

NATIONAL HEALTH POLICY - 2002

1. INTRODUCTORY

1.1 A National Health Policy was last 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.

1.2 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 net-work 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.

1.3 Government initiatives in the public health sector have recorded some noteworthy successes over time. Smallpox and

Guinea Worm Disease have been eradicated from the country; Polio is on the verge of being eradicated; Leprosy, Kala Azar, and Filariasis can be expected to be eliminated in the foreseeable future. There has been a substantial drop in the Total Fertility Rate and Infant Mortality Rate. The success of the initiatives taken in the public health field are reflected in the progressive improvement of many demographic / epidemiological / infrastructural indicators over time – (Box-I).

Box-1 : Achievements Through The Years - 1951-2000

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	110	70 (99 SRS)

Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no of cases)	>44,887	Eradicated	
Guineaworm (no. of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)

Dispensaries & Hospitals(all)	9209	23,555	43,322 (95–96- CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors(Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

1.4 While noting that the public health initiatives over the years have contributed significantly to the improvement of these health indicators, it is to be acknowledged that public health indicators / disease-burden statistics are the outcome of several complementary initiatives under the wider umbrella of the developmental sector, covering Rural Development, Agriculture, Food Production, Sanitation, Drinking Water Supply, Education, etc. Despite the impressive public health gains as revealed in the statistics in Box-I, there is no gainsaying the fact that the morbidity and mortality levels in the country are still unacceptably high. These unsatisfactory health indices are, in turn, an indication of the limited success of the public health system in meeting the preventive and curative requirements of the general population.

1.5 Out of the communicable diseases which have persisted over time, the incidence of Malaria staged a resurgence in the 1980s before stabilising at a fairly high prevalence level during the 1990s. Over the years, an increasing level of insecticide-resistance has developed in the malarial vectors in many parts of the country, while the incidence of the more deadly P-Falciparum Malaria has risen to about 50 percent in the country as a whole. In respect of TB, the public health scenario has not shown any significant decline in the pool of infection amongst the community, and there has been a distressing trend in the increase of drug resistance to the type of infection prevailing in the country. A new and extremely virulent communicable disease –

HIV/AIDS - has emerged on the health scene since the declaration of the NHP-1983. As there is no existing therapeutic cure or vaccine for this infection, the disease constitutes a serious threat, not merely to public health but to economic development in the country. The common water-borne infections – Gastroenteritis, Cholera, and some forms of Hepatitis – continue to contribute to a high level of morbidity in the population, even though the mortality rate may have been somewhat moderated.

1.6 The period after the announcement of NHP-83 has also seen an increase in mortality through 'life-style' diseases- diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem.

1.7 Another area of grave concern in the public health domain is the persistent incidence of macro and micro nutrient deficiencies, especially among women and children. In the vulnerable sub-category of women and the girl child, this has the multiplier effect through the birth of low birth weight babies and serious ramifications of the consequential mental and physical retarded growth.

1.8 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 is 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 is 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 will, therefore, attempt to maximize the broad-based availability of health services to the citizenry of the country on the basis 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 is now necessary to review the field, and to formulate a new policy framework as the National Health Policy-2002. NHP-2002 will attempt to set out a new policy framework for the accelerated achievement of Public health goals in the socio-economic circumstances currently prevailing in the country.

2. CURRENT SCENARIO

2.1 FINANCIAL RESOURCES

2.1.1 The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 17 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual per capita public health expenditure in the country is no more than Rs. 200. Given these statistics, it is no surprise that the reach and quality of public health services has been below the desirable standard. Under the constitutional structure, public health is the responsibility of the States. In this framework, it has been the expectation that the principal contribution for the funding of public health services will be from the resources of the States, with some supplementary input from Central resources. In this backdrop, the contribution of Central resources to the overall public health funding has been limited to about 15 percent. The fiscal resources of the State Governments are known to be very inelastic. This is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget. If the decentralized public health services in the country are to improve significantly, there is a need for the injection of substantial resources into the health sector from the Central Government Budget. This approach is a necessity – despite the formal Constitutional provision in regard to public health, -- if the State public health services, which are a

major component of the initiatives in the social sector, are not to become entirely moribund. The NHP-2002 has been formulated taking into consideration these ground realities in regard to the availability of resources.

2.2 EQUITY

2.2.1 In the period when centralized planning was accepted as a key instrument of development in the country, the attainment of an equitable regional distribution was considered one of its major objectives. Despite this conscious focus in the development process, the statistics given in Box-II clearly indicate that the attainment of health indices has been very uneven across the rural – urban divide.

Box II : Differentials in Health Status Among States

Sector	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mortality per 1000 (NFHS II)	Weight For Age- % of Children Under 3 years (<-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 population	Malaria +ve Cases in year 2000 (in thousands)
India	26.1	70	94.9	47	408	3.7	2200
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharashtra	25.02	48	58.1	50	135	3.1	138
TN	21.12	52	63.3	37	79	4.1	56

Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

Also, the statistics bring out the wide differences between the attainments of health goals in the better- performing States as compared to the low-performing States. It is clear that national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country. Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide inter-State disparity implies that, for vulnerable sections of society in several States, access to public health services is nominal and health standards are grossly inadequate. Despite a thrust in the NHP-1983 for making good the unmet needs of public health services by establishing more public health institutions at a decentralized level, a large gap in facilities still persists. Applying current norms to the population projected for the year 2000, it is estimated that the shortfall in the number of SCs/PHCs/CHCs is of the order of 16 percent. However, this shortage is as high as 58 percent when disaggregated for CHCs only. The NHP-2002 will need to address itself to making good these deficiencies so as to narrow the gap between the various States, as also the gap across the rural-urban divide.

2.2.2 Access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially disadvantaged sections of society. The

statistics given in Box-III highlight the handicap suffered in the health sector on account of socio-economic inequity.

Box-III : Differentials in Health status Among Socio-Economic Groups

Indicator	Infant Mortality/1000	Under 5 Mortality/1000	% Children Underweight
<u>India</u>	70	94.9	47
Social Inequity			
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

2.2.3 It is a principal objective of NHP-2002 to evolve a policy structure which reduces these inequities and allows the disadvantaged sections of society a fairer access to public health services.

2.3 DELIVERY OF NATIONAL PUBLIC HEALTH

PROGRAMMES

2.3.1 It is self-evident that in a country as large as India, which has a wide variety of socio-economic settings, national health programmes have to be designed with enough flexibility to permit the State public health administrations to craft their own programme package according to their needs. Also, the implementation of the national health programme can only be carried out through the State Governments' decentralized public health machinery. Since, for various reasons, the responsibility of the Central Government in funding additional public health services will continue over a period of time, the role of the Central

Government in designing broad-based public health initiatives will inevitably continue. Moreover, it has been observed that the technical and managerial expertise for designing large-span public health programmes exists with the Central Government in a considerable degree; this expertise can be gainfully utilized in designing national health programmes for implementation in varying socio-economic settings in the States. With this background, the NHP-2002 attempts to define the role of the Central Government and the State Governments in the public health sector of the country.

2.3.2.1 Over the last decade or so, the Government has relied upon a 'vertical' implementational structure for the major disease control programmes. Through this, the system has been able to make a substantial dent in reducing the burden of specific diseases. However, such an organizational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain. Over a long time-range, 'vertical' structures may only be affordable for those diseases which offer a reasonable possibility of elimination or eradication in a foreseeable time-span.

2.3.2.2 It is a widespread perception that, over the last decade and a half, the rural health staff has become a vertical structure exclusively for the implementation of family welfare activities. As a result, for those public health programmes where there is no separate vertical structure, there is no identifiable service delivery system at all. The Policy will address this distortion in the public health system.

2.4 THE STATE OF PUBLIC HEALTH INFRA-STRUCTURE

2.4.1 The delineation of NHP-2002 would be required to be based on an objective assessment of the quality and efficiency of the existing public health machinery in the field. It would detract from the quality of the exercise if, while framing a new policy, it were not acknowledged that the existing public health infrastructure is far from satisfactory. For the outdoor medical facilities in existence, funding is generally insufficient; the presence of

medical and para-medical personnel is often much less than that required by prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and, the buildings are in a dilapidated state. In the indoor treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services. As a result of such inadequate public health facilities, it has been estimated that less than 20 percent of the population, which seek OPD services, and less than 45 percent of that which seek indoor treatment, avail of such services in public hospitals. This is despite the fact that most of these patients do not have the means to make out-of-pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition.

2.5 EXTENDING PUBLIC HEALTH SERVICES

2.5.1 While there is a general shortage of medical personnel in the country, this shortfall is disproportionately impacted on the less-developed and rural areas. No incentive system attempted so far, has induced private medical personnel to go to such areas; and, even in the public health sector, the effort to deploy medical personnel in such under-served areas, has usually been a losing battle. In such a situation, the possibility needs to be examined of entrusting some limited public health functions to nurses, paramedics and other personnel from the extended health sector after imparting adequate training to them.

2.5.2 India has a vast reservoir of practitioners in the Indian Systems of Medicine and Homoeopathy, who have undergone formal training in their own disciplines. The possibility of using such practitioners in the implementation of State/Central Government public health programmes, in order to increase the reach of basic health care in the country, is addressed in the NHP-2002.

2.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

2.6.1 Some States have adopted a policy of devolving programmes and funds in the health sector through different levels of the Panchayati Raj Institutions. Generally, the experience has been an encouraging one. The adoption of such an organisational structure has enabled need-based allocation of resources and closer supervision through the elected representatives. The Policy examines the need for a wider adoption of this mode of delivery of health services, in rural as well as urban areas, in other parts of the country.

2.7 NORMS FOR HEALTH CARE PERSONNEL

2.7.1 It is observed that the deployment of doctors and nurses, in both public and private institutions, is ad-hoc and significantly short of the requirement for minimal standards of patient care. This policy will make a specific recommendation in regard to this deficiency.

2.8 EDUCATION OF HEALTH CARE PROFESSIONALS

2.8.1 Medical and Dental Colleges are not evenly spread across various parts of the country. Apart from the uneven geographical distribution of medical institutions, the quality of education is highly uneven and in several instances even sub-standard. It is a common perception that the syllabus is excessively theoretical, making it difficult for the fresh graduate to effectively meet even the primary health care needs of the population. There is a general reluctance on the part of graduate doctors to serve in areas distant from their native place. NHP-2002 will suggest policy initiatives to rectify the resultant disparities.

2.8.2.1 Certain medical disciplines, such as molecular biology and gene-manipulation, have become relevant in the period after the formulation of the previous National Health Policy. The components of medical research in recent years have changed radically. In the foreseeable future such research will rely increasingly on the new disciplines. It is observed that the current under-graduate medical syllabus does not cover such emerging

subjects. The Policy will make appropriate recommendations in respect of such deficiencies.

2.8.2.2 Also, certain speciality disciplines – Anesthesiology, Radiology and Forensic Medicine – are currently very scarce, resulting in critical deficiencies in the package of available public health services. This Policy will recommend some measures to alleviate such critical shortages.

2.9 NEED FOR SPECIALISTS IN ‘PUBLIC HEALTH’ AND ‘FAMILY MEDICINE’

2.9.1 In any developing country with inadequate availability of health services, the requirement of expertise in the areas of ‘public health’ and ‘family medicine’ is markedly more than the expertise required for other clinical specialities. In India, the situation is that public health expertise is non-existent in the private health sector, and far short of requirement in the public health sector. Also, the current curriculum in the graduate / post-graduate courses is outdated and unrelated to contemporary community needs. In respect of ‘family medicine’, it needs to be noted that the more talented medical graduates generally seek specialization in clinical disciplines, while the remaining go into general practice. While the availability of postgraduate educational facilities is 50 percent of the total number of qualifying graduates each year, and can be considered adequate, the distribution of the disciplines in the postgraduate training facilities is overwhelmingly in favour of clinical specializations. NHP-2002 examines the possible means for ensuring adequate availability of personnel with specialization in the ‘public health’ and ‘family medicine’ disciplines, to discharge the public health responsibilities in the country.

2.10 Nursing Personnel

2.10.1 The ratio of nursing personnel in the country vis-à-vis doctors/beds is very low according to professionally accepted

norms. There is also an acute shortage of nurses trained in super-speciality disciplines for deployment in tertiary care facilities. NHP-2002 addresses these problems.

2.11 USE OF GENERIC DRUGS AND VACCINES

2.11.1 India enjoys a relatively low-cost health care system because of the widespread availability of indigenously manufactured generic drugs and vaccines. There is an apprehension that globalization will lead to an increase in the costs of drugs, thereby leading to rising trends in overall health costs. This Policy recommends measures to ensure the future Health Security of the country.

2.12 URBAN HEALTH

2.12.1.1 In most urban areas, public health services are very meagre. To the extent that such services exist, there is no uniform organizational structure. The urban population in the country is presently as high as 30 percent and is likely to go up to around 33 percent by 2010. The bulk of the increase is likely to take place through migration, resulting in slums without any infrastructure support. Even the meagre public health services which are available do not percolate to such unplanned habitations, forcing people to avail of private health care through out-of-pocket expenditure.

2.12.1.2 The rising vehicle density in large urban agglomerations has also led to an increased number of serious accidents requiring treatment in well-equipped trauma centres. NHP-2002 will address itself to the need for providing this unserved urban population a minimum standard of broad-based health care facilities.

2.13 MENTAL HEALTH

2.13.1 Mental health disorders are actually much more prevalent than is apparent on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families.

Sometimes, based on religious faith, mental disorders are treated as spiritual affliction. This has led to the establishment of unlicensed mental institutions as an adjunct to religious institutions where reliance is placed on faith cure. Serious conditions of mental disorder require hospitalization and treatment under trained supervision. Mental health institutions are woefully deficient in physical infrastructure and trained manpower. NHP-2002 will address itself to these deficiencies in the public health sector.

2.14 INFORMATION, EDUCATION AND COMMUNICATION

2.14.1 A substantial component of primary health care consists of initiatives for disseminating to the citizenry, public health-related information. IEC initiatives are adopted not only for disseminating curative guidelines (for the TB, Malaria, Leprosy, Cataract Blindness Programmes), but also as part of the effort to bring about a behavioural change to prevent HIV/AIDS and other life-style diseases. Public health programmes, particularly, need high visibility at the decentralized level in order to have an impact. This task is difficult as 35 percent of our country's population is illiterate. The present IEC strategy is too fragmented, relies too heavily on the mass media and does not address the needs of this segment of the population. It is often felt that the effectiveness of IEC programmes is difficult to judge; and consequently it is often asserted that accountability, in regard to the productive use of such funds, is doubtful. The Policy, while projecting an IEC strategy, will fully address the inherent problems encountered in any IEC programme designed for improving awareness and bringing about a behavioural change in the general population.

2.14.2 It is widely accepted that school and college students are the most impressionable targets for imparting information relating to the basic principles of preventive health care. The policy will attempt to target this group to improve the general level of awareness in regard to 'health-promoting' behaviour.

2.15 HEALTH RESEARCH

2.15.1 Over the years, health research activity in the country has been very limited. In the Government sector, such research has been confined to the research institutions under the Indian Council of Medical Research, and other institutions funded by the States/Central Government. Research in the private sector has assumed some significance only in the last decade. In our country, where the aggregate annual health expenditure is of the order of Rs. 80,000 crores, the expenditure in 1998-99 on research, both public and private sectors, was only of the order of Rs. 1150 crores. It would be reasonable to infer that with such low research expenditure, it is virtually impossible to make any dramatic breakthrough within the country, by way of new molecules and vaccines; also, without a minimal back-up of applied and operational research, it would be difficult to assess whether the health expenditure in the country is being incurred through optimal applications and appropriate public health strategies. Medical Research in the country needs to be focused on therapeutic drugs/vaccines for tropical diseases, which are normally neglected by international pharmaceutical companies on account of their limited profitability potential. The thrust will need to be in the newly-emerging frontier areas of research based on genetics, genome-based drug and vaccine development, molecular biology, etc. NHP-2002 will address these inadequacies and spell out a minimal quantum of expenditure for the coming decade, looking to the national needs and the capacity of the research institutions to absorb the funds.

2.16 ROLE OF THE PRIVATE SECTOR

2.16.1 Considering the economic restructuring under way in the country, and over the globe, in the last decade, the changing role of the private sector in providing health care will also have to be addressed in this Policy. Currently, the contribution of private health care is principally through independent practitioners. Also, the private sector contributes significantly to secondary-level care and some tertiary care. It is a widespread perception that private health services are very uneven in quality, sometimes even sub-standard. Private health services are also perceived to be financially exploitative, and the observance of professional ethics

is noted only as an exception. With the increasing role of private health care, the implementation of statutory regulation, and the monitoring of minimum standards of diagnostic centres / medical institutions becomes imperative. The Policy will address the issues regarding the establishment of a comprehensive information system, and based on that the establishment of a regulatory mechanism to ensure the maintaining of adequate standards by diagnostic centres / medical institutions, as well as the proper conduct of clinical practice and delivery of medical services.

2.16.2 Currently, non-Governmental service providers are treating a large number of patients at the primary level for major diseases. However, the treatment regimens followed are diverse and not scientifically optimal, leading to an increase in the incidence of drug resistance. This policy will address itself to recommending arrangements which will eliminate the risks arising from inappropriate treatment.

2.16.3 The increasing spread of information technology raises the possibility of its adoption in the health sector. NHP-2002 will examine this possibility.

2.17 THE ROLE OF CIVIL SOCIETY

2.17.1 Historically, it has been the practice to implement major national disease control programmes through the public health machinery of the State/Central Governments. It has become increasingly apparent that certain components of such programmes cannot be efficiently implemented merely through government functionaries. A considerable change in the mode of implementation has come about in the last two decades, with the increasing involvement of NGOs and other institutions of civil society. It is to be recognized that widespread debate on various public health issues has, in fact, been initiated and sustained by NGOs and other members of the civil society. Also, an increasing contribution is being made by such institutions in the delivery of different components of public health services. Certain disease control programmes require close inter-action with the beneficiaries for regular administration of drugs; periodic carrying

out of pathological tests; dissemination of information regarding disease control and other general health information. NHP-2002 will address such issues and suggest policy instruments for the implementation of public health programmes through individuals and institutions of civil society.

2.18 NATIONAL DISEASE SURVEILLANCE NETWORK

2.18.1 The technical network available in the country for disease surveillance is extremely rudimentary and to the extent that the system exists, it extends only up to the district level. Disease statistics are not flowing through an integrated network from the decentralized public health facilities to the State/Central Government health administration. Such an arrangement only provides belated information, which, at best, serves a limited statistical purpose. The absence of an efficient disease surveillance network is a major handicap in providing a prompt and cost-effective health care system. The efficient disease surveillance network set up for Polio and HIV/AIDS has demonstrated the enormous value of such a public health instrument. Real-time information on focal outbreaks of common communicable diseases – Malaria, GE, Cholera and JE – and the seasonal trends of diseases, would enable timely intervention, resulting in the containment of the thrust of epidemics. In order to be able to use an integrated disease surveillance network for operational purposes, real-time information is necessary at all levels of the health administration. The Policy would address itself to this major systemic shortcoming in the administration.

2.19 HEALTH STATISTICS

2.19.1 The absence of a systematic and scientific health statistics data-base is a major deficiency in the current scenario. The health statistics collected are not the product of a rigorous methodology. Statistics available from different parts of the country, in respect of major diseases, are often not obtained in a manner which make aggregation possible or meaningful.

2.19.2.1 Further, the absence of proper and systematic documentation of the various financial resources used in the health sector is another lacuna in the existing health information scenario. This makes it difficult to understand trends and levels of health spending by private and public providers of health care in the country, and, consequently, to address related policy issues and to formulate future investment policies.

2.19.2.2 NHP-2002 will address itself to the programme for putting in place a modern and scientific health statistics database as well as a system of national health accounts.

2.20 WOMEN'S HEALTH

2.20.1 Social, cultural and economic factors continue to inhibit women from gaining adequate access even to the existing public health facilities. This handicap does not merely affect women as individuals; it also has an adverse impact on the health, general well-being and development of the entire family, particularly children. This policy recognises the catalytic role of empowered women in improving the overall health standards of the community.

2.21 MEDICAL ETHICS

2.21.1 Professional medical ethics in the health sector is an area which has not received much attention. Professional practices are perceived to be grossly commercial and the medical profession has lost its elevated position as a provider of basic services to fellow human beings. In the past, medical research has been conducted within the ethical guidelines notified by the Indian Council of Medical Research. The first document containing these guidelines was released in 1960, and was comprehensively revised in 2001. With the rapid developments in the approach to medical research, a periodic revision will no doubt be more frequently required in future. Also, the new frontier areas of research – involving gene manipulation, organ/human cloning and stem cell research – impinge on visceral issues relating to the sanctity of human life and the moral dilemma of

human intervention in the designing of life forms. Besides this, in the emerging areas of research, there is the uncharted risk of creating new life forms, which may irreversibly damage the environment as it exists today. NHP – 2002 recognises that this moral and religious dilemma, which was not relevant even two years ago, now pervades mainstream health sector issues.

2.22 ENFORCEMENT OF QUALITY STANDARDS FOR FOOD

AND DRUGS

2.22.1 There is an increasing expectation and need of the citizenry for efficient enforcement of reasonable quality standards for food and drugs. Recognizing this, the Policy will make an appropriate policy recommendation on this issue.

2.23 REGULATION OF STANDARDS IN PARA MEDICAL

DISCIPLINES

2.23.1 It has been observed that a large number of training institutions have mushroomed, particularly in the private sector, for para medical personnel with various skills – Lab Technicians, Radio Diagnosis Technicians, Physiotherapists, etc. Currently, there is no regulation/monitoring, either of the curriculae of these institutions, or of the performance of the practitioners in these disciplines. This Policy will make recommendations to ensure the standardization of such training and the monitoring of actual performance.

2.24 ENVIRONMENTAL AND OCCUPATIONAL HEALTH

2.24.1 The ambient environmental conditions are a significant determinant of the health risks to which a community is exposed. Unsafe drinking water, unhygienic sanitation and air pollution significantly contribute to the burden of disease, particularly in urban settings. The initiatives in respect of these environmental factors are conventionally undertaken by the participants, whether private or public, in the other development sectors. In this backdrop, the Policy initiatives, and the efficient

implementation of the linked programmes in the health sector, would succeed only to the extent that they are complemented by appropriate policies and programmes in the other environment-related sectors.

2.24.2 Work conditions in several sectors of employment in the country are sub-standard. As a result, workers engaged in such employment become particularly vulnerable to occupation-linked ailments. The long-term risk of chronic morbidity is particularly marked in the case of child labour. NHP-2002 will address the risk faced by this particularly vulnerable section of society.

2.25 PROVIDING MEDICAL FACILITIES TO USERS FROM

OVERSEAS

2.25.1 The secondary and tertiary facilities available in the country are of good quality and cost-effective compared to international medical facilities. This is true not only of facilities in the allopathic disciplines, but also of those belonging to the alternative systems of medicine, particularly Ayurveda. The Policy will assess the possibilities of encouraging the development of paid treatment-packages for patients from overseas.

2.26 THE IMPACT OF GLOBALIZATION ON THE HEALTH SECTOR

2.26.1 There are some apprehensions about the possible adverse impact of economic globalisation on the health sector. Pharmaceutical drugs and other health services have always been available in the country at extremely inexpensive prices. India has established a reputation around the globe for the innovative development of original process patents for the manufacture of a wide-range of drugs and vaccines within the ambit of the existing patent laws. With the adoption of Trade Related Intellectual Property Rights (TRIPS), and the subsequent alignment of domestic patent laws consistent with the commitments under TRIPS, there will be a significant shift in the scope of the parameters regulating the manufacture of new drugs/vaccines. Global experience has shown that the

introduction of a TRIPS-consistent patent regime for drugs in a developing country results in an across-the-board increase in the cost of drugs and medical services. NHP-2002 will address itself to the future imperatives of health security in the country, in the post-TRIPS era.

2.27 INTER-SECTORAL CONTRIBUTION TO HEALTH

2.27.1 It is well recognized that the overall well-being of the citizenry depends on the synergistic functioning of the various sectors in the socio-economy. The health status of the citizenry would, inter alia, be dependent on adequate nutrition, safe drinking water, basic sanitation, a clean environment and primary education, especially for the girl child. The policies and the mode of functioning in these independent areas would necessarily overlap each other to contribute to the health status of the community. From the policy perspective, it is therefore imperative that the independent policies of each of these inter-connected sectors, be in tandem, and that the interface between the policies of the two connected sectors, be smooth.

2.27.2 Sectoral policy documents are meant to serve as a guide to action for institutions and individual participants operating in that sector. Consistent with this role, NHP-2002 limits itself to making recommendations for the participants operating within the health sector. The policy aspects relating to inter-connected sectors, which, while crucial, fall outside the domain of the health sector, will not be covered by specific recommendations in this Policy document. Needless to say, the future attainment of the various goals set out in this policy assumes a reasonable complementary performance in these inter-connected sectors.

2.28 POPULATION GROWTH AND HEALTH STANDARDS

2.28.1 Efforts made over the years for improving health standards have been partially neutralized by the rapid growth of the population. It is well recognized that population stabilization measures and general health initiatives, when effectively synchronized, synergistically maximize the socio-economic well-being of the people. Government has separately announced the 'National Population Policy – 2000'. The principal common features covered under the National Population Policy-2000 and NHP-2002, relate to the prevention and control of communicable diseases; giving priority to the containment of HIV/AIDS infection; the universal immunization of children against all major preventable diseases; addressing the unmet needs for basic and reproductive health services, and supplementation of infrastructure. The synchronized implementation of these two Policies – National Population Policy – 2000 and National Health Policy-2002 – will be the very cornerstone of any national structural plan to improve the health standards in the country.

2.29 ALTERNATIVE SYSTEMS OF MEDICINE

2.29.1 Under the overarching umbrella of the national health frame work, the alternative systems of medicine – Ayurveda, Unani, Siddha and Homoeopathy – have a substantial role. Because of inherent advantages, such as diversity, modest cost, low level of technological input and the growing popularity of natural plant-based products, these systems are attractive, particularly in the underserved, remote and tribal areas. The alternative systems will draw upon the substantial untapped potential of India as one of the eight important global centers for plant diversity in medicinal and aromatic plants. The Policy focuses on building up credibility for the alternative systems, by encouraging evidence-based research to determine their efficacy, safety and dosage, and also encourages certification and quality-marking of products to enable a wider popular acceptance of these systems of medicine. The Policy also envisages the consolidation of documentary knowledge contained in these systems to protect it against attack from foreign commercial entities by way of malafide action under patent laws in other countries. The main components of NHP-2002

apply equally to the alternative systems of medicines. However, the Policy features specific to the alternative systems of medicine will be presented as a separate document.

3. OBJECTIVES

3.1 The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be 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. Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country. Emphasis will be given 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. Within these broad objectives, NHP-2002 will endeavour to achieve the time-bound goals mentioned in Box-IV.

Box-IV: Goals to be achieved by 2000-2015

Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kala Azar	2010
Eliminate Lymphatic Filariasis	2015

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	2005
Further increase to 8%	2010

4. NHP-2002 - POLICY PRESCRIPTIONS

4.1 FINANCIAL RESOURCES

4.1.1 The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, 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 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010. The State Governments would also need to increase the commitment to the health sector. In the first phase,

by 2005, they would be expected to increase the commitment of their resources to 7 percent of the Budget; and, in the second phase, by 2010, to increase it to 8 percent of the Budget. With the stepping up of the public health investment, the Central Government's contribution would rise to 25 percent from the existing 15 percent by 2010. The provisioning of higher public health investments will also be contingent upon the increase in the absorptive capacity of the public health administration so as to utilize the funds gainfully.

4.2 EQUITY

4.2.1 To meet the objective of reducing various types of inequities and imbalances – inter-regional; across the rural – urban divide; and between economic classes – the most cost-effective method would be to increase the sectoral outlay in the primary health sector. Such outlets afford access to a vast number of individuals, and also facilitate preventive and early stage curative initiative, which are cost effective. In recognition of this public health principle, NHP-2002 sets out an increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targeted for 35 percent and 10 percent respectively. The Policy projects that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms for such facilities.

4.3 DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES

4.3.1.1 This policy envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, NHP-2002 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. The Policy also envisages that programme implementation be effected through autonomous bodies at State and district levels. The interventions of State Health Departments may be limited to the overall monitoring of the achievement of programme targets and other technical aspects. The relative distancing of the programme implementation from the State Health Departments will give the project team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-informed decision-making.

4.3.1.2 The Policy also highlights the need for developing the capacity within the State Public Health administration for scientific designing of public health projects, suited to the local situation.

4.3.2 The Policy envisages that apart from the exclusive staff in a vertical structure for the disease control programmes, all rural health staff should be available for the entire gamut of public health activities at the decentralized level, irrespective of whether these activities relate to national programmes or other public health initiatives. It would be for the Head of the District Health administration to allocate the time of the rural health staff between the various programmes, depending on the local need. NHP-2002 recognizes that to implement such a change, not only would the public health administrators be required to change their mindset, but the rural health staff would need to be trained and reoriented.

4.4 THE STATE OF PUBLIC HEALTH INFRASTRUCTURE

4.4.1.1 As has been highlighted in the earlier part of the Policy, the decentralized Public health service outlets have become practically dysfunctional over large parts of the country. On account of resource constraints, the supply of drugs by the State

Governments is grossly inadequate. The patients at the decentralized level have little use for diagnostic services, which in any case would still require them to purchase therapeutic drugs privately. In a situation in which the patient is not getting any therapeutic drugs, there is little incentive for the potential beneficiaries to seek the advice of the medical professionals in the public health system. This results in there being no demand for medical services, so medical professionals and paramedics often absent themselves from their place of duty. It is also observed that the functioning of the public health service outlets in some States like the four Southern States – Kerala, Andhra Pradesh, Tamil Nadu and Karnataka – is relatively better, because some quantum of drugs is distributed through the primary health system network, and the patients have a stake in approaching the Public Health facilities. In this backdrop, 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. It is expected that the provisioning of essential drugs at the public health service centres will create a demand for other professional services from the local population, which, in turn, will boost the general revival of activities in these service centres. In sum, this initiative under NHP-2002 is launched in the belief that the creation of a beneficiary interest in the public health system, will ensure a more effective supervision of the public health personnel through community monitoring, than has been achieved through the regular administrative line of control.

4.4.1.2 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. Such training would help to update the personnel on recent advancements in science, and would also equip them for their new assignments, when they are moved from one discipline of public health administration to another.

4.4.1.3 Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of

investment through public funding in the primary health sector. Box-V gives statistics which clearly show that standards of health are more a function of the accurate targeting of expenditure on the decentralised primary sector (as observed in China and Sri Lanka), than a function of the aggregate health expenditure.

Box-V: Public Health Spending in select Countries

Indicator	%Population with income of <\$1 day	Infant Mortality Rate/1000	%Health Expenditure to GDP	%Public Expenditure on Health to Total Health Expenditure
India	44.2	70	5.2	17.3
China	18.5	31	2.7	24.9
Sri Lanka	6.6	16	3	45.4
UK	-	6	5.8	96.9
USA	-	7	13.7	44.1

Therefore the Policy, while committing additional aggregate financial resources, places great reliance on the strengthening of the primary health structure for the attaining 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.

4.5 EXTENDING PUBLIC HEALTH SERVICES

4.5.1.1 This policy envisages that, in the context of the availability and spread of allopathic graduates in their jurisdiction, State Governments would consider the need for expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian Systems of Medicine and

Homoeopathy. Simple services/procedures can be provided by such practitioners even outside their disciplines, as part of the basic primary health services in under-served areas. Also, NHP-2002 envisages that the scope of the use of paramedical manpower of allopathic disciplines, in a prescribed functional area adjunct to their current functions, would also be examined for meeting simple public health requirements. This would be on the lines of the services rendered by nurse practitioners in several developed countries. These extended areas of functioning of different categories of medical manpower can be permitted, after adequate training, and subject to the monitoring of their performance through professional councils.

4.5.1.2 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 under-served areas. State Governments could also rigorously enforce a mandatory two-year rural posting before the awarding of the graduate degree. This would not only make trained medical manpower available in the underserved areas, but would offer valuable clinical experience to the graduating doctors.

4.6 ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS

4.6.1 NHP-2002 lays great emphasis upon the implementation of public health programmes through local self-government institutions. The structure of the national disease control programmes will have specific components for implementation through such entities. The Policy urges all State Governments to consider decentralizing the implementation of the programmes to such Institutions by 2005. In order to achieve this, financial incentives, over and above the resources normatively allocated for disease control programmes, will be provided by the Central Government.

4.7 NORMS FOR HEALTH CARE PERSONNEL

4.7.1 Minimal statutory norms for the deployment of doctors and nurses in medical institutions need to be introduced urgently

under the provisions of the Indian Medical Council Act and Indian Nursing Council Act, respectively. These norms can be progressively reviewed and made more stringent as the medical institutions improve their capacity for meeting better normative standards.

4.8 EDUCATION OF HEALTH CARE PROFESSIONALS

4.8.1.1 In order to ameliorate the problems being faced on account of the uneven spread of medical and dental colleges in various parts of the country, 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. Also, it is envisaged that the Medical Grants Commission will fund the upgradation of the infrastructure of the existing Government Medical and Dental Colleges of the country, so as to ensure an improved standard of medical education.

4.8.1.2 To enable fresh graduates to contribute effectively to the providing of primary health services as the physician of first contact, this policy identifies a significant need to modify the existing 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 also recommends a periodic skill-updating of working health professionals through a system of continuing medical education.

4.8.2 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. The policy also envisages that the creation of additional seats for post-graduate courses should reflect the need for more manpower in the deficient specialities.

4.9 NEED FOR SPECIALISTS IN 'PUBLIC HEALTH' AND 'FAMILY MEDICINE'

4.9.1 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 ¼ th of the seats are earmarked for these disciplines. It is envisaged that in the sanctioning of post-graduate seats in future, it shall be insisted upon that a certain reasonable number of seats be allocated to 'public health' and 'family medicine'. Since the 'public health' discipline has an interface with many other developmental sectors, specialization in Public health may be encouraged not only for medical doctors, but also for non-medical graduates from the allied fields of public health engineering, microbiology and other natural sciences.

4.10 NURSING PERSONNEL

4.10.1.1 In the interest of patient care, the policy emphasizes the need for an improvement in the ratio of nurses vis-à-vis doctors/beds. In order to discharge their responsibility as model providers of health services, the public health delivery centres need to make a beginning by increasing the number of nursing personnel. The Policy anticipates that with the increasing aspiration for improved health care amongst the citizens, private health facilities will also improve their ratio of nursing personnel vis-à-vis doctors/beds.

4.10.1.2 The Policy lays emphasis on improving the skill -level of nurses, and on increasing the ratio of degree- holding nurses vis-à-vis diploma-holding nurses. NHP-2002 recognizes a need for the Central Government to subsidize the setting up, and the running of, training facilities for nurses on a decentralized basis. Also, the Policy recognizes the need for establishing training courses for super-speciality nurses required for tertiary care institutions.

4.11 USE OF GENERIC DRUGS AND VACCINES

4.11.1.1 This Policy emphasizes the need for basing treatment regimens, in both the public and private domain, on a limited number of essential drugs of a generic nature. This is a pre-requisite for cost-effective public health care. In the public health system, this would be enforced by prohibiting the use of proprietary drugs, except in special circumstances. The list of essential drugs would no doubt have to be reviewed periodically. To encourage the use of only essential drugs in the private sector, the imposition of fiscal disincentives would be resorted to. The production and sale of irrational combinations of drugs would be prohibited through the drug standards statute.

4.11.1.2 The National Programme for Universal Immunization against Preventable Diseases requires to be assured of an uninterrupted supply of vaccines at an affordable price. To minimize the danger arising from the volatility of the global market, and thereby to ensure long-term national health security, NHP-2002 envisages that not less than 50% of the requirement of vaccines/sera be sourced from public sector institutions.

4.12 URBAN HEALTH

4.12.1.1 NHP-2002 envisages the setting up of an organised urban primary health care structure. Since the physical features of urban settings are different from those in rural areas, the policy envisages the adoption of appropriate population norms for the urban public health infrastructure. The structure conceived under NHP-2002 is a two-tiered one: the primary centre is seen as the first-tier, covering a population of one lakh, with a dispensary providing an OPD facility and essential drugs, to enable access to all the national health programmes; and a second-tier of the urban health organisation at the level of the Government general hospital, where reference is made from the primary centre. The Policy envisages that the funding for the urban primary health system will be jointly borne by the local self-government institutions and State and Central Governments.

4.12.1. 2 The Policy also envisages the establishment of fully-equipped 'hub-spoke' trauma care networks in large urban agglomerations to reduce accident mortality.

4.13 MENTAL HEALTH

4.13.1.1. NHP – 2002 envisages a network of decentralised 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.

4.13.1. 2 In regard to mental health institutions for in-door treatment of patients, the Policy envisages the upgrading of the physical infrastructure of such institutions at Central Government expense so as to secure the human rights of this vulnerable segment of society.

4.14 INFORMATION, EDUCATION AND COMMUNICATION

4.14.1 NHP-2002 envisages an IEC policy, which maximizes the dissemination of information to those population groups which cannot be effectively approached by using only the mass media. The focus would therefore be on the inter-personal communication of information and on folk and other traditional media to bring about behavioural change. The IEC programme would set specific targets for the association of PRIs/NGOs/Trusts in such activities. In several public health programmes, where behavioural change is an essential component, the success of the initiatives is crucially dependent on dispelling myths and misconceptions pertaining to religious and ethical issues. The community leaders, particularly religious leaders, are effective in imparting knowledge which facilitates such behavioural change. The programme will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programmes on the targeted groups. The Central/State Government initiative will also focus on the development of modules for information

dissemination in such population groups, who do not normally benefit from the more common media forms.

4.14.2 NHP-2002 envisages giving priority to school health programmes which aim at preventive-health education, providing regular health check-ups, and promotion of health-seeking behaviour among children. The school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'. This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but the future generation as well.

4.15 HEALTH RESEARCH

4.15.1 This Policy envisages an increase in Government-funded health research to a level of 1 percent of the total health spending by 2005; and thereafter, up to 2 percent by 2010. Domestic medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB and Malaria, as also on the sub-types of HIV/AIDS prevalent in the country. Research programmes taken up by the Government in these priority areas would be conducted in a mission mode. Emphasis would also be laid on time-bound applied research for developing operational applications. This would ensure the cost-effective dissemination of existing / future therapeutic drugs/vaccines in the general population. Private entrepreneurship will be encouraged in the field of medical research for new molecules / vaccines, inter alia, through fiscal incentives.

4.16 ROLE OF THE PRIVATE SECTOR

4.16.1.1 In principle, this Policy welcomes the participation of the private sector in all areas of health activities – primary, secondary or tertiary. However, looking to past experience of the private

sector, it can reasonably be expected that its contribution would be substantial in the urban primary sector and the tertiary sector, and moderate in the secondary sector. This Policy envisages the enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions by 2003. Also, statutory guidelines for the conduct of clinical practice and delivery of medical services are targeted to be developed over the same period. With the acquiring of experience in the setting and enforcing of minimum quality standards, the Policy envisages graduation to a scheme of quality accreditation of clinical establishments/medical institutions, for the information of the citizenry. The regulatory/accreditation mechanisms will no doubt also cover public health institutions. The Policy 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.

4.16.1.2 In the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive Government mechanism to provide health services to this category. It has sometimes been felt that a social health insurance scheme, funded by the Government, and with service delivery through the private sector, would be the appropriate solution. The administrative and financial implications of such an initiative are still unknown. As a first step, this policy envisages the introduction of a pilot scheme in a limited number of representative districts, to determine the administrative features of such an arrangement, as also the requirement of resources for it. The results obtained from these pilot projects would provide material on which future public health policy can be based.

4.16.2 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.

4.16.3 This Policy recognizes the immense potential of information technology applications in the area of tele-medicine in the

tertiary health care sector. The use of this technical aid will greatly enhance the capacity for the professionals to pool their clinical experience.

4.17 THE ROLE OF CIVIL SOCIETY

4.17.1 NHP-2002 recognizes the significant contribution made by NGOs and other institutions of the civil society in making available health services to the community. In order to utilize their high motivational skills on an increasing scale, this Policy envisages that the disease control programmes should earmark not less than 10% of the budget in respect of identified programme components, to be exclusively implemented through these institutions. The policy also emphasizes the need to simplify procedures for government – civil society interfacing in order to enhance the involvement of civil society in public health programmes. In principle, the state would encourage the handing over of public health service outlets at any level for management by NGOs and other institutions of civil society, on an 'as-is-where-is' basis, along with the normative funds earmarked for such institutions.

4.18 NATIONAL DISEASE SURVEILLANCE NETWORK

4.18.1 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. The programme for setting up this network will include components relating to the installation of data-base handling hardware; IT inter-connectivity between different tiers of the network; and in-house training for data collection and interpretation for undertaking timely and effective response. This public health surveillance network will also encompass information from private health care institutions and practitioners. It is expected that real-time information from outside the government system will greatly strengthen the capacity of the public health system to counter focal outbreaks of seasonal diseases.

4.19 HEALTH STATISTICS

4.19.1.1 The Policy envisages the completion of baseline estimates for the incidence of the common diseases – 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. NHP-2002 envisages that, with access to such reliable data on the incidence of various diseases, the public health system would move closer to the objective of evidence-based policy-making.

4.19.1.2 Planning for the health sector requires a robust information system, inter-alia, covering data on service facilities available in the private sector. NHP-2002 emphasises the need for the early completion of an accurate data-base of this kind.

4.19.2 In an attempt at consolidating the data base and graduating from a mere estimation of the annual health expenditure, NHP-2002 emphasises the need to establish national health accounts, conforming to the `source-to-users' matrix structure. Also, the policy envisages the estimation of health costs on a continuing basis. Improved and comprehensive information through national health accounts and accounting systems would pave the way for decision-makers to focus on relative priorities, keeping in view the limited financial resources in the health sector.

4.20 WOMEN'S HEALTH

4.20.1 NHP-2002 envisages the identification of specific programmes targeted at women's health. The Policy notes that women, along with other under-privileged groups, are significantly handicapped due to a disproportionately low access to health care. The various Policy recommendations of NHP-2002, in regard to the expansion of primary health sector infrastructure, will facilitate the increased access of women to basic health

care. The Policy commits the highest priority of the Central Government to the funding of the identified programmes relating to woman'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.

4.21 MEDICAL ETHICS

4.21.1.1 NHP – 2002 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.

4.21.1. 2 By and large, medical research within the country in the frontier disciplines, such as gene- manipulation and stem cell research, is limited. However, the policy recognises that a vigilant watch will have to be kept so that the existing guidelines and statutory provisions are constantly reviewed and updated.

4.22 ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS

4.22.1 NHP – 2002 envisages that the food and drug administration will be progressively strengthened, in terms of both laboratory facilities and technical expertise. Also, the policy envisages that the standards of food items will be progressively tightened up at a pace which will permit domestic food handling / manufacturing facilities to undertake the necessary upgradation of technology so that they are not shut out of this production sector. The Policy envisages that ultimately food standards will be close, if not equivalent, to Codex specifications; and that drug standards will be at par with the most rigorous ones adopted elsewhere.

4.23 REGULATION OF STANDARDS IN PARAMEDICAL DISCIPLINES

4.23.1 NHP-2002 recognises the need for the establishment of statutory professional councils for paramedical disciplines to register practitioners, maintain standards of training, and monitor performance.

4.24 ENVIRONMENTAL AND OCCUPATIONAL HEALTH

4.24.1 This Policy envisages that the independently -stated policies and programmes of the environment -related sectors be smoothly interfaced with the policies and the programmes of the health sector, in order to reduce the health risk to the citizens and the consequential disease burden.

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

4.25 PROVIDING MEDICAL FACILITIES TO USERS FROM

OVERSEAS

4.25.1 To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sectors, NHP-2002 strongly encourages the providing of such health 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.

4.26 IMPACT OF GLOBALISATION ON THE HEALTH SECTOR

4.26.1 The Policy takes into account the serious apprehension, expressed by several health experts, of the possible threat to health security in the post-TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines. To protect the citizens of the country from such a threat, 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.

5. SUMMATION

5.1 The crafting of a National Health Policy is a rare occasion in public affairs when it would be legitimate, indeed valuable, to allow our dreams to mingle with our understanding of ground realities. Based purely on the clinical facts defining the current status of the health sector, we would have arrived at a certain policy formulation; but, buoyed by our dreams, we have ventured slightly beyond that in the shape of NHP-2002, which, in fact, defines a vision for the future.

5.2 The health needs of the country are enormous and the financial resources and managerial capacity available to meet them, even on the most optimistic projections, fall somewhat short. In this situation, NHP-2002 has had to make hard choices between various priorities and operational options. NHP-2002 does not claim to be a road-map for meeting all the health needs of the populace of the country. Further, it has to be recognized that such health needs are also dynamic, as threats in the area of public health keep changing over time. The Policy, while being holistic, undertakes the necessary risk of recommending differing emphasis on different policy components. Broadly speaking, NHP – 2002 focuses on the need for enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also, the Policy is focused on those diseases which are principally contributing to the disease burden – TB, Malaria and Blindness from the category of historical diseases; and HIV/AIDS from the category of ‘newly emerging diseases’. This is not to say that other items contributing to the disease burden of the country will be ignored; but only that the resources, as also the principal focus of the public health administration, will recognize certain relative priorities. It is

unnecessary to labour the point that under the umbrella of the macro-policy prescriptions in this document, governments and private sector programme planners will have to design separate schemes, tailor-made to the health needs of women, children, geriatrics, tribals and other socio-economically under-served sections. An adequately robust disaster management plan has to be in place to effectively cope with situations arising from natural and man-made calamities.

5.3 One nagging imperative, which has influenced every aspect of this Policy, is the need to ensure that 'equity' in the health sector stands as an independent goal. In any future evaluation of its success or failure, NHP-2002 would wish to be measured against this equity norm, rather than any other aggregated financial norm for the health sector. Consistent with the primacy given to 'equity', a marked emphasis has been provided in the policy for expanding and improving the primary health facilities, including the new concept of the provisioning of essential drugs through Central funding. The Policy also commits the Central Government to an increased under-writing of the resources for meeting the minimum health needs of the people. Thus, the Policy attempts to provide guidance for prioritizing expenditure, thereby facilitating rational resource allocation.

5.4 This Policy broadly envisages a greater contribution from the Central Budget for the delivery of Public Health services at the State level. Adequate appropriations, steadily rising over the years, would need to be ensured. The possibility of ensuring this by imposing an earmarked health cess has been carefully examined. While it is recognized that the annual budget must accommodate the increasing resource needs of the social sectors, particularly in the health sector, this Policy does not specifically recommend an earmarked health cess, as that would have a tendency of reducing the space available to Parliament in making appropriations looking to the circumstances prevailing from time to time.

5.5 The Policy highlights the expected roles of different participating groups in the health sector. Further, it recognizes the

fact that, despite all that may be guaranteed by the Central Government for assisting public health programmes, public health services would actually need to be delivered by the State administration, NGOs and other institutions of civil society. The attainment of improved health levels would be significantly dependent on population stabilisation, as also on complementary efforts from other areas of the social sectors – like improved drinking water supply, basic sanitation, minimum nutrition, etc. - to ensure that the exposure of the populace to health risks is minimized.

5.6 Any expectation of a significant improvement in the quality of health services, and the consequential improved health status of the citizenry, would depend not only on increased financial and material inputs, but also on a more empathetic and committed attitude in the service providers, whether in the private or public sectors. In some measure, this optimistic policy document is based on the understanding that the citizenry is increasingly demanding more by way of quality in health services, and the health delivery system, particularly in the public sector, is being pressed to respond. In this backdrop, it needs to be recognized that any policy in the social sector is critically dependent on the service providers treating their responsibility not as a commercial activity, but as a service, albeit a paid one. In the area of public health, an improved standard of governance is a prerequisite for the success of any health policy.
