National Health Policy 2002: A brief critique

AMIT SEN GUPTA

INTRODUCTION

The National Health Policy (NHP), released by the Ministry of Health and Family Welfare, marks the culmination of a rather tortuous process. It has reportedly been with the drafting board for many years. One would have assumed that such a process would involve wide ranging discussions at all levels. Unfortunately, besides a small group in the Central Health Ministry, almost everyone appears to have been kept out of the process of drafting the new policy. We are now presented with a *fait accompli*. While the policy itself repeatedly states that health is a state subject as per the Indian constitution, from all accounts the state governments have not been involved in the process of drafting, nor has the Central Council of Health and Family Welfare been consulted.

ELOQUENT SILENCE

A critique of the policy is difficult as it is most eloquent where it is silent! It completely omits the concept of comprehensive and universal healthcare. In contrast, the NHP 1983 had said: 'India is committed to attaining the goal of "Health for All by the Year AD 2000", through the universal provision of comprehensive primary health care services.' The policy thus departs from the fundamental concept of the NHP 1983 and the Alma Ata Declaration. It is also conspicuously silent on the village health worker—the first contact in the primary healthcare system. By its silence, the NHP 2002 provides a framework for the dismantling of the entire concept of primary healthcare. Importantly, the section on policy prescriptions in the NHP 2002 is silent on the content of the primary healthcare system.

The policy has nothing substantive to say of the population control programme, which the health movement has long held to constitute a major drain on primary healthcare. It repeats the usual excuse that advances in public health have been nullified by an increase in the population. This refrain contradicts all evidence available across the globe, which show that population stabilization follows attainment of certain socioeconomic standards and do not precede them. The policy practically ignores pharmaceuticals and their impact on healthcare, thereby accepting that it has no role in the formulation of the drug policy. This is even more surprising given the fact that a new drug policy has also been recently announced. Are we to understand that the NHP 2002 believes that increased drug prices and non-availability of essential drugs have no impact on the health sector?

IMPORTANT CONCERNS IGNORED

Other important concerns are either ignored or referred to only in passing. The policy has a four-line section on women's health, without any specific proposals being spelt out. Child health is not even given a separate section. It is silent on child nutrition despite the fact that half the children below 5 years of age are malnourished in India—a dubious distinction that India shares with only one other country (Bangladesh) in the world.

In the area of medical education, the policy talks of the need to introduce postgraduate courses in 'family medicine'. The long-standing position of the health movement has been to limit specialization and reorient undergraduate education to equip doctors in a manner that they are able to better address the health needs of the common people. Such a purpose cannot be served by just introducing another specialty called family medicine. The NHP 2002 betrays a lack of understanding regarding the need to create a system of medical education oriented to the needs of primary care, and instead is biased towards urban specialist-based healthcare. However, it is silent about the bane of private medical colleges and the need to stop setting up new ones and to regulate these institutions.

The section on research harps on 'frontier areas' and medical research. There is no understanding of the necessity to initiate and sustain research on public health. There is no mention of the necessity to regulate medical research and to develop appropriate ethical criteria. The impact of Trade-Related Intellectual Property Rights (TRIPS) is discussed in terms of the possible impact on drug prices, but there is no mention of the crippling effect of TRIPS on medical research.

COMPROMISE AND CONTRADICTIONS

The policy document appears to be a compromise effort that marries contradictory concerns. Section 2, titled 'Present Scenario' analyses many of the present initiatives and their deficiencies. Some of the conclusions drawn in this section are based on sound assumptions. However, many of these assumptions are ignored or contradicted in the operative part of the document, Section 4, titled 'Policy Prescriptions'. The document makes appropriate references to decentralization, inadequate funds, non-viability of vertical programmes, inadequate and dysfunctional infrastructure, etc. in Section 2. However, there are either no matching policy prescriptions in Section 4 or these prescriptions are expressed in vague generalities. Out of the main policy prescriptions, most relate to encouragement of the private sector and legitimization of privatization of the healthcare delivery system.

INCREASED FUND ALLOCATION: TOO LITTLE AND OVERDUE

A further perusal of the policy document throws up many fundamental concerns. The document admits that public health investment has been 'comparatively low'. What it does not admit is the fact that such investment as a percentage of total health expenditure is possibly the lowest in the world; that India has the most privatized health system in the world! The document recommends a welcome increase in public health expenditure from the present 0.9% of GDP to 2% in 2010. However, the quantum suggested is too little and comes very late. It falls far short of the 5% of GDP that has been a long-standing demand of the health movement and recommended by the World Health Organization long ago. Moreover, the policy projects that the public expenditure in 2010 will be 33% of the total health expenditure—up from the present 17%. However, even 33% is lower than that of the average of any region in the globe today—India would continue to be one of the most privatized health systems in the world even in 2010! The policy is eloquent on the inability of states to increase expenditure on

Delhi Science Forum and Peoples Health Assembly

healthcare and laments that the allocation by states has in fact decreased in the past decade. There is a veiled attempt to castigate the states for their inability to increase expenditure. Such insinuations are meaningless without a detailed analysis of the manner in which the process of economic liberalization in India has shattered the financial stability of states.

TOP-DOWN PRESCRIPTION

The NHP 2002, for all the rhetoric on community participation, is replete with 'top-down' prescriptions. While admitting the wastage involved in running centrally sponsored and controlled vertical disease control programmes and envisaging their integration in the decentralized primary healthcare system, it goes on to recommend that we would need to retain many of them! All subsequent formulations in the policy, especially in the section on policy formulations, assume the continuance of vertical programmes. Moreover, the policy repeatedly asserts that the Centre will continue to plan all public health programmes. It continuously harps on the availability of expertise with the Centre to justify strong Central control. It is not clear where the basis of such assertions lie. The document is vague about the actual devolution of responsibility and financial powers to *Panchayat Raj* institutions (PRIs) and relocation of accountability to appropriate levels of local self-governments. In the absence of such clarity there is danger of the primary healthcare system becoming a collector-driven exercise, which is controlled by the Centre, thereby defeating the entire effort at decentralization.

The policy talks about using Indian health facilities to attract patients from other countries. It also suggests that such incomes can be termed 'deemed export' and should be exempt from taxes. This formulation draws from recommendations that the industry has been making and specifically from the 'Policy Framework for Reforms in Health Care' drafted by the Prime Minister's Advisory Council on Trade and Industry, headed by Mukesh Ambani and Kumaramangalam Birla. Such a proposal, termed by many as 'health tourism' will divert our best resources within the country. The policy also talks of encouraging 'the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages'. Further, the document refers to the 'valuable' contributions made by the private sector and the need to 'encourage' more such contributions. While it is often critical of the public health system (justifiably so), there is no criticism of the ills of the unregulated private medical care system, though reference is made to the need to develop regulatory norms.

In brief, the NHP 2002 identifies many of the gross deficiencies of the existing healthcare scenario, proposes a substantial rise in Central Government expenditure on healthcare and has some other positive features such as the proposed regulation of the private sector. However, in operative terms, it constitutes an abandonment of the Alma Ata Declaration, and legitimizes further privatization of the health sector.

(Based on the critique to the Draft National Health Policy, 2001, formulated by the Jana Swasthya Abhiyan: A network of Health Movements across the country.)

Draft National Health Policy 2001: A leap forward in assessment but limping in strategies

V. MOHANAN NAIR

SITUATIONAL ANALYSIS AND STATED OBJECTIVES

The 'Draft National Health Policy—2001' is a leap forward in the history of evolution of healthcare in India. The background against which the draft was prepared is realistic because it was clear that the country could not make all the expected strides mentioned in the previous National Health Policy (NHP) of 1983. The claims on the initiatives in primary healthcare and control or eradication of communicable diseases, and the quoted achievements in demographic, epidemiological and infrastructural indicators are well founded. The concern shown regarding the alarmingly increasing trends of morbidity, even in the wake of declining mortality and the relative inability of the public healthcare system in the country to cope with the mortality and morbidity burdens, is also apt. Thus the justifications provided for the new health policy are convincing and the attempt to have a framework for accelerated achievement of the set public health goals optimistic.

The draft document realizes that the greatest impediment in achieving the set goals of NHP 1983 were factors outside the formal healthcare delivery system such as the fiscal crisis. The equity considerations which the policy emphasizes are also relevant in the current context. Wide variations in health indices across regions is a matter of concern and even in 'better performing states' the overall indicators mask the reality of differentials across regions. This amply justifies the concerns about 'access'. Inequitable distribution of services has worked to the disadvantage of the poor. Still worse is the case of women, children and marginalized sections such as coastal, tribal and migrant populations. Against such a background, the stated objectives of the policy appear realistic.

(A report of the workshop organized jointly by the Achutha Menon Centre for Health Science Studies of Sree Chitra Tirunal Institute for Medical Sciences and Technology and the Department of Health and Family Welfare, Government of Kerala.)

Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, Kerala 695011, India

V. MOHANAN NAIR Achutha Menon Centre for Health Science Studies; *vmnair@sctimst.ker.nic.in*