UNIT 9 HEALTH POLICY IN INDIA

Structure

9.0 OBJECTIVES

After reading this unit, you will be able to:

- define the term 'public health' indicating its main thrust and objectives;
- compare the trends in the changing health status of India over time;
- identify the factors responsible for the poor public health outcomes in India;
- explain the major initiatives taken under the 'public health programmes' in India; and
- bring out the thrust in the National Health Policies of India between the pre-2000 and post-2000 years.

9.1 INTRODUCTION

Health status of a country is measured by a number of indicators. These are: (i) life expectancy at birth, (ii) infant mortality rate, (iii) child and maternal mortality rate, (iv) morbidity incidence and prevalence rate, (v) disability adjusted life years, (vi) anthropometric measures like stunting, wasting and under-weight children, (vii) body mass index (BMI), etc. Poor child health outcomes are due to poor reproductive health status of women. The term reproductive health of women implies: (i) access to safe, effective, affordable

and acceptable methods of birth control and (ii) access to appropriate healthcare services during pregnancy and later after child birth. The ultimate objective of reproductive health is to ensure good health of the mothers and new born babies.

The socio-economic development of a country is determined by the health status of the population along with other factors like income and educational attainment. Health outcome and educational attainment acts as complementary to each other. This is well documented for different countries in the annual UNDP's Human Development Report (HDR). Research shows that poor health outcomes and poverty are both interdependent and are simultaneously determined. This means, health affects poverty and poverty, in turn, aggravates the health status of a country. Hence, poverty cannot be eradicated if health is ignored. Likewise, health status of the population can be improved if poverty is tackled. Deprivation such as lack of access to resources and critical amenities (including safe drinking water, sanitation, lack of education and general awareness) contribute to reinforcing ill health, morbidity and higher mortality levels. Contrary to this, attainments of other dimensions of human development, especially education and economic well-being, reinforces the transition towards better health and longevity. At the time of independence, the health situation of India was extremely poor. There have been large gains in the health status of India measured in terms of increase in life expectancy at birth and a continuous decline of infant mortality rate (IMR). However, India has not been able to perform well compared to international standards. India shares about 17.5 percent of global population but its disease burden is disproportionately higher (about 20 percent of global disease burden).

9.2 PUBLIC HEALTH POLICY IN INDIA

Public health is defined as 'the science and art of preventing disease, prolonging life and promoting human health through organised efforts and informed choices of society, organisations (public and private), communities and individuals'. Public health aims at improving the quality of life through prevention and treatment of disease, including reproductive and child heath and mental health. Public health practice requires numerous professionals like doctors, nurses, midwives, medical assistants, epidemiologists, biostatisticians, microbiologists, etc. The focus of a public health intervention is to prevent and manage diseases, injuries and other health conditions. This is achieved through surveillance of cases and promotion of healthy behaviours in communities and environment. Many diseases are preventable through simple, non-medical methods. For instance, simple act of hand washing with soap can prevent the spread of many contagious diseases. Similarly, treating a disease or controlling a pathogen can be vital to prevent its spread, either during an outbreak of infectious disease or through contamination of food or water supply.

Public health communication programmes (e.g. distribution of condoms) and vaccination programmes are examples of common preventive public health measures. Measures like these have contributed greatly to the health of population like increasing the average life expectancy at birth. Public health, through local health systems and non-governmental organisations, plays an important role in disease prevention efforts in both the developing and developed countries. The 'world health organisation' (WHO) coordinates and acts on global public health issues. Most countries have their own governmental public health agency. Often called as the 'ministry of health', they are responsible for domestic health issues. India is the first country in the world which has officially initiated the family planning programme to tackle population growth and unwanted pregnancies. However, over the decades the strategy and policies of family planning programme has changed (family planning is now renamed as family welfare programme). The main objective of this programme is not to increase the couple protection rate (or to increase the contraceptive prevalence rate) but rather to ensure safe delivery and give proper pre and post natal care comprising of complete immunisation of children along with safe motherhood strategies.

9.2.1 Health Status in India: Progress and Challenges

India has progressed considerably since independence on certain health indicators. Bad indicators of health like CBR, CDR and IMR have reduced dramatically. Likewise, good indicator of health like life expectancy at birth has increased (from 33 in 1947 to 69 years in 2016). This suggests that India is progressing in respect of health outcomes over time. India has eradicated

Table 9.1: Health Status in India: Progress and Challenges

Indicators	1947	2014
Crude Birth Rate (CBR)	40.8	21
Crude Death Rate (CDR)	27.4	6.7
Infant Mortality Rate (IMR)	146	39
Life Expectancy at Birth	32.7	68.6 (2016, projected)

Source: Sample Registration System, Registrar General, GoI.

many communicable diseases. Certain diseases like polio, leprosy and neo-natal tetanus are on the verge of elimination. In spite of this progress, non-communicable diseases are expected to continue to remain a major public health problem in the coming decades posing a real threat to India's public health. Some endemic diseases like AIDS, tuberculosis (TB), malaria, dengue, swine flu, etc. continues to challenge India's public health

infrastructure. In order to combat these diseases, a high level of readiness, in terms of early detection and rapid response is required.

There is also an increase in non-communicable (chronic) diseases [NCD]. Some of these diseases are associated with life style (e.g. diabetes, high blood pressure, stroke, heart disease, cancer etc.). These diseases are predominantly found among the persons belonging to age group 35 to 60. Recent surveys reveal that by 2025 about 189 million Indian population will be more than 60 years of age. Majority of this aged population will suffer from non-communicable or life style diseases. Life style disease claim more than 50 lakh lives every year in India (5.9 million in 2014) constituting about 15.6 percent of the global NCD's share. Diabetes has become the most alarming health issue with major public health consequence in India. The proportion of diabetics for adults above the age 20 in urban India has increased from 2.1 percent in 1970 to 12.1 percent in 2011. International Diabetes Federation suggests that of the 366 million diabetes all over the world (in 2011), 61 million (or 16.7 percent) are in India. These trends indicate that there will be an enormous burden on India's health infrastructure. The public health in India is therefore under serious threat since it is poor and inadequate.

9.2.2 Causes of Poor Health Outcomes

India accounts for 16.5 percent of the world's population but shoulders one-fifth (20 percent) of the world's share of diseases. A major health challenge posed by the specific phase of its current demographic transition relates to infant mortality, child malnutrition, anaemic mothers and women with poor reproductive health. Given that the proportion of women in the reproductive age-group is a high 55 percent (in 2016) and is expected to remain around this level for the next decade, the situation is extremely challenging from the point of view of health policy. This requires increased efforts to reduce not only maternal mortality but also the number of infant and child deaths. About 1.6 billion people across the world are estimated to be living in multidimensional poverty (in which health figures as an important component). Nearly 440 million of them (i.e. 27.5 percent) are in the eight large Indian states of Bihar, Jharkhand, Madhya Pradesh, Uttar Pradesh, Chhattisgarh, Odisha, Rajasthan and West Bengal. Poor health and multidimensional poverty are interlinked. India's public health expenditure is extremely low compared to all major countries in the world (it is just about one percent of our GDP). As a result, there is a high proportion (85.6 percent) of out-of-pocket expenditure in India.

The health sector is a state subject in India. There exists wide range of health inequality (as well as inequality of health expenditure) across the states in India. Hence, in order to ensure health equality across the states in India, there is a need to address income inequality. This is a critical issue needing to be addressed from the dimensions of social justice, equity and balanced regional development. This calls for more development grants for eradicating poverty in the poorer states of the country.

Check Your Progress 1 [answer within the given space about 50-100 words]

1) State the indicators with which health status of an economy is assessed.

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2) Define the term 'public health'.

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3) In what respect, the strategy of 'family health programme' has changed over time in India?

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4) Would you say that India has made good progress in its public health status? What are its present challenges in this regard?

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5) Do you think that India shoulders a disproportionately higher burden of disease burden of the world? Justify your answer.

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9.3 PUBLIC HEALTH PROGRAMMES IN INDIA

The 'ministry of health and family welfare', government of India, is responsible to formulate and execute all 'public health programmes' including family welfare. It deals with public healthcare, awareness campaign, immunisation programmes and preventive medicine. There are 13 national programmes run by this central authority. The areas covered under these public health programmes include treatment/prevention of: AIDS, cancer, filaria, iodine deficiency disorder, leprosy eradication, mental health, control of blindness, prevention and control of deafness, etc. Family welfare, in particular, is responsible for aspects pertaining to: (i) rural healthcare services, (ii) family planning and welfare, (iii) reproductive and child health (RCH), (iv) maternal health, (v) paediatrics, (vi) information, communication and knowledge about family planning, (vii) cooperation with NGOs and other international donors.

9.3.1 National Health Mission

In order to address the health needs of under-served rural areas in India, the government has launched the 'national rural health mission' (NRHM) in 2005. Subsequently, a 'national urban health mission' (NUHM) was launched in 2013 as a part of overarching 'national health mission' (NHM). Under the NRHM, 18 states, found to be weak in respect of public health indicators compared to other developed states are given special focus. The major objectives of the NRHM are to: (a) set-up community owned decentralised healthcare delivery system, (b) establish a fully functional healthcare delivery system so as to ensure inter-sectoral convergence at all levels and (c) ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Some of the major initiatives of NRHM are the following.

- Community health volunteers called 'accredited social health activists' (ASHA) are entrusted to act as link between community and health system in rural areas.
- Capacity building programmes are undertaken under NRHM with due importance given to training of nursing staff and 'auxiliary nurse midwives' (ANM).
- 'Safe motherhood intervention scheme' [called 'Janani Suraksha Yojona (**JSY**)'] is introduced under NRHM. JSY aims at promoting institutional delivery among poor pregnant women to reduce neo-natal and maternal mortality. The Scheme provides cash incentive to poor pregnant mothers where institutional delivery is low.
- 'Janani Shishu Suraksha Karyakram' (JSSK) is introduced to provide free to and fro transport, free drugs, free diagnostic and free diet to pregnant mothers who come for delivery in public health institutions.

- There is a significant departure in the implementation of NRHM. This is in terms of a pre-requisite to allocation of funds to states requiring the signing of a MOU (memorandum of understanding) with the centre. The MOU is to the effect that agreement to the policy is bound by the 'timeline and performance benchmarks' against identified activities.

9.3.2 Reproductive and Child Health Programmes

Recent findings reveal that India is one of the most backward countries in the world in terms of gender inequality, especially in respect of health and survival. Gender is one of the main social determinants of health which includes cultural, economic and social factors which play a major role in health outcomes of women. Thus, higher gender inequality adversely affects the health of women (especially those belonging to reproductive age group) as well as new born babies. Various studies have revealed that, in our patriarchal society, boys are more likely to receive treatment from healthcare compared to girls. Widespread malnutrition of children further contributes to the incidence and severity of health related problems. It poses a major threat to the children and, in extreme cases, threaten their lives. Malnutrition creates serious health problems by contributing to premature births and to abnormally 'low weight at birth'. Malnutrition is also a major contributing factor in spreading infectious diseases. By weakening the body response to diseases, malnutrition reduces acquired immunity. Research on health has established that malnutrition of children, besides others, is mainly due to ill reproductive health of the mothers. Therefore, reproductive and child health plays an important role in the context of future demographic health of a nation like India. This is particularly important to be focused upon in our national health policy since India is slated to reap the benefit of demographic dividend around 2025.

Poor maternal health contributes to future economic disparities of both mothers and their children. Poor maternal heath also affects child's heath in adverse ways and decreases a women's ability to participate in economic activities. Thus, NRHM and 'family welfare programmes' have set up and implemented various programmes to strengthen the health of the mothers and children. The RCH (reproductive and child health), Phase I, was launched in 1997. This includes four major components viz. (i) family planning, child survival and safe motherhood, (ii) need based cliental approach to healthcare, (iii) prevention and management of sexually transmitted diseases (STD) and AIDS and (iv) reproductive tract infection (RTI). The RCH – Phase II's (begun in 2005) major focus is to reduce maternal and child mortality in rural areas. Its major strategies are: (i) essential obstetric care including institutional delivery or delivery attended by skilled attendant and (ii) emergency obstetric care which includes operationalisation of first referral units, primary health centre (PHCs) and Community Health Centre (CHCs) for round-the-clock-delivery of health services.

Check Your Progress 2 [answer within the space given in about 50-100 words]

1) State the objectives of NRHM.

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2) State the specific objective of JSY under NRHM.

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3) How is 'malnutrition' a serious health hazard?

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9.4 NATIONAL HEALTH POLICIES IN INDIA

India's health policies and programmes are influenced by Bhore Committee's recommendation initiated in the pre-independence period. Set-up in 1943, under the chairmanship of Sir Joseph William Bhore to assess the health status of India, the committee submitted its report in 1946. The major objective of the Bhore Committee was to strengthen the public healthcare system. The Committee therefore undertook a survey to ascertain: (i) the existing health conditions of the population, (ii) the nature and functions of healthcare organisations and (c) the healthcare policy orientation needed to shape the future development of India. The Bhore Committee recommended that: (i) preventive and curative healthcare services must be integrated at all levels and (ii) for a short-term measure, there should be a 'primary health centre' (PHC) per 40,000 population (with two doctors, one nurse, four public health nurses, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacist, and fifteen other employees as attendants). For a long-term measure, setting-up of 'primary health units' with 75 bedded hospitals for each 10,000-20,000 population and 'secondary

health units' with 650 bedded hospitals regionalised around district hospitals (which should be of 2500 beds). The committee further recommended that medical education should include three months training in preventive and social medicine. The recommendations of the Bhore Committee were accepted in 1952 but due to fiscal constraints soon after independence, the proposals could not be implemented. However, the subsequent 'national health policies' (NHPs) and programmes were greatly influenced by the Bhore Committee recommendations. Under the NHPs, for the period prior to the year 2000, the NHP of 1983 and the 'national population policy' of 2000 (for the health issues covered under it) are important and therefore is briefly discussed here.

9.4.1 Prior to 2000

The first National Health Policy (NHP) after independence was adopted in 1983. The basic objective of the NHP-1983 was to ensure 'healthcare for all' by 2000. A massive rural healthcare infrastructure was undertaken by the government in which the rural public healthcare infrastructure was split into three tiers [viz. Sub-Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC)]. The NHP-1983 suggested that there should be one SC for 5,000 population, one PHC for 30,000 population and one CHC for 1,20,000 population in plain areas. For hilly, tribal and difficult areas, the norm recommended was: one SC per 3,000 population, one PHC for 20,000 population and one CHC for 80,000 population. The NHP-1983 highlighted the following to be focused upon: (i) nutritional development of the population, (ii) measures to prevent food adulteration, (iii) maintenance of quality of drugs, (iv) water supply and sanitation, (v) protection of environment, (vi) strengthening the immunisation programme, (vii) maternal and child health services, (viii) school health programmes, (ix) occupational health services, (x) re-orientation of health personnel and (xi) inclusion of various systems of medicine and healthcare at the appropriate level.

The above outlines were to be evolved within a integrated planning framework seeking to provide universal comprehensive primary healthcare services, relevant to the needs and priorities of the community at a cost which the people can afford. The policy was to ensure the planning and implementation of various health programmes through the organised involvement and participation of the community by utilising the services of private voluntary organisations active in the health sector.

The National Population Policy (NPP) 2000 also provided a policy framework for achieving the goals of meeting the RCH needs along with the target to achieve the net replacement levels (called 'total fertility rate') aimed at stabilising the population by 2045. In order to achieve the outlined national socio-demographic goals and the health issues, RCH was especially to be given the top most priority. Specifically, these included: (i) addressing the unmet needs for basic reproduction, (ii) focusing on child health services, (iii) reducing the IMR to below 30, (iv) reducing the MMR to below 100, (v)

achieving the universal immunisation of children, (vi) reducing the reproductive time span of women by increasing the age at marriage, (vii) achieving universal access to information and services pertaining to fertility regulation and contraception, (viii) achieving 80 percent institutional deliveries and 100 percent deliveries by trained health professionals, (ix) preventing and controlling the STDs and AIDS and (x) integrating the Indian system of medicine in the provision of RCH services.

9.4.2 Post-2000

The National Health Policy (2002) recognised that morbidity and mortality levels of the country are exceptionally high and hence stronger preventive and curative measures are needed. It took special note of the fact that macro and micro nutrient deficiency among women and children are high. Major diseases like Malaria, TB and HIV received special mention. Given this scenario, the main features of the policy thrust are the following:

1) flexibility to state public health administrations to implement policies in their areas;
2) vertical implementation of structure for disease control programmes;
3) more training to paramedical staff to cater to backward regions of the country;
4) rectifying the uneven distribution of medical colleges across country;
5) upcoming medical disciplines like molecular biology to get developed infrastructure;
6) increase the number of persons specialised in family medicine and public health;
7) encourage the usage of generic drugs and vaccine;
8) include mental health in the public health domain;
9) since college and school children are the most impressionable target for inculcating the basic principles of preventive healthcare, the policy to target these youth for increasing the awareness of health promoting behaviour; and
10) encourage health related research among non-government service providers.

The National Mental Health Policy (2014) aims at: (i) providing universal access to mental health care; (ii) increasing access to mental health service to the vulnerable section of the society; (iii) reducing the risk and stigma of mental disease; (iv) ensuring the supply of skilled resources to treat the cases of mental sickness; and (v) identifying the social, biological and psychological determinants of mental health disorder. The more recent National Health Policy, 2017 also reiterates the goal of attaining the highest possible level of health and well-being by ensuring universal access to good

quality healthcare services (without financial hardship) linked to the Sustainable Development Goals. To achieve universal health coverage, specific steps identified are: (i) establishment of a comprehensive and free primary healthcare service for maternal, child and adolescent health through public hospitals and not-for profit private care providers; and (ii) providing a good quality secondary and tertiary healthcare service. The policy particularly emphasises the need for reducing the out-of-pocket expenditure on healthcare needs. The other major objectives of this policy are to: (i) increase the life expectancy at birth from 67.5 to 70 by 2025; (ii) reduce the under-five mortality to 23 by 2025 and maternal mortality to 100 by 2020; (iii) reduce the infant mortality rate to 28 by 2019; (iv) reduce neo-natal mortality to 16 and still birth rate to single digit by 2025; (v) eliminate leprosy by 2018; (vi) comprehensively immunise 90 percent newborn by 2025; (vii) ensure adequate availability of paramedics and health workers for primary and secondary healthcare in high priority districts by 2025; (viii) ensure district level electronic database of information on health system by 2020; etc.

The 2017 policy thus aims to project an incremental assurance based approach. However, the policy gives cause for two types of criticisms viz. (i) agency stakeholder critique; and (ii) feasibility critique. On the first, while the policy identifies what needs to be done, it does not identify the 'who, what and the how' sides of its implementation. This is perhaps due to the reason that healthcare is a state's responsibility. But it is important to improve the monitoring of the delivery systems. On the second (i.e. the feasibility critique), the policy calls for a reform in financing the public healthcare facilities where the operational costs would be in the form of reimbursements for care provision on a per capita basis for primary care. But the policy is silent on how this financing reform can be achieved and who will manage them. Thus, while the policy more lucidly identifies the need to address problems with respect to the three 'As' (Access, Affordability, Accountability) of healthcare system of India, it fails to provide a cohesive, tangible action plan to address the problems pertaining to any of the 'As' (especially when the public healthcare system is sinking under micro and macro managerial inefficiencies and is low on training and capacity building efforts).

Check Your Progress 2 [answer within the space given in about 50-100 words]

1) In what way is Bhore committee recommendation significant for India's national health policy?

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2) When was the first NHP adopted in independent India and in what way did it differ in its recommended emphasis from that of Bhore committee's recommendations?

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3) State the thrust on health policy front in the NPP 2000. What were some of NPP's specific quantitative health oriented targets set?

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4) In what respects NHP 2002 differed in its thrust from that of NHP 1983?

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5) What are some of the notable quantitative targets set in the NHP 2017?

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9.5 LET US SUM UP

Given its socio-economic and demographic features, public health plays an important role in India. Private healthcare is not only expensive but creates a situations of market failure causing the problems of moral hazard and adverse selection. The poorer section of society therefore needs public health to a greater extent compared to the economically well-off segments. The NRHM is therefore a notable step aimed at mitigating the suffering of the poor rural population for their healthcare needs. There is a built-in efficiency clause in

NRHM for ensuring 'timeline and performance benchmarks' against identified activities. Despite some of the initiatives, the public health sector in India is considered stagnant when looked at from the share of public health expenditure to GDP which is just about 1 percent of GDP. Considering that India is slated to enjoy the benefit of demographic dividend roughly after 2025, it is necessary that various aspects of public health and in particular the RCH services needs to be given utmost priority. The NPP, 2000 had set a target of achieving IMR 30 which was achieved by 2016. However, many other targets, particularly the health infrastructure in terms of CHCs for every 1.2 lakh population is yet to be achieved. Even in terms of SCs and PHCs, although it is achieved at the aggregate average level, there are huge variations across states and districts.

9.6 KEY WORDS

Public Health : The science and art of preventing disease, prolonging life and promoting human health through organised efforts and informed choices of society, communities and individuals.

Health Equity : Refers to minimising disparity in health outcomes in respect of gender, caste, religion, occupational groups as well as different geographical regions.

NRHM : In order to address the health needs of under-served rural areas in India, the government of India has launched National Rural Health Mission (NRHM) in 2005. NRHM, particularly lays emphasis on states that are weak in respect of public health indicators compared to other developed states.

RCH : The RCH was launched in 1997 and includes four major components viz. (i) family planning, child survival and safe motherhood, (ii) need based cliental approach to healthcare, (iii) prevention and management of sexually transmitted diseases (STD) and AIDS and (iv) reproductive tract infection (RTI).

Demographic Dividend : During the process of demographic transition, for a certain period of time, the growth of working age population (between the age group of 15-60) would be higher than the non-working population (i.e. population below age 15 and above age 60). This is basically due to falling fertility and stable mortality. This gives a 'window of opportunity' to the economy. This is known as 'demographic dividend'. For India, this is expected to reach its peak during 2020 to 2030, roughly around 2025, and is expected to last up to late 2060.

9.7 SOME USEFUL BOOKS AND REFERENCES

1) Bajpai, N Sachs D J Dholakia, R H (2010). Improving Access and Efficiency in Public Health Services: Mid-Term Evaluation of India's National Rural Health Mission, The Earth Institute, Columbia University, Sage Publications.

2) Goel S (2007). From Bhore Committee to National Rural Health Mission, A Critical Review, The Internet Journal of Health, 7(1).

9.8 ANSWERS/HINTS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress 1

1) Life expectancy at birth, infant mortality rate, child and maternal mortality rate, morbidity incidence and prevalence rate, disability adjusted life years, anthropometric measures like stunting, wasting and under-weight children and body mass index (BMI).

2) It is defined as the 'science and art of preventing disease, prolonging life and promoting human health through organised efforts and informed choices of society, communities and individuals'.

3) It has changed from targeting the 'couple protection rate' to ensuring safe delivery and giving proper pre- and post-natal care comprising of complete immunisation of children along with safe motherhood strategies.

4) Yes. In many terms (e.g. life expectancy, CDR, CBR, IMR), there has been considerable progress over the years. The new challenges, however, include tackling endemic diseases like AIDS, tuberculosis (TB), malaria, dengue, swine flu, etc. Besides, there is also an increase in non-communicable life style diseases like diabetes, high blood pressure, stroke, heart disease, cancer etc.

5) Yes. Of the total of 1.6 billion people living under conditions of multi-dimensional poverty (MDP), nearly 440 million (i.e. 27.5 percent) live in the 8 major poor states in India. Because of the linkage between poor health and MDP, this requires better health infrastructure which, in turn, demands higher public health investment. But as a proportion of GDP, India spends low (less than 1 percent of GDP) forcing a high rate of out-of-pocket private health expenditure (86 percent).

Check Your Progress 2

1) Set-up community owned decentralised healthcare delivery system, establish a fully functional healthcare delivery system so as to ensure inter-sectoral convergence at all levels and ensure simultaneous action on

a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

2) Promotion of institutional delivery among poor pregnant women to reduce neo-natal and maternal mortality.

3) It creates serious health problems by contributing to premature births and to abnormally 'low weight at birth'. It is also a major contributing factor in spreading infectious diseases.

Check Your Progress 3

1) In recommending population-centred establishment of health centres (at grass roots and district levels) and in recommending that medical education should include three months training in preventive and social medicine. The recommended norms have been a guiding factor for all subsequent NHPs till now.

2) In 1983. The first NHP specified the population based norms for health units in terms of SC, PHC and CHC. The population norms also differed from the 40000 and 1000-20000 suggested by Bhore committee to 5000, 30000 and 120000 for SC, PHC and CHC respectively. The NHP 1983 also laid emphasis on as many as 11 different areas coving the areas of expansion in infrastructure, training of personnel, nutritional development and quality of drugs, etc.

3) Its thrust was to meet the goals of RCH and focus on achieving 'net replacement level' aimed at stabilising the population by 2045. Reduction of IMR below 30, MMR below 100, achievement of 80 percent of institutional deliveries and 100 percent of assisted deliveries were the NPP's quantitative targets set.

4) Taking special note of high levels of macro and micro nutrient deficiency in women and children, the NHP 2002 laid emphasis on preventive and curative measures to reduce high levels of morbidity and mortality levels in the country. Inclusion of mental health in public health domain was also a major shift of NHP 2002 as compared to that of NHP 1983.

5) Increasing the life expectancy at birth from 67.5 to 70 by 2025; (ii) reducing the infant mortality rate to 28 by 2019; (iii) reducing the under-five mortality to 23 by 2025 and maternal mortality to 100 by 2020; (iv) reduce neo-natal mortality to 16 and still birth rate to single digit by 2025; and (v) comprehensively immunise 90 percent newborn by 2025;