# NATIONAL HEALTH POLICY-2002

The Ministry of health and family welfare, government of India, evolved a National Health Policy in 1983 keeping in view the national commitment to attain the goal of Health For All by the year 2000. Since then there has been significant changes in the determinant factors relating to the health sector, necessitating the revision of the policy, and a new National Health Policy-2002 was evolved.

**OBJECTIVES OF NHP-2002:**

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by
upgrading the infrastructure in the existing institutions.

- Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country.
- Emphasis will be given to increasing the aggregate public health investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the State level to render effective service delivery.
- The contribution of the private sector in providing health services would be much enhanced, particularly for the population group which can afford to pay for services.
- Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation.
- Emphasis will be laid on rational use of drugs within the allopathic system.
- Increased access to tried and tested systems of traditional medicine will be ensured.

Within these broad objectives, NHP-2002 will endeavor to achieve the time-bound goals which are as follows:

**Goals to be achieved by 2000-2015**

| S. No. | Goals | Year |
|---|---|---|
| 1. | Eradicate Polio and Yaws | 2005 |
| 2. | Eliminate Leprosy | 2005 |
| 3. | Eliminate Kala Azar | 2010 |
| 4. | Eliminate Lymphatic Filariasis | 2015 |
| 5. | Achieve Zero level growth of HIV/AIDS | 2007 |
| 6. | Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases | 2010 |
| 7. | Reduce Prevalence of Blindness to 0.5% | 2010 |
| 8. | Reduce IMR to 30/1000 And MMR to 100/Lakh | 2010 |
| 9. | Increase utilization of public health facilities from current Level of <20 to >75% | 2010 |
| 10. | Establish an integrated system of surveillance, National Health Accounts & Health Statistics | 2005 |
| 11. | Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0% | 2010 |
| 12. | Increase share of Central grants to Constitute at least 25% of total health spending | 2010 |
| 13. | Increase State Sector Health spending from 5.5% to 7% of the budget<br><br>Further increase to 8% | 2005<br><br>2010 |

**NHP-2002 - POLICY PRESCRIPTIONS:**

**1. FINANCIAL RESOURCES**

The paucity of public health investment is a stark reality. Given the extremely difficult fiscal position of the State Governments, the Central Government will have to play a key role in augmenting public health investments.

- Taking into account the gap in health care facilities, it is planned, under the policy to increase health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010.
- The State Governments would also need to increase the commitment to the health sector. In the first phase, by 2005, they would be expected to increase the commitment of their resources to 7 percent of the Budget; and, in the second phase, by 2010, to increase it to 8 percent of the Budget.
- With the stepping up of the public health investment, the Central Government's contribution would rise to 25 percent from the existing 15 percent by 2010. The provisioning of higher public health investments will also be contingent upon the increase in the absorptive capacity of the public health administration so as to utilize the funds gainfully.

**2. EQUITY**

To meet the objective of reducing various types of inequities and imbalances – inter-regional; across the rural – urban divide; and between economic classes – the most cost effective method would be to increase the sectoral outlay in the primary health sector. Such outlets afford access to a vast number of individuals, and also facilitate preventive and early stage curative initiative, which are cost effective.

- In recognition of this public health principle, NHP-2002 sets out an increased allocation of 55 percent of the total public health investment for the primary health sector; the secondary and tertiary health sectors being targeted for 35 percent and 10 percent respectively.
- The Policy projects that the increased aggregate outlays for the primary health sector will be utilized for strengthening existing facilities and opening additional public health service outlets, consistent with the norms for such facilities.

**3. DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES**

a)This policy envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre.

- However, to optimize the utilization of the public health infrastructure at the primary level, NHP-2002 envisages the gradual convergence of all health programmes under a single field administration.
- Vertical programmes for control of major diseases like TB, Malaria, HIV/AIDS, as also the RCH and Universal Immunization Programmes, would need to be continued till moderate levels of prevalence are reached.
- The integration of the programmes will bring about a desirable optimisation of outcomes through a convergence of all public health inputs.
- The Policy also envisages that programme implementation be effected through autonomous bodies at State and district levels. The interventions of State Health Departments may be limited to the overall monitoring of the achievement of programme targets and other technical aspects. The relative distancing of the programme implementation from the State Health Departments will give the project team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-informed decision-making.

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

c)The Policy envisages that apart from the exclusive staff in a vertical structure for the disease control programmes, all rural health staff should be available for the entire gamut of public health activities at the decentralized level, irrespective of whether these activities relate to national programmes or other public health initiatives.

- It would be for the Head of the District Health administration to allocate the time of the rural health staff between the various programmes, depending on the local need.
- NHP-2002 recognizes that to implement such a change, not only would the public health administrators be required to change their mindset, but the rural health staff would need to be trained and reoriented.

**4. THE STATE OF PUBLIC HEALTH INFRASTRUCTURE**

a)As has been highlighted in the earlier part of the Policy, the decentralized Public health service outlets have become practically dysfunctional over large parts of the country. On account of resource constraints, the supply of drugs by the State Governments is grossly inadequate. The patients at the decentralized level have little use for diagnostic services, which in any case would still require them to purchase therapeutic drugs privately. In a situation in which the patient is not getting any therapeutic drugs, there is little incentive for the potential beneficiaries to seek the advice of the medical professionals in the public health system. This results in there being no demand for medical services, so medical professionals and paramedics often absent themselves from their place of duty. It is also observed that the functioning of the public health service outlets in some States like the four Southern States – Kerala, Andhra Pradesh, Tamil Nadu and Karnataka – is relatively better, because some quantum of drugs is distributed through the primary health system network, and the patients have a stake in approaching the Public Health facilities.

- In this backdrop, the Policy envisages kick-starting the revival of the Primary Health System by providing some essential drugs under Central Government funding through the decentralized health system.
- It is expected that the provisioning of essential drugs at the public health service centres will create a demand for other professional services from the local population, which, in turn, will boost the general revival of activities in these service centres. In sum, this initiative under NHP-2002 is launched in the belief that the creation of a beneficiary interest in the public health system, will ensure a more effective supervision of the public health personnel through community monitoring, than has been achieved through the regular administrative line of control.

b) This Policy recognizes the need for more frequent in-service training of public health medical personnel, at the level of medical officers as well as paramedics. Such training would help to update the personnel on recent advancements in science, and would also equip them for their new assignments, when they are moved from one discipline of public health administration to another.

c) Global experience has shown that the quality of public health services, as reflected in the attainment of improved public health indices, is closely linked to the quantum and quality of investment through public funding in the primary health sector.

- Therefore the Policy, while committing additional aggregate financial resources, places great reliance on the strengthening of the primary health structure for the attaining of improved public health outcomes on an equitable basis.
- Further, it also recognizes the practical need for levying reasonable user charges for certain secondary and tertiary public health care services, for those who can afford to pay.

**5. EXTENDING PUBLIC HEALTH SERVICES**

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

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

b) NHP-2002 also recognizes the need for States to simplify the recruitment procedures and rules for contract employment in order to provide trained medical manpower in under-served areas. State Governments could also rigorously enforce a mandatory two-year rural posting before the awarding of the graduate degree. This would not only make trained medical manpower available in the underserved areas, but would offer valuable clinical experience to the graduating doctors.

**6. ROLE OF LOCAL SELF-GOVERNMENT INSTITUTIONS**

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

**7. NORMS FOR HEALTH CARE PERSONNEL**

Minimal statutory norms for the deployment of doctors and nurses in medical institutions need to be introduced urgently under the provisions of the Indian Medical Council Act and Indian Nursing Council Act, respectively. These norms can be progressively reviewed and made more stringent as the medical institutions improve their capacity for meeting better normative standards.

**8. EDUCATION OF HEALTH CARE PROFESSIONALS**

a) In order to ameliorate the problems being faced on account of the uneven spread of medical and dental colleges in various parts of the country, this policy envisages the setting up of a Medical Grants Commission for funding new Government Medical and Dental Colleges in different parts of the country. Also, it is envisaged that the Medical Grants Commission will fund the upgradation of the infrastructure of the existing Government Medical and Dental Colleges of the country, so as to ensure an improved standard of medical education.

b) To enable fresh graduates to contribute effectively to the providing of primary health services as the physician of first contact, this policy identifies a significant need to modify the existing curriculum. A need-based, skill-oriented syllabus, with a more significant component of practical training, would make fresh doctors useful immediately after graduation. The Policy also recommends a periodic skill-updating of working health professionals through a system of continuing medical education.

c) The Policy emphasizes the need to expose medical students, through the undergraduate syllabus, to the emerging concerns for geriatric disorders, as also to the cutting edge disciplines of contemporary medical research. The policy also envisages that the creation of additional seats for postgraduate courses should reflect the need for more manpower in the deficient specialties.

**9. NEED FOR SPECIALISTS IN 'PUBLIC HEALTH' AND 'FAMILY MEDICINE'**

a) In order to alleviate the acute shortage of medical personnel with specialization in the disciplines of 'public health' and 'family medicine', the Policy envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these discipline in medical training institutions, to reach a stage wherein ¼th of the seats are earmarked for these disciplines. It is envisaged that in the sanctioning of post-graduate seats in future, it shall be insisted upon that a certain reasonable number of seats be allocated to `public health'

and `family medicine'. Since the `public health' discipline has an interface with many other developmental sectors, specialization in Public health may be encouraged not only for medical doctors, but also for nonmedical graduates from the allied fields of public health engineering, microbiology and other natural sciences.

**10. NURSING PERSONNEL**

a) In the interest of patient care, the policy emphasizes the need for an improvement in the ratio of nurses vis-à-vis doctors/beds.

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

b)The Policy lays emphasis on improving the skill -level of nurses, and on increasing the ratio of degree-holding nurses vis-à-vis diploma-holding nurses.

- NHP-2002 recognizes a need for the Central Government to subsidize the setting up, and the running of, training facilities for nurses on a decentralized basis. Also, the Policy recognizes the need for establishing training courses for super-specialty nurses required for tertiary care institutions.

**11. USE OF GENERIC DRUGS AND VACCINES**

a) This Policy emphasizes the need for basing treatment regimens, in both the public and private domain, on a limited number of essential drugs of a generic nature. This is a prerequisite for cost-effective public health care.

- In the public health system, this would be enforced by prohibiting the use of proprietary drugs, except in special circumstances. The list of essential drugs would no doubt have to be reviewed periodically. To encourage the use of only essential drugs in the private sector, the imposition of fiscal disincentives would be resorted to. The production and sale of irrational combinations of drugs would be prohibited through the drug standards statute.

b) The National Programme for Universal Immunization against Preventable Diseases requires to be assured of an uninterrupted supply of vaccines at an affordable price.

- To minimize the danger arising from the volatility of the global market, and thereby to ensure long-term national health security, NHP-2002 envisages that not less than 50% of the requirement of vaccines/sera be sourced from public sector institutions.

**12. URBAN HEALTH**

a) NHP-2002 envisages the setting up of an organized urban primary health care structure. Since the physical features of urban settings are different from those in rural areas, the policy envisages the adoption of appropriate population norms for the urban public health infrastructure.

- The structure conceived under NHP-2002 is a two-tiered one: the primary centre is seen as the first-tier, covering a population of one lakh, with a dispensary providing an OPD facility and essential drugs, to enable access to all the national health programmes; and a second-tier of the urban health organization at the level of the Government general hospital, where reference is made from the primary centre.
- The Policy envisages that the funding for the urban primary health system will be jointly borne by the local self-government institutions and State and Central Governments.

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

**13. MENTAL HEALTH**

a) NHP – 2002 envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general duty medical staff.

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

## 14. INFORMATION, EDUCATION AND COMMUNICATION

a) NHP-2002 envisages an IEC policy, which maximizes the dissemination of information to those population groups which cannot be effectively approached by using only the mass media.

- The focus would therefore be on the inter-personal communication of information and on folk and other traditional media to bring about behavioral change.
- The IEC programme would set specific targets for the association of PRIs/NGOs/Trusts in such activities. In several public health programmes, where behavioral change is an essential component, the success of the initiatives is crucially dependent on dispelling myths and misconceptions pertaining to religious and ethical issues. The community leaders, particularly religious leaders, are effective in imparting knowledge which facilitates such behavioural change. The programme will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programmes on the targeted groups.
- The Central/State Government initiative will also focus on the development of modules for information dissemination in such population groups, who do not normally benefit from the more common media forms.

b)NHP-2002 envisages giving priority to school health programmes which aim at preventive-health education, providing regular health check-ups, and promotion of health seeking behavior among children.

- The school health programmes can gainfully adopt specially designed modules

in order to disseminate information relating to 'health' and 'family life'. This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but the future generation as well.

## 15. HEALTH RESEARCH

a) This Policy envisages an increase in Government-funded health research to a level of 1 percent of the total health spending by 2005; and thereafter, up to 2 percent by 2010.

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

## 16. ROLE OF THE PRIVATE SECTOR

a) In principle, this Policy welcomes the participation of the private sector in all areas of health activities – primary, secondary or tertiary. However, looking to past experience of the private sector, it can reasonably be expected that its contribution would be substantial in the urban
primary sector and the tertiary sector, and moderate in the secondary sector.

- This Policy envisages the enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions by 2003. Also, statutory guidelines for the conduct of clinical practice and delivery of medical services are targeted to be developed over the same period. With the acquiring of experience in the setting and enforcing of minimum quality standards, the Policy envisages graduation to a scheme of quality accreditation of clinical establishments/medical institutions, for the information of the citizenry. The regulatory/accreditation mechanisms will no doubt also cover public health institutions.
- The Policy also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages.

b) In the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive Government mechanism to provide health services to this category. It has sometimes been felt that a social health insurance scheme, funded by the Government, and with service delivery through the private sector,

would be the appropriate solution. The administrative and financial implications of such an initiative are still unknown. As a first step, this policy envisages the introduction of a pilot scheme in a limited number of representative districts, to determine the administrative features of such an arrangement, as also the requirement of resources for it. The results obtained from these pilot projects would provide material on which future public health policy can be based.

c) NHP-2002 envisages the co-option of the nongovernmental practitioners in the national disease control programmes so as to ensure that standard treatment protocols are followed in their day-to-day practice.

d)This Policy recognizes the immense potential of information technology applications in the area of telemedicine in the tertiary health care sector. The use of this technical aid will greatly enhance the capacity for the professionals to pool their clinical experience.

**17. THE ROLE OF CIVIL SOCIETY**

a) NHP-2002 recognizes the significant contribution made by NGOs and other institutions of the civil society in making available health services to the community.

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

**18. NATIONAL DISEASE SURVEILLANCE NETWORK**

This Policy envisages the full operationalization of an integrated disease control network from the lowest rung of public health administration to the Central Government, by 2005. The programme for setting up this network will include components relating to the installation of data-base handling hardware; IT inter-connectivity between different tiers of the network; and in-house training for data collection & interpretation for undertaking timely and effective response.

This public health surveillance network will also encompass information from private health care institutions and practitioners. It is expected that real-time information from outside the government system will greatly strengthen the capacity of the public health system to counter focal outbreaks of seasonal diseases.

**19. HEALTH STATISTICS**

a) The Policy envisages the completion of baseline estimates for the incidence of the common diseases – TB, Malaria, Blindness – by 2005.

- The Policy proposes that statistical methods be put in place to enable the periodic updating of these baseline estimates through representative sampling, under an appropriate statistical methodology.
- The policy also recognizes the need to establish, in a longer time-frame, baseline estimates for non-communicable diseases, like CVD, Cancer, Diabetes; and accidental injuries, and communicable diseases, like Hepatitis and JE. NHP-2002 envisages that, with access to such reliable data on the incidence of various diseases, the public health system would move closer to the objective of evidence-based policy-making.

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

c)In an attempt at consolidating the data base and graduating from a mere estimation of the annual health expenditure, NHP-2002 emphasizes the need to establish national health accounts, conforming to the `source-to-users' matrix structure. Also, the policy envisages the estimation of

health costs on a continuing basis. Improved and comprehensive information through national health accounts and accounting systems would pave the way for decision makers to focus on relative priorities, keeping in view the limited financial resources in the health sector.

**20. WOMEN'S HEALTH**

NHP-2002 envisages the identification of specific programmes targeted at women's health. The Policy notes that women, along with other under-privileged groups, are significantly handicapped due to a disproportionately low access to health care.

- The various Policy recommendations of NHP-2002, in regard to the expansion of primary health sector infrastructure, will facilitate the increased access of women to basic health care.
- The Policy commits the highest priority of the Central Government to the funding of the identified programmes relating to woman's health.
- Also, the policy recognizes the need to review the staffing norms of the public health administration to meet the specific requirements of women in a more comprehensive manner.

**21. MEDICAL ETHICS**

a) NHP – 2002 envisages that, in order to ensure that the common patient is not subjected to irrational or profit-driven medical regimens, a contemporary code of ethics be notified and rigorously implemented by the Medical Council of India.

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

**22. ENFORCEMENT OF QUALITY STANDARDS FOR FOOD AND DRUGS**

NHP – 2002 envisages that the food and drug administration will be progressively strengthened, in terms of both laboratory facilities and technical expertise.

- Also, the policy envisages that the standards of food items will be progressively tightened up at a pace which will permit domestic food handling / manufacturing facilities to undertake the necessary up gradation of technology so that they are not shut out of this production sector.
- The Policy envisages that ultimately food standards will be close, if not equivalent, to Codex specifications; and that drug standards will be at par with the most rigorous ones adopted elsewhere.

**23. REGULATION OF STANDARDS IN PARAMEDICAL DISCIPLINES**

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

**24. ENVIRONMENTAL AND OCCUPATIONAL HEALTH**

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

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

**25. PROVIDING MEDICAL FACILITIES TO USERS FROM OVERSEAS**

To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sectors, NHP-2002 strongly encourages the providing of such health services on a payment basis to service seekers from overseas. The providers of such services to patients from overseas will be encouraged by extending to their earnings in foreign exchange, all fiscal incentives, including the status of "deemed exports", which are available to other exporters of goods and services.

## 26. IMPACT OF GLOBALISATION ON THE HEALTH SECTOR

The Policy takes into account the serious apprehension, expressed by several health experts, of the possible threat to health security in the post-TRIPS era, as a result of a sharp increase in the prices of drugs and vaccines. To protect the citizens of the country from such a threat, this policy envisages a national patent regime for the future, which, while being consistent with TRIPS, avails of all opportunities to secure for the country, under its patent laws, affordable access to the latest medical and other therapeutic discoveries. The policy also sets out that the Government will bring to bear its full influence in all international fora – UN, WHO, WTO, etc. – to secure

commitments on the part of the Nations of the Globe, to lighten the restrictive features of TRIPS in its application to the health care sector.

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