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Legal Scenario Related to International Organizations and National Health Policies, Plans in Present Aspect

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INTERNATIONAL HEALTH ORGANIZATIONS

With the shrinking of the world into a global village, the jet travel and human interactions has increased the transmission of diseases from one country. Hence, international co-operation in health and disease is desirable.

Several attempts were made in the past for achieving an universal agreement on health issue. These attempts ultimately culminated in the establishment of world Health Organization (WHO) and other International Health Agencies. Bilateral Government agencies and several Non-Government Organizations also play a significant role in international health.

First International Sanitary conference (1851)

This was convened in Paris. Many European countries attended the conference. The objective was to introduce uniformity into quarantine measures, because quarantine measures varied from country-to-country. But the conference was ended in failure, because it was ratified by only three countries. So this code never came into force. Ten more conferences were held between 1851 and 1902 to reach an agreement. All proved futile to achieve agreement on an uniform quarantine procedure, partly because of the gaps in the knowledge of the natural history of the quarantinable diseases and party because of the political difference. However, there was a feeling of arriving at an international plan of action to control communicable diseases.[1]

Pan American Sanitary Bureau (1902)[2]

Pan American Sanitary Bureau (PASB) was the World's first international health agency established in 1902, to co-ordinate quarantine procedures among the American states. The Pan American Sanitary Code evolved by the PASB in 1924, is still in force. In 1947, the PASB was reorganized and was renamed as pan American Sanitary Organized (PASB) Later in 1949, it was agreed that PASO would serve as WHO regional office for Americas. In 1958, it was renamed as pan American Health Organization (PAHO), with its headquarters in Washington DC. PAHO member state include all the 35 countries of America. A major effort of PAHO was the launch of polio eradication in 1985. In September 1994, America was officially declared polio-free.

Office International d'Hygiene Publique (1907)[3]

Following the establishment of PASB, France also felt the need to have a permanent health agency (permanent inter-national health bureau-office International d'Hygiene Pub-lique (OIHP) –popularly called 'Paris office', to disseminate information about communicable diseases and to evolve uniform quarantine procedures. The agreement for the establishment of OIHP was signed in Rome in 1907. It was started purely as European organization, grew steadily, grew steadily, covering 60 countries including British India. Thus, OIHP attained an International character.

OIHP did remarkable work in disseminating the knowledge of communicable diseases and their control and also contributed to other areas of international health. OIHP continued to serve for 40 years as an International Health Organization. Eventually in 1950, it was wound up with WHO.

[1] Suryakantha, AH. , COMMUNITY MEDICINE With Recent Advances (third Ed.), p.809.
[2] Ibid.
[3] Ibid.

Health Organizations of the league of Nations (1923)[4]

The League of Nations was established after the First world War (1914-1918) to ensure peace and stability in the world. However, it was unable to prevent the Second World War and was thus a political failure. It established a Health Organization in 1923 and carried out a commendable work in the field of health, hygiene, nutrition, rural housing, training of health workers, etc. in addition to quarantine and control of communicable disease. It established Eastern Bureau at Singapore. Its effects to amalgamate OIHP and PASB did not succeed. It started to publish Weekly Epidemiological Records, in 1939, the League of Nations was dissolved. But its activities including the publication of Weekly Epidemiological Records continued for your years, i.e. till the start of Second World War. Its functions was ultimately taken over by WHO.

United nations Relief and Rehabilitation Administration[5]

This was an outcome of Second World War. The Health Organization of League of Nations was isolated in Geneva, during the second world war period (1939-1945) and the Paris Office (OIHP) had fallen in German hands. Then United Nations Relief and Rehabilitation Administration (UNRRA) was set up during 1943 with the purpose of organization recovery from the effects of Second World War, specially epidemics. There was a need to tide over the situation. The inspiration came from President Roosevelt himself and so UNRRA was established in 1943. The objectives were to control the epidemics and to offer health and rehabilitative services to displaced persons. It existed hardly for 3 years and did commendable work including control of malaria in Greece and Italy, eradicating malaria in Sardinia and preventing the spread of typhus.

World heath organizations[6]

After the Second World War, United Nations Organization (UNO) was established in 1945 to maintain world peace and security. The member countries proposed the establishment of an International Health Organization in the conference held at San Francisco during 1945. An International health conference was held in New York in 1946 to draft the constitution of the proposed organization. The constitution was ratified on 7th April 1948 and on the same day World Health Organization officially came to into existence. Hence, 7th April of every year is celebrated as the World Health Day, with a special message. A new theme is suggested every year to focus the attention of the world on current specific, health issue of international significance and generate a favorable climate foe their management and control. Thus, WHO is a specialized agency of United Nations. It is a non-political health agency.

Policies and planes for Health Care

POLICIES

Policy is a system which provides the logical framework and rationality of decision making for the achievement of intended objectives It is the statements that guide and provide discretion within limited boundaries. Policies sets priorities and guide resources allocations.[7]

National health policy.-

(NHP) is a statement, enunciated by Government of India, as a 'blue-print' for further action, about the manner in which the task related to health and allied subjects, to be performed. It aims at the elimination of poverty, illiteracy, ill-health, ignorance and equality. India is the one of the few countries in the world to have come out with a national policy on health. In view of the commitment made by the Government of India to achieve the global, social target HFA by 2000 AD[8], the expert committee (appointed by the planning commission) submitted to report in 1981, about accessing the health status of the country, in terms of various indicators, which become the basis of National Health policy.[9] Because of certain comments and criticism, the policy was revised by Ministry of Health and Family welfare, in the year 2002 as 'New National Health Policy-2002;

Goals

Goals of NHP-2002, to be achieved by 2005-2015 are:

- Eradication of poliomyelitis and yaws -2005
- Elimination of leprosy -2005
- Elimination of kala-azar -2010
- Elimination of lymphatic filariasis -2015
- Achieve zero level growth of HIV/AIDS -2007

[4] Id.
[5] Ibid.
[6] Id.
[7] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 302
[8] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P. 799 National health policy, 2002
[9] Rehabilitation Council of India Preamble Amendment Act 2000.

- Reduce mortality by 50 percent on account of TB Malaria and other water-borne ad vector-borne diseases by -2010
- Reduce prevalence of blindness to, 0.5 percent -2010
- Reduce IMR to 30/1000 LB and MMR to 1/1000 LB (i.e. 100/lakh LB)
- Increase utilization of public health facilities from current level of <20 to >75 percent -2010
- Establish an integrated system of surveillance, health statistics and health accounting by -2005[10]

NHP-2002 will endeavour to achieve the time-bond goals mentioned in table 0 (38.4)

Table 5 Goals to be achieved by 2000 – 2015[11]

TABLE NO. 1

Eradicate polio and yaws	2005
Eliminate leprosy	2005
Eliminate kala-bazar	2010
Eliminate lymphatic filariasis	2015
Achieve zero level growth	2007
Reduce mortality by 50% on account of TB. Malaria and other vector- & water-borne disease	2010
Reduce of prevalence of blindness to 0.5%	2010
Reduce IMR to 30/1000 and MMR to 100/lakh	2010
Increase utilization of public health facilities from current level of <20->75>%	2010
Establish an integrated system of surveillance, national health accounts and health statistics	2005
Increase health expenditure by government as a GDP from the existing 0.9-2.0%	2010
Increase share of central grants to constitute at least 25% of total health spending	
Increase state sector health spending from 5.5 to 7% of the budget, further increase to 8%	2005-2010

TABLE . 2 Achievement of India From The Year - 1951-2000[12]

Indicator	**1951**	**1981**	**2005**
Demographic Changes			
Life Expectancy	36.7	54	64.8
Crude Birth Rate (per 1000 population	40.8	33.9 (SRS)	25.0 (2002)
Crude Death Rate (per 1000 population	25	12.5 (SRS)	8.1 (2002)
IMR (Per 1000 live births)	146	110	64 (2002)
Couple Protection Rate (%)	-	10.4	48.6
Total Fertility Rate	6.0	-	3.2
Epidemiological Shifts			
Malaria (cases in Million)	75	2.7	1.84(2003)
Leprosy (Per 10,000)	38.1	57.3	2.44(2004)
Small Pox (No. of Cases)	>44887	Eradicated	---
Guinea Worm	NA	>39709	Eradicated
Polio	-	29709	265
Infrastructure			
Sub-Centers	725	57363	138368 (2004)
Dispensaries & Hospital	9209	23555	43322 (CBHI-96)
Beds (Private)	117198	569495	870161(CBHI-96)
Doctors (Allopathy)	61800	268700	1:1800
Nursing Personnel	18054	143887	1:5600

Universal immunization Programme

India's UIP is the world largest program on health immunization. India has the highest number of unimmunized children in the world. BCG was the first immunization that was the initiate for

[10] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P. 799
[11] Thirunavalli Ra Bhaskar, "TEXT BOOK OF COMMUNITY MEDICINE "3rd edition p. 851
[12] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 302

tuberculosis in 1962 According to the MOHFW[13] full immunization has reached 62 % children and there is no immunization in 7.6% population. UIP was launched in 1985 and it was accorded the status of a National Technology Mission in 1986[14]

Objectives

1. 85% coverage of the entire new bond with three doses DPT, three dosages of OPV and one dose of BCG and measles vaccine by the end of 1st year of the child.
2. All pregnant should receive (100% coverage) two doses of tetanus toxoid.
3. To lower the neonatal mortality and number of orthopedically children.
4. To reduce neonatal mortality to less than 1 per 1000 live births and poliomyelitis incidence rate to less than 0.5 per 100,000 populations.
5. To generate people's demand of immunization by involving the community and by the health education.
6. To ensure cooperative and active involvement of ministries of social welfare, rural development, education, in-formation and broadcasting, voluntary organizations and international agencies.[15]

TABLE.3 Vaccination Given Under UIP

Age	Vaccination
At birth	BCG, Polio, Hepatitis B
1 1/2	DPT, Polio 1, Hepatitis B 1
2 1/2	DPT2, Polio 2, Hepatitis B2
3 1/2	DPT3, Polio 3, Hepatitis B3
9 months	Measles-1 and Vitamin A
16-24 months	Booster shots of DPT and Polio, Vitamin A, Measles-2, JE in selected areas

Integrated Child Development Services (ICSD Scheme)

This is one scheme that has been around for about four decades and was launched on 2 October 1975. The scheme is meant for children below 6 years in age, pregnant and lactating women, women in the age group of 15-45 years and adolescent girls in selected blocks. The scheme is intended to benefit about 79 million children aged 0-6 years, about 18.24 million expectant and lactating mothers through 13.54 lakh operational anganwadi centers. This scheme is based on coast sharing between the center and the states in the following formula:

- ► 90:10 for NE states including supplementary Nutritional program (SNP) for NE
- ► 50:50 for SNP and 90:10 for all other components for all states other than NE[16]

Objectives

1. Improve the nutrition and health status of children in the age group of 0-6 years.
2. Lay the foundation for proper psychological, physical and social development of the child.
3. Effective coordination and implementation of policy among the various departments.
4. Enhance the capability of the mother to look after the normal health and nutritional needs through proper nutrition and health education.[17]

Beneficiaries

1. Children below 6 years,
2. Pregnant and lactating women,
3. Women in the group of 15-45 years,
4. Adolescent girls in selected Blocks.[18]

National family Welfare Programme

Previously this programme was known as National Family Planning program. In 1977, the name was changed to National Family welfare programme. Family planning program was launched in India in 1952. India is a pioneer in starting the national family planning program[19] Beginning of the Programme was modest, i.e., establishment of few FP clinics, distribution of FP educational material training of health functionaries and research. During the 3rd 5 Year plan (1961-1966), family planning was declared as center of planned development.

Then the emphasis was shifted from clinic approach to extension education approach (i.e., motivating

[13] IEC, MOHFW, 2013, CES-2009
[14] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. p- 145
[15] Thirunavalli Rao Bhaskar, "TEXT BOOK OF COMMUNITY MEDICINE "3rd edition p. 856
[16] (Min of WCD, GOI, 2013).
[17] Thirunavalli Rao Bhaskar,"TEXT BOOK OF COMMUNITY MEDICINE "3rd edition p. 856
[18] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 199
[19] (Taneja, 2013, p. 95)

people about small family norm). A separate Department of family planning was created in 1966 in the ministry of Health. In 1972, the MTP act was passed. In April 1976, National population policy was framed.[20] The Government of India provides financial incentive to people who voluntarily opt for sterilization and covers for the loss of wages to availing the services across all states.

ASHA workers have the responsibility to deliver contraceptives at the door steps of rural residents, which includes Re 1 for a pack of 3 condoms, Re 1 for a cycle of oral contraceptives pills (OCPs) and INR 2 for emergency contraceptive pills (ECPs).[21]

Actual position of the National Family Welfare Programme data shows all over of India in the following Table[22]

National Rural Health Mission.

National Rural Health Mission (NRHM) was launched on 12 April 2005[23] for 7 years, to cover the entire country and address the various shortfalls in the health care system in India. So, in a sense, this can be considered as the most recent health care reforms in India with a focus on rural health and maternal and child health, besides a host of other issues in urban health care delivery under National Urban Health Mission (NUHM). During the 11th plan, 67.52% of the budget was allocated for NRHM. Later, the NRHM was extended till 31 March 2017.[24] Recognizing the importance of health in the process of economic and social development and improvement of the quality of life of our citizens, the Govt. of India has resolved to launch the National Rural Health Mission (NRHM) to carry out necessary architectural correction in the basic healthcare delivery system. The mission adopts a synergistic approach by relating the health to determinants of good health, viz., and segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian system of medicine to facilitate healthcare.[25]

- Reduction in infant Mortality Rate and Maternal Mortality Ratio by 50% from existing levels in Next 7 Years.
- Universalize access to public health services: such as Women's health, child health, water, sanitation, immunization, Nutrition, etc.
- Prevention and control of communicable and non-communicable disease, including locally endemic disease
- Access to integrated comprehensive primary healthcare
- Assuring Population stabilization, gender and demographic balance.
- Promotion of healthy life styles.[26]

National Urban Health Mission

National Urban Health Mission (NUHM) has been taken up during the 11th five year plan (2008-2012) to meet the health needs of the urban poor, particularly the slum dwellers, through primary health care services by investing high professionals, appropriate technology through public private partnership and health insurance. This covers all cities with a population more than 1, 00,000. It covers slum dwellers, other marginalized urban dwellers like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers, who may be in slums or sites.[27]

Health Condition of the Urban poor

- U5MR of 72.7 against urban average of 51.9
- 46% under- weight children among urban poor – urban average – 32.8%
- 46.8% women with no education; urban average 19.3%
- 44.4% institutional deliveries; urban average – 67.5%
- 71.4% anemic among urban poor; urban average – 62.9%

[20] Thirunavalli Rao Bhaskar,"TEXT BOOK OF COMMUNITY MEDICINE "3rd edition p. 858
[21] Gupta Rajendra Pratap, "Health care Reforms in India", ELSEVIER Reed Elsevier India Pvt. Ltd., p.134
[22] New, Jin Rou; Cahill, Niamh; Stover, John; Gupta, Yogender Pal; Alkema, Leontine (2017-03-01). "Levels and trends in contraceptive prevalence, unmet need, and demand for family planning for 29 states and union territories in India: a modelling study using the Family Planning Estimation Tool". The Lancet Global Health. 5 (3):e350–e358. ISSN 2214-109X. doi:10.1016/s2214-109x(17)30033-5., https://en.wikipedia.org/wiki/Family_planning_in_India (visited on Fri Aug 25, 2017 at 4:50 pm.)
[23] http://nrhm.gov.in (Visited on 2.09.2017 at 2:23 pm)
[24] Gupta Rajendra Pratap, "Health care Reforms in India", ELSEVIER Reed Elsevier India Pvt. Ltd., p.128
[25] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 314
[26] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P. 781
[27] Thirunavalli Rao Bhaskar,"TEXT BOOK OF COMMUNITY MEDICINE "3rd edition p. 926 Goals of NRHM

- 18.5% urban poor have access to piped water supply; urban average – 50%
- 60% miss total immunization before completing one year.
- Poor environmental condition with high population density – lung diseases, TB, etc.
- Poor access to safe water and sanitation – water-borne diseases, diarrhea, dysentery
- High incidence of vector borne diseases among urban poor[28]

National Population Policy 2000

In 1952, India becomes the first country in the world to launch National Family Planning Program, with a view to stabilize the population. The decline in the mortality rate after 1952, was not matched with the decline extra child with the decline in the fertility rates, in 1976, India formed its first National population policy (NPP). It called for an increase in the legal minimum age of marriage from 15 to 18 for females and from 18 to 21 for males however, the policy was modified in 1977 and reiterated the importance of small family norm without compulsion and changed the program title to 'National Family welfare program'[29]

1948: Bhore committee Report

1952: Launching of Family Planning Program

1976: Statement of National Population Policy

1977: Policy Statement of Family Welfare Program

1979: Conversion on the elimination of all forms of discrimination against women

1983: the Indian Government framed a National Health Policy in 1983, has set the long-tern demographic goal of achieving a Net Reproduction Rate (NRR) of one by the year 2000. National demographic Goals were spelt out fellows:

1. The average size of the family would be reduced to 2.3.
2. The birth rate per'1000 population would be reduced to 21.
3. The death per rate 1000 would be reduced to 9.
4. Infant mortality rate would be reduced to <60 per 1000 live births.
5. The Effective couple protection rate would be raised to >60%

1986: the policy was evolved and promoted the slogan "movement of the people, by the people, for the people"

1991: National Development Council appointed a Committee on population

1993: Dr. MS Swami Nathan report was submitted on National Population Policy

1995: 4th world conference on women in Beijing cabinet approved the draft National population Policy but could not be placed front of Both the houses of parliament

1999: Another draft National Population Policy was finalized and approved by the parliament as "National Population policy 2000."[30]

The policy documents hope that if NPP 2000 was fully implemented, India's population in 2010 would be 1,107 million. In other words, the absolute population would be lower by over 55 million of TFR is brought down to replacement level by 2010[31]

The long-term Objectives are to achieve a stable by 2045 at a level consistent with the requirement of sustainable economic growth, social development, and environmental protection. In pursuance of the objectives, the following National Socio-Demographic Goals to be achieved in each case by 2010 are formulated:

i. Address the unmet needs for the basic reproductive and child health services, supplies and infrastructure.

ii. Make school education up to age 14 free and compulsory, and reduced dropouts at primary and secondary school levels to below 20% for both boys and Girls.

iii. Reduced infant mortality rates to below 13 per thousand live births.

[28] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P. 803 Milestones.

[29] No. L 1907/1/2008-UH Government of India Ministry of Health & Family Welfare Department of Health & Family Welfare http://www.pbhealth.gov.in/NUHM_Framework.pdf visited on 26.8.2017 at 4:10 pm

[30] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 322

[31] www.yourarticlelibrary.com>law>high.. (visited on 02.09.2017 at 7:45 pm)

iv. Reduce maternal mortality ratio to below 100 per 1 lakh live births.

v. Achieve universal immunization of children of against all vaccine preventable diseases.

vi. Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.

vii. Achieve 80% institutional deliveries and 100% deliveries by trained persons.

viii. Achieve universal access to information/counseling, and services for fertility regulation and contraception with a white basket of choices.

ix. Achieve 100% registration of births, deaths, marriage and pregnancy.[32]

National AIDS Prevention and Control Policy.

Epidemic of Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS) in India has emerged as one of the most serious public health problems in the country. The initial cases were reported among commercial sex workers in Mumbai and Chennai and injecting drugs users in the northeastern State of Manipur. The infection has since that spread rapidly in almost every district of the country. However, the overall prevalence in the country is still, every low, a rate much lower (0.75%) than many other countries in the Asia region like Cambodia (2.77%), Myanmar (1.99%), Thailand (1.85%).[33]

The NAPCP 2002 has been announced with the aim of bringing AIDS transmission at zero level by 2007.

1. Prevention of further spread of the disease by making the people at large and specially the high-risk groups aware of its implications and provide from with necessary tools for protecting themselves from getting infected. Control of sexually transmitted disease among sexually active and economically productive groups together with promotion of condom use a measure of prevention from HIV infection will be that most important component of the prevention strategy.

2. To provide an enabling socioeconomic environment so that individuals and families affected with HIV/AIDS can manage the problem.

3. Improve services for the care of people living with AIDS (PLWA) in times of sickness both in hospitals and at homes through community healthcare.[34]

Government of India planned various programs to control AIDS Control- phase III. India is a signatory of the MDGs of NACP-III launched in 2007, which aims to halt and reverse the prevalence of AIDS. The government has established National AIDS control Organization (NACO) under the MOHFW for a focused approach on AIDS at the Central level.[35]

National Blood Policy

Blood is safety is vital for the prevention and control of blood transfusion transmitted infections. Unfortunately, the blood transfusion service in the country lacks many vital resources like manpower, adequate infrastructure and financial base beside poor management private agencies. There is a wide gap in quality of service, between various states and cities. The blood component production/availability and utilization is extremely limited.[36]

Objective

1) To reiterate firmly the Govt. commitment to provide safe and adequate quantity of blood, blood components and blood products.

2) To make available adequate resources to develop and recognize the blood transfusion service in the entire country.

3) To make latest technology available for operating the blood transfusion services and ensure its functioning in an updated manner.

4) To launch extensive awareness programs for blood banking services including donor motivation, so as to ensure adequate availability of safe blood.

5) To encourage appropriate clinical use of blood and blood products.

[32] www.youarticlelibrary.com (visited on 26.8.17 at 6:20 pm)
[33] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 37
[34] Thirunavalli Rao Bhaskar,"TEXT BOOK OF COMMUNITY MEDICINE "3rd edition p. 133.
[35] Gupta Rajendra Pratap, "Health care Reforms in India", ELSEVIER Reed Elsevier India Pvt. Ltd., p.133
[36] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p.336

6) To strengthen practitioner registered as per the provision of Medical council Act – 1956

7) To encourage research & development in the field of transfusion Medicine and related technology.

8) To take adequate legislative and education steps to. Eliminate profiteering in blood banks.[37]

The first is permitting the transfer of blood from one blood bank to another in case of shortage.

National Chater for Children 2003

The health and social condition of the children are not favorable for their growth and development. There is still large number of population suffers from poverty and illiteracy that have adverse health impacts especially on children. Protein Energy Malnutrition (PEM), Iodine Deficiency Disorder, Vitamin deficiency and Iron deficiency anemia are the major problems attacking more than half of the young child population in India. Large number of children are employed which directly and indirectly damaging their health. There is widespread exploitation of children for sex and hazardous works and nonhazardous works.[38] Wherever the Constitution of India enshrines both in parts III and IV the cause and the best interest of children, insofar that: the state can make special provision for children, (Article 15 (3)). The state shall provide free and compulsory education to all children of age 6 to 14 years, (Article 21). No child below the age of 14 years shall be employed to work in a factory, mine or any other hazardous employment.[39] The tender age of children is not abused and citizens are not forced by economic necessity to enter avocations unsuited to their age or strength,[40] children are given are opportunities and facilities to develop in a healthy manner and in a conditions of freedom and dignity and that youth are protected against exploitation and against moral and material abandonment[41]

The state shall endeavour to provide early childhood care and education for all children until they complete the age of six years,[42] Whereas it's a fundamental duty of a parent or guardian to provide opportunities for education to his child or ward between the age of six and fourteen years, (Article 51A)[43]

National youth policy

The first national Youth[44] Policy was formulated in 1988. A need was felt to review the existing National Youth Policy (1988) as a result of socioeconomic modification in the country. The National Youth Policy, 2003 is planned to galvanize the youth to rise up the new challenges, keeping in view the global scenario, and goals at inspiring them to be an active partner in national development

Objectives

The policy shall be directed towards the achievement of the following objectives:

1) To instill in the youth a deep awareness of and respect for the principles and values enshrined in the Constitution such as National integration, nonviolence, secularism and socialism;

2) To promote among the youth awareness of historical and cultural heritage and imbue them a sense of pride and national identify, together with a deep commitment towards their preservation, as well as the enrichment of the environmental and ecology;

3) To help develop in the youth qualities of discipline, self-reliance, justice and fair play, concern for public, sporting and above all, a scientific temper in their modes of thinking and action which, inter alia, will enable from them to combat superstition, obscurantism and the numerous social ills that best the nation;

4) To provide the youth with maximum access to education which, in addition to developing their all-round personality imparts appropriate professional and vocational training with a view to enabling them to avail of employment and self-employment opportunities towards the aim of "Bekari Hatao" (remove unemployment); and

5) To make the youth aware of international issues and involve them in promoting world peace, understanding and a just international economic order.[45]

[37] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p.344
[38] ibid
[39] Art. 23
[40] Art.39e
[41] Art.39f
[42] Art.42
[43] Published in the Extraordinary Gazette of India, part-1, section-1, NO.F.6-15/98-CW, Government of India, Ministry of Human Resources Development, Department of Women and Child Development, New Delhi, the 9th February, 2004, http://india.gov.in (Visited on 27.8.2017 at 5:45 pm)
[44] Under the policy 1988, (NYT) defined the age group of youth 15 to 35 years. With the object of bringing a large segment of the adolescent population, the age group for youth has been lowered 13 to 35 years in the National Youth Policy, 2003.
[45] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 348-349

National Policy for Older Persons (1999)

Aging is a universal phenomenon. In India, the 60 plus population in 1951 was just 5.43% that had gone up to more than 7.7% in 2001 and based on estimates it will reach up to 21% 2050. Approximately 40% of them live below poverty line and another 30% live just above subsistence level. Major causes of morbidity among elderly according to ICMR (1980) are as follows: visual impartment 88% Locomotor disabilities 40% Neurological disease 18.7% cardiovascular disease 17.4% respiratory disease 16.1%; skin disease 13.3%. The recent trend is little different because hypertension (39.53%) CHD (18.85%), Benign Hypertrophy of prostate (16.23%), diabetes Mellitus (15.23%), Dyspepsia (11.03%), irritable bowel syndrome (9.2%) and depression (8.5%) are among top 10 morbid conditions among elderly[46]

Objectives

1) To encourage individuals to make various provisions like health and social insurance for their own as well as their spouse's old age;

2) To encourage families to take care of their order family members;

3) To enable and support voluntary non-governmental organizations to supplement the care provided by the family, with greater emphasis on non-institutional care;

4) To provide care and protection to vulnerable elderly specially widows, frail, handicapped, abused and destitute elderly;

5) To provide health care facilities especially suited to the elderly;

6) To promote research and training facilities to rain geriatric care givers and organizers of services for the elderly

7) To continually evaluate and upgrade existing services and program for older people;

8) To facilitate and strengthen inter sectoral partnership in the field; and

To create awareness regarding elder persons to develop themselves into fully independent citizens.[47]

National Nutrition Policy 2003

Nutrition influence growth and development of the person. There is wide awake in food production and food consumption and Underweight children in India account for 42% of the world's underweight children though India achieved self-sufficiency and food grains in 1970s[48]

1. Approximately 27% (NFHS-II 2000) of the population is still living below poverty time.

2. As many as 43.8% children suffer from moderate degrees of protein energy malnutrition (PEM) and 8.7% suffer from severe extreme forms malnutrition

3. 50% of the rural and 60% of the tribal children below 5 years age suffer from malnutrition.

4. Roughly 74% under 3 year's children and almost 50% of the expectant mothers in the third trimester of pregnancy suffer from fever.

5. It is estimated that 2.2 million children are afflicted with cretinism and about 6.6 millions are mildly retarded and motor handicaps. It also estimated that iodine deficiency account for 90,000 still births and neonatal deaths.

6. Nutritional blindness affects 7 million children in India per year results mainly from the deficiency of Vitamin A, couples with PEM. Prevalence of conjunctival xerosis and Bitot's spot was observed as high as 7.8% among slum children, followed by industrial labor (6.3%)

7. Prevalence of low birth Weight babies in India ranged between 26% and 57% in the urban slums and 35% and 41% in rural areas.

8. In large parts of India, the rainy months are the worst month for the rural and landless poor. There are regions in the country which are almost every year affected by famines, droughts and floods.

9. 40% of the adult in rural and 50% of the tribal adults are suffering from chronic energy and deficiency.

[46] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 350
[47] ibid
[48] Kishore, 2012, p. 440

10. Almost universal deficiency of Zinc in pregnant mothers in developing countries (Caulfield et al 1998).[49]

National Health Research Policy

"Whatever the level of development of its health research systems, every contry will benefit from having a strong health research policy. A well- designed health policy framework is an enabler and a driver for the national research effort to have a positive impact on national development- whether in health , health services performance, health equity, or for more general social and economic development"

Andrew Kennedy and Carel IJ sselmuiden

1. Preamble

India is a significant contributor to knowledge on health, with research output sranging over the full spectrum, from epidemiology and clinical care to biotechnology and genomics. A large number of Government Departments (Health, Science and Technology, Atomic Energy, Human Resource Development, Social Welfare etc.) support health research. Work is carried out in National Institutes, Autonomous Research Institutes, Universities and other Academic Institutions and by a variety of private organisations, including the Pharmaceutical Industry. The Indian Council of Medical Research, an autonomous council established in the Ministry of Health, is the agency responsible for research in the nodal ministry.[50]

Objectives

Health is fundamental right of all people. It is highly needed to have proof based high quality health care delivery and system

Investment in health has been recognized as a fundamental necessity for justifiable national development and that is why health research is supreme important to set significances and maximizing the return on investment. The national health research policy is therefore aims to facilitate this process by:

1. Generating the evidence base for health system and services, so that they will be significant promoters of equity and contribute to National Development. In addition to active in- country research, this would involve critical review of the global evidence base, its adaptation for National conditions and communication to policy makers.

2. Establishing linkages between health research and national health programs to facilitate the operationalization of evidence based programs and to obtain feedback for the optimization of health research.

Encourage the development of fundamental research in areas relevant to health, such as physiology, Biochemistry, pharmacology, microbiology, pathology, molecular sciences and cell sciences, to ensure that a national critical mass of scientist who can contribute the sciences, to ensure that a national critical mass of scientist who can contribute the cell benefits of modern technology to health research is developed. A critical mass of health researchers can only be built up by developing a research culture in the educational institutions.

Ensure that the optimum benefits of modern technology are harnessed to promote national health, e.g., development of a national vaccine policy, genomics based drug development, utilization of molecular biologic development for diagnosis, therapy and prevention, utilization of remote sensing data and geographic information systems, appropriate animal experimentation facilities, microbial containment facilities, and gene and tissue banks.

1. Build and integrate capacity for research in National Health Programs, Research institutions and in the private sector (profit and nonprofit organization)

2. The optimal use of Information, communication and Networking technology to ensure that the global knowledge base is available for National Programs and that research is channeled in relevant directions without necessary duplication.

3. Managing global resources and transnational collaborations optimally to ensure that collaborative health research primarily facilitates the development of national health systems and services. The world is developing into a global village, but there is a danger that in all research sponsored transnationally, priorities may not be focused on national needs. The policy would require that the paramount nature of the priorities of the national health system and services is ensured.

4. Health research should be truly intersect oral and harness the resources in areas such as social sciences, economics and traditional systems of medicine.

5. Optimum harmonization of national policies in a variety of areas (education, social

[49] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 353

[50] http://webcache.googleusercontent.com/search?q=cache:http://icmr.nic.in/newnhr_policy.pdf&gws_rd=cr&ei=T_yjWcrDA4PpvASNxpK4w (visited on 28.8.2017 at 5:20 pm)

sciences, population, agriculture, Nutrition, trade, commerce, etc.) is essential to facilitate intersect oral collaboration and partnership, so that maximum development returns can occur from Health research etc.

6. A National Health research management forum should be established as the body responsible for evolving, harmonizing and evaluating the implementation of the national health research policy. The India Council of medical Research has already identified a set of research priorities in a major national multidisciplinary effort. This will form the basis of the priorities to be determined by the national health Research management Forum.[51]

Pharmaceutical Policy

Pharmaceutical policy is a division of health policy that contracts with the development, provision and use of medications within a health care system. It holds drugs (both brand name and generic), biologics (products derived from living sources, as opposite to chemical compositions), vaccines and natural health products. Price of drugs need to be control because in India, medicines constitute 40-50% of the cost of treatment, whereas in the west, it is about 10%. About 30% of the hospitalized patients are mortgage or sell their assets, and 35% are pushed below the poverty line due to hospitalization. Drug traders earn huge margins. Trade margin for six antibacterial, antitubercular and antiacidity drugs ranged from 296% to 1531%. Surprisingly, the policy aims at reducing the number of price controlled drugs from 76 to five, when this number has already been reduced from 347 in 1979 to 142 in 1987 in 1995. The drug price control order in 1995 has made the most important drugs out of price control such as painkillers, antanemic drugs, and drugs in the treatment of epilepsy, elephantiasis, heart disease, cancer, AIDS, Vaccines and sera to prevent and treat dangerous infections. Some of the essential drugs.[52]

National Housing and Habitat Policy 1998

The National Agenda declared by the government as "housing for all" a priority area and has set a target of structure of 2 million houses every year with emphasis on the poor and downtrodden persons, out of which 0.7 million houses shall be constructed in the urban areas.

With this background, the New National Housing and Habitat policy (NHHP) was formulated in 1998. The policy was laid before the parliament on 29.07.1998.

- Creation of surplus in housing stock either on rental or ownership basis
- Providing quality and cost effective shelter options, especially to the vulnerable groups and the poor
- Ensuring that housing, along with supporting services, is treated as a priority and at par with infrastructure
- Removing legal, financial and administrative barriers for facilitating access to land, finance and technology
- Forging strong partnership between private, public and cooperative sectors to enhance the capacity of the construction industry to participate in every sphere of housing and habitat
- Using technology for modernizing the housing sector to increase efficiency, productivity, energy efficiency and quality

Empowering the Panchayat raj institutions and village cooperatives to mobilize credit for adding to the housing stock[53]

Plans:-

From 1947 to 2017, the Indian economy was premised on the concept of planning. This was carried though the Five-Year Plans, developed, executed, and monitored by the Planning Commission and the NITI Aayog. Government of India constitute a planning commission consisting of a chairman, a deputy chairman and 5 members, To access of the resources of country in 1950, (manpower, material and money/capital) and to draft various plans for the socioeconomic development of the country. Pt. Jawaharlal Nehru presented the First Five-Year Plan to the parliament of India on December 8, 1951.[54] Meanwhile Health development establish an integral part of socioeconomic development of the country, National development plans were framed by the planning commission on five year basic including health development plans, framing five year plans.

[51] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 357-358
[52] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 359
[53] Kishore J., "NATIONAL HEALTH PROGRAMS OF INDIA", Fifth Ed p. 373
[54] http://webcache.googleusercontent.com/search?q=cache:http://el.doccentre.info/eldoc/j10_/hou_pol.htm&gws_rd=cr&dcr=0&ei=UZamWa36KoeGvQSf-pWIBQ (visited on 30.8.2017 at 4:30 pm)

The main aims of the health programs during the five year plans here:

- Control or eradication of infectious disease
- Steadying of population
- Strengthening of the fundamental health services
- Increasing of health manpower resources.

The main achievement of the health sector in the five year plans are as follows:[55]

First Five-Year-plan (1951-1956)

- PHCs were established as per the recommendations of Bhore Committee
  - National Water Supply and Sanitation program (1954)
  - National Filarial control program (1955)
- Prevention of food Adulteration Act was passed in 1954 by parliament
- Contributory Health service Scheme was introduced in 1954.[56]

"Statics of positive health are difficult to obtain. Information in regard to morbidity is available only to a limited extent.' The collection and compilation of vital statistical data are defective in completeness and accuracy'. 'More than half of the deaths are recorded under fevers by reporting agency has no means of proper diagnosis of the cause of death'. 75% of doctors are in urban areas and their distribution in rural areas is very sparse; the number of medical institutions at present available is far too small to provide a reasonable standard of medical service to the health, particularly in the rural areas.[57]

Second Five-Year-Plan (1956-1961)

The Second Plan was particularly foccsed in the development of the public sector and "rapid Industrialisation". The main Aim of the second plan is given below.

- The National Health Program implemented during the first plans were continued.
- The NMPC was switched over to National Malaria Eradication Program.
- The following institutions were established - Control Health Education Bureau (- Indian medical Council (1956) -National Tuberculosis institute, Bangalore (1959)[58] Total budget outlay INR 145.80 Crore. Priority- Health Protection of rural population.[59] "To expand existing health services, to bring them increasingly within the reach of all people and to promote a progressive improvement in the level of national health.[60]

Third Five-Year-Plan (1961-1966)

This Plan stressed agriculture and improvement in the production of wheat, but after the war of 1962.The object of this Plan towards the defence industry and the Indian Army.In this plan following plan were launched for Health are given below.

- Following National Health Programs Were launched
  - National Smallpox Eradication Program (1962)
  - National Goiter Control Program
  - National/District Tuberculosis Control Program (1962)
  - School health program (1962)
  - National Trachoma Control Program (1963)
  - Applied Nutrition Program (1963)
- Following instructions were established.
  - Central Bureau of Health Intelligence (1961)
  - Central Family planning Institute (1962)
  - National institute of communicable disease (1963)
  - National institute of health administration and education (1964)[61]

[55] Arora Surbhi, "economics For Law Students" (Reprint: 2014), p. 405
[56] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P. 793
[57] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd., P. 287
[58] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. p- 793)
[59] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. P. 272
[60] Planning Commission, GOI.
[61] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P. 793

Total Budget outlay INR 250.80 Crore Priority- Drinking water available in the most of the villages by the end of the plan

- ► Rural sanitation Eradication of Malaria, Smallpox, and to control other communicable diseases
- ► Addressing urban water supply, drainage and sewerage in urban areas
- ► Family planning[62]

Forth Five-Year-Plan (1969-1974)

- Chittarajnan were started (1970)
- National All India hospital Postpartum Program was launched (1970)
- Medical termination of Pregnancy Act (MTP-Act) was passed (1971)
- Multipurpose Health Worker Scheme (1977)
- National Program of minimum Needs (1973) was launched.[63]

Total Budget Outlay INR 613.50 Crore

Priority

- ► Family planning
- ► Strengthening the primary health centers
- ► Communicable disease
- ► Medical and paramedical man power training[64]
- ► To achieve social and economic justice[65]

Fifth Five –Year-Plan (1974-1979)

- The programs launched in the previous plans were stressed.
- The following activities were introduced.
  - Rural health scheme (1977)
  - Integrated child Development Service Scheme (1975)
  - Community Health worker scheme (1977)
  - MFEP strategy was replaced by modified plan Operation of Malaria Control (1977)
  - 20-points program (1975)
  - National program for Prevention of Blindness (1976)
  - National Program for control of Blindness (1976)
  - Population Policy (1976)
  - Reorientation of Medical Education (ROME) Scheme (1978)
  - Expanded Program of Immunization (1978)
  - Child Marriage Restraint Act (1978) was passed
  - Smallpox was eradicated (1977)[66]

Priority

- ► Family planning
- ► Malaria Eradication
- ► Mother and Child health[67]
- ► To bring about expansion of social welfare programs;
- ► To adopt a program of adequate public procurements and public distribution system for an assumed supply of essential consumption goods at reasonable prize, at least to the poorer sections of society;[68]

National program of minimum needs was made which included primary education, drinking water, medical facilities in rural areas, nursing food[69]

Sixth five-Year-Plan (1980- 1985)

[62] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. P. 273
[63] Ibid. P. 287
[64] Id P. 273
[65] Myneni Dr. S.R., "India Economics", (fifth Ed.) p. 134
[66] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P- 795 Total Budget outlay INR 1252.60 Crore.
[67] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. P. 274
[68] Myneni Dr. S.R., "India Economics", (fifth Ed.) p. 134
[69] Arora Surbhi, "economics For Law Students" (Reprint: 2014), p. 409

- Government of India become signatory to the Doha Declaration of Alma-Ata on Primary health Care to achieve the social target for health For All-by-2000 AD in 1981 and accordingly revised the minimum Needs Program to Reinforce the health care infrastructure.
- National Health Policy was approved (1983)
- International Drinking Water and Sanitation Decade was launched (1981)
- Leprosy control Program was switched over to National Leprosy Eradication Program (1983)
- Leprosy Eradication Program (1983)
- National Guineaworm Eradication Program was launched (1983).[70]

Total Budget outlay INR 3412.20 Crore. Priority

► Rural health

► Promotive, preventive and curative services

► Communicable disease[71]

Seventh five-Year-Plan (1985-1990)

- Expanded Program of immunization was converted into universal immunization program (1985)
- Following health programs were launched

i. National diabetes Control program (1987)

ii. National AIDS Control Program (1987)

iii. New 20- point program (1987)

iv. National Acute Respiratory infection Control program (1990).[72]

Priority

► Seventh plan was also aligned to the goal of 'Health for All' by 2000 with primary care being the basis of the plan.[73]

Rural Health

► Improvement of infrastructure

► Monitoring, evolution and surveillance through better coordination guidance

► Inter-sectoral coordination, cooperation and integration of MCH programmes.

► Community participation

► Supplies and logistic

► Education and training programs.

► Urban health

► Voluntary organizations and local bodies

► Communicable disease

► Research for treatment of T.B. and leprosy.[74]

Eighth five-Year-Plan (1992-1997)

- Child survival and safe Motherhood Program was launched (1992)
- CSSM-program was converted into reproductive and child health (RCH) program (1994)
- Rational Drug Policy was revised (1995)
- NTB Control program was revised and called as revised National Tuberculosis Control Program (RNTCP) (1997)
- Act was passed on Infant Feeding and Infant foods (1992)
- Right to person with disabilities were conferred (1995)[75]

Total Budget outlay INR 14,102.20 Crore.

Priority

► Health facility must be available for all by the end of eight plans.

► Instead of expansion, consolidation and operationalization of the rural health network (CHC/PHC).

[70] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P. 795
[71] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. P. 274
[72] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P- 795
[73] Planning Commission, GOI. Total Budget outlay INR 6809.45 Crore.
[74] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd., P. 276
[75] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P- 795

- ► Secondary and territory care.
- ► Containing population growth.
- ► Decentralization with area specific micro planning.
- ► MCH.
- ► Health man power training[76]

Provision of safe drinking water and primary health care facilities including immunization, accessible to all the villages and the entire population and complete elimination and scavenging;[77]

Ninth five-Year-plan (1997-2002)

- Pulse polio immunization program was intensified and called intensive pulse polio immunization program (1999)
- Government of India announced national population policy 2000 National Health Policy 2002 and National AIDS prevention and Control Policy 2002
- Guinea worm disease was eradicated
- Tenth five-Year plan was launched (2003).[78]

Total Budget outlay INR 35,204.95 Crore.

Priority

- Tackle the issue of communicable and non-communicable disease.
- Leading to sustained improvement in health status of the population.

Re-structure PHCs into CHCs (FRUs).

Access to primary health care and safe drinking water.

Involving people's representatives and voluntary and organizations.

Tribal heal Levy user charges for people above BPL and explore option to meet the growing cost of health care.[79]

- ► Ensuring food and nutritional security for all, particularly the vulnerable sectors of the society;
- ► Providing the basic minimum services of safe drinking water, primary health care facilities, universal primary education, shelter and connectivity to all in a time bound manner;[80]

To provide basic minimum services like clean drinking water, primary health care facility[81]

Tenth five-Year-plan (2002-2007)[82]

During this period, efforts are directed to improve the health status of the people by improving the access to and enhance the quality of primary health care and to improve the efficiency of existing health care infrastructure at primary, secondary and tertiary care settings.

The targets of the tenth five-Year-plan and beyond are follows:

- Reduction of poverty ratio by 5 percent points by 2007 and by 15 percent points by 2012
- All children in school by 2003 and all children to complete 5 years of schooling by 2007
- Reduction in gender gaps in literacy and wage rates by at least 50 percent by 2007
- Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2 percent
- Increases in literacy rate to 75 percent within the plan period
- Reduction of infant morbidity Rate to 45 per 1000 live births by 2007 and to 28 by 2012
- Reduction of maternal mortality ratio to 2 per 1000 live births by 2007 and to 1 by 2012
- All villages to have potable drinking water within the plan period

[76] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. p- 276-277)
[77] Myneni Dr. S.R., "India Economics", (fifth Ed.) p. 138
[78] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P- 795
[79] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. P- 276)
[80] Myneni Dr. S.R., "India Economics", (fifth Ed.) p. 139
[81] Arora Surbhi, "economics For Law Students" (Reprint: 2014), p. 413
[82] Suryakantha AH, COMMUNITY MEDICINE with Recent Advances "third edition, Jaypee brothers Medical Publishers (P) Ltd. P- 795

Achievement during the past 55 years of planned period.

Table- 9

	First plan (1951- 1956)	Tenth plan (2002-2007)
1. primary health center	725	2,29,367
2. sub centers	-	1,38,368
3. community health centers	-	3,076
4. total hospital beds	1,25,000	9,08,168 (2001)
5. Medical colleges	42	222
6. Annual admission in medical colleges	3,500	19,000
7. Dental colleges	7	142
8. Allopathic doctors	65,000	5,75,000 (2001)
9. Nurses	18,500	8 ,39,862
10. ANMs	12,780	5,02,503
11. health visitors	578	40,536
12. Health worker (Female) 13. Health worker male	- -	1,37,407 71,053
14. village health guides	-	

Reorganization and restructuring of the government health care system (Planning Commission, GOI, 2013).

- Usage of IT for developing a referral system.
- Efficient of logistic system.
- Horizontal integration for all programs.
- Quality of care at all levels.
- Treatment protocols.
- Monitoring and evolution.
- Health care financing.
- Skills up gradation.
- HMIS.
- Research and development.
- Disease surveillance.
- Civil registration system.
- Improving efficiency of public, private and voluntary sectors building linkages.
- Mainstreaming ISM & H.
- Inter- sectorial coordination.
- Participation of PRIs.
- Environmental health impact assessment.
- Capability and Development.
- Occupation health.
- Food and drug safety.
- Screening of common nutritional deficiencies.
- Compiling hard and soft health care infrastructure data all levels in the entire health care system.
- Macro environmental pollution.[83]

to reduce Maternal Mortality Rate (MMR) from 4 to 2 per 1000 live births by 2007 and to 1 by 2012[84]

Eleventh Five-Year-Plan (2007-12)

Total Budget outlay INR 140,135.00 Crore.

Priority

- Reduce disparities of health care across regions and communities
- Special attention to vulnerable section and marginalized groups
- Major focus on NRHM initiatives
- Secondary and tertiary care
- Promote law cost and indigenous technologies.
- Usage of health implementing IHPS
- Convergence of all programs to horizontal programs below district level
- Mainstream AYUSH
- Increase focus on Human resources
- Decentralizing governance
- Accreditation of health care institutions

[83] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. p- 276)
[84] Arora Surbhi, "economics For Law Students" (Reprint: 2014), p. 414

- Focus on geriatric care, mental health, oral health and health for the disabled
- Enhancing efforts for reducing/reversing disease
- Health systems and bio-medical research[85]
- Health and education services to all.[86]

Twelfth Five-Year-Plan (2012-2017)

To reduce infant mortality rate and maternal mortality rate[87]

Total Budget outlay INR 384, 223.00 Crore.

Priority

- Move towards UHC.
- Transition of NRHM into NHM.
- Prioritization of primary health care.
- Making essential drugs available free at public health facilities as a part of EHP (essential health package).
- Special attention to the needs of marginalized sections.
- Treatment guidelines and protocols
- Decentralized planning.
- MCH.
- Universal immunization coverage (UIC)
- Family welfare.
- Prevention and control of communicable and Non- communicable diseases.
- Focus on public health.[88]

CONCLUSIONS AND SUGGESTIONS

After the freedom of nation Indian government introduces various. Health Policies the question improve the Health of people. Here the question is now much these polices fulfillment their objects.

Even in its present form, the implementation of the policy will be fraught with for midable challenges because of the disparate health in infrastructure landscape in the country, particularly in the poor state and the need for aligning existing systems in the state with a national plan of action as Nadda himself had stated in rajya sabha last year public health is a state subject and providing health care is a responsibility of the states. But the new Government promise to spending 2.5 % of the G.D.P. on health.

Universal health coverage (UHC), in which people receive health care without suffering financial hard ship, in an ideal that many countries in the world are successfully moving towards. It's also sustainable Development goals (S.D.G.) that India has agreed to achieve by 2030.

According to the World Health Organization[89] "one of the most important commitments a country can make for future economic, social, and political progress and stability is to address the health and development needs of its adolescents."

The Narendra Modi sworn into service. There were a number of high-priority reforms outlined in the party's election manifesto, and a few of these reforms were targeted at the healthcare sector. The most important healthcare reform in the manifesto stated that the party would assure health care assistance to all Indians, and reduce the out-of-pocket spending on health care with the help of state governments. Along with this, they also intended to focus on the key factors that are detrimental to our health, such as sanitation and drinking water, to help reduce the number of water-borne diseases in the country.

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[85] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd. p- 282)
[86] Myneni Dr. S.R., "India Economics", (fifth Ed.) p. 143
[87] Arora Surbhi, "economics For Law Students" (Reprint: 2014), p. 415
[88] Gupta Rajendra Pratap, "health care reforms in India" ELSEVIER Reed Elsevier India Pvt. Ltd., P. 283-284

[89] (1995, p.3.)