# An Overview of Health Policy in India

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## Abstract

The nation-states across the world endeavor to maintain health of their citizens for better development. The last few decades witnessed decolonization process, making many countries independent. The political parties that came to power in these newly formed countries announced their commitment to social sectors goals especially in achieving "Education for all" and "Health for all", which as yet appears to be a mirage. India made appreciable progress in industry, self-sufficiency in agriculture, and evolving policies on safety nets. However, it seems to have a long way to go in the health sector. This article attempts to analyze the major health policies in India. It also focuses on the status of health policies and the new challenges in the wake of the Sustainable Development Goals (SDGs), an international policy agenda.

*Keywords:* Bhore Committee, comprehensive policy, health policy, incrementalism, National Health Policy, Sustainable Development Goals

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## Introduction

The phrase, "Health is wealth", continues to be a critical success factor to measure the development of nations worldwide. The nation-states across the world endeavor to maintain the health of their citizens, as health is recognized as a critical input for human development the world-over, and it is widely known to contribute towards national development.

Historically, the last few decades witnessed decolonization, making many nations independent and improving their policy landscape. The political parties that came to power announced their commitment to social sectors goals among others especially in achieving "Education for all" and "Health for all". Intergovernmental organizations like the United Nations (UN) also declared its commitment to health through the introduction of the Millennium Development Goals (MDGs) in 2000 and the recent Sustainable Development Goals (SDGs). Out of the eight MDGs that were committed to be achieved by 2015, three (Goals 4, 5, 6) focused on the area of health. In the recent times, the developed, developing and underdeveloped nations committed to achieve the 17 Sustainable Development Goals (SDGs) by 2030 "to end poverty, protecting the planet and ensure that all people enjoy peace and property." One such goal, SDG 3 on Good Health and Well-being emphasizes on "ensuring healthy lives and promoting well-being for all at all ages." Table 1 presents the UN's policy prescriptions for ensuring the health of people across its member states, which are now referred to as policy agenda for countries.

If one dovetails these policy goals to Indian health policy, it has interesting insights to offer. With a population of nearly 1210.1 million and largely living in rural areas, the challenges for effective healthcare delivery have been many. In terms of the Human Development Index,[1]India stood at 130 in 2018 falling one place from 129 in 2016 and featuring in the group of medium human development countries (United Nations Development Programme, 2018).

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[1]The Human Development Index (HDI), developed by the United Nations, is a composite score consisting majorly of life expectancy at birth, expected years of schooling, mean years of schooling and Gross National Income (GNI) per capita

The debate on India's healthcare began to assume a critical mass after 1980s with the introduction of the National Health Policy in 1983 followed by increased focus on health in the Eighth Five Year Plan. In addition to domestic policies on health, a student of public policy can notice international advisories in the form of SDGs which have added value on policy process in this country.

There are also major shifts in the policy regime in the country. From the earlier role of sole provider to facilitator in the later part and post-liberalized and post neo-liberal era, the state governments started creating insurance-based healthcare. The pioneer in this is the erstwhile Andhra Pradesh Government which introduced the Rajiv Aarogyasri scheme (Ramabrahmam & Sudhakar Babu, 2008). The union government recently seems to have appreciated the advantages in this scheme as all those below the poverty line are being given an opportunity to access primary, secondary and tertiary health care. Christened as Ayushman Bharat,[2]the present government's policy resulted in up scaling the insurance-driven healthcare policy.

In this context, it becomes pertinent to understand and revisit health—its policies and processes in the country. Accordingly, this article takes in its sweep milestones in the evolution of a comprehensive policy on health in the post-independent India using a descriptive tool for depicting its highs and lows. It attempts to analyze the major Indian health policies. Accordingly, the first part provides an overview of the Indian health sector—the coverage, spending on health, institutional mechanism and other resources. The second part of the article deals with an overview of the health policies in the post-independent India encompassing the Five Year Plans[3] and Health Policies. The third part discusses the health policies/programs through the lens of Public Policy. The last part attempts to understand the status of policy on health, new challenges and the existing over-dependence on state institutes

[2]It is an umbrella of two major health schemes, which are the Health and Wellness Centres (HWCs) and Pradhan Mantri Jan Arogya Yojana (PMJAY).

[3]Five Year Plans constituted the planning framework in India, which are centralized and focused on the development of various sectors. India had 12 Five Year Plans starting from 1951 till 2017. The Five Year Plans were formulated, executed and monitored by the erstwhile Planning Commission. However, the Planning Commission was dissolved in 2014, thus bringing to an end the Five Year Plans and was replaced by NITI Aayog.

alone to promote or achieve the goal of “Health for all" and the SDG 3 (Table 1).

With India being the second-most populous country in the world, its achievement of SDGs is critical to the overall achievement of the goals.

**Table 1: Targets of Sustainable Development Goal 3: Good Health and Well- Being**

| Target | Indicator |
|---|---|
| 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births | 3.1.1 Maternal mortality ratio<br>3.1.2 Proportion of births attended by skilled health personnel |
| 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births | 3.2.1 Under-five mortality rate<br>3.2.2 Neonatal mortality rate |
| 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases | 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations<br>3.3.2 Tuberculosis incidence per 1,000 population<br>3.3.3 Malaria incidence per 1,000 population<br>3.3.4 Hepatitis B incidence per 100,000 population<br>3.3.5 Number of people requiring interventions against neglected tropical diseases |
| 3.4: By 2030, reduce by one third premature mortality from non- communicable diseases through prevention and treatment and promote mental health and well-being | 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease<br>3.4.2 Suicide mortality rate |
| 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol | 3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for |

| Target | Indicator |
|---|---|
| | substance use disorders<br>3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol |
| 3.6: By 2020, halve the number of global deaths and injuries from road traffic accidents | 3.6.1 Death rate due to road traffic injuries |
| 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes | 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods<br>3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group |
| 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all | 3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)<br>3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income |
| 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination | 3.9.1 Mortality rate attributed to household and ambient air pollution<br>3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and |

| Target | Indicator |
|---|---|
| | Hygiene for All (WASH) services)<br>3.9.3 Mortality rate attributed to unintentional poisoning |
| 3.A: Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate | 3.A.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older |
| 3.B. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all | 3.B.1 Proportion of the population with access to affordable medicines and vaccines on a sustainable basis<br>3.B.2 Total net official development assistance to medical research and basic health sectors |
| 3.C. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States | 3.C.1 Health worker density and distribution |
| 3.D: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks | 3.D.1 International Health Regulations (IHR) capacity and health emergency preparedness |

Source: United Nations, (n.d.).

**Health Sector in India—An Overview**

India has the second largest population in the world after China, however, the services of the health sector are not commensurate to the population. This part throws light on the infrastructure, institutional mechanism, spending on health and the manpower in the Indian health sector.

The aspect of Health is a state subject[4]in India wherein the state governments and the Union Territory (UT) administrations are responsible for providing healthcare to the citizens. However, the union government also makes provisions and spends on health through Centrally-Sponsored Schemes (CSCs) and other initiatives.

**Spending on health.** The recent Interim Budget in India (2019-20) allocated Rs. 63,538 crore to the health sector, which constitutes about 2.2 percent of the total budget, as against Rs. 54,600 crore budget allocation in 2018-19 (Ministry of Finance, Govt. of India, 2019). The public health expenditure constitutes merely 1.02 percent of the Gross Domestic Product (GDP) of the country. The public expenditure on health has ranged from 0.98 to 1.3percent of the GDP between 2009-10 and 2017-18. Although in terms of per capita expenditure on health, it has risen from Rs. 621 in 2009-10 to Rs. 1,112 in 2015-16, the per capita expenditure in the developed as well as other developing nations is much higher. In the United States of America, the per capita expenditure on health is $10,224.

According to the World Health Statistics by the World Health Organization (WHO) (2018), the contribution of public sector to the total expenditure in India is low as compared to the other developing nations. The outlays for health in the Five Year Plan periods are as follows, in Figure 1.

[4]According to Schedule Seven of the Constitution of India, there are three lists: Union, State and Concurrent, wherein various subjects like home, education, health etc. are distributed between the centre and states. While the Union and State Lists encompass subjects of national and local/ state interests respectively, the Concurrent List contains subjects that can be legislated both by the union and the state governments.

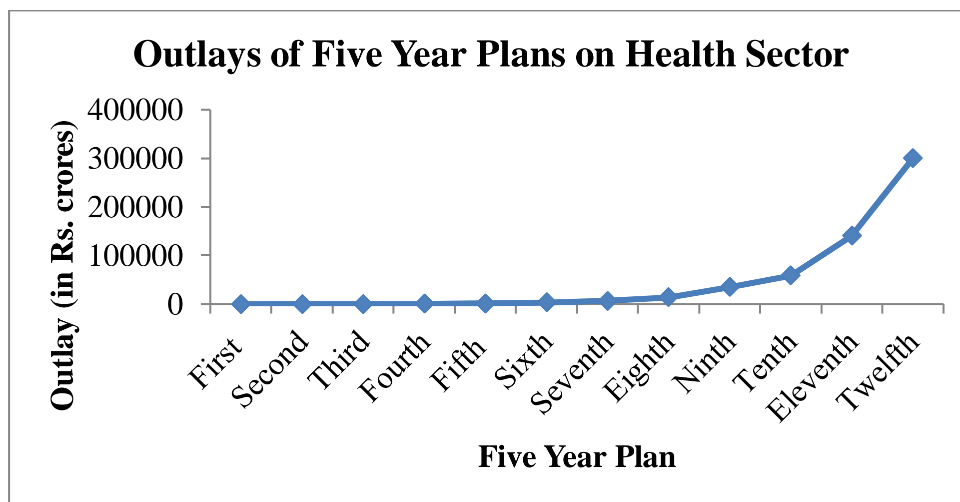


**Figure 1: Outlays of Five Year Plans on Health Sector**

Source: Central Bureau of Health Intelligence, Directorate General of Health Services, MoHFW, 2018

It is evident from Figure 1 that the spending by the central government on health has progressively increased from about Rs. 65 crores in the First Plan period (1951-56) to nearly three lakh crores in the Twelfth Plan period. In the post-Five Year Plan periods, allocations to the health sector became a part of the annual plans. Nevertheless, expenditure on health calls for further allocations.

**Institutional mechanism.** The Ministry of Health and Family Welfare (MoHFW), Government of India (GoI), is the nodal agency for the subject of health in the country at the central level. It functions through the Department of Health and Family Welfare (DoHFW) and the Department of Health Research. While the DoHFW is responsible for the implementation of health schemes and acts as the regulator for medical education and training, the Department of Health Research focuses on medical research. At the state level, most states have their respective Department of Health and Family Welfare that formulates, implements and monitors the health-related policies and programs.

**Infrastructure.** Healthcare system in India is characterized by public and private healthcare service providers. The public healthcare operates in a three-tier system—the primary level, secondary level, and tertiary level. At the primary level, healthcare is provided through the Sub-Health Centers (SHCs) and Primary Health Centers (PHCs). At the secondary level, the Community Health Centers (CHCs) and Sub-District Hospitals provide

health care facilities. The District Hospitals and the Medical Colleges cater at the tertiary level. The vast private healthcare sector includes individual doctor-run clinics, hospitals and super-specialty hospitals.

**Table 2: Glimpse of the health infrastructure in India (as of March 31, 2017)**

| S. No. | Type of Health Centers | Number (as of March 31, 2017) |
|---|---|---|
| 1. | Sub-Centers | 1,56,231 |
| 2. | Primary Health Centers (PHCs) | 25,650 |
| 3. | Community Health Centers (CHCs) | 5,624 |

Source. Central Bureau of Health Intelligence, Directorate General of Health Services, 2018

**Manpower.** According to the National Health Profile 2018, there are a total of 10.4 lakh doctors who have a recognized medical qualification and registered with State Medical Councils/Medical Council of India, as of 2017. Of this, the government allopathic doctors constitute 1.14 lakhs who serve an average of 11,000 people each. Similarly, the number of dental surgeons (as of 2017) is 2.5 lakhs who include 11,082 government surgeons. Each of them serves an average of 1.7 lakh people. (Central Bureau of Health Intelligence, Directorate General of Health Services, 2018).

With the investment in public health being comparatively low, the health care sector continues to suffer. Consequently, the health sector in India is plagued with challenges of investments, institutions and their governance on one hand, and access and affordability on the other. In its efforts to achieve the SDG targets by 2030, the union government and governments of many states have mapped the targets and indicators to the existing schemes and the concerned ministries or departments.

The SDG Index India 2018[5]captures the data[6]for 13 out of 17 SDGs (leaves Goals 12, 13, 14, and 17). In the domain of health, it measured 4 indicators under SDG 3 (namely 3.1, 3.2, 3.3 and 3.8) (refer Table 1) across the country. Based on the performance, the states are

[5]SDG Index 2018, developed by NITI Aayog, is an index which is guided by the Ministry of Statistics and Programme Implementation (MOSPI)'s National Indicator Framework, and is based on consultations with union ministries/departments and states/UTs. It consists of 62 priority indicators across 13 out of 17 SDGs.

[6] The data is based on the availability of data at the national level and from the states and UTs

categorized as Achievers (100), Front Runners (65-99), Performers (50-64) and Aspirants (0-49).[7] Accordingly, nine states and one UT (Kerala, Tamil Nadu, Telangana, Punjab, Karnataka, Andhra Pradesh, Manipur, West Bengal, Goa, and Puducherry) were ranked Front Runners, ten states and two UTs (Maharashtra, Haryana, Odisha, Jammu and Kashmir, Mizoram, Tripura, Gujarat, Meghalaya, Sikkim, Lakshadweep, and Andaman and Nicobar Islands)asPerformers,andtenstatesandfourUTs(Rajasthan,Chhattisgarh,Bihar,Jharkhand, Arunachal Pradesh, Madhya Pradesh, Uttarakhand, Nagaland, Assam, Uttar Pradesh, Daman and Diu, Delhi, Dadra and Nagar Haveli, and Chandigarh) as Aspirants (NITI Aayog, 2018).

**Health Policy in India—Current Status**

Health policies[8] in the post-independent India find their genesis in the colonial administration. Accordingly, any discussion on health policies in India needs to acknowledge the contributions of the Health Survey and Development Committee Report, 1946,[9] popularly known as the Bhore Committee Report of the pre-independent India. The Committee studied the status of health in India, and recommended a blueprint of action points. Some of the major recommendations included universal coverage of healthcare, increased health centers, provision of care regardless of the ability to pay, linking of ill health to environmental hygiene, and so on. It becomes pertinent to note that some of these recommendations still hold good in the present day, which if implemented would contribute to improving the health scenario in the country.

In terms of the framework of planning for health sector, in the post-independent India, it was provided through the Five Year Plans[1010] and annual plans in addition to the

[7] The SDG Index Score for SDG 3 on Good Health and Well-being is in the range between 25 and 92 for states and between 23 and 66 for UTs.

[8] It is a challenge for public policy analysts to evaluate health policies. Macro indicators like the crude birth rate, crude death rate, life expectancy and Infant Mortality Rate (IMR), suggest success for the initiatives. However, micro-indicators leave one with dissatisfaction.

[9] In 1943, The Government of India appointed a Health Survey and Development Committee which was led by Sir John Bhore.

[10] Five Year Plans constituted the planning framework in India, which are centralized and focused on the development of various sectors. India had 12 Five Year Plans starting from 1951 till 2017. The Five Year Plans were formulated, executed and monitored by the erstwhile Planning Commission. However, the Planning

recommendations of various committees constituted by the government. The country did not have a dedicated policy on health until the year 1983, almost three and a half decades since independence.

India, for many years both during pre-independence and post-independence times, suffered from epidemics like malaria, small pox, tuberculosis, leprosy, filaria, cholera, and so forth. In this context, the major initiatives by the government in the health sector revolved around managing and eradicating the epidemics. Accordingly, national-level programs were launched, including the National Malaria Eradication Program of 1953.

**Healthcare through Five Year Plans and National Health Policies.** Starting from 1951, the Five Year Plans in India included outlays on health under the head, Social Services and Rehabilitation, which included other sectors like education, medical and public health services, housing, backward classes (including scheduled castes and tribes), labor and labor welfare, and assistance to voluntary social welfare organizations (Planning Commission, Government of India, n.d.).

As pointed out by studies and reports, disease burden and eradication and elimination of communicable diseases were the primary challenges that post-independent India had to deal with. Each of the Five Year Plans had a specific focus area, like agriculture, industrial development, economic growth, and so forth. While, till 1990s, health was one among the other social welfare programs like education and family planning, it was only in the Eighth Plan (1992-1997) that public health became a specific focus area.

As pointed out in Figure 1, the outlays on health increased substantially over the years although there is a long way to go before the percentage of GDP on health expenditure and per capita expenditure on health increased. If one considers the Five-Year Plans, preventive health care has been a common feature of almost all the Five-Year Plans. The evolution of the National Health Policy has been discussed at length by R. Duggal in his article "Evolution of Health Policy in India," beginning with the Bhore Committee Report and covering upto the

Commission was dissolved in 2014, thus bringing to an end the Five Year Plans and was replaced by NITI Aayog.

tenth Five Year Plan. The article also points out the influence of international agencies in policy making on program design of the governments (Duggal, 2006).

***National Health Policy (NHP), 1983.*** There was a need felt in the country for a dedicated and robust health policy to addresss the challenges in the domain of health in the post-independent India. The first national-level Health Policy in India was introduced in 1983during the Sixth Five Year Plan period (1980-1985), which brought in a paradigm shift in healthcare in the country. It draws from the Alma Ata Conference of 1978, wherein India committed itself to achieving "Health for all by 2000 AD" through "universal provision of comprehensive primary health care services."

Addressing the concerns in the healthcare domain, the first NHP document, states that: "… it is felt that an integrated, comprehensive approach towards the future development of medical education, research and health services requires to be established to serve the actual health needs and priorities of the country. It is in this context that the need has been felt to evolve a National Health Policy." (Ministry of Health and Family Welfare, Government of India, 2017a). However, one of the major limitations of the Indian policy process is the absence of financial commitments and an unalterable time frame.

***National Health Policy (NHP), 2002.*** A new NHP was introduced in 2002 (during the ninth Five Year Plan period (1997-2002) in the backdrop of the MDGs. The NHP 2002 was introduced nearly two decades after the first NHP to cater to the changing needs of the health sector in the country. It noted that "the policy initiatives outlined in NHP 1983 have yielded results, while in several other areas the outcome has not been as expected." While stating the paucity of public health investments in the country, the NHP 2002 emphasized on "realistic considerations of capacity and a new policy framework" (Ministry of Health and Family Welfare, Government of India, 2017a).

The NHP 2002 endeavored to achieve time-bound goals like eradication and elimination of diseases, increase: the use of public health facilities, the GDP on health expenditure to 2 per cent, central grants share to constitute at least 25 percent of total health spending, and state

sector health spending from 5.5 percent to 7 percent of the budget by 2005 and further increase to 8 percent by 2010. Various programmes including the National Rural Health Mission (NRHM)and National Urban Health Mission (NUHM)[11]were introduced after 2002. In addition, the Rashtriya Swasthya Bima Yojana (RSBY), a health insurance scheme for the unorganized sector, was also introduced under this framework.

Like the NHP 1983, NHP 2002 also could not achieve the target of "Right to Health" to all the citizens of India. Besides lack of resources, monitoring and evaluation of the health policy also made it necessary to call for a revamp. Let us now look at NHP 2017.

***National Health Policy (NHP), 2017.*** The most recent health policy, the third National Health Policy (NHP) was introduced in 2017. Drawing from the previous NHPs of 1983 and 2002, the goal of the NHP 2017 is "the attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive healthcare orientation in all developmental policies, and universal access to good quality healthcare services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery." According to the NHP 2017 (Ministry of Health and Family Welfare, Government of India, 2017a), the thrust areas include:

- "Adequate investments to achieve the target of raising public health expenditure to 2.5 percent of the GDP in a time-bound manner. In addition, incentives to states for incremental resources for public health expenditure. Funds under Corporate Social Responsibility to be leveraged for well-focused programs aiming at addressing health goals
- Preventive and promotive health through institutionalization of inter-sectoral coordination of national and sub-national levels
- Organizing public healthcare delivery through policy shifts"

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[11]The National Rural Health Mission (NRHM) and National Urban Health Mission (NURM) were converged as National Health Mission (NHM) in 2013.

A study of health policies in India cannot be complete without acknowledging the role of the political will of the different political parties. For instance, the election manifestos of 2014 general elections set various priorities for healthcare. The Bharatiya Janata Party (BJP) emphasized on health services to increase and improve access, quality, and reduce the costs. Accordingly, it proposed various mission-mode projects for providing health care services like the National Rural Internet and Technology Mission, women-specific projects, and so on. It sought to empower citizens through health and education and provide, "Health Assurance to all Indians and to reduce the out-of-pocket spending on health care." It also suggested reforms in terms of a New Health Policy, National Health Assurance Mission, modernization, and medical insurance and quality healthcare services (Bharatiya Janata Party,2014).

The present opposition party, Indian National Congress (INC) has been reiterating on providing health as a right since the 2014 Elections. In its manifesto of the 2014 general elections, INC proposed to enact Right to Health as a part of the rights-based framework of development, to ensure easy access and quality health services based on public provision and social insurance for the citizens. Universal and quality healthcare with an increased health expenditure of 3 percent of GDP was one of the major agenda points. In addition, it envisioned to use the aggregate revenue of Goods and Service Tax (GST) to fund the extra investment in infrastructure, health and education (Indian National Congress, 2014).

***Discussion.*** The Indian health sector is, thus, just three policies old even after seventy-two years of independence. It is evident from the previous section that health planning and policy making had become a priority only much later. An effective Health Policy is a challenge in a country like India for owing to the heterogeneous nature of population and the varying topography across the country. However, various governments have been striving towards universal health coverage. For instance, in the recent interim Budget 2019-2020, envisioning healthy India as the ninth dimension of the vision of the government, it was stated that the government "aims at healthy society with an environment of health assurance and the support

of necessary health infrastructure. Our Government has rolled out the Ayushman Bharat scheme. By 2030, we will work towards a distress free healthcare and a functional and comprehensive wellness system for all. Such a healthy India built with the participation of women having equal rights and concern for their safety and empowerment" (Ministry of Finance, Govt. of India, 2019).

An important policy process in the social sector and especially health is guidance to the policies through experts. Starting with the Mudaliar Committee in 1961, some of the other major committees for health included the Chadha Committee (1963) for reviewing the healthcare services during the first two Five Year Plans, Mukherjee Committee (1965) for reviewing the staffing patterns and provisions under family planning, and Jungalwalla Committee (1967), Kartar Singh Committee (1973), Srivastava Committee (1975) dealt with medical education and manpower shortage. Some of the recommendations of the committees mentioned above have gone into the policies. Hence, such committees or commissions play a critical role in policy-making as they enable the governments for better decision- making. In his article on "Commissions in Policy-making," Chapman (1973) brings forth the critical elements of the commissions and how they serve in providing inputs and insights to policy-making. The representativeness of the commissions and the preparation of evidences by various interests and the ensuing impact on policy emphasize the need for such committees or commissions for policy-making. The recommendations by the commissions serve as critical evidence, form the basis for future work, and also facilitate reforms.

Many experienced practitioners, academicians, and policy analysts too have been recommending measures for health reforms. Some of these include 80 percent of health budget for disease prevention, health promotion, improving quality of services at primary level, health as people's right, state health policies, improvement in functioning of health functionary, evidence-based policy-making, equitable access to healthcare, leveraging technology for healthcare, and empowerment of health leadership and governance (Narain, 2016); proper regulatory framework for public and private providers, enhanced public spending on health,

and appropriate human resource policies (Sen &Iyer, 2015).

**Rights-based approach to health.** An oft-repeated recommendation and election promise has been the call for a rights-based approach to health. As proposed by the UPA in its 2014 election agenda, a rights-based agenda for health has become the need of the hour.

With the rights-based framework, which includes legislations like Right to Information (RTI), Right to Work, Right to Education, and the Right to Food recording good results, it is time the country prepares itself for a Right to Health Act. Rao (2017) in her book, "Do We Care?", points out that "at the policy level, there was always the apprehension that enacting a law making health a right in the absence of adequate fund and a fragmented, dysfunctional health system would only generate substantial litigation that the government would not be able to cope with." In such a scenario, an approach similar to the Right to Education (RTE) may be adopted wherein the age group is fixed. Accordingly, the Right to Health, if proposed to be introduced may have to fix a certain age group or criteria so that at least every citizen in the country has the right to access primary healthcare. This makes the health system also more vibrant while ushering in enhanced responsibility and accountability. However, we also need to look at other alternatives to provide universal health care to people ofIndia.

**Corporate Social Responsibility (CSR) for health.** According to the Companies Act, 2013, the large public sector and private sector firms have been mandated "to spend 2 percent of their net profits on CSR activities." Although health and education continue to receive the major share of funds, with about 65 percent of the projects and 61 percent of the expenditure (KPMG, 2018), there still exists a lot of scope for the CSR to support the health sector. According to the KPMG survey, the expenditure on health and sanitation increased from Rs. 1,641 crore to Rs. 1,691 crore in 2017-18, a mere 3 percent increase from the previous year. It is also interesting to note that pharmaceutical companies spent a majority of 41 percent of their CSR expenditure on health and sanitation. However, overhead expenditure on health and sanitation has remained constant at 21 percent over the last two years within the

CSR funding. Hence, it becomes imperative for the companies to realign their CSR strategies to enhance their spending on the domain of health care.

**Is prevention not better than cure?** Although, most of the policies emphasized preventive care, little is being done on the ground especially in the domains of new diseases that are affecting people. One such case is that of cancer, which has become the second biggest killer, next to heart disease. As reported in an article “Explained: The cancer crisis in India” (2019), the Indian Council of Medical Research (ICMR) estimated that India will have over 17.3 lakh cancer cases by 2020. It also points that 8.8 lakh deaths may occur due to cancer with only 12.5 percent receiving treatment in the early stages. Hence, it becomes imperative for the country to take stock of on-the-ground situations and carry out policy interventions on need basis. Evidence-based research is of high relevance here as screening of students by voluntary teams of experts in educational institutions preliminarily promotes awareness about terminal illnesses, and secondly promotes prevention at an early stage. Political class, bureaucracy, and other stakeholders should be sensitized accordingly.

**Evidence-based policy making of health policy.** Many scholars argued that there is a need for rethinking in the Indian healthcare scenario. Berman (1998) argued that developing countries, including India, need to rethink their healthcare policies while recognizing the dominant role of non-governmental health care providers. He adds that “dominance of private provision in India clearly implies a failure of public policy in the last four decades” (Berman, 1998). Osman (2002) while analyzing the health policy of Bangladesh, through Alford’s theory of structural interests, emphasizes that “socio-economic and political conditions of a country determine or shape the network of a particular policy.”

It is held that policy neglects popular will. Of late, we have been coming across loud articulation of areas of neglect within. It may be difficult for the government to have a prior look at multiple sources of opinion. However, it is worth taking into consideration the opinions of at least the majority of stakeholders. This is applicable to health policy particularly as we frequently hear of doctors refusing to serve in rural areas. The last four

years saw a massive ‘Swachh Bharat’ campaign which has been helping in realizing the objective of “Clean India”. Society cannot escape the responsibility for cleanliness, which is the first step for prevention. More initiatives like ‘Swachh Bharat Abhiyan’ should be promoted across the country to improve cleanliness and hygiene, which in turn would improve the health parameters of the population. May be such initiatives should be evaluated by public funded universities, thus encouraging students to participate in public health.

The National Health Policies starting from 1982 have been making gradual changes with each new policy. Public policy analysts attribute the policy paralysis in this sector as an outcome of the incrementalist paradigm. As Charles Lindblom’s (1959) well-tested article, ‘The Science of “Muddling Through”’, gets mostly vindicated. Changes happen gradually ensuring acceptance and legitimacy. However, this approach poses hindrances in terms oflack of innovation and long-term perspective. In this context, it becomes imperative for the Indian health policy to realign and rebuild itself for greater effectiveness and efficiency. As Rao (2017) points out, “there is an urgent need to move away from incrementalism and acknowledge the complexity of rebuilding the existing inefficient health system. The policies and strategies should be evidence-based, embedded within the socio-economic context of the country, and devised on the basis of a close study of the past failures and an uncompromising commitment to equity and fairness.” Hence, there is a need for the public policies, especially like the Health Policy, to be formulated taking into consideration the human and financial resources required for implementation. This would help promote an ear-to-ground approach while helping in setting realistic and achievable targets and outcomes.

The NHP 2017 which is third in the series is also not free from critical appraisal. It is stated by a well-known authority that the targets set in the 2017 policy are almost reached due to multiple interventions launched earlier. As is evident from Table 3, many of the targets for some of the macro indicators continue to have similar targets as the previous policies. This has also been echoed in an article titled “Repackaged: 15-Year-Old National Health Policy Resurrected in 2017” (Salve & Yadavar, 2017). With the role of media enhanced in the

present day, it is critically watchful of the policies and programs, thus bringing to fore the emphasis by siphons on interest and association groups and media.

**Innovations in health sector.** Let us consider innovations in fields closer to the health policy—for instance, insurance, international practices seemed to be escaping the attention of policy makers. Particular notice of insurance policies serves as a useful guide here. Popularly known as conditional health policies, "some clinical commissioning groups in England have restricted non-urgent surgeries to patients who are obese or smoke, unless they demonstrate periods of dieting and cessation" (Campbell, 2016). Similarly, the author of the study titled "Can conditional health policies be justified? A policy analysis of the new NHS dental contract reforms" raised an issue "whether conditional health policies conflict with the patient's right to care, and are ethically justifiable" (Laverty & Harris,2018).

**Table 3: Targets of some of the major National Health Policies and the current status of parameters**

| S. No. | Parameter | Unit | Targets | | | | | | | | Present Status* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | NHP 1983 | | | NHP 2002 | SDG 3 | NHP 2017 | | | |
| | | | 1985 | 1990 | 2000 | 2010 | 2030 | 2019 | 2020 | 2025 | |
| 1. | Life Expectancy at birth | Years | Male: 55.1<br>Female: 54.3 | 57.6<br>57.1 | 64 | - | - | - | - | 70 | 68.3[a] |
| 2. | Under- Five Mortality | Per 1,000 live births | 20- 24 | 15- 20 | 10 | - | 11 | - | - | 23 | 39[b] |
| 3. | Infant Mortality Rate (IMR) | Per 1,000 live births | 106 | 87 | Below 60 | 30 | 25 | 28 | - | - | 34[c] |
| 4. | Maternal Mortality Rate (MMR) | Per 1 lakh live births | 3- 4 | 2-3 | Below 2 | 100/ lakh | 70 | - | 100 | - | 130[d] |
| 5. | Increase in health expenditure by government as percentage of GDP | Per cent | - | - | - | 2.0 | - | - | - | 2.5 | 1.15[e] |
| 6. | State sector health spending as per cent of budget | Per cent | - | - | - | 8** | - | - | >8 | - | 1.36[f] |

Note. (*) = Collected from various sources of Data. (a)= (Ministry of Health and Family Welfare, Government of India, 2017b) (b)= (Office of the Registrar General, India, 2016) (c)= (Office of the Registrar General, India, 2016) (d)= (Office of the Registrar General, India, 2018) (e)= (Central Bureau of Health Intelligence, Directorate General of Health Services, MoHFW, 2018) (f)= (Bhattacharya & Kundu, 2017)
(**) = The target was to increase to 7 percent of the budget by 2005, and 8 percent by 2010

## Conclusion

It emerges from the discussion that the government's role in providing healthcare has transformed from that of a provider to a facilitator. The stakeholders in the country are expecting sectoral policies to address diseases like oral healthcare. While funding to the health sector is increasing incrementally in India along with insurance cover, what are actually emerging are the role and the need for public consultation on any modification of health schemes. It is clear that there cannot be any alternative to enhanced funding. In such a scenario, best practices from the states and from other countries need to be studied and customized to the local needs. The best success stories of previous policies may also be documented and disseminated for replication purposes. As observed by United Nations Development Programme (UNDP), for SDG 3 on health, "multi-sectoral, rights-based and gender-sensitive approaches are essential to address health-related inequalities, strengthening inclusive governance and building resilient systems for health" (UNDP, n.d.).

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