

Comments on India's Draft National Health Policy 2015

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1. Introduction and Overview

The Center for Global Development appreciates the opportunity to provide comment to the Draft National Health Policy 2015 for India (NHP-2015). We commend the Ministry of Health and Family Welfare for its transparent and informed policy process, which other countries can and should adopt.

The draft NHP-2015 comes at a critical juncture in India's development trajectory. Since the formulation of the last NHP in 2002, there have been significant achievements in eradicating polio, arresting the spread of HIV and AIDS, raising the proportion of safe deliveries, reducing under-5 mortality rates, expanding health service delivery infrastructure, and increasing human resources for health, among others. At the same time, however, private provision and utilization of healthcare services has increased, resulting in very high out-of-pocket share in total health expenditure.

India still has a long way to go to provide quality health services and reduce the financial burden of health expenditure, especially on the poor. Therefore, India's health system—especially the financing and delivery of health care services—needs radical reform to achieve the objectives of universal health coverage that has, in large part, motivated the draft NHP-2015.

This comment focuses on four key elements we believe are inadequately addressed in the draft document, and offers the following recommendations:

- States should be given the primary responsibility of implementing NHP and be provided with adequate fiscal space to do so
- NHP-2015 should propose incentive-based payment for performance at the State level
- Health financing should be on the basis of risk adjustment and realistic benefits plans
- An independent institution should collect, manage, and analyze health-related information to determine resource allocation decisions

2. Move Money to the States

2.1 NHP-2015 should be clear in its policy stance that health is the primary responsibility of States as mandated in the Constitution. The task of the Central government is to set goals and standards, fill resource needs, and ensure accountability for health outcomes at the State level.

2.2 NHP-2015 sets the target for public expenditure on health to be 2.5 percent of GDP, of which 40 percent (1 percent of GDP) would come from Central government (Para 2.18). This implies State

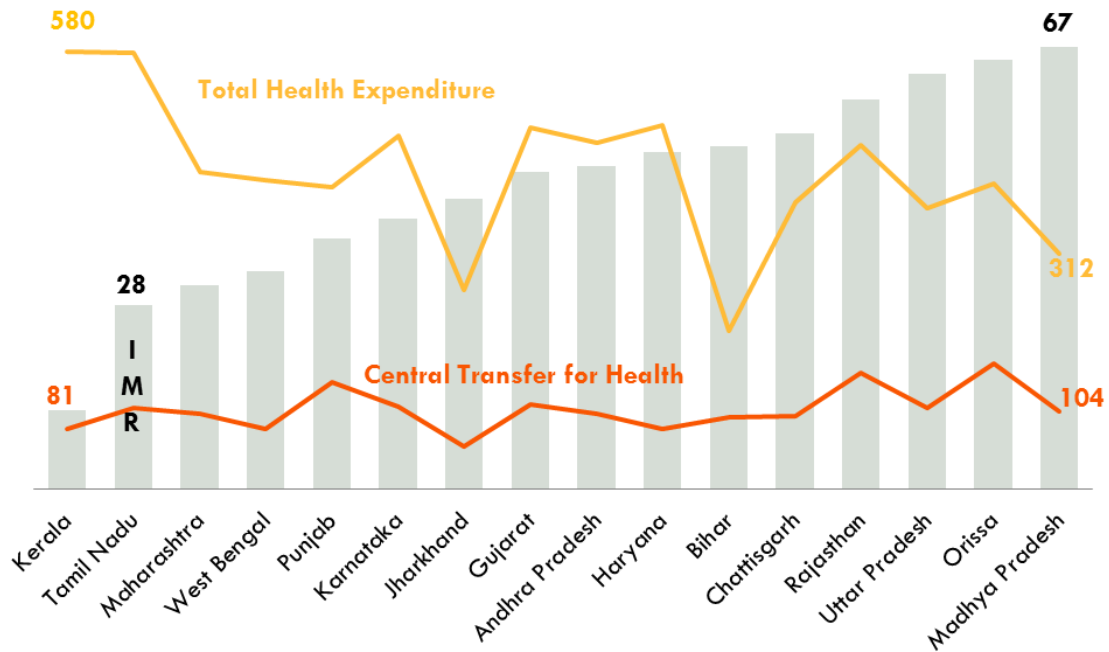
governments will have to more than double their expenditure on health from 0.75 percent to 1.5 percent of GDP. Yet, States do not have the fiscal capacity at present to do so.

- 2.3 We submit that significant fiscal devolution from the Center to States will be necessary to increase the share of public expenditure on health at the sub-national level. This has been recommended in the recent report of the 14th Finance Commission. The NHP-2015 should clearly state that achieving universal health coverage objectives would require not only higher expenditure as a share of GDP, but also greater fiscal space to invest in health in the States in the long term.
- 2.4 Allocating funds from the Central government to States through centrally sponsored schemes should be discontinued. It leads to a 'one-size-fits-all' approach, which does not fully account for the divergence in health and financial resource needs at the State and district levels. Centrally sponsored scheme (CSS) allocations should be replaced with block grants from the Center, thereby increasing States' fiscal space.
- 2.5 NHP-2015 notes that "the major source of financing would remain general taxation but would also explore the possibility of imposing a 'health cess', mobilize contribution from specific commodity taxes such as tobacco and alcohol, from specific industries and innovative forms of resource mobilization" (Para 4.1.2). This approach is fraught with uncertainty, especially in the light of indirect tax reform leading to the introduction of the Goods and Service Tax (GST). It would further complicate jurisdictional responsibility given tobacco and alcohol taxes are in the domain of the States even after the proposed reform.
- 2.6 India should aim at allocating at least 5-6 percent of GDP for health, of which at least 90 percent should be at the State level for service delivery. We strongly recommend that NHP-2015 sets the stage for a risk pooling and contributory health financing system, which would be sustainable in the long-run and thereby reduce the reliance on taxes as the only basis for revenue mobilization in the short-to-medium term.

3. Pay States for Performance

- 3.1 NHP-2015 should acknowledge India is simply too big and too decentralized to require single solutions for health care provision. The one-size-fits-all resource allocation approach under the National Rural Health Mission (NRHM, currently NHM) is detrimental to equity and effectiveness. Instead, States should be paid for performance on a clear and transparent set of indicators.
- 3.2 One main problem with CSS in general is that federal monies have done little to respond to need. Our research (1), summarized in the figure below, illustrates that Center-to-State transfers are divided more or less equally across states on a per capita basis in 2009-2010. There was little variation for differences in need or the amount of funding that states mobilize themselves for health.

Figure 1: Per Capita Health Expenditure, Central Transfers and Infant Mortality Rates across Indian States, 2009-10



Source: Sample Registration System and the Registrar General of India, 2010; Choudhury, M. and Amarnath, H.K. (2012). An Estimate of Public Expenditure on Health in India.

Notes: Per capita expenditure in Rupees (current prices). Total Health Expenditure and Central Transfers for health are on one scale and IMR is on another.

3.3 Although the motivation of the National Rural Health Mission was to differentiate states on the basis of health status, it effectively forced them to buy into conditions that may have limited applicability in their contexts. This includes infrastructure norms for public health centers and human resource norms for medical and para-medical personnel, especially “accredited social health activists” (ASHAs). States should be free to choose their own delivery model as long as it meets national health policy objectives.

3.4 Need-based equalization grants would be a better solution to address inequities in health expenditure across states. However, our research findings show that the 12th and 13th Finance Commission equalization transfers for health did not have their intended results. NHP-2015 should articulate a clear roadmap for combining equalization transfers with performance-based payment as the optimal financing mechanism for health going forward.

4. Adjust State-level Risk and Benefits Package

- 4.1 The NHP-2015 should articulate the need for a risk-adjusted capitation formula that would be equitable and efficient. Fund allocation should be on the basis of a benefits package decided on the basis of State-level risk assessment and priority setting exercise. This would be a significant advancement over the NRHM and Finance Commission transfers and would move India closer to international good practice.
- 4.2 NHP-2015 notes that “priority setting in health care is a political decision based on our core value as a nation and informed by technological knowledge of disease prevalence and feasibility of interventions” (Para 4.3E). Priority setting should be made by institutions that are capable of taking a long-term view using all relevant information and tools of analysis that are considered good practices around the world. NHP-2015 should make this approach to priority-setting very clear.
- 4.3 In this context, we welcome NHP-2015’s declaration that “inclusion of cost-benefit and cost-effectiveness studies in program design and evaluation would also contribute significantly to increasing efficiency of public expenditure” (Para 6.2). Still, it should take the next step of setting up independent health technology and cost assessment agencies with commensurate powers to recommend and guide effective and transparent allocation decisions. India could follow the example of institutions such as the National Institute of Health and Care Excellence (NICE), which advises the National Health Service in the United Kingdom (2).
- 4.4 The NHP-2015 should recognize that existing health benefits plans are neither equitable nor sustainable (3). The Central Government Health Service (CGHS) package serving central government employees is 80 times more expensive in per capita terms than the Rashtriya Swasth Bima Yojana (RSBY) targeted at families below the poverty line. Tertiary care-based benefits packages in Tamil Nadu and Karnataka cost between one quarter and one third of their total per capita health expenditure, and would constitute nearly 80 percent of the per capita expenditure of Bihar. Even the most limited RSBY benefits plan would be beyond the scope of most states if they have to share the full cost of implementation.
- 4.5 We recommend the NHP-2015 prioritize three key elements to obtain maximum efficiency in health outcomes:
- (i) allocating resources on the basis of a risk equalization formula preferably at the district level;
 - (ii) creating institutions at State level (e.g., a “State Health Assurance Agency”) to manage the transition and implement the new framework; and
 - (iii) drawing up costed and relevant benefit plans that take into account burden of disease and demand for health services over the next decade.

5. Deliver on Data

- 5.1 India's health policy is conducted in an information vacuum. Collection and analysis of health data is sporadic and the quality of the data cannot be independently verified. Without high quality, timely, and relevant data that feeds into a Health Management Information System (HMIS), none of the structural reforms outlined above will be effective.
- 5.2 We therefore welcome the NHP-2015's focus on the need for an "integrated health information system that serves the needs of all stake-holders and improves efficiency, transparency, citizen experience, and delivery of better health outcomes in terms of access, quality, affordability and lowering of disease burden and facilitates monitoring of health entitlements to citizens" (Para 9.2). However, it seems beyond the capacity of the Ministry of Health and Family Welfare to deliver on this critical objective.
- 5.3 We suggest NHP-2015 provide guiding principles for the Ministry of Health to establish an independent authority, similar to how the Unique ID Authority of India (UIDAI) has been set up. The new authority would be tasked with collection, management, and analysis of health data as its core business. It would be outside the Ministry of Health, and act as a nodal agency to collect data from other ministries such as Defence, Railways, and Labour as well as from the State governments and private sector. It would have legal status with strict data protection and dissemination protocols, but would facilitate independent research and evaluation.
- 5.4 Significant investment will be needed to build capacity for collection and processing of health information proposed in NHP-2015 (4). India should take lessons from international best practices in this area and seek the help of the development partners to create a modern strategic information system, both at national and state levels.

Citations:

- (1) CGD Research Project on Fiscal Federalism for Health in Large Populous Countries (<http://www.cgdev.org/blog/most-money-health-subnational-what-will-donors-do-about-it>)
- (2) CGD Working Group Report on Priority Setting Institutions for Global Health (<http://www.cgdev.org/working-group/priority-setting-institutions-global-health>)
- (3) Samik Choudhury and Indrani Gupta (2015), Public spending on health coverage: Are we raising the right questions? Ideas for India Blog (http://ideasforindia.in/article.aspx?article_id=411)
- (4) Amanda Glassman (2014), Data Revolution from the Bottom Up. Center for Global Development, Washington DC. (<http://www.cgdev.org/blog/data-revolution-bottom>)