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National Health Policy 2017: Assurance for Whom?

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THE government has finally approved the National Health Policy-2017, bringing to an end a two year long process. A draft of the policy was available since mid-2015 but it is believed that the government, at the Niti Ayog's behest had been unhappy with some specific parts of the earlier draft that was critical of the private sector.

Experience with past National Health Policy documents (we have had two in the past – one in 1983 and one in 2002) have not been particularly positive. In the past the policy has seldom been actually followed up by concrete actions on the ground to redeem promises made in these documents. It is however important to examine the new policy not necessarily because the targets set are likely to be met, but to understand how the current government is planning to roll out its priorities regarding healthcare services. It may be mentioned here that while the policy primarily focuses on proposed actions on healthcare delivery, a majority of health outcomes are not a function merely of available healthcare services but are fashioned by a wide range of social, economic, and environmental determinants. Thus food security, employment, education, housing, water and sanitation, gender relations, etc all have a bearing on health outcomes. Clearly the realisation of the targets set in the policy, such as lowering of child and maternal mortality rates, increase in life expectance, etc depend crucially on attending to these determinants. Given that this government has been particularly aggressive in pushing a neoliberal agenda that has made savage cuts in welfare and entitlements is a cause for pessimism that the targets will be met.

PROPAGANDA OR REAL INTENT FOR CHANGE?

Past experience shows that targets are set in the National Health Policy as merely propaganda points allowing the government to declare its good intentions. Without follow up actions such tall claims are bound to flounder. The NHP 1983 and again the NHP-2002 (the latter adopted during the term of the previous NDA government) had promised significant expansion in public financing for health – to reach 2-2.5 percent of GDP. Yet in this entire period public expenditure on healthcare has languished at around 1 percent of GDP. The 1983 policy promised that all births would be attended by trained attendants, yet even in 2015 over one-fourth of births were not attended by trained health workers or doctors. There are myriad such examples if one were to list the gap between past promises and actual achievement.

Even the targets that have been set in NHP-2017 reflect the poor state of public health in India, poor even in comparison with our immediate South Asian neighbours. NHP-2017 sets a target of 70 years life expectance (that is at birth all Indians will have an average chance of reaching 70 years of age) to be achieved by 2025. This target is something that Nepal had already achieved in 2016 and five years less than what Sri Lanka has achieved. The target of reducing child mortality rate (that is the number of child deaths for a 1,000 live births) has been set as 23 per 1000 live births, to be achieved by 2025. The target is more than twice of what Sri Lanka has already achieved (9.8). Let alone aspiring to be among the best in the world, the NHP's targets are a decade or more behind what our South Asian neighbours have already achieved. Yet the spin doctors of the current government continue to declaim in parliament and outside about the bold and visionary targets of NHP-2017.

The abiding characteristic of India's health policy over the past decades has been the persistence of extremely low investment for health. Currently at 1.1 percent of GDP, India's health expenditure is among the lowest ten in the world. This has been the primary cause of very high private expenditures to access healthcare services that is borne by patients. In fact NHP-2017 admits that: "*growing incidences of catastrophic expenditure due to health care costs, which are presently estimated to be one of the major contributors to poverty*". So, as if by rote, the new policy once again repeats that public expenditure on health would increase to 2.5 percent of GDP by 2025. This itself is an extremely modest target, half of the global average (4.9 percent of GDP) and half of the five percent of GDP public expenditure on healthcare that the World Health Organisation suggests. The promise of 2.5 percent of GDP by 2025 is a step back from the draft policy of 2015 which had a target of achieving 2.5 percent of GDP by 2020. The more important point perhaps is that given the past record of the current government, there seems little cause for hope that even this modest target will be achieved. The last three union budgets of the BJP government have either slashed allocation to healthcare or have provided for a very marginal increase. In fact, in real terms after controlling for inflation, central budget allocation currently is less than the level achieved in 2011-12.

The NHP-2017 also glosses over the fact that over two-thirds of expenditure on health are made by states and states face a squeeze on funds because of neoliberal macroeconomic pressures – essentially low collection of revenues by taxing the rich. In fact right after the announcement of NHP-2017, the parliamentary standing committee on health, in its report, has lamented that states are finding it difficult to raise allocations to health and some states have actually reduced allocation.

The aggregate effect of low public finances is a public sector in healthcare that is starved of resources – financial, technical and human. In spite of some modest gains made through the National Rural Health Mission (NRHM) public facilities in most parts of the country fall far short of need. In spite of repeated claims, public facilities in most parts of the country do not provide free access to medicines and diagnostics. There is a huge deficit of human resources and this rises to over 80 percent in the case of specialists.

After having deliberately starved public facilities of necessary resources, the NHP-2017 comes up with a strategy that is designed to further strangulate public services. NHP-2017 claims that it is going to promote 'health assurance' by what it calls 'strategic purchasing' from privately run facilities. While the NHP does keep harping on the need to strengthen public facilities, the promises are continuously tempered by the need for 'strategic purchasing'. Neoliberal jargon is replete with innovative use of phrases that mean something totally different from what they appear to infer at first glance. So it is with 'strategic purchasing'. In effect strategic purchasing is another name for outsourcing of care facilities to the private sector. It is an abandonment of the government's responsibility to provide healthcare services. This is the principal policy thrust of the NHP-2017. As we shall see later the policy now extends the concept of 'purchasing' not just for hospital based care but also for primary level services.

MARKET MECHANISMS FOR 'HEALTH ASSURANCE'

Let us then look at what NHP-2017 tells us about how it proposes to organise healthcare services and how these proposals square up with evidence we have? The NHP says: "*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".* 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 "as the last preference". However, past evidence with the public funded insurance schemes shows that when the concept of 'purchasing' is legitimised, majority of outsourcing is done to private for-profit facilities.

Critiques of a public sector led model for health care provision point out that universalisation of access to care needs harnessing of private providers and facilities in India given its dominance in healthcare provision. What is not said is that the demise of public facilities has been brought about through deliberate neglect and now its incapacity is being used as an exercise of opening up healthcare for

extraction of profits by private enterprises. This is an explicitly neoliberal project that should be understood.

Further, in underserved areas, where the gap regarding provision is the worst, the private sector just does not exist and is hence not an option. Minus general platitudes there is very little in the NHP that concretely proposes to progressively strengthen public services. Instead, 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 reverse by further strengthening the private sector and denuding 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 (RSBY and others), where the bulk of 'purchasing' is done from private facilities, it is not far-fetched to apprehend that public money will largely be used to purchase secondary and tertiary care services from private for-profit providers. Significantly NHP-2017 has scrubbed the text of the reference in the draft NHP of the unethical role of private providers, where the 2015 draft of the NHP had noted: "However 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".

Hitherto the discourse on outsourcing care to the private sector was confined to secondary and tertiary services, ie, basically hospital based care. NHP 2017 now goes beyond this to propose: "For achieving the objective of having fully functional primary healthcare facilities – especially in urban areas to reach under-serviced populations and on a fee basis for middle class populations, government would collaborate with the private sector for operationalising such health and wellness centres to provide a larger package of comprehensive primary health care across the country". This is what is being attempted (in the face of public protests) in several states such as Rajasthan, MP, Chhattisgarh and UP. NHP 2017 thus puts its stamp of approval on opening up of primary care services to the private sector as additional avenue for profit making.

The benevolence shown to the private sector extends to medical education in NHP-2017. The policy says: "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". What is proposed 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 elsewhere has turned even the Medical Council of India into a corrupt and toothless body.

OVERALL CONTEXT OF ECONOMIC LIBERALISATION

It wouldn't be too far-fetched to guess that perhaps it took eighteen months for this policy to be adopted because the earlier draft needed to be scrubbed of all references that did not refer to the private sector in glowing terms. Further, the only section in NHP-2017 which has been elaborated extensively is the one that charts out the possible collaborations with NGOs and private providers. In contrast NHP-2017 has deleted large sections on food security, social determinants, research capacity building, public sector strengthening, etc, which were contained in draft NHP-2015

The picture of what 'health assurance' really means is clear. It is assurance of profit to private providers whose representatives have been centrally involved in finalising the NHP-2017. To summarise it means a basic package of services at the primary level to be delivered by public services targeted at the poor; outsourcing of other primary care activities to private providers that will be paid for (at least partially) by people; 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.

Thus NHP-2017, contrary to claims about it made in parliament and outside, is in sync with a range of measures initiated by the government in the social sectors. Successive union budgets have seen wide ranging cuts in social sector spending. The vision of 'Health Assurance' in NHP 2017 is part of the same vision that reduces the government's investment in welfare and opens up public services to private actors. It is an explicitly neoliberal vision that needs to be opposed.