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National Health Policy, 2017- A Milestone towards Health Security in India? Some Annotations

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ABSTRACT The new National Health Policy (NHP) announced by the government recently, has the same objectives of health attainment, as earlier stated, without specific timeline. The present government has been ambitious and aims to achieve many goals in quick time. The use of military words like "surgical" and "strategic" in government programmes and schemes including the present NHP, 2018, indicates towards more clarity and focus on the objectives. The present scheme amongst many other features has two novel feature of "strategic purchase of health care" from the private sector and making the health care a social movement. These are massive, long term objectives and unlike military precision, no time line is specified. By its own admission, the key government intervention by spending of 3 percent of GDP in public health facilities is to be achieved only by 2025. The social movement is still a longer-term goal involving decades of scaling and sustainment.

INTRODUCTION

Provision of equitable health care is an unavoidable agenda of all government. Yet there is no best method of designing and delivering the health care for the needy people. Depending upon the historical, cultural and political circumstances, various methods are in force today all around the world. India's tryst with health insurance schemes goes back to the early 1950s, when the employer-mandated social security like CGHS and ESIS were launched. The commercial health insurance market opened up for the rest of the population in 1986. Mediclaim was the only health insurance policy sold by the four government owned insurance companies for a long time (GOI 2011). It had very limited coverage in Indian population and the policy was sold only in urban areas. The insurance sector was opened up in 1999 with FDI of 26 percent and further in 2014, raising the FDI to foreign players to 49 percent. It was hoped that the private (domestic and foreign) insurance providers would rapidly develop the sector and improve insurance coverage using new products and better management. Competition, it was hoped, would not only lead to increased beneûts in terms of lowered costs and increased consumer satisfaction but also improve access to healthcare and provide better services (Mavalankar and Bhat 2000; Sen 2012). But all these hopes were belied.

Public spending on healthcare in India is amongst the lowest in the world at just over 1 percent of gross domestic product (GDP), and the Indian health system is characterised by substantial shortcomings relating to workforce, infrastructure, and the quality and availability of services (Angell et al. 2019). The vast majority remained uncovered, prompting the government to intervene in providing health care to poor and people employed in informal sector. With more than 100 countries having already started Universal Health Care (UHC) reforms and, India with only 11 percent of the population having any form of health insurance (Sriram 2018), was facing the rising international pressures to initiate Universal Health Care (UHC). WHO and UNICEF's Alma Atta Declarations (1978) and United Nations Millennium Development Goals (2000), the governments in India, central and states, started direct intervention by providing health care to these uncovered section of Indian people.

Various government health policies from time to time has been launched with the basic and high objectives of health for all. But most schemes and programmes have fallen too short

of the stated objectives. Due to budget constraints in investing in public health, the government encouraged private sector to invest in public health care. Over time this has become a problem in itself. The cost of care in the private sector in India increased 6 to 10 times (at current prices) between 1987 and 2014 (Hooda 2015a, b). The medicine, mostly the branded medicines, prescribed by private providers, is the single largest component of total OOP payments. This had pushed 3.09 percent, that is, 38 million persons into poverty in the year 2011-12 in India (Selvaraj et al. 2014; Selvaraj et al. 2018). Hooda (2017) in a recent study, evaluated the impact of the interventions on access and cost of care and financing medical expenses using the NSSO 2004–05 and 2011–12 data. His estimates show that though these health insurance schemes promote access to healthcare utilization for hospitalization it is ineffective in reducing the mean hospitalization cost of the households at the aggregate level. In a surprise result, his study finds that insurance enrolments has led to higher health payments. Thus households in higher insurance enrolment districts are more likely to be impoverished than the households living in the districts where enrolment is low.

The cross sectional, temporal recent studies reveals that in absence of public health facilities, the health provision through private providers has led to cost escalations and more impoverishments amongst the poorer Above Poverty Line (APL) and Below Poverty Line (BPL) people (Singh and Kumar 2017). When people use these private services they suffer financial hardship or even impoverishment. Many sell assets or borrow to finance such expenses (WHO 2008). The domination of private health sector is overwhelming and cannot be wished away. The only and the best solution is the increase in provision of public facilities and generate competitive environment in health care market.

The present health policy attempts to, on the one hand gradually increase the public provision in health care and in the long run provide competition to private providers in order to reach efficiency in the provision. The second most important goal is making the health care a social movement which is very cost effective, as the results show in poor countries like Bangladesh.

Objectives

The paper aims to highlight the failures of the public financed health insurance (PHFIs) schemes in India. It also aims to highlight the persistence of basic flaws in the new health policy, namely the Ayusman Bharat National Health Protection mission (AB-NHPM). The paper also aims to suggest some bold corrective measures that must be incorporated in the new scheme to make it effective.

METHODOLOGY

The study consists of extensive review of past and recent literatures on the subject to understand the public health care schemes. The reviews are meant to highlight the gaps in the existing public health care schemes in India. The paper also makes reference of such successful schemes in some of the developing countries in the world to draw a lessons for Indian public health care schemes. Two main features of the new Indian public financed health care scheme are analysed in light of the lessons learnt. These lessons are used to recommend improvements in the newly launched Indian health care scheme.

OBSERVATIONS AND DISCUSSION

Ayusman Bharat National Health Protection Mission (AB-NHPM): The New Universal Health Care

After a long gap, Prime Minister Mr Narendra Modi launched a new Universal health scheme on 23 September 2018. A national health assurance plan was part of the BJP's electoral manifesto but it has taken close to 34 months after the government took office to finally announce the policy. Amongst the various provisions of the scheme, two key features are:

1. The strategic purchase of secondary care hospitalization and tertiary care services from both public and from non-government sector. The Strategic purchase of secondary and tertiary care amounts to the present status of the health care system in the country which has more ills than the cure.

2. Making preventive and promotive action, that is the Primary care, a social movement –the *Swasth Nagrik Abhiyan* or Health in All. A "health and wellness centers" are to be established which will transform the current sub-centre and PHC from its current and very limited package of services to a much larger coverage of non-communicable diseases.

(a) Strategic Purchase of Health Care

There are two ways of implementing Universal Health Care (UHC) scheme. A Supply-side Financing Strategy (SFS), which strengthens essential primary, secondary and tertiary healthcare services, financed through general taxation. Under SFS, health services are provided through the government healthcare system. One of the major strengths of SFS is that it provides universal healthcare services almost free or at low cost at the point of delivery to all its citizens. In addition, SFS can provide comprehensive services to the remotest areas, if implemented effectively. The other strategy is the Demand-side Financing Strategy (DFS), which is also tax based scheme but implemented through health insurance route. The care is purchased and provided by private sources. The present UHC announcement is based on DFS strategy, though mention is also made for strengthening public provisioning.

Since independence, India's health care was to be the responsibility of the government, and thus it set up a three-tiered health infrastructure network in the country, including in the remotest areas. This system provided inpatient as well as outpatient services at very subsidized rates, or almost free, to every citizen. The government provided primary, secondary and tertiary healthcare Services through Sub-centres (SCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), sub-divisional hospitals, civil/district hospitals across districts, and state spending on drugs/medicines. These are the important pillars of supply-side intervention.

However, since 1990s India have followed the other, DFS model of UHC, the insurance-based health financing mechanisms towards universal health coverage. National- (Rashtriya Swasthya Bima Yojana [RSBY]) and state-sponsored (Aarogyasri, Kalaignar, Yeshasvini, Vajpayee Arogyashree, Rajiv Gandhi Jeevandayee Arogya Yojana) pro-poor health insurance schemes are examples of ongoing demand-side interventions, which allow the poor to access medical care from public and private hospitals. The same DFS model with some novel features are launched now in Ayushman Bharat Health Scheme.

The change of strategy was enforced due to inadequate public investment in health sector, coupled with enforced liberalization and privatization economic policy reforms. The policy changes were made to encourage private sectors investments in health care industries. The policy provided tax and other incentives for the setting up of private hospitals and clinics which resulted in the rapid growth of the private health sector. Over the period, the private sector became dominant in service provisioning (10.67 lakh providers, ranging from informal to large formal and corporate entities, as against only 1.96 lakh public hospitals and healthcare centres), with the private sector providing roughly three-fourths of all outpatient and two-thirds of all inpatient treatment (Hooda 2015a). The dominance of private sector in health sector appears to have assumed irreversible proportion.

Several studies suggests that the present model of UHC based on purchase of care from the private sector has been unsuccessful not only in India but all over the world, in providing financial protection to the households. Rather it has led to more impoverishment amongst less provided people and lesser states. Hooda (2017) evaluated the impact of these interventions on access and cost of care and financing medical expenses using the NSS 2004–05 and 2011–12 data. The estimates show that though these health insurance schemes promote access to healthcare utilization for hospitalization it is ineffective in reducing the mean hospitalization cost of the households at the aggregate level. A field-based study conducted by Prayas-Oxfam in 2011 in five states of India also shows that in areas where the RSBY and other state UHC programmes were implemented, the out-of-pocket (inpatient as well as outpatient) expenses actually increased. The recent works by Singh and Kumar using NSSO 71st round data also confirm the increased impoverishment specially among

Above Poverty Line (APL) and Below Poverty Line (BPL) families. The similar results were found between the states.

The study by Hooda (2017), also found that in the present scheme, the higher insurance enrolments of the population, rather than reducing health payments, increases it. Thus households in high insurance enrolment ratio districts are more likely to be impoverished than the households living in the districts where enrolment ratio in health insurance scheme is low. State-level evidence is similar to that of district- and household-level estimates.

The reason is not difficult to find. An overwhelming majority of accredited health facilities are in the private sector. Sengupta and Prasad (2011) reported that almost all providers of hospital care under the Kalaignar scheme and 80 percent under the Aarogyasri scheme were in the private sector. In addition, the majority of insurance beneficiaries prefer to go to an accredited private facility and have a tendency to switch to more costly tertiary care services, sidetracking preventive/primary care and the primary healthcare approach. The cost of care is bound to rise. Under the new framework, private providers will get more benefits from these schemes indirectly.

It is well known that the private health care providers, in absence of strict regulations, indulge in an unnecessary testing and prescriptions , leading to high healthcare costs. On the other hand, the study reveals that promoting health service use from public facilities has been quite affordable and less impoverishing. Rajasthan and West Bengal have been able to secure low medical and medicine cost per hospitalization case because of the high use of public facilities in those states (Hooda 2017).

This phenomenon is not limited to India. A review of the performance of private and public healthcare systems in low- and middle-income countries including India, by Basu et al. (2012), suggest that the private health sector is inefficient, unaccountable and medically ineffective compared to the public health sector. Comparatively, the study suggest that providers in the private sector violate standards of practices more frequently, and had poorer patient outcomes. Reported efficiency tended to be lower in the private than in the public sector, resulting in part, from perverse incentives for unnecessary testing and treatment. Public sector services in these countries, however, had more limited availability of equipment, medicines and trained healthcare workers. Public sector performance would have been much better if these gaps had been filled. Thus the cost of care in the private sector in India increased 6 to 10 times (at current prices) between 1987 and 2014 (Hooda 2015a).

What India needs is a radical transformation of the health system that puts people in front and centre. For this to happen, the entire health system needs to be recast along the lines of the Primary Health Care approach proposed in the 1978 Alma-Ata declaration. The stated intent of the government to introduce UHC is welcome, but it must be built around a strengthened public system that prioritizes the primary health needs of the majority, and not indulge in same mistake of purchasing care from the private health sector. The policy in theory, envisages the strategic purchase to be only temporary in nature. However, in practice the whole system may maintain status quo with the practice and outcomes, since the strengthening of public health care requires massive public investment. The goal of investing at least 3 percent of GDP in public health, which was supposed to have been achieved by 2018, is now pushed to the year 2025.

Some studies, based on international experiences, have argued that improving the existing (tax-based) public health system is far less complex than expanding health insurance provided by private health care sector. Global experience shows it is much difficult in regulating an insurance-based private health sector to keep costs down and assure quality (Gupta and Muraleedharan 2014). The private health sector also does not mitigate inequitable access to health services (Sodhi and Rabbani 2014). Based on study of international experiences, it is argued that strengthening the publicly provided basic healthcare network is an important means of attaining equitable and affordable universal healthcare care in India. The free or low-cost healthcare provisioning by the state remains the best way to enhance the health and well-being of households. In order to provide the superiority and preference for public health services the government must undertake the massive strengthening and

expansion of the public health services that is called for (Rao et al. 2015).This has to be supported by reducing the inadequacies and inequalities across districts, in public health care provisions. It also will involve the provision of low-cost medicines and diagnostics to all (Hooda 2017). This can be made possible by allocating more government funds in the health sector. The propoor insurance system can only work well in settings where services are adequate. In other words, the probability of falling below the poverty line due to health payments would be low if states spent high amounts on medicines and drugs. The earlier three-tiered structure of public facilities in a state was critical in lowering the average hospitalization cost. Further, considering the high share of drugs spending (70%) in total OOP expenditure, the Drug Price Control seems to be insufficient and ineffective, as it covers only about 18 percent of medicines, and the average reduction in prices has been only 6 percent (Phadke 1998).

(b) Swasth Nagrik Abhiyan –A Social Movement for Health

Another very far reaching feature of the new UHC scheme is making the preventive and promotive action, that is, the Primary care, a social movement. The policy now correctly realize that years of various forms of government interventions have not the desired results in health attainment and health equality. It has, on the contrary resulted in more stress and impoverishment to health seekers in India. The disparity between rich and poor at district level and also at state level has widened. It is rightly realized that like the present government's "*Swachh Bharat Abhiyan or Swachh Bharat Mission*" (which is a nation-wide campaign in India for the period 2014 to 2019 that aims to clean up the streets, roads and infrastructure of India's cities, smaller towns, and rural areas), the better health as a way of life can be attained, only if there is people involvement in the form of a social movement.

There are successful examples are the neighbouring countries like Bangladesh and Sri Lanka. Bangladesh is pioneer not only in making micro finance a successful popular movements, it is also one of the pioneer countries in attaining better health outcomes by making preventive and promotive care a social movement. Bangladesh is still one of the poorest countries in the world. But it has made rapid progress in some crucial aspects of living standards, particularly in the last twenty years overtaking India in terms of many social indicators. It is not through any massive public investments. The country spend 3.8 percent of GDP on health and is comparable to India. The OOP is one of the highest at 96.6 percent but the health outcomes are better than India. In most vital health indicators, Bangladesh is ahead of India.

The roots of Bangladesh's health achievements can be attributed to the few silent factors that are rooted in social rather than government initiatives. The government at the most has played the role of facilitator. In terms of gender equality, the women participation in work force is twice as much as in India. The female literacy is 82 percent. The media has been used very effectively to bring about changes in some vital social norms like health, education and related fields that has impacted the health outcomes. Tens of thousands of grassroots health and community workers (mobilized by the government as well as by NGOs) have been going from house to house and village to village for many years facilitating child immunization, explaining contraception methods, promoting improved sanitation, organizing nutrition supplementation programmes, counselling pregnant or lactating women, have become widely accepted social norms in Bangladesh. Bangladesh, has made very substantial progress with essential, low-cost measures, particularly related to public health. More than 90 percent of households in Bangladesh do have access to some sanitation facilities, including rudimentary latrines and washing facilities, so that only 8.4 percent have to resort to 'open defecation' (Sen and Dreze 2013). Bangladesh has implemented a fairly effective, non-coercive family planning programme which has led to a dramatic reduction of fertility in a relatively short time – from around 7 children per woman in the early 1970s to 4.5 in 1990 and 2.2 in 2011 (very close to the 'replacement level' of 2.1). These changes has helped Bangladesh achieve better health outcome over the last twenty years.

Another example of long term sustained and successful public intervention is Sri Lanka. The

successive governments in Sri Lanka, after its Independence, has implemented welfare oriented schemes that has resulted in high level of health attainments. Sri Lanka's health gains deserve the epithet of a "health miracle" (Rannan-Eliya 2006). In spite of its prolonged civil war, Sri Lanka holds a unique position in South Asia as one of the first of the less developed nations to provide universal health, free education, strong gender equality, and better opportunity to social mobility.

Like Bangladesh, Sri Lanka enjoys a number of intrinsic advantages when it comes to health. Female equality and autonomy is not resisted in this country owing to legacy of the island's Buddhist influences. This made it easier to introduce mass education of girls, and also facilitated women taking responsibility for looking after their own health and that of their children. The second is a tradition of state activism in social and health provision, which has its origins in the pre-colonial era when Sri Lankan kings constructed public hospitals and nursing homes (Uragoda 1987). Today, health seekers in Sri Lanka, do not have to travel far to avail health care. The third, which is connected with the plentiful rainfall and rivers in the island, has been a culture encouraging cleanliness and frequent bathing, which was noted even by Marco Polo. Even though it spends less than India (3.3% of GDP), public expenditure on health is higher at 42.1 percent compared to India's only 30.5 percent.

Within the country, the state of Tamil Nadu, is considered the best model of public health care in the country. The state is one of the pioneer states in state health insurance scheme for the people in the state**.** Tamil Nadu has effective health service provisioning, along with good procurement, storage and distribution (PSD) systems for providing and distributing free or low cost medicines in government hospitals. This policy initiative has been able to secure a low share (about 56%) of drugs/medicine in total OOP spending in the state in 2011–12, compared to the 70 percent national average (Hooda 2017). The state has been able to keep medicine costs (per hospitalization case) at low levels (Rs.182 as against the national average of Rs.1,707) in the public healthcare system (Hooda 2017). In addition, Tamil Nadu also has high penetration under the state-sponsored health insurance scheme.

CONCLUSION

Implementing a comprehensive public financed health insurance scheme is more difficult that devising it. Besides the resource constraints in investing in public health care facilities, the implementation is constrained by the difficult to regulate private provides, which has been proved to be inefficient and exploitative. Many Public Financed Health Insurance (PHFI) that have been launched from time to time have miserably failed due to overdependence on private providers. The main lesson learnt is to strengthen and revive the three tier public health care system and to make them cost effective and the scheme should have system of public participation through social movement. These objectives cannot be achieved in short time and thus an independent corporate like institution should be created which can be protected against political vagaries. The present AB-NHPM, can succeed if these points are incorporated or else may face the same fate like earlier schemes.

Therefore, drug pricing of an increasing range of essential drugs should continue to be regulated, along with timely revisions of National Essential List of Medicines (NELM) and appropriate price control mechanisms for generic drugs.

RECOMMENDATIONS

Attaining Universal Health Care (UHC) in poor countries is all the more difficult task. Various strategies adopted from time to time, has complicated rather than solved the problem of providing equitable and affordable health care to all. The policy makers are in fix over their resource crunch on the one hand and the run away, difficult to regulate costly and inefficient private providers on the other. The, present National Health Policy, 2017, finally takes cognizance of this dilemma and has aimed at temporary strategic purchases of health care from the private providers, while gradually making the public provision match to their proportion of health facilities in the market, even in remotest areas. The second objective of making health care a social movement is very much desirable.

The problem is huge and it cannot be solved through series of schemes with rules and weak regulations. The health problems of poor countries are a social problem which can be solved better by public participations. A social movement may be effective way to solve it. The basic lacuna in such strategy is often the absence of long period of sustained efforts in the direction with capable and inclusive leadership. In a democratic set up, no leader in government may have the luxury of extended time.

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