UNIT 11 HEALTH POLICY AND NATIONAL HEATLH MISSION*

Structure

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11.0 OBJECTIVES

After reading this Unit, you should be able to:

- Understand the significance and meaning of Health Policy;
- Grasp the various stages in the evolution of National Health Policies; and
- Examine the impact of initiatives under the National Health Mission.

11.1 INTRODUCTION

Of the gains including wealth and fame, health is the greatest. Health is man's greatest possession, his source of real happiness. In terms of resources for socio-economic development, nothing can be considered of higher significance than the health of the people. An investment on health is an investment on human resource development on which depends the national security and prosperity. Development of health in terms of improvement of the quality of life is, therefore, imperative. But, in order to ensure that the health programmes move as scheduled, and to bring about the requisite effort and direction in the wide-ranging health activities, and in government machinery itself, it is necessary to indicate the framework of health policy.

The term 'health policy' may be defined as the declaration of a definite course of action for the achievement of health objectives. It is a general directive as to how health tasks should be interpreted and performed. To quote the Executive Board of the WHO: "A national health policy is an expression of goals for improving the health situation, the priorities among those goals, and the main directions for attaining them" (WHO, 2000).

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11.2 HEALTH CARE SYSTEM BEFORE ADOPTION OF NHP 1983

At the time of Independence, the country inherited a health care system devised during the British imperial rule, essentially to provide services to defence forces and the colonial administrators, including the native gentry. By and large, the health care system was urban-based, elite-centric and curative-oriented; it was not geared even to providing minimum health care services to the mass of the rural people. Broadly speaking, there were four major problems associated with health status of the people: overpopulation, widespread incidence of communicable diseases, malnutrition and inadequacy of health care infrastructure.

Bhore Committee Report (1946)

The present health care system in India has its origin in the recommendations of the Health Survey and Development Committee appointed in 1943 under the chairmanship of Sir Joseph Bhore (GOI, 1946).

Besides recommending certain principles for future development of the health sector, the Bhore Committee laid special stress on provision for safe drinking water, sanitation and housing. The Committee insisted that "medical relief and preventive health care must be urgently provided as soon as possible to the vast rural population of the country".

PHCs and Village Health Guide Scheme

With the launching of the Community Development Programme in October, 1952, a modest beginning was made to implement a programme of setting up of Primary Health Centres (PHCs) as an integral component for all-round development of rural areas. A PHC with three sub-centres for every Community Development Block covering approximately 60,000 people was designed to provide integrated curative, preventive and promotive services to rural population. The PHCs were envisaged as the focal point from which primary health care services would radiate through sub-centres under each PHC.

A decision was taken in 1973 that each sub-centre would be manned by a trained female health worker (Auxiliary Nurse Mid-wife) and trained male health worker known as Multi-purpose Worker to provide health services in the form of a package. Another decision taken by the Government of India pertained to implementing the Village Health Guide Scheme from October1977 by having a worker from within the community, trained in some basic health work to render assistance in maternal care and to educate mothers about immunisation and family welfare schemes.

Health for All by 2000 AD

An important milestone in India's health services development was reached with the signing of the Alma-Ata Declaration (WHO-UNICEF-sponsored International Conference on Primary Health Care, 12 September 1978) at Kazakhstan, recommending "Health for All by 2000 AD" through Primary Health Care approach.

11.3 NATIONAL HEALTH POLICY, 1983

The National Health Policy (NHP), 1983,which was approved by Parliament, was a response to the commitment to the Alma Ata Declaration to achieve "Health for All by 2000". It accepted that health was central to development and had a focus on access to health services. It reiterated the resolution of taking health services to community and ensuring cooperation of the community. It recognises nutrition, prevention of food adulteration and maintenance of the quality of drugs, water supply and sanitation, environmental protection; immunisation programme, maternal and child health services and occupational health services as priorities for inputs required for improved health care. Also calls on for re-orientation of the existing health personnel and inclusion of various systems of medicine and health care at the appropriate levels, within specified areas of responsibility and functioning, in the over-all health care delivery system, especially in regard to the preventive, promotional and public health objectives. Through the PHC model, the NHP recognises the value of integrated health services, mentioned in the Alma-Ata Declaration.

The noteworthy initiatives under the NHP 1983 were: (i) a phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services; (ii) intermediation through 'health volunteers' having appropriate knowledge and simple skills; (iii) establishment of a well-worked out referral system; and (iv) an integrated network of evenly spread specialty and super-specialty services.

Despite marked improvements in certain areas of the health care sector, it still had many deficiencies. Recognition of these trends led to the enunciation of NHP, 2002.

11.4 NATIONAL HEALTH POLICY, 2002

NHP was last formulated in 1983 and since then there has been marked changes in the determinant factors relating to the health sector. The main objective of the NHP 2002 was "to achieve an acceptable standard of good health amongst the general population of the country." The approach has been to "increase access to the decentralised public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions".

Overriding importance had been given to ensuring a more equitable access to health services across the social and geographical expanse of the country. Emphasis was given to increase the aggregated public health investment through a substantially increased contribution by the Union Government. Besides, the policy envisaged the involvement of the private sector in providing health services particularly for the population group which could afford to pay for services. Primacy was given to preventive and first-line curative initiatives at the primary health level through increased, sectoral share of allocation. Emphasis was laid on rational use of drugs within the allopathic system. The NHP 2000 also laid emphasis on the practice of tested systems of traditional medicines.

In brief, the NHP 2002 identified many of the gross deficiencies of the existing healthcare scenario, proposed a substantial rise in Central government expenditure on healthcare. It has also proposed regulation of the private sector. However, in

operational terms, it constitutes an abandonment of the Alma-Ata Declaration, and legitimises further privatisation of the health care sector.

Check Your Progress 1

Note: i) Use the space given below for your answers.

ii) Check your answers with those given at the end of the Unit.

1) Write a note on Health Care System before adoption of NHP 1983.

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2) Briefly discuss the problems in the implementation of the National Policy on Education.

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11.5 NATIONAL HEALTH POLICY 2017

The National Health Policy (NHP) 2017 announced by the Union Government marks the culmination of a complex process. Before the adoption of the NHP 2017, the Government of India formulated the Draft NHP and placed it in public domain in December 2014. Following detailed discussion with the stakeholders and State governments, the Draft National Health Policy was further fine-tuned. It received the assent of the Central Council for Health and Family Welfare in February 2016.

With its focus on preventive and promotive health care and universal access to quality health care services, the NHP 2017 envisages provision of a large package of assured comprehensive primary health care through the 'Health and Wellness Centres'. The health care package also includes care for major NCDs {non-communicable diseases}, mental health, palliative care and rehabilitative care services.

Goal and Objectives of NHP 2017

The primary aim of NHP, 2017 is to "inform, clarify, strengthen and priorities the role of the Government in shaping health system in all its dimensions – investment in health, organisation of health care services, prevention of diseases and promotion of good health through cross-sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base…" In health care deficit areas in the public domain the

NHP seeks to utilise the services of accredited non-governmental healthcare providers. The policy aims at achieving a significant reduction in out-of- pocket expenditure in healthcare costs of patients; reinforce trust in public healthcare system and influence operation and growth of private healthcare industry as well as medical technologies in alignment with public health goals. The NHP 2017 also proposes free drugs, free diagnostics and free emergency care services in all public hospitals. The NHP envisages private collaboration for strategic purchasing, capacity building, skill development programmes, awareness generation, developing sustainable networks for community to strengthen mental health services, and disaster management. The policy also advocates financial and non-financial incentives for encouraging private sector participation in provision of health care services.

Further, the policy proposes raising public health expenditure to 2.5% of the GDP in a time-bound manner. The emphasis in NHP 2017 is on comprehensive primary health care package which includes primary health care, preventive care and rehabilitative care services. The policy advocates allocating major proportion, (up to two-third or more) of resources to primary care followed by secondary and tertiary care.

The policy assigns specific quantitative targets aimed at reduction of diseases. It seeks to strengthen the health surveillance system and establish registries for diseases of public health importance, by 2020. It also seeks to align other policies for medical devices and equipment with public health goals. The policy envisages optimum levels of child and adolescent healthcare, and school health programmes as major focus areas. In order to leverage the pluralistic health care legacy, the policy recommends mainstreaming the different health systems, including better access to AYUSH remedies through co-location in public facilities. It states that Yoga should also be introduced much more widely in school and work places as part of promotion of good health.

Further, the NHP 2017 advocates extensive deployment of digital tools for improving the efficiency and outcome of the healthcare system and proposes establishment of National Digital Health Authority (NDHA) to regulate, develop and deploy digital health across the continuum of care.

The NHP 2017 has also enunciated the long-term health goals for improvement of health care from the current levels. These are as follows:

Health Status and Programme Impact

S.No.	Indicator	Present	Status(year:2017) Target (by)
1)	Life Expectancy at Birth (yrs.)	67.5	70 (2025)
2)	Total Fertility Rate (TFR)	2.43	2.1 children per woman (2025)
3)	Infant Mortality Rate (IMR)	40.5	28 (2019)
4)	Maternal Mortality Rate (MMR)	174	100 (2020)
5)	Under Five Mortality	35	23 (2025)
6)	Access to safe water and sanitation		To all (2020) under Swachh Bharat Mission.

7)	Public health expenditure (as percentage of GDP)	1.15%	2.5% (2025)
8)	Availability of Doctors	-	AS per IPHS norm in high priority districts (2020)
9)	Primary and secondary care facility	-	As per norms in high priority districts (2025)
10)	National Health Information Network	-	Networks (2025)

Principles of National Health Policy 2017

For the first time the NHP 2017 prescribes ten key policy principles. These are:

- Professionalism, Integrity and Ethics;
- Equity;
- Affordability;
- Universality
- Patient-centered & Quality of Care;
- Accountability;
- Inclusive Partnerships;
- Pluralism;
- Decentralisation; and
- Dynamism and Adaptiveness

NHP 2017 identifies coordinated action in the following seven priority areas for improving the environment for health:

1) The Swachh Bharat Abhiyan;
2) Balanced, health diets and regular exercises;
3) Addressing tobacco, alcohol and substances abuse;
4) Yatri Suraksha – preventing death due to rail and road traffic accidents;
5) Nirbhaya Nari – action against gender violence;
6) Reduced stress and improved safety in the work place; and
7) Reducing indoor and outdoor air pollution.

The policy also articulates the need for the development of strategies and institutional mechanisms in each of these seven areas, to create Swasth Nagrik Abhiyan – a social movement for health. It recommends the prescription of indicators, their targets as also mechanisms for realising them.

Implementation Framework

The National Health Policy envisages that an implementation framework be put in place to deliver on these policy commitments. Such an implementation framework would provide a roadmap with milestones and deliverables to achieve the goals of the policy.

Critical Assessment of NHP 2017

The National Health Policy 2017, which the Centre announced on 15 March 2017, appears to be an appreciable measure towards improving health status of the people through concerted policy action. While the policy itself repeatedly states that 'health' is a state subject as per the Indian Constitution, state governments were not meaningfully involved in the process of NHP formulation.

Second, the NHP 2017 faces the challenging task of ensuring affordable and quality health care to every citizen. Although the NHP enunciated ten key principles, they are, in reality, not followed in the course of implementation of the policy.

While India is surging ahead in terms of GDP growth (7.1 per cent in 2018-19), the country's Human Development Index (HDI) ranks at 130 among 189 countries in 2018. The life expectancy at birth of people in India stood at 68.3 years in 2016 and the Gross National Income (GNI) per capita was US$ 5663 in the same year. But with a fifth of the world's disease burden, a growing incidence of non-communicable diseases such as diabetes, and poor financial arrangements to pay for care, India is at the rear end among the BRICS countries in health sector performance. Although the NHP 2017offers an opportunity to rectify well-known deficiencies through national Health Mission, most villages in the country lack sanitation and drinking water facilities causing poor health and high incidence of communicable diseases.

Among the most glaring lacunae is the lack of public funding for health. Rectifying this in partnership with the states is crucial if the Central government is to make the best use of the targeted government spending of 2.5% of GDP by 2025 — up from the current 1.15%. Looking at the health situation in the country, the suggested increase of expenditure on health is unlikely to meet policy goals. More doctors and paramedics and would need to be deployed for primary care in rural areas. Availability of trained doctors and nurses would help meet the new infant mortality and maternal mortality goals, and build on the gains from higher institutional deliveries - - the figure exceeded 80% in recent years. Critics point out that rural India is painfully short of doctors, nurses, medicines and hospitals. As such, the regional inequality in the HDI cannot be mitigated unless priority attention is paid to cover this shortage fast.

The 21st century witnessed the major epidemic outbreak in the entire world. The World Health Organisation (WHO) declared the Novel Corona virus Disease (COVID-19) a pandemic on 11th March, 2020. It made the entire world to realise the importance of investing in the healthcare sector. It also brought the realisation that health is a major indicator of human capital's productivity. After the major outbreak of this pandemic, the Government of India initiated preparedness and response measures. It included measures such as lockdown, social distancing, surveillance, contract tracing, testing and checking the community spread, community participation, preparedness of hospitals, infection prevention and control and implementation of containment plans at the national, state and district levels. On 24th of March 2020, the first phase of lock down was implemented in India, after which it was extended in a phased manner, depending upon the intensity of COVID-19 impact. India also came up with specific rules and regulations under the Epidemic Disease Act, 1897. For effective management of COVID-19 crisis, the hospitals were segregated into three categories, i.e.,

Dedicated COVID Hospital (DCH), Dedicated COVID Health Centre (DCHC) and Dedicated COVID Care Centre (DCCC).

Reliance on health services from the private sector is indispensable given the fact that 70% of all out-patient treatments are provided by it. But this raises the question of accountability, both on the quality and cost of care provided by the private sector. It is, therefore, necessary to setup regulatory and accreditation mechanisms for health care at the national level. Without such oversight, unethical commercial entities would find easy access to public funds. To prevent unhealthy practices it should be mandatory for all health institutions to be accredited, and to publish the approved cost of treatments. There is also need of securing balance between the primary, secondary and tertiary healthcare.

11.6 NATIONAL HEALTH MISSION

National Health Mission (NHM), representing the National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM), is an initiative undertaken by the Central Government to address the health needs of the under-served areas. Initially, the RHM was launched in 2005 and was tasked with addressing the health needs of 18 states that had been identified as having weak public health indicators. With the launch of National Urban Health Mission (NUHM) in 2013 RHM got merged into the National Health Mission (NHM). The duration of the NHM was extended till March 2020.

NHM seeks to achieve of universal access to equitable, affordable and quality healthcare services that are accountable and responsive to people's needs. The main programmatic components include the strengthening of healthcare in rural and urban areas, Reproductive-Maternal-Neonatal-Child and Adolescent health (RMNCH+A) interventions and control of communicable and non-communicable diseases. The focus of the Mission is on establishing a fully functional, community -owned, decentralised health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as education, clean water, sanitation, nutrition and gender equality.

Major Initiatives of NHM

Some of the major initiatives under the National Health Mission (NHM) are as follows:

1) Increase in Funding for Healthcare: Untied Grants to Sub-Centers have been used to fund grass-root improvements in health care. Examples include: (i) improved efficacy of Auxiliary Nurse Midwives (ANMs) in the field that can now undertake better antenatal care and other health care; (ii) Village Health Sanitation and Nutrition Committees (VHSNC) have used untied grants to increase their involvement in the respective local communities to address the needs of poor households and children.

2) Accredited Social Health Activists (ASHAs): Community Health volunteers called Accredited Social Health Activists are engaged under the mission for establishing a link between the community and the health system. These volunteers take care of demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHA Programme is expanding across States and has particularly been successful in bringing people back to public health system

for outpatient services, diagnostic facilities, institutional deliveries and inpatient care. Main activities of ASHAs include intensification of advocacy activities, awareness generation activities, diarrhea management service provision, establishing ORS-zinc demonstration sites, ORS distribution through home visitation, etc.

3) Janani Shishu Suraksha Karyakram: Janani Shishu Suraksha Karyakram (JSSK) scheme entitles all pregnant women delivering in public health institutions to absolutely free delivery, services, including caesarean operations.

4) Janani SurakshaYojna: Janani SurakshaYojna (JSY) is a safe motherhood intervention under the National Health Mission. The objective is to reduce maternal and neonatal mortality by promoting institutional delivery among poor pregnant women.

5) Health Care Contractors: National Rural Health Mission (NRHM) has provided health care contractors to underserved areas, and has been involved in training to expand the skill set of doctors at strategically located facilities identified by the state governments. Similarly, due importance is given to capacity building of nursing staff and auxiliary workers, NHM also supports co-location of AYUSH services in PHCs, CHCs and District Hospitals.

6) Free Drugs: The initiative has been launched with an objective to put in place systems such as facility wise Essential Drug List (EDL), robust procurement system, IT backed logistics and supply chain management, proper warehousing and necessary drug regulatory and quality assurance mechanism, standard treatment guidelines, prescription audit and grievance redressal systems, etc. to ensure provision of quality free essential drugs.

7) Free Diagnostic Services: To improve the quality of care, support is provided to states for providing essential diagnostics free of cost in public health facilities. Five states, namely, Andhra Pradesh, Karnataka, Maharashtra, J & K and Tripura, have already adopted the model as per the national guidelines.

8) National Ambulance Services: Provision of basic transport to patients has been one of the components of NRHM. Ambulances operating under Dial 108/102 ambulance service have been part of this.

9) National Mobile Medical Unit: Objective of MMU is to take health care to the door step of the people in the rural areas, especially in under-served areas.Thereare1122 MMUs operating across 335 districts in the country. A whole range of health care services meant for treatment of minor ailments, communicable and non-communicable diseases, reproductive and child health, family planning services are provided.

10) Rashtriya Bal Swasthya Karyakram (National Child Health Scheme): This initiative, launched in 2013, entails provision for child health screening and early intervention services through early detection and management of 4 Ds, that is, defects at birth, diseases, deficiencies, development delays including disability and free management of 30 identified health conditions. Children between 0-18 years of age are expected to be covered in a phased manner across the country.

11) District Hospital as Knowledge Centre for Clinical Care & Training: Under this scheme district hospitals are being strengthened to provide multi-specialty health care, including dialysis care, intensive cardiac care, cancer treatment, mental illness, emergency medical and trauma care, etc. These hospitals would provide knowledge, support for clinical facilities down the line through a tele-medicine center located in the district head-quarters. They also serve as centers for training of paramedics and nurses.

Critical Evaluation of NHM

Firstly, it is found that the utilisation of untied funds and other grants are not being properly monitored. Second, lack of coordination between key functionaries like ASHA, ANM and poor involvement of Village Health and Sanitation Committees (VHSCs) have affected the healthcare services under the National Health Mission. Third, inadequacy of ambulances or their non-functioning at the PHCs, sub-centres and community health centres for strengthening outreach of healthcare in the rural and urban areas has affected the healthcare services. Fourth, ASHA's mentoring and training for updating skills are weak. Additional training of ASHAs for vaccinations would further strengthen antenatal care and children's complete immunisation programme.

Check Your Progress 2

Note: i) Use the space given below for your answers.

ii) Check your answers with those given at the end of the Unit.

1) What are the strengths and weaknesses of NHP 2017?

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2) State the principles and priority areas for improving health care under NHP 2017

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11.7 CONCLUSION

A number of developing countries, including India, have shown that broad reforms in the health sector are possible when there is sufficient political will and when changes in the health care system are designed and implemented by capable policy-makers and policy-implementers.

In the current phase of governance, competition can improve quality and bring down costs. It is important that governments foster competition and diversify efforts in the supply of health services and inputs, particularly drugs and medical equipment. However, strong government regulation of privately-delivered health services is necessary to ensure quality of services and their affordability. While government itself has a major role to play in healthcare, there is much advantage to be gained through a genuine partnership between private business and government. The present reforms (initiated since May 2014), will help to augment the management of the health care services, implement the social accounting and adhere to the prerequisite that health is of prime importance to the human resource development. And finally, it may be concluded that significant improvements in the health of our people cannot be brought about unless we achieve a high level of success in our efforts in the promotion of the small family norm and in containing the growth of population.

11.8 GLOSSARY

Gross Domestic Product (GDP): The total value of all goods and services produced in a country.

Mortality Rate: Number of deaths in a given area or period.

Life Expectancy: It means the average period (in years) that a person may expect to live.

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11.10 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress 1

1) Your answer should include the following points:

- The present health care system in India has its origin in the recommendations of the Health Survey and Development Committee appointed in 1943.

- Setting up of Primary Health Centres (PHCs) as an integral component for all-round development of rural areas.
- Each sub-centre would be manned by health workers.
- Signing of the Alma-Ata Declaration recommending "Health for All by 2000 AD".

2) Your Answer should include the following points:
   - Brief description of NHP 1983.
   - Brief description of NHP 2002.

Check Your Progress 2

1) Your answer should include the following points:
   - Healthcare system prior to adoption of NHP 2017.
   - Strengths of NHP 2017.
   - Deficiencies of NHP 2017.

2) Your Answer should include the following:
   - Principles of NHP 2017.
   - Priority areas for improving the environment of health care.
   - Critical assessment of NHP 2017.