16th March 2015 to receive feedback from experts on the draft bill (the list of participants is given in the annexure). The meeting was chaired by Dr. B. D. Athani, Spl. DG, Dte. GHS.

The meeting began with opening remarks by Dr. Sanjiv Kumar, Executive Director, NHSRC who extended a very warm welcome to all the participants. He set the tone for the day long discussion by making broad comments on the Draft Bill. He remarked that it was a good draft which has addressed the knowledge component fairly well and now it is at a stage were inputs from service providers and beneficiaries could be taken. He also urged that the law should be futuristic and should take into account the major burden of disease (like NCD which accounts for 53% deaths in India and other major causes like accidents/injuries and suicide). Other areas which can be incorporated are the Grievance redressal mechanism, 'Health in All Policy' concept (that other departmental policies should also keep its linkages with health), Medical devices regulation, and Silent emergencies like malnutrition etc.

Mr. Prasanth K S, NHSRC explained the objectives of the consultation and clarified that NHSRC was given a mandate to make a model act only and its adoption by states will be a subject matter of negotiation with respective states. Responding to a query, he also pointed out that in light of the changed political scenario, possibility of getting the mandate under Article 249 is also be expected. He also shared that the consultation with the States, which was proposed by the Task force, will now be conducted, if NHSRC receives assent from the Ministry. He also shared that the consultation expects the experts to provide feedback on the 'role of Local Self Governments (LSGs) as implementing bodies under the Act', 'provision to mandate the creation of Public Health Cadre' in States, 'appropriate authorities under the Act', 'Indicators for reviewing performance of LSGs' etc. as well. He further clarified that the approach for the implementation of the act has to be both rights and duty based.

Dr. B. D. Athani, Spl. DG remarked that India has the experience of successfully fighting major battles on smallpox, polio etc. and dealt with emergencies like dengue, H1N1, which clearly demonstrate that we have a very sound public health infrastructure in place. The need is to deal with underlying determinants which are not in control of the health system and because of that we are not in a position to promote health. For eg: there are several health consequences of lack of clean drinking water. But the provision of clean drinking water is not the task of the health department. Such

measures have to be done by the respective states, but experience reveals that they are hesitant to adopt legislations and hence keeping it exclusively for states, could be problematic. He also suggested that in addition to programmes, Missions run by the central government also can find a place in the act.

Further, on rights-based approach, he stressed on the need to strike a balance, as to whether this access to rights is absolute, or limited, or to preventing or to curative measures etc.? What exactly is the entitlement and what is the responsibility of the State? He also stressed on the need to take into account the economic cost of the entitlements. (He also quoted the example of supply of 'Oseltamivir' to patients who are affected by Swine flu - to emphasize that talking about rights can be tricky). This could require several meetings (involving State Governments) and lots of background work/research. He also shared that the act should be precise, crisp and implementable. The draft has to be circulated to other ministries where convergent action is required and a consultation with those sectors is also necessary. He further suggested that NHSRC should also bring on board, the Central Council of Health and Family Welfare (CCHFW). NHSRC could facilitate to include Public Health Act as an agenda in CCHFW so as to get a wider consensus from the States and also for obtaining any suggestions and recommendations for improving the Act.

He observed that when it comes to expenditure, the states look at the Centre. What is the cost sharing mechanism between centre and states? What is the allocation of responsibilities between states and centre? Can centre totally remain out of the picture and abdicate its responsibilities?

After the Chair's remarks, the draft bill was presented by Prof. O.V. Nandimath, Prashant Desai and Anita Srinivasan from NLSIU. After the brief overview, NLSIU raised following specific issues for discussion, on which they required clarity for the purpose of drafting the public health bill.

- What should be the definition/conceptualization of public health for the purpose of this act?
- Are we going for a decentralized model and by all levels?
- Suggestions on the authority structure and bodies at various levels?
- What should be the nomenclature of the body - Public Health Board or Authority - depends on functions we want them to perform
- What should be the composition of the Board/Authority?

Dr. Himanshu Bhushan, NHSRC suggested that the draft bill must add penal provisions for violations of provisions of the act, and also service guarantees which is not very clearly articulated under Clinical Establishment Act (CEA). He also emphasized that when rights are enjoyed by the public they must also perform corresponding duties.

The perspective of the law should be from the eyes of the public. Our aim should be that every state has a robust Grievance Redressal system in place.
The forum was then open for discussion and feedback.

Dr. Pradeep Saxena agreeing with Prasanth K S, urged that State consultation is a priority action that will ensure acceptance of the Bill at State level.

Dr. Joshi and Ms. Lorraine said that the draft bill should reflect the draft National Health Policy, 2015. Prasanth (NHSRC) responded that we still don't know what final form the health policy may take.

Dr. Joshi agreed with point made earlier by Dr. Sanjiv Kumar that the Bill should have provisions for current as well as emerging diseases and challenges. He suggested that this Bill should include provisions on Bioterrorism and Natural disasters as well. Further, he categorically said that we should not include the provision of Clinical Establishment Act (CEA) in this bill. He added that we should stick to three elements of public health– protection of health, environmental conditions, prevention and control of diseases & hazards. The fourth element of public health is of health promotion (curative, diagnostic) and it can be included if there is a consensus among the experts.

Dr. Salunke suggested that state boards should include members of other ministries and departments, and that the convergence mechanism must be enumerated in the draft, by having membership in the health boards etc. He also gave the example of Kerala which started the 'Health protection agency'.

Prof. Nandimath suggested that we should start advocacy to bring health under the concurrent list. On the issue of how to determine the standards of underlying determinants, he suggested that the MoHFW could decide the benchmark standard for drinking water and the suppliers of water must adhere to that standard.

Dr. Raman shared that in the draft, right to health should come before the right to underlying determinants. He suggested doing a comparative study on providing right to health in countries with larger populations like UK, Thailand, Brazil etc. What would be the liabilities/ obligations of the government in financing? How functions, functionaries and finances will go to the LSG should be clearly defined and mandated to the states. The role of other ministries in convergent actions should also be spelt out. He expressed concern on the institutional capacity of different states to implement the provisions of the draft bill.

Dr. Rajan – LSG should be included in the definition of 'Government' in the draft. No provision should be there which is against the spirit of decentralization. It is possible that certain states may not have capacity but then our focus should be to build that

capacity rather than not giving them the powers. It is also imperative that obligations of the government are clearly spelt out.

Manoj – was of the view that even in Kerala it is not going on well. He was also of the view that the Act developed in Kerala, (A revision of Travancore-Cochin Public Health Act) is coercive based and is the way to go. Unless powers are given, punitive actions cannot be taken.

Dr. Joe Verghese agreed with Dr. Rajan on the spirit of decentralization. He said that emergence of CEA has actually led to many legislative processes in the State and in fact certain State level acts are superior to the Central Act. So even getting it passed as a model act is very important as it will push the states to legislate. He also shared that along with the Act, programmatic support to build capacity of the states to implement the provisions.

Dr. Ajit – As per the constitution there are two bodies, which are visualized, one is gram Panchayat and another is Gram Kachhari, Gram Panchayat is an executive body and Gram Kachhari has judiciary power. So as per the Article 50 of constitution of India "The State shall take steps to separate the judiciary from the executive in the public services of the State". He suggested taking stock of how these bodies are functioning and to explore whether the Gram Kachhari can perform public health functions.

Dr. Rajan, Prof. Nandimath and Dr. Himanshu were of the opinion that if the body has to be an Authority, then the regulation and implementation functions of the Authority should be separate. So institutional mechanism should be very clearly spelt out with sufficient human resource provisions.

Prof. Nandimath – Responding to Dr. Sanjiv Kumar's comments on the responsibility of the states has suggested borrowing language from the Thailand statute on the lines that the state shall not start a program without first ensuring sufficient funds.

Ms. Shivangi – The language should be carefully written as couching it in negative terms may have the effect of discouraging states from initiating any program. The language instead should be affirmative – that states must ensure adequate funds for the programs. Further, that there should be a provision that protocols/guidelines formulated by the Authority/Board should be scientific and evidence-based and conform to rights-based principles. This will be a tool to ensure that states don't formulate inadequate and/or regressive protocols or guidelines.

Prasanth K S - clarifying a query on the same topic; the protocols under the Act by the national body will be binding only if the draft is a National Act not a model Act for States, which is not the case now.

Dr. Salunke - The states are looking at guidance from the centre in setting up programs etc. so they may not be averse to following central protocols or guidelines on specific issues. This act shall be of generic nature. Let the States accept/reject the protocols/standards but we can provide them.

Ms. Lorraine - the bill should be rights-based. She also expressed concern that there could be different packages of services depending on financial/infrastructural capacity of states and there could be regressive public health laws/policies with reference to certain marginalized groups. There has to be some mechanism to address this. She also asked how does the bill reflect the policy on UHC or package? How do the vertical programmes like HIV program get reflected?

Dr. Sanjiv Kumar – Responded to Lorraine that there are 4 taskforces constituted by the MoHFW on the issue of integration and NHSRC is involved in all the four.

On the issue of whether the approach of the Bill should be punitive, Ms. Lorraine and Mr. Ajit were of the opinion that the bill should move away from penalties and towards health promotive and curative approach. Prof. Nandimath explained that the bill will have a mixture of minor civil and criminal penalties eg. fines, but the approach won't be punitive.

General Consensus

By the end of the consultation some of the areas in which a general consensus emerged were:

1. The bill should be based in the spirit of decentralization and the role of the LSG should be clearly spelt out
2. We will not recommend amendment of all the existing laws for which a Framework Law does exist already
3. Bill may bring some provisions from the related pending bills (e.g. Bio terrorism Act); without conflicting what is already passed and contemplating on what is to be passed.
4. Public health has advanced a lot. We must take the newer perspectives and challenges into context. The preamble could state 'programs and protocols developed under the Act would be scientific, evidence-based and incorporating the principles of human rights and public health principles'.
5. The bill shall be rights as well as duty based
6. We must engage with the states – the State consultations must be open for all, but engagement with at least 8 of them, who have some Act or bill in place must be ensured.
7. The body at the State level should be an authority and not a board. Then we need to have a separate executive group, because in this case we have a board (with standard setting functions) as well as an executive authority (for

implementation). The Authority must have representation from civil society, NGOs etc.

Points of Action

1. NLSIU will update the draft as per recommendations of the expert consultation
2. NHSRC will organize State consultation on revised draft Bill, subject to approval to do so from Ministry
3. Dr. Rajan to share indicators for LSG performance

The consultation ended with concluding remarks from Prasanth K S and vote of thanks from Dr. Himanshu Bhushan.

ANNEXURE

List of Participants

S. No.	Name	Designation/Organisation	Email
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