EDITORIAL

Draft National Health Policy 2015: getting behind the rhetoric

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The Ministry of Health and Family Welfare recently unveiled a draft "National Health Policy (NHP)" (1), which was available for public comments till March 10, 2015. Arguably the exercise of crafting a national policy on health is an important and necessary step towards universalising access to healthcare. However, past experience would make us somewhat cynical while analysing the process and its outcome. The 2015 policy is to replace the 2002 Health Policy (2), which, in turn, was preceded by the first NHP of independent India, declared in 1983 (3). The fact that it took successive governments 36 years following Independence to develop a national policy on health, in itself speaks of their degree of seriousness, as does the fact that the policy has been revised only once in the intervening 32 years.

Perhaps even more importantly, in the past there has been little synchrony between the health policy and the actual policies pursued on the ground. While our remit here is not to analyse previous policies and match them with their real trajectory on the ground, it is still useful to recount what the 1983 and 2002 policies had promised.

The 1983 policy, drawing upon the Alma Ata declaration of 1978 (and, in fact, borrowing many of its phrases) had declared, *inter alia*, that: "In sum, the contours of the National Health Policy have to be evolved within a fully integrated planning framework which seeks to provide universal, comprehensive primary healthcare services; relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector" (3: pp 3-4)).

The policy had gone on to set various targets to be achieved by 2000. These included promises that all pregnant women would receive antenatal care, all deliveries would be conducted by trained attendants, and the coverage by the DPT vaccine would reach 85%. These targets have not been met even by 2015. Meanwhile, within a decade of the unveiling of the 1983 policy, health expenditure was subjected to savage cuts as part of the neoliberal reforms in the early 1990s.

The 2002 policy had stated: "Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment through public funding in the primary health sector… Therefore the policy while committing additional aggregate financial resources, places strong reliance on the strengthening of the primary health structure, with which to attain improved public health outcomes on an equitable basis" (2: pp 24-25). It further commented: "Broadly speaking, NHP-2002 focuses on the need for enhanced funding and an organisational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities."(2: p 35) In the 14 years since this policy was announced, there has neither been a significant increase in public funding, nor an adequate population-wide expansion in the coverage and quality of primary healthcare services or enhanced equity in access to healthcare services.

It is this obvious gap between the rhetoric in successive health polices and the actual delivery on the promises made which leads us to question the relevance of the new policy. Sadly, the experience has been that planning for the health sector has always been subservient to larger macroeconomic and political goals, and has seldom been anchored in the priorities and requirements of the health sector.

Subsuming health policy under the dynamics of the market

It is still useful, however, to analyse the major features and broad thrust of the draft policy of 2015. This is not an easy exercise, given that the draft itself contains a reasonable and balanced analysis of the state of healthcare services. The reasons behind the poor record of the country's health services and the consequent hardships faced by the people, in the form of financial burden and poor access to necessary services, are generally identified correctly. What is, however, significant is that the proposals to

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remedy the situation is located in a very clear macroeconomic vision, that needs to be read in conjunction with the government's clear neoliberal trajectory in all sectors.

Thus, for example, the draft identifies four major changes since 2002. The first change relates to the need to look beyond maternal and child health and focus on communicable diseases as well as rapidly emerging non-communicable diseases. What is, however, more revealing are the three other "changes" that are identified:

- The emergence of a robust healthcare industry that is growing at a compound annual growth rate of 15%
- The (growing) incidence of catastrophic expenditure due to healthcare costs; and
- An increase in the fiscal capacity available due to economic growth.

While these changes have been identified accurately, what is revealing is that only these have been singled out for mention. Underlying all of them is a running discourse that subsumes polices on healthcare under issues of financing and markets, while the importance of a discourse on the actual content and quality of services is ignored. Thus, it is the growth of the "healthcare industry" and "increased fiscal space" that would presumably guide strategies to address the issue of catastrophic health expenditure. This provides the justification for many of the prescriptions of the NHP, which are described in the following paragraphs.

Provider–payer split and purchasing of services

The overarching premise that informs the NHP's prescriptions is what is known as the "provider–payer split". While the government's role in financing healthcare services is acknowledged, its role as a provider of care services is circumscribed by the description of its being a "strategic purchaser" of services. While the NHP claims that the priority would be to "purchase services from public facilities and not-for-profit private facilities", it also foresees purchasing from for-profit private facilities. The policy deliberately shies away from acknowledging that the government will finance and provide services on the basis of needs and priorities. Instead, by borrowing the term "purchase" from insurance language, its underlying attempt seems to be to continue and expand insurance-based schemes.

Critiques of a model for healthcare provision led by the public sector are quick to point out that universalisation of access to care cannot be achieved unless a significant proportion of private providers and facilities are also harnessed. The issue here is not which interim steps need to be taken – these can include harnessing private providers where necessary, provided that they work within the overall logic and control of a public system. Though it needs to be mentioned that in underserved areas, where the gap in healthcare provision is the worst, the private sector just does not exist and hence, is not an option. The important issue is that of framing a plan that can progressively strengthen public services. The overall prescriptions in the draft regarding insurance schemes that rely largely on private sector provisioning in the case of secondary- and tertiary-level care (hospital care) are designed to do the opposite, i.e. further strengthen the private sector and denude the public sector.

This links with the NHP's stated objective to integrate the public-funded insurance schemes into a single-payer system, thus maintaining the possibility of purchase from private for-profit facilities. Given the past experience of public-funded insurance schemes (Rashtriya Swasthya Bima Yojana [RSBY] and others), in which the bulk of "purchasing" is done from private facilities, it is not unrealistic to apprehend that public money will be used to purchase secondary and tertiary care services from private facilities. This is not in keeping with the NHP draft's generally correct analysis of the different problems associated with the existing insurance schemes. The problems mentioned include "denial of services by private hospitals for many categories of illnesses, and over-supply of some services" and "resort[ed] to various fraudulent measures, including charging informal payments".

Incorrect vision of primary healthcare

The NHP proposes free services for all at the primary level of care. However, it erroneously claims that this is based on the "primary health care" (PHC) model. The vision of PHC, as described in the Alma Ata declaration, includes comprehensive primary healthcare services located in a national health system that integrates care at the primary, secondary and tertiary levels, with appropriate linkages and integrated networks of facilities. The NHP draft, instead, proposes a disjunction, with primary level care being provided by public facilities and secondary and tertiary services being "purchased" from an array of facilities under an insurance scheme. It is not possible to call such a schema a "system" as there are no clear linkages between the different levels of care. The NHP trivialises this vital aspect of a PHC model – which requires health systems to be networked and interlinked with clear backward and forward linkages – by proposing improved transport services to secondary and tertiary healthcare facilities as the solution. At the secondary and tertiary levels of care, the NHP does not commit itself to the provision of free services to all patients. Instead, it proposes free "emergency services".

Benevolence towards the private sector

The NHP appears to characterise the rapid growth of the private sector as a positive trend, when it says: "The second important change in context is the emergence of a robust healthcare industry growing at 15% compound annual growth rate (CAGR)." This, taken together with the claim that the growth of the private medical sector cannot be explained solely by deficiencies in the public system, illustrates a clearly benevolent outlook towards the private sector. No indication or evidence is provided of the other reasons behind the rapid expansion of the private sector, which would imply that the growth of the private sector is a natural process. This is not borne out by global evidence. It must be noted that the existence of a strong and growing private sector has an adverse impact on the public sector since it draws away human and financial resources. The draft policy identifies the number of concessions and benefits to be granted to the private sector by the government, but does not mention any concrete ideas pertaining to the private sector's obligations towards the promotion of health. The regulation of the private sector is mentioned in several places, but vague generalities are used to deal with the subject. The draft policy fails to spell out concrete measures for regulation, or even the proper implementation of the Clinical Establishments Act.

No concrete commitment to increasing financial support

The NHP correctly points out that in the case of public services, "Much of the increase in service delivery was related to select reproductive and child health services and to the national disease control programmes, and not to the wider range of healthcare services that were needed." It further states: "The budget received and the expenditure thereunder was only about 40% of what was envisaged for a full re-vitalization in the NRHM Framework." Both statements would imply that there is a need to increase financial support for the health sector by at least to 3–5 times the present levels – if comprehensive quality care is to be made available to the entire population. Further, the NHP proposes various new measures that would require additional resources, including the provision of free medicines and diagnostics in public facilities, enhanced staffing, new infrastructure and the establishment of new medical colleges. Yet, the NHP refuses to commit to a concrete roadmap for greater allocation. It states: "It would be ambitious if India could aspire to a public health expenditure of 4% of the GDP, but most expert groups have estimated 2.5% as being more realistic." It goes on to argue: "At current prices, a target of 2.5% of GDP translates to Rs 3800 per capita, representing an almost four-fold increase in five years. Thus a longer time frame may be appropriate to even reach this modest target." In other words, the NHP refuses to commit to a target of even 2.5% of the GDP as public expenditure at the end of five years from now. In the absence of such a commitment, it is inconceivable that the plans proposed in the NHP have any possibility of materialising.

Access to medicines: moving two steps back

The NHP claims that the prices of drugs are being monitored effectively, but glosses over the fact that the National Pharmaceuticals Pricing Policy of 2012 legitimised the inordinately high prices of many drugs by switching over from a "cost-based" formulation of ceiling prices on essential drugs to a "market-based" formula for fixing prices (4). The NHP speaks in two voices about the availability of free drugs in public facilities. The initial part of the draft policy refers to a commitment to make free drugs and diagnostics available in private facilities. However, the latter part circumscribes this claim by the following proposal: "The drugs and diagnostics available free would include all that is needed for comprehensive primary care, including all chronic illnesses, in the assured set of services. At the tertiary care level, too, at least for in-patients and out-patients in geriatric and chronic care segments, most drugs and diagnostics should be free or subsidised with fair price selling mechanisms for most and some co-payments for the well-to-do."(1: p 46) Clearly, the NHP is reluctant to commit to a system in which all drugs and diagnostics that are essential and life-saving would be available free in public facilities. This is, in fact, represents a regression from the system already followed in states such as Tamil Nadu and Rajasthan, as well as what was promised in the 2002 NHP.

Legislation on right to health

The reference to a "National Right to Health (RTH) Act" in the draft NHP has generally been welcomed by policy advocates and activists alike. The NHP says: "The Centre shall enact, after due discussion and on the request of three or more states (..), a National Health Rights Act, which will ensure health as a fundamental right, whose denial will be justiciable. States would voluntarily opt to adopt this by a resolution of their legislative assembly. .."

In the absence of an actual draft, it is not possible to concretely comment on the extent to which such an Act would advance public health goals. However, a perusal of the NHP draft itself provides some indicators. The proposal to enact an RTH legislation is prefaced by several questions. These include: (i) whether the level of economic development and that of the development of the health systems allows us to make denial an offence; (ii) whether a central law is feasible, given that health is a state subject; and (iii) whether such a law should focus mainly on the enforcement of public health standards on water, sanitation, food safety, air pollution, etc., or on access to healthcare and the quality of healthcare. Clearly, the attempt is to circumscribe the discussions on the Act by questioning its feasibility, given the economic constraints and those of the health system, and by proposing that such an Act might pertain merely to adherence to certain (yet unstated) standards in certain areas (water, sanitation, food safety,

etc). It is important to note that the latter course of action would pertain only to standards and not to entitlement to services. The ambition of the proposed Act is weak to begin with. It may be contrasted with the bold vision of the Universal Declaration of Human Rights, which affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services"(5), or with the International Covenant on Economic, Social and Cultural Rights, which recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".(6)

Further, the mere enactment of a piece of legislation does not translate into real benefits in the absence of a system that can help to enforce the rights enshrined in the legislation. For example, the Brazilian Constitution recognised health as a human right in 1988 and made its provision the duty of the state. Yet, not much progress was made in the actual realisation of the benefits in the ensuing decades as the conservative government in power at the time was reluctant to frame the polices and pledge the resources that were necessary. It was only when a more progressive government was elected to office that concerted attempts were made to match the language of the constitutional guarantee with real action. Closer home, the Right to Education Act has been widely perceived of as a failure. This failure is due to the contradiction between a relatively progressive legislation and a neoliberal government that actively promotes cuts on social sector spending. The NHP provides indications that the government is reluctant to commit itself to significantly enhancing the allocation to healthcare. The model of healthcare it proposes is based on the premise of "strategic purchasing", which signals a retreat of the state from the provision of healthcare services. In such a milieu, even a progressive Right to Health Act might turn out to be mere empty rhetoric.

However, the actual mention of intent regarding a Right to Health Act in the NHP is a welcome step and can pave the way for larger debates on the progressive realisation of this right.

Challenges before the health movement

The NHP needs to be read along with a range of measures initiated by the government in the social sector. The recent budget has seen wide-ranging cuts in social sector spending, including a cut of almost 20% in the health budget. The various pronouncements on a new model of "'Health Assurance" indicate the same overall vision that emerges from a close reading of the NHP – a very basic package of services for primary care and outsourcing of hospital services to the private sector. The prescriptions of the NHP need to be seen in the overall policy framework of the aggressive promotion of neoliberalism, evidence of which may also be found in the government's pursuance of policies that curb the rights of labour and of farmers through the legislation on land acquisition. Clearly, the health movement and other popular movements have their work cut out if they are to turn the tide towards a vision of development that promotes equity and justice.

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