National Health Policy, 2017
Revealing Public Health Chicanery

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The National Health Policy, 2017 reflects the perfunctory attitude towards public health, so deeply entrenched among the mandarins of the health ministry. The policy paves the way for the contraction of public healthcare systems, thereby reducing the government's involvement in the delivery of health services, and facilitates the dominance of the private sector in curative care. However, in the absence of a robust public healthcare system, the goal of achieving "healthcare for all" becomes even more onerous.

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After a long hiatus, perhaps contemplative, the government finally came out with the National Health Policy (NHP), 2017 (MoHFW 2017a). Since the policy document has been finalised after almost two years, one hoped for changes being incorporated in the health policy in light of the debate around the Draft National Health Policy (DNHP), 2015 document. In an earlier article published in this journal, this author along with others had analysed this draft document (Rao et al 2015). However, concerns raised in this critique have remained unaddressed in the 2017 policy document. There can be little satisfaction in stating that the basic premises of our critique not only remain valid but seem to have been further strengthened by some baleful changes that have been strategically deployed in the NHP, 2017. It is immensely important that we absorb the import of these changes to calibrate our response to the new health policy; however, we shall begin by mentioning the points where credit is due to the policymakers. Additionally, the arguments made in the earlier critique (Rao et al 2015) shall not be revisited, except to facilitate the argument being made here.

Giving Credit Where It Is Due

It is heartening that the health policy reaffirms its objective to "improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality" (MoHFW 2017a: 3). In order to make funds available to achieve this laudable objective, the policy reaffirms the earlier resolve of raising the public expenditure on health to 2.5% of the gross domestic product (GDP) in a time-bound manner. Additionally, the preferred method of funding healthcare shall continue to be by way of general taxation (MoHFW 2017a: 5).

Nothing could be more desirable than this solemn commitment coming true. However, our enthusiasm needs to be tempered by realpolitik. The previous United Progressive Alliance (UPA) government had committed to raise the contribution of the public exchequer to health to up to 3% of the GDP over the period of the implementation of the first phase of the National Rural Health Mission from 2005 to 2011, a promise that remained as elusive as ever. The current Narendra Modi government, in its very first budget, presented in 2014, slashed the healthcare budget by 20% in one go, imperilling even day-to-day activities of many disease control programmes. Further, Arvind Panagariya, the vice-chairman of the NITI (National Institute for Transforming India) Aayog, which has replaced the erstwhile Planning Commission, feels that the healthcare needs of all poor can well be taken care of in just about three-quarters of 1% of the GDP (qtd in Kurian 2015). What is all the more intriguing is that the magnanimity of our rulers towards their countrymen seems to have dried up precisely at a time when they are making claims of India being the fastest-growing economy in the world. Nevertheless, though the odds remain onerous, one can always hope for a turnaround.

The novelty of the policy document over and above the DNHP, 2015 is that it has incorporated "Specific Quantitative Goals and Objectives." The policy states:

> The indicative, quantitative goals and objectives are outlined under three broad components viz (a) health status and programme impact, (b) health systems performance and (c) health system strengthening. These goals and objectives are aligned to achieve sustainable development in health sector in keeping with the policy thrust. (MoHFW 2017a: 3)

The salience of these quantitative goals and objectives lies in their being a benchmark against which the achievements of the health policy can be judged in time to come. This may also serve to

hold the government and the health machinery to account with respect to success or failure in achieving these benchmarks.

Dismal Track Record

However, India's accomplishments with respect to past benchmarks are disappointing. With respect to the achievement of Millennium Development Goals (MDGs), the "Situation Analysis" document, which provides a backdrop to the NHP, 2017, states:

> India is close to reaching the Millennium Development Goals (MDGs) … . From a baseline of 556 in 1990, the nation has achieved Maternal Mortality Ratio (MMR) of 167 by 2011–13. Assuming that the Annual Compound Rate of decline observed during 2007–09 and 2011–13 continues, the MMR is likely to reach the MDG-5 target of 139. In case of under-5 mortality rate (U5MR) the MDG target is 42. From a baseline of 126 in 1990, the nation has reached an U5MR of 49 in 2013, and if the rate of reduction over the past decade is sustained, the achievement in 2015 will be very close to the target. (MoHFW 2017b: 1)

It is difficult to infer much in regard to the country's public health capacity and achievements from such kind of analysis and how to use this so as not to repeat the same mistakes over and over again.

To put things in perspective, a newspaper article citing the Global Burden of Disease (GBD) study published in the *Lancet* said that "newborns in India have a lesser chance of survival than babies born in Afghanistan and Somalia" (*Hindu* 2017). The same article further stated:

> In the GBD (Global Burden of Disease) rankings for healthcare access and quality (HAQ), India has fallen 11 places, and now ranks 154 out of 195 countries. Further, India's healthcare index of 44.8 is the lowest among the sub-continental countries, as Sri Lanka (72.8), Bangladesh (51.7), Bhutan (52.7), and Nepal (50.8) all fared better. … India's downward slide in the rankings indicates that it has failed to achieve healthcare targets, especially those concerning neonatal disorders, maternal health, tuberculosis, and rheumatic heart disease. Last year, India was ranked 143 among 188 countries.
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> In the case of neonatal mortality, on a scale of 1 to 100, India scored 14 in the HAQ index, while Afghanistan scored 19/100 and Somalia, 21/100. Access to tuberculosis treatment in India was scored 26 out of 100, lower than Pakistan (29), Congo (30) and Djibouti (29). (*Hindu* 2017)

There were many other observations in the article worth worrying about, but with the numero uno of our national concerns being "cow vigilantism," we could not care less about such irresponsible and blatantly "anti-national" reports. Little wonder then that these findings were soon forgotten, leaving little chance of any deliberation.

Reducing Government's Liability

The lackadaisical and perfunctory attitude towards public health, deeply entrenched among the mandarins of the health ministry, is also reflected in the paragraph regarding the "social determinants of health" which mercifully has been included in the "Situation Analysis" document. The concerned paragraph states:

> This policy recognises the causal links between health outcomes and social determinants of health. Health of the population is determined largely by lifestyle (50%) followed by biological and environmental factors (20% each), whereas health systems related factors contribute only 10%. Achievement of national health goals would require addressing all the social determinants (distal and proximal) in the *context of rapid economic growth and changing life styles* with a focus on the most vulnerable and marginalised. This preventive aspect needs to be adequately addressed through assessing the impact of existing and future non-health sector programmes and policies through the health lens. (MoHFW 2017b; emphasis added)

In their enthusiasm to assert that they have already arrived at the international high table, the use of words "context of rapid economic growth and changing life styles" by the mandarins seems to have entirely eclipsed the phenomenon of "poverty" that constitutes the most important context of the lives of those hundreds of millions of people whose interests are most affected by this policy. It might help reminding our mandarins of the findings of the National Commission for Enterprises in the Unorganised Sector (NCEUS), popularly known as the Arjun Sen Gupta Committee report. The committee had famously declared that 77% of Indians subsisted on less than ₹20 a day and a daily per capita expenditure of merely ₹96 put a person in the "high income group" (Sengupta et al 2008). This reflects both on the extent of poverty and the much-trumpeted rising level of affluence of our common people. This was as far back as 2007. However, since the world economic crisis of 2008, it has been a downward slide for the economy and for the people, the novel ways of recalibrating the country's GDP notwithstanding.

On the social determinants of health, the "Situation Analysis" document (MoHFW 2017b: fn 18) cites a World Health Organization (2008) report, "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health." If the authors had cared to look at the large body of literature on the social determinants of health from India other than this one reference, they would have realised that those being referred to as "vulnerable and marginalised" in the document are not just any people. They have a definite social and political identity as members of certain caste groups, tribes and religious minorities just like the United States (US) where the "vulnerable and marginalised" communities comprise primarily of blacks and some other racial minorities. Perhaps, there is a fear that recognition of these identities might lead the government to acknowledge a systemic and systematic discrimination prevalent in the society against these people. This is a particularly touchy issue with the present Modi government, which perceives such articulation as denigration of "Bharat Mata" (Mother India) by left-leaning intellectuals.

The "Situation Analysis" document (MoHFW 2017b: fn 19) also refers to a report by the surgeon general of the US on the physical activity and health of US citizens (US Department of Health and Human Services 1996). The percentages of 50, 20, 20, and 10 allocated to "lifestyle factors," "biological factors," "environmental factors" and "health system related factors," respectively, which shape the health of the population, are taken from the surgeon general's report and cited in the "Situation Analysis" document, and may strictly apply to the people of the US. All of these factors, while remaining relevant to Indian conditions as well, will not carry the same weight as they may in the context of American society.

For example, in the US, the majority of the population is urban, living in a society with much higher levels of mechanisation; the society is characterised by lower levels of poverty, and the poverty line in the US is not the same as our poverty line, which actually is a destitution line. As opposed to this, in India, an overwhelming number of people live in villages, in societies with very low levels of mechanisation, and where poverty is deeply entrenched. These are also the people who are most in need of caring social sector policies so that they can exist with a modicum of dignity. Can it be said then that the lifestyle of these Indians is the same as that of the Americans and contributes up to 50% in the shaping of their health, while the contribution of health system related factors is a mere 10%?

In the US, diabetes and hypertension could well be an outcome of sedentary lifestyles and consumption of fast foods leading to obesity. However, in India the epidemic of diabetes even among the poor is not explained by lifestyles as much it perhaps is by Barker's hypothesis, which privileges intergenerational impact of malnutrition as the triggering mechanism. The health of a landless agricultural labourer and a casual manual labourer living in a shanty in an average Indian city is far more likely to be shaped by health system (which includes not just the system of health services, but almost the entire development sector) related factors than by their starved lifestyle.

The use of this reference drawn from a country like the US is not just a matter of casual oversight. It is on purpose. After all, if lifestyles shape peoples' health to as high an extent as 50%, then the overwhelming responsibility of improving their health also lies on individuals. Perhaps, only little can be done by either individuals or by health systems about the 20% impact of biological factors in shaping the health of the people. And, even if the public health systems are dysfunctional, it can at its worst adversely affect your health only to the extent of 10%. Such a reductionist approach also reduces the government's liability towards peoples' health. Any rationale that supports a reduced liability on part of the government paves the way for contraction of public healthcare systems, leaving the field wide open for private players. This is precisely what the NHP, 2017 argues, albeit in a roundabout manner; and it is in doing this that the chicanery of the health planners plays out.

Corporate Hospitals

Just like the DNHP, 2015, NHP, 2017 also lauds the high growth rates of the healthcare industry in the country. It also proclaims as an achievement the fact that "The Government has invested heavily in the last 25 years in building a positive economic climate for the healthcare industry." However, the DNHP, 2015 was more forthright in acknowledging that corporate hospitals cannot be expected to toe the public health goals set by the government. Hence, it proposed that

> Given that the private sector operates within the logic of the market and that they contribute to the economy through their contribution to the growth rate and by the national earnings from medical tourism, there need not be any major effort to persuade them to care for the poor, as long as their requirements and perceptions do not influence public policy towards universal healthcare. Where corporate hospitals and medical tourism earnings are through a high degree of associated *hospitality arrangements*, one could consider forms of taxation/cess, especially for *certain procedures and services* as a form of resource mobilisation towards the health sector. (MoHFW 2014: 36; emphasis added)

The NHP, 2017 has sought to reinfuse, with little academic finesse, a sense of altruism in what is otherwise a purely profit-oriented hospital industry. It has modified the above formulation thus:

> The policy enunciates the core principle of societal obligation on the part of private institutions to be followed. This would include:
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> - Operationalisation of mechanisms for referral from public health system to charitable hospitals.
> - Ensuring that deserving patients can be admitted on designated free / subsidised beds.
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> The policy proposes to consider forms of resource generation, where corporate hospitals and medical tourism earnings are through a high degree of associated *hospitality arrangements* and on account of *certain procedures and services*, as a form of resource mobilisation towards the health sector. (MoHFW 2017a: 15; emphasis added)

However, what is left unexplained in the policy document is how our policymakers shall reconcile the two diametrically opposite aims, that of the imperative to maximise profits of the corporate hospitals, and that of the government to provide healthcare to people irrespective of their ability to pay, and that too when the energies of these hospitals shall be focused on generating revenue through "hospitality arrangements" and through "certain procedures and services" (read unnecessary procedures and services). Is there even one example from across the world where this has been possible with any measure of success? The DNHP, 2015 had at least acknowledged this and mentioned that

> Though there is an obligation imposed by their access to considerable tax exemptions and public acquisition of land, it is only a rare private commercially run hospital that meets these obligations (those towards fulfilment of public health objectives). A number of not-for-profit hospitals however offer this, but these are few. (MoHFW 2014: 36)

However, this acknowledgement has been removed without a trace from both the "Situation Analysis" document for the NHP, 2017 and the policy per se.

It might be argued nonetheless that the government can facilitate affordable curative care for the people by becoming a net purchaser of the expertise offered by these private tertiary care hospitals. Moreover, considerable experience from across the country and the world is now available to show as to how these publicly funded health insurance schemes have been an utter failure in achieving their desired goals and have worked towards rendering the already weak public sector further effete (Reddy K S et al 2011; Shukla et al 2011; Reddy S 2013; Prasad and Raghavendra 2012; Mohanan et al 2014; Reddy and Mary 2013; Selvaraj and Karan 2012; Narasimhan et al 2014; Sujatha Rao 2014; Averill and Marriott 2013; Bajpai and Saraya 2012). A particularly pithy indictment of publicly funded health insurance schemes is provided by the following statement:

> Universal Health Coverage (UHC) is being widely promoted as a panacea for health inequities yet there are fundamental differences in its interpretation and implementation especially on financing. … health insurance schemes, often promoted by the World Bank and other donors, invariably disadvantage the poorest and unhealthiest. Without more equitable, tax based approaches, inequalities in health will continue to grow and threaten us all. (qtd in Averill and Marriott 2013)

As far as the question of affordability and fair pricing of services is concerned, the government can achieve that only if it retains the ability to provide curative health services to a considerable extent through a robust public sector healthcare system. The absence of a robust public sector and thereby the government's inability to provide curative services can only beget a helpless dependence for these services on the private sector. The consequence will either be a huge cost to the public exchequer for purchasing these services or else the government may simply abdicate its responsibility, leading to huge out-of-pocket expenditures for the people or economic inaccessibility of curative care.

The policy does talk of "purchasing care after due diligence from non-Government hospitals as a short-term strategy *till public systems are strengthened*" (emphasis added). However, prudence demands that we go not by the words of the government, but by its deeds. The behemoth of the private healthcare industry, led by the corporate tertiary care hospitals, is a result of concerted efforts by various governments since 1990 to bring it into existence. While there have been several inquiry committees that have documented the various instances of how private tertiary care hospitals reneged on their mandatory obligations towards poor patients over the years, it is difficult to recall if ever an example was made of any of these hospitals by any government in the country. On the other hand though, the government's policy commitment to further the interests of the private healthcare industry seems absolute.

Addressing Malnutrition

The commitment towards furthering the interests of the private sector can also be seen in other sectors that have an impact on health; for example, let us take up something as fundamental as "nutrition." The extent and depth of malnutrition in India allows many poorer countries to humble us. Nutrition was one public health problem that was given short shrift in the DNHP, 2015, and to that extent the inclusion of a separate section on nutrition, "Interventions to Address Malnutrition and Micronutrient Deficiencies," in the NHP, 2017 is creditworthy.

The one fundamental truth about human nutrition is that so long as people have their staple diets to their fill, they manage to get all the energy and nutrients, including micronutrients, required by the body to remain healthy even in harsh environments such as the Kalahari, desert in South Africa and the Arctic (Kuhnlein and Receveur 1996; Lang 2014). It cannot possibly be anyone's case that all the bushmen of Kalahari and Eskimos in the polar region are malnourished. The inability of people to get adequate amounts of their staple diet leads to deficiency of dietary energy derived from macronutrients (carbohydrates, proteins

and fat) and micronutrients (vitamins and minerals). With the exception of iron and vitamin B12 deficiency, which can be derived only from animal source foods, rarely does micronutrient deficiency occur in the absence of dietary energy or macronutrient deficiency (Kennedy et al 2003; Black 2003). Additionally, poverty is the foremost cause of dietary energy deficiency worldwide.

In defiance of these fundamentals of human nutrition, NHP, 2017 states:

> Malnutrition, especially micronutrient deficiencies, restricts survival, growth and development of children. It contributes to morbidity and mortality in vulnerable population, resulting in substantial diminution in productive capacity in adulthood and consequent reduction in the nation's economic growth and well-being. Recognising this, the policy declares that micronutrient deficiencies would be addressed through a well-planned strategy on micronutrient interventions. Focus would be on reducing micronutrient malnourishment and augmenting initiatives like micro nutrient supplementation, food fortification, screening for anemia and public awareness. … Policy recommends exploring fortified food and micronutrient sprinkles for addressing deficiencies through Anganwadi centers and schools. (MoHFW 2017a: 11)

So, the whole problem of malnutrition has been rendered into a problem of micronutrient deficiencies which seem to occur in the absence of the problem of hunger; and if there is no hunger, then poverty as the biggest cause of undernutrition has no business to be in the reckoning. So, the solution to India's massive problem of malnutrition is micronutrient sprinklers and fortified foods, both of which shall be supplied by companies and the people shall be mere recipients.

Let us just try and think of what could have been achieved if the government were to roll out poverty alleviation programmes centred around well-thought-out land reforms, accompanied with agrarian reforms in rural areas and simultaneously initiate measures to create sustainable livelihoods in the urban areas by curbing the rapacious urge for maximisation of profits by the corporates. These changes would have given the people the agency to try and overcome their poverty and hunger, and take their destiny in their own hands rather than being passive recipients of help. Enhanced economic productivity would just have been a byproduct in this march for social transformation. There could not be a better way of soliciting collaboration between sectors to address wider determinants of health of which we find many a laudable references in the policy document. Alas, this has never been the intention of India's ruling elite.

The solution to the public health problems of the people suggested in the form of the NHP, 2017 is nothing but chicanery of the highest order, designed to benefit the big corporate healthcare providers at the cost of public healthcare. It seeks to reduce the meaning of "health" to just provisioning of "curative care," rather than being a state of "complete physical, mental and social well-being" as enshrined by the World Health Organization.

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