India's new National Health Policy sets a very low bar for better public health

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The policy recently adopted by the cabinet has weak targets and hands too much over to the private sector.

An Indian staff nurse prepares beds inside an isolation and intensive care unit at The Government Chest Hospital in Hyderabad. | Noah Seelam / AFP

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Last week, the Union Cabinet approved the National Health Policy, finally adopting a plan that has been in the drafting stage for more than a year and a half. The new policy will replace the 2002 Health Policy, which was preceded by the first National Health Policy of independent India in 1983.

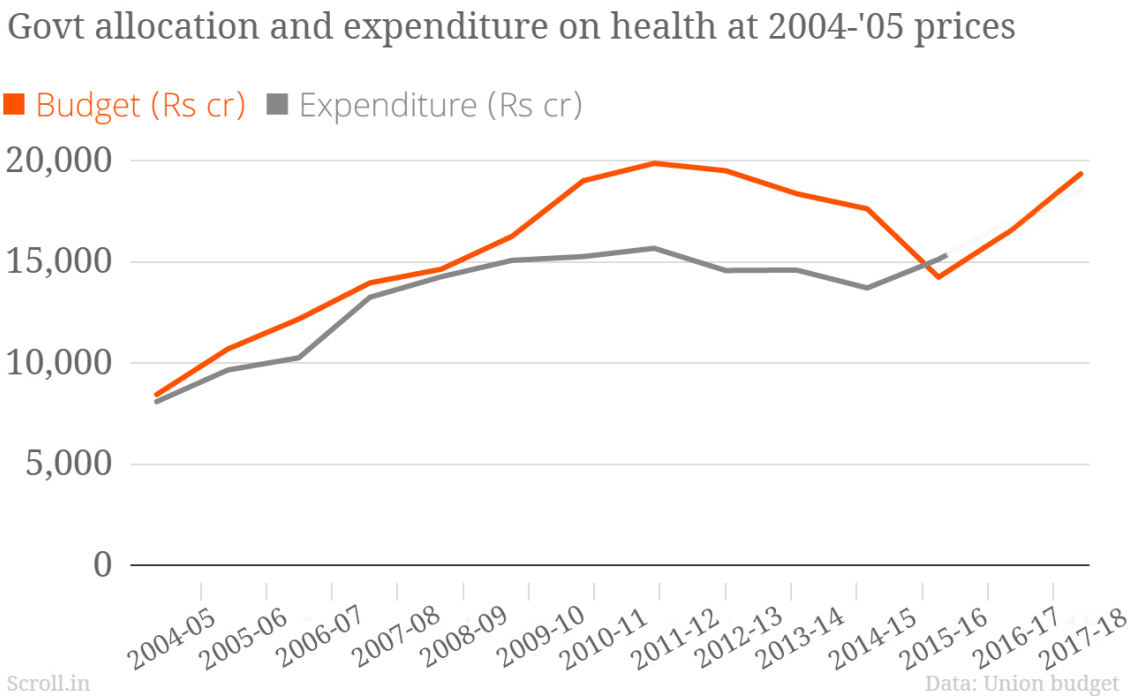
Neither the 2002 policy nor the 1983 policy have been very effective in achieving what they set out to do. Many targets set in the 1983 policy have not been met even till date. For example, the 1983 policy projected that all births would be attended by trained attendants by the year 2000. One in four births were still not supervised by a trained attendant in 2015.

The 2002 policy had stated: “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.” In the 15 years since, public funding as a percentage of GDP has languished at 1.1%, compared to a global average of 4.9%. Furthermore, healthcare access continues to elude the poor. The 2017 policy admits that “growing incidences of catastrophic expenditure due to health care costs” are estimated to be “one of the major contributors to poverty”.

We can choose to believe that the new policy will actually galvanise change. What we must then examine are the quantum of change proposed in the targets set out, what concrete mechanisms for change have been proposed, and if there is evidence that these will lead to better public health outcomes. We must also ask whether proposals in the policy are in sync with policies in the health sector in the past three years since the NDA government came to power.

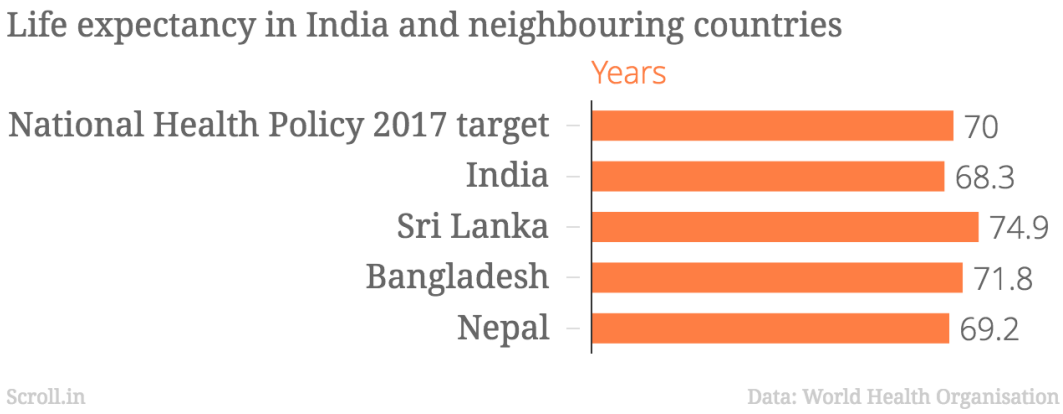
The National Health Policy 2017 has actually rolled back promises in two significant areas. The policy proposes that the government undertake an increase in health expenditure as a percentage of GDP from the existing 1.15% to 2.5 % by 2025. The draft policy released in 2015 had promised that this will be achieved by 2020. In other words, in 18 months, the government has already doubled the number of years it forecasts will be necessary to increase public spending on health to 2.5% of GDP. Even if this is achieved, it will be half of what the World Health Organisation recommends as optimum public spending on health.

If we now contrast this with public spending by the central government in the last three years, there is a clear gap between claims and rhetoric on health. The Union Budget of 2015-’16 effected a 5.7% cut in total allocation to the health sector. The 2016-’17 budget allowed a marginal rise of just 5% when adjusted for inflation and there was a similar marginal increase in the 2017-’18 budget. In fact, the sum allocated in the 2017-’18 budget is less than the 2011-’12 allocation when adjusted for inflation.



The National Health Policy 2017 has also retreated from tentative claims that the government had started making that healthcare would be made a justiciable right. The policy now says: “The policy therefore advocates a progressively incremental assurance based approach, with assured funding to create an enabling environment for realising healthcare as a right in the future”.

The policy also falls short on ambition with other targets. The document says that the target that life expectancy at birth should be 70 years will be achieved in 2025. This future target is less than what both Sri Lanka and Bangladesh have already achieved.



The policy has set targets that mortality for children below the age of five should be brought down to 23 deaths per 1,000 live births and that neonatal mortality should be brought down to 16 deaths per 1,000 live births, both to be achieved by 2025. These rates would still be more than twice of what Sri Lanka has already achieved – 9.8 for mortality of children under five years and 5.4 for neonatal mortality. Clearly, the National Health Policy’s targets are a decade or more behind what our South Asian neighbours have already achieved.

Market mechanisms

How does the National Health Policy propose to organise healthcare services? The answer lies in the oft-repeated term in the document: “health assurance”. The government’s role as provider of healthcare services is repeatedly qualified by emphasising its role as a “strategic purchaser” of services.

"The health policy recognizes that there are many critical gaps in public health services which would be filled by 'strategic purchasing'. Such strategic purchasing would play a stewardship role in directing private investment towards those areas and those services for which currently there are no providers or few providers."

— National Health Policy 2017

While the policy 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.

Critiques of a public sector-led model to provide healthcare point out that private providers need to be harnessed and given dominant roles if healthcare needs to be universalised in India. But private facilities barely exist in underserved areas where the gap in healthcare services is the worst.

This raises the more important question of whether there is a plan to progressively strengthen public services. The overall prescriptions in the policy regarding insurance schemes that rely largely on private sector provisioning in cases of secondary and tertiary level care are designed to further strengthen the private sector and denude the public sector.

The policy also states its objective to integrate public-funded insurance schemes into a single payer system, thus maintaining the possibility of buying medical services from private for-profit facilities. The working of public-funded insurance schemes like the Rashtriya Swasthya Bima Yojna has shown how public money goes largely towards secondary and tertiary care services from private for-profit providers.

Significantly, the 2017 health policy has scrubbed text in the draft that referred to the unethical role of private providers.

"The experience is that insurance mechanisms are unable to act against the denial of services, supply driven irrational care, unethical practices, and charging patients for what should be cashless services. It is clear that without a regulatory structure in place, it would be difficult to ensure that public private partnerships or insurance based purchasing would deliver on either health outcomes or financial protection."

— Draft National Health Policy 2015

Till now, the discourse on outsourcing care to the private sector was confined to secondary and tertiary services or hospital-based care.

"For achieving the objective of having fully functional primary healthcare facilities – especially in urban areas to reach underserved populations and on a fee basis for middle class populations, Government would collaborate with the private sector for operationalizing such health and wellness centres to provide a larger package of comprehensive primary health care across the country. Partnerships that address specific gaps in public services: These would inter alia include diagnostics services, ambulance services, safe blood services, rehabilitative services, palliative services, mental health care, telemedicine services, managing of rare and orphan diseases."

— National Health Policy 2017

This is what is being attempted even in the face of public protests in several states such as Rajasthan, Madhya Pradesh, Chhattisgarh and Uttar Pradesh. The 2017 policy thus puts its stamp of approval on opening up primary healthcare services to the private sector as an additional avenue for them to make profits.

The benevolence shown to the private sector extends to medical education in 2017 policy.

"Keeping in view, the rapid expansion of medical colleges in public and private sector there is an urgent need to review existing institutional mechanisms to regulate and ensure quality of training and education being imparted."

— National Health Policy 2017

What has been proposed here is not a policy that treats public and private medical colleges differentially but a "regulatory structure" for both to ensure quality. The ability of the government to regulate the

functioning of private medical colleges has repeatedly shown to be suspect, and by the government's own admission earlier has turned even the Medical Council of India into a corrupt and toothless body.

Thus, the government's pledge of "health assurance" seems to be restricted to a basic package of services at the primary level to be delivered by public services targeted at the poor. Other primary care activities will be outsourced to private providers who will be paid for, at least partially, by taxpayers. There will continue to be poorly functioning and under-resourced public facilities at the secondary and tertiary levels and increasing insurance-based provision of care mainly outsourced to private facilities. The package of services that are to be thus assured through the insurance-based system will be circumscribed by gross overall under spending on healthcare.

The 2017 policy, contrary to claims about it made in Parliament, is part of the same vision that reduces the government's investment in welfare and opens up public services to private actors.