Communist Party of India (Marxist)

Perspective & Action Agenda on Health Issues

Introduction

Neoliberal policies pursued by the BJP regime under Modi have accelerated the transformation of public health into a market commodity, leading to the consolidation of a powerful medico-industrial-financial complex. This process has steadily weakened the fundamental principles of universality, accessibility, and equity that must form the foundation of a democratic and people-oriented health system. Healthcare is increasingly being treated not as a social responsibility of the state, but as a sphere for profit-making and surplus extraction.

At the same time, the Manuvadi, obscurantist, and pseudo-scientific outlook promoted by the RSS have further distorted the health discourse. The propagation of practices such as urine and dung therapy, rigid dietary dogmas, and other irrational beliefs undermines scientific temper and encourages differential treatment based on caste, creed, and superstition, in direct opposition to constitutional values and modern medical science.

Disease does not discriminate on the basis of status, religion, caste, language, or any other social marker. Treatment, therefore, must be universal, equal, and guided strictly by scientific and evidence-based principles. However, under the present corporate–communal regime, health has been reduced not only to a commodity but has also been infused with superstitious and mythical elements, pushing it away from rationality, science, and public welfare.

Historically marginalized and oppressed people face outsized material deprivation and compounded forms of discrimination and exploitation in the workplace and society at large. Social relations along intersecting axes of class, caste, race, ethnicity, sex, gender, sexuality, ability, citizenship shapes power relations and the distribution of resources. Health system is an expression of the socioeconomic inequalities that prevail in the society. The medico-industrial complex, working in connivance with the elites of the society and medical fraternity who have enormous control over state policies and resources, ensures that scope of pro-people policies remains limited to the extent that it safeguards the interest of big capital.

In this context, the health sector has emerged as one of the most critical areas of intervention for our Party and mass organisations. Our task is not only to resist the heavy burdens imposed on the people by harmful health policies and to provide whatever relief and support is possible, but also to counter the growing

influence of the RSS and other communal forces. Ironically, the very forces responsible for the present crisis in healthcare are attempting to expand their ideological and organisational influence through selective health-related service activities. Given the seriousness of this threat, it is imperative that we significantly strengthen and scale up our interventions in the health sector.

Current situation in Health sector

India's health sector stands at a critical juncture, facing systemic challenges rooted in deep structural socio-economic inequities. The World Health Organization (WHO) in its 1948 Constitution defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Health is fundamentally a political issue to be viewed within the framework of social justice and critical political economy, not merely as a techno-medical problem. Good health requires more than access to healthcare facilities, and is dependent on social, economic, political, and environmental determinants including income, caste, gender, food and nutrition, water and sanitation, housing and habitat, environment, occupation and working conditions, education, and freedom from violence and discrimination.

Health System Crisis, Neo-Liberal Reforms and Privatization: Three to four decades of neo-liberal reforms have worsened health inequalities, which have got even worse under the BJP/NDA dispensation. The Structural Adjustment Programmes from the 1980s onwards have reduced public expenditure and subsidies, promoted privatization, and weakened public infrastructure. Currently, the private sector dominates healthcare in India, providing nearly 80% of health services and owning about 62% of all hospitals. Out of a total of 69,000 hospitals in the country, 43,486 are in the private sector. About 63% of hospital beds (10.18 lakh) are in private institutions, whereas only 7.14 lakh beds are in the public sector.

Over the last decade (2015–2023), the private healthcare sector has witnessed rapid expansion, registering a compound annual growth rate (CAGR) of 25.3%, reflecting the accelerating corporatisation and commercialisation of healthcare.

Privatization and corporatization have created a two-tier system: advanced care for the elite, wealthy, better-off and overseas patients versus poor quality, inadequate care for the masses.

Medical education has been commoditized through private colleges charging exorbitant fees, perpetuating elitism and excluding marginalized sections, while regulatory oversight is weakened. The rise of capitation fees and coaching culture has turned medical education into a privilege for the wealthy, undermining equity in healthcare delivery.

Public Sector Undermined: Public-sector drug manufacturing units have been systematically weakened to promote privatization, with all state pharmaceutical companies except in Kerala facing existential threat. Weakening of pharma PSUs has led to higher prices, lowered access to life-saving medicines, undermined innovation and increased dependence on MNCs and other external sources for intermediates and finished medicines. Diagnostic tests remain entirely in a poorly unregulated private sector, driven by corrupt referral networks and market promotion rather than by actual need.

Crisis in Medicines: Medicine prices have surged, with only 18% of drugs subject to price controls. 70% of out-of-pocket health expenditure is spent on medicines. Irrational Fixed Drug Combinations constituting over 40% of marketed drugs are hazardous and expensive. New intellectual property (IP) regimes have replaced earlier process-based models in India that made life-saving drugs more affordable. The revised Indian Patent Laws legislated at the Party's insistence during UPA-1 continues to be under pressure from MNCs and advanced capitalist countries. The nexus between pharmaceutical companies and ruling political parties, facilitated through purchase of electoral bonds worth over Rs.900 crore by 30 pharma firms, undermines public accountability. Pharmaceutical advertising worth Rs.2000+ crore annually inflates drug prices.

Insurance-Based Schemes and Corporate Expansion: Private healthcare expansion has accelerated under the BJP government, with growing monopolistic corporate hospital chains. In recent times, international private equity firms (e.g. KKR, Blackstone, and TPG Growth) have acquired stakes in hospital chains all over the country, clearly chasing profits rather than people's interests. Exorbitant charges by corporate hospitals continue without adequate regulation. Schemes like PM-JAY prioritize insurance-based financing over strengthening public systems, offering minimal financial protection to patients while benefiting private providers. Benefits disproportionately reach better-off sections, draining resources away from primary health care. Profit-driven models incentivize unnecessary diagnostics and procedures, increasing out-of-pocket health expenses and exploitation of health workers.

There is a very worrying and growing trend of involvement of financial markets, investment firms and speculative capital entering the corporate health sector in India. These investment sources are often based overseas in shady tax-havens making regulation very difficult. Under the BJP/NDA, investment in corporate hospitals, diagnostics centres and related medical facilities is open to 100% FDI under the automatic route. This financialisation driven only by short-term interests is reshaping healthcare into a relentlessly profit-driven industry with significant negative consequences for society. This erodes medical professionalism and significantly impacts healthcare workers. Doctors in

corporate hospitals have reported significant pressure to meet revenue targets, often compromising clinical judgment for financial gains. Financialisation and corporatization amplify the complete social disembodying of healthcare, stripping it of its social function, and reducing healthcare workers to interchangeable labour, while patients are treated merely as revenue sources rather than individuals in need of care.

***Crisis in Public Funding*:** Public health expenditure in India remains critically low: India spends less than 1.5% of GDP on health. Thailand spends 10 times more, and China 15 times more! This chronic under-investment forces people to rely increasingly on out-of-pocket expenditure, pushing over 55 million people annually into poverty due to excessive health expenses. Out-of-pocket spending constitutes 70% of health costs in India, making treatment unaffordable for millions.

Centralization: As is well known, concentration of powers, schemes and finances by the Union government at the expense of States and their due roles under List-2 of the Constitution has become a major problem under the BJP Government. This has had serious adverse effects on the Health sector. The Union government dictates norms and controls disbursal of funds for Schemes like Ayushman Bharat including PM Jan Arogya Yojana (PM-JAY) and the National Health Mission (NHM). This erodes federalism, which is being resisted by Kerala, sharply reduces fund flow to States, and has also led to uniform health programming across states whereas state-specific approaches are needed to meet local contexts and requirements, for example in States with advanced health indices and infrastructure like Kerala and Tamil Nadu. Devolution to States is vital for the health sector.

State of the Health Sector in the States

According to the NITI Aayog Health Index, the best-performing states include Kerala, Punjab, Tamil Nadu, and Mizoram. The least-performing states are Uttar Pradesh, Nagaland, Rajasthan, Bihar, Haryana, Odisha, Madhya Pradesh, Uttarakhand, Chhattisgarh, and Jharkhand. All other states fall in the middle or “middling” category in terms of health indicators and performance.

Although there are variations between states, public health infrastructure is either stagnating or deteriorating across the country, while the private health sector is expanding rapidly. This has resulted in declining access to quality healthcare for ordinary people. Good healthcare has become increasingly unaffordable for the common population and is accessible mainly to the rich.

Current Health Crisis and Structural Inequities

Despite progress over time, India's health indicators remain severely compromised. Maternal mortality stands at 145 per lakh live births, significantly higher than in Sri Lanka (36) and China (29). Under-five mortality accounts for over 20% of global deaths, reflecting systemic failures in maternal and child health. Stark regional disparities reveal the role of governance and political will: infant mortality is 5 (per 1000 live births) in Kerala but 37 in Madhya Pradesh, Chhattisgarh, and Uttar Pradesh. Among Scheduled Tribes in Chhattisgarh, infant mortality reaches 58 compared to 3 among general castes in Kerala. C-section rates range from 75 per 100 deliveries in urban Srinagar to 3 per 100 deliveries in Sukma district, Chhattisgarh. States with left-wing governance (Kerala) and those prioritizing public health systems (e.g. Tamil Nadu) demonstrate better outcomes, showing that politics of governance shapes health results.

Infrastructure and Human Resource Crisis: Public health facilities suffer from chronic shortages — 20–30% shortfall in Sub-centres, Primary Health Centres (PHC) and Community Health Centres (CHCs), alongside workforce deficits and urban bias. According to the Indian Public Health Standards and norms, India still needs at least 25000 more Sub-Centres, 5000 more PHCs and 2000 more CHCs. A large number of districts lack fully functional district hospitals, and many of these are being privatized or converted to PPP mode. The backbone of community health — ASHAs (Accredited Social Health Activists) and frontline workers — face insecure employment, low wages, and exploitative conditions.

Vulnerable Populations and Systemic Exclusion:
Capitalism depends crucially on unpaid social reproduction work by women, to pay workers low and below subsistence wages. The emergence of welfare state in health and care work played a key role in sharing the burden of social reproduction which created favourable condition for women to join labour force and hence lead to social progress and economic prosperity. Declining welfare state and emergence of market in health and care economy has put back the responsibility on family and particularly women and lead to multiple burden of work.

Gender and reproductive health inequities are particularly severe. Women, queer, intersex, trans and gender-diverse persons as well as disabled face pervasive discrimination, violence, stigma, and denial of essential services. Women and girls with disabilities are 2-4 times more likely to face violence, while reporting mechanisms remain inaccessible due to physical, legal, communication, and attitudinal barriers. Intersecting identities intensify these challenges.

Caste-based social divisions continue to assign cleaning, waste management, and scavenging work predominantly to Dalits and vulnerable communities. Such work remains undignified, underpaid, un-recognized, and unprotected, exposing these groups to greater illness and even threat to life. Occupational health hazards

across many industries continue to afflict workers especially those from marginalized and low-income groups with little attention paid by government or corporates. Healthcare and public health facilities in urban slums, rural Dalit hamlets, and Adivasi areas are abysmal. The urban and rural poor, along with the lower middle class, are the worst sufferers of the neglect of the public health system and the commercialization of healthcare.

These forms of exclusion or discrimination are not isolated practices, but reflect deep structural inequities shaped by gender, caste, disability, sexuality, and entrenched social hierarchies.

Other Recent Issues

Climate Change and Emerging Health Threats: Climate change compounds pre-existing health vulnerabilities. Over 56% of India's population faces high climate-induced health risks. Malnutrition, water scarcity, poor water quality, air pollution, and heat-related illnesses intensify, particularly affecting workers especially outdoor workers, infants and the elderly, disabled, homeless populations, and other marginalized sections. Chronic non-communicable diseases (NCDs) are rising sharply, straining already inadequate systems. Government measures remain inadequate. Vector-borne diseases are increasing and are expected to increase further due to climate change, calling for greater vigilance and public health response.

Health Data and Authoritarian Governance: Health data can improve healthcare decisions, but data collection methods and systems also risk loss of privacy, state dominance, and commercialization of personal information, corporate monopolies, and suppression of individual rights. Experience during the pandemic revealed how data systems are being weakened, healthcare decisions are taken without adequate evidence basis, and data is selectively used to serve vested interests. Data manipulation by the BJP governments has reached unprecedented levels, pressurizing government and autonomous agencies to change data to suit political narratives, and challenging international data and comparative rankings that may embarrass the BJP government. The deliberate and inordinate delay in holding the decadal census and unwarranted interventions in the sample survey results by the current regime, are some examples.

Communalism and Pseudo-science: Democracy is facing a systematic attack from the corporate-communal nexus, and the health sector has not escaped either. Besides the corporate take-over of the hospital, diagnostics and pharma systems, as well as the targeted violence faced by religious minorities and vulnerable sections, , the health sector is faced with majoritarian reframing through renaming of local health care institutions as "Arogya Mandirs," and the

deliberate spreading of pseudo-scientific beliefs and remedies reinforcing Hindutva narratives. Many examples may be cited. For instance, the push for lighting lamps and clanging pans during Covid along with claims that NASA had recorded efficacy of these measures. False claims were made by corporate crony "godmen" of "cures" for serious ailments through unproven medications such as Coronil in the name of "traditional or Indian knowledge systems (IKS)" was another notorious case, with government agencies and regulators turning a blind eye even when hauled up by the Supreme Court. Strengthening of the Magical Remedies legislation should be taken up. Popularization of various cow urine products and aggressive, even violent, promotion of vegetarianism including dropping eggs from mid-day meals, seek to promote a particular brand of Hindutva. Considerable government funding is also being extended for pseudo-scientific research, including under the National Education Policy (NEP). These must be rebuffed through robust, science- and evidence-based campaigns.

Specific Health Challenges

Mental health is highly under-emphasized at present. This demands comprehensive diagnosis and treatment, family- and community-based care, and wider promotion through expanded District Mental Health Programmes addressing challenges among children, youth, the elderly, women, healthcare workers, and vulnerable groups like farmers and low-income workers. Appropriate training should be built-in for health care workers and professionals at all levels.

Major diseases (HIV-AIDS, polio, TB, leprosy) require expanded, reoriented programmes with heightened vigilance, and due attention to nutrition and proper drug regimens. Large-scale internal migration poses additional burden and problems for the health care sector.

People with disabilities need greater attention and resource allocation to ensure health rights and address specific concerns.

Traditional health care systems and medicines: There is much confusion under the BJP dispensation regarding AYUSH health systems, with government pushing untested and non-validated so-called "Ayurvedic" treatments and medicines in the name of "Indian knowledge systems" (IKS) and even attempting to give greater role for "Ayurvedic" practitioners in the modern medical system including surgery, correctly opposed by medical professionals. At the same time, greater clarity is also required in the Party and mass organizations on the role and place of traditional health systems and medicines, and the stand to be taken towards them. Most traditional health systems and medicines have evolved over centuries through trial-and-error and some remedies have at least some empirical evidence of efficacy. Large sections of the people follow these

traditional systems, which have established a strong position especially in some States. WHO "promotes integration of traditional, complementary, and integrative medicine (TCIM) into national health systems, recognizing its widespread use (in 170+ member states) for holistic health, focusing on evidence, safety, quality, and cultural respect (emphasis added)." International experience of large-scale use alongside modern medicine and health care, for example in China, South Korea and Vietnam, may also be kept in mind. A serious dialogue within the Party and mass organizations on attitude towards and role of traditional health systems is called for, while emphasizing validation, approvals and standards, alongside modern diagnostics and inter-system medical boards to insure against mis-diagnosis and mis-treatment.

Influence of social and digital media: The growing influence of social and digital media—such as YouTube counselling channels, wellness centres, the gym and fitness industry, quack practices, and the aggressive promotion of junk foods—needs to be critically examined and explained, particularly their impact on public health, behaviour, and perceptions of well-being.

Legal and moral issues that require careful understanding: Issues such as surrogacy, the coexistence of different medical systems, assisted death, and related ethical questions must be approached carefully. Our position on these matters should be balanced, rational, and grounded in scientific understanding, constitutional values, and social justice, avoiding both uncritical acceptance and dogmatic rejection.

Abuse of drugs, narcotics and alcohol: Across India, the rising use of alcohol, tobacco, cannabis, opioids and newer synthetic drugs is increasingly visible among adolescents and young adults, cutting across rural and urban settings and deepening existing social and economic vulnerabilities. From a people's health perspective this trend is not just about individual "addiction," but about how unemployment, precarious work, gendered stress, parental pressures, urbanisation, conflict, and aggressive marketing intersect with weak public mental health services and limited, stigmatizing de-addiction care, shifting the burden onto already marginalized communities and households. Careful social initiatives are to be designed for addressing this, empathising with the victims, while opposing and addressing the menace.

Rising obesity, increasing stress, anxiety, and depression have become serious health concerns among children and youth. Food adulteration and the spread of fake and spurious medicines are adversely affecting people's health.

Towards People-Centric Alternatives

Health and healthcare are fundamental rights, ***not commodities***. Healthcare must be available, accessible, and affordable for all, irrespective of income, region, religion, caste, or gender. This requires legislation guaranteeing universal, comprehensive, free healthcare and annual public expenditure of at least 5% of GDP.

Strengthen and enable public health systems at all levels, rural and urban to provide free, comprehensive services, essential drugs, and diagnostics, all delivered to high standards. This requires facility upgrades, adequate human resources, and improved governance. Ensure nationwide access to essential medicines and diagnostics based on successful models (Tamil Nadu, Kerala, and Rajasthan). Where necessary, build genuinely autonomous public corporations with competent staff, transparency, and responsiveness. Substantially scale up budgetary allocations for medicines.

Minimize out-of-pocket spending by people to alleviate poverty and prevent indebtedness. Adopt a national goal of reducing out-of-pocket spending to less than 25% of total health expenditure, reversing current under-utilization of services.

State-specific, People-centred and Decentralized governance is essential in the health sphere due to diverse ecological and morbidity profiles, social and cultural contexts, health care systems and health related behaviour. Community-led health governance requires active participation of local bodies, strong monitoring and grievance redressal mechanisms, and greater devolution of administrative as well as financial powers, to enable contextualized health system management. This also requires building transparency and social accountability, democratising and empowering community participation, and eliminating corruption.

Workforce Dignity and Regulation: A well-trained, adequately remunerated workforce with dignified working conditions is essential. ASHAs and Anganwadi workers should be regularized, contractual appointments should be eliminated in favour of permanent posts, and public medical education needs to be scaled up for all levels of the health system with proper and on-going skill development and upgradation. Proper workforce should be ensured in rural, urban, tribal, conflict-ridden, and remote areas. Private sector facilities should be well regulated e.g. through a strong Clinical Establishment Act. Disguised privatization in the name of PPP should be ended, transparent medicines pricing should be enforced, and unethical practices should be curbed.

Addressing climate challenges and social determinants require universalizing Public Distribution Systems (PDS), Integrated Child Development Services (ICDS) and mid-day meals, ensuring gender-, disability- and elderly--sensitive care for all, also tackling violence and discrimination. This includes sustainable

infrastructure, clean energy investments, and disaster preparedness. Climate policy and health policy must be integrated so as to build climate-resilient primary care systems and localized adaptation strategies requiring inter-sectoral coordination among health, environment, agriculture, disaster management, and development infrastructure sectors.

Our own initiatives and activities for people's health

The Party and associated mass organisations have long been intervening in the health sector in various states through multiple initiatives. Broadly, these interventions fall into four categories:

1. Building and/or supporting movements around key health policy and programme issues
2. Leading or facilitating public health education and awareness initiatives
3. Organising or supporting service-oriented health programmes and activities
4. Building and strengthening professional organisations and trade unions in the health sector

While most of these initiatives are well known and accepted by the people, we need to critically analyse and strengthen these initiatives. It is also important that such interventions are to be further expanded, with an aim to provide support to the working class and the marginalised populations.

Beginning with early post-independence science popularisation, several of our comrades and Organizations in the then nascent Peoples Science Movement also joined health movements in India through various networks, organisations, platforms and health sector trade unions, strengthening them as regards perspective and organization. In these forums, our comrades were able to initiate and sustain Marxist and progressive critiques of the health sector, unethical pharmaceutical practices, pro-capitalist patent laws, challenges toaccessing essential medicines, and issues of self-reliance in the Indian health, vaccines, pharma and medical equipment sectors, both at national and state levels. In response to neoliberal "health sector reforms" that promoted privatisation, user fees and public–private partnerships, several initiatives were taken by the peoples science movements led, influenced or supported by our comrades. Some of them regularly engaged and interacted with like-minded global actors as well, and also all contributed to the gradual establishment of a broader movement for people's health at national and global level in which our comrades actively participate, providing conceptual, and organisational support or leadership at different levels, navigating through the usual frictions and differences of opinions between various actors within a large collective. .

As above, several people's science organisations, mass organisations like AIDWA, medical sector trade unions like the FMRAI and several civil society formations guided or led by members and sympathisers of the Party, became a powerful force within India's health movement. Over the years, the health movement established in the country has become the largest popular platform for people's health in India, and major figures from India are also playing lead roles in the global movement. Our involvement and contributions to the People's movement for health in India has been significant, building it as a diverse and strong national platform uniting various groups and networks including women's organisations, health sector associations and trade unions, intellectual groups, medical and health rights networks, faith-based community-level health care and other organisations, strengthening the calls for health as a fundamental right and for strong public health systems. The overall engagement and progress of this movement is vibrant across most states, with some comrades performing leadership roles.

Over 25 years, the people's movement for health in India has led several key interventions: these included (a) national and state level assemblies for people's health with clearly articulated demands and strategy (b) engagements with National Human Rights Commission to establish Right to Health Care; (c) engagement with the Patent Act amendments to secure safeguards such as Section 3(d) and compulsory licensing, including several legal interventions led to successful price control interventions; and (d) deep engagement with government initiatives like the National Rural Health Mission, ASHA programme design and community-based monitoring, including shaping of critical health policy related commitments. It also engaged in presenting people's manifestos during parliamentary as well as assembly elections, raising demands for pro-people changes in health systems at national and state levels. It has prepared and disseminated a series of public awareness materials on important issues of health and allied themes. State wings of the health movement have organised important initiatives with varying strengths , opposing hospital privatisation, financialisation and profiteering, commercial insurance models and inadequate budgets for public health systems , while also organising grassroots community health monitoring and other public engagement activities. National gatherings of the movement have consolidated work on defending public health systems, gender perspectives in health, equitable access to medicines and combating social exclusion. The recent national level meeting of the movement renewed the call for a justiciable Right to Health, halting privatisation and expanding quality public care, with party-supported organisations and activists playing a central role in mobilisation and convening of state-level preparatory conventions.

In addition to the involvement in movements for people's health, organisations dedicated to work on health sector policy issues, led by our members and

sympathisers, have also been functioning on ground for several years. For example, our comrades in Andhra Pradesh and Telangana has been actively engaged in orienting medical students and to make them providers of peoples friendly and respectful health care. In States like Kerala, our mass organisations are engaged in providing support to patients and their relatives in the hospitals, preparing community level care for the needy populations like the cancer patients or bedridden patients, age old patients and so on. In several other states, organisations involved in diverse social activities also take up health-related issues as part of their broader interventions. From time to time, they organise health awareness campaigns and undertake health service activities among the people. In addition, medical camps, generic medicine shops, and blood donation drives are regularly organised and conducted in almost all states.

Party comrades working on literacy and mass education, and the organisations that they are part of also are engaged deeply on the issues around health awareness. During COVID-19, the party-supported science and social organisations mobilised and provided support to communities, documented denial of Covid care and excessive profiteering in the private hospitals, identified and highlighted service delivery gaps in the public facilities, and demanded equitable access to services and vaccines. Health sector leaders amongst our cadre prepared and issued over forty joint statements on behalf of the people's science movements, and fought misinformation through rigorous public awareness campaigns and educational initiatives.

There are also clinics, nursing homes, and hospitals run by doctors who are Party members, strong sympathisers, or by trusts, societies, charities, or specially constituted organisations promoted by us in states such as Kerala, West Bengal, Andhra Pradesh, and Telangana. We have initiated some health care institutions in the cooperative sector as well, in some of these states. These institutions are rendering commendable service by providing free or affordable and accessible healthcare to the common people.

Party and Mass Organisation Influence in the Health Sector

In several states, we have considerable number of doctors, nurses, allied health workers and public health experts associated with or sympathetic to the Party or Left politics. However, among the younger generation of medical practitioners, Left sympathies have declined significantly due to the careerism and weakening of the political engagement amongst students and lack of space for student movements in medical colleges.

In many states, trade union work exists among public health employees. However, our political influence and engagement on public health concerns among them remain weak, except in the cases of the medical and service

representatives. Among medical representatives, our influence in unionisation, along with public health awareness and actions are relatively strong. Further the leaders of the state level unions and national level federation are contributing to the discourses and actions on the drug price issues, intellectual property issues in the medical sector, rationalisation of prescriptions, profiteering by the companies and so on. In the private health sector, working conditions are very poor, and most employees remain unorganised, wherein our interventions are weaker.

The rapidly expanding pharmaceutical industry employs large numbers of workers, most of whom are concentrated in specific locations. However, hardly any campaigns on health policy issues have been conducted among them, and our trade union presence in this sector remains limited.

Strategic Tasks

The Madurai Congress Political Resolution's paras2.46 and 2.47lay the foundations for the broad task of struggles for the right to health and health care, for reversing the privatization and commercialization of healthcare, and for strengthening democratic publicly financed and run health systems which serve the people especially the poor with equity, social justice, freedom from exploitation and discrimination.

The following priority issues require focused attention of the party comrades, party branches and units, and mass organizations in which the Party works:

Our Demands:

1. **Recognise Health as a Fundamental Right**

Enact legislation to recognise health as a fundamental public right. Strengthen publicly funded and publicly run healthcare systems at all levels, with a substantial increase in well-staffed and well-equipped Sub-Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs). Ensure full staffing, infrastructure and services in all PHCs, supported by decentralized, community-based governance systems. Increase public health expenditure to at least **5% of GDP** by the Union Government.

2. **Oppose Privatization and Commercialization of Healthcare**

Oppose privatization and commercialization of health services. Roll back Public–Private Partnership (PPP) models in healthcare and strictly regulate charges in corporate and private hospitals. Use insurance-based programmes only as a supplementary measure, while prioritizing and strengthening public provisioning of healthcare.

3. **Strengthen Anganwadi, ICDS, Mid-Day Meal and ASHA Schemes**

Strengthen Anganwadi (ICDS), Mid-Day Meal and ASHA schemes. Campaign for adequate recruitment, regularization of employment, fair remuneration and proper training for ASHA workers, Anganwadi workers, ICDS staff and all other health workers.

4. **Revitalize Public Sector Production of Medicines and Vaccines**

Revitalize public sector production of vaccines, essential medicines and intermediates. Enforce compulsory licensing wherever required to ensure self-reliance and equitable access to essential medicines.

5. **Ensure Affordable Medicines for All**

Struggle for lower medicine prices through stronger regulation and price controls. Campaign for universal free-medicine schemes, as implemented successfully in some States.

6. **Strengthen Food Security and Nutrition**

Campaign for a universal Public Distribution System (PDS) that includes pulses and edible oils, highlighting progressive models such as Kerala. Struggle for improved quality and coverage of Mid-Day Meals and ICDS nutrition services.

7. **Oppose Pseudo-Science and Unscientific Health Narratives**

Expose and oppose pseudo-science and irrational “remedies,” the promotion of unscientific health information or practices, and Hindutva-driven narratives on health.

8. **Oppose Privatization of Medical Education**

Struggle against privatization and commercialization of medical education. Oppose centralized NEET-type entrance examinations that undermine equity, social justice and State-level health priorities, while promoting an expensive and exclusionary coaching ecosystem.

9. **Defend Federalism in Health Systems**

Oppose excessive centralization in health systems. Campaign for States’ autonomy in designing and implementing State-specific health systems and programmes, with adequate and timely funding from the Union Government.

10. **Ensure Inclusive Health Care**

Campaign for comprehensive healthcare programmes for certain categories, including persons with disabilities, the elderly, LGBTQ+, those with chronic illnesses, and workers facing occupational health hazards. Demand full integration of mental health services into primary healthcare systems.

11. **Ensure Environmental and Public Health Safeguards**

Campaign for effective provision of clean drinking water meeting strict potable standards; safe sewage and sanitation systems with dignified working conditions and safety protections for sanitation workers; pollution-free clean air meeting appropriate standards; and robust measures to protect people, especially vulnerable groups, from extreme heat and other climate-change-related impacts.

12. Ensure Health and Public Services for Marginalized Communities

Ensure adequate essential public services, including healthcare, in Dalit and Adivasi hamlets and urban slums.

13. Promote Physical Activity and Well-Being

Increase playgrounds and facilities for sports and extracurricular activities in public educational institutions and in economically disadvantaged localities.

14. Ensure Accountability for Occupational and Environmental Health

Make managements legally accountable for occupational diseases and environmental health hazards.

Immediate Tasks to be undertaken:

The above tasks for public mobilisation on health must be supported by building the capabilities of Party workers and Mass Organisation (MO) activists through the following measures:

1. **Strengthen the Party's and Mass Organisations' Intervention on Health**
   Strengthen the Party's and Mass Organisations' political intervention on health by independently taking up health issues, actively participating in broader health platforms, consistently raising health policy matters at State and Central levels, and conducting regular campaigns. This should be combined with engagement in policy debates, public education, collaboration with professional and civil society organisations, and ensuring active participation of all MOs in major health campaigns.

2. **Capacity Building**
   Build the capacity of Party and MO activists through regular training, workshops, and experience-sharing, while developing grassroots strength by forming Village Health Rights Groups and recruiting and training Health Rights Volunteers.

3. **Strengthen Joint programmes and alliances**
   Build joint and coordinated programmes with the health staff on relevant issues, while expanding and strengthening alliances with progressive, left, and democratic networks as well as platforms such as People's Health Movement and to shape and advance commonly level health agenda.

4. **Work among health professionals and sectoral organisations**
   Strengthen Party work among doctors, ASHA workers and their unions, paramedical and other health workers, medical representatives' organisations, and people's science and health movements, and engage them in joint and coordinated campaigns to build the independent strength of the Party and the broader Left and democratic movement in the health sector.

5. **Strengthen levels of health interventions**
   Work in the health sector must be carried out simultaneously at:
   Policy level: Interventions on health policies, budgets, and regulatory frameworks.
   Sectional level: Among workers, labour, women, youth, children, the aged, and other sections, combining agitational work with service-oriented activities.
   Residential/locality level: In neighbourhoods and communities through both agitational and service-based interventions. Special attention must be paid to urban slums, rural Dalit hamlets, tribal areas, and minorities.

6. **Formation of Party-led Health Forums**
   Form dedicated Health Forums/Platforms led by Party followers at the state level wherever such platforms/forums do not exist. These forums should strengthen Party work in the health sector and function as catalysts for mobilising broader social, professional, and democratic forces.

7. **Intervention among students, workers, and industry**
   Formulate strategies for systematic intervention among medical and paramedical students, healthcare personnel in both public and private sectors, and employees and representatives in the pharmaceutical industry.

8. **Local studies and research-based interventions**
   Health forums should regularly conduct local and regional studies on people's health conditions. Present concrete solutions to the public and government and formulate suitable action plans based on these studies.

9. **Health awareness campaigns**
   Organise periodic and regular health awareness programmes among the people through individual MOs, broader formations, and Party health forums.

10. **Agitational and action-oriented programmes**

Carry out action-oriented and agitational programmes on specific health issues and demands at local and area levels. Give special emphasis to Primary Health Centres (PHCs) and concrete local health problems.

11. Service-oriented health initiatives

- Support and help run people's hospitals and clinics. People's trust- or cooperative-based hospitals must work as model institutions that extend human and expert resources for social and public health work.
- Hold regular local medical camps through Party branches, MO local units, and health forums in villages, hamlets, urban slums, and residential localities.
- Provide services such as:
  - Palliative care
  - Generic medicine shops
  - Community health clinics
  - Blood donation groups and networks
  - Assist people during health emergencies.

12. Grassroots health movement building

Form Village Health Rights Groups and recruit and train Health Rights Volunteers. Build the health movement around local struggles for access, dignity, and justice in healthcare.

13. Organise state level meetings of cadre on the lines of the all India Convention.

14. Form a Party coordination committee/platform at the all India level to help the Party to coordinate health related activities.

15. Bring out a digital news bulletin/newsletter to help disseminate developments in the health sector and to exchange experiences of our work in different states.

16. Organise a broad-based state health convention to highlight health related issues.

This comprehensive framework integrates political struggle, organisational strengthening, alliance-building, mass campaigns, service initiatives, and grassroots mobilisation to develop a strong, people-oriented health movement under Party leadership and within a broad Left and democratic front.