# National Health Policy 2015

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1. Introduction: Context, Need and Scope

1.1. India today is the world’s third largest economy in terms of its Gross National Income (in PPP terms) and has the potential to develop more equitably, and emerge as one of the developed nations of the world. It possesses as never before, a sophisticated arsenal of interventions, technologies and knowledge required for providing health care to her people. Yet the gaps in health outcomes continue to widen. On the face of it, much of the ill health, disease, premature death, and suffering we see on such a large scale is needless, given the availability of effective and affordable interventions for prevention and treatment. “The reality is straightforward- the power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in a comprehensive and affordable way, and on an adequate scale”.

1.2. This National Health Policy addresses the urgent need to improve the performance of health systems. It is being formulated at the last year of the Millennium Declaration and its Goals, in the global context of all nations committed to moving towards universal health coverage. Given the two-way linkage between economic growth and health status, this National Health Policy is a declaration of the determination of the Government to leverage economic growth to achieve health outcomes and an explicit acknowledgement that better health contributes immensely to improved productivity as well as to equity.

1.3. The National Health Policy of 1983 and the National Health Policy of 2002 have served us well in guiding the approach for the health sector in the Five-Year Plans and for different schemes. Now 13 years after the last health policy, the context has changed in four major ways. Firstly- Health Priorities are changing. As a result of focused action over the last decade we are close to attaining Millennium Development Goals with respect to maternal and child mortality. Maternal mortality is rapidly declining but we still have 44,000 maternal deaths annually and commitments to further reduction must not lag. However there is a rising and unfulfilled expectation of many other health needs that currently receive little public attention. There are many infectious diseases which the system has failed to respond to – either in terms of prevention or access to treatment. Then there is a growing burden of non-communicable diseases. The second important change in context is the emergence of a robust health care industry growing at 15% compound annual growth rate (CAGR). This represents twice the rate of growth in all services and thrice the national economic growth rate. Thirdly, Out of Pocket Expenditures due to health care costs are growing and incidences of catastrophic expenditure are now being estimated to be one of the major contributors to poverty. The drain on family incomes due to health care costs can neutralize the gains of income increases and every Government scheme aimed to reduce poverty. The fourth and final change in context is that economic growth has increased the fiscal capacity available. Therefore, the country needs a new health policy that is responsive to these contextual changes and which strengthens health governance.

1.4. The primary aim of the National Health Policy, 2015, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investment in health, organization of healthcare services, prevention of diseases and promotion of good health through cross sectoral actions, access to technologies, developing human resources, encouraging
medical pluralism, building the knowledge base, financial protection strategies and regulation and legislation for health.

2. Situation Analysis

2.1 Achievements in Millennium Development Goals (MDGs)

2.1.1 India is close to reaching the Millennium Development Goals (MDG) with respect to maternal and under 5 mortality. From a baseline of 560 in 1990, the nation has achieved Maternal Mortality Ratio (MMR) of 167 by 2011-13. At this rate of decline it is estimated to be 140 by 2015 against the MDG target of 109. In case of under-5 mortality rate (U5MR), the MDG target is 42. From a baseline of 126 in 1990, the nation has reached an U5MR of 49 in 2013, and if the rate of reduction over the past decade is sustained, the achievement in 2015 will be very close to the target. However, the rate of decline of still-births and neonatal mortality has been slow. In addition there are inter and intra state variations. For instance, U5MR ranges from 73 (Assam) to 12 (Kerala) and Madhya Pradesh has wide disparity in Infant Mortality Rate, with Indore at 37 and Panna at 85. Also, four States i.e. UP, Bihar, MP and Rajasthan together contribute to 69.6% of all maternal deaths in the country. These inequities in health outcome are analyzed under section on inequity and constitute a focus of this policy. Progress and challenges related to MDG 6 (combating AIDS, malaria and other diseases) are described under communicable diseases (Section 2.5).

2.1.2 Nutrition status is an important underlying cause of mortality and morbidity especially for young children. To achieve MDG target for eradicating hunger, proportion of under-weight children should decrease to 26% by 2015. India has been able to reduce proportion of under-weight children to 42.5% in 2005-06 from the estimated 52% in 1990. Percentage of under-weight children <3 years (weight for age) is higher in rural areas (44%) compared to urban areas (30%). Prevalence of underweight children <3 years vary widely between states –from 58% in Madhya Pradesh to 14% in Mizoram. At the current rate of decline, the prevalence of underweight children is expected to be 29% by 2015, and 27% by 2017.

2.2 Achievements in Population Stabilization

2.2.1 India has also shown consistent improvement in population stabilization, with a decrease in decadal growth rates, both as a percentage and in absolute numbers. Eleven of the 20 large States for which recent Total Fertility Rates (TFR) is available, have achieved a TFR of at or below the replacement rate of 2.1 and three are likely to reach this soon. The challenge is now in the remaining six states of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Jharkhand and Chhattisgarh although the rates are declining but together, these six States account for 42% of the

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1 UN Intra-Agency Expert Group
2 Millennium Development Goals, India Country Report 2015, Ministry of Statistics and Programme Implementation
3 Statistical Report 2013, Registrar General of India
4 Annual Health Survey 2012-13
5 National Family Health Survey 2005-06
6 12th Plan Steering Committee Meeting 2012
7 Statistical Report 2013, Registrar General of India
national population and 56% of the annual population increase. National Population Policy (2002) lays out the strategic directions for population stabilization.\(^8\)

2.2.2 The persistent challenge on this front is the declining sex ratio. India has Child Sex Ratio (0-6 years) at 919 females per 1000 males which is worse in urban areas (905) compared to rural areas (923). States having Child Sex Ratio less than the national average are Haryana (834), Punjab (846), Jammu & Kashmir (862), Delhi (871), Maharashtra (894), Rajasthan (888), Gujarat (890), Uttarakhand (886), Uttar Pradesh (902), Himachal Pradesh (909) and Madhya Pradesh (918). Similar to most state averages, the sex ratio shows wide intra state variations. Haryana with a state average of 834 masks the wide disparity between the districts of Jhajjar (774) and Mewat (903).\(^9\)

2.3 Burden of Disease

2.3.1 India is currently experiencing a rapid health transition. There is an unfinished agenda of infectious diseases, nutritional deficiencies, safe motherhood as well as the escalating epidemic of non-communicable diseases (NCDs) and accidents/injuries. Overall, communicable diseases contribute to 37% of the entire disease burden. Non-communicable diseases (53%) and injuries (10%) now constitute the bulk of the country’s disease burden.\(^10\)

2.3.2 All the diseases for which national programmes provide universal coverage have been declining. The communicable diseases addressed by national health programmes include three chronic diseases - HIV, TB and leprosy in addition all vector borne diseases. Also, through immunization programme common childhood infections are significantly reduced. However, climate variability in India can exacerbate vector borne diseases as well as water borne diseases. Also, increased heat stress and air pollution would have health impact.\(^11\) Persistent levels of TB transmission and incidence of drug resistance are also new challenges. Although proportion of underweight children aged less than three years has a declining trend, 40% still suffer from malnutrition. This needs to be addressed on an accelerated footing with emphasis on caring practices. Anaemia in women has a multiplier effect through birth of low birth weight babies which affects the mental and physical growth in children. The present policy and implementation lacks focus on a systematic approach to address heterogeneity in micronutrient adequacy across regions in the country. Micronutrient malnutrition requires renewed focus on food fortification.

The focus of policy and its implementation need to encompass communicable diseases and non-communicable diseases which are presently not part of existing National Programmes in order to address the issues of morbidity and mortality.

2.3.3 The rising occurrence of Non-Communicable diseases in India is a public health challenge. WHO estimates that these diseases (with mostly preventable risk factors) account for 53% of all

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\(^8\)National Population Policy 2002
\(^9\) Census, 2011
\(^10\)WHO 2008, Mortality & Burden of Disease Estimates
\(^11\)Bush KF et.al. (2011) Impacts of Climate change on Public health in India; Environ Health Pers. 765-770
deaths and significant morbidity in India\textsuperscript{12}. Despite a policy intent in the form of National programme on Non-Communicable Diseases the efforts are nascent and need to be up scaled and integrated for diseases like diabetes, cardio-vascular diseases and stroke. Non-communicable diseases require renewed focus on prevention and management while integrating AYUSH.

2.3.4 The occupational health needs are largely unaddressed for both formal and informal sector. For instance, there are 263 million agricultural workers in India of which 45,000 workers die and 755,000 suffer various injuries annually while working in the field.\textsuperscript{13} This policy supports efforts to improve occupational health through inter-sectoral collaboration.

2.3.5 Like nutrition, adolescent health also has an inter-generational effect. WHO (2002) estimated that more than 33\% of disease burden and 60\% of premature deaths in adults are associated with behaviors/conditions beginning in adolescence. Injuries and communicable diseases as prominent causes of disability and death in 10-14 years age group are being replaced by outcomes of sexual behaviors and mental health for 15-19 years age group. Intersectoral action is required to address the priority issues like nutrition, reproductive health, substance abuse, mental health and gender based violence in this age group. School Health Programme undertakes screening for disease, deficiency and disability amongst students aged 6-18 years through dedicated teams and convergence with Department of Education.

2.3.6 There has been a steady rise in mental illnesses in the country. According to a recent publication one in every four women and 10\% men suffer from depression in India reflected in 528\% rise in antidepressants market size between 2001 and 2014. There’s a shortfall of 8,500 psychiatrists, 6,750 psychologists, 22,600 psychiatric social workers and 2,100 psychiatric nurses and these needs can be addressed by family physicians only to some extent.\textsuperscript{14}

2.3.8 Increase in life expectancy has increased the requirement of geriatric care. The elderly (population above 60 years) comprises of 103.8 million or 8.6\% of total population and 8\% of these are confined to bed or home.\textsuperscript{15} In 2011, a national programme of health care delivery for the elderly has been initiated. Another related issue is the growing need of palliative care requiring culturally appropriate and cost effective community centered approach. Given the reality that there is a major natural or manmade disaster almost every year in India the disaster preparedness and response system needs further capacity development.

\textsuperscript{12} Non-communicable Diseases Country profiles- WHO (2011)
\textsuperscript{13} Data published by Indian Council of Agricultural Research
\textsuperscript{14} Depression: The Silent Epidemic, India Today March 2, 2015
\textsuperscript{15} Morbidity, Healthcare and Conditions of the Aged, NSSO 60\textsuperscript{th} Round, Ministry of Statistics and Programme Implementation, 2006.
2.4 Social Determinants of Health

2.4.1 This policy recognizes that there are causal links between health outcomes and social determinants of health\textsuperscript{16}. Health of the population is determined largely by lifestyle (50%) followed by biological and environmental factors (20% each)\textsuperscript{17} with health systems having a weight of 10%\textsuperscript{17}. Achievement of national health goals would require addressing all the social determinants (distal and proximal) in the context of rapid economic growth and changing life styles with a focus on most vulnerable and marginalized. This preventive aspect needs to be adequately addressed. As the impact of policies and programmes of non-health sectors on health manifest with a lag, it is necessary to take preemptive action by assessing the impact of existing and future programmes and policies in these sectors through the health lens.

2.5 Inequities in Health Outcomes

2.5.1 While acknowledging these achievements we need to be mindful of the fact that high degree of health inequity in health outcomes and access to health care services as evidenced by indicators disaggregated for vulnerable groups. High degree of inequity exists in health outcomes between and within states in India. Identifying the deprived areas/ vulnerable population groups (including sub-groups like LGBT) through disaggregated data is a first step to address the existing inequity in health outcomes between and within States in India.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>India</th>
<th>% difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>TFR (2013)</td>
<td>2.3 2.5 1.8</td>
<td>39% difference</td>
</tr>
<tr>
<td>Source: Statistical Report 2013, Registrar General of India</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMR (2013)</td>
<td>40 44 27</td>
<td>63% difference</td>
</tr>
<tr>
<td>Source: SRS Bulletin, 2014</td>
<td></td>
<td></td>
</tr>
</tbody>
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Even in states where overall averages are improving marginalized communities and poorer economic quintiles of the population especially in remote and tribal areas continue to fare poorly. For instance fully immunized children aged 12-23 months in Odisha were only 45% in scheduled tribes as compared to 62% for the state. Corresponding figures for skilled attendance stand at birth are 26% and 51%\textsuperscript{18}. There can be social issues restricting access to special subgroups like LGBT.

\textsuperscript{16} Report of Commission on Social Determinants of Health, WHO (2009)
\textsuperscript{17} Centre for Disease Control (CDC) Report 1996
\textsuperscript{18} UNICEF (2011) Situation of Children in India - A profile
Demarcating areas/populations with low coverage, is a precursor to identification and removal of barriers in the underserved areas/population. The Tanahashi framework for systemic bottlenecks analysis identified six key bottlenecks under the NRHM. These being (1) Limited availability of skilled human resources; (2) low coverage in marginalized communities with low skilled staff posting; (3) inadequate supportive supervision of front line workers; (4) low quality of training and skill building; (5) lack of focus on quality of services and (6) Insufficient IEC on key family practices. Some of these requiring policy consideration e.g. human resource; skill building and quality of services are addressed in this policy.

### 2.6 Concerns on Quality of Care

#### 2.6.1 The quality of care determines its effectiveness. For example though over 90% of pregnant women received one antenatal checkup, only about 69% received the mandatory three antenatal check-ups. Similarly for institutional delivery standard protocols are often not followed during labour and the postpartum period. Sterilization related deaths are often a direct consequence of poor quality of care. There are gaps in access to safe abortion services too, and in care for the sick neonate.

#### 2.6.2 Accreditation and certification through a voluntary process are nascent methods introduced to determine standards of a particular health care unit. Also, the Indian Public Health Standards (IPHS) revised in 2010, lays out the essential and desirable requirements for services, building, equipment, manpower, and drugs for sub-centres, PHCs, CHCs, and hospitals. For ethical practice and patient safety it is important that rules, standards and notifications are applied to all sectors uniformly.

### 2.7 Performance in Disease Control Programmes

India’s progress on communicable disease control is mixed. The most acclaimed success of this period is the elimination of polio. In Leprosy too there have been significant reductions, but after a reduction of an annual incidence of 120,000 cases, there is stagnation, with new infective cases and

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19 Strategic Approach to RMNCH+A in India, Ministry of Health and Family Welfare, 2013

20 Coverage Evaluation Survey (2009), All India Report, UNICEF
disabilities being reported. Kala-azar and Lymphatic filariasis are expected to decline below the threshold, but with blocks where the prevalence is above this threshold. In AIDS control, progress has been good with a decline from a 0.41% prevalence rate in 2001 to 0.27% in 2011- but this still leaves about 21 lakh persons living with HIV, with about 1.16 lakh new cases and 1.48 lakh deaths in 2011. In tuberculosis the challenge is a prevalence of close to 211 cases and 19 deaths per 100,000 population and rising problems of multi-drug resistant tuberculosis. Though these are significant declines from the MDG baseline, India still contributes to a significant percentage of global new case detection. In malaria there has been a significant decline, but there are also the challenges, of resistant strains developing and of sustaining the gains, in a disease known for its cyclical re-emergence and focal outbreaks. Viral Encephalitis, Dengue and Chikungunya are on the increase, particularly in urban areas and as of now we do not have effective measures to address them.

2.7.2 Performance in disease control programmes is largely a reflection of the strengths of the public health systems. Where there are sub-critical human resource deployment, weak logistics and inadequate infrastructure, all national health programmes do badly. This was one of the important reasons for the launch of the National Rural Health Mission, which was geared to strengthen health systems.

2.8 Developments under the National Rural Health Mission

The National Rural Health Mission (NRHM) led to a significant strengthening of public health systems. It brought in a workforce of close to 900,000 community health volunteers, the ASHAs, who aided in bringing the community closer to public services, improving utilization of services and health-seeking behaviors. The NRHM deployed over 18,000 ambulances for free emergency transport of a million patients monthly, added over 178,000 health workers to a public system that had depleted its workforce to sub-critical levels, provided cash transfers to over ten million pregnant women annually- empowering and facilitating them to seek free care in the institutions- and began to address infrastructure gaps. Across States, there were major increases in outpatient attendance, bed occupancy and institutional delivery. However, these developments have been uneven across public health facilities. Much of the increase in service delivery was related to select reproductive and child health services and to the national disease control programme. Further, States with better capacity at baseline were able to take advantage of NRHM financing sooner. Larger gaps in baselines and more time taken to develop capacity to absorb the funds meant that gaps between the desired norms and actual levels of achievement were relatively larger in high focus states. Inefficiencies in fund utilization, poor governance and leakages have further added to the problems in high focus states. Therefore there is a need for a differential strategy. Action on social determinants of health has been even weaker requiring renewed focus.

2.9 NRHM as an instrument for strengthening State health systems

The National Rural Health Mission was intended to strengthen State health systems to cover all health needs, not just those of the national health programmes. In practice, however, it remained confined largely to national programme priorities. While such a limited scope enabled progress in a
few indicators, this was inadequate strategy. Beyond a point, such selective facility development is neither sustainable nor efficient. For example female sterilization operations or surgery for Emergency Obstetrics Care is safest if performed in an operation theatre, that is functional throughout the year, and undertaken by professional teams with support systems that are in constant use. But if such operations are undertaken on a few days per year, in a camp mode or during an occasional emergency sustaining the quality of care for such sporadic events is much more difficult. Strengthening health systems for providing comprehensive care required higher levels of investment and human resources than were made available. The budget received and the expenditure thereunder was only about 40% of what was envisaged for a full re-vitalization in the NRHM Framework.

2.10 Urban Health

Rapid and unplanned urbanization has led to massive growth in the number of the urban poor population including migrants. This section of the population has poorer health outcomes due to adverse social determinants and poor access to health care facilities, despite living in close proximity to many hospitals - public and private. There is almost no arrangement for primary care in many cities and towns. The National Urban Health Mission (NUHM), sanctioned in 2013 has a strong focus on primary care especially for urban poor and vulnerable population. NUHM aims at strengthening primary health care- through additional ANMs, urban ASHAs, women’s health committees and a network of primary health centers and intersectoral convergence. However, substantial expansion of funding on a sustained basis is required to improve urban health.

2.11 Cost of Care and Efforts at Financial Protection

2.11.1 All services available under national programmes are free and universally accessed with fairly good rates of coverage. Thus India has one of the largest programmes of publicly financed ART drugs for HIV. All drugs and diagnostics in vector borne disease programmes, tuberculosis, leprosy, immunization programme and much of the maternity, newborn and infant care are free. Private markets so far have little contribution to make in most of these areas.

2.11.2 Yet, the failure of public investment in health to cover the entire spectrum of health care needs is reflected in the worsening situation in terms of costs of care and impoverishment due to health care costs. Many hospitalizations amongst the poor leads to catastrophic health expenditure and over 63 million persons are faced with poverty every year due to health care costs. In 2011-12, the share of out of pocket expenditure on health care as a proportion of total household monthly per capita expenditure was 6.9% in rural areas and 5.5% in urban areas. This led to an increasing number of households facing catastrophic expenditures due to health costs (18% of all households in 2011-12 as compared to 15% in 2004-05). Under NRHM free care in public hospitals was extended to a select set of conditions and for all other services, user fees especially for diagnostics

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22 Consumer Expenditure Survey, NSS 68th Round 2011-12
and “outside prescriptions” for drugs continued. Several essential services especially for chronic illness were only available at overcrowded district and medical college hospitals resulting in physical and financial hardship and poor quality of care. Innovative solutions to address chronic conditions can make services affordable, accessible and reduce the cost of care e.g. Information and communication technologies (ICTs) and e-health initiatives.

2.12 Publicly Financed Health Insurance

A number of publicly financed health insurance schemes were introduced to improve access to hospitalization services and to protect households from high medical expenses. Eight states introduced health insurance programmes for covering tertiary care need and over time as expenditures increased, many of these States (Andhra Pradesh, Karnataka, Tamilnadu, Maharashtra, etc.) moved to direct purchasing of care through Trusts and reserving some services to be delivered only through public hospitals. The Central Government under the Ministry of Labour & Employment, launched the Rashtriya Swasthya Bima Yojana (RSBY) in 2008. The population coverage under these various schemes increased from almost 55 million people in 2003-04 to about 370 million in 2014 (almost one-fourth of the population). Nearly two thirds (180 million) of this population are those in the Below Poverty Line (BPL) category. Evaluations show that schemes such as the RSBY, have improved utilization of hospital services, especially in private sector and among the poorest 20% of households and SC/ST households. However there are concerns such as low awareness among the beneficiaries about the entitlements and how and when to use the RSBY card. Another is related to denial of services by private hospitals for many categories of illnesses, and over supply of some services. Some hospitals, insurance companies and administrators have also resorted to various fraudulent measures, including charging informal payments. There have been reports of major increase in certain operations like hysterectomies in context of health insurance schemes following which modifications made in schemes like Arogyasri in Andhra Pradesh to avoid such excessive procedures. Schemes that are governed and managed by independent bodies have performed better than other schemes that are located in informal cells within existing departments or when managed by insurance companies. The insurance schemes vary widely in terms of benefit packages and have resulted in fragmentation of funds available for health care; especially selective allocation to secondary and tertiary care over primary care services. All National and State health insurance schemes need to be aligned into a single scheme and a single fund pool reducing fragmentation. The RSBY scheme has now been shifted to the Ministry of Health & Family Welfare, helping the State and Central Ministry move to a

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tax financed single payer system approach, thereby enabling comparative assessment of the relative cost per patient for alternative routes of financing, viz., purchase through insurance, direct purchase from private sector and from public sector, free care by public sector, etc to take the best decision for a given context.

2.13 Healthcare Industry

2.13.1 The private health care industry is valued at $40 billion and is projected to grow to $ 280 billion by 2020 as per market sources.\(^3^0\) The current growth rate of the healthcare industry, at 14% is projected to be 21% in the next decade. The private health care industry is complex and differentiated. It includes insurance and equipment, which accounts for about 15%, pharmaceuticals which accounts for over 25%, about 10% on diagnostics and about 50% is hospitals and clinical care.

2.13.2 The Government has invested heavily with an active policy in the last 25 years of building a positive economic climate for the health care industry. Amongst these measures are lower direct taxes; higher depreciation in medical equipment; Income Tax exemptions for 5 years for rural hospitals; custom duty exemptions for imported equipment that are lifesaving; Income Tax exemption for Health Insurance; and active engagement through publicly financed health insurance which now covers almost 27% of the population. Further forms of assistance are preferential and subsidized allocation of land that has been acquired under the Public Acquisitions Act, and the subsidized education for medical, nursing and other paramedical professional graduating from government institutions and who constitute a significant proportion of the human resources that work for the private sector; and the provision for 100% FDI. Indeed in one year alone 2012-13-as per market sources the private health care industry attracted over 2 billion dollars of FDI much of it as venture capital. For International Finance Corporation, the section of the World Bank investing in private sector, the Indian private health care industry is the second highest destination for its global investments in health. While recognizing that the growth of such industry brings in revenue through medical tourism and that it provides employment, there is a necessity and a rationale for the Government to intervene and to actively shape the growth of this sector for ensuring that it is aligned to its overall health policy goals, especially with regards to equity, access and financial protection. Private sector is expected to fulfill its mandatory obligations in return of myriad benefits described above which is objectively verifiable. There is also a need to ensure that excessive capitalization and overcrowding in a few cities does not lead to demands on public financing, and that the basic policy structure, especially as regards costs, standards and regulation is not unduly influenced by the requirements and perceptions of industry.

2.14 Private Sector in Health

2.14.1 The private sector today provides nearly 80% of outpatient care and about 60% of inpatient care.\(^3^1\)(By NSSO estimates as much as 40% of the private care is likely to be by informal unqualified

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\(^3^0\) Federation of Indian Chambers of Commerce and Industry (FICCI) Report (2010)

\(^3^1\) National Sample Survey Organization (NSSO) Health and Morbidity Survey 2004-05
providers). 72% of all private health care enterprises are Own-Account-Enterprises (OAEs), which are household run businesses without regular hiring of a worker. But over time OAEs are declining and the number of medical establishments and corporate hospitals is rising. There are major ongoing efforts to organize such OAEs within the corporate sector and to regulate these by the Government. Often for OAEs and smaller medical establishments the main grounds for engagement are not financial partnerships with government, but skill up-gradation, referral support, sharing information of public health importance and improved clinical quality for effectiveness in public health priority areas.

The quality and rationality of care currently provided by the private medical sector is variable. There is evidence of supplier induced demand and lack of standard treatment practices, leading to aberrations such as unnecessary injections, irrational treatment regimes and excessive medications being provided in the Private medical sector.32

2.14.2 In terms of comparative efficiency, public sector is value for money as it accounts for less than 30% of total expenditure, but provides for about 20% of outpatient care and 40% of inpatient care.33 This same expenditure also pays for 60% of end-of-life care (RGI estimates on hospital mortality), and almost 100% of preventive and promotive care and a substantial part of medical and nursing education as well.

2.15 Realizing the Potential of AYUSH services
The implementation of National Policy on Indian Systems of Medicine and Homeopathy adopted in 2002, by Department of AYUSH and through NRHM led to phased integration of ISM with health delivery systems enabling considerable expansion of AYUSH services. A National AYUSH Mission has been launched for overall strengthening of AYUSH network in the public sector with focus on AYUSH services, development of infrastructural facilities of teaching institutions, improving quality control of drugs, capacity building, and community based preventive and promotive interventions. In addition, there is need to recognize the contribution of the large private sector and not-for-profit organizations providing AYUSH services, conducting research for growth of the knowledge base of the AYUSH systems and their services. The contribution of several organizations across the country is also visible in documenting, validating and promoting home and community based traditional practices and special knowledge held by various population groups e.g. tribes, thereby empowering the marginalized groups. Globally there has been the emergence of integrative medicine as a new frontier and India has the potential to become a world leader in this sphere, given adequate support for research and institution building.

2.16 Human Resource Development
The last decade has seen a major expansion of medical, nursing and technical education e.g. in nursing this has led to 1050 ANM courses, 1541 GNM courses, 1160 graduate nursing schools, and 388 post-graduate nursing schools being set up. Similar expansion in medical colleges, AYUSH institutions, dental colleges and pharmacy education has occurred. Though even further expansion

33 National Sample Survey Organization (NSSO) Health and Morbidity Survey 2004-05
is needed and planned for, there is a need to ensure that the outputs of these institutions meet the needs of orientation to rural services with optimal skill sets, thereby reducing the need for extensive in-service training. The challenge is to guide the expansion of educational institutions to provide skilled health workers to where they are needed most, and with the necessary skills. It may be noted that the huge human resource deficit in public and especially rural services is not only because of inadequate production but also conditions of work and remuneration.

2.17 Health Research
2.17.1 The Department of Health Research established in 2007 delivers through the research institutions under the Indian Council of Medical Research and through strengthening of research support to Medical Colleges. There have been significant contributions made by the Department, but modest funding of less than 1% of all public health expenditure has resulted in limited progress. Research presently is largely confined to medical field and needs expansion to encompass areas of health systems, services and policy. Increase in government funded health research and providing fiscal incentives to private sector for medical research on identified issues is required. The report of the Committee that examined the functioning of the ICMR in 2012, and the report of the Working Group constituted for the 12th Plan can guide policy in this area.

2.17.2 India’s strengths in AYUSH can also be leveraged for becoming a world leader in drug discovery as also in integrative medicine. This would need investment in creating institutional structures for documentation, validation and accreditation of AYUSH systems.

2.18 Regulatory Role of Government
The Government’s regulatory role extends to the regulation of drugs through the CDSCO, the regulation of food safety through the office of the Food Safety and Standards Authority of India, support to the regulation of professional education through the four professional councils and the regulation of clinical establishments by the National Council for the same. Progress in each of these areas has been challenging. Some of the challenges relate to institutional strengthening and also the mechanisms of institutional governance, and some of the latter require amendments to the laws. Regulation of drug pricing is under the Department of Pharmaceuticals and this has been playing an active and effective role in monitoring prices and taking actions. Reforms in each of these areas, but especially in professional councils and clinical establishments is also facing resistance from certain stakeholders and will require considerable political leadership and public support to implement these reforms. There are also genuine concerns that it would bring back “license raj” the unnecessary and inefficient Government interference in private sector growth. But clearly as private industry grows at a massive pace, and as this is an area touching upon the lives and health of its population the Government has to find ways to move forward on these responsibilities.

2.19 Investment in Health Care
2.19.1 Despite years of strong economic growth and increased Government health spending in the 11th Five Year plan period, the total spending on healthcare in 2011 in the country is about 4.1% of
Global evidence on health spending shows that unless a country spends at least 5–6% of its GDP on health and the major part of it is from Government expenditure, basic health care needs are seldom met. The Government spending on healthcare in India is only 1.04% of GDP which is about 4% of total Government expenditure, less than 30% of total health spending. This translates in absolute terms to Rs. 957 per capita at current market prices. The Central Government share of this is Rs. 325 (0.34% GDP) while State Government share translates to about Rs. 632 per capita basis at base line scenario. Perhaps the single most important policy pronouncement of the National Health Policy 2002 articulated in the 10\textsuperscript{th}, 11\textsuperscript{th} and 12\textsuperscript{th} Five Year Plans, and the NRHM framework was the decision to increase public health expenditure to 2 to 3% of the GDP. Public health expenditure rose briskly in the first years of the NRHM, but at the peak of its performance it started stagnating at about 1.04% of the GDP. The pinch of such stagnation is felt in the failure to expand workforce, even to train and retain them. This reluctance to provide for regular employment affects service delivery, regulatory functions, management functions and research and development functions of the Government.

2.19.2 Though there is always space to generate some more value for the money provided, it is unrealistic to expect to achieve key goals in a Five Year Plan on half the estimated and sanctioned budget. The failure to attain minimum levels of public health expenditure remains the single most important constraint. While it is important to recognize the growth and potential of a rapidly expanding private sector, international experience (as evidenced from the table below) shows that health outcomes and financial protection are closely related to absolute and relative levels of public health expenditure.

2.19.3 Of the developing countries in the table, two nations, Brazil and Thailand, are considered to have achieved close to universal health coverage. Thailand has almost the same total health expenditure as India but its proportion of public health expenditure is 77.7% of total health expenditures (which is 3.2% of the GDP) and this is spent through a form of strategic purchasing in which about 95% is purchased from public health care facilities which is what gives it such a high efficiency. Brazil spends 9% of its GDP on health but of this public health expenditure constitutes 4.1% of the GDP (which is 45.7% of total health expenditure). This public health expenditure accounts for almost 75% of all health care provision. It would be desirable but ambitious if India could aspire to a public health expenditure of 4% of the GDP, but most expert groups have estimated 2.5% as being more realistic. At such levels of expenditure, “purchasing,” would have to be mainly from public providers for efficient use of resources with purchasing from private providers only for supplementation.

34 Planning Commission of India (2013) 12\textsuperscript{th} Five Year Plan (2012-2017)
### Table-2: Health Outcomes and Health Expenditures in Selected Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Health Exp per capita (USD) - 2011</th>
<th>Total Health Exp as % of GDP – 2011</th>
<th>Govt. Health Exp as % of Total Health Exp - 2011</th>
<th>Life Expectancy at birth (years) 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>$62</td>
<td>3.9%</td>
<td>30.5%</td>
<td>66</td>
</tr>
<tr>
<td>Thailand</td>
<td>$214</td>
<td>4.1%</td>
<td>77.7%</td>
<td>75</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>$93</td>
<td>3.3%</td>
<td>42.1%</td>
<td>75</td>
</tr>
<tr>
<td><strong>BRICS Countries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>$1119</td>
<td>8.9%</td>
<td>45.7%</td>
<td>74</td>
</tr>
<tr>
<td>China</td>
<td>$274</td>
<td>5.1%</td>
<td>55.9%</td>
<td>75</td>
</tr>
<tr>
<td>Russia</td>
<td>$803</td>
<td>6.1%</td>
<td>59.8%</td>
<td>69</td>
</tr>
<tr>
<td>South Africa</td>
<td>$670</td>
<td>8.7%</td>
<td>47.7%</td>
<td>59</td>
</tr>
<tr>
<td><strong>OECD Countries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>$8,467</td>
<td>17.7%</td>
<td>47.8%</td>
<td>79</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$3,659</td>
<td>9.4%</td>
<td>82.8%</td>
<td>81</td>
</tr>
<tr>
<td>Germany</td>
<td>$4,996</td>
<td>11.3%</td>
<td>76.5%</td>
<td>81</td>
</tr>
<tr>
<td>France</td>
<td>$4,968</td>
<td>11.6%</td>
<td>76.8%</td>
<td>82</td>
</tr>
<tr>
<td>Norway</td>
<td>$9,908</td>
<td>9.9%</td>
<td>85.1%</td>
<td>82</td>
</tr>
<tr>
<td>Sweden</td>
<td>$5,419</td>
<td>9.5%</td>
<td>81.6%</td>
<td>82</td>
</tr>
<tr>
<td>Denmark</td>
<td>$6,521</td>
<td>10.9%</td>
<td>85.3%</td>
<td>80</td>
</tr>
<tr>
<td>Japan</td>
<td>$4,656</td>
<td>10%</td>
<td>82.1%</td>
<td>84</td>
</tr>
</tbody>
</table>

### 3. Goal, Principles and Objectives

#### 3.1 Goal
The attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.

The policy recognizes the international efforts now underway for Sustainable Development Goals (SDG). An indicative list of time bound quantitative goals aligned to ongoing national efforts as well as the global strategic directions is detailed at the end of this Section.

#### 3.2 Key Policy Principles

I. **Professionalism, Integrity and Ethics**: The health policy commits itself to the highest professional standards, integrity and ethics to be maintained in entire system of health care delivery in the country supported by a credible, transparent and responsible regulatory environment.

II. **Equity**: Reducing inequity would mean affirmative action to reach the poorest and minimizing disparity on account of gender, poverty, caste, disability, other forms of social exclusion and geographical barriers. It would imply greater investments and financial
protection for the poor who suffer the largest burden of disease. Also principle of portability is embedded for all to enhance access and coverage.

III. **Affordability:** As costs of care rise, affordability, as distinct from equity, requires emphasis. Household health care expenditures exceeding 10% of its total monthly consumption expenditures or 40% of its monthly non-food consumption expenditure, designated catastrophic health expenditure are unacceptable.

IV. **Universality:** Systems and services are designed to cater to the entire population- not only a targeted sub-group including those with disability or special groups like LBTG. Care would be taken to prevent exclusions on social, economic or current health status grounds.

V. **Patient Centered & Quality of Care:** Health Care services would be effective, safe, and convenient, provided with dignity and confidentiality with all facilities across all sectors being assessed, certified and incentivized to maintain quality of care.

VI. **Accountability:** Financial and performance accountability, transparency in decision making, and elimination of corruption in health care systems, both in the public systems and in the private health care industry, would be essential.

VII. **Inclusive Partnerships:** The task of providing health care for all cannot be undertaken by Government, acting alone. It would require the participation of all non-health ministries and communities – who view this participation as a means and a goal, as a right and as a duty. It would also require expanding and strengthening the partnerships with academic institutions, not for profit agencies and with the commercial private sector and health care industry to achieve these goals.

VIII. **Pluralism:** Patients who so choose and when appropriate, would have access to AYUSH care providers based on validated local health traditions. These systems would also have Government support, including in research, and supervision to develop and enrich their contribution to meeting the national health goals and objectives through integrative practices.

IX. **Decentralization:** For ensuring responsiveness and greater participation, increasing transfer of decision making to as decentralized a level as is consistent with practical considerations and institutional capacity would be promoted. This would be linked with enhancing community participation in health planning processes.

X. **Dynamism and Adaptiveness:** constantly improving dynamic organization of health care based on new knowledge and evidence with learning from the communities and from national and international knowledge partners is designed.

### 3.3 Objectives

3.3.1 Reinforcing trust in Public Health Care System: Strengthening the trust of the common man in public health care system as predictable, rational, efficient, client friendly affordable and effective with a comprehensive package of services and products that meet immediate health care needs of most people.

3.3.2 Improve population health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided by the public health sector.
3.3.3 Achieve a significant reduction in out of pocket expenditure due to health care costs and reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment.

3.3.4 Assure availability of free, comprehensive primary health care services, as an entitlement, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable and non-communicable and occupational diseases in the population.

3.3.5 Ensure improved access and affordability of secondary and tertiary care services through a combination of public hospitals and well measured strategic purchasing of services in health care deficit areas from accredited private care providers, especially the not-for profit providers.

3.3.6 Influence the operation and growth of the private health care industry and medical technologies to ensure alignment with public health goals, and enable contribution to making health care systems more effective, efficient, rational, safe, affordable and ethical. Strategic purchasing by the government to fill critical gaps in public health facilities would create a demand for private health care industry, in alignment with the public health goals.

3.4 Specific Quantitative Goals and Objectives

The indicative quantitative goals and objectives aligned to major thrust of this policy and to achieve sustainable development are proposed under three broad components viz. health status, health systems performance and health system inputs.

3.4.1 Health Status and Programme Impact

3.4.1.1 Life Expectancy and healthy life

<table>
<thead>
<tr>
<th>Life Expectancy and healthy life</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Increase Life Expectancy at birth from 66.8 to 70 by 2025</td>
</tr>
<tr>
<td>b. Establish regular tracking of Disability Adjusted Life Years (DALY) Index as a measure of burden of disease and its trends by major categories</td>
</tr>
<tr>
<td>c. Reduction of TFR to 2.1 at national and sub-national level</td>
</tr>
</tbody>
</table>

3.4.1.2 Mortality by Age and/or cause

<table>
<thead>
<tr>
<th>Mortality by Age and/or cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reduce Under five mortality by one-third from current levels by 2025 and MMR from current levels to less than 90 by 2025</td>
</tr>
<tr>
<td>b. Reduce neo-natal mortality and still birth rate to “single digit” by 2030.</td>
</tr>
</tbody>
</table>
3.4.1.3 Reduction of disease prevalence/ incidence

Reduction of disease prevalence/ incidence

a. Achieve global target of 2020 which is also termed as target of 90:90:90, i.e., 90% of all people living with HIV know their HIV status, 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy viral suppression Achieve and Maintain Elimination status of leprosy, kala-azar and lymphatic filariasis in endemic pockets

b. To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases to reach elimination status by 2025

c. To reduce the prevalence of blindness to 0.25/ 1000 by 2025 and disease burden by one third from current levels

d. To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025

3.4.2 Health Systems Performance

3.4.2.1 Coverage of Health Services

Coverage of Health Services

a. Increase utilization of public health facilities by 50% from current levels by 2025

b. Antenatal care coverage to be sustained above > 90% and skilled attendance at birth above 80%

c. More than 90% of the newborn are fully immunized by one year of age

d. Meet need of family planning above 90% at national and sub national level

c. 80% of known hypertensive and diabetic individuals at household level maintain controlled disease status by 2025.

3.4.2.2 Cross Sectoral goals related to health

Cross Sectoral goals related to health

a. Relative reduction in prevalence of current tobacco use by 15% by 2020 and 30% by 2025.

b. Reduction of 40% in prevalence of stunting of under-five children

c. Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission)

d. Reduction of occupational injury by half from current levels of 334 per lakh agricultural workers by 2020

c. National/ State level tracking of selected health behaviours e.g. 150 minutes exercise amongst adults below 60 years

3.4.3 Health Systems strengthening related

3.4.3.1 Health finance

a. Increase health expenditure by Government as a percentage of GDP from the existing 1.1% to 2.5 % by 2020

b. Increase State Sector Health spending to > 8% of the budget by 2020

c. Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25%, by 2025.
3.4.3.2 Health Infrastructure and Human Resource

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Paramedics and doctors available as per GOI norm in high priority districts</td>
</tr>
<tr>
<td>b.</td>
<td>Population per community health volunteers as per GOI norm in high priority districts</td>
</tr>
<tr>
<td>c.</td>
<td>Target population per primary health care facility as per GOI norm in high priority districts</td>
</tr>
</tbody>
</table>

3.4.3.3 Health Management Information

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Establish/ strengthen the health surveillance system</td>
</tr>
<tr>
<td>b.</td>
<td>Review and act on Health consequences of non-health sector policies (e.g. WCD; social justice; environment, industries etc.)</td>
</tr>
<tr>
<td>c.</td>
<td>Establish integrated e Health system from PHC to Medical College level</td>
</tr>
</tbody>
</table>

4. Policy Directions

4.1 Ensuring Adequate Investment

4.1.1 The National Health Policy realizes that the full achievement of the goals and principles as defined would require an increased public health expenditure to 4 to 5% of the GDP. However, given that the NHP, 2002 target of 2% was not met, and taking into account the financial capacity of the country to provide this amount and the institutional capacity to utilize the increased funding in an effective manner, this policy proposes a potentially achievable target of raising public health expenditure to 2.5% of the GDP in a time bound manner with at least 40% of this coming from Central expenditures. At current prices, a target of 2.5% of GDP translates to Rs. 3800 per capita in a five year period. Firm commitment is made that not less than 70 per cent of the public resources will be directed towards primary health care facilities; 20 per cent towards secondary health care, and 10 per cent towards tertiary health care facilities.

4.1.2 Allocation of resources to states should be linked to state development indicators, fiscal and absorption capacity and performance as also financial indicators. Mechanism for monitoring of financial indicators such as out of pocket expenditure, and government spending on health would be put in place for allocation. The major source of financing would remain general taxation. With the projection of a promising economic growth, the fiscal capacity to provide this level of financing should become available. The Government would explore the creation of a health cess on the lines of the education cess for raising the necessary resources. Other than general taxation, this cess could mobilize contributions from specific commodity taxes- such as the taxes on tobacco, and alcohol, fatty, salty and sugary food with negative impact on health, from specific industries and innovative forms of resource mobilization from extractive industries. Funds available under CSR would also be leveraged for well-focused programmes aiming to address health goals.
4.2 Preventive and Promotive Health: addressing the wider social & environmental determinants of health

4.2.1 Given the multiple determinants of health, it is clear that a prevention agenda that addresses the social and economic environment requires cross-sectoral, multilevel interventions that involve sectors such as food and nutrition, education, safe drinking water and sanitation, housing, employment, industrial and occupational safety, welfare including social protection, family and community services, tribal affairs and communications.

4.2.2 This will require institutionalizing inter-sectoral coordination at national and sub national levels. Constitution of bodies that have representation from relevant non-health ministries will be considered for cross sectoral and inter-ministerial cooperation to optimize health outcomes influenced by non-health sectors. This is in line with the emergent international “Health In All” approach as complement to Health For All.

4.2.3 All sectors would need to be convinced that preventive and promotive health care approaches are not only a health gain but a first order economic gain as well and would be enabled to take ownership of making this health challenge their own challenge. Focus will be on individuals and families to prevent disease and promote good health at their own individual levels. This requires enabling environment for behavior change. There is much that individuals and families can do to prevent disease and promote good health at their own individual levels. But if the social and economic environment in which they exist – where they work, live and play, where they bring up their families, interact with the community and experience life – is not conducive to good health, the impact of individual behaviours may be severely limited.

4.2.4 Other than its own policy action and initiatives, the Government therefore has an obligation to build community support and capacity to enjoy good health, particularly among those who are most vulnerable and have the least capacity to make choices and changes in their lifestyle or living conditions that might improve and protect their health: the very young, the marginalized or socially excluded, the poor, labourmigrants, thosevulnerable to violence, the old, and the disabled. The Village Health Sanitation and Nutrition Committees and its urban equivalents that are a part of Local Government Institutions are a platform that must be strengthened and utilized for this purpose.

4.2.5 The policy identifies coordinated action on seven priority areas for improving the environment for health with measurable achievements through well thought out and financed institutional mechanisms. These include:

4.2.5.1 The Swachh Bharat Abhiyan: Its success would be measured by the reduction of water and vector borne diseases and declines in improperly managed solid waste.

4.2.5.2 Balanced and Healthy Diets: This would be promoted through action in Anganwadi centers and schools and would be measured by the reduction of malnutrition, reduction of micronutrient
deficiency and improved Food Safety. The Policy recommends judicious and responsible use of electronic and print media to create public awareness and action on the subject.

4.2.5.3 Addressing Tobacco, Alcohol and Substance Abuse: (NashaMuktiAbhiyan) This Policy fully endorses tobacco control on the lines outlined in COPTA 2003 and commitments under WHO-FCTC, Success would be judged in terms of measurable decreases in use of tobacco, alcohol and substance abuse.

4.2.5.4 YatriSuraksha: Deaths due to rail and road traffic accidents should decline through a combination of response and prevention measures that ensure road and rail safety. This concept could be expanded to include injuries on account of other causes.

4.2.5.5 NirbhayaNari- Action against gender violence ranging from sex determination, to sexual violence would be addressed through a combination of legal measures, implementation and enforcement of such laws, timely and sensitive health sector responses, and working with young men.

4.2.5.6 Reduced stress and improved safety in the work place, would include action on issues of employment security, preventive measures at the work place including adequate exercise and movement, and occupational health- and would strengthen understanding of occupational disease epidemiology and demonstrate measurable decreases.

4.2.5.7 Action would be taken on reducing indoor and outdoor air pollution and measured through decreases in respiratory disease especially in children, and other pollution related illnesses.

4.2.6 The policy articulates the need for the development of strategies and institutional mechanisms in each of these seven areas to synergize societal, individual and family level action to create a social movement for improving environment for health, traditional folk, electronic and print media with appropriate policy interventions will highlight these issues and popularize this Health in all approach as the SwasthNagrikAbhiyan- a social movement for health.

4.2.7 The role of the health sector would be to undertake evidence based advocacy within Government and in the media- which highlights the link between these social determinants and disease and the need for collective will to change these determinants. This would also require the development and use of indicators to measure the determinants and the disease outcomes and systems to measure such indicators. Preventive and Promotive Care has a two-way continuity with Curative care- an under recognised reality that this policy recognizes and builds upon. Also the benefits of prevention are most visible when the burden of costs is undertaken by the State.

4.2.8 Some aspects of disease prevention and health promotion are specific health care services. Currently it includes immunization, ante-natal care, school health programmes and limited health education and health communication efforts. Besides extending the coverage and quality of
existing package of services, this policy recommends expansion of its scope to include early detection and response to early childhood development delays and disability, adolescent and sexual health education, behavior change with respect to tobacco and alcohol use, screening, counseling for primary prevention and secondary prevention for common chronic illness—both communicable and non-communicable. Preventive and promotive care has a two-way continuity with Curative Care—an under recognized reality that this policy recognizes and builds upon.

4.2.9 Of these programmes, the one that would require much greater emphasis, investment and action is in school health—by incorporating health education as part of the curriculum and by promoting hygiene and safe health practices within the school environs and by acting as a site of primary health care. The school noon meal programme and the food supplementation at the anganwadi must both be leveraged to achieve better school attendance, learning outcomes and the reduction of child malnutrition to the extent possible.

4.2.10 Occupational Health also requires greater emphasis. Work-sites and institutions must be encouraged and monitored to ensure safe health practices and accident prevention, and provide preventive and promotive services. Diseases that are more prevalent in certain occupational groups must have corresponding preventive action and linkages with primary care facilities which in turn are linked to the specialist services needed. Institutional mechanisms to monitor the progress should be established.

4.2.11 Delivery of such an expanded range of services requires firstly moving away from highly selective primary care approaches to a strengthened comprehensive primary care approach (as outlined in the next section), linked to and supported by secondary and tertiary care facilities, use of appropriate ICT tools and wider involvement of communities and multiple stakeholders. Nurtured for nearly a decade now, the nearly one million ASHAs serving as Community Health Workers in rural and urban areas would have significant role in disease prevention and health promotion. ASHA will also be supported by other frontline workers like health workers (male/female) to undertake primary prevention for non-communicable diseases, provide community or home based palliative care and mental health services through health promotion activities. These workers would get support from local self-government, and Village Health Sanitation and Nutrition Committee.

4.2.12 Promotion of Yoga at the work-place, in the schools and in the community would also be an important form of health promotion that has a special appeal and acceptability in the Indian context.

4.2.13 Wider involvement of stakeholders includes elected local governments, local communities and community based organizations like self-help groups, students of schools and colleges, non-government organizations, professional organizations, and corporate social responsibility mechanisms. Taken together these could constitute a 'Social Movement for Health' with mass media providing necessary momentum.

4.2.14 For action on determinants of health, developing capacities and processes for 'Health Impact Assessment' of existing and emerging policies of key non-health departments that directly or indirectly
impact health would be taken up. Establishing systems that seek concurrence of Department of Health in new policies of key non-health sectors would also be prioritized. This policy recognizes that actions for improving population health are required by ministries of Agriculture, Labor, Education, Industries, Road and transport, Human Resource and Urban & Rural development etc. and aims to strengthen cross sectoral collaboration through “Health in all Policies” approach and inter-ministerial mechanisms. To address social determinants of health effectively on ground by enforcing regulatory provisions, an empowered public health cadre is required.

4.2.15 The policy also recommends the setting up of seven Task Forces’ for formulation of a detailed ‘Preventive and Promotive Care Strategy’ in each of the seven priority areas for preventive and promotive action outlined above, and to set the indicators and the targets and mechanisms for achievement in each of these areas.

4.3 Organization of Public Health Care Delivery

A. The approach is to provide free, assured and comprehensive primary care services through a network of public primary care health centers with viable two way linkages with secondary and tertiary care facilities. In addition, as a short term measure there will be strategic purchase of secondary and tertiary care services preferably from public sector hospitals followed by from not-for profit private sector and then from the commercial private sector in underserved areas. In the long run, the policy envisages to have fully equipped and functional public sector hospital in these areas to meet secondary and tertiary health care needs of population.

B. Access to services remains the key issue for most of India’s poor- with very limited services being available, especially in rural and remote areas and urban slums. Targeted investments in under serviced areas in building health infrastructure, human resources and augmenting supplies will help address issues of inequities and access.
 Organization of Health Care Services: The 7 Key Policy Shifts

| 1. In Primary Care: From a **Selective Care** that is fragmented from secondary/tertiary care to **Assured Comprehensive care** that has continuity with higher levels |
| 2. In Secondary and Tertiary Care: From an input oriented, budget line financing to an output based strategic purchasing. |
| 3. In Public Hospitals: From User Fees & Cost Recovery Based Public Hospitals to Assured Free Drugs, Diagnostic and Emergency Services to all in Public Health Facilities: |
| 4. In Infrastructure and Human Resource Development: From normative approaches in their development to targeted approaches to reach under-serviced areas. |
| 5. In Urban Health: From token under-financed interventions to on-scale assured interventions that reach the Urban Poor and establish linkages with national programmes: Scaling up of the interventions with focus on the urban poor and achieving convergence among the wider determinants of health. |
| 6. In National Health Programmes - Integration with health systems for effectiveness, and contributing to strengthening health systems for efficiency |
| 7. In AYUSH services: From Stand-Alone AYUSH to a three dimensional mainstreaming. |

C. Free Drugs, Free diagnostics and free emergency care services in public hospitals, free emergency response and patient-transport systems would be the norm, thus providing a high degree of access and financial protection at secondary and tertiary care levels. Public Hospitals and the network of public health care facilities are to be perceived as a form of tax based insurance with a single payer, where the public hospitals are providing cashless services in return for pre-payment as happens in any standard insurance package.

D. Urban health is a growing challenge. About 31% of our population lives in urban areas and 17% of this lives in slums. Despite supposed proximity to health care facilities their access to such facilities is severely limited. Weak fiscal and management capacity of urban local bodies and inadequate sub-optimal public health facility network have also to be addressed. The major shift needed therefore is to scale up this programme to cover the entire urban population within the next five years- and this requires adequate financing on a sustained basis to match the requirement.

E. Priority setting in health care should be based on our core values as a nation and informed by technological knowledge of both disease prevalence and feasibility of interventions. The health priorities, which are included in national programmes, like Maternal and child mortality reduction, Polio eradication, TB and Leprosy elimination represent important social goals and core values of the nation. Whereas markets in health care cannot and do not and perhaps will not address many of these priorities, because they are not value for money propositions in the logic of markets, public health systems must gear up to address these goals. Even for the health security of the nation, as brought out in our response to disasters and even in our recent preparedness against Ebola virus, public health care systems must retain a certain excess in terms of health infrastructure, human resource and advanced technological capacity that can be mobilized in times of crisis. However all national health programmes require, that for effective implementation they are well integrated with state
health systems and for efficient functioning must contribute to strengthening state health systems meaningfully.

F. India has a legacy of pluralism in health care, with many indigenous and alternative approaches to health and medical care also contributing to the health and well-being of its population. This is a legacy that the nation is proud of, and which it will continue to build on and mainstream. Mainstreaming under the NHP 2015, would have three very different dimensions that would run concurrently-firstly at the level of knowledge where increasing validation and evidence and research leads to its growth as part of a common fund of science and technology, secondly in being available at all major public health care facilities so that the population have easy access and can make an informed choice of the system of care they want to follow, and thirdly to ensure that the considerable existing human resource and infrastructure gets the requisite conditions to provide quality services, which includes medicines and equipment as well as an enabling environment to practice their system with confidence, even while recognizing the strengths of other systems and encouraging cross-referral. Supporting validated practices of self-care by communities and households would form the community level component of this mainstreaming and empower people to participate in improving their own health.

4.3.1 Primary Care Services & Continuity of Care

4.3.1.1 Health Care Service delivery would be built on the bedrock of high quality comprehensive primary health care services that are made universally accessible, that are free and that are provided as close to where people live and work as is feasible.

4.3.1.2 Hitherto primary care has been very selective, covering less than 20% of primary health care needs. This has made primary care less responsive to felt health care needs and contributed in no small measure to the image of the under-performing public health care system. Primary Health Care is necessarily comprehensive- addressing primary care for all of reproductive and child health, communicable, and non-communicable diseases and accidents and injuries through appropriate health communication, technologies and care provision. Comprehensive primary health care package will also include geriatric health care, palliative care and rehabilitative care services. To denote this important policy change, facilities which start providing the larger package of comprehensive primary health care will be called health and wellness centers.

4.3.1.3 Comprehensive Primary health care is value for money and would reduce morbidity and mortality greatly at much lower costs to the system and to the individual than any other approach, and would significantly reduce the need for secondary and tertiary care.

4.3.1.4 Comprehensive Primary care must be available as the entitlement that we are in a position to assure at this level of social and economic development. To make this entitlement a reality, every family would have a health card that links them to a primary care facility and be eligible for this package of services anywhere in the country. The Village Health, Sanitation and Nutrition
Committees supervised by the panchayats would ensure that there is no exclusion and that locally felt health priorities are included. Community based monitoring will be strengthened to ensure continuous feedback on equity, access and quality of services.

4.3.1.5 The Organization of Primary care systems depend upon the establishment of a network of primary health facilities, which are adequately staffed, skilled and supported to perform their functions effectively and efficiently. In difficult to reach and remote areas health centres could be established on geographical norms rather than population norms. This therefore requires a matching human resource development strategy, a logistics support system and a referral back up. It involves an up-gradation of the existing health sub-centres and orientation of all primary health centers to provide this comprehensive set of preventive, promotive, curative and rehabilitative services. The assured services of this level would include AYUSH elements as appropriate for this level of care as well as support for validated local home and community based practices.

4.3.1.6 Most elements of primary care can be delivered by suitably trained and authorized AYUSH doctor, Nurse practitioners, pharmacists or paramedical supported by ASHA, rural practitioners, health workers and anganwadi workers in rural and urban areas. For chronic illness, a doctor/specialist may have to initiate the treatment, but most elements of the continuity of care can be provided by the primary care team. The use of ICT tools including tele-medicine would support the primary care teams.

4.3.1.7 A system of individual and team incentives would support achievement, documentation and verification of population based primary care services including registration, screening for specific diseases, full treatment compliance and timely referrals for complications.

4.3.1.8 Careful leveraging of the potential in telemedicine/ICT for two way systemic linkages between primary care on one hand and secondary and tertiary care on the other would ensure continuity of care. The public health system would put in place a gate keeping mechanisms at primary level in a phased manner. accompanied by an effective feedback and follow-up mechanism.

4.3.2 Secondary Care Services

4.3.2.1 Our aspirational goal is that all of secondary care, redefined to include a considerable part of what happens currently only in medical college hospitals should now become available within a standard district- and as a first step to a region or cluster of districts with a population of about 2 to 5 million. Basic secondary care services such as cesarean section and neonatal care would be made available at least at sub-district level, in a cluster of a few blocks.

4.3.2.2 There are two policy implications for such an aspiration, viz., to have at least 1000 beds per million population (1 per 1000) and to have specialists skills available withing the district. The policy therefore aims to have at least one bed per thousand population distributed in such a way that it is accessible within an hour- travel time. This implies an efficient emergency transport system. The policy also aims that ten categories of what are currently specialist skills are available.
within the district and four or five of these at sub-district levels by strengthening the district hospital and a well-chosen, well located set of sub-district hospitals.

**4.3.2.3.** Part of the public investment, especially that going to core infrastructure and a part of human resources and supplies would be through budgetary allocation, but an increasing part would be through reimbursement for services provided- or in other words a resource allocation that is responsive to quantity, diversity and quality of caseloads provided care. Purchasing care from private hospitals to close critical gaps in provisioning of services after due diligence for poorly served areas is a short term strategy till public systems are strengthened.

**4.3.2.4** Strategic purchasing refers to the Government acting as a single payer- purchasing care from public hospitals and private providers as part of a strategic plan for district health systems development. This can bring about efficiencies in use of funds- when services delivered are very skewed across facilities and where there are complex local needs of equity and marginalization. Strategic purchasing would give preference to public facilities since requirements and needs of national health programmes may not be commercially remunerative and since there is need to retain adequate reserve capacity for public health emergencies. This policy affirms that public facilities would remain the focal point in the healthcare delivery system and services in the public health facilities would be expanded from current levels.

**4.3.2.5** Strategic purchasing is also an opportunity to provide stewardship to the private sector- and encourage growth to bridge critical service gaps. Norms for strategic purchasing should be responsive to the nature of provider; different for not-for-profit providers as compared to for-profit provider. A responsive and strong regulatory framework should guide purchasing of care from private sector so that challenges of quality of care, cost escalations and impediments to equity are addressed effectively. Private health facilities availing any benefits from the Government like concessional land or tax concessions, should make public disclosure of the services offered in lieu of the benefits availed from the Government.

**4.3.2.6** Development of such secondary care capacity also means certain obligations as regards HR, especially the challenge of finding the necessary specialist skills and in the organization of more comprehensive facility development that can assure at least all common surgical care and emergency medical services. A special scheme to develop this capacity across public and private hospitals that operate in large number of districts where there is currently no capacity at all- would be one important corollary of this scheme. This is discussed further in the section on human resources for health.

**4.3.3 Re-orienting Public Hospitals**

**4.3.3.1** An important change in policy mind-set is to view public hospitals as part of a tax financed single payer health care system where the care is cost efficient and is viewed as pre-paid care and not as free care. The other corollary of viewing public services- not as free, but as pre-paid is that quality of care would become an imperative- and all public facilities must have periodic
measurements and certification for level of quality that is financed and incentivized to meet and retain quality standards.

4.3.3.2 Public hospital would provide universal access to a progressively wide array of free drugs and diagnostic with flexibilities for States to add/delete services to suit their context. In terms of services other than services covered under national health programmes, public health systems should be able to provide all emergency health services. Affirmative action through cash transfers, help-desks, rest houses, half way homes, hospices, etc. would be required for ensuring that the poorest two quintiles are able to access public health care adequately. The policy seeks to eliminate the risks of inappropriate treatment by maintaining adequate standards of diagnosis and treatment. There is a need for an information system with comprehensive data on services available and utilized not only in public but also in private sector.

4.3.4 Closing Infrastructure and Human Resource/Skill Gaps

4.3.4.1 The policy duly acknowledges the roadmap of the 12th Five Year Plan for managing human resources for health. The main challenge in closing human resources and skill gaps is in areas with highest level of health inequity. There would be a conscious policy to identify districts and blocks which have the larger gaps for development of infrastructure and deployment of additional human resources.

4.3.4.2 In areas where there is high density of population but there are also large gaps in terms of density of facilities and human resources for primary care- the policy would simply be to add on more human resources in the given infrastructure rather than more infrastructure. In urban areas operating the infrastructure in two shifts may also enable higher access- provided the human resources for primary care never falls below the population to provider ratio. In facilities, which have much higher case-loads, the human resources deployed must be proportionately higher to ensure quality of care.

4.3.4.3 In secondary hospitals the policy approach would be to add more beds and staff to match caseloads if distance is not a barrier to access, rather than fragment the available specialists and medical and nursing staff across several facilities. But where distance is a barrier, new hospitals of the standard CHC model- with 30 beds would have to be strengthened with necessary skilled staff including specialist skills. However if hospitals become very large- then also they could become inefficient and new hospitals would need to be constructed beyond a threshold level of say 1000 beds. A minimum population to bed ratio should be at least 1000 beds per million population- with corresponding human resources and equipment to match. Any additional infrastructure or HR financing would be linked to increases in outpatient and inpatient attendance and utilization of key services in a measurable manner.

4.3.4.4 Another policy objective would be measurable improvements in quality of care. For public health care facilities, the strategy would be to ensure that every health care facility is measured and scored for quality, and certified and incentivized when it achieves a certain minimum score. Quality measurements would include in the least clinical quality of care, as well as patient safety, comfort
and satisfaction. Quality Improvement would require technical support and capacity building as well as institutional arrangements for measurement and certifying. In private sector accreditation process and quality of care provided would necessarily abide by criteria under the Clinical Establishments Act (2010). The policy recommends that Government of India should persuade States to adapt the Act using appropriate constitutional mechanisms.

4.3.4.5 One major area of concern in district health care services is access to blood and blood safety. Expanding the network of blood banks and ensuring that there is improved access to safe blood shall be one of the important components of improving service delivery.

4.3.5 Urban Health Care

4.3.5.1 National Health Policy prioritizes addressing the primary health care needs of the urban population with special focus on poor populations living in listed and unlisted slums, other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants. The National Urban Health Mission (NUHM) would need to be strengthened and adequately financed to achieve this while National Rural Health Mission would cover smaller cities and towns with populations less than 50,000.

4.3.5.2 Strategy for an appropriate urban health system would lead to strengthening of the existing primary public health systems & establishing new facilities for the unserved & underserved population. Given the large presence of private sector in urban areas there is considerable scope for developing sustainable models of partnership with for profit and not for profit sector for health care delivery. Peri-urban areas would also be addressed under NUHM.

4.3.5.3 Urban health is dependent on the urban environment- and therefore the policy would emphasize measures of reduction of air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress. An important focus area of the urban health policy will be achieving convergence among the wider determinants of health. The approach to achieving this is two pronged. Firstly, through a major effort at behavior change as exemplified by the Swachh Bharat Abhiyan and secondly through modern technological and social approaches to public services and appropriate regulatory measures to address urban health determinants. In addition, building synergies with other urban development schemes is advocated.

4.3.5.4 Addressing the major prevalence of non-communicable diseases such as hypertension and diabetes through planned early detection, and better secondary prevention would be an integral part of urban health strategy. Improved health seeking behavior influenced through capacity building of the community based organizations & establishment of an appropriate referral mechanism would also be important components of this strategy.
National Health Programmes:

4.3.6 RMNCH+A services

4.3.6.1 For further acceleration in the gains made in all Reproductive and Child Health (RCH) programmes, the greatest challenge is to address the social determinants of health. Maternal and perinatal mortality is highest in population sub-groups which are poorer, more malnourished, less educated, have lower age of parity and have too many children or too soon. It is also a reflection of patriarchal mindsets and lack of gender equity which makes women more vulnerable. Thus child and maternal survival is a mirror that reflects the entire spectrum of social development and addressing these social determinants through developmental action of all sectors will remain a priority.

4.3.6.2 Reduction of Maternal Mortality: Within such a context, the challenge in further reductions in maternal mortality and morbidity lies now in improving the quality of care in health care facilities, including better management of complications due to Non Communicable Diseases. Promoting universal access to quality ante natal care, skilled attendance at birth, institutional deliveries and referral transport to ensure comprehensive emergency obstetric care would further reduce maternal mortality. The policy strongly recommends strengthening of general health systems to ensure continuity of care and emergency services for maternal health.

4.3.6.3 Cash Transfers, Quality of Care Issues: Though there is a persistent level of home delivery in many states, an improved access, quality of care and ensuring that there are no financial barriers, would be adequate to achieve a further shift to safe delivery. The existing cash transfer (JananiSurakshaYojana) has been effective to cover non- medical costs of care and needs to be retained, and enhanced if necessary in line with the needs of select sub-groups who face a greater financial barrier.

4.3.6.4 Child and Adolescent Health: The policy endorses the national consensus on accelerated achievement of single digit neonatal mortality and stillbirth rates through improved home based and facility based management of sick newborns. Developing such high quality facility based care for the sick newborn and child will be strengthened by better primary and secondary care facility development. Community based interventions strategies must go beyond immunization to include ready availability and access to Oral Rehydration Salts/Solution (ORS) and Zinc for diarrhea and appropriate antibiotics for pneumonia, better identification and management of anemia, and screening for developmental defects. District hospitals must ensure screening and treatment of growth related problems; birth defects, genetic diseases and support palliative care for children. The policy affirms commitment to school health programmes as a major focus area and health and hygiene being made as part of the school curriculum. The high prevalence of child under-nutrition has been a serious concern in India. The slow pace of reduction of child malnutrition poses a serious policy challenge to development and health planners. In this context focus on infant and young child feeding practices through intensive community based behaviour change initiatives,
promotion of dietary diversification, innovative solutions on food fortification will enable us to deal with the problem. We also need to give special emphasis to the health challenges of adolescents (10 to 19 years) and long term potential of investing in their health care. In this age group there is one section affected by under-nutrition, and there is another section that requires attention to reduction of obesity. Paradoxically both of these can be more common in poorer sections. The scope of Reproductive and Sexual Health (ARSH) should be expanded to address issues like inadequate calorie intake, nutrition status and psychological problems etc as these are important determinants influencing the health-seeking behaviour of adolescents.

4.3.6.5 Interventions to address micronutrient deficiencies: Focus on reducing micronutrient malnourishment will need continuous policy and health system support to augment initiatives like screening for anemia, micro nutrient supplementation, food fortification and public awareness. Malnutrition, especially, micronutrient deficiencies, restricts survival, growth and development of children, contributes to morbidity and mortality in vulnerable population, resulting in substantial diminution in productive capacity in adulthood and consequent reduction in the nation’s economic growth and well-being. The need to address the effects of these deficiencies through a well-planned strategy on micronutrient interventions is considered essential. Signs of under-nutrition are less overtly visible in those affected by it. A systematic approach to address heterogeneity in micronutrient adequacy across regions in the country with focus on the more vulnerable sections of the population is needed; hence, screening for multiple micronutrient deficiencies is advocated. During the critical period of pregnancy, lactation, early childhood, adolescence and old age the consequences of deficiencies are particularly severe, and many are irreversible.

While dietary diversification remains the most desirable way forward, supplementation and fortification require to be considered as short and medium term solutions to fill nutrient gaps. Select micronutrient deficiency is currently being addressed through age-specific supplementation of iron folic acid (IFA) for addressing iron deficiency, calcium supplements (during pregnancy) to prevent pre-eclampsia and eclampsia related complications, iodized salt to prevent iodine deficiency disorders such as impaired mental development in newborns, Zinc and Oral Rehydration Salts/Solution(ORS) for childhood diarrhoea management, Vitamin A supplementation for preventing childhood blindness and improving overall immunity, and folic acid supplementation for prevention of neural tube defects. While these interventions need to be intensified, efforts should be made to ensure reach to every beneficiary, and that intensive monitoring mechanisms are in place.

The scope of micronutrient deficiency management could further be enlarged by including interventions such as fortification of staples under the social safety net programs like Mid-Day Meal, ICDS and Public Distribution System.

The policy advocates developing a strong evidence base, of the burden of collective micronutrient deficiencies, which should be correlated with disease burden and also particularly understanding the etiology of anemia. Feasibility of improving the nutritive value of food provided in the Anganwadi centers and schools through fortified food and micronutrient sprinkles for addressing deficiencies could be explored. A strong nutrition education component with focus on improving infant and young child feeding and nutrition practices during pregnancy and lactation,
through timely contact and counseling by health workers via the National Health Mission and ICDS platforms needs to be evolved.

In recognition of the key complementary role of various nutrition-sensitive interventions, implemented from different platforms, synergies need to be built and embedded with activities in fields such as Women and Child Development, Education, WASH, Agriculture and Food and civil supplies. MoHFW would take on the role of 'convener' to monitor and ensure effective integration of both nutrition-sensitive and nutrition-specific interventions for coordinated optimal results.

4.3.6.6 Universal Immunization Programme: One of the immediate challenges is to further increase immunization coverage with quality and safety. Better adverse event reporting and compensation policies would be built up. Vaccine security through encouragement of multiple suppliers and appropriate procurement policies is also a frontier. While the introduction of new cost effective vaccines is a frontier, these would be introduced and scaled up along with building the institutional capacity to deliver the vaccines and as a complement to other health priorities of primary health care after a review of relevant epidemiological information. It may be pointed out that supportive supervision of National Health programmes including UIP is an area of critical concern.

4.3.6.7 Population Stabilization including maintaining a gender balance has been and will continue to be one of the main components of national health policy. The strategic objectives now are better and safer contraceptive choices, with a further push back in age of marriage and improvement in spacing. Though declining, fertility rates continue to be unsustainably high in as many as nine states which account for over 35% of the population. Here the policy imperative is to move away from camp based services with all its attendant problems of quality, safety, and dignity of women, to a situation where these services are available on any day of the week or at least on a fixed day. Other policy imperatives are to increase the proportion of male sterilization from less than 5% where it is currently, to at least 30% and if possible much higher. The National Health Policy is explicit that coercive methods are not justified nor even effective to meet the goals. Improved access, education and empowerment would be the basis of successful population stabilization. There is a need to increase basket of contraceptive choice in the national family planning. The private sector has to expand access to family planning services to complement the government toward population stabilization.

4.3.6.8 Women’s Health & Gender Mainstreaming: Women’s health issues and concerns go far beyond maternal health, the ability of the health sector to address these issues needs to be strengthened. Despite the introduction of new technologies, access to safe abortion services and for reproductive tract illness remains a major gap that must be seriously addressed. There will be enhanced provisions on reproductive morbidities and health needs of women beyond the reproductive age group (40+)

4.3.6.9 Gender based violence: Gender based violence against women is serious, wide-ranging and the health care in the public and private sector to the survivors/ victims needs to be provided free, confidential, non-judgmental with social support and a sense of responsibility. Women’s access to
health care needs to be strengthened by making public hospitals more women friendly and ensuring that that the staff have orientation to gender –sensitivity issues.

4.3.6.10 Supportive Supervision: The enormous needs and challenges of capacity building and supportive supervision in more vulnerable districts with very weak internal capacity require a new strategy. The policy will support innovative measures like use of ICT tools and HR strategies like using Nurse Trainers to support field workers.

4.3.7 Communicable Diseases under National Disease control programmes

4.3.7.1 Integrated Disease Surveillance Programme: A comprehensive approach to communicable diseases needs districts to respond to the communicable disease priorities of their locality through network of well-equipped laboratories backed by tertiary care centers and the public health capacity to collect, analyze and respond to the disease outbreaks.

4.3.7.2 Control of Tuberculosis: The current challenges in tuberculosis are persistent high levels of disease transmission, rapid progression of the disease in infected patients, HIV and TB co infection and increase in incidence of drug resistant tuberculosis. This calls for more active case detection with a greater involvement of private sector, and adherence to standard treatment protocols. It also requires a choice of strategy with regard to treatment regimes that reflects the changing patterns of microbial sensitivity and medication compliance. These treatment based control measures need supplementation by preventive and promotive action in the workplace and in living conditions. Access to free drugs would need to be complemented by affirmative action to ensure that the treatment is carried out; drop outs reduced and transmission of resistant strains are contained.

4.3.7.3 Control of HIV/AIDS: India’s achievements in HIV control owe a lot to both its emphasis on prevention, its partnership with active and vibrant communities and civil society, evidence based programming and in the production of generic anti-retroviral drugs at affordable rates. These advantages will be sustained and built upon. With prevalence rates higher in certain southern and north east states, and with rising trends of HIV in certain pockets in northern states, policy recommends for interventions to be focused on high risk communities (MSM, Transgender, Female Sex Workers and Injecting Drug Users) and prioritized geographies while the current emphasis on prevention continues. Finances are required to support clinical care and treatment to people living with HIV with inclusion of 1st, 2nd and 3rd line ARV, Hep-C and other costly drugs into essential medical list.

4.3.7.4 Leprosy Elimination: Despite achievement of leprosy elimination at the national level, given the epidemiological characteristics of the disease, there would be new cases each year. The thrust of policy is therefore to build a system’s sensitivity to ensure that cases of leprosy lesions in the gamut of skin lesions are identified and treated in time. The proportion of grade 2 cases amongst new cases will become the measure of community awareness and health systems capacity and dedication to this task- and this keeps in mind the global goal of a reduction of grade 2 disability to less than 1 per million by 2020.
4.3.7.5 Vector Borne Disease Control: Some challenges in National Vector Borne Disease Control Programme deals with six diseases. Of these, Malaria, Filaria and Kala-azar are on decline. With malaria, there is a growing challenge of drug resistance and the country would have to keep a vigil on the same, changing treatment regimens with logistics support as appropriate. Lymphatic filariasis and kala-azar are targeted for elimination by 2015, but even after this, surveillance and follow up on localized outbreaks would need to be sustained. Dengue is emerging as the fastest growing infection globally and India too faces a challenge. National programme for prevention and control of Japanese Encephalitis (JE)/Acute Encephalitis Syndrome (AES) have been initiated with a strong component of inter-sectoral collaboration, but they require strengthening in many dimensions. Good quality disease surveillance data should also include entomological information for which a dedicated team of entomologists with support staff is essential. Taken together the battle against vector borne disease is an example of how one needs to be ahead of the problem in biomedical research for understanding of disease and its transmission, in drug innovation and drug discovery and bringing innovations on to the market with very short lag time and in building public health capacity at district levels.

4.3.7.6 Integrated approach in communicable disease interventions

The policy recognizes the circularity in relationship between communicable disease control programmes and public health system strengthening. Every one of these programmes requires on one hand a robust public health system as their core delivery strategy, and on the other they can be considered as opportunities to strengthen health care systems- and designed keeping this goal in mind. Thus blood safety is an important element of HIV control, but the policy imperative is that blood safety measures are designed as part of a universal access to blood transfusion services. Tuberculosis control needs excellent laboratory support for its effectiveness but the programme would be designed to strengthen laboratory services on the whole.

4.3.8 Non-Communicable Diseases:

4.3.8.1 This policy will support an integrated approach where screening for the most prevalent NCDs with secondary prevention would make a significant impact on reduction of morbidity and preventable mortality. This would be incorporated into the comprehensive primary health care network with linkages to specialist consultations and follow up at the primary level. Emphasis on medication and access for select chronic illness on a round-the-year basis would be ensured. As part of the “planned early detection, and better secondary prevention” screening for oral, breast and cervical cancer and for COPD (Chronic Obstructive Pulmonary Disease) will also be focused in addition to hypertension and diabetes. The National Programme will also ensure that the necessary resource and capacity building support for such an integrated approach is built up at the district level. This is one area where research and protocol development for mainstreaming AYUSH and as part of integrated medical care has huge potential for effective prevention and therapy that is safe and cost-effective. In view of the growing burden of NCDs in the country it is recommended that a
National Institute of Chronic Diseases including Trauma may be set up to generate evidence for adopting cost effective approaches and showcase best practices.

4.3.8.2 The policy continues to support the prevention of programmes against blindness, deafness and for better oral health. Endemic diseases like fluorosis, sickle cell anemia or thalassemia as well as occupational diseases like silicosis and injuries to agricultural farm workers require urgent attention.

4.3.8.3 The National Health Policy commits itself to culturally appropriate community centered solutions to meet the health needs of the ageing community and also to comply with constitutional obligations as per the Maintenance and Welfare of Parents and Senior Citizens Act, 2007 and within the various provisions of the National Program for Health Care Delivery of the Elderly 2011 (NPHCE). A closely related concern is the growing need for palliative care for all geriatric illness, and continuity of care across all levels.

4.3.9 Mental Health
This policy will also take into consideration the provisions of the National Mental Health Policy 2014 by simultaneous action on several fronts. First, an increase in creation of specialists with public financing with special rules to give preference to those willing to work in public systems. Further strengthening of mental health services at primary level facilities would require creating a network of community members to provide psycho-social support and supplementing primary level facilities with counselors and psychologists. Leveraging ICT in a context where access to qualified psychiatrists is difficult will be supported by this policy. There should be a decreasing need for committing individuals to institutional care and current institutions should have the necessary financial and human resource support and supervision for ensuring humane and caring approaches to the inmates.

4.3.10 Emergency Care and Disaster preparedness
Better response to disasters both natural and manmade requires a dispersed and effective capacity for emergency management and an army of community members trained as first responder for accidents and disasters, and regularly strengthening their capacities in close collaboration with the local self-government and community based organisations. This is not only for the surgical emergency- but includes burns, drowning, stampede during fairs and festivals, etc. To support disaster response the policy would call for building earthquake and cyclone resistant health infrastructures in vulnerable geographies and develop mass casualty management protocols for CHC and higher facilities and develop emergency response protocols at all levels. A network of emergency care that has an assured provision of life support ambulances, trauma management centers - one per 30 lakh population in urban and one for every 10 lakh population in rural areas a unified emergency response system, linked to a dedicated universal access number is recommended by this policy. Rehabilitative care at community and through the nearest health institutions would be made available. Therefore, the public health care system has to be designed accordingly, so as to, respond to disasters which create maximum load on primary facilities, which cater to a minimal package of services.
4.3.11 Realizing the Potential of AYUSH

4.3.11.1 A large part of the population uses AYUSH remedies and prefers to do so, choosing this for reasons that include perceived lower side effects, costs and/or considerations of it being more natural. The most important consideration in public policy with respect to AYUSH is to ensure that persons who so choose have access to these remedies through co-location in public facilities providing allopathic care, investing more on making AYUSH drugs available and standardizing drugs and treatment protocols, and propagation of the potential of AYUSH remedies in a number of conditions especially for selected number of conditions. Further disciplines like Yoga would be introduced much more widely in the school and in work places as part of promotion of good health as adopted in National AYUSH Mission.

4.3.11.2 This policy recognizes that principles of care differ for AYUSH systems of medicines and mainstreaming would involve ‘nurturing’ these individual system of medicines through development of infrastructural facilities of teaching institutions, improving quality control of drugs, capacity building of institutions & professionals, building research and public health skills of practical utility and initiating community-based AYUSH interventions for preventive & promotive healthcare. Linking them with the ASHAs and VHSNCs would be an important plank of this policy.

4.3.11.3 The second important meaning of mainstreaming, which was accelerated with NRHM, was training of AYUSH professionals to help them perform ‘national program’ functions. Given human resource constraints, the national health policy would continue with this but with the addition of a mandatory bridge course that gives them the competencies of mid-level care provider with respect to allopathic remedies by enabling provisions. Simultaneously, continuing education for upgrading of knowledge and skills in their own systems as regular in-service capacity strengthening would be instituted.

4.3.11.4 This policy further support the integration of AYUSH systems at the level of knowledge systems by validating processes of health care promotion and cure and sensitizing practitioners of each system (Allopathic and AYUSH) to the strengths of the others. Such validation would lead to greater acceptability and use of AYUSH remedies by all practitioners- especially for NCDs care, geriatric care and promotive health. Promotion of further research in this field will be actively pursued, and application of available integrative knowledge through development of appropriate clinical protocols for primary, secondary and tertiary levels will be part of this approach. The policy recognizes the need to standardize and validate Ayurvedic medicines.

4.3.11.5 To better regulate the AYUSH drugs market the policy would also support establishment of separate Central Drug Controller for AYUSH drugs and strengthening of quality enforcement mechanism in the States for application to mass manufactured drugs. The development of sustainable livelihood systems through involving local communities and establishing forward and backward market linkages in processing of medicinal plants will also be supported by this policy. The policy would also strengthen steps for farming of herbal plants. Developing mechanisms for certification of ‘prior knowledge’ of traditional community health care providers and involving
them in this process, engaging them in the conservation and generation of the raw materials required, as well as creating opportunities for enhancing their skills are part of this policy.

4.3.12 Tertiary Care Services:

4.3.12.1. There has been a considerable expansion in tertiary care services in recent years- most of it in the private sector. The needs of tertiary care are growing, but the costs are growing even faster and have become prohibitive. NSSO 60th round (2004-05) observed that tertiary care by private providers is more than twice (Rs. 7408) that of public providers (Rs. 3238) in rural areas. The difference is almost three times in urban areas. This policy believes that the tertiary services are best organized along lines of regional, zonal and apex referral centres and government efforts to create AIIMS, upgrade state medical colleges to centre of excellence, upgrade district hospitals to medical colleges would conform to this broad principle. There is need for further expansion of infrastructure for specialty and super specialty services at State level.

4.3.12.2. The challenge with respect to this expansion of medical colleges and AIIMS is to find the faculty to staff these, to start up advanced tertiary care services as is expected of these centers, and to build them as centers of excellence for research and medical education. Building their capacity as tertiary care institutions of excellence needs exposure and training to the latest skills, a policy of benchmarking with better institutions, enlightened HR policies, and also an emphasis on research.

4.3.12.3. The challenge with respect to expansion of medical colleges in the private sector is the high cost they charge for clinical care and professional education. The fees and the orientation make it less likely for graduates to take up public sector services or even serve in towns and cities outside the main metropolis. This policy would support periodic review and standardization of fee structure and quality of clinical training. The greater the gap between the need and the availability of specialists in a given domain, the greater the likelihood that many may just emigrate, given the need for specialists in developed nations as well. In most private medical colleges and tertiary care hospitals, research is not even seriously on the agenda, though there is a potential for cross-subsidization so that some less affluent sections can be treated. Though there is an obligation imposed by their access to considerable tax exemptions and public acquisition of land, it is only a rare private commercially run hospital that meets these obligations. This Policy enunciates the core principle of societal obligation on the part of private institutions to be followed. This would include operationalisation of mechanisms for referral from public health system to charitable hospitals, ensuring that deserving patients can be admitted on designated free / subsidized beds, in keeping with the defined obligations. A number of not-for-profit hospitals however follow this, but these are a few only. Given that the private sector operates within the logic of the market, and are governed by the rules and regulations of the country, there need not be any separate effort to persuade them to do charity by providing free care for the poor, as long as their requirements and perceptions do not influence public policy towards universal health care. It is also proposed that where corporate hospitals and medical tourism earnings are through a high degree of associated hospitality arrangements, one could consider forms of taxation/cess, especially for certain procedures and services as a form of resource mobilization towards the health sector.
4.3.12.4. Developing criteria to empanel the socially motivated and committed tertiary care centers into the government efforts and developing partnerships with them to close the specialist gaps would be a way forward.

4.3.12.5. In addition to expansion of its own provisioning, the government would purchase select tertiary care services from empaneled public and private sector hospitals to assist the poor. Coverage in terms of population covered and services included will expand gradually. Development of evidence based standard guidelines of care applicable both to public and private sector and establishing National Healthcare Standards Organization would be a necessary.

5. Human Resources for Health

5.1. The need of the day is not a headlong (market-driven) expansion of the pool of professional and technical human resources for health, but a planned increase that creates human resources that meet the specific requirements for professional and technical skills that are needed most. The key principle around which we build a policy on human resources for health is that workforce performance of the system would be best when we have the most appropriate person, in terms of both skills and motivation, for the right job in the right place, working within the right professional and incentive environment.

5.2. A policy framework in human resources for health that is based on the above principle would need to align decisions regarding judicious growth of professional and technical educational institutions, better financing of professional and technical education, defining professional boundaries and skill sets, reshaping the pedagogy of professional and technical education, revisiting entry policies into educational institutions, ensuring quality of education and regulate the system to generate the right mix of skills at the right place. Similarly public health institutions would need to have enlightened rules – formal and informal- for attracting, retaining and ensuring adequate numbers of persons with the rights skills in the right place. Such policies would have an impact on the growth and work culture of the private sector too. Currently most human resources created, crowds into urban areas, creating a highly competitive market for clients who can pay. Given the information asymmetry that characterizes this sector- such competition leads to considerable degrees of unnecessary and irrational care that regulation alone cannot remove.

5.3. To expand the number of specialists and doctors, and to do so with public health needs in mind, the Government shall invest in States with larger human resource deficits by strengthening existing medical colleges and further converting district hospitals to new medical colleges. To build up a continuous flow of faculty for the medical colleges that would be in existence and to provide centers of excellence in biomedical and clinical research, the center shall also expand the number of AIIMS like centers of medical education and research. The ownership and burden of financing this would be shared between the Central and State/UT Governments. The rules regarding setting up of medical colleges and the entire system of regulation of medical education (including AYUSH) would also be informed and guided by the needs of correcting the current distortions of medical educational policy that have led to this mismatch between needs and skills. Connectivity provided
by National Knowledge Network shall be networked for Tele-education, Tele-CME, Tele-
consultations and access to digital library.

5.4. Ensuring that doctors are attracted to work in remote areas and that their services can be
retained there also requires specific policy measures. Most effective of the various possible
approaches is a positive preference given to students from under-serviced areas, who are likely to
make a lifelong commitment to go back and serve in these areas. Another positive determinant of
voluntary rural location of doctors is a more rural location of medical colleges and a curriculum and
pedagogy of medical education which provides exposure and motivation to work with
communities. Equally important is to create a positive practice environment where professionals
can stay in touch with peers and upgrade their skills and a positive social environment, through
better housing, more flexible terms of employment and active measures of community support.
Incentives- financial and non-monetary would also be used – and where these are substantial they
would make a big difference. Measures of compulsion- whether through mandatory rural postings
or mandatory rotational postings are valuable strategies. The exact package of policy measures that
would successfully address the problem of doctor vacancy would vary from State to State and
would change over time.

5.5. Specialist attraction and retention is a much greater challenge, and the public sector has been
performing very poorly on this. This policy proposes that most needs for specialist consultation
would need to be met within a district. Measures to address this would include the expansion of
specialist education both of the mainstream MCI registered courses and educational options linked
to the National Board of Examinations and College of Physicians and Surgeons. All the measures for
retention described with reference to medical doctors would also apply to specialists. The
requirement of patient care in super specialty services is very different from the General Specialties
with regard to skills required to render effective care. This calls for developing human resources for
super specialty care, which would entail developing training centres for the same. Creating a
specialist cadre with suitable pay scales and in addition a performance linked payment would be
useful. But most important would be an upgradation of short term training to medical officers who
are willing to work in these areas and providing them with a set of basic specialist skills as needed
at the block and district level. In many nations these take the form of MD courses in family medicine
or general practice. These courses have started up here, but despite being highlighted in the 2002
National Health Policy operate on a sporadic basis and on a scale too small, and without the
necessary support to make an impact. Supplemental policy initiatives to make this post
interchangeable with the post of any of the basic specialists sanctioned for CHC would also expedite
the rolling out of this strategy. Another essential policy initiative to realize such re-definitions of
professional boundaries, not only for family medicine courses but for many other specialist needs,
is to convert National Board of Examinations as a statutory body to innovate new education and
training models to train appropriate specialists. Technological innovations coupled with advances
in cellular biology knowledge are influencing therapeutic interventions. Hence, developing teams
comprising of clinicians, cellular biologists, researchers, academicians, etc. in each specialty who
can deliver holistic care becomes pertinent.
5.6. Given the changing professional norms, non-specialists tend to refer away far too many cases to specialists, undermining general practice. For a number of conditions general practice is as good as or even better than specialists in that domain. A large number of distance and continuing education options by which general practitioners in both the private sector and the public sector who work in such areas and with under-served communities can upgrade their skills in what would otherwise have to be referred away, would be used to address this problem- so that general practitioners at all levels can resolve more problems and refer less.

5.7. The expansion of primary care from selective care to comprehensive care requires a complementary human resource strategy. One important element of this strategy is the development of a cadre of mid-level care providers. This may be achieved through appropriate courses like a B.Sc in community health and/or through competency-based bridge courses and short courses. Such bridge courses may admit graduates from different clinical and paramedical backgrounds, like AYUSH Doctors, BSc Nurses, Pharmacists, GNMs, etc., and equip them with skills to provide services at the sub-center and other peripheral level. Besides improving of manpower, this will also provide additional promotional avenues to many cadres and attract them to work in remote areas. Locale based selection, a special curriculum of training close to the place where they live and work; conditional licensing, enabling legal framework and a positive practice environment will ensure that this new cadre is preferentially available where they are needed most, i.e. in the under-served areas. Paramedical cadre such as perfusionists, physiotherapists, occupational therapists, radiological technicians, audiologists, MRI technicians etc. requires special skills and knowledge. There is need to develop training courses and curriculum in these areas to efficiently and effectively support the super specialties.

5.8. Recognizing that nurses form about two-thirds of the health workforce in India, the policy would strengthen its governance systems so that, nurses are enabled to assume leadership positions, regulation of practice is improved, quality of nursing education is strengthened establishing cadres like nurse practitioners and public health nurses. This would increase the total availability of nurses in the areas where they are needed most. There are very few institutions providing specialized nursing courses. It is very important that specialized tertiary level medical care is supported with specialized nursing and para-medical care. Tertiary care facilities like critical care, cardio-thoracic vascular care, neurological care, and trauma care, palliative care and care of terminally ill, etc. requires specialized knowledge and skills. The policy recognizes the need for developing training courses and curriculum in these areas.

5.9. The nearly one million community level work force in the form of ASHA created under the National Rural Health Mission, have now creditably established themselves as activists, facilitators and providers of community level care across various contexts. Taking stock of this achievement the policy direction would be to move from treating this cadre as an ad hoc arrangement to visualizing and shaping ASHA as a unique institution for possible enhanced role as a community health nurse or Facilitator. This policy will support the certification programme for ASHA for their preferential selection into ANM, nursing and paramedical courses and also for upgrading their skills in areas like community based geriatric and palliative care. This will also provide career
progression opportunities for ASHAs and deployment at appropriate level of health care facilities. While most ASHAs will remain mainly voluntary, and remunerated for time spent, those who obtain qualifications for career opportunities could be given more regular terms of engagement. The policy will enable engagement with NGOs to serve as support and training institutions for ASHA and to serve as learning laboratories on future roles of community health workers. Adding a second Community Health Worker would be based on geographic considerations, disease burdens, and time required for multiple tasks to be performed by ASHA/Community Health Worker.

5.10. To expand the availability of nurses the Ministry would encourage a nursing school in every large district or cluster of districts of about 20 to 30 lakh population. Building up quality in nursing education would require not only a HR policy for the faculty but peer trainers who would come and work with them for two to three years to build up practice and behavioural norms which are benchmarked with the best nursing schools. Centers of Excellence for Nursing and Allied Health Sciences would also be established in each State. Nursing cadre within public service requires both career progression opportunities as well as specialization in areas like public health nursing and clinical specialties. Multipurpose male health worker cadre needs to be revived and strengthened to manage emerging infectious and non-communicable diseases at community level. States which have adequate nursing institutions may explore gradually shifting to three year nurses even at the sub-center level to support the implementation of the comprehensive primary health care agenda.

5.11. There is a similar need to have a planned expansion of allied technical skills—radiographers, laboratory technicians, physiotherapists, pharmacists, audiologists, optometrists, occupational therapists etc. Here there is much greater opportunity to make use of these needs to provide for local employment in public health systems without compromising quality. The measures outlined, for creating and retaining medical officers for public service, are equally applicable to the allied health professionals. The policy would allow for multi-skilling with different skill sets so that when posted in more peripheral hospitals there is more efficient use of human resource.

5.12. The last seven years have seen a major inculcation of public health management skills of different backgrounds into the public health systems contributing considerably to programme effectiveness. The nation has also seen a major expansion of public health and public health management education. However, in the absence of a public health cadre this inculcation of public health skills remains an ad hoc arrangement, which is inadequate for building long term systems. There is a need to create a Public Health Management Cadre in all States which would be based on public health or related disciplines as an entry criteria, an appropriate career structure and recruitment policy to attract young and talented multi-disciplinary professionals. Medical & health professionals would form a major part of this, but professionals coming in from diverse backgrounds such as sociology, economics, anthropology, nursing, hospital management, communications, etc. who have since undergone public health management training would also be considered. States could decide to locate these public health managers with medical and non-medical qualifications into same or different cadre streams belonging to directorates of health.
5.13. Certain specialized skills which are essential but not limited to public health- like entomology, housekeeping, bio-medical waste management, communication skills, management of call centers and even ambulance services, need to be nurtured as part of a team that is working on this in a continuous manner and in touch with their national and international peers. Such skills are better utilized by insourcing through partnership arrangements, than by creating posts, where it is not only difficult to find personnel- but even more difficult to retain their skills.

5.14. To ensure quality of Medical Education, a common entrance exam on the pattern of NEET for UG entrance at All India level needs to be enforced. A common national-level Licentiate/exit exam will be introduced for all medical and nursing graduates with a regular renewal at periodic intervals with Continuing Medical Education (CME) credits accrued. This policy recommends that the current pattern of MCQ (Multiple Choice Question) based entrance test for post graduates medical courses- that drive students away from practical learning- should be reviewed. Similar strategy would be scoped for improving quality of AYUSH education. All Indian students studying medicine abroad should undertake a screening test and serve at least one year in rural areas to obtain registration with the regulatory body. The policy recognizes the need to revise the under graduate and post graduate medical curriculum keeping in view the changing needs, technology and the newer emerging disease trends. Keeping in view, the rapid expansion of medical colleges in public and private sector there is an urgent need to review existing institutional mechanisms to regulate and ensure quality of training and education being imparted. The policy recommends that the discussion on recreating a regulatory structure for health professional education like National Commission for Human Resources in Health to be revived.

5.15. The policy also envisages the use of telemedicine, online training, etc. to support continuing medical and nursing education and on the job support to providers, especially those working in professional isolation in rural areas. The strengthening of in-service training and training institutions remains one of the important challenges in strengthening health delivery- both in the public and in the private sector. There is a need to strengthen human resource governance in public health system through establishment of robust recruitment, selection, promotion and transfer postings policies whose implementation should be leveraged through information technology for bringing transparency in the processes.

6. Financing of Health Care & Engaging the Private Sector

6.1. To reduce out of pocket expenditures, catastrophic expenditures and eliminate impoverishment, tax based financing would remain the predominant source of financing for at least 70% of the population who are poor and vulnerable (Whose per capita monthly consumption expenditure is less than Rs. 1640 in Rural and Rs. 2500 in urban areas at current prices). The policy proposes a potentially achievable target of raising public health expenditure to 2.5 % of the GDP in a time bound manner with commitment for allocating 70 percent of resources to primary care, 20 percent to secondary care and 10 percent to tertiary care presently to meet existing gaps in the primary health care. This distribution across various levels of health care would be a dynamic process aligned with a
critical gap analyses. Free primary care provision by the public sector supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and from private sector to fill critical gaps would be the main financing strategy of assuring health care services. The existing government financed health insurance schemes shall be aligned to cover selected benefit package of secondary and tertiary care services purchased from public, not for profit and private sector in the same order of preference according to availability of services.

6.2 Raising resources for investing in health is one challenge (which was discussed in section 4.1.) Spending these resources equitably and efficiently is another. The latter has two constituent parts- improving efficiency of public sector expenditure- and second is the various forms of engagement of private sector. Issues relating to governance of both public sector engagement and purchase from private sector are discussed in the section on governance. Efficiency of public expenditure relates to the organization of service delivery, efficiency in procurement, logistics management, the timely recruitment and deployment of the required human resources required for service provision and programme management, (including financial management), and ensuring minimum standards of workforce management. Central to improving efficiency in public health expenditure is therefore clear allocation of powers to specific officers for each of these functions and then holding them accountable for their performance. Inclusion of cost-benefit and cost effectiveness studies consistently in programme design and evaluation would inform policy and contribute significantly to increasing efficiency of public expenditure.

6.3 Resource allocation/payment mechanisms to public health facilities could also contribute significantly to improving public sector efficiency. A robust National Health Accounts System needs to be operationalized to enable this. The policy therefore calls for major reforms in financing for public facilities where a significant part of the funds- especially most of those related to operational costs would be in the form of reimbursements for care provision and on a per capita basis for primary care. Items like infrastructure development and maintenance, the non-incentive cost of the human resources i.e salaries, much of administrative costs would however continue to flow on a fixed cost basis. Considerations of equity would be factored in- with higher unit costs for more difficult and vulnerable areas or more supply side investment in infrastructure. Total allocations would be made on the basis of differential financial ability, developmental needs and high priority districts to ensure horizontal equity through targeting specific population sub groups, geographical areas, health care services and gender related issues. A risk equalization formula based on health care needs could be developed. A higher unit cost or some form of financial incentive payable on quarterly or annual basis could be given for facilities providing a measured and certified quality of care.

6.4 Private Sector engagement would largely take the form of need based purchasing of secondary and tertiary care. This requires creation of institutional mechanisms at the national and state levels – in the forms of trusts or registered societies. These agencies would lay down the standards of care and treatment, empanel the providers, negotiate for rates based on volumes and processes and make payment for the claims. They would be under the Ministry of Health at center and in States, but with institutional autonomy. These agencies would also be charged with ensuring that purchasing is strategic- giving preference to care from public facilities where they are in a position to do so- and
developing a market base through encouraging the creation of capacity in services in areas where they are more needed. Private ‘not for profit’ and ‘for–profit’ hospitals would be empanelled with preference for the former, for comparable quality and standards of care. The payments will be made by the trust/society on a reimbursement basis for services provided.

6.5 Private sector engagement could also take other forms. One form is contracting out of, primary care facilities to not for profit organizations with a known tradition of public services, in areas where government has limitations in organizing services. Other is contracting out certain services where a team of specialized human resources and a domain specific organizational experience is required—like in the case of contracting out of ambulance services, or advanced diagnostics, or imaging services are required. This is often more needed and easier to implement in non-medical services in hospital settings—like in laundry, catering, housekeeping, security services etc. though in such outsourcing the care should be that, efficiency is not at the cost of compromising on fair and decent wage labour conditions. Private sector has grown passively and continues to evolve with very little, if any, policy guidance and regulatory mechanism. As a result, they are not oriented to public health goals and are not available for many public health interventions.

6.6 The private sector could be actively engaged in the many health intervention/campaign day programmes of the Government. Private providers, especially those working in rural and remote areas, or with under-serviced communities, could be offered encouragement through provision of appropriate skills to meet public health goals, opportunities for skill up-gradation to serve the community better, participation in disease notification and surveillance efforts, sharing and support through provision of certain high value services—like laboratory support for identification of drug resistant tuberculosis or other infections, supply of some restricted medicines needed for special situations, building flexibilities into standards needed for service provision in difficult contexts, etc. Even social recognition of their work—would greatly encourage such providers to do better.

7. Regulatory Framework

7.1 The regulatory role of the Ministry of Health and Family Welfare includes regulation of clinical establishments, professional and technical education, food safety, medical technologies and medical products with reference to introduction, manufacturing, quality assurance and sales, clinical trials and research, and implementation of other health related laws. Each of these areas needs urgent and concrete steps toward reforms. This will entail moving away from reactive, voluminous, poorly implemented regulatory regimes, cobbled up in an ad-hoc manner to a more effective, rational, transparent and consistent regime. The regulatory levers need to be wielded, far more consistently and effectively to meet the challenges associated with health care throughout the country, safeguarding the public interest as well as encouraging private initiative. Statutory autonomous bodies regulate Medical Education and Food Safety. The Ministry directly regulates issues such as drugs, cosmetics, other professional education and clinical establishments. The prices and availability of drugs is regulated by the Department of Pharmaceuticals. Some of the areas that need to be addressed with regard to drugs and pharmaceutical encompasses: streamlining the system of
procurement of drugs; a strong and transparent drug purchase policy for bulk procurement of drugs; facilitating spread of low cost pharmacy chain such as Jan Aushadhi stores linked with ensuring prescription of generic medicines; education of public with regard to branded and non-branded generic drugs; setting up of drug banks; setting up common infrastructure for development of the pharmaceutical industry. The policy advocates strengthening and rationalizing the drug regulatory system, promotion of research and development in the pharmaceutical sector, and building synergy and evolving a convergent approach with related sectors.

7.2 The Government of India had enacted the Clinical Establishments Act 2010, after a resolution to that effect was passed by four states and since framed its rules. Nine States and Union Territories have adopted the Act so far. The Government of India should persuade the remaining States to adopt this Act using appropriate constitutional provision. All clinical establishments should also be networked on the Health Information System, and share data on nationally required parameters. A few states have enacted their own State laws but they are inadequate. There are growing concerns regarding costs, unfair practices like kickbacks, irrational and inessential care. Empanelment for insurance and public private partnerships was expected to provide better acceptance for regulation. However the experience is that insurance mechanisms are unable to act against the denial of services, supply driven irrational care, unethical practices, and charging patients for what should be cashless services. It is clear that without a regulatory structure in place, it would be difficult to ensure that public private partnerships or insurance based purchasing would deliver on either health outcomes or financial protection. Much greater emphasis would be given to make the regulation work. Accreditation of clinical establishments and active promotion and adoption of standard treatment guidelines would be one starting point. Involvement of communities and their representatives in this process - especially in client support for publicly financed health insurance is another. Protection of Patients rights in clinical establishments (such as rights to information, access to medical records and reports, informed consent, second opinion, confidentiality and privacy) as key process standards would be another important step. The policy recommends separate empowered medical tribunal to be created for speedy resolution to address disputes /complaints regarding standards of care, prices of services, negligence and unfair practices. Standard Regulatory framework for laboratories and imaging centers and assisted reproductive techniques will be created. For strategic purchase where deemed necessary from private facilities, mandatory accreditation will be required after compliance with other regulatory requirements.

7.3 Regulatory Framework for Professional Education: The six professional councils for Medical, Ayurveda Unani & Siddha, Homeopathy, Nursing, Dental and Pharmacy face many challenges in enforcing quality in professional education or professional ethics and good practice. With respect to the Medical Council there are also concerns about widespread conflict of interests in professional practice with respect to pharmaceuticals and diagnostic industries and within itself. The policy calls

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for a major reform and strengthening of these bodies and their accountability through expanding membership of these councils between three key stakeholders - doctors, patients and society in equal or balanced numbers. In meeting Government’s own accountability in professional education, the establishment of independent National Council for Human Resources in Health (NCHRH) is expected to address the gaps in regulation of professional and para-professional education. This will be expedited toward ensuring that the process leads to providing professionals who correspond to national needs. One has to build an approach to governance such that there is a balance between autonomy that professional councils require and the good governance, accountability, effectiveness and responsiveness to national priorities and needs. Combined with uniform standards for entry and exit examinations at the national level, it is expected the quality of medical education and para medical education will considerably improve national standards. The policy supports setting up of National Allied Professional Council to regulate and streamline all allied health professionals and ensure quality standards.

7.4 Availability of safe, wholesome, and healthy foods is an important requirement for health. Microbial contamination of the food contributes to communicable disease burden and the rise in the Non-Communicable Diseases (NCDs) has links to the consumption of food high in fats, sugars and salts; residues of pesticides, food additives and contaminants. Though enacted in 2006, the Food Safety and Standards (FSS) Act, was operationalized only from late 2011. Effective implementation of the Act will require increase in infrastructure including manpower, adequate budgetary support and reviewing framework of the Act including the standards and the degree of enforcement. Since there were few standards in place, science based standard setting has been one of the challenges to its implementation. Harmonization with international standards is also required. Simultaneously the Government will strengthen and put in place the necessary network of offices, laboratories, e-governance structures and human resources needed for the enforcement.

7.5 India is known as the manufacturing hub and pharmacy of the world with exports to over 200 nations. To ensure the safety, efficacy, and quality of drugs and medical devices and cosmetics that are manufactured, imported, or sold in the country, a dynamic regulatory regime would be put in place. This is essential to safeguard the public from sub-standards or unsafe drugs and medical devices and to ensure the Indian pharmaceutical industry’s global and domestic reputation and leadership. Domestic Regulatory standard will be harmonized with international standards. Post market surveillance program for drugs, blood products and medical devices shall be strengthened to ensure high degree of reliability and to prevent adverse outcomes due to low quality and/or refurbished devices/health products. The policy recommends medical devices regulation and establishing a regulatory body for medical devices to unleash innovation and the entrepreneurial spirit for manufacture of medical device in India. Strengthening testing and surveillance capacities in center and states, a national data bank of all regulatory actions, and e-governance tools would strengthen and speed up regulatory processes. Building capacities in line with international practices in our regulatory personnel and institutions would have the highest priority.
7.6 Clinical trials are essential for new product discovery and development. But these have great risks for the human volunteers. With the objective of ensuring the rights, safety and well-being of clinical trial participants, while facilitating such trials as are essential, a separate chapter be included in the Drugs and Cosmetic Act for its regulation. Transparent and objective procedures shall be specified, and functioning of ethics and review committees will be strengthened. The Global Good Clinical Practice Guidelines, which specifies standards, roles and responsibilities of sponsors, investigators and participants would be adhered to. Further accreditation of sites, investigators and ethics committees and formula for payment of compensations shall be laid down and compliance with it monitored. Irrational drug combination will continue to be monitored and controlled. Appropriate regulatory framework for standardization of AYUSH drugs will be enforced.

7.7 Vaccine safety and security requires development of a rational vaccine policy and effective regulation. It will encompass commissioning more research and development for manufacturing new vaccines, including against locally prevalent diseases; to build more public sector manufacturing units to generate healthy competition; and to guard against the risks of batch failure; and to develop innovative financing and assured supply mechanisms with built in flexibility. In this context, units such as the integrated vaccine complex at Chengalpattu would be set up and vaccine, anti-sera manufacturing units in the public sector upgraded with rise in their installed capacity. The challenge lies in taking timely steps to ensure sufficient availability of quality vaccines at affordable prices.

8. Medical Technologies

8.1. India is the pharmacy of the developing world; but about half of its population does not have access to essential lifesaving medicines and the situation is worse when it comes to medical devices and in-vitro diagnostics. India has a great tradition and capacity for innovation in most areas, but despite having the technical capacity to manufacture any drug, its role in new drug discovery and drug innovation including in bio-pharmaceuticals and biosimilars, even for its own health priorities is limited. India has a public health system with a stated commitment to providing universal access to free care, but out of pocket expenditures on account of payments towards drugs and diagnostics is prohibitively high, one of the highest in the world. These are the paradoxes that the national health policy attempts to address.

8.2. Learning from experience and the consensus amongst expert groups that have examined the issue of progress to universal health care, making available good quality, free essential and generic drugs and diagnostics, at public health care facilities is the most effective way at this present juncture. The drugs and diagnostics available free would include all that is needed for comprehensive primary care including all chronic illnesses in the assured set of services. At the tertiary care level too, at least for in-patients and out-patients in geriatric and chronic care segments, most drugs and diagnostics should be free or subsidized with fair price selling mechanisms for most and some co-payments for the “well to do”.
8.3. One of the challenges to ensuring access to free drugs and diagnostics through public services is the quality of public procurement and logistics. A well-executed public procurement and distribution, as Tamilnadu and more recently Rajasthan has shown, reduces out of pocket expenditures on account of drugs and diagnostics considerably and increases access while limiting irrational prescription practices. Quality assurance of a very high order has also been demonstrated to be possible in such systems. To provide leadership in this area, the center is also setting up a central procurement agency which shall be charged with the procurement and distribution of vaccines and a number of key drugs while keeping pace with the latest technological advancements in this areas and which shall use a state of the art IT platform for inventory management and logistics, and ensure quality and timeliness of central drug supplies.

8.4. Pricing of drugs, medical devices and equipment: The regulatory environment around pricing of drugs, medical devices and equipment requires a balance between the patient's concern for affordability and the industry's concern for adequate returns on investment for growth and sustainability. Pricing for drugs shall continue to be regulated for an increasing range of essential drugs via notifications released by National Pharmaceutical Pricing Authority (NPPA) under National Essential List of Medicines (NELM). Both the list and the cap on prices shall be periodically revised. Timely revision of NELM along with appropriate price control mechanisms for generic drugs shall remain a key strategy for decreasing costs of care for all those patients seeking care in the private sector. An approach on the same lines but suiting specific requirements of the sectors would be considered for price control with regard to a list of essential diagnostics and equipment.

8.5. Availability of drugs and medical devices also requires corresponding industrial growth and trade policies. The Indian pharmaceutical industry has already established itself as a leader in the production of generic drugs- and indeed a large part of the drugs used not only in third world, but also in the developed world are Indian generics. National Health Policy requires the need to strengthen and sustain this not only as part of its economic growth strategy but also as an imperative for the health security of the nation. Special focus on production of Active Pharmaceutical Ingredient (API) which is the back-bone of the generic formulations industry must be provided. In medical devices and equipment over 80% is imported. There is need to incentivize local manufacturing of medical technology sector to provide customized indigenous products for the Indian population in the long run. Medical technology and medical devices which have multiplier effect in the health care delivery and therefore this sector needs greater focus. Thus, there is a need to regulate the use of medical devices to ensure safety and quality compliance as per norms. The goal with respect to medical devices shall be to encourage domestic production compliant with safety and quality norms, in consonance with the “Make in India” national agenda, and such a development would ensure more affordable prices as well as increased access to life saving technologies.

8.6. Drug Innovation and New Drug Discovery are important aspects of access. One aspect of this is access to drugs for neglected diseases, diseases which are our public health priority- but are not viable commercial propositions to discover and bring to the market because only the poorest need them or the numbers requiring them are small. Another aspect of this is affordable access to the
new drugs that would come into the market tomorrow- the next generation of drugs. In certain areas this link is obvious- the most well-known being anti-HIV drugs, drugs for multi-drug resistant tuberculosis, drugs against hepatitis, and against vector borne diseases, drugs for new and emerging infections, and anti-cancer drugs. However in many other non-communicable diseases also there is a potential for improving available therapies with better medicines and diagnostics. Government policy would be to both stimulate innovation and new drug discovery as required to meet health needs as well as ensure that new drugs discovered and brought into the market are affordable to those who need them most. The main constraints to innovation are: funding, the inadequate structure and functioning of regulatory institutional mechanisms, barriers to clinical and animal research and problems of sustaining an innovation ecosystem even if one is developed. Public procurement policies and public investment in priority research areas must also be aligned to drug discovery in areas which are our priority. Similar policies are required for discovering more affordable, more frugal and appropriate point of care diagnostics and robust medical equipment for use in our rural and remote areas.

8.7. There is a need to align our policies in trade, commerce, industry and science and technology and external affairs policies so that they are in consonance with the public health goals of access to new drugs at affordable rates and sustaining our advantage in generics. For medical devices and equipment, trade barriers such as inverted duty structures would be corrected for facilitating cross border trade and indigenous development. Establishing sufficient labeling and packaging requirements on part of industry and effective port - clearance mechanisms for required medical products on part of authority shall be an immediate priority.

8.8. A public sector capacity in manufacture of certain essential drugs and vaccines is also essential to retain in the larger long term understanding of health security and to address some needs which are not attractive commercial propositions. Institutions like CRI, Kasauli, the BCG Institute, Chennai, the Institute of Serology, Kolkata, the National Biological Institute, Noida, and Indian Pharmacopeia Commission play vital roles in production of biologicals and vaccines and in quality assurance and testing mechanisms. Most of these institutions perform functions that none in the private sector can or would take up. Though for the developing world, these are unique achievements, these institutions need more investment and appropriate HR policies and governance initiatives to enable them to become comparable with their benchmarks in the developed world.

8.9. One special problem area is anti-microbial resistance and the failure of the pharmaceutical industry to keep pace with the increased resistance shown by organisms, by developing new antibiotics. Microbial resistance is being seen even among the most common organisms, largely due to antibiotic misuse by physicians in the country. This calls for a rapid standardization of guidelines, regarding antibiotic use, limiting the use of antibiotics as Over- the -Counter medication (but permitting certain antibiotics to front line paramedics), banning or restricting the use of antibiotics as growth promoters in animal livestock and hospital infection control guidelines a mandatory part of all hospital quality guidelines. Pharmaco-vigilance including prescription audit regarding antibiotic usage in the hospital and community is a must, in order to enforce change in existing practices.
8.10. One important capacity with respect to introduction of new technologies and their uptake into public health programmes is health technology assessment. This new multi-disciplinary domain, modeled on the work of the National Institute of Clinical Excellence in the UK, is required to ensure that technology choice is participatory and is guided by considerations of scientific evidence, safety, cost effectiveness considerations and social values. This approach is extended also to technology choice involved in the development of standard treatment guidelines and in public health programmes. The National Health Policy commits to the development of capacity in this areas and the use of this approach for making technology choices that impacts on public health.

9. ICT for Health & Health Information Needs

9.1 Health Information is acknowledged as one of the key dimensions of the health systems. Use of ICT has the potential to reduce frequency of hospital visits & management of chronic diseases. Similarly population level health metrics could guide the development of health policy. E-Health could also facilitate medical consultation with specialists, capacity building of health care workers/professionals, and improve program monitoring and supervision, and delivery of emergency care. However, much of this potential in public health has largely remained under-realized due to a number of policy and operational constraints. This policy will focus on improved deployment of ICT for improving the outcome of the Indian healthcare system.

9.2 An integrated health information system which serves the needs of all stake-holders and improves efficiency, transparency, citizen experience, and delivery of better health outcomes in terms of access, quality, affordability and lowering of disease burden and facilitates monitoring of health entitlements to citizens is the goal. This integrated health information architecture will stand on five pillars- first, the systems for increasing public access to information of community health and the individual’s access to her/his own health records, secondly the tools required for public health providers- at the periphery and at mid-level management, thirdly systems for support to providers and hospital managers for a measurable improvement in quality and efficiency of care, fourth, an IT enabled supply chain management systems and finally, systems for better monitoring, planning and governance.

9.3 A caution that the policy takes note of is that such digitization of all health events and processes should be firmly embedded in a modern understanding of civil liberties and therefore safeguard patient privacy and autonomy and ownership over information that concerns them. Such aspects pertaining to data privacy & security, etc. will be addressed through appropriate regulatory and statutory framework. National e-Health Authority (NeHA) will be set up to provide leadership in implementation of the integrated health information system, to ensure information availability across all health system components, to promote adoption of standards and facilitate exchange of patients health records across facilities in a secure way.

9.4 The transformation of primary care in the larger understanding of district health systems is linked to many steps. One step is every individual and family is issued a health card which entitles them to a range of preventive and promotive services from the primary care team. Another is
digitizing the functions of recording service delivery, enabling follow up, reporting on services delivered and analytics of local public health situation, while measurably reducing the time the peripheral provider spends on register and data work. The third step is a feature which enables continuity of care with higher levels. And finally building district and sub-district capacity for management including appropriate payment gateways to facilities and to individual beneficiaries as required. Functions like appointment scheduling, effective grievance redressal, case record maintenance which have never happened earlier at primary care levels can now be enabled by ICT.

9.5 A robust growth of ICT to meet various needs of health care system requires a national health information architecture where States and facilities can develop systems to suit their needs and priorities as long as they are consistent with Electronic Health Record Standards and Data and Metadata Standards and inter-operability guidelines as laid down and enforced by the National eHealth Authority (NeHA).

9.6 The integrated health information system will be based on key principles and strategies like (a) adoption of National Electronic Health Record Standards (announced by the Ministry in 2013) and Metadata and Data Standards; (b) federated architecture to roll-out and link systems across public and private health providers at State level and national level; (c) progressive use of “Aadhaar” (Unique ID) for identification (in case UID is not available, then other ID would be created as per the standards notified by the Ministry) and issue of a unique Health Card to every citizen; (d) creation of registries (i.e. patients, provider, service, diseases, document and event) for enhanced public health analysis; (e) creation of health information exchange platform and national health information network; (f) use of existing/planned national & state level IT infrastructures such as the National Optical Fiber Network, Meghraj (cloud), (g) smartphones/tablets for capturing real-time data; and (h) setting-up of dedicated governance structures.

9.7 The National Health Policy also sees tremendous potential for the application of Tele-medicine systems and M-Health. These have applications in ensuring continuity of care across levels of care and for reaching out to rural and remote areas. It also has great scope along with other communication channels like the internet for creation of online clinical and non-clinical learning materials that can transform systems of training and distance education for both in-service needs and for the private sector partners. All these growing needs will require the creation of a new discipline and the building of capacity within public systems for health informatics - which itself emerges from the combination of public health, information sciences, information technology and understanding of social contexts and institutions in the application of technology. The policy advocates scaling of various initiatives in the area of tele-consultation which will entail linking tertiary care institutions (medical colleges) to District and Sub-district hospitals which provide secondary care facilities, for the purpose of specialist consultations.

9.8 ICT would similarly be used for generation and sharing of information about AYUSH services and AYUSH practitioners, the traditional community level healthcare providers, and household level preventive, promotive and curative practices. This will strengthen the management and quality of AYUSH services in the public system and also provide an outreach component for prevention and promotion of health.
Demographic and health surveys will continue to play a major role in policy formulation- partly as a validation of data from routine systems, partly because it would take time to establish routine reporting into the system by private health care facilities and partly because some types of information are better captured through surveys. The scope of surveys would also need to be extended to capture information regarding costs of care and financial protection provided by different forms of financing and provisioning. Such information is vital for measuring progress towards the national health policy objectives and improving upon the mix of strategies used in different contexts. In addition to the NFHS surveys, a sample survey of districts done every year for morbidity and cost of care analyses modeled on the 71st round of the NSSO surveys would build on the baseline provided by the 71st round with a moving average and a real-time situation analysis on cost of care. In addition, the policy recommends rapid programme appraisals and periodic disease specific surveys to monitor the impact of public health and disease interventions.

One other important source of information is vital events reporting, especially cause of death reporting. Today, we have reliable medically certified causes for only about 28% of deaths. Careful deployment of ICT tools, improvement of work processes, and innovative capacity building has to come together to make this fundamental tool of decentralized and disaggregated burden of disease measure reliable enough for health planning and health outcome measurements at all levels.

10. Knowledge for Health

The National Health Policy recognizes the key role that health research plays in the development of a nation’s health. Health research internationally incorporates two approaches (i) research on country specific health problems necessary to formulate sound policies and plans for field action; and (ii) contributions to global health research aimed at developing new knowledge and technologies to solve health problems of general significance, which are also relevant to the population of the country. In knowledge based sector like health, where advances happen daily, it is important to invest at least 5% of all health expenditure on health research. The establishment of a Department of Health Research (DHR) in the Ministry of Health & Family Welfare was in recognition of the key role that health research would play for the nation.

The policy envisages strengthening the publicly funded health research institutes under the Department of Health Research, the apex public health institutions under the Department of Health & Family Welfare, and research activity in the Government and private medical colleges in the nation. The fact is that in 2007, 96% of the research publications in India emanated from as little as 9 medical colleges that reflect how little most of them are geared to the challenges of health research. Further much of this published research is not on priority health concerns and the translation of key research findings into policy, which could improve the health of the people, is very limited and needs to be enhanced. The health policy encourages development of a culture of research in all public and private institutions of higher learning, enabling evidence based policymaking and implementation. The health policy also notes the need for partnerships with the growing presence in research of universities, and privately owned research institutes and research laboratories.
Health research in India needs to advance on three fronts. One front is to generate the evidence base required for decision making in Health Systems and Services. This requires establishing linkages between health research and national health programs to identify key operational issues and to ensure uptake of research findings into decision making in public health. The second front is in medical product innovation and discovery as required for our public health needs and to sustain a vibrant Indian pharmaceutical and medical device industry on par with global standards. The third front is to encourage the development of fundamental research in all areas relevant to Health, such as Physiology, Biochemistry, Pharmacology, Microbiology, Pathology, Molecular Sciences and Cell Sciences, to ensure that a national critical mass of scientists who can contribute the benefits of modern technology to health research is developed. Each of these three fronts of advance needs their own distinct strategies, and institutional and governance mechanisms. While aiming to integrate systems of medicine, the Policy aims to promote innovation, discovery and translational research of drugs from AYUSH and allocate adequate funds towards it. Emerging areas of research including stem cell research and use of nanotechnology will also be encouraged. Research on social determinants of health and neglected health issues such as disability and transgender health will also be promoted. Additionally, a vision document for time bound prioritized research agenda based on consultative approach, is envisioned to address future health needs.

For health systems and operational research, at least half of it should come from research that is commissioned by programme managers in charge of implementing programmes as formative research, problem solving or evaluation. This research is by nature very inter-disciplinary with the social science and uptake of research findings requires engagement with the health systems. The human resources in this research needs to have interaction and even mobility between implementers, researchers and administrators. Coordinating committees led by implementing agencies would be essential. Such research must cover areas of patient safety, quality improvement, use of drugs and diagnostics and must involve a range of public, private and academic and non-profit players through research networks.

For drug and devices discovery and innovation, both from Allopathy and traditional medicines systems, Steering Committees that bring together the Department of Pharmaceuticals, the Department of Biotechnology, the regulatory bodies, the Department of Industrial Policy and Promotion, the Department of Science and Technology with the Health Ministry are important. A common sector innovation council for the Health Ministry should be strengthened and made functional to play this role with its leadership shared between the Department of Health & Family Welfare and Department of Health Research. Here the challenges are not only in discovery, but in managing intellectual property rights, testing of products especially clinical trials, health technology assessment, and managing the transition from laboratory to the market. Here innovative strategies of public financing and careful leveraging of public procurement can help generate the sort of innovations that are required for Indian public health priorities. Drug research on critical diseases such as TB, HIV/AIDS, and Malaria may be incentivized to address them on priority.
Publicly finances research institutions that were established as core of nation building contributed significantly but many lag behind. These would be benchmarked with the best institutions in their domain nationally and internationally and supported by financing and partnerships to achieve highest levels of performance. It would also require appropriate HR policies, a considerable degree of autonomy and transparency without compromising on responsiveness to policy priorities and systems of constantly upgrading the knowledge base, capacity and skills. A good permeability across institutional boundaries through networking and collaborations with multiple partners is also essential.

For making full use of all research capacity in the nation, grant in aid mechanisms which provide extramural funding to research efforts would be scaled up so that potentially every research institution in medicine and health related field in the nation is engaged- even if it requires considerable efforts in capacity building. Grant-in-aid mechanisms will also encourage academic and research contributions from health NGOs and private institutions.

One area of growing concern in health research is in the ethical dimensions, especially with reference to clinical trials and conflict of interest situations. The clinical trials registry established by ICMR and DST is a good start but would need to be implemented well. However, if India has to get into drug and device discovery, it would need to ensure that while there is no relaxation of ethics and safeguards in trials, delays in approvals and a blanket fear of any trials would be most unhelpful. Clear and transparent guidelines, with independent monitoring mechanisms are the way forward, to foster a progressive and innovative research environment, while safeguarding the rights and health of the trial participants.

In order to develop a strong base of data and information, academia, public policymakers, private sector and industry needs to come together in the form of information sharing partnerships and research collaborations.

There is also the need to develop information data-bases that researchers can share on a wide variety of areas. This includes ensuring that all unit data of major publicly funded surveys related to health are available in the net in a research friendly format. This would include disease registries, data from National Anti-Microbial Resistance Surveillance and other surveillance programmes, microbial, viral bio-banks, causes of death data, and so on.

International aid agencies were once important sources of financing of public health programmes, but today their entire contribution is less than 1% of public health expenditure. In recent years their role therefore has been largely focused on technical assistance and capacity building where they are making substantial contributions, especially in states like Uttar Pradesh, Bihar, Jharkhand where much greater investment is needed to build up organizational capacity. International Partnerships will continue to play an important in developing national capacity. This could be done through technical assistance and through provision of access to updated knowledge and skills from across all nations, by sharing best practices, and by setting standards and benchmarks.
10.12 India needs to also develop its own new policy towards international health and health diplomacy. Such a policy should leverage our strengths in cost effective innovations in the areas of pharmaceuticals, medical devices, health care delivery and information technology - to assist all nations in improved access to essential healthcare services at much lower costs. The policy should benefit from learnings and experiences of other nations and bring in their strengths and best practices with respect to generating new knowledge and technologies needed to address health priorities of the developing world, for improving quality of care, for better regulation of private sector and as advocacy for increasing public investment in health. The country should leverage international cooperation, especially involving nations of the Global South, to build domestic institutional capacity in green-field innovation, and for knowledge and skill generation. It could build alliances with nations in similar situations, like the BRICS nations to develop terms of trade and intellectual property rights regimes that are supportive of national economic growth and health policies.

10.13 In the context of India being an emerging developed nation, the policy must move towards repositioning India from being a recipient of aid and technical assistance to an equal partner in international technical cooperation and the pace-setter in setting international norms and standards that prioritize people’s health as the central consideration. In partnership with other BRICS nations, it must guide the multilateral institutions like WHO, towards strengthening their democratic and representative structure.

11. Governance

11.1 Federal Structure- Role of State and Role of Center: One of the most important strengths and at the same time challenges of governance in health is the distribution of responsibility and accountability between the Center and the States. Though health is a State subject, the Center has accountability to parliament for central funding – which is about 36% of all public health expenditure and in some states over 50%. Further, it has its obligations under a number of international conventions and treaties that is a party to. Further, disease control and family planning are in the concurrent list and these could be defined very widely. Finally though state ownership has been used by some states to become domain leaders and march ahead setting the example for others, the Center has a responsibility to correct uneven development and provide more resources where vulnerability is more. The way forward is for equity sensitive resource allocation, strengthening institutional mechanisms for consultative decision-making and coordinated implementation, better management of fiduciary risks, and provision of capacity building and technical assistance to states. This should be done through the active involvement of local self-governments and ensuring community based monitoring of health outputs.

11.2 The Institutional Framework: The main challenge at both Center and the States is strengthening the synergistic functioning of the directorate as the technical leadership and the civil services as the administrative leadership and coordinating both of these with the increasing number of State owned or fully State financed corporations, and registered societies and
autonomous or semi-autonomous institutions. Directorates need to be strengthened by HR policies, central to which is that, those from a public health management cadre must hold senior positions in public health. Civil servants too should have clear induction and orientation programmes in the domain as also general understanding of institutional processes that they need to put in place so that the directorates and various state owned institutions in a knowledge based sector are able to perform optimally. Hospital and facilities management should be the domain of the hospital management professionals. There should be a clear separation of roles and responsibilities between doctors providing clinical services, hospital management professionals and public health specialists. Capacity building of all cadres / levels of health professionals should be systemically a continuous process.

11.3 State Owned, Guided and Financed Institutions: Examples of State owned, financed and guided institutions include State health societies and programme management units, medical services corporation that look after procurement and logistics, in some states infrastructure and transport management bodies, State institutes of health and family welfare and State health systems resource centers, State agencies for management of emergency response services, and State agencies or trusts for managing purchasing of care from private sector and a number of large tertiary care centres which have autonomous status. These are becoming essential either because they require very specialized skill sets that general human resource policies cannot bring together and sustain, and/or because a financial autonomy is essential for carrying out a set of complex operations in an accountable and time bound manner. A systematic study of best practices in such institutions across States can inform us of the most appropriate institutional design and mechanisms for such institutions. General guidelines in the form of minimum governance standards for such state owned or state financed corporations and trusts and societies within which one can have flexibility to frame rules and incur expenditure without referral for approvals at each step would be put in place for ensuring optimal functioning. These would include, clear terms of reference for the organization, a board where both the chairperson and members have their accountability as much as the CEO as his, and clear statement of measures of performance and performance reviews.

11.4 Role of Panchayati Raj Institutions: All elected local bodies-rural and urban would be enabled to provide leadership and participate in the functioning of district and sub-district institutions. Most important of these are the RogiKalyanSamitis (RKS) and the Village Health Sanitation and Nutrition Committee (VHSNC). PRIs would be strengthened to play an enhanced role at different levels for health governance, including the social determinants of health. VHSNCs should be made functional universally. In particular they would be in charge of, and could be financed for implementing a number of preventive and promotive health actions that are to be implemented at the level of the community. There is need to make mandatory Community based monitoring and planning (CBMP) to place people at the center of the Health system. It enables better monitoring of quality of services and improves accountability in management and delivery of health care services.
11.5 Addressing Fiduciary Risks: One of the key problems of the Central Government’s financing of the states relates to fiduciary risks. This is only one part of improving accountability, but mismanagement of funds is what brings the programme the most disrepute. While routine systems of audit would continue to be strengthened- the center as funding agency can insist on some key institutional mechanisms that reduce this risk and monitor whether these are in place, at least with respect to its funds. The four most important processes where the States should be asked to create rules that conform to good governance standards as laid out by the Center and then comply with them would be a) procurement and logistics for drugs and devices b) transfers and postings c) appointment of a regular district chief health and medical officer or equivalent by due process – since most funds are given to or spent by district health society d) selection of partners and timely payments to them in public private partnerships and similarly grant-in-aid mechanisms for NGOs.

11.6 Improving Accountability: The policy would be to increase both horizontal and vertical accountability of the health system. This would be done by providing a greater role and participation of local bodies and encouraging community monitoring along with ensuring grievance redressal systems and programme evaluations.

11.7 Involving Communities: Communities have a right and duty to participate in their health care and health programmes would be designed to provide the role to do so. The village health, sanitation and nutrition committee is one major institutional mechanism for ensuring this- and under the leadership of the gram panchayat, it must be strengthened with capacity building and support to play this role. Involvement of community based organizations, NGOs and representatives in decision-making in hospital development societies and district consultative bodies would also be undertaken. A Peoples Health Assembly at the district level and urban wards should be held at least once in three years to discuss issues of preventive and promotive health and progress made on health plans, and to develop health and health care as a social movement would also be encouraged. In the process of engagement with communities and empowering them to contribute, non-governmental organizations with a tradition of working for community health have an important contribution to make.

11.8 Professionalizing Management, Incentivizing Performance: Improved governance must also be reflected in better leadership – which is as much a matter of motivation as of competence. Competence requires formal training for the requisite management and leadership skills. It also requires bringing in at the leadership level, on a regular basis or through consultancies and partnerships, the mix of professional knowledge and skills that are needed. It also needs to build up an environment where good performance is incentivized. Unless the system is able to demonstrate that it is providing more health for the money being allocated to it, it would be unable to sustain its case for more money for the health sector.

12. Legal Framework for Health Care and the Right to Health Pathway

12.1 There are a large number of laws that govern health policy and implementation in a number of areas- and health policy has not only to be compliant with these laws but also contribute to
strengthening implementation. There are unfortunately a number of laws that have over time developed inadequacies due to changed contexts and a number of newly emerged services and technologies where laws are needed. Laws under review include the Mental Health Bill, the Medical Termination of Pregnancy Act, the bill regulating surrogate pregnancy and assisted reproductive technologies, Food Safety Act, and Drugs and Cosmetics Act. The process of aligning many of these laws to meet our needs and changed circumstances and understanding becomes one of the urgent tasks in the coming years.

12.2 One of the fundamental policy questions being raised in recent years is whether to pass a health rights bill making health a fundamental right- in the way that was done for education. Many of the developing nations that have made significant progress towards universal health coverage like Brazil and Thailand have done so and the presence of an enabling law was a major contributory factor. A number of international covenants to which we are joint signatories give us such a mandate- and this could be used to make a national law. Courts have also rulings that in effect see health care as a fundamental right- and a constitutional obligation flowing out of the right to life. There has been a ten-year long discussion over this without a final resolution. The policy question is whether we have reached the level of economic and health systems development as to make this a justiciable right- implying that its denial is an offense. And whether when health care is a State subject, it is desirable or useful to make a Central law? And whether such a law should mainly focus on the enforcement of public health standards on water, sanitation, food safety, air pollution etc, or on it should focus on health rights- access to health care and quality of health care – i.e. whether focus should be on what the State enforces on citizens or on what the citizen demands of the state?

12.3 Right to healthcare covers a wide canvas encompassing issues of preventive, curative, rehabilitative healthcare across rural and urban areas, infrastructure availability, health human resource availability, as also issues extending beyond health sector into the domain of poverty, equity, literacy, sanitation, nutrition, drinking water availability, etc. Excellent health care system need to be in place to ensure effective implementation of the health rights at the grassroots level. Right to health cannot be perceived unless the basic health infrastructure like doctor-patient ratio, patient- bed ratio, nurses- patient ratio, etc are near or above threshold levels and uniformly spread-out across the geographical frontiers of the country. It would therefore be imperative that there is a clear understanding on the sequencing, of the health care interventions in terms of: the scope and coverage of health care (preventive, curative and rehabilitative), the financial limits, the levels (primary, secondary and tertiary), the rural- urban coverage, the population coverage, coverage of diagnostics and drugs etc. Further, the procedural guidelines, common regulatory platform for public and private sector, standard treatment protocols, etc needs to be put in place. The management, administrative and overall governance structure in the health system accordingly needs to be overhauled. Additionally, the responsibilities and liabilities of the providers, insurers, clients, regulators and government in administering the right to health need to be clearly spelt out. Merely providing constitutional protection, may not guarantee a good track record in implementing. Therefore any roadmap for introducing an Act on health care requires a clear perspective on rules to be framed, notifications etc. to follow there under, the scope, coverage and depth of health interventions to be brought within the ambit of a right.
12.4 As a precursor, an essential step would be identification of services to be covered, institutions/persons responsible for delivery of care, rights and duties of citizens. Keeping in view the policy objective of ensuring public health expenditure at the level of 2.5% of GDP in coming five years, it is expected that a threshold of per capita public health expenditure of over Rs. 3800 (at current prices) could be achieved in many states, forming the basis for operationalisation of Right to Healthcare. A threshold of per capita public health expenditure of over Rs 3800 (at current prices) would be the floor level for consideration. The policy while supporting the need for moving in the direction of rights based approach to healthcare is conscious of the fact that threshold levels of finances and infrastructure is a precondition for an enabling environment, to ensure that the poorest of the poor stands to gain the maximum and not embroiled in legalities. The policy advocates a progressively incremental assurance based approach, with assured funding to create an enabling environment for realizing healthcare on rights based approach in the near future.


A Policy is only as good as its implementation. Past policies have faced innumerable constraints in implementation. The National Health Policy therefore envisages that an implementation framework be put in place to deliver on these policy commitments. Such an implementation framework would enable prioritization and sequencing the activities linked to output targets and time schedules that can be taken up based on financial resource availability. The implementation framework would also reflect learnings from past experience, identify good practices as also administrative reforms required for more appropriate rules and regulations to govern public financing, institutional design and human resource policies for this sector. It also delineatesthere-structuring of institutions required for better governance and management at national, state and district levels, measures for improving institutional capacity to deliver, and most important the division of powers, functions and accountability between Center and States with respect to health sector performance.