NHPP8: National Health Policy 2002

Quadrant – I

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Description of Module:

Items	Description of Module
Subject Name	Community Medicine
Paper Name	National Health Policies and Programmes
Module Name/Title	National Health Policy 2002
Module Id	NHPP8
Pre-requisites	Knowledge on health problems and health system in India; knowledge on national policies in general
Objectives	To study about the National Health Policy2002
Key words	National Policy; Health

Introduction

Health policy of a Nation is its strategy for controlling and optimising the social uses of its health knowledge and health resources. India has made considerable progress in public health since independence including eradication of small pox, poliomyelitis, guinea worm, yaws and elimination of leprosy and neonatal tetanus from the country. The strategies of the National Rural Health Mission have resulted in significant improvements in key health indicators like institutional deliveries, full immunisation, and availability of diagnostic and family welfare services in many states of the country. However, the country's health system continues to face many challenges. Population of India as per census 2011 stood 1210 million.

The demographic transition of the country has been relatively slow, so the population has been aging slowly. Because of epidemiological transition, the county is facing double burden of communicable as well as non-communicable diseases. The rate of coronary heart disease (CHD) has increased rapidly in India recently which is also attributed partly to a demographic transition. The country is facing other several public health problems. In 2012, the infant mortality rate (IMR) was 42/1000 live births and there was a huge gap between IMR of rural (46/1000 live births) and urban (28/1000 live births), while the maternal mortality ratio was 178/100,000 live births. According to National Family Health Survey (NFHS-3), nearly 50% of children under 5 years of age have protein energy malnutrition of various grades.

Under National Health Policy in 1983 (NHP 1983) Government initiatives in the public health sector have recorded some noteworthy successes over time. Smallpox and Guinea Worm Disease were eradicated from the country; Polio was on the verge of being eradicated; Leprosy, Kala Azar, and Filariasis were expected to be eliminated in the foreseeable future. There was a substantial drop in the Total Fertility Rate and Infant Mortality Rate. The success of the initiatives taken in the public health field was reflected in the progressive improvement of many demographic / epidemiological / infrastructural indicators over time.

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 was felt that it would be appropriate to pitch NHP-2002 at a level consistent with the realistic expectations about financial resources, and about the likely increase in Public Health administrative capacity. The recommendations of NHP-2002 attempted to maximise 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 had generated a situation in which it was necessary to review the field, and to formulate a new policy framework as the National Health Policy-2002. NHP-2002 attempted to set out a new policy framework for the accelerated achievement of Public health goals in the socioeconomic circumstances then prevailing in the country. On the above background National Health Policy 2002 focused on the need for enhanced funding and an organisational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. The Policy was focused on those diseases which were 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'.

The governments and private sector programme planners were required to design separate schemes, tailor-made to the health needs of women, children, geriatrics, tribal population and other socio-economically under-served sections. An adequately robust disaster management plan had to be in place. Consistent with the primacy given to 'equity', a marked emphasis had been provided for expanding and improving the primary health facilities, including the new concept of the provisioning

of essential drugs through central funding. The Policy also required the Central Government to provide increased resources for meeting the minimum health needs of the people. Thus, the Policy attempted to provide guidance for prioritising expenditure, thereby facilitating rational resource allocation.

Learning outcomes

At the end of this module student should be able in

•Achieving an acceptable standard of good health of Indian Population,
•Decentralising public health system by upgrading infrastructure in existing institutions,
•Ensuring a more equitable access to health service across the social and geographical expanse of India.
•Enhancing the contribution of private sector in providing health service for people who can afford to pay.
•Giving primacy for prevention and first line curative initiative.
•Emphasising rational use of drugs.
•Increasing access to tried systems of Traditional Medicine.

Main Text

NHP 2002 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 recognised 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. NHP 2002 highlights the expected roles of different participating groups in the health sector. Further, it recognises 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 minimised.

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In the ultimate analysis, 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. 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.

The challenge in the twenty-first century is to ensure optimal quality of life and be worthwhile to give due importance to comprehensive health care services at the primary health care level. Individualised health promotion and preventive checkups for people have been shown to be highly effective and are likely to be among the reasons for the falling disability to the point of stabilising healthcare expenditure. Strengthening of existing health care services in accordance with the need assessment of common existing problems, especially preventive and promotive services in the community are required. Further qualitative research is needed to explore the depth of the problems of health care delivery system. Health care has two connotations (a) health care programs and (b) medical care organisations. Medical care organisations are mainly providing curative care. They are attractive and high-technology oriented and they should be cost effective. In recent years, quality assurance has emerged as an internationally important aspect in the provision of health care services. The health care system depends on availability, affordability, efficiency, feasibility, and other factors. Consumer satisfaction is recognised as an important parameter for assessing the quality of patient care services. Satisfaction regarding the attitude of providers towards these services is expected to affect treatment outcome and prognosis. There is a need to analyse the health care system as often as possible.

1. National Health Policy – 2002: Goals to be achieved by 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 Tuberculosis, Malaria, Other vector and water borne Diseases - 2010
- Reduce prevalence of blindness to 0.5% - 2010
- Reduce of IMR to 30/1000 & MMR to 100/lakh - 2010
- Increase utilisation of public health facilities from current level of <20% to > 75% - 2010
- Establish an integrated system of surveillance, National Health Accounts and Health Statistics - 2007
- 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 of State sector Health spending from 7% to 8% - 2010

In the concept of positive health, man must cease to be the target of disease or preventive measures. He becomes a *collaborator,* an active person who accepts responsibility for his own health. Hence greater involvement of families and communities in health matters is a must. Here health care *for* the people changes to health care *by* the people. As the eminent medical historian Henry Sigerist said way back in 1941:

The people's health ought to be the concern of the people themselves. They must struggle for it and plan for it. The war against disease and for health cannot be fought by physicians alone. It is a people's war in which the entire population must be mobilised permanently.

In the past, people were neglected as a health resource. They were merely looked upon as sources of pathology or victims of pathology and consequently as targets for preventive and therapeutic services. This negative view of people's role in health has slowly but surely changed. Now people work towards keeping their own health, they struggle and plan for it and take proper responsibility of looking after it.

2. Major points from draft national health policy (DNHP) 2015:

The DNHP states its overall goal as:
The attainment of highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.

2.1. Major Recommendations

2.1.1. Primary Care Services and Continuity of Care
To provide "comprehensive set of preventive, promotive, curative and rehabilitative services

2.1.2. Secondary and Tertiary Care Services
A concept of "strategic purchasing," which refers to "the government acting as a single payer - purchasing care from public hospitals and private providers as part of strategic plan for district health systems development."

2.1.3. Infrastructure Development:
"From normative approaches in their development to targeted approaches to reach under-serviced areas" wherein "a conscious effort shall be made to identify districts and blocks which have the larger gaps for development of infrastructure and deployment of additional human resources"

2.1.4. Human Resources for Health
Some measures have been proposed to enhance the training, retraining, placement, incentives for doctors.

2.2. Suggestions to be incorporated in National health policy 2015

1. To provide affordable, quality healthcare through the public health system as its main form of social protection Government should make it compulsory for all levels of health care to get accreditation from the National Accreditation Board for Hospitals and Healthcare Providers (NABH) for uniformity in public and private health care.

2. Holistic multi-sectoral approach needed to address public health challenges and universal health coverage including for elderly population, including those of communicable diseases, non-communicable diseases and impact of climate change.

3. Health care in India has a long tradition of voluntarism. For centuries, traditional healers have taken care of the health needs of their own community as a part of their social responsibility. They have used knowledge that has passed down the generations, regarding the medicinal value of locally available herbs and plants. This tradition still continues, particularly in the tribal pockets of the country. According to a rough estimate, more than 7,000 voluntary organisations are working in the above areas of health care throughout the country. In spite of numerous well-meaning but centralised, unimaginative economic development schemes of the government, the grim tale of poverty and underdevelopment of millions of our citizens remain overwhelmingly distressing. We have come across countless instances of communities putting up a brave struggle against all odds. We were confronted with an equality large number of incidents of their social, political and economic exploitation. We also encountered new groups of power brokers and self-interest groups who siphon on social, political and economic exploitation. The time has come for us to stand up and recognize this growing menace and change the direction of our poverty eradication programs to a decentralized, imaginative and participatory model, as has been exemplified by many voluntary organizations. The economic development of one-third of our total population needs to be undertaken with appropriate inputs for their social development. Perhaps in the health and development agenda of India, solving their problems will remain the most complex challenges for many years.

4. The DNHP 2015 actually amounts to dismembering the complex process of health policy formulation in a hugely diverse country like India. Overriding this diversity, it adopts a "one solution suits all" approach by decisively pushing an insurance based healthcare model for facilitating a near monopoly of the corporate sector in curative care. Much is being made of the possibilities of harnessing private healthcare for achieving public health goals; however, the fundamental contradiction between the objectives of the private and public health sectors is too powerful to be undone by theoretical formulations. A huge body of evidence that negates the feasibility of the DNHP recommendations has been conveniently ignored. Given the existing political and economic environment in the country, this is not an inadvertent omission. Complex national and international forces have been at work in shaping the present idea of universal healthcare which is a cruel distortion of the fi rst attempt made by the international community to achieve universal healthcare through a much more holistic approach of primary healthcare. Rather than alleviate the suffering of the poor due to disease, this policy has every potential to become the quintessential millstone around their necks. The final results would depend on the rigour with which pro-people health professionals, academics, activists, and the civil society oppose the pro-business formulations of the DNHP.

The global burden and threat of non-communicable diseases constitutes a major public health challenge that undermines social and economic development throughout the world, and inter alia has the effect of increasing inequalities between countries and within populations. Strong leadership and urgent action are required at the global, regional and national levels to mitigate inequality. World Health Assembly in resolution WHA64.11 has decided to prepare a draft global action plan for the prevention and control of non-communicable diseases for the period 2013–2020, building on what has already been achieved through the implementation of the 2008–2013 action plan.

Summary

NHP 2002 has given a continuum to NHP 1983, where primary health care is adopted as the main strategy through

–Decentralisation
–Equity
–Private sector/indigenous system participation
–Rise in public investment

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact. The context of people's lives determine their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health.

The health of any nation is the sum total of the health of its citizens, communities and settlements in which they live. A healthy nation is, therefore, only feasible if there is total participation of its citizens towards this goal. In India, in the last five decades, we have followed a path of social transformation that mainly relies on five major institutions, namely, the parliament, assembly, cabinet, bureaucracy and party functionaries. In the absence of mediating and reconciling agencies between the state and society, the state lacks a base, and remains remote and insensitive to people's needs. Unfortunately, development efforts have not been rooted in our traditional institutions nor community initiatives that exist in some form or other throughout the country. Progress is easiest made if we are tuned in with the national genius that has developed over the centuries, with certain special traits. If this domestic capacity is ignored or discarded, development efforts will lose their bearing and roots, and, gradually, vitality.

Quadrant-III. Self-Assessment

Q.1 What were the objectives of National Health policy 2002?

Q. 2 Briefly delineate important directions in National Health policy 2002 in comparison to the previous health service activities in India.

Q. 3. Current National Health policy was promulgated in 2000 – True/ False [Key: false]

Q. 4. National Health policy is proposed to be modified in [Key: b]

a. 2014
b. 2015
c. 2016
d. 2017

Q. 5 Current National Health policy targeted to achieve by the year ---------- Zero level growth of HIV/AIDS [Key: 2007]

Q. 6. Match the Columns: [Key: A1: B2; A2: B3; A3: B1]

Column A	Column B
1. First National Health policy	1. 1983
2. Second National Health policy	2. 2015
3. National Health policy has been proposed to be modified in	3. 2002

Quadrant-IV: Learn more/Web Resources/Supporting Materials/Interesting Facts:

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