Viewpoints: National Health Policy 2002

National Health Policy 2002: New perspectives

S. P. AGARWAL

The last National Health Policy (NHP) was formulated in 1983[1] in the wake of the Alma Ata Declaration of 1978. The results of the 1983 policy have been mixed. The most noteworthy initiative under this policy was a phased, time-bound programme for setting up a well dispersed network of comprehensive primary healthcare services. However, outcomes have been far less than targets as NHP 1983 was a set of broad-based macro-level recommendations spanning not only the health sector, but also sectors associated with other contributors such as water supply, sanitation, environment, nutrition, etc. to the health status of the population. Commitment of resources and the role of the private sector, non-governmental organizations and other institutions of civil society to achieve the set targets also did not get the desired focus.

However, the success of the initiative in the public health field is reflected in the progressive improvement of indications over time in terms of demographic changes (Table I), epidemiological shifts (Table II) and infrastructure improvement (Table III).

TABLE I. Demographic changes: 1951–2000

Indicator	1951	1981	2000
Life expectancy (in years)	36.7	54	64.6*
Crude birth rate (per 1000 population)	40.8	33.9†	26.1‡
Crude death rate (per 1000 population)	25	12.5†	8.7‡
Infant mortality rate (per 1000 live births)	146	110	70‡

*Registrar General of India † Sample Registration System ‡ Sample Registration System 1999

TABLE II. Epidemiological changes: 1951–2000

Indicator	1951	1981	2000
Malaria cases (in million)	75	2.7	2.2
Leprosy cases (per 10 000 population)	38.1	57.3	3.74
Smallpox (cases)	>44 887	Eradicated	–
Guineaworm (cases)	–	>39 792	Eradicated
Polio (cases)	–	29 709	265

TABLE III. Health infrastructure: 1951–2000

Infrastructure	1951	1981	2000
SC/PHC/CHC	725	57 363	163 181*
Dispensaries and hospitals (all)	9209	23 555	43 322†
Hospital beds (private and public)	117 198	569 495	870 161†
Doctors (Allopathy)	61 800	268 700	503 900‡
Nursing personnel	18 054	143 887	737 000 ‖

SC/PHC/CHC Subcentre/primary health centre/community health centre
*Rural health statistics, 1999 †Central bureau of health intelligence, 1995–96 ‡MCI Medical Council of India, 1998–99 ‖ Indian Nursing Council, 1999

Director General Health Services, Government of India, New Delhi

TABLE IV. National Health Policy goals: 2000–2015

Goal	Target dates
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 and other vector and water-borne diseases	2010
Reduce prevalence of blindness to 0.5%	2010
Reduce infant mortality rate to 30/1000 and maternal mortality rate to 100/100 000	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%	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 budget)	2005
Further increase state sector health spending to 8% of budget	2010

Undoubtedly, over the years there have been major changes in disease profile, healthcare infrastructure and health-seeking behaviour of the population. Thus, the demographic and epidemiological transition has finally culminated in the nation's new health policy, nearly two decades after the first one in 1983.

The policy, which defines the vision for the future, would be implemented in a phased manner over the long term (say a decade) and would attempt to maximize the broad-based availability of health services to the citizens of India on the basis of realistic considerations of capacity. Mindful of the problems and constraints which face the health system but conscious of the opportunities available for corrective action, the National Health Policy 2002 renews its commitment to expeditiously control communicable diseases, eliminate a few and contain the rest in a time-bound manner.[2] Thus, time-bound goals (Table IV), which have been formulated in the policy, recognize relevant priorities in view of unlimited health needs and limited resources (financial and physical), placing differing emphasis on different policy components.

FINANCIAL RESOURCES

Broadly the policy focuses on the need for enhanced funding and on organizational restructuring of the national public health initiatives to facilitate a more equitable access to health facilities. Consistent with the overriding importance given to 'equity', a marked emphasis has been provided in the policy for expanding and improving the primary health facilities including the concept of providing essen-

tial drugs through Central funding. Primacy would be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation. Out of the total public health spending, sectoral outlay is proposed to be increased from around 48% to 55% in the primary health sector, as such interventions not only increase access to healthcare but are also the most cost-effective. Further, to address the concern of the poor, the policy envisages the introduction of a social health insurance scheme in a few representative districts to determine the requirements of resources as well as the administrative arrangements. Success stories in this area could thereafter be replicated. The policy also envisages a greater contribution from the Central budget for the delivery of public health services at the state level. Specifically, the policy aims to increase health sector expenditure from 5.2% of GDP at present (approximately Rs 80 000 crore per annum) to 6% of GDP with the government contribution increasing from 0.9% to 2% by 2010. Out of the total spending on health, it is proposed to increase the Central government contribution to health from 15% to 25% by 2010 and that of the states from 5.5% to 8% during the same period.

MEDICAL RESEARCH

Based on the need to re-orient strategy and meet the emerging challenges of an increasingly technology-driven, interdependent world, the policy seeks to strengthen the area of research. It envisages an increase in government expenditure on medical research to 2% of total health spending by 2010 (from the <0.5% at present). It also envisages encouraging private entrepreneurship in the field of medical research for new molecules and vaccines through fiscal incentives.

ROLE OF DIFFERENT STAKEHOLDERS

The policy highlights the expected roles of different participating groups in the health sector, namely the Central and state governments, private sector, non-governmental organizations (NGOs) and other institutions of civil society. Rising incomes and a demand for improved care has stimulated rapid growth of the private sector. However, due to the absence of a regulatory environment, the spread has been uneven and the quality of services mixed. The policy, although welcoming participation of the private sector at all levels of healthcare—primary, secondary and tertiary—clearly recognizes the need to enact suitable legislation for regulating minimum infrastructure and quality standards by 2003 in medical institutions and developing statutory guidelines for the conduct of clinical practices and delivery of medical services to protect the interest of the patients.

While recognizing the need for state governments' decentralized public health machinery in implementation of the national health programmes, the policy also envisages a key role of the Centre in national programmes—designing, providing financial resources, technical support as well as monitoring and evaluation. A gradual merging of all health programmes under a single field administration is envisaged in order to optimize the utilization of the public health infrastructure at the primary level. However, it is necessary to continue vertical programmes for diseases such as tuberculosis, malaria, HIV/AIDS and preventive programmes such as the RCH (Reproductive and Child Health) and universal immunization programme till moderate levels of prevalence are reached.

MEDICAL EDUCATION AND RELATED ISSUES

The policy identifies the need to modify the medical curriculum and make it need-based and skill-oriented to enable fresh graduates to contribute to the primary health services. Further, to reduce the problems on account of uneven standards and spread of medical and dental college in various parts of the country, the policy envisages the setting up of a Medical Grants Commission for funding new government medical and dental colleges in different parts of India.

Taking note of the uneven spread of graduate doctors, impeding equitable access, the policy suggests ways and means of extending public health services by expanding the pool of medical practitioners. This group from the extended health sector, after adequate training and subject to monitoring of performance through professional councils, could be considered by the states for providing some of the basic primary health services in underserved areas.

PUBLIC HEALTH

The policy, in an endeavour to encourage specialization in public health, envisages progressive implementation of mandatory norms to raise the proportion of postgraduate seats in the disciplines of 'public health' and 'family medicine' to reach a stage wherein one-fourth of the seats are earmarked for these disciplines.

A necessary condition for cost-effective public healthcare is to base treatment regimens on a limited number of essential drugs of a generic nature, requiring periodical review. Also, in the interest of health security, the policy envisages that not less than 50% of the requirements of vaccines and sera should be met from public sector institutions.

OTHER CONCERNS

In view of the increasing urbanization, the policy also envisages the setting up of an organized urban health structure. It suggests a two-tiered structure with the primary health centre providing the first tier and a referral government general hospital the second tier.

Further, the policy attempts to alleviate the concerns of the pharmaceutical industry, operating in a Trade-Related Intellectual Property Rights (TRIPS) compliant regime, securing commitments worldwide for a dilution of TRIPS restrictive features in its application to the health sector.

The policy also looks at various other issues including those relating to nursing personnel, mental health, disease surveillance network, women's health, medical ethics, health statistics, enforcement of quality standards for food and drugs, environment and occupational health.

INTER-SECTORAL CONTRIBUTION TO HEALTH

It has also been clearly recognized in the policy that attainment of improved health levels would be greatly dependent on population stabilization, as also on complementary efforts from other social sectors such as improved drinking water supply, basic sanitation, minimum nutrition, etc.

CONCLUSION

Finally, a committed and empathetic attitude of service providers coupled with an improved standard of governance is a prerequisite for the success of any health policy, aimed at accelerated achievement of public health goals.

REFERENCES

1 Government of India. *National Health Policy*. New Delhi:Ministry of Health and Family Welfare, 1983:1–17.

2 Government of India. *National Health Policy 2002*. New Delhi: Ministry of Health and Family Welfare, Department of Health, 2002:1–39.