Comments on the National Health Policy 2015 Draft, AMCHSS, SCTIMST, Trivandrum

These are the comments from a discussion on the draft policy convened by the Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences & Technology, Trivandrum on February 7, 2015.

General Comments

The draft policy is a departure from the earlier ones in terms of dictating the principles on which the policy is crafted and specifying goals and objectives unambiguously. It is to be lauded for having put together the policy principles which form its guiding spirit.

The draft policy is very good at diagnostics – in terms of honestly accepting what has worked and what has not during the earlier policy regimes. However, in terms of moving forward, in an effort to be pragmatic, it has attempted to find solutions to existing problems instead of sketching the broad sweeps of public policy and leaving the minutiae to programme planners. In the effort to find solutions to existing problems, the overall policy seems patchy, with varying potential to hold together for effectiveness.

For the first time the policy explicitly talks of the methods of financing health care, admits to the inability to increasing expenditure on health care. The policy fails to overcome this limitation by identifying the means to enhancing public expenditure on health. Instead, we have the platitude ridden acceptance of this inability, and therefore, the draft policy falls short of making a push for universal health care for all.

The policy also has recognised the need for human resources and policy imperative to develop them. However, it is silent on the necessary policy directives needed to build the human power with training to achieve the envisaged comprehensive primary health care. The market driven expansion will not address the requirements of training to suit primary health care.

The policy has recognised the relevance of medical technologies to a robust health care delivery system. To achieve this, the development of an Indian Medical Device Industry or growth of the indigenous industry needs to be facilitated. This can only be done if the regulatory framework for medical devices is independent of the regulation of drugs. The current regulation folds drugs and devices together thereby doing a dis-service to the device industry and also to the end users in the country. The legal regulations for medical devices need to be put in place.

The policy speaks of governance for health systems for the first time. That this is taken cognizance of is encouraging. The complex structures of governance, the intricacies involved in a federal setup such as India are all explicitly stated. But it fails to identify the solutions that have also emerged within such a set up. The potential to use Local Self Governments (LSGs) as a possible arm for governance of health systems at grass roots level remains unrecognized.

In terms of the legal framework, the policy fails to opt for a goal of free universal access to health care services. Instead it talks of affordability as an option rather than universal

access. As a concept, 'affordable' is difficult to define. It is also possible that such 'affordable' services fail to reach those individuals in dire need.

The policy also fails to recognise two essential principles which are necessary for universalizing health care access in a federal system which obtains in India. These are the principles of solidarity and principles of portability. The principle of solidarity is needed to bridge the equity gap in access and portability addresses the continuity of access across state boundaries in a country that is rapidly urbanizing and migration for various socio-economic reasons is becoming a way of life.

The policy addresses women's health needs in terms of meeting specific needs like reproductive and child health, but fails to recognise the cross cutting nature of gender across all its policy prescriptions. This needs to be addressed systematically and not specifically with respect to only maternity or Nirbhaya-nari schemes.

Specific Comments

The specific comments on each of the directives under the policy are addressed in the following paragraphs.

1. **Goals, Principles and Objectives**

The goal of the National Health Policy 2015 is ' the attainment of the highest possible level of good health and wellbeing, 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.'
Objectives:
3.3.6 ..... should include the phrase 'with a view to closing the health gap'. Therefore, the objective should be altered to read as:
Influence the growth of the private health care industry and medical technologies to ensure alignment with public health goals, and enable contribution to making health care systems more effective, efficient, rational, safe, affordable and ethical, with a view towards closing the health gaps in access.

2. **Policy Directions**

<u>Ensuring Adequate Investment:</u>

(i) The policy envisages increasing the public investment in health to 2.5percent of GDP. While this might seem realistic and pragmatic in keeping with current levels of investment, no country in the world has achieved universal health coverage with such low levels of investment. During times of serious economic crisis such as that the country is passing through, there is a need to protect the health budget (as was done in the case of Thailand), instead of planning for lower levels of investment.

(ii) The draft policy seeks to mobilise the additional fiscal resources through direct taxation, health cess and sin tax imposed on tobacco, alcohol and other products that adversely affect health. These indirect forms of taxation can be regressive and exacerbate the condition of people already adversely affected. The levying of a universal health cess will also not be equitable because, those at lower ends of the income quintiles will pay a greater proportion of their income as cess whereas those at the higher ends will pay a smaller proportion. This would be morally unacceptable.

Preventive and Promotive Health:

(i) Preventive and promotive strategies for health cannot work in isolation and need to be linked to food security, water supply and sanitation facilities. Food security forms an important component of good health outcomes. Conditional cash transfer does not address food security concerns and may dilute the agency to act for one's health. Public Distribution Systems (PDS) reforms should be undertaken to address this lacuna rather than substituting it with conditional cash transfers.

(ii) The policy reiterates the educational needs of adolescents for sexual and reproductive health (SRH) education. The policy should explicitly target boys for such education as it is also their lack of or inadequate knowledge that is the cause for some of the problems in SRH.

(iii) The policy recognizes that many of the social determinants of health fall beyond the scope of the Ministry of Health and will require advocacy with other ministries. But while doing so, the policy should explicitly recognise the monitoring role to be played by the Ministry of Health with regard to action taken on these sectors by the other ministries. Appropriate governance mechanisms for the Ministry of Health to do so should be thought of both in terms of budget allocations and national level monitoring though Niti Aayog.

Organisation of Public Health Care Delivery:

(i) The availability of free comprehensive primary health care can result in its mis-use. This can be checked by teaching student in schools about when and for what conditions health care is essential.

(ii) The road map for an implementation plan for comprehensive primary health care services needs to be made explicit, as this has not been achieved in spite of concerted efforts through the other health policy periods.

(iii)The Accredited Social Health Activist (ASHA) workers are voluntary and charged with responsibilities for several of the health programmes. The accountability of the ASHA to the health system is not addressed. This gap needs to be corrected.

(iv) What is envisaged by 'three dimensional mainstreaming' of alternative therapies such as Ayurveda, Unani, Siddha and Homeopathy (AYUSH) should be made explicit. Does it mean integrated mutually respectful joint practice at the various levels, or exclusive stand alone practices in the same site?

(v) The referral pathways and mechanisms for gate keeping at different levels need to be defined. Primary care, secondary care and tertiary care services should be well connected through protocol based management and referral systems.

(vi) The policy is silent on oral health, rehabilitative and palliative care, replacement therapy (artificial organs). This gap needs to be addressed at all three levels of care.

(vii) The policy needs signal identities that may indicate vulnerability such as unmarried women, unemployed older men, rather than using household status alone to determine financial barriers to seeking care.

3. Human Resources for Health

(i) The draft national health policy is silent on the need for adequate manpower with training to achieve comprehensive Primary Health Care (PHC). Market driven expansion will not address the requirements of appropriate education/training to suit primary health care needs. The process of sanctioning new medical colleges needs a careful scrutiny. The growing evidence regarding poor quality of training imparted in some of the newly approved institutions calls for a review of the Medical Council of India's procedures for sanctioning

(ii) Policy pronouncements on the use of private sector for expanding access should not result in utilisation of inadequately trained personnel as part of the programme for comprehensive PHC. Therefore the policy for procurement of services from the private sector should specify standards of care to be delivered.

(iii) The process of incentivising performance should explicitly state a gamut of non-monetary incentives that would facilitate retention of trained staff. The policy could suggest infrastructural facilities, non-practicing allowance for other health professionals and other non-financial incentives to deploy and retain health professionals in underserved areas.

(iv) Currently, it has been noted that 50 percent of the expenditure of any health system is on staff. Staffing for reaching the underserved areas will need additional financing for monetary and non-monetary incentives.

(v) The policy merely pays lip-service to the issue of access to underserved areas by suggesting that medical colleges will be started in rural areas and students from such areas would be recruited to continue to work in these under-served areas. This form of deployment calls for regulating the development of professional institutions for training personnel at different levels of care starting with comprehensive PHC, their options for occupational mobility, renewal and development of skills, and deployment at higher levels of care require strong control over skill building and maintaining, especially in states with skill deficits. Such training should include providers of all systems of medicine. Such control

currently resides with professional guilds. Therefore regulatory frameworks would need to address this and the policy is silent on this.

(vi) The policy is silent on providing a safe working environment for health care professionals, especially women and other vulnerable groups within the system. The goal is to provide a gender equal work environment. This needs to be addressed.

4. Financing of Health Care & Engaging the Private Sector

(i) The possibility of increasing the proportion of Gross Domestic Product (GDP) expended on health is doubtful as we have low tax base, government spending has grown slow in comparison to GDP in past 10 years plus due to recent cut in GDP spending. At the same time, by spending just 2.5% GDP, one cannot reach universal health care goal. No country reached this goal of universal health care with such limited spending. Thailand spent 4% of its GDP, most of which was in the public sector, resulting in desirable health outcomes. However, in India, as most of the tax revenue usually comes from Indirect Taxes which is regressive in nature, tax based financial mechanism may not be progressive. "Free and comprehensive primary health care services by the public sector for all aspects of reproductive, maternal, child, adolescent health and the most prevalent communicable and non-communicable diseases" has been proposed. There are also a growing number of corporate actors in primary health care in private sector like Razi health care, Nationwide primary health care services, Life-spring hospitals private limited, Malappuram health care limited, Vita life, Global health care, Pathfinder international. The methods envisaged to achieving this growth in spending in the health sector should be spelt out in the policy document.

(ii) Strategic purchase from private sector can also inflate & skew the public expenditure in Health towards secondary and tertiary care at the cost of primary care. Limited evidence exists on success of contracting out as suggested for one of the method for engaging Private players. The policy mentions support and social recognition to private providers in "difficult and remote areas". This may be a step towards legitimizing unqualified practitioners, and therefore strategic purchase should be linked to quality of services to be provided.

(iii) Strategic purchasing from the private sector is another suggestion for concern as most of the Private players are located in urban setting where most of the Tertiary care institutions are located. The policy acknowledges that insurance mechanisms have been inadequate to meet the health care needs, but has not suggested strategies to tackle the same. This gap has to be addressed.

(iv) The policy is silent on the health care needs of the elderly. All financing schemes, especially insurance based ones are most likely to not address the problems of the elderly. Therefore this should be addressed through special provisioning.

(v) The policy needs to spell out how the private sector will be engaged in meeting preventive and promotive care and needs to rationale costs of care in the private

sector by regulating charges for services. The policy needs to specify the mechanisms which it proposes to regulate and evaluate the private sector in order to ensure accountability for public health goals.

5. Regulatory Framework

(i) The regulatory framework needs to envisage the development of councils for other allied medical professionals such as physiotherapy, medical technicians, etc

6. Medical Technologies

(i) The reporting of adverse events as per regulations is done only with respect to drugs. However, adverse events are also caused by medical devices and equipment. Monitoring these would result in improved device development. Moreover, the evaluation of devices needs to be under the Good Laboratory Practice (GLP) and not Good Clinical Practice (GCP) alone. GCP is needed for clinical evaluation, but for devices, GLP is also a requirement. This can only be achieved if the regulatory framework for devices and equipment is independent of the drug development framework.

(ii) The policy is silent on the need for a cadre of clinical engineers to procure and maintain medical devices and equipment, especially in secondary and tertiary levels of care. The development of such a cadre, their training needs and re-training needs in keeping with the health system evolution and their professionalization should be envisaged. Therefore a cadre of clinical engineers needs to be recognized. Such a cadre can be deployed as hospital safety officers to maintain medical equipment. This will also help to bring down time and other costs and maintain efficiency and quality of services.

(iii) Inclusion of any new technology in the public health programmes of India should be done only after its evaluation – not merely clinical evaluation but public health technology assessment procedures to evaluate the relevance for India's public health programmes.

7. Information and Communications Technology (ICT) for Health & Health Information Needs

(i) The policy has addressed the issue of Electronic Health Records (EHR) or Electronic Medical Records (EMRs) within a framework for privacy. However, the current public health requirement is for use of such records for early detection of global trends in health and health care use. Therefore a policy that is conservative on use of EHRs without any leeway for their public health use could be very limiting. The policy needs to recognize that in order that legislative mechanisms to address the same may be developed.

(ii) The policy does not take into account the problems experienced with use of telemedicine, which has remained underutilized. The policy needs to address the

links to medical practice and medical responsibility even as it envisages telemedicine for reaching out to the underserved areas.

(iii) ICT enabled drug dispensing mechanisms can be envisaged as a mechanism to prevent pilferage and misuse of prescriptions.

(iv) While envisaging use of ICT enabled services in rural areas, the issues of infrastructural development to enable real time use of such services should also be taken into account. It should be informed by such initiatives within the country, such as the e-health initiative in Kerala.

8. Knowledge for Health

(i) The role of building knowledge for health systems research has to be seen as a shared responsibility with the private and not for profit sector, which the policy is silent on.

(ii) The policy needs to envisage mechanisms of addressing privacy needs through decentralized privacy officers while at the same time meeting the needs for sharing data to meet public health needs.

(iii) The policy should enable trans-disciplinary research in public health.

9. **Governance**

The policy recognizes the role of governance in public health and the need for a dedicated public health cadre trained in management to achieve the goals envisaged in the policy.

It does not address the following:

(i) While recognizing the role played by the govt in growth of the private sector, it shies away from how to regulate it to address the public health needs of the country.

(ii) The policy is also silent on the role of LSGs in managing health. Evidence on this has been complied from the Kerala experience. The policy fails to recognize the role for LSGs in governance of public health, especially at grassroots level.

(iii) While the policy talks about imparting professional management skills and incentives for performance, the reality is that the avenues for training in Public Health are limited. The last government created a huge institution in the form of the Public Health Foundation of India; this document is silent on its role and functions. The NHSRC was also created for this purpose. Perhaps we have to be more specific on the type of training, and the strategies to achieve the target in training of professionals. The policy needs to make explicit the role of the district

medical officer, and the training and experience required. He/ she should be the pivot on which the governance of the health system should revolve.

(iv) A problem that is recognized in the policy draft but not clearly mentioned is about modalities of funding and the numerous semi-independent bodies handling the funds in human resources are unaware of each other's work. This has created numerous problems and these have not been recognized or addressed in the policy.

(v) More integration of the public health system with academic institutions, both for training as well as for research should be envisaged. A state level cell for evidence and policy would be a great step forward if it can be implemented. This would also facilitate evaluation of technologies for use in public sector.

Professionalizing Management, Incentivizing Performance:

(i) The effort to incentivise delivery of curative care through evaluation of cost and savings can result in disincentivising preventive and promotive efforts where the benefits are very difficult to measure and therefore difficult to incentivise. Therefore, mechanisms to incentivize delivery of preventive and promotive care should be mentioned in the policy.

10. Legal Framework for Health Care and the Right to Health

(i) The policy does not include two essential principles while stating its goal:

Principle of solidarity: It is a kind of theoretical basis of ethics which addresses inequity. Unless there is evidence of solidarity with those who are less able bodied, especially among who are earning more and are going to pay better for the health care services through taxation and social insurance; we will not cover people who are not in a position to purchase insurance. With less than 2 percent of GDP being expended for health, it is not clear how such provisioning will be made unless there is such a feeling of solidarity with those less endowed.

Portability across states: If we have right to health such a right should be portable all over the country. We can get treatment anywhere across India under same conditions.

These two principles need inclusion among the principles.

(ii) The policy is silent on 'right to health care'. To achieve universal health care access, there is a need to make explicit the type of entitlement that each one is going to have at primary care and have proper referral system (Justiciability)

(iii) There is a need for the policy to recognize the justiciability of the right to health care in a federal system.

Appendix 1

List of participants and their affiliations

Sl. No	Name	Department	E-mail id
1	Dr. KR Thankappan	AMCHSS	thank@sctimst.ac.in
2	Dr. V Ramankutty	AMCHSS	rkutty@sctimst.ac.in
3	Dr. Sankara Sarma	AMCHSS	sarma@sctimst.ac.in
4	Dr. Sundari Ravindran	AMCHSS	sundari@sctimst.ac.in
5	Dr. Mala Ramanathan	AMCHSS	mala@sctimst.ac.in
6	Dr. Biju Soman	AMCHSS	bijusoman@sctimst.ac.in
7	Dr. K Srinivasan	AMCHSS	ksrini@sctimst.ac.in
8	Dr. Manju R Nair	AMCHSS	manjun@sctimst.ac.in
9	Dr. Ravi Prasad Varma	AMCHSS	rpvarma@sctimst.ac.in
10	Ms. Jissa V T	AMCHSS	jissa@sctimst.ac.in
11	Dr. Nagesh	BMT Wing	nagesh@sctimst.ac.in
12	Mr. Thomas T.A	Biochemistry, BMT wing	thomastain@rediffmail.com
13	Mr. Vinodkumar V	BMT Wing	vinod@sctimst.ac.in
14	Dr. Sundar Jayasingh	Dy. Registrar, SCTIMST	jsingh@sctimst.ac.in
15	Dr. Asha Raghavan	WHO India, NPSP	asha.raghavan@gmail.com
16	Dr. Sreelekha Nair	Independent Researcher	writetosree@gmail.com
17	Ms.Nutan Tigga	CDS	tigga.nutan@gmail.com
18	Mr.Shrey Jain	CDS	shreyjain1992@gmail.com
19	Dr. C K Jagadeesan	DHS Office, Govt of Kerala	drjagadeesan@yahoo.com
20	Dr. Kamlesh K Gulia	SDRL, BMT Wing	kkgulia@sctimst.ac.in
21	Mr.Upasak Das	CDS	upasakdas@gmail.com
22	Dr. Kavitha Raja	Microbiology, SCTIMST	kavitha.raj@sctimst.ac.in
23	S. Balram	BMT Wing	balrams@sctimst.ac.in
24	Dr. A S Pradeep Kumar	Addl. Director, DHS, Govt of Kerala	aspksct@yahoo.com
25	Dr.Amar Jesani	IJME	amarjesa@gmail.com
26	Mr.Bevin Vinay Kumar V N	AMCHSS	bevinvinay@sctimst.ac.in
27	Dr.Bandagar Sanjay Babasaheb	AMCHSS	Sanjay_7@sctimst.ac.in

Sl. No	Name	Department	E-mail id
28	Dr.Aakshi Kalra	AMCHSS	draakshikalra@sctimst.ac.in
29	Minu Abraham	AMCHSS	Minuapk7@sctimst.ac.in
30	Dr.Souvik Pyne	AMCHSS	pyne@sctimst.ac.in
31	Dr.Shreeporna Bhattacharya	AMCHSS	shree@sctimst.ac.in
32	Ms.Nayana E P	AMCHSS	Nayanaep12@sctimst.ac.in
33	Mr.Peeyush	AMCHSS	peeyush@sctimst.ac.in
34	Dr. Tijo George	AMCHSS	tigeo@sctimst.ac.in
35	Dr.Aayam Gupta	AMCHSS	draayamgupta@sctimst.ac.in
36	Ms.Athulya Thomas	AMCHSS	Athutom1@sctimst.ac.in
37	Dr.Shabna D S	AMCHSS	Shabnaleju3113@sctimst.ac.in
38	Dr.Sambit Kumar Behera	AMCHSS	sambit@sctimst.ac.in
39	Ms.Pritty Titus	AMCHSS	pritty@sctimst.ac.in
40	Mr.Vishnu Nataraj	AMCHSS	vishnu@sctimst.ac.in
41	Dr.Suseendar.K.K	AMCHSS	kksuseendar@gmail.com
42	Dr.Ariba Peerzada	AMCHSS	aribapeerzada@gmail.com
43	Dr.Lalchhanhima Ralte	AMCHSS	chhanhima@gmail.com
44	Ms.Neethu T	AMCHSS	panshneethu@gmail.com
45	Dr.Asmita Behera	AMCHSS	asmita.b@sctimst.ac.in
46	Dr.Revathi V	AMCHSS	revathivv@sctimst.ac.in
47	Ms.Sreeja M	AMCHSS	sreejamnair05@sctimst.ac.in
48	Dr.Donald M. Paul	AMCHSS	donaldmp@sctimst.ac.in
49	Mr.Sarath. S. M	AMCHSS	sarathsm92@gmail.com
50	Ms.Lijimol A.S	AMCHSS	lijimolas25@sctimst.ac.in
51	Dr.Sakeena .K	AMCHSS	drsakeena@sctimst.ac.in
52	Ms.Liss Maria Scaria	AMCHSS	lismariascaria@gmail.com
53	Ms.Sumitha T S	AMCHSS	sumitha2013@gmail.com
54	Ms. Anjali Krishnan. R	AMCHSS	
55	Dr.Mini G K	AMCHSS	gkmini.2014@gmail.com
56	Ms.Neena Elezebeth Philip	AMCHSS	neenaphilip87@gmail.com
57	Dr.Neethu Suresh	AMCHSS	neethusuresh@sctimst.ac.in
58	Dr.Malu Mohan	AMCHSS	dr.malumohan@gmail.com
59	Mr.Satheesh Joy	AMCHSS	satheeshjoy@gmail.com
60	Ms.Uma V Santhosh	AMCHSS	umasanthosh23@gmail.com

Sl. No	Name	Department	E-mail id
61	Ms.Elezebeth Mathews	AMCHSS	elezebeth kmathews@gmail.com
62	Mr.Dhanush	AMCHSS	dhanushms22@gmail.com
63	Mr.Rajesh K	AMCHSS	rajeshkrajesh@gmail.com
64	Dr. Ebrahim	AMCHSS	ebra3000@gmail.com
65	Ms.Reni Shiju	AMCHSS	renimolthomas@gmail.com
66	Ms.Aishwarya P V	AMCHSS	pvaiswarya@gmail.com
67	Dr.Sabitha Das	AMCHSS	sabithasuresh@gmail.com
68	Mr.Prejith Chandran	AMCHSS	ssprejithchandran@gmail.com
69	Ms. Jayasree Neelakantan	AMCHSS	amchss@sctimst.ac.in
70	Ms.Sherli.S.R.	AMCHSS	sherlisureshkumar@gmail.com

Acknowledgements

The preparation of these comments was facilitated by the inputs from experts, Dr.Raman Kutty V, Dr.TK Sundari Ravindran, Dr.K Srinivasan, Dr.Biju Soman and Dr.Amar Jesani. Mr.Nagesh DS, BMT Wing, SCTIMST also provided written inputs on the draft. Other participants at the meeting provided inputs regarding the various aspects of the policy. The students of the MPH 2014 batch volunteered their services as rapporteurs for the meeting to discuss the draft National Health Policy and Dr.Aakshi Kalra and Mr.Bevin Vinay Kumar of the MPH 2014 helped to compile the rapporteur's reports.

Comments drafting history

Comments on the draft National Health Policy 2015 were drafted by Dr.Mala Ramanathan based on the presentations and oral comments made during the discussions on Feb 7, 2015 at AMCHSS, SCTIMST.
The draft was circulated among the participants for suggesting revisions on Feb 24, 2015. Suggestions were received from Drs.KR Thankappan, Srinivasan, Amar Jesani, Sreelekha Nair, Aayam Gupta, Biju Soman, Jagadeesan DK and Mr.Upasak Das. These were incorporated into the draft by Dr.Mala Ramanathan on 02/03/2015.
The comments on the draft policy were finalised on March 2, 2015 by Dr.Mala Ramanathan, Additional Professor, AMCHSS, SCTIMST and submitted to the Ministry of Health and Family Welfare, Govt of India on March 3, 2015.