NATIONAL HEALTH POLICY – 2015
A CATALYST FOR SUSTAINABLE DEVELOPMENT IN PRIMARY HEALTH CARE

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This National Health Policy addresses the urgent need to improve the performance of health systems. It is being formulated at the last year of the Millennium Declaration and its Goals, in the global context of all nations committed to moving towards universal health coverage. National Health Policy is a declaration of the determination of the Government to cover economic growth to achieve health outcomes and an explicit acknowledgement that better health contributes immensely to improved productivity.

There are many infectious diseases which the system has failed to respond to – either in terms of prevention or access to treatment. Then there is a growing burden of non-communicable disease. The second important change in this context is the emergence of a robust health care industry growing at 15% compound annual growth rate (CAGR). Thirdly, incidence of catastrophic expenditure due to health care costs is growing and is now being estimated to be one of the major contributors to poverty. The drain on family incomes due to health care costs can neutralize the gains of income increases. The fourth change is that economic growth has increased the available fiscal capacity. Therefore, the country needs a new health policy that is responsive to these contextual changes. The political will to ensure universal access to affordable healthcare services in an assured mode – the promise of Health Assurance – is an important catalyst for the framing of a New Health Policy in a developing India.

Aim of the National Health Policy

The primary aim of the National Health Policy, 2015, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investment in health, organization and financing of healthcare services, prevention of diseases and promotion of good health, developing human resources, encouraging medical

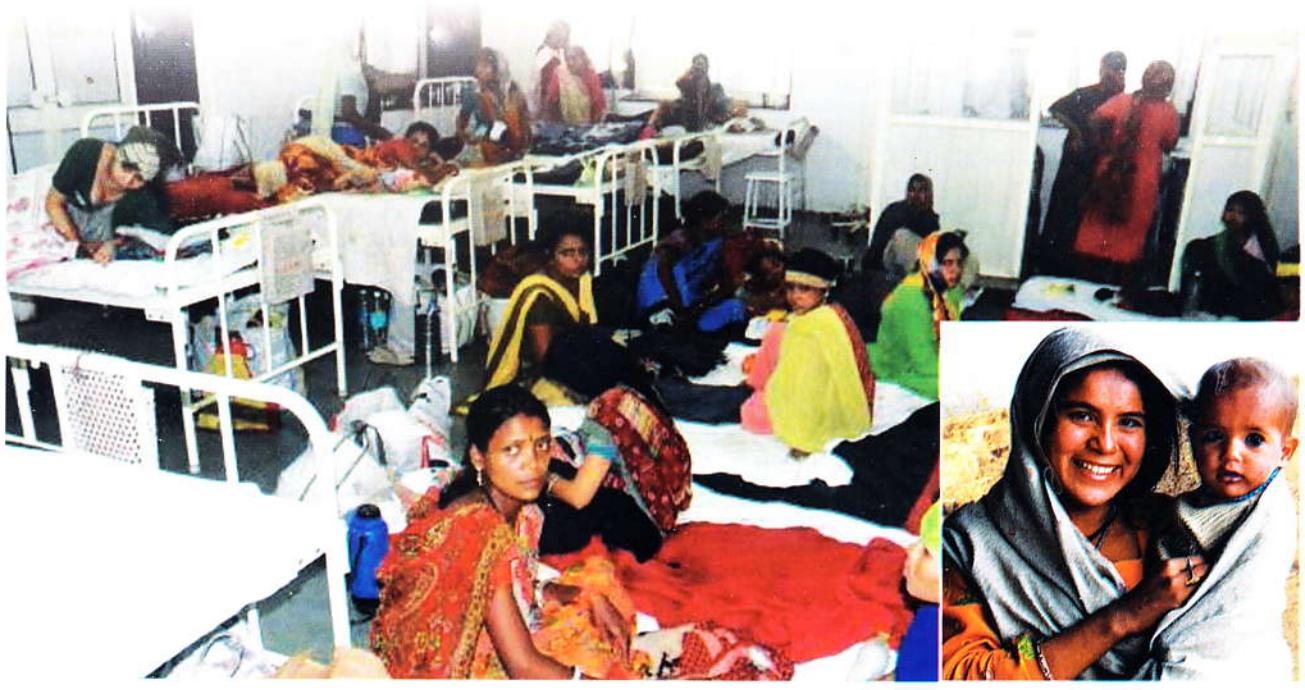

TABLE - I

Government Expenditure as on 2013 (percentage of total expenditure)

Country	Defence	Education	Health
India	28.6	19.3	4.2
Bangladesh	13.7	14.8	5.3
Srilanka	16.8	13.7	6.2
Pakistan	36.5	3.5	2.05
Costa Rica	19.6	23.4	28.8
UK	16.4	8.2	15.7
USA	27.5	6.1	18.6
Germany	14.6	3.4	20.1

Source : World Development Report, 2013

pluralism, building the knowledge base required for better health, financial protection and regulation and legislation for health.

Comparative Health Investment Analysis

A comparative analysis of the government expenditure on Defence, Education and Health in developed and developing countries reveal that the investment on health sector in India is lowest in the world.

The above (Table – I) reveals that the percentage of total expenditure on Health sector is India is only 4.2 percent as per the World Development Report 2009. A comparative analysis of health investment reveals that the performance of Srilanka, Bangladesh in the health sector is more satisfactory compared to India. The health investment in Bangladesh is about 5.3%, Srilanka, 6.2% Pakistan 2.05%, UK 15.7%, USA 18.6% while in Germany it is 20%. The table shows there is certainly a downward trend in health investment in India.

Global Investment in Health Care

Despite years of strong economic growth and increased Government health spending in the 11th Five Year plan period, the total spending on healthcare in 2011 in the country was about 4.1% of GDP. Global evidence on health spending shows that unless a country spends at least 5–6% of its GDP on health and the major part of it is from Government expenditure, basic health care needs are seldom met. The Government spending on health care in India's expenditure on health care is only 1.04% of GDP which is about 4 % of total Government expenditure. This translates in absolute terms to Rs.957 per capita at current market prices. The Central Government share is Rs.325 (0.34% GDP) while State Government share translates to about Rs.632 on per capita basis at base line scenario. Perhaps the single most important policy pronouncement of the National Health Policy 2002 articulated in the 10th, 11th and 12th Five Year Plans, and the NRHM framework was the decision to increase public health expenditure to 2 to 3 % of the GDP. Public health expenditure rose briskly in the first years of the NRHM, but at the peak of its performance it started stagnating at about 1.04 % of the GDP. The pinch of such stagnation is felt in the failure to expand workforce, even to train and retain them. This reluctance to provide for regular employment affects service delivery, regulatory functions, management functions and research and development functions of the Government. Though there is always space to generate some more value for the money provided, it is unrealistic to expect to achieve key goals in a Five Year Plan on half the estimated and sanctioned budget. The failure to attain minimum levels of public health expenditure remains the single most important constraint.

Role of State and the Centre

According to NH Policy one of the most important strengths and at the same time challenges of governance in health is the distribution of responsibility and accountability between the Center and States. Though health is a State subject, the Centre has accountability to Parliament for central funding – which is about 36% of all public health expenditure and in some states over 50%. Further it has its obligations under a number of

international conventions and treaties that it is party to. Further, disease control and family planning are in the concurrent list and these could be defined very widely. Finally though State ownership has been used by some states to become domain leaders and march ahead setting the example for others.

The Centre has a responsibility to correct uneven development and provide more resources where vulnerability is more. The way forward is for equity sensitive resource allocation, strengthening institutional mechanisms for consultative decision-making and coordinated implementation and provision of capacity building and technical assistance to States. The main challenge at both Centre and States are strengthening the synergistic functioning of the directorate as the technical leadership and the civil services as the administrative leadership and coordinating both of these with the increasing number of State owned or fully state financed corporations, and registered societies and autonomous or semi-autonomous institutions.

Budget Allocation for Flagship Schemes

Under public policy approach the successive governments at the centre started innovative Flagship schemes to improve the socio economic conditions of the rural poor under Social Welfare Reconstruction Programme in 2003, 2004.

The ICDS success depends on the Anganwadi worker a woman who is the pilot of the programme. The scheme is government's main weapon to combat child malnutrition. The expenditure towards health in India under NRHM is gradually showing increasing trend. The investment for NRHM in 2006 was Rs. 7786 crores in 2008-09 Rs. 11988 crores while in 2013-14 the out lay on NRHM was about Rs. 16972 crores. However, India's achievement on the Health front is not encouraging due to faulty implementation of public health policy (PHP).

Mental Health – Psycho-social Support

One public health priority that needs urgent attention is the state of neglect of mental health issues. The gap between service availability and needs is widest here- 43 facilities in the nation with a 0.47 psychologists per million people. Improving this situation requires simultaneous action on mental health. Integration with the primary care approach so as to identify those in need of such services and refer them to the appropriate site and follow up with medication and tele-medicine linkages. This would also require specially trained general medical officers and nurses who are able to provide some degree of referral support at the secondary care level in a context where qualified psychiatrists will remain difficult to access for many years. These mid -level psychiatrists would also be enabled by tele-medicine linkages. Supplementing primary level facilities with counselors and psychologists would be useful in several programmes including mental health, such as adolescent and sexual health programmes and HIV control. They could also be charged with creating a network of community members who can provide psycho-social support for such problems.

The key principle around which we build a policy on human resources for health is that workforce performance of the system would be best when we have the most appropriate person , in terms of both skills and motivation, for the right job in the right place, working within the right professional and incentive environment.

A policy framework in human resources for health that is based on the above principle would need to align decisions regarding how and where

TABLE - II Union Budget Allocation for Flagship Schemes - 2004-2014 (Rs. In Crores)

Flagship Scheme	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2013-14
ICDS	1802	1934	3326	1088	4857	5665	6026	84306
Sarva Shiksha Abhiyan	2732	4734	7166	10146	12020	19040	11933	10986
Mid Day meal	1375	1508	3011	413	6004	9514	7014	9087
NRHM	0	0	6713	7986	10708	11988	14367	16972

to encourage growth of professional and technical educational institutions, how to finance professional and technical education, how to define professional boundaries and skill sets, how to shape the pedagogy of professional and technical education, how to frame entry policies into educational institutions, how to define and ensure quality of education and how to regulate the system so as to generate the right mix of skills at the right place. Similarly public health institutions would need to have enlightened rules – formal and informal- for attracting, retaining and ensuring adequate numbers of persons with the right skill in the right place. Such policies would have an impact on the growth and work culture of the private sector too. Currently most human resources created, crowds into urban areas, creating a highly competitive market for clients who can pay.

The efforts towards de-stigmatising the psychological disabilities would be further strengthened under this policy. The National Health Policy reveals that the need of the day is not a headlong (market-driven) expansion of the pool of professional and technical human resources for health, but a planned increase that creates human resources that meet the specific requirements for professional and technical skills that are needed to the public.

Revamping Medical Technologies

India is the pharmacy to the developing world, but about half of its population does not have access to essential lifesaving medicines and the situation is worse when it comes to medical devices and in-vitro diagnostics. India has a great tradition and capacity for innovation in most areas, but despite having the technical capacity to manufacture any drug useful to the common people with ensured marketing facilities. Its role in new drug discovery and drug innovation including in bio-pharmaceuticals and biosimilar, even for its own health priorities is limited. India has a public health system with a stated commitment to providing universal access to free care, but out of pocket expenditures as a proportion on account of access to drugs and diagnostics is prohibitively highest in the world. These are the paradoxes that the national health policy addresses. Learning from the experience and the consensus amongst expert groups that have examined the issue of progress to universal health care, making available good quality, free essential and generic drugs and diagnostics, at public health care facilities is the most effective way at this present juncture. The drugs and diagnostics available free would include all that is needed for comprehensive primary care including all chronic illnesses in the assured set of services. One of the challenges to ensuring access to free drugs and diagnostics through public services is the quality of public procurement and logistics. Public procurement and distribution when well done, as Tamilnadu and more recently Rajasthan has shown, reduces out of pocket expenditures on account of drugs and diagnostics considerably and increases access while limiting irrational prescription practices. Quality assurance of a very high order has also been demonstrated to be possible in such systems.

Conclusion

National Health Policy 2015 would play a significant role in improving Medicare and primary health care in India, provided the policy is implemented by the state and central governments with a total responsibility and a political will. The earlier health policies have faced innumerable constraints in implementation. The policy envisages proper implementation of frame work with approved financial allocations with measurable output targets and policy frame work. The implementation frame work would also reflect learning from past experience and identify administrative reforms required to govern public financing, institutional frame work, human resource policies to achieve sustainable development in the field of primary health care in India.

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