IJFANS INTERNATIONAL JOURNAL OF FOOD AND NUTRITIONAL SCIENCES
ISSN PRINT 2319 1775 Online 2320 7876
, UGC CARE Listed (Group -I) Journal Volume 11, Iss 04, 2022

NATIONAL HEALTH POLICY 2017

M. Raghavendran, Pratibha Srivastava, Madan Mohan Gupta, Shahanwaj Khan, Alan. V. Joseph
Faculty of Nursing, Rama University, Kanpur, Uttar Pradesh, India
Email id: dean.nursing@ramauniversity.ac.in

ABSTRACT
The National Health Policy of 1983 and the National Health Policy of 2002 have served well in guiding the approach for the health sector in the Five-Year Plans. The current context has however changed in four major ways. First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases. The second important change is the emergence of a robust health care industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to health care costs, which are presently estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, a new health policy responsive to these contextual changes is required. The National Health Policy, 2017 (NHP, 2017) seeks to reach everyone in a comprehensive integrated way to move towards wellness. The policy envisages as its 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. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery.

Key words: policy, approach, maternal, disease and incidence.

1. INTRODUCTION

The National Health Policy of 1983 and the National Health Policy of 2002 have served well in guiding the approach for the health sector in the Five-Year Plans. Now 14 years after the last health policy, the context has changed in four major ways. First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases. The second important change is the emergence of a robust health care industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to health care costs, which are presently estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, a new health policy responsive to these contextual changes is required. The primary aim of the National Health Policy, 2017, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investments 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 knowledge base, developing better financial protection strategies, strengthening regulation and health assurance. NHP 2017 builds on the progress made since the last NHP 2002. The developments have been captured in the document "Backdrop to National Health Policy 2017- Situation Analyses", Ministry of Health & Family Welfare, Government of India.

2. GOAL, PRINCIPLES AND OBJECTIVES

2.1 Goal

The policy envisages as its 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. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery. The policy recognizes the pivotal importance of Sustainable Development Goals (SDGs). 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.

2.2. Policy Principles

I. **Professionalism, Integrity and Ethics:** The health policy commits itself to the highest professional standards, integrity and ethics to be maintained in the 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. It would mean 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.

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

IV. **Universality:** Prevention of exclusions on social, economic or on grounds of current health status. In this backdrop, systems and services are envisaged to be

designed to cater to the entire population- including special groups.

V. **Patient Centered & Quality of Care**: Gender sensitive, effective, safe, and convenient healthcare services to be provided with dignity and confidentiality. There is need to evolve and disseminate standards and guidelines for all levels of facilities and a system to ensure that the quality of healthcare is not compromised.

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

VII. **Inclusive Partnerships**: A multi stakeholder approach with partnership & participation of all non-health ministries and communities. This approach would include partnerships with academic institutions, not for profit agencies, and health care industry as well.

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

IX. **Decentralization:** Decentralisation of decision making to a level as is consistent with practical considerations and institutional capacity. Community participation in the health planning processes is promoted side by side.

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.

2.3 Objectives

Improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality.

2.3.1 Progressively achieve Universal Health Coverage:

A. Assuring availability of free, comprehensive primary health care services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population. The Policy also envisages optimum use of existing manpower and infrastructure as available in the health sector and advocates collaboration with non -government sector on pro-bono basis for delivery of health care services linked to a health card to enable every family to have access to a doctor of their choice from amongst those volunteering their services.

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

C. Achieving a significant reduction in out of pocket expenditure due to health care costs and achieving reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment.

2.3.2 Reinforcing trust in Public Health Care System:

Strengthening the trust of the common man in public health care system by making it predictable, efficient, patient centric, affordable and effective, with a comprehensive package of services and products that meet immediate health care needs of most people.

2.3.3 Align the growth of private health care sector with public health goals:

Influence the operation and growth of the private health care sector and medical technologies to ensure alignment with public health goals. Enable private sector 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 sector, in alignment with the public health goals.

3. POLICY THRUST

3.1 Ensuring Adequate Investment The policy proposes a potentially achievable target of raising public health expenditure to 2.5% of the GDP in a time bound manner. It envisages that the resource allocation to States will be linked with State development indicators, absorptive capacity and financial indicators. The States would be incentivised for incremental State resources for public health expenditure. General taxation will remain the predominant means for financing care. The Government could consider imposing taxes on specific commodities- such as the taxes on tobacco, alcohol and foods having negative impact on health, taxes on extractive industries and pollution cess. Funds available under Corporate Social Responsibility would also be leveraged for well-focused programmes aiming to address health goals.

3.2 Preventive and Promotive Health The policy articulates to institutionalize inter-sectoral coordination at national and sub-national levels to optimize health outcomes, through constitution of bodies that have representation from relevant non-health ministries. This is in line with the emergent international "Health in All" approach as complement to Health for All. The policy prerequisite is for an empowered public health cadre to address social determinants of health effectively, by enforcing regulatory provisions.

The policy identifies coordinated action on seven priority areas for improving the environment for health:

o The Swachh Bharat Abhiyan

- Balanced, healthy diets and regular exercises.
- Addressing tobacco, alcohol and substance abuse
- Yatri Suraksha – preventing deaths due to rail and road traffic accidents
- Nirbhaya Nari –action against gender violence
- Reduced stress and improved safety in the work place
- Reducing indoor and outdoor air pollution

3.3 Organization of Public Health Care Delivery:

The policy proposes seven key policy shifts in organizing health care services

- In primary care – from selective care to assured comprehensive care with linkages to referral hospitals
- In secondary and tertiary care – from an input oriented to an output based strategic purchasing
- In public hospitals – from user fees & cost recovery to assured free drugs, diagnostic and emergency services to all
- In infrastructure and human resource development – from normative approach to targeted approach to reach under-serviced areas
- In urban health – from token interventions to on-scale assured interventions, to organize Primary Health Care delivery and referral support for urban poor. Collaboration with other sectors to address wider determinants of urban health is advocated.
- In National Health Programmes – integration with health systems for programme effectiveness and in turn contributing to strengthening of health systems for efficiency.
- In AYUSH services – from stand-alone to a three dimensional mainstreaming

4. NATIONAL HEALTH PROGRAMMES

4.1 RMNCH+A services: Maternal and child survival is a mirror that reflects the entire spectrum of social development. This policy aspires to elicit developmental action of all sectors to support Maternal and Child survival. The policy strongly recommends strengthening of general health systems to prevent and manage maternal complications, to ensure continuity of care and emergency services for maternal health. In order to comprehensively address factors affecting maternal and child survival, the policy seeks to address the social determinants through developmental action in all sectors.

4.2 Child and Adolescent Health: The policy endorses the national consensus on accelerated achievement of neonatal mortality targets and „single digit" stillbirth rates through improved home based and facility based management of sick newborns. District hospitals must ensure screening and treatment of growth related problems, birth defects, genetic diseases and provide palliative care for children. The policy affirms commitment to pre-emptive care (aimed at pre-empting the occurrence of diseases) to achieve optimum levels of child and adolescent health. The policy envisages school health programmes as a major focus area as also health and hygiene being made a part of the school curriculum

4.3 Interventions to Address Malnutrition and Micronutrient Deficiencies: Malnutrition, especially micronutrient deficiencies, restricts survival, growth and development of children. It 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. Recognising this, the policy declares that micronutrient deficiencies would be addressed through a well-planned strategy on micronutrient interventions. Focus would be on reducing micronutrient malnourishment and augmenting initiatives like micro nutrient supplementation, food fortification, screening for anemia and public awareness. 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.

4.4 Universal Immunization: Priority would be to further improve immunization coverage with quality and safety, improve vaccine security as per National Vaccine Policy 2011 and introduction of newer vaccines based on epidemiological considerations. The focus will be to build upon the success of Mission Indradhanush and strengthen it.

4.5 Communicable Diseases: The policy recognizes the interrelationship between communicable disease control programmes and public health system strengthening. For Integrated Disease Surveillance Programme, the policy advocates the need for districts to respond to the communicable disease priorities of their locality. This could be through network of well-equipped laboratories backed by tertiary care centers and enhanced public health capacity to collect, analyze and respond to the disease outbreaks.

4.5.1 Control of Tuberculosis: The policy acknowledges HIV and TB co infection and increased incidence of drug resistant tuberculosis as key challenges in control of Tuberculosis. The policy calls for more active case detection, with a greater involvement of private sector supplemented 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, dropouts reduced and transmission of resistant strains are contained.

4.5.2 Control of HIV/AIDS: While the current emphasis on prevention continues, the policy recommends focused interventions on the high risk communities (MSM, Transgender, FSW, etc.) and prioritized geographies. There is a need to support care and treatment for people living with HIV/AIDS through inclusion of 1st, 2nd and 3rd line antiretroviral(ARV), Hep-C and other costly drugs into the essential medical list.

4.5.3 Leprosy Elimination: To carry out Leprosy elimination the proportion of grade-2 cases amongst new cases will become the measure of community awareness and health systems capacity, keeping in mind the global goal of reduction of grade 2 disability to less than 1 per million by 2020. Accordingly, the policy envisages proactive measures targeted towards elimination of leprosy from India by 2018.

4.5.4 Vector Borne Disease Control: The policy recognizes the challenge of drug resistance in Malaria, which should be dealt with by changing treatment regimens with logistics support as appropriate. New National Programme for prevention and control of Japanese Encephalitis (JE)/Acute Encephalitis Syndrome (AES) should be accelerated with strong component of inter-sectoral collaboration. The policy recognizes the interrelationship between communicable

disease control programmes and public health system strengthening. Every one of these programmes requires a robust public health system as their core delivery strategy. At the same time, these programmes also lead to strengthening of healthcare systems.

4.6 Non-Communicable Diseases: The policy recognizes the need to halt and reverse the growing incidence of chronic diseases. The policy recommends to set-up a National Institute of Chronic Diseases including Trauma, to generate evidence for adopting cost effective approaches and to showcase best practices. 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. The policy focus is also on research. It emphasizes developing protocol for mainstreaming AYUSH as an integrated medical care. This has a huge potential for effective prevention and therapy, that is safe and cost-effective. Further the policy commits itself to support programmes for prevention of blindness, deafness, oral health, endemic diseases like fluorosis and sickle cell anaemia/thalassemia,etc

4.7 Population Stabilization: The National Health Policy recognises that improved access, education and empowerment would be the basis of successful population stabilization. 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% currently, to at least 30% and if possible much higher.

5. Women's Health & Gender Mainstreaming: There will be enhanced provisions for reproductive morbidities and health needs of women beyond the reproductive age group (40+). This would be in addition to package of services covered in the previous paragraphs**.**

6. Gender based violence (gbv):

Women's access to healthcare needs to be strengthened by making public hospitals more women friendly and ensuring that the staffs has orientation to gender – sensitivity issues. This policy notes with concern the serious and wide ranging consequences of GBV and recommends that the health care to the survivors/ victims need to be provided free and with dignity in the public and private sector.

7. Supportive supervision:

For supportive supervision in more vulnerable districts with inadequate capacity, the policy will support innovative measures such as use of digital tools and HR strategies like using nurse trainers to support field workers.

8. Emergency care and disaster preparedness:

Better response to disasters, both natural and manmade, requires a dispersed and effective capacity for emergency management. It requires an army of community members trained as first responder for accidents and disasters. It also requires regular strengthening of their capacities in close collaboration with the local self-government and community based organisations. The policy supports development of earthquake and cyclone resistant health infrastructure in vulnerable geographies. It also supports development of mass casualty management protocols for CHC and higher facilities and emergency response protocols at all levels.

9. Tertiary care Services: The policy affirms that the tertiary care services are best organized along lines of regional, zonal and apex referral centers. It recommends that the Government should set up new Medical Colleges, Nursing Institutions and AIIMS in the country following this broad principle. Regional disparities in distribution of these institutions must be addressed. The policy supports periodic review and standardization of fee structure and quality of clinical training in the private sector medical colleges. The policy enunciates the core principle of societal obligation on the part of private institutions to be followed. This would include:

- Operationalization of mechanisms for referral from public health system to charitable hospitals.
- Ensuring that deserving patients can be admitted on designated free / subsidized beds. .

10. Human Resources for Health: There is a need to align decisions regarding judicious growth of professional and technical educational institutions in the health sector, 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 regulating the system to generate the right mix of skills at the right place. This policy recommends that medical and para-medical education be integrated with the service delivery system, so that the students learn in the real environment and not just in the confines of the medical school.

12. Financing of Health Care: The policy advocates allocating major proportion (upto two-thirds or more) of resources to primary care followed by secondary and tertiary care. Inclusion of cost-benefit and cost effectiveness studies consistently in programme design and evaluation would be prioritized. This would contribute significantly to increasing efficiency of public expenditure. A robust National Health Accounts System would be operationalized to improve public sector efficiency in resource allocation/ payments. The policy calls for major reforms in financing for public facilities – where operational costs would be in the form of reimbursements for care provision and on a per capita basis for primary care. .

13. Regulatory Framework: The regulatory role of the Ministry of Health and Family Welfare- which includes regulation of clinical establishments, professional and technical education, food safety, medical technologies, medical products, clinical trials, research and implementation of other health related laws- needs urgent and concrete steps towards reform. This will

entail moving towards a more effective, rational, transparent and consistent regime.

14 Vaccine Safety: Vaccine safety and security would require effective regulation, research and development for manufacturing new vaccines in accordance with National Vaccine Policy 2011. The policy advocates commissioning more research and development for manufacturing new vaccines, including against locally prevalent diseases. It recommends building more public sector manufacturing units to generate healthy competition; uninterrupted supply of quality vaccines, developing innovative financing and creating assured supply mechanisms with built in flexibility.

15 Medical Technologies: India is known as the pharmacy of the developing world. However, its role in new drug discovery and drug innovations including bio-pharmaceuticals and bio-similars for its own health priorities is limited. This needs to be addressed in the context of progress towards universal health care. Making available good quality, free essential and generic drugs and diagnostics, at public health care facilities is the most effective way for achieving the goal. The free drugs and diagnostics basket would include all that is needed for comprehensive primary care, including care for chronic illnesses, in the assured set of services.

16. Public Procurement: Quality of public procurement and logistics is a major challenge to ensuring access to free drugs and diagnostics through public facilities. An essential pre-requisite that is needed to address the challenge of providing free drugs through public sector, is a well-developed public procurement system.

17. Availability of Drugs and Medical Devices: The policy accords special focus on production of Active Pharmaceutical Ingredient (API) which is the back-bone of the generic formulations industry. Recognizing that over 70% of the medical devices and equipments are imported in India, the policy advocates the need to incentivize local manufacturing to provide customized indigenous products for Indian population in the long run. The goal with respect to medical devices shall be to encourage domestic production in consonance with the "Make in India" national agenda. Medical technology and medical devices have a multiplier effect in the costing of healthcare delivery.

18. Aligning other policies for medical devices and equipment with public health goals: For medical devices and equipment, the policy recommends and prioritises establishing sufficient labeling and packaging requirements on part of industry, adequate medical devices testing facility and effective port - clearance mechanisms for medical products.

19. Anti-microbial resistance: The problem of anti-microbial resistance calls for a rapid standardization of guidelines, regarding antibiotic use, limiting the use of antibiotics as Over-the-Counter medication, banning or restricting the use of antibiotics as growth promoters in animal livestock. Pharmaco-vigilance including prescription audit inclusive of antibiotic usage, in the hospital and community, is a must in order to enforce change in existing practices.

20. Health Technology Assessment: Health Technology assessment is required to ensure that technology choice is participatory and is guided by considerations of scientific evidence, safety, consideration on cost effectiveness and social values. The National Health Policy commits to the development of institutional framework and capacity for Health Technology Assessment and adoption.

21. Health Surveys: The scope of health, demographic and epidemiological surveys would be extended to capture information regarding costs of care, financial protection and evidence based policy planning and reforms. The policy recommends rapid programme appraisals and periodic disease specific surveys to monitor the impact of public health and disease interventions using digital tools for epidemiological surveys.

22. Health Research: The National Health Policy recognizes the key role that health research plays in the development of a nation's health. In knowledge based sector like health, where advances happen daily, it is important to increase investment in health research.

23. Implementation Framework and Way Forward

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

REFERNCE

1. "National Health Policy 2017" (PDF). Ministry of Health and Family Welfare. 2017. Retrieved 2019-01-22.

2**.** Jugal Kishore (2005). National health programs of India: national policies & legislations related to health. Century Publications. ISBN 978-81-88132-13-3. Retrieved 2 September 2012.

3. Berman, Peter (2010). "The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings". Economic and Political Weekly. **45** (16): 65–71. JSTOR 25664359

4. Thayyil, Jayakrishnan; Jeeja, MathummalCherumanalil (2013). "Issues of creating a new cadre of doctors for rural India". International Journal of Medicine and Public Health. **3** (1): 8.

5. Dey, DK; Mishra, V (2014). "Determinants of Choice of Healthcare Services Utilization: Empirical Evidence from India". Indian Journal of Community Health. **26** (4): 357–364.

6. International Institute for Population Sciences and Macro International (September 2007). "National Family Health Survey (NFHS-3), 2005 –06". Ministry of Health and Family Welfare, Government of India. pp. 436–440. Retrieved 5 October 2012.

7. De Costa, Ayesha; Diwan, Vinod (2007). "Where is the public health sector?". Health Policy. **84** (2–3): 269–276.