Draft National Health Policy 2015
A Public Health Analysis

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This paper contributes to the debate on the Draft National Health Policy 2015 by analysing and critiquing some of its key recommendations within the prevailing social, economic, and political context of the country. This policy seems to suggest that strategic purchasing of curative health services from both the public and private sectors can enable India to achieve the goal of "universal healthcare." The draft policy is based on two assumptions. One, policy interventions since the National Health Policy 2002 have been largely successful and two, there is harmony of purpose between public and private healthcare delivery systems which allows the private sector to be used for achieving public health goals. This article argues that these assumptions are flawed, highlights the various contradictions in the policy and cautions against over-optimism on publicly-financed health insurance schemes.

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The Ministry of Health and Family Welfare (MoHFW) had put up its Draft National Health Policy (DNHP) 2015 document for public debate, comments, and suggestions. Chowdhury (2015) and Phadke (2015) have both contributed rich perspectives to the debate on the DNHP. This paper offers a critique and is meant to contribute to this debate. However, there are points of divergence and congruence between this critique and the opinions expressed by these two authors. Chowdhury (2015: 25) introduces his submissions thus:

> The National Health Policy 2015, which is in the process of being finalised, should, in place of the earlier 'broadband' approach, adopt a 'narrow focus' on primary healthcare through the National Rural Health Mission. The latter has focused on primary healthcare and has shown visible results.

This opinion essentially implies that the DNHP ought to have taken the initiatives introduced as part of the National Rural Health Mission (NRHM) further by expanding their reach and making them more comprehensive. It should be noted that the NRHM was designed for a specific purpose and as such cannot be a substitute for a "National Health Policy" which by definition ought to cover the entire gamut of issues that affect people's health and healthcare services. Not only did the NRHM falter in achieving the goals set before it; but as is argued in this paper, its success has been marred by the larger trends that have come to dominate the health services system of the country. As such, the differentiation between a "broadband approach" and a "narrow focus" only on primary healthcare is artificial and could be counterproductive. Phadke (2015), on the other hand, has concentrated on two important issues of "strategic purchasing" of secondary and tertiary care services, an important recommendation of the DNHP, and the regulation of the private health sector. Our critique discusses these issues, but brings forth very different aspects without repeating the views expressed in Phadke (2015).

In order to put the draft policy document in perspective, Section 1 looks at the economic, political and historical context. Section 2 highlights the basic premise of the DNHP 2015, and Section 3 discusses the major recommendations of the draft policy. The last section critiques its major formulations.

1 Economic, Political and Historical Context

This draft policy comes in the background of the implementation of the "neo-liberal" economic policies by different governments since 1990. Despite basic unity among the ruling classes on such policies, there have nevertheless been contestations among them over the issue of mitigating their adverse impact. These contestations were at play in the formulation of various

social sector initiatives by the erstwhile United Progressive Alliance government. The NRHM, announced on 12 April 2005, with the intention of rejuvenating the rural healthcare in the country, has been one of the most important health policy initiatives in recent history.

However, with the publication of the DNHP, health policy formulation in the country seems to have come full circle since the launch of the NRHM. While the NRHM was preceded by extensive consultations, this has not been the case with the DNHP. As a consequence, even the notional social-democratic considerations of the kind associated with the formulation of the NRHM are missing.

These are worrying signs and point towards an acceleration in the consolidation of the neo-liberal development paradigm. The disparate forms of this trend became increasingly concretised during the 2000s. Beginning with the unanimous passage of the Special Economic Zone (SEZ) Act in May 2005, Parliament has shown remarkable unity in passing major laws towards strengthening the legal framework for the implementation of neo-liberal economic policies. The recent passage of the Labour Laws (Exemption from Furnishing Returns and Maintaining Registers by Certain Establishments) Amendment Bill, 2011 (*Hindu* 2014a) and the Apprentices (Amendment) Bill, 2014 (*Hindu* 2014b) in Parliament by voice vote, without a single vote being cast against these, furnishes further proof of this unity.

The global economic crisis of 2008 was followed by the deceleration in economic growth rates which contributed to the gloomy economic scenario both internationally and nationally. This has further added to the desperation in the pursuit of elusive high economic growth by rendering ever more areas of the economy to maximisation of profits by private capital. In this respect, the potential of the healthcare industry had been recognised early on. Recognising this as an important context for the present draft policy, the document states:

> The second important change in context[1] is the emergence of a robust health care industry growing at 15% compound annual growth rate (CAGR). This represents twice the rate of growth in all services and thrice the national economic growth rate (MOHFW 2014: 3).

It further states:

> Indeed in one year alone 2012–13, as per market sources the private health care industry attracted over 2 billion dollars of FDI much of it as venture capital. For International Finance Corporation, the section of the World Bank investing in private sector, the Indian private health care industry is the second highest destination for its global investments in health (MOHFW 2014: 9).

These statements are potent tools of policy formulation designed to leverage the role of markets in healthcare that benefits capital. Health and well-being of the people is thus incidental to this primary objective. The DNHP thus privileges an economic agenda in healthcare rather than a public health agenda.

2 Overall Premise

Before analysing the actual recommendations, it is important to understand the overall premise of the policy document, which seems to proceed from two fundamental assumptions:

(i) Barring some shortcomings, overall the policy initiatives taken subsequent to the National Health Policy 2002 have served us well, and that further development of health services can be achieved by strengthening earlier initiatives and supplementing them with new policy initiatives.

(ii) There is seamless continuity and harmony of purpose between the public and the private healthcare delivery systems which renders the latter amenable to achieve public health goals in health policy.

The document states the various achievements made as a result of the previous policies, such as a near total achievement of the Millennium Development Goals (MDGs) related to health; a substantial increase in the number of health personnel in the peripheral health services, especially an increase in the number of accredited social health activists (ASHAs) who have served as a principal instrument for pushing the institutional delivery rates; and "major increases in outpatient attendance, bed occupancy and institutional delivery" (MoHFW 2014: 6).

Another major achievement that is listed is in the area of publicly financed health insurance schemes. The document states:

> The population coverage under these various schemes increased from almost 55 million people in 2003–04 to about 370 million in 2014 (almost one-fourth of the population). Nearly two thirds (180 million) of this population are those in the Below Poverty Line (BPL) category. Evaluations show that schemes such as RSBY, have improved utilisation of hospital services, especially in private sector and among the poorest 20% of households and SC/ST households (MOHFW 2014: 8).

The document is also forthcoming in acknowledging some of the shortcomings of the previous health policy initiatives. Regarding the NRHM, it states:

> Much of the increase in service delivery was related to selective reproductive and child health services and to the national disease control programmes, and not to the wider range of health care services that were needed (MOHFW 2014: 6).
> While such a limited scope enabled progress in a few indicators, this was a poor strategy. Beyond a point, such selective facility development is neither sustainable nor efficient (MOHFW 2014: 7).

Likewise, with respect to publicly financed health insurance, it states:

> The insurance schemes vary widely in terms of benefit packages and have resulted in fragmentation of funds available for health care; especially selective allocation to secondary and tertiary care over primary care services. All National and State health insurance schemes need to be aligned into a single insurance scheme and a single fund pool reducing fragmentation (MOHFW 2014: 9).

These pronouncements, however, ought to be seen in relation to the emphasis laid in the document on (i) non-coverage of conditions like non-communicable diseases and injuries in the present set of interventions, and (ii) the need to reduce the catastrophic out-of-pocket expenditures incurred both in public as well as private health facilities.

Hence, among its objectives the draft policy emphasises the following (MoHFW 2014: 14–15):

(i) Significant reduction in out-of-pocket expenditures on healthcare to reduce the incidence of catastrophic expenditures and consequent impoverishment.

(ii) Apart from reproductive, maternal, child and adolescent health services, include care for most prevalent communicable and non-communicable diseases as free, comprehensive and universal primary healthcare entitlement.

(iii) Universal access to free essential drugs, diagnostics, emergency ambulance services, and emergency medical and surgical care services.
(iv) Improve the access to affordable secondary and tertiary medical care through both public hospitals and their strategic purchase from private health sector.
(v) An "effective, efficient, rational, safe, affordable and ethical" health services system shall be sought to be developed by seeking to align the goals and objectives of the private healthcare industry with public health goals.

The document seems to suggest that a health policy can broaden the ambit of services delivered through primary healthcare services while simultaneously reducing the catastrophic health expenditures through a policy of strategic purchasing of curative health services from both the public and private sectors, and that such a policy can enable India to achieve the goal of "universal healthcare."

3 Major Recommendations

The DNHP states its overall goal as:

> The attainment of highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence (MoHFW 2014: 13).

In order to achieve this, the DHNP lists some major recommendations, which are summarised below.[2]

3.1 Primary Care Services and Continuity of Care (MoHFW 2014: 22–23)

- While the draft policy talks of "upgrading existing health sub-centres" and orienting all primary health centres (PHCs) to provide "comprehensive set of preventive, promotive, curative and rehabilitative services," it simultaneously talks of delivering "comprehensive primary care" as an entitlement, wherein every family shall possess a health card that will link them to a primary care facility and be eligible for this "package of services."
- This package of services is to be delivered through suitably trained nurses and paramedical workers. For all chronic illnesses, it is proposed that once a treatment is started by a doctor or specialist at a higher facility, the continuance phase of treatment can be provided locally by the primary care team.
- The successful implementation of the package of "primary care interventions" shall be supported through a system of individual or team incentives and that ASHAs shall have a crucial role in such implementation.
- The draft policy talks of referral linkages and support mechanisms for primary care facilities by leveraging their two-way linkage with secondary and tertiary facilities through telemedicine and information and communication technology.

3.2 Secondary and Tertiary Care Services (MoHFW 2014: 25–25, 42)

- It is proposed to purchase the secondary and the tertiary care services from the public sector as well as the private sector facilities with public funds, either by the government directly or through national or state level intermediary institutional mechanisms like insurance agencies and trusts.
- The DNHP introduces a concept of "strategic purchasing," which refers to "the government acting as a single payer—purchasing care from public hospitals and private providers as part of strategic plan for district health systems development." Another important aspect of strategic purchasing:

> One element of strategic purchasing is that there is preference to public facilities—justified by the needs of national health programmes, many of which are not and never will be commercially remunerative; by the need to retain adequate reserve capacity for public health emergencies ...Even within the private sector a strategic preference for not for profit hospitals which are prepared to work on cost recovery principles and address public health goals in a spirit of service would require to be prioritised (MoHFW 2014: 24).

- It is claimed that strategic purchasing shall help provide stewardship to the private sector to develop itself for providing health services privileged by the state in strategic purchase.
- In relation to the public sector facilities, it is proposed that while expenditure on core infrastructure facilities, human resources, and supplies would be met through budgetary allocation; an increasing part of resource allocation would be "responsive to quantity, diversity and quality of caseloads provided care."
- As part of reorienting public hospitals, it is proposed that rather than being viewed as providers of free healthcare, they shall be viewed as part of a "tax financed single payer healthcare system" wherein they shall be remunerated through prepayment akin to commercial insurance—a method that has been deemed "cost effective" in providing for the healthcare needs of the population.

3.3 Infrastructure Development

- With regard to infrastructure development the policy makes a very important shift: "From normative approaches in their development to targeted approaches to reach under-serviced areas" (MoHFW 2014: 20) wherein "a conscious effort shall be made to identify districts and blocks which have the larger gaps for development of infrastructure and deployment of additional human resources" (MoHFW 2014: 25).
- The policy also seeks to achieve a measurable improvement in the quality of care in public health facilities with certification from competent boards. It is also intended to incentivise the facilities showing a measurable improvement in this regard (MoHFW 2014: 26).

3.4 Human Resources for Health (MoHFW 2014: 37–38)

- The government intends to strengthen the existing 58 medical colleges and upgrade district hospitals in 58 districts to medical colleges.
- To fulfil the faculty requirement in these medical colleges and provide personnel for high quality biomedical research, it is proposed that the number of AIIMS-like institutions shall be increased from nine to 15.
- It is proposed that the "rules regarding setting up of medical colleges and the entire system of regulation of medical education would also be informed and guided by the needs of correcting the current distortions of medical educational

policy that have led to this mismatch between needs and skills."

- Apart from measures such as attractive pay scales and better living and service conditions, it is proposed to give preference to students from under-serviced areas, in the hope that they will be willing to go back and serve in these areas. To motivate doctors to work in disadvantaged communities, it has been suggested to combine a more rural location of medical colleges and a curriculum and pedagogy of medical education which provides exposure and motivation to work with communities.
- A slew of measures have been proposed to enhance the training of specialists and to increase the availability of personnel from paramedical disciplines and ayurveda, yoga and naturopathy, unani, siddha and homeopathy (AYUSH) for taking care of curative needs of the people in primary care settings, by introducing various bridge courses to impart them necessary skills.

Will These Policy Prescriptions Succeed?

Health is produced in the social, economic, political, and cultural context of a given society. It is only natural then that the recommendations of the draft policy should be analysed within the prevailing social, economic, and political context of the country.

There are two principal contradictions that bedevil the development of health services in the country and the public health outcomes resulting therefrom. These are:

(1) Contradiction between the private sector healthcare, with corporatised tertiary care hospitals as its highest form, and the public sector healthcare (including all primary, secondary and tertiary care institutions) to leverage the healthcare needs of the people.

(2) Contradiction between the healthcare needs of the affluent sections and those of the masses, that is, class interests in healthcare provisioning.

These contradictions are formative for other contradictions in the delivery of healthcare services, such as between preventive and curative care; between rural and urban; between primary and secondary or tertiary levels of care; between pre-/para-clinical disciplines and clinical disciplines and those between different clinical disciplines themselves.

The policy planners have tried to resolve these principal contradictions by negating their very existence. Their argument is that: (i) Both public and private sectors can be leveraged towards fulfilling the public health needs of India (MoHFW 2014, 2002), and (ii) there is no contradiction between providing for the healthcare needs of the affluent and those of the poor; and that the government is fully committed towards providing affordable healthcare for the poor. However these arguments merit a closer scrutiny.

The Public and Private Sectors

To borrow from the Chinese leader Deng Xiaoping's famous maxim, "It doesn't matter whether a cat is white or black, as long as it catches mice," one might ask: how does it matter whether it is public or private sector healthcare so long as it successfully caters to the health needs of the people? Meanwhile, we need to remember that Deng Xiaoping led the establishment of market socialism in China.

The supposed harmony between the public and private sectors, of which public–private partnerships (PPPs) are a specific form, is the new age panacea constructed at the end of the 1990s. These partnerships were initiated to circumvent the problems created by blanket privatisation of the development sector under neoliberal economic policies. The International Monetary Fund (IMF) in its policy paper of March 2004 on PPPs stated the following:

> By the late 1990s privatisation was losing much of its earlier momentum, yet concerns about infrastructure remained in many countries. It was at this time that PPPs began to emerge significantly as a means of obtaining private sector capital and management expertise for infrastructure investment, both to carry on where privatisation had left off and as an alternative where there had been obstacles to privatisation (IMF 2004: 4).

There is an irreconcilable conflict between the very motives of the "private" and "public" sectors—the motive of "profit maximisation" of the private sector, and the "need to serve all irrespective of the ability to pay" of the public sector, which precludes any symbiotic relationship between the two. The public health sector is entirely dependent on public resources and government patronage for its nourishment. But when the government itself is committed to encourage the expansion of the private sector, the relationship between the two sectors becomes outright parasitic wherein the private sector flourishes at the cost of enfeebling the public sector. The formal pronouncements of commitment towards strengthening public sector are meant only for public consumption.

In terms of government encouragement and committing public resources towards the growth of the private health sector, the health policy draft states:

> The Government has had an active policy in the last 25 years of building a positive economic climate for the health care industry. Amongst these measures are lower direct taxes; higher depreciation in medical equipment; Income tax exemptions for five years for rural hospitals; custom duty exemptions for imported equipment that are lifesaving; Income tax exemption for Health Insurance; and active engagement through publicly financed health insurance which now covers almost 27% of the population. Further forms of assistance are preferential and subsidised allocation of land that has been acquired under the public acquisitions Act, and the subsidised education for medical, nursing and other paramedical professional graduating from government institutions and who constitute a significant proportion of the human resources that work for the private sector;... (MOHFW 2014: 9).

Contrary to this, under the section "NRHM as an instrument for strengthening state health systems," the state of affairs has been acknowledged as follows:

> The National Rural Health Mission was intended to strengthen State health systems to cover all health needs, not just those of the national health programme. In practice, however it remained confined largely to national programme priorities…Strengthening health systems for providing comprehensive care required higher levels of investment and human resources than were made available. The budget received and the expenditure there under was only about 40% of what was envisaged for a full re-vitalisation in the NRHM Framework (MOHFW 2014: 7).

There have been instances when even the programmatic interventions under the NRHM became an excuse for privileging the private health sector, rather than strengthening the public sector rural healthcare. In 1992, Uttar Pradesh (UP) launched a PPP called the Merrygold scheme, based on a "social franchising model" (UP NRHM 2013). The Programme Implementation

Plan for 2013–14 submitted to the MoHFW states one of the objectives of the Merrygold scheme was "to provide choice of services of assured quality to people at affordable pre fixed prices and thereby *shifting the workload of public health facilities"* (UP NRHM 2013, emphasis ours).

The role of the NRHM in the scheme was described as (i) Accreditation of the franchised hospitals with the government health schemes, that is, Janani Suraksha Yojana and Family Planning; and (ii) Linkage of ASHA workers with each franchised facility for client referrals (UP NRHM 2013).

So the services that were to be provided by a strengthened public health apparatus were finally opened up to the private sector, subsidised through public money, in the name of providing a "choice of services" and ASHA—the "social health activist"—was turned into the agent for bolstering the private healthcare industry.

In 2013, Uttarakhand outsourced 16 of its best community health centres (CHCs) to private for-profit sectors for fully operationalising their services. As per the terms of reference of the contract, the state government assured 15% profit for the operators irrespective of the footfall at the facilities. Further, the operator was to provide only the clinical services and had no responsibility for implementing preventive and promotive functions of the national health programmes (Bajpai 2014).

The phenomenon of non-compliance by many corporate hospitals of their obligation to treat poor patients free of charge despite availing of huge public subsidies has been well documented (Qureshi Committee Report 2001). However, in a remarkable example of how the government is willing to privilege the "profit" interest over public interest, the draft policy document states:

> 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 health care (MoHFW 2014: 36).

But have their "requirements and perceptions" not already influenced public policy insofar as such a statement finds place in the National Health Policy document?

Corporate hospitals today have come to occupy the "commanding heights"[3] of medical practice in the country—a place that not so long ago was reserved for medical college hospitals. As a consequence, the motto of earning super profits from human misery due to disease, instead of earning a decent living by rendering necessary services, has come to be recognised as a legitimate goal of medical practice. This has dislodged the medical profession from its ethical roots in serving the society. The overall objective of maximising profits and absolute accountability to shareholders imposes a political economy of medical practice that has the following consequences. One, curative care must be privileged over preventive and promotive care leading to a neglect of the social determinants of health. Two, within curative care, high-end technologies, irrespective of their desirability and affordability, must be privileged even if simpler, effective, efficient, and affordable technologies are available. Such a pattern of care prioritises the healthcare needs of the rich over those of the poor.

This pattern of care also places its demands on the content of medical education—it moulds the career choices and ethical moorings of medical graduates. Today, the skill set of graduates and postgraduates from our medical colleges makes them feel more at home in the better-equipped medical facilities of the cities, or indeed the "world class" hospitals in the US or the UK, rather than in a rural PHC or CHC in India.

Privileging curative care also fuels the pursuit of specialisation and super-specialisation in clinical disciplines at the cost of preventive and socialised medicine. A health services system geared to cater to the needs of the affluent in the main, seeks to enhance the monopoly of the elite over the medical profession such that there is little dichotomy between the aspirations of medical professionals and the overall objectives of the market-oriented health services system they serve. The rapid spurt in private medical colleges is but a consolidation of this trend. The few recruits from marginalised regions or communities who manage to enter the profession might find their sense of belonging for their region or community too weak to stand up to the dominant moorings of the system, for compliance with the latter is essential for their rise in the system (Ananthakrishnan 2010).

Domination of the market in the healthcare system of the country is both systemic and systematic. The multi-specialty hospitals of the bigger cities are linked up with smaller nursing homes, doctors, and employees in the public health facilities, private clinics, formal and non-formal medical practitioners down to the level of towns and districts to ensure a steady supply of patients. There is a well-oiled system of cuts, commissions and agents (Nagral 2014; Nundy 2014; Gadre 2015).

A viable public sector is a threat to the hegemony of the private sector; hence, it is imperative that public health services be undermined. Starving public facilities of funds, stopping recruitment altogether or recruiting personnel on contractual basis, offering unattractive wages such that the best talent is kept out, and poor supply of material are just some of the measures adopted to demoralise public sector health workers and reduce the functionality of services. Public health facilities have also been undermined by engraining commercial principles and processes in their functioning through commercialisation of their services.

This however does not mean that no form of private sector can be harnessed for achieving public health goals. The National Health Service of the UK utilises the services of many general practitioners integrated with the national health system in order to meet the primary-level healthcare needs of the people. But a highly regulated private practice and public health services continuing to define the "commanding heights" of medical practice is a necessary condition to achieve such collaboration between the public and the private sectors.

Interventions since 2002: Some Lessons

As mentioned before, one of the assumptions underlying the premises of the DNHP is that the policy interventions post-NHP 2002 have been largely successful. Some of the successes that have been mentioned in the document are achieving MDGs with respect to maternal and child mortality along with a rise in rates of institutional deliveries; and a wide expansion of publicly provided

health insurance which seems to have hugely powered the most prominent recommendation of the present policy—strategic purchasing of secondary and tertiary level health services.

MDGs and the Package of RCH Related Interventions: The attribution of the decline in maternal mortality ratio (MMR) and child mortality rates to the package of interventions in reproductive and child health (RCH) is highly circumspect. First, there is no evidence to show a direct correspondence between the two at the all-India level. Rather, in the case of UP, a steep rise in the rates of institutional deliveries has been accompanied with a slower decline in the infant mortality rate and the MMR; with this slowdown being particularly sharp for the latter (Bajpai, undated).

The network of sub-centres, PHCs, CHCs, and district hospitals in the country meant to cater to the healthcare needs of rural India might be huge, but there are serious questions regarding the level of functionality of these facilities and the quality of services rendered by them even with regard to the limited services offered by them.

All CHCs, as conceived to begin with, were to provide secondary level care with specialist consultation in all basic clinical disciplines and were to function as the first referral unit (FRU) for various kinds of emergencies. However, the non-availability of specialists in many of these disciplines has compromised their ability to perform these functions. At the all-India level, only 52% of the CHCs were designated as FRUs and only 18.7% were providing caesarean section facilities even though 25% of the CHCs had the services of an obstetrician (see Table). Of the CHCs providing C-section services, less than half had blood storage facility, without which, performing C-section is fraught with immense risk. One can likewise read the data of some of the other Empowered Action Group (EAG) states in north India to draw appropriate conclusions. Such discrepancies can lead to situations where the services cannot be delivered despite physical infrastructure, either because of the absence of doctors, or some other critical facility (such as blood storage). Another issue is unreliable electricity supply due to missing power back-up, which renders these centres dysfunctional. As a result, the system operates suboptimally.

In 2014, a number of civil society groups came together with a report *Dead Women Talking* on 124 maternal deaths reported from 10 different states. Of the total number of maternal deaths, 60% had managed to reach a medical facility in the face of complication, whereas 60 women died in medical facilities, of which 48 died in public health facilities while 12 died in private facilities; 22 women died while travelling from one facility to another. There were heart-rending stories of public health institutions referring women in distress to higher facilities without even having a look at them (Sri and Khanna 2014). The recent death of 13 women, all in their 20s and 30s, in a family planning sterilisation camp organised at Bilaspur, is another case in point (SAMA, JSA and NAMHHR 2014).

These stark findings notwithstanding, with respect to health infrastructure and manpower development, the DNHP talks of moving "from normative approaches in their development to targeted approaches to reach under-serviced areas." Taken in the totality of things, this is nothing but an admission of the fact that "since we cannot meet the norms, we shall emphasise reaching under-serviced areas in a targeted manner." The rationale for targeting could have existed if the need was to address underdeveloped public health services only in some geographical pockets, in an overall reasonably well-performing public health system; this however is not the case with respect to India where the malady is far more pervasive.

Experience of Publicly Funded Health Insurance with Private Service Provisioning: It would be prudent to point out some of the important pitfalls of publicly financed health insurance scheme as a caution against overoptimistic reliance on them to achieve the goals laid out in the DNHP. Providing protection against catastrophic out-of-pocket expenditure has been the stated rationale for implementing publicly financed health insurance schemes; however, available evidence shows that these schemes end up undermining financial protection for the poor.

A study on the impact of the Rashtriya Swasthya Bima Yojna (RSBY), Rajiv Aarogyasri (RAS) in Andhra Pradesh (AP), and Tamil Nadu Health Insurance schemes on out-of-pocket expenditure showed that poorer households in the districts where these schemes were implemented ended up having higher out-of-pocket expenditure, including catastrophic expenditure, as compared to poor households in districts where these schemes were not implemented (Selvaraj and Karan 2012). In AP the annual budget spent under the RAS on surgeries in private hospitals was higher than that spent on tertiary care in public hospitals, but the private hospital associations, by threatening to withdraw from the scheme bargained for higher costs to be paid to them. Hence, while the profits were privatised; the losses were socialised, besides rendering such schemes untenable in the long run (Reddy and Mary 2013; Prasad and Raghavendra 2012). The list of problems in the implementation of these schemes—moral hazard, unnecessary diagnostic tests, the spate of hysterectomies, among others—is indeed too long to be summarised here.

Table: Infrastructure, Staff and Services at CHCs (%)

India/State	Obs and Gyne	24 hr Normal Delivery Services	Functional Operation Theatre	Designated as FRUs	Designated as FRUs Offering Cesarean Section	Newborn Care on 24 Hour Basis	Blood Storage Facility
India	25.2	90.0	65.2	52	18.7	76.1	9.1
Bihar	40.9	90.9	86.4	87.9	18.8	72.4	0.0
Chhattisgarh	19.7	99.3	73.0	56.9	22.1	80.8	7.7
Jharkhand	62.5	100.0	87.5	87.5	0.0	85.7	0.0
Madhya Pradesh	15.8	99.6	70.7	61.4	17.7	86.2	6.3
Odisha	87.3	79.0	59.4	53.7	15.5	53.7	15.5
Rajasthan	29.9	98.9	60.3	52.7	38.0	88.2	15.0
Uttar Pradesh	19.5	92.1	88.5	55.8	6.2	71.8	1.3

Source: Government of India (2013).

Pointing to the huge cost to public health on account of the RAS scheme in AP, the former health secretary to the Government of India wrote:

> Among 19 major States, Andhra Pradesh incurred the lowest expenditure of Central grants (National Rural Health Mission and disease control programmes) as proportional to its total health spending during 2011; 16% against 31 and 28 percentages by Maharashtra and Karnataka respectively and the only State to slash its primary care budgets from 53% to 46% and allocate just 9% for secondary care down from 12% during 2007–12. In comparison, RAS was provided 23% of the

health budget for less than 1% of the population (not necessarily poor) or 11.3% of total hospitalization (Rao 2014).

These health insurance schemes are only payment mechanisms which fail to account for a number of non-financial barriers that temper the impact of these schemes on out-of-pocket expenditure. Some of these barriers are regional and rural–urban imbalance in the socioeconomic development and the consequent imbalance in the development of health services, connectivity to health facilities and the availability of efficient means of transport, literacy status of the populace, and their confidence and trust in the available health facilities (Narasimhan et al 2014; Bajpai and Saraya 2012).

Policy planners fail to acknowledge that these schemes are nothing but a sort of reverse cash transfer of public money for ensuring mega profits for corporate-driven healthcare (Rao 2014; Prasad and Raghvendra 2012; *Hindu* 2007).

4 A Critique

Comprehensive versus Package of Services: On the one hand, the policy promises to deliver a "comprehensive set of preventive, promotive, curative, and rehabilitative services" through the sub-centres and the PHCs, and on the other, it refers to a "package of services"—the contradiction between the terms "comprehensive" and "package of services" is self-evident.

Moreover, this package is to be delivered by suitably trained nurses and paramedical workers, implying that the role of trained physicians stands further marginalised at the primary level of care. This means that components such as curative care, which are not within the package, shall be even more difficult to provide at the primary level. This could weaken the credibility of public health institutions and hence be a reason for continued reliance on the private sector.

Commercial Financing Mechanism for Public Hospitals*:* Other than the regular budgetary support for manpower and infrastructure, it is proposed to provide budgetary support for the services of a public hospital through the mechanism of a "commercial insurance scheme." This is meant to bring the operations of public hospitals at par commercially to those of the private hospitals contracted in by the government through strategic purchasing. Given the trend of privileging private healthcare in publicly financed health insurance schemes; this sets the stage for a quiet shift of a greater part of the budgetary support to the private sector at a later date.

Under the RSBY, 3,200 private and 1,100 public hospitals were enrolled throughout India (Basu, undated). Likewise, the bulk of business under the Rajiv Aarogyasri scheme went to the private sector (Srivatsan et al 2011).

Abolition of User Charges and Provision of Free Medicines in Public Hospitals: This by far is the most welcome of the proposals in the draft policy document. However, the extent to which this will be able to provide relief will depend on whether drugs will be free and user charges exempt only for the predefined package of services or for all conditions. If there is large scale outsourcing of services to the private sector, this might only end up increasing the out-of-pocket expenditure besides further deterioration in the services rendered by the public sector.

Even though there has been a reduction in out-of-pocket expenditure on institutional deliveries due to the Janani Shishu Suraksha Karyakram (JSSK); the institutional delivery programme has not managed to bring it down completely (Govil et al, undated; Tripathi et al 2014; Modugu et al 2012). Even the conditional success of the JSSK could be possible because the public health services shouldered the bulk of responsibility for this and not the private sector.

Social Determinants of Health: The DNHP appropriately lays emphasis on "holistic approach and cross-sectoral convergence in addressing social determinants of health" including "measurable achievements" to be achieved through planned and adequately financed institutional mechanisms (MoHFW 2014: 17–18) to improve the "environment for health." However, apart from the Swachh Bharat Abhiyan and the Integrated Child Development Services, there is absence of other initiatives in this regard.

Intersectoral coordination has largely remained a non-starter in the health sector. The policy should have reflected on past experience in this regard to prime the health sector to take initiative in bringing about such a coordinated functioning. Instead, the DNHP reduces the health sector to the role of only undertaking "evidence based advocacy within government and in the media" (MoHFW 2014: 17) to highlight the link between social determinants and disease. Recognising the centrality of social determinants of health, authors have even called for a specific sub-cadre for facilitating action in this regard (Priya and Chikersal 2013).

AYUSH: The principal problem regarding the alternative or Indian systems of medicine is their perception as a poor substitute to allopathic medicine. It has taken a long time since the 1946 Health Survey and Development Committee Report (Bhore Committee Report) for ending the official apartheid against the indigenous systems at least at the level of policy; however, this apartheid seems to continue in practice despite repeated assurances of strengthening educational, curative, and research institutions in this stream. The policy fails to suggest measures to break this logjam, even though it reposes faith in the potential for AYUSH to strengthen the preventive and promotive aspects of health apart from its curative potential.

However, it is to the document's credit that it gives more space and emphasis on folk medicine beyond the textual systems, and that is a welcome shift, which recognises knowledge as an empowering tool.

Institutional Mechanisms: Even a preliminary reflection reveals that countries where the insurance-driven model of healthcare provisioning works with any measure of efficiency have a highly regulated health sector, while in India, private health sector is almost unregulated. In fact, the very character of private health sector poses immense difficulties in its regulation (Baru 2013). In countries like the US, despite regulation, much is left to be desired in terms of fulfilling public health objectives. Phadke (2015) has discussed this issue in more detail.

5 In Conclusion

The DNHP 2015 actually amounts to dismembering the complex process of health policy formulation in a hugely diverse country like India. Overriding this diversity, it adopts a "one solution suits all" approach by decisively pushing an insurance based healthcare model for facilitating a near monopoly of the corporate sector in curative care. Much is being made of the possibilities of harnessing private healthcare for achieving public health goals; however, the fundamental contradiction between the objectives of the private and public health sectors is too powerful to be undone by theoretical formulations.

A huge body of evidence that negates the feasibility of the DNHP recommendations has been conveniently ignored. Given the existing political and economic environment in the country, this is not an inadvertent omission. Complex national and international forces have been at work in shaping the present idea of universal healthcare which is a cruel distortion of the first attempt made by the international community to achieve universal healthcare through a much more holistic approach of primary healthcare (Bisht 2013). Rather than alleviate the suffering of the poor due to disease, this policy has every potential to become the quintessential millstone around their necks. As Qadeer (2013:) has put it:

> A model of Universal Health Care based on public private partnerships [PPPS] in the form public financing and private delivery, focusing on universal access to an essential health package while keeping silent on tertiary care, will ultimately strengthen the for profit health sector at the cost of the public health care services and undermine access to care for the marginalised.

The final results would depend on the rigour with which pro-people health professionals, academics, activists, and the-civil society oppose the pro-business formulations of the DNHP.

NOTES

1 The draft policy document describes four important ways in which the context of healthcare has changed in the country. These are changes in the health priorities, emergence of a robust healthcare industry, rise in catastrophic health expenditure due to healthcare costs, and increased fiscal capacity due to economic growth.

2 We are mentioning here only those recommendations which in our opinion constitute the core thrust of the policy as distinct from the pre-existing public health interventions; or recommendations regarding aspects of health policy which are of structural importance to health services, irrespective of their novelty. Some other recommendations have been commented upon briefly in a separate subsection of the paper.

3 While the heights attained by these hospitals in terms of rational treatment and medical ethics are circumspect, they have certainly defined the heights of technology-driven treatments irrespective of their desirability and the glamour associated with corporate medical practice.

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