EDITORIAL

National Health Policy 2017: An Overview

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The previous National Health Policies (NHP) in 1983 and in 2002 did their job of serving the nation during the five year plans. Since last NHP in 2002, there have been few changes in the overall health scenario of India. First and foremost, India has achieved gradual improvement in the Infant Mortality Rate (IMR) and Maternal Mortality Rate(MMR) along with control of infectious diseases to a larger extent but the burden of Non-communicable diseases is showing an upward trend. The emergence of private sector as robust healthcare industry is the second discernible feature. Of late, the rising cost of medical care is pushing more and more people into poverty due to catastrophic out of pocket expenditures. Last but not the least, rising economy of India has not been able to transform the public health infrastructure across the vast stretches of the country.

Against this backdrop, National Health Policy 2017(1) aims at providing good quality healthcare services in an assured manner to all by addressing current and emerging challenges arising from the ever changing socio-economic, epidemiological and technological scenarios. Among the key policy principles, equity, affordability, accountability, inclusive partnership and decentralisation are worth mentioning. NHP-2017 also identifies seven priority areas for improving the environment for health. These priority areas needing coordinated action include:

1. The Swachh Bharat Abhiyan
2. Balanced, healthy diets and regular exercises.
3. Addressing tobacco, alcohol and substance abuse
4. Yatri Suraksha - preventing deaths due to rail and road traffic accidents
5. Nirbhaya Nari -action against gender violence
6. Reduced stress and improved safety in the work place
7. Reducing indoor and outdoor air pollution

NHP-2017 faces a challenging task of ensuring affordable, quality medical care to every citizen of the nation. To achieve Universal Health Coverage by 2025, NHP-2017 assures a comprehensive primary care to one and all. Both the quantifiable and measurable goals have been laid down. It has been proposed to set up health and wellness centres which would provide full range of preventive and promotive services to prevent diseases and enhance well-being. To address the serious shortage of human resources, the policy has proposed: i) reviving the multipurpose male worker cadre ii) empowerment of ASHA's to undertake preventive education at the community level and iii) training AYUSH doctors, nurses and para-medics for six months on public health so as to position them in the Health and Wellness centres. From the current spending of 1.15% on public health, the policy envisages raising the spending to 2.5% of GDP by 2025.

The policy provides clearer directions regarding the role of state from being a service provider to overseeing the functioning of stakeholders with a thrust on strengthening the public-private collaboration in the sector. The policy also proposes an ambitious agenda of establishing institutions to cope up with the transition from welfarism to market economies. The proposed institutions include The National Institute for Chronic Diseases, National Allied Professional Council, Medical Tribunals for Grievance Redressal, National Digital Health Authority and a common sector innovation council to facilitate interdepartmental collaboration for medical research and discovery. NHP-2017 has also recognised the need for strengthening the regulatory frameworks related to medical devices, clinical establishments and certification of public hospitals for ensuring adherence to quality benchmarks. NHP-2017 also mentions the need to shift the financing modalities ranging from per capita allocation to performance based devolution of funding to facilities, besides differential funding of central grants to fiscally weaker states.

Although NHP-2017 strongly asserts that primary health care will be provided by public sector, it envisages the role of private as well as Non-governmental actors. Access to urban primary care has been proposed to be ensured by incentivizing social enterprises and the private sector while in case of rural areas which are underserved, policy seeks collaboration with private sector to fill this gap. Availability of trained doctors and nurses would help to meet the new IMR and MMR goals and build on gains

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accrued so far from higher institutional deliveries which exceed 80% in recent years.

Concerns and Challenges: The first and foremost concern is low public spending to the tune of 1.15% of GDP. Public investment on primary care is barely $ 17 per capita whereas estimates prepared for Sustainable Developmental Goal 3's target of universal health coverage to essential care by 2030 in about $ 85 per capita (2). The low spending on public health has resulted in poorly developed primary healthcare infrastructure and even if available, it largely remains underutilised like providing only 15% of the services to the under-5 children (3). The non-availability of skilled human resources and essential infrastructure is a serious barrier as more than two-thirds of this deficit is in the 'underserved' areas that have only a fifth of money and three-quarters of the disease burden.

Another concern is regarding the primary care services which the policy states would be provided by the Government. The policy assumes that the public and private sectors can function and compete in the same space, thereby simplifying the complete dynamics. NHP-2017 time and again mentions 'strategic purchasing 'of private services for filling the so called gap to addresses the issue of 'supply side' imbalances. But in reality, this gap is really huge as private sector is providing about 70% OPD and 60% inpatient care, especially in the sphere of secondary and tertiary care. In this context, public hospitals provide a rational and cheaper care and thus keep a check on private sector from unnecessary procedures leading to profiteering. It would then be pertinent to invest in public hospitals in the first instance before pushing to purchase services from the private sector.

Next concern is the weak commitment made to building the required infrastructure in urban and rural areas for delivering primary health care services. NHP-2017 affirms the desire to achieve the Indian Public Health Standards(IPHS) but it fails to assess its fiscal implications. The policy seeks an additional role for community health workers for prevention and diagnosis of NCDs including mental health counselling. It would be appropriate in this context to seek reasons why the 2010 model of equipping and enhancing capacity of CHCs by a team consisting of a medical doctor, health workers, physiotherapist etc. to screen, identify and diagnose NCDs didn't take off.

Finally, NHP-2017 shows weak commitment towards regulations. It is not just instituting better laws and restructuring of the medical and nursing councils to be more accountable and less corrupt but establishing an independent drug regulator to oversee the licensing of drugs is equally important. In this regard, regulatory and accreditation agencies for healthcare providers at national and state level as suggested by expert group on Universal health coverage of Planning Commission earlier should be set up at the earliest. Centre receives robust health data as inputs from multiple sources along with sample surveys which are hardly reconciled and private sector is mostly not in picture. To reduce high out of pocket spending, early deadlines need to be set up for public institutions to offer essential medicines and diagnostic test free to everyone. In 2011, estimates revealed that it requires only 0.4% of GDP which is well within the ambit of 2.5% which the centre is aiming for.

Primary care remains critical and effective in promoting good health and reducing disease and the attendant costs. US data shows that focussing on primary care for over a decade resulted in 36% reduction in hospital days, 42% reduction in emergency and a 25% increase in childhood immunisations (4). In the same vein, Family Health Program of Brazil (2000-2010) reported that for every 1 lakh population in 24-74 age group, there was a reduction in number of CVS disease cases from 40 to 27 and a reduction in hospitalization from 3.32 to 2.83 (5).The current scenario of high costs is making hospital care unsustainable and in this situation, comprehensive primary care to prevent , avert and manage disease at the early stages is emerging a global priority which needs to be kept in mind while implementing NHP 2017.

Prevention, promotion and early diagnosis of disease is the only cost-effective option for India on the basis of current spending of 1.15% of GDP on health. Such low resources make hospital based treatment non-affordable and non-feasible. So, assured primary health care to all is the need of the day. The challenge rests with the implementing agencies to formulate plans for transformative change envisioned in the NHP-2017.

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