Chapter

1

National Health Policies of 1983, 2002, 2017

NATIONAL HEALTH POLICY, 1983

The first National Health Policy was formulated in 1983, and since then there have been marked changes in the determinant factors relating to the health sector. Some of the policy initiatives outlined in the NHP, 1983 have yielded results, while, in several other areas, the outcome has not been as expected. The NHP, 1983 gave a general exposition of the policies which required recommendation in the circumstances then prevailing in the health sector. The noteworthy initiatives under that policy were:

i. A phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves

ii. Intermediation through "health volunteers " having appropriate knowledge, simple skills and requisite technologies;

iii. Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level;

iv. An integrated network of evenly spread speciality and super-speciality services; encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government's facilities is limited to those entitled to free use.

NATIONAL HEALTH POLICY, 2002

NHP, 1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged, had

hoped to provide Health for All by the year 2000 AD through the universal provision of comprehensive primary health care services. In retrospect, it was observed that the financial resources and public health administrative capacity which it was possible to marshal, was far short of that necessary to achieve such an ambitious and holistic goal. Against this backdrop, it was felt that it would be appropriate to pitch NHP, 2002 at a level consistent with our realistic expectations about financial resources, and about the likely increase in public health administrative capacity. The recommendations of NHP, 2002 were, therefore, attempted to maximize the broadbased availability of health services to the citizenry of the country on the basis the National Health Policy, 2002 of realistic considerations of capacity. The changed circumstances relating to the health sector of the country since 1983 have generated a situation in which it was now necessary to review the field, and to formulate a new policy framework as the National Health Policy, 2002.

Objectives of National Health Policy, 2002

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country.

A Approaches of National Health Policy, 2002

- To increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions.
- To ensuring a more equitable access to health services across the social and geographical expanse of the country.
- To increasing the aggregate public health investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the state level to render effective service delivery.
- The contribution of the private sector in providing health services would be much enhanced, particularly for the population group which can afford to pay for services.
- Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation. Emphasis will be laid on rational use of drugs within the allopathic system. Increased access to tried and tested systems of traditional medicine will be ensured.

Table 1.1: Goals of policy to be achieved by 2000–2015

Eradicate polio and yaws	2005
Eliminate leprosy	2005
Eliminate kala-azar	2010
Achieve zero level growth of HIV/AIDS	2007
Reduce mortality by 50% on account of TB, malaria and other vector- and water-borne diseases	2010
Reduce prevalence of blindness to 0.5%	2010
Reduce IMR to 30/1000 and MMR to 100/lakh	2010
Increase utilization of public health facilities from current level of <20 to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
Increase health expenditure by Government as a % of GDP from the existing 0.9 to 2.0%	2010
Increase share of central grants to constitute at least 25% of total health spending	2010
Increase state sector health spending from 5.5 to 7% of the budget further increase to 8%	2005 2010
Eliminate lymphatic filariasis	2015

Policy Prescriptions

1. Equity

For reduction of various types of inequities and imbalances in inter-regional; across the rural and urban divide; and between economic classes and the most cost-effective method would be to increase the sectoral outlay in the primary health sector. Policy sets out an increased allocation of 55% of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targeted for 35% and 10% respectively.

2. Financial Resources

The Central Government will have to play a key role in augmenting public health investments. Taking into account the gap in health care facilities, it is planned, under the policy to increase health sector expenditure to 6% of GDP, with 2% of GDP being contributed as public health investment, by the year 2010.

3. Delivery of National Public Health Programmes

The Policy envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, malaria, HIV/

AIDS, as also the RCH and Universal Immunization Programmes, would need to be continued till moderate levels of prevalence are reached. The integration of the programmes will bring about a desirable optimisation of outcomes through a convergence of all public health inputs. Policy lays great emphasis upon the implementation of public health programmes through local self-government institutions.

The Policy also envisages the role of autonomous bodies at state and district levels, state government officials, social activists, private health professionals and MLAs/MPs in the implementation of national health programmes.

4. The State of Public Health Infrastructure

The Policy envisages kick-starting the revival of the primary health system by providing some essential drugs under Central Government funding through the decentralized health system. This policy recognizes the need for more frequent in-service training of public health medical personnel, at the level of medical officers as well as paramedics. The policy, while committing additional aggregate financial resources, places great reliance on the strengthening of the primary health structure for the attainin of improved public health outcomes on an equitable basis. Further, it also recognizes the practical need for levying reasonable user-charges for certain secondary and tertiary public health care services, for those who can afford to pay.

5. Extending Public Health Services

Policy envisages the enhance of pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Systems of Medicine and Homoeopathy. NHP-2002 also recognizes the need for states to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in underserved areas.

6. Education of Health Care Professionals

This policy envisages the setting up of a medical grants commission for funding new government medical and dental colleges in different parts of the country. This policy identifies a significant need to modify the existing medical curriculum. A need-based, skill-oriented syllabus, with a more significant component of practical training, would make fresh doctors useful immediately

after graduation. The Policy emphasises the need to expose medical students, through the undergraduate syllabus, to the emerging concerns for geriatric disorders, as also to the cutting edge disciplines of contemporary medical research.

7. Need for Specialists in Public Health and Family Medicine

In order to alleviate the acute shortage of medical personnel with specialization in the disciplines of public health and family medicine, the Policy envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these discipline in medical training institutions, to reach a stage wherein one-fourth of the seats are earmarked for these disciplines.

8. Nursing Personnel

The Policy emphasizes the need for an improvement in the ratio of nurses vis-vis doctors/beds. Policy emphasis on improving the skill-level of nurses, and on increasing the ratio of degree-holding nurses vis-vis diploma-holding nurses. The Policy also recognizes the need for establishing training courses for super-speciality nurses required for tertiary care institutions.

9. Use of Generic Drugs and Vaccines

This Policy emphasizes the need for basing treatment regimens, in both the public and private domains, on a limited number of essential drugs of a generic nature. The production and sale of irrational combinations of drugs would be prohibited through the drug standards statute. The National Programme for Universal Immunization against Preventable Diseases requires to be assured of an uninterrupted supply of vaccines at an affordable price. This policy envisages that not less than 50% of the requirement of vaccines/sera be sourced from public sector institutions.

10. Urban Health

Policy envisages the setting up of an organised urban primary health care structure and the funding for the urban primary health system will be jointly borne by the local self-government institutions and state and central governments.

11. Mental Health

It envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis

of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff. Policy envisages the upgrading of the physical infrastructure of such institutions (where indoor facilityies are available) at Central Government expense.

12. Women's Health

The Policy commits the highest priority of the Central Government to the funding of the identified programmes relating to women's health. Also, the Policy recognizes the need to review the staffing norms of the public health administration to meet the specific requirements of women in a more comprehensive manner.

13. Health Research

This Policy envisages an increase in government-funded health research to a level of 1% of the total health spending by 2005; and thereafter, up to 2% by 2010.

14. Role of the Private Sector

This Policy envisages the enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions by 2003. It also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages. NHP-2002 envisages the co-option of the non-governmental practitioners in the national disease control programmes so as to ensure that standard treatment protocols are followed in their day-to-day practice.

15. National Disease Surveillance Network

This Policy envisages the full operationalization of an integrated disease control network from the lowest rung of public health administration to the Central Government by 2005.

16. Health Statistics

The Policy envisages the completion of baseline estimates for the incidence of the common diseases, i.e. TB, malaria, blindness, by 2005. The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology. The policy also recognizes the need to establish, in a longer time-frame, baseline estimates for non-communicable

diseases, like CVD, cancer, diabetes; and accidental injuries, and communicable diseases, like hepatitis and JE.

17. Environmental and Occupational Health

NHP, 2002 envisages the periodic screening of the health conditions of the workers, particularly for high- risk health disorders associated with their occupation.

18. Medical Ethics

This envisages that, in order to ensure that the common patient is not subjected to irrational or profit-driven medical regimens, a contemporary code of ethics be notified and rigorously implemented by the Medical Council of India.

19. Providing Medical Facilities to Users from Overseas

This policy strongly encourages the providing of secondary and tertiary health care services on a payment basis to service seekers from overseas. The providers of such services to patients from overseas will be encouraged by extending to their earnings in foreign exchange, all fiscal incentives, including the status of "deemed exports", which are available to other exporters of goods and services.

20. Impact of Globalisation on the Health Sector

This Policy envisages a national patent regime for the future, which, while being consistent with TRIPS, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries. The policy also sets out that the government will bring to bear its full influence in all international fora—UN, WHO, WTO, etc. to secure commitments on the part of the nations of the Globe, to lighten the restrictive features of TRIPS in its application to the health care sector.

NATIONAL HEALTH POLICY, 2017

The National Health Policy of 1983 and the National Health Policy of 2002 have served well in guiding the approach for the health sector in the five-year plans. Now 14 years after the last health policy, the context has changed in four major ways:

1. Health priorities are changing: Growing burden of non-communicable diseases and some communicable diseases.
2. Emergence of a robust health care industry estimated to be growing at double digit.
3. Growing incidences of catastrophic expenditure due to health care costs.
4. A rising economic growth enables enhanced fiscal capacity.

In keeping view these contextual changes, there is need to have a new health policy which is responsive to the changes.

Goal of NHP, 2017

i. Attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental policies.

ii. Universal access to good quality health care services without anyone having to face financial hardship as a consequence.

Objectives of NHP, 2017

1. Progressively achieve universal health coverage

1.1 Assuring availability of free, comprehensive primary health care services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population.

1.2 Ensuring improved access and affordability, of quality secondary and tertiary care services.

1.3 Achieving a significant reduction in out of pocket expenditure due to health care costs and achieving reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment.

2. Reinforcing trust in public health care system: Strengthening the trust of the common man in public health care system by making it predictable, efficient, patient centric, affordable and effective.

3. Align the growth of private health care sector with public health goals: Influence the operation and growth of the private health care sector and medical technologies to ensure alignment with public health goals.

Specific Quantitative Goals and Objectives

The indicative, quantitative goals and objectives are outlined under three broad components:

a. Health status and programme impact,

b. Health systems performance, and

c. Health system strengthening.

a. Health status and programme impact

1. Increase life expectancy at birth from 67.5 to 70 by 2025.
2. Establish regular tracking of Disability Adjusted Life Years (DALY) Index as a measure of burden of disease and its trends by major categories by 2022.
3. Reduction of TFR to 2.1 at national and sub-national level by 2025.
4. Reduce under five mortality to 23 by 2025.
5. Reduce MMR from current levels to 100 by 2020.
6. Reduce infant mortality rate to 28 by 2019.
7. Reduce neonatal mortality to 16 and stillbirth rate to "single digit" by 2025.
8. Achieve global target of 2020 which is also termed as target of 90:90:90, for HIV/AIDS, i.e. 90% of all people living with HIV know their HIV status, 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.
9. Achieve and maintain elimination status of leprosy by 2018, kala-azar by 2017 and lymphatic Filariasis in endemic pockets by 2017
10. To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.
11. To reduce the prevalence of blindness to 0.25/1000 by 2025 and disease burden by one-third from current levels.
12. To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.

b. Health systems performance

1. Increase utilization of public health facilities by 50% from current levels by 2025.
2. Antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025.
3. More than 90% of the newborn are fully immunized by one year of age by 2025.
4. Meet needs of family planning above 90% at national and subnational level by 2025.
5. 80% of known hypertensive and diabetic individuals at household level maintain, controlled disease status by 2025.
6. Relative reduction in prevalence of current tobacco use by 15% by 2020 and 30% by 2025.
7. Reduction of 40% in prevalence of stunting of under-five children by 2025.
8. Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).
9. Reduction of occupational injury by half from current levels of 334/lakh agricultural workers by 2020.
10. National/state level tracking of selected health behavior.

c. Health system strengthening

1. Increase health expenditure by government as a percentage of GDP from the existing 1.15 to 2.5 % by 2025.
2. Increase state sector health spending to >8% of their budget by 2020.
3. Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25%, by 2025.
4. Ensure availability of paramedics and doctors as per Indian Public Health Standard (IPHS) norm in high priority districts by 2020.
5. Increase community health volunteers to population ratio as per IPHS norm, in high priority districts by 2025.
6. Establish primary and secondary care facility as per norms in high priority districts (population as well as time to reach norms) by 2025.
7. Ensure district-level electronic database of information on health system components by 2020.
8. Strengthen the health surveillance system and establish registries for diseases of public health importance by 2020.

9. Establish federated integrated health information architecture, health information exchanges and national health information network by 2025.

Key Principles of NHP, 2017

1. **Professionalism, integrity and ethics:** These principles have to be maintained throughout the health care delivery system by all health care professionals.
2. **Equity:** Achievment of equity by minimizing disparity on account of gender, poverty, caste, disability, other forms of social exclusion and geographical barriers.
3. **Affordability:** Health care expenditure should be affordable. Catastrophic household health care expenditures defined as health expenditure exceeding 10% of its total monthly consumption expenditure or 40% of its monthly non-food consumption expenditure, are unacceptable.
4. **Universality:** Health care system should cater the entire population-including special groups.
5. **Patient-centered and quality of care:** Gender sensitive, effective, safe, and convenient health care services to be provided with dignity and confidentiality.
6. **Accountability:** Financial and performance accountability should be entrusted .
7. **Inclusive partnerships:** A multi stakeholder approach with partnership and participation of all non-health ministries and communities.
8. **Pluralism:** Patients choice to choose any system of medicine and when appropriate.
9. **Decentralization:** Community participation in health planning processes, to be promoted.
10. **Dynamism and adaptiveness:** Constantly improving dynamic organization of health care based on new knowledge and evidence with learning from the communities and from national and international knowledge partners is designed.

Policy thrust on following areas in health delivery system

1. ***Ensuring sdequate investment***
2. ***Preventive and promotive health***
3. ***Organization of public health care delivery:*** The policy proposes seven key policy shifts in organizing health care services:

a. In primary care—from selective care to assured comprehensive care with linkages to referral hospitals.
b. In secondary and tertiary care—from an input oriented to an output based strategic purchasing.
c. In public hospitals—from user fees and cost recovery to assured free drugs, diagnostic and emergency services to all.
d. In infrastructure and human resource development–from normative approach to targeted approach to reach underserviced areas.
e. In urban health—from token interventions to on-scale assured interventions, to organize primary health care delivery and referral support for urban poor. Collaboration with other sectors to address wider determinants of urban health is advocated.
f. In national health programmes—integration with health systems for programme effectiveness and in turn contributing to strengthening of health systems for efficiency.
g. In AYUSH services—from stand-alone to a three-dimensional mainstreaming.

4. ***National health programmes***
   a. *Universal immunization:* Improve immunization coverage with quality and safety, improve vaccine security as per National Vaccine Policy, 2011 and introduction of newer vaccines based on epidemiological considerations.
   b. *Communicable diseases:* The policy recognizes the interrelationship between communicable disease control programmes and public health system strengthening.
   c. *Control of tuberculosis:* The policy acknowledges HIV and TB coinfection and increased incidence of drug resistant tuberculosis as key challenges in control of tuberculosis. The policy calls for more active case detection, with a greater involvement of private sector supplemented by preventive and promotive action in the workplace and in living conditions.
   d. *Control of HIV/AIDS:* Policy recommends focused interventions on the high-risk communities (MSM, transgender, FSW, etc.) and prioritized geographies. There is a need to support care and treatment for people living with HIV/AIDS

through inclusion of 1st, 2nd and 3rd line antiretroviral (ARV), Hep-C and other costly drugs into the essential medical list.

e. *Leprosy elimination:* Policy envisages proactive measures targeted towards elimination of leprosy from India by 2018.

f. *Vector-borne disease control:* The policy recognizes the challenge of drug resistance in malaria. New national programme for prevention and control of Japanese encephalitis (JE)/acute encephalitis syndrome (AES) should be accelerated with strong component of intersectoral collaboration.

g. *Non-communicable diseases*: The policy recognizes the need to halt and reverse the growing incidence of chronic diseases. The policy recommends to set-up a National Institute of chronic diseases including trauma, to generate evidence for adopting cost-effective approaches and to showcase best practices.

h. *Mental health:* This policy will take into consideration the provisions of the National Mental Health Policy, 2014.

i. *Population stabilization:* The National Health Policy recognises that improved access, education and empowerment would be the basis of successful population stabilization.

5. ***Women's health and gender mainstreaming:*** There will be enhanced provisions for reproductive morbidities and health needs of women beyond the reproductive age group (40+).
6. ***Gender-based violence (GBV):*** This policy notes with concern the serious and wide ranging consequences of GBV and recommends that the health care to the survivors/victims need to be provided free and with dignity in the public and private sector.
7. ***Emergency care and disaster preparedness:*** The policy envisages creation of a unified emergency response system, linked to a dedicated universal access number, with network of emergency care that has an assured provision of life support ambulances, trauma management centers—one per 30 lakh population in urban areas and one for every 10 lakh population in rural areas.
8. ***Mainstreaming the potential of AYUSH:*** The National Health Policy would continue mainstreaming of AYUSH with general health system but with the addition of a mandatory bridge course

that gives competencies to mid-level care provider with respect to allopathic remedies. The policy further supports the integration of AYUSH systems at the level of knowledge systems, by validating processes of health care promotion and cure.

9. ***Tertiary care services:*** The policy affirms that the tertiary care services are best organized along lines of regional, zonal and apex referral centers. It recommends that the government should set up new medical colleges, nursing institutions and AIIMS in the country.
10. ***Human resources for health:*** The key principle around the policy on human resources for health is that workforce performance of the system would be best when we have the most appropriate person, in terms of both skills and motivation, for the right job in the right place, working within the right professional and incentive environment.
    - **Medical education:** The policy recommends strengthening existing medical colleges and converting district hospitals to new medical colleges to increase number of doctors and specialists, in states with large human resource deficit.
    - **Attracting and retaining doctors in remote areas:** Policy proposes financial and non-financial incentives, creating medical colleges in rural areas; preference to students from under-serviced areas, realigning pedagogy and curriculum to suit rural health needs, mandatory rural postings, etc.
    - **Specialist attraction and retention:** Proposed policy measures include—recognition of educational options linked with National Board of Examination and College of Physicians and Surgeons, creation of specialist cadre with suitable pay scale, upgradation of short-term training to medical officers to provide basic specialist services at the block and district level, performance linked payments and popularise MD (doctor of medicine) course in family medicine or general practice.
    - **Mid-level service providers:** For expansion of primary care from selective care to comprehensive care, complementary human resource strategy is the development of a cadre of mid-level care providers.
    - **Nursing education:** The policy recognises the need to improve regulation and quality management of nursing education.

- Other measures suggested are—establishing cadres like nurse practitioners and public health nurses to increase their availability in most needed areas.

ASHA: This policy supports certification programme for ASHAs for their preferential selection into ANM, nursing and paramedical courses.

Paramedical skills: Training courses and curriculum for super specialty paramedical care (perfusionists, physiotherapists, occupational therapists, radiological technicians, audiologists, MRI technicians, etc.) would be developed.

Public health management cadre: The policy proposes creation of public health management cadre in all states based on public health or related disciplines, as an entry criterion. The policy also advocates an appropriate career structure and recruitment policy to attract young and talented multidisciplinary professionals.

Human resource governance and leadership development: The policy recognizes that human resource management is critical to health system strengthening and health care delivery and therefore, the policy supports measures aimed at continuing medical and nursing education and on the job support to providers, especially those working in professional isolation in rural areas using digital tools and other appropriate training resources.

11. ***Financing of health care:*** The policy advocates allocating major proportion (up to two-thirds or more) of resources to primary care followed by secondary and tertiary care. Inclusion of cost-benefit and cost-effectiveness studies consistently in programme design and evaluation would be prioritized. This would contribute significantly to increasing efficiency of public expenditure.

    A robust national health accounts system would be operationalized to improve public sector efficiency in resource allocation/payments. The policy calls for major reforms in financing for public facilities—where operational costs would be in the form of reimbursements for care provision and on a per capita basis for primary care. Items like infrastructure development and maintenance, non-incentive cost of the human resources, i.e. salaries and much of administrative costs, would, however, continue to flow on a fixed cost basis.

12. ***Collaboration with non-government sector/engagement with private sector:*** The policy suggests exploring collaboration for primary care services with "not-for-profit" organizations having a track record of public services where critical gaps exist, as a short-term measure. Collaboration can also be done for certain services where team of specialized human resources and domain specific organizational experience is required.
13. ***Corporate social responsibility (CSR):*** The policy recommends engagement of private sector through adoption of neighborhood schools/colonies/slums/tribal areas/backward areas for healthcare awareness and services.