# Prioritising Maternal and Newborn Child Health:

# A Consultation on the Changing Landscape of Health Policy and Fiscal Federalism in India

**Concept Note**

***Global and National Commitments on MNCH***

India formulated its first National Health Policy in 1983 in the context of the Alma Ata Declaration of 1978. The Policy committed to universal provision of comprehensive primary health care (PHC), including interventions for Maternal and Newborn Child Health (MNCH). The Alma Ata Declaration, though non-binding, had helped renew the focus on PHC across the world, with a commitment to achieve "Health for All" by 2000. In 2004-05, India launched the National Rural Health Mission (NRHM) with an aim to address the weaknesses and problems prevailing in the PHC in rural India. It focussed on MNCH from the beginning with a strong Reproductive and Child Health (RCH) component and involved community in the provision of healthcare services. India's global commitments, such as the Millennium Development Goals (MDGs) until 2015, and then the Sustainable Development Goals (SDGs) which are meant be achieved by 2030, have required the country to incorporate specific MNCH indicators and targets, such as reduction in Infant Mortality Rate (IMR), Maternal Mortality Ratio (MMR) and Total Fertility Rate (TFR) under the NRHM (and later National Health Mission – NHM which included the National Urban Health Mission) framework.

***Persistence of Deficits in the Domain of MNCH***

Notwithstanding some improvements in heath indicators in India since the turn of the century, the situation remains grim with over 40 thousand maternal deaths estimated each year in India, accounting for nearly 15 percent of global deaths of women in pregnancy, childbirth, post-abortion and in the postpartum period. According to the latest government data (SRS, 2018), India has been able to reduce the MMR from 167 per 1 lakh live-births during 2011-13 to 130 per 1 lakh live-births during 2014-16. Although an impressive decline in MMR by 22 percent over a three-year period, we still have not reached the MDG target of 109 which was to be met by 2015. As far as achieving MDG targets is concerned, apart from MMR, the IMR stands at 34 per thousand live-births (2016) against the target of 29 by 2015. The only target that India has been able to achieve is that for U5MR, which stands at 39 per thousand live-births (2016) against the target of 42 under MDGs.

In 2017, the Office of the Comptroller and Auditor General of India (CAG) published the performance audit report of NRHM, especially focusing on its impact on improving RCH for the period 2011-12 to 2015-16. The observations made by the CAG report clearly point towards the fact that there is a critical need to address the less than satisfactory provisioning of healthcare services across States, plugging the gaps in planning and implementation at all levels of governance and smoothening out the anomalies. The audit pointed towards inadequate funding, under-spending of available financial resources, delays in transfer of funds, diversion of allocated programme funds, limited capacity to spend due to shortages in infrastructure and human resources among other issues. A degree of inequity in health outcomes and access to healthcare services in India, across different vulnerable

groups and between and within States necessitates stronger role of the state. The National Health Policy (NHP) 2017 notes that "even in States where overall averages are improving, marginalised communities and poorer economic quintiles of the population, especially in remote and tribal areas, continue to fare poorly".

***Changes in Health Policy***

The health sector in India is mired by multiple problems which include lack of adequate financial resources, shortfalls in availability of human resources and infrastructure facilities, and unequal access to and availability of healthcare across regions and social groups. The presence of a large private sector also contributes to high out of pocket expenditure on health. In addition to the need for increasing the overall quantum of public spending on health, the utilisation and implementation aspects, too, need to be addressed.

The new health policy, NHP 2017, has come after a gap of nearly 15 years since the last health policy in 2002. On the one hand, NHP 2017 talks about strengthening PHC through the upgradation of Sub Centres into Health and Wellness Centres; on the other, it focuses on secondary and tertiary healthcare through insurance-based provision of healthcare under the National Health Protection Mission (NHPM).

Both these components under the *Ayushman Bharat* have a significant involvement of the private sector, indicating a shift from public provisioning of health towards privatisation. These developments are altering the policy and governance landscape in India, which would have far reaching implications especially in the area of health and healthcare. It is important to look at these developments from the perspective of MNCH which constitutes a critical area of intervention. The health sector, in general, and MNCH in particular, is susceptible to an ill-effect, if any, resulting from such fundamental shifts in the health policy. It is important to note that in all these policy pronouncements and shifts, there is hardly any attention being given to MNCH.

***Changes in Fiscal Federalism***

In recent years, India's policy framework, both generally and in the specific context of health, has been changing. Over the last few years, India has undergone changes in the federal-fiscal architecture during the 14$^{th}$ Finance Commission (FC) period and has seen fast- paced changes in the health policy framework. As recommended by the 14$^{th}$ FC, the share of States in the divisible pool of Central taxes increased from 32 percent to 42 percent every year since 2015-16. However, there were also reductions in Union Government's financial assistance to States for their Plan spending. Further, the Centre-State funding pattern across various Centrally Sponsored Schemes (CSSs) also changed, which included the NHM, for which the Centre-State ratio has been changed to 60:40 from the erstwhile 75:25. This changed funding pattern has transferred larger responsibilities of financing NHM, among other CSS, to the States.

These developments have effected changes across States, reflected both in budgets and policies across social sector. In the health sector, different States have responded differently to these developments. While some States such as Assam and Bihar have prioritised health sector over other sectors in their State budgets, others have not. Some State Governments have introduced State

specific schemes to address the problem of malnutrition and other related problems among girls and pregnant women. However, these have been few and far between.

It is, thus, the need of the hour to discuss the emerging policy framework for health in India in the context of existing outcome deficits, inadequacy of financial resources, bottlenecks in utilisation and shortage of human resources and infrastructure, particularly under the domain of maternal and child health. There is also a need to assess the impact of changes effected by the 14th FC across States in the health sector. An analysis of the impact of 14th FC would be a fruitful exercise at this juncture as the 15th FC has been constituted for the period 2020-2025 and which, in turn, has constituted a High Level Group on Health Sector in order to "examine the strengths and weaknesses for enabling balanced expansion of Health Sector". The function of the Group includes evaluation of the regulatory framework and suggesting ways to optimise use of financial resources and incentivise States governments on the basis of their performance; the latter being contentious on the grounds of affecting federal structure and the concerns regarding regional disparities.

***Convening Key Civil Society Actors***

In August 2016, White Ribbon Alliance India (WRAI) and Centre for Budget and Governance Accountability (CBGA) had come together to organise a consultation focusing on the gaps in budgetary priorities and processes to improve quality of care in MNCH. The Consultation brought together the grassroots activists from networks, such as the White Ribbon Alliance India, Jan Swasthya Abhiyan and People's Budget Initiative, academicians and researchers. The discussion yielded some key policy advocacy asks to address the concerns regarding quality of care in MNCH and ensure adequate interventions at the national and State level, focusing on the experience in three States, namely Bihar, Jharkhand, Rajasthan, Uttar Pradesh and West Bengal. During the partnership over two years, WRAI-CBGA generated evidence on state of MNCH, engaged with Parliamentarians to strengthen government's accountability towards ensuring quality care in MNCH and collaborated on building capacity of civil society actors.

Building on this work and in the light of recent developments in the health sector, such as the formulation of the NHP 2017, completion of the 14th FC period and constitution of the 15th FC and the launch of the *Ayushman Bharat* model, it is important that we meet again and deliberate, especially on the implications of these changes on the quality of care under MNCH. In this context, WRAI and CBGA are organising a National Consultation on July 05, 2018, with the **objectives** to:

- strengthen our collective understanding on the directions in health policy and fiscal federalism in India from the perspective of MNCH issues/challenges;
- develop collectively the advocacy positions/messages on health policy and fiscal federalism from the lens of challenges towards ensuring quality of care under MNCH;
- identify the advocacy opportunities in 2018-19 so as to shape policy directions at the national and State level, especially with respect to engaging with the 15th FC.

The consultation will be held at India International Centre (IIC) – Annexe (Lecture Room 2), Lodhi Road, New Delhi.