

## EDITORIALS

### *National Health Policy 2017: a cautious welcome*

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On March 15, 2017 the union cabinet approved the new National Health Policy. The next day a 28-page policy text (1) and an accompanying 13-page situational analysis (2) were placed in Parliament and in the public domain. To have, at all times, a health policy in place that shows a road map on how a nation would show “progressive realization” of health as a basic human right is an obligation under the International Covenant on Economic, Social and Cultural Rights. This is an international treaty adopted in 1976, to which India became a signatory in 1979, and this was one of the catalysts for the adoption of the first National Health Policy in 1983 (3). The immediate political backdrop to the articulation of a *National Health Policy 2017 (NHP 2017)*, replacing the 2002 policy, is that a new health policy and a national health assurance plan were both part of the BJP’s electoral manifesto. It has taken close to 34 months after the government took office, and some 26 months after the draft was circulated for public discussion, to finally approve the policy. This is reflective of the considerable contestation and contradictory pressures, often almost evenly matched, that went into finalising this policy.

There is much that is positive in the 2017 policy. The articulation of goals, key policy principles and objectives is in tune with India’s commitment towards Universal Health Coverage (UHC). The suggested architecture for achieving UHC (as articulated in para 3.3) is “Free primary care provision by the public sector, supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and from non-government sector to fill critical gaps would be the main strategy of assuring healthcare services.” It further clarifies that this “strategic purchase” is a short term measure; in the long term, even in secondary and tertiary care, the public sector would predominate. When it comes to strategic purchase it repeatedly sets out the order to be followed: “public sector hospitals followed by not-for-profit private sector and then commercial private sector in underserved areas” (1:para 3.3). The policy also calls for retaining a certain excess capacity in the public sector to meet the needs of health security and in times of crisis.

The document describes seven key policy shifts that it sees as mandatory for organising healthcare services to meet the needs of universal health coverage. The first and the third of these shifts directly reverse two important prescriptions of the structural adjustment-driven health sector reforms of the 1990s -- the introduction of selective primary healthcare, and of user fees for cost recovery. *NHP 2017*, in contrast, assures a policy shift “In primary care -- from selective care to assured comprehensive care with linkages to referral hospitals” and “In public hospitals – from user fees & cost recovery to assured free drugs, diagnostic and emergency services to all” (1: para 3.3).

There are other ideas in this policy that have considerable potential for change if implemented imaginatively. One such idea is the articulation of inter-sectoral preventive and promotive action packaged into seven priority areas adding up to a social movement of health - what it calls the *Swasth Nagrik Abhiyan* or Health in All.

Another fresh articulation in *NHP 2017* is of “health and wellness centers”- a term used to denote transforming the current sub-centre and PHC from its current and very limited package of services to a much larger coverage of non-communicable diseases. There is available in the form of a Ministry document published in 2015 an elaboration of this concept (4), which clearly recognises the importance of and the barriers to achieving such a transformation of primary healthcare. The mention of this commitment to upgrade primary healthcare facilities into 1.5 lakh “health and wellness centers” in the finance minister’s budget speech, a month before the policy was announced, also provides grounds for optimism.

Also, the policy needs to be hailed for a large number of policy formulations related to national programmes for noncommunicable diseases and mental illness(1: paras 4.6,4.7), retention of doctors and specialists in remote areas in public

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services (1: para 11.3), creation of a multi-disciplinary public health management cadre (1: para 11.8), access, pricing, regulation and manufacture of technologies (1: paras 14.3 to 21); the crisp definition of the scope and needs of health technology assessment (1: para 22) and several new ideas and institutions proposed under research and development (1: paras 24 and 25). There are many in a democratic society who would have hoped for more. For example, a firm commitment to make use of the provisions of the Doha Declaration would have been welcome. The Doha Declaration is meant to ensure affordable access of nations to essential medicines even if they are on patent through compulsory licensing and other such remedies. Implementation of this declaration is now included as Target 11 under Goal 3 of the Sustainable Development Goals. But given the overall economic policies of the government, this would be all that could be reasonably expected. Even if a part of all these commitments were to be implemented, there would be much to celebrate.

However, celebration could be premature. There are many grounds for caution. Thus, though the use of numerical targets in three categories-- in terms of health status, health sector performance and health systems strengthening -- is a welcome step forward in systems level thinking, many of these targets have been set very low or pushed back, both in comparison to equally placed South Asian nations, and in comparison to our own previous targets. For example, an achievement of life expectancy of 70 or a total fertility rate (TFR) of 2.1 by 2025 could be anticipated with extrapolation of existing trends-- even without further efforts. A public health expenditure target of 2.5% of GDP was to have been achieved by 2018 in the 2015 draft (5), but has now been shifted back to 2025. Such a low expansion of investment is unlikely to match the funds needed to meet commitments like health and wellness centres, or free drugs and diagnostics in all public hospitals.

There are also major silences or inadequacies that are worrying since many key objectives are unattainable without the necessary policy corollaries. In urban health while the categories of urban vulnerability have been listed, the commitment to undertake affirmative action going beyond free care, that is required to meet these needs, has gone missing. In malnutrition the policy limits itself to micronutrients, perhaps on the grounds that the ministry's remit is limited -- but it should be clear that without addressing India's malnutrition burden the achievement of targets on child mortality are seriously compromised.

But the three under-stated policy corollaries that are major areas of concern relate to human resource adequacy, private sector regulation and governance. The "health and wellness centers" which form the core primary healthcare strategy cannot be operationalised without substantial investment in a regular, well-trained and motivated public provider workforce. Mere optimal use of existing human resources, while necessary, is a very far cry from being adequate. A very wishful, fanciful call for private sector volunteering pro-bono to close this gap (1: para 2.3.1 A), or a partnership with the private sector where a fee would be charged for the middle class to join in (1: 13.6.3 pg 20), are based neither on evidence nor on experience, and are completely contradictory to the meaning and scope of strategic purchasing in the rest of the text. The reluctance to invest in a well-managed public workforce is one vestige of the structural adjustment years that has not been overturned by this policy draft.

Secondly any large-scale private sector involvement requires a major effort at reform of the professional councils and regulation of clinical establishments. But when it comes to regulation of the private sector, all that *NHP 2017* has to offer is a weak call for "advocacy with the other states ... for adoption of the Act", and this some seven years after the Act was passed. The Clinical Establishments Act requires each state to independently pass a resolution in their state assemblies adopting the Act- or else adopt a state level act for this purpose. Very few states have done so. When the accompanying situational analysis report itself indicates that existing purchasing of secondary healthcare has been seriously compromised by unethical practices and inappropriate care (2: para 2.12), adoption of the Clinical Establishments Act should have been projected as a necessary corollary to the expansion of purchasing. What is equally worrying is a new section (1: para 13), where strategic purchasing has (implicitly) a different purpose from that articulated earlier. This paragraph proposes an across-the-board engagement with the commercial private sector and seems more concerned about identifying and enhancing business opportunities for the commercial private sector and in routing part of public expenditure on healthcare through it. The meaning of strategic purchase in this section shifts from securing health outcomes to providing an economic stimulus to the healthcare industry. And this despite the clear statement in the situational analysis (2: para 2.13) of the multiple ways in which the government is already contributing to the booming profit-hungry private healthcare industry.

Similarly, while the assertions for restoring trust in public health systems, re-orienting public hospitals and providing free care in public hospitals are most welcome, the weak articulation on governance and accountability is worrying (1: para 26.1 to 26.3). Community monitoring and involvement of local bodies, though welcome measures, are inadequate with respect to the main sources of mis-governance. The 2015 draft had identified four main pathways of corruption in public health systems – weak procurement and logistic systems, transfers and postings, appointment of the chief district health officer and the selection of partners for partnership. There are well known best practices from amongst the states which show how each of these pathways could be effectively blocked. Unfortunately, that formulation (5: para 11.5) did not survive--and an opportunity was lost. One is thankful that one particular solution to the problems of governance did not succeed: viz: the creation of an over-arching body called a National Health Authority which would combine in itself the roles of setting standards, regulation and

purchasing care, possibly abridging the roles of states and central ministries, with little accountability of its own, and quite open to professional or corporate capture. But there is a need for creating many new institutions as correctly identified in this policy (eg National Healthcare Standards Organization (1: para 10), National Digital Health Authority (1: para23, also see paras 14.1, 14.5, 22, 25.1), and there is a need to strengthen the functioning of many existing ones. A policy statement on how institutional governance and coordination would be achieved would have been desirable. The earlier draft had called for specifying clear institutional governance policies and minimum standards of governance that would apply to all these institutions. That was dropped, perhaps for lack of clarity, but it is a direction worth pursuing.

Finally, one area of silence is the role and remit of the states as compared to the centre – not only in financing, but also in areas like setting standards, strategic purchasing and in the human resources strategies. Clearly a leave-it-to-the-states approach will not work, but nor will a single centralised set of standards or guidelines. At a time when taxation reforms reduce the fiscal space of states, specifying the share of public health expenditure that the centre would undertake was essential. Space for states to modify centrally set standards and guidelines but within specified timelines, and within frameworks defined on the basis of non-negotiable principles, was a desirable policy corollary.

What next? What the nation has now is a document with considerable strengths and clarity on many key issues and with some ideas that have great potential. But it is also a document with certain critical gaps that make one worry about the seriousness and ability of the government to implement this.

A policy does not necessarily translate into action on the ground. Between the policy and its implementation there occurs a process of selective amplification and attenuation of recommendations. Such amplification and attenuation is a combined result of the political environment, the influence of key stakeholders, the feasibility of different recommendations and the technical and administrative competence involved in implementation. The whole contestation over policy directions with respect to the terms and extent of private sector involvement has helped identify the key players and their positions. And though the corporate hand is strong, and its needs and thinking well supported by Niti Aayog and international aid agencies (a space now almost exclusively occupied by the Gates Foundation, with some support from USAID and the Bank), it is not a walkover for any side. For the community of health policy activists in civil society and in academics, as well as for the Ministry of Health, which by definition owns and is accountable for implementation of the policy in its final shape, the work is cut out. The challenge would be first to ensure that the government puts its money where its mouth is. We do not have enough indication of this happening. Budgets have been stagnant under the present government. Just two days after the policy was announced, *The Hindu* reported that major public hospitals are required to raise 30% of the funds required to meet the Seventh Pay Commission recommendations (6). This would mean that hospitals like JIPMER, which provides free high quality, comprehensive, tertiary care, and institutions like AIIMS which charge modest user fees, would have to raise the funds needed from their service users. But these are early days and one remains hopeful.

An equally important challenge is to make use of the budget as allocated to demonstrate and build the evidence required to support the strengths and big ideas of this health policy. Instead of expending time on producing another document called an implementation framework (as proposed in the policy document), it would be more useful to set up multi-stakeholder working groups or task forces for the many different policy proposals with their secretariats located in the concerned divisions of the ministry, so that implementation is fast-forwarded.

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