# National Health Policy 2015
## Mapping the Gaps

Forum for Medical Ethics Society

The draft National Health Policy 2015 is an improvement over its predecessors—the policies of 1984 and 2002. However, it also reveals several gaps, inconsistencies and blind spots which tend to dilute otherwise constructive proposals. The purpose of this article is to open up the draft to further public debate and comment.

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Forum for Medical Ethics Society (*fmesmumbai@gmail.com*) is a voluntary, non-profit organisation registered in Mumbai. The society was formed in 1989 out of an effort by a group of concerned doctors to focus attention on the need for ethical norms and practices in healthcare in India. The body has grown over the decades to include several non-medical members as well. It is also the owner–publisher of the *Indian Journal of Medical Ethics*.

The draft National Health Policy (NHP) 2015 admits that while India's population growth rate has significantly dropped (Section 2.2) and the gross domestic product (GDP) has grown (Section 1.1), the country's health equity has not merely stayed the same but moved in the reverse direction (Section 2.3). The document stresses the "two way linkage between economic growth and health status" (Section 1.2) but this linkage has evidently not just failed to work in the Indian context, it has actually boomeranged. It is important to examine if the document offers insights about addressing this issue. Is it equipped to make amends before it is too late?

The objective of this article is to map some of the blind spots and the contradictions and gaps in the NHP 2015 in order to keep the debate on it alive.

### Diluting the Positive Shifts

**Urban Poor Health**: The draft distinctly focuses on urban (poor) health and underlines the need to step up the pace of the National Urban Health Mission (NUHM). The volume of the population of the urban poor has been growing exponentially especially in the metropolitan and high-end cities. It has also been shown that this voluminous population often ends up suffering the worst of both the rural and the urban settings. The document mentions that "A technical resource group has examined the urban health situation at length and suggested measures needed to address the most vulnerable and marginalised sections of the urban poor and the way forward in convergence." Yet, it remains strangely silent on what the "suggested measures" are, accounting for one of its several blind spots, and diluting the seriousness of the concern to engage with urban health.

**ASHAs:** The imperative to develop a cadre of urban accredited social health activists (ASHA) seems to be a proactive step. In fact, there is a significant stress on the role of ASHAs and the duties they have been discharging, but the blind spot lies in the document not revealing any indication of having taken into cognisance the volume of criticism (made by several health rights groups) pertaining to the way they have been exploited and under-recognised in terms of payment, access to facilities, etc. ASHAs have credibly established themselves as "activists" in only rare circumstances. Certification of skills is essential, but not a substitute for compensation and social security. It is almost criminal to keep thinking of female labour as "voluntary" while increasingly investing more responsibility onto this segment of the health system. We could take our cue from how Iran has scaled up and supported the *behvarz* (Iran's community health activists) by creating posts and institutional structures for their activities. Greater synergy and cooperation between ASHAs and auxiliary nurse midwives (ANM), therefore, is urgently called for.

**Health Research**: Section 10 ("Knowledge for Health") of the document is

important because it underscores the importance of health research. It refers to the Department of Health Research but refrains from making any observation on its rather little known existence and insubstantial style of functioning. Interestingly, it talks about the need for India to contribute to global health research, and develop its own policy in international health and health diplomacy, besides stating that India should reposition itself as an equal partner in international technical cooperation rather than remain a mere recipient of aid and technical assistance. The suggestion that India, in collaboration with the other BRIC (Brazil, Russia, India and China) nations, must explore building multilateral institutions like the World Health Organization (WHO) is not just radical but too ambitious at present. This is so especially against the backdrop of India's own poor health status and tottering public healthcare system, the escalating out-of-pocket expenditure and an acknowledged link between the country's poverty and unregulated healthcare costs. While it can be inspirational to project such visions, concrete and realistic steps to go about it should be drawn up especially when planning national documents (Bandewar 2015).

## Self-Contradictions

**Attitude towards the Private Healthcare Sector:** The draft policy acknowledges that "catastrophic expenditure due to healthcare costs is growing and is now being estimated to be one of the major contributors to poverty" (Section 1.3) after acknowledging that there is a "two way linkage between economic growth and health status." Yet, when discussing the private healthcare sector, the document engages primarily with its not-for-profit version and leaves the issue of regulation of the already-vast-in-size-and-further-growing for-profit private sector to the margins, despite this being the sector which is overwhelmingly instigating the said catastrophic healthcare expenditures.

**Regulatory Role of the Government**: The document mentions that the government has a regulatory role in managing healthcare: "...clearly as private industry grows at a massive pace, and as this is an area touching upon the lives and health of its population the Government has to find ways to move forward on these responsibilities" (Section 2.17). However, it is rather curious that the draft, representing the agency and voice of the Ministry of Health and Family Welfare (MoHFW), does not discuss the possible "ways to move forward" in this serious, overwhelming and complex issue, but simply leaves it to the "government." Who is the concerned government apparatus in this case one wonders, if not the MoHFW itself!

**Unrealistic Budgetary Allocation:** Inadequate budgetary allocation to health has been a concern for more than five decades and continues to be so in this 2015 document. The NHP 2002 had promised an increase in public health expenditure from 0.9% of GDP to 2% in 2010 (though it was still far short of the 5% of GDP recommended by WHO and also demanded by the health movement in India). In comparison the document proposes only 2.5% of GDP on grounds of inadequate financial capacity of the country and institutions for effective utilisation of funds. It also adds that "most expert groups have estimated 2.5% as being more realistic" (Section 2.18), but does not elaborate on the supposed inherent realism in the figure even when this seems to (financially) sabotage several of the goals the document sets for itself. Thus, while it assures us of investment in the idea of a Health Care Act, it refrains from substantially increasing the budgetary allocations which would make the idea seem practicable.

**Harmful, Hazardous Industries:** The draft states that it will levy a "health cess" along the lines of an "education cess." The supposed cess will come from industries that are unhealthy and toxic: "Extractive industries and development projects that result in displacement or those that have negative impacts on natural habitats or the resource base can be considered for special taxation extractive" (Section 4.1.2). This is very disturbing since it implies that the government accepts evidently unhealthy development—even that which it distinctly identifies as causing displacement and having a negative impact on natural resources and people's lives. The only "action" the government will take is by imposing special taxes on these industries —which hardly sounds like a punitive measure. This stand of the government severely undermines and violates a sustainable and eco-preserving development model. The overt conceding of unhealthy industry and unhealthy development also contradicts the "preventive and promotive health" component (Section 4.2) the document itself stresses.

**The 2010 Clinical Establishments Act**: The discussion on the "failure" of the implementation of the Clinical Establishments Act (CEA) tends to suggest that the government can do nothing much to deal with the terms of the insurance companies: the language of the draft at this point seems to be one of "giving in" to the demands of the private insurance industry. There is no mention of how to fix the purported gaps in the CEA, but instead, in Section 12.1 it is listed amongst other acts which are deemed to require a legal makeover.

## Omissions and Gaps

**Women's Health:** The draft subsumes the topic of women's health under the Millennium Development Goals (MDG) and "Population Stabilisation," and later women's health crops up in the discussion on the reproductive and child health (RCH) services. While improvements in maternal health indicators (such as the maternal mortality rate (MMR) and under-five mortality rate—U5MR)

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are expected to find mention in such a document, it is a huge disappointment to realise that the State continues to perceive women and their healthcare needs only in terms of reproductive needs. Conflating women's health and gender mainstreaming under the RCH clearly indicates (a) misplaced emphasis on population stabilisation, ignoring evidence from around the world contrary to the idea that reduced fertility rates contribute to enhancing socio-economic opportunities; (b) that the responsibility for population stabilisation is to be shouldered by women, defying even the very modest expectation of the progressive health and women's movements; and (c) the government has once more let down the women's health movement. The document fails to respond to women's health needs in compliance with the gender justice commitment.

There is mention of the need to increase the targets for male sterilisation and contraception utilisation as well, but a number of questions arise at this point: why does the government want to continue with the target-oriented approach? Should population stabilisation be the agenda even in 2015? What stops us from accepting the evidence that supports the view that moving away from target-oriented approach to population stablisation serves people better by focusing on enhancing their socio-economic well-being?

**Relation with the For-Profit Private Sector:** The draft document points out that the private healthcare industry will receive a substantial variety of exemptions and benefits ("higher depreciation in medical equipment," "custom duty exemptions for imported equipment that are lifesaving," "preferential and subsidised allocation of land that has been acquired under the public acquisitions Act," etc). However, while several private hospitals are forgoing their part of the memoranda of understanding (MoU) to offer 10% free beds and treatment to the underprivileged, the document says nothing about regulation, monitoring or accountability. And through this stark silence, it ignores the activities of the civil society groups which have been fighting long and hard to foreground and curb such corruptions.

**More Medical Colleges:** Having acknowledged that there has been a significant increase in the number "of medical colleges" and "seats for both undergraduate and postgraduate [medical] education," the document adds that "... even further expansion is needed and planned for." But no rationale is provided for simply adding to the number of medical colleges, without interrogating the quality of medical education. It is common knowledge that a lot of medical colleges that have come up after 1990 are privately funded, often abysmally equipped, and arguably churning out inadequately trained professionals, while receiving accreditation through equally dubious means; there are accosting issues of seat auctionings as well (Seethalakshmi 2013; Nagarajan 2014). So, without even addressing these factors which are eating away at the existing healthcare system, a simple glorification of numbers of quality is naïve at best and criminal at worst.

**The Wait Continues for Right to Healthcare:** The document refers to the need to enact the right to healthcare legislation in the coming times (Section 12.2), and this is a reason to both rejoice and despair about. It seems that it would be a long wait before a Right to Health (RTH) Act could be legislated, since it is said to follow the CEA 2010, that is, it will be enacted only on the request of at least three or more states (with a per capita public health expenditure of Rs 3,800). The proposal to enact the RTH is also prefaced by several questions, including whether the level of economic and health systems' development allows us to make the denial of health rights an offence; and whether such a law should focus on the enforcement of public health standards related to conditions for health, or on access to healthcare and quality of healthcare.

**State Medical Councils**: Yet another omission is the absence of discussion on the role and achievements of the state medical councils: the state medical councils have a strong and powerful role to play in regulating medical practice, service and delivery in the state; while it is known that the performance of most state councils have not been satisfactory (George 2011), as a national level policy document, the NHP 2015 should have emphasised the role of the councils, invested them with responsibility and made them accountable in more possible ways.

**Possible Interfaces**: The document does not explicate how it will interface with the other existing allied policies, such as, the health research policy of 2010, the drugs policy, the palliative care policy of 2012, the occupational health policy, and the changing terrain on patent regime in relation to ensuring availability of generic medicine.

## Conclusions

Health is a priority area and the NHP 2015 should have been able to provide a more concrete road map with doable timelines and practicable end-points. The document does contain interesting and much-awaited interventions and shifts, yet falters—primarily—in offering a realistic support structure for that. That is, with all the much appreciated plans and end-points, the NHP 2015 suffers from a meagre budget. From implementing the urban health mission to training a new cadre of urban ASHAs to facilitating the RTH, a health budget of 2.5% is far too less. The paradox of this third national health policy is that it is self-defeating.


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