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An Overview of Trends in the Health Policies in India

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Abstract : *In this paper an attempt is made to broadly review about the4 trend in the Health Policy in India in the light of implementation of economic planning India. The basic issues relating to the implementation of National Health policy are also briefly reviewed. This study ultimately concludes that, national structured health policy making and health planning in India is not a post-independence phenomena. In fact, the most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946. The Bhore Committee recognized the vast rural-urban disparities in the existing health services and hence based its plan with specifically the rural population in mind. Its plan was for the district as a unit. Two requirements of the district health scheme are that the peripheral units of the organization should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration. The public health service system will be primarily established with clear distribution of work, information exchange, resource sharing, coordination and interaction; it will promote equal access of urban and rural residents to basic public health services*

Key Words: *National Health policy, Universal Health Coverage, Community Development Program,*

Introduction

At the time of independence, the prevailing health care facilities are far below any acceptable human standard. Even the targets set out by the Bhore Committee are nowhere close to being achieved. We have not even reached half the level in provision of health care that most developed countries had reached between the two world wars. Curative health care services in the country are mostly provided by the private sector and preventive and promotive services are almost entirely provided by the State sector. It was not until 1983 that India adopted a formal or official National Health Policy. Prior to that health activities of the state were formulated through the Five year Plans and recommendations of various Committees. For the Five Year Plans the health sector constituted schemes that had targets to be fulfilled. Each plan period had a number of schemes and every subsequent plan added more and dropped a few.

In the fifties and sixties the entire focus of the health sector in India was to manage epidemics. Mass campaigns were started to eradicate the various diseases. These separate countrywide campaigns with a techno-centric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. Cadres of workers were trained in each of the vertical programmes. The policy of going in for mass campaigns was in continuation of the policy of colonialists who subscribed to the percepts of modern medicine that health could be looked

after if the germs which were causing it were removed.

Health Policy during Early Plans:

During the First Two Five Year Plans the basic structural framework of the public health care delivery system remained unchanged. Urban areas continued to get over three-fourth of the medical care resources whereas rural areas received "special attention" under the Community Development Program (CDP). History stands in evidence to what this special attention meant. The CDP was failing even before the Second Five Year Plan began. The governments own evaluation reports confessed this failure.

The health sector organization under CDP was to have a primary health unit (a very much diluted form what was suggested by the Bhore Committee per development Block (in the fifties this was about 70,000 population spread over 100 villages) supported by a Secondary health unit or every three such primary health units. It is clear from the above statement of objectives of the health organization under CDP that medical care had no priority within the structure of such an organization. In contrast, in the urban areas (which developed independent of CDP) hospitals and dispensaries which provided mainly curative services (medical care) proliferated. Thus at the start of the third Five year Plan there was only one Primary Health Unit per 140,000 rural population in addition to one hospital per 320,000 rural population. In sharp contrast urban areas had one hospital per 36,000 urban populations and one hospital bed per 440 urban residents.

To evaluate the progress made in the first 2 plans and to make recommendation for the future path of development of health services the Mudaliar Committee was set up in 1959. The report of the committee recorded that the disease control programmes had some substantial achievements in controlling certain virulent epidemic diseases. Malaria was considered to be under control. Deaths due to malaria, cholera, smallpox etc. were halved or sharply reduced and the overall morbidity and mortality rates had declined. The death rate had fallen to 21.6% for the period 1956-61. The expectation of life at birth had risen to 42 years. However, the tuberculosis program lagged behind. The report also stated that for a million and half estimated open cases of tuberculosis there were not more than 30,000 beds available.

The Mudaliar Committee further admitted that basic health facilities had not reached at least half the nation. The PHC programme was not given the importance it should have been given right from the start. There were only 2800 PHCs existing by the end of 1961. Instead of the "irreducible minimum in staff" recommended by the Bhore Committee, most of the PHC's were understaffed, large numbers of them were being run by ANM's or public health nurses in charge. The rural areas in the process had very little or no access to them. The condition of the secondary and district hospitals was the same as that of the PHC's. The Third Five Year Plan launched in 1961 discussed the problems affecting the provision of PHCs, and directed attention to the shortage of health personnel, delays in the construction of PHCs, buildings and staff

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quarters and inadequate training facilities for the different categories of staff required in the rural areas. The Third Five Year Plan highlighted inadequacy of health care institutions, doctors and other personnel in rural areas as being the major shortcomings at the end of the second Five Year Plan.

The 3rd plan gave a serious consideration for suggesting a realistic solution to the problem of insufficient doctors for rural areas that a new short term course for the training of medical assistants should be instituted and after these assistants had worked for 5 years at a PHC they could complete their education to become full-fledged doctors and continue in public service. The Medical council and the doctors lobby opposed this and hence it was not taken up seriously. Ignoring the Mudaliar Committee's recommendation of consolidation of PHC's this plan period witnessed a rapid increase in their numbers but their condition was the same as the Committee had found at the end of the second plan period. In case of the disease programme due to their vertical nature we find a huge army of workers.

Focus on Family PlanningProgrammes:

India was the first country in the world to adopt a policy of reducing population growth through a government sponsored family planning programme in 1951. In the first two plans the FP programme was mainly run through voluntary organizations, under the aegis of FPAI. Faced with a rising birth rate and a falling death rate the 3rd plan stated that the objective of stabilizing the growth of population over a reasonable period must therefore be at the very center of planned development.

The heavy emphasis on population control was due to the influence of various developed countries, but especially the USA. In 1966 a U.N. advisory mission visiting India strongly recommended. The directorate (health and family planning) should be relieved from other responsibilities such as maternal and child health and nutrition. It is undoubtedly important for family planning to be integrated with MCH in the field particularly in view of the loop programme, but until the family planning campaign has picked up momentum and made real progress in the states the director general concerned should be responsible for family planning only" (U.N. Advisory Mission 1961).. This committee indicated that the camp approach had failed to give the family planning program a mass character and hence the coming in of IUCD (loop) was a great opportunity. This committee also recommended introduction of target fixation, payments for motivation and incentives to acceptors. It suggested reorganization of the FP program into a vertical program like malaria and recommended addition of one more Health visitor per PHC who would specifically supervise the ANMs for the targets of this program.

The Fourth Plan which began in 1969 with a 3 year plan holiday continued on the same line as the 3rd plan. It quoted extensively from the FYP II about the socialist pattern of society but its policy decisions and plans did not reflect socialism. Infact the 4th plan is probably the most poorly written plan document. It does not even make a passing comment

on the social, political and economic upheaval during the plan Holiday period (1966-1969). These 3 years of turmoil indeed brought about significant policy changes on the economic front and this, the 4th plan ignored completely. It lamented on the poor progress made in the PHC programme and recognized again the need to strengthen it. It pleaded for the establishment of effective machinery for speedy construction of buildings and improvement of the performance of PHCs by providing them with staff, equipment and other facilities. For the first time PHCs were given a separate allocation. It was reiterated that the PHC's base would be strengthened along with, sub-divisional and district hospitals, which would be referral centers for the PHCs. The importance of PHCs was stressed to consolidate the maintenance phase of the communicable diseases programme.

Special Programmes during Fifth Five Year Plan:

It was in the Fifth Plan that the government ruefully acknowledged that despite advances in terms of infant mortality rate going down, life expectancy going up, the number of medical institutions, functionaries, beds, health facilities etc, were still inadequate in the rural areas. This shows that the government acknowledged that the urban health structure had expanded at the cost of the rural sectors. This awareness is clearly reflected in the objectives of 5th Five Year Plan which were : Increasing the accessibility of health services to rural areas through the Minimum Needs Programme (MNP) and correcting the regional imbalances.

Major innovations took place with regard to the health policy and method of delivery of health care services. The reformulation of health programmes was to consolidate past gains in various fields of health such as communicable diseases, medical education and provision of infrastructure in rural areas. This was envisaged through the MNP which would "receive the highest priority and will be the first charge on the development outlays under the health sector. It was an integrated packaged approach to the rural areas. The Kartar Singh Committee in 1973 recommended the conversion of uni-purpose workers, including ANMs, into multi-purpose male and female workers. It recommended that each pair of such worker should serve a population of 10,000 to 12,000. Hence the multi-purpose worker scheme was launched with the objective to retrain the existing cadre of vertical programme workers and the various vertical programmes were to be fully integrated into the primary health care package for rural areas. (

Another major innovation in the health strategy was launched in 1977 by creating a cadre of village based health auxiliaries called the Community Health workers. These were part time workers selected by the village, trained for 3 months in simple promotive and curative skills both in allopathic and indigenous systems of medicine. They were to be supervised by MPWs, and the programme was started in 777 selected PHCs where MPWs were already in place. This scheme was adopted on the recommendations of the Shrivastava Committee which was essentially a committee to look into medical education and support manpower. The committee proposed to rectify the dearth of trained manpower in rural areas. The committee

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pointed out that "the over-emphasis on provision of health services through professional staff under state control has been counterproductive.

The main recommendations of the committee were to have part-time health personnel selected by the community from within the community. They would act as a link between the MPW at the sub-centers and the community. With regard to medical education the committee cried for a halt to opening of new medical colleges (Ibid.) The committee emphasized that there was no point in thinking that doctors would go to rural areas because there were a number of socio-economic dimensions to this issue. Thus their option for rural areas was the CHW scheme. This attitude was clearly supportive of the historical paradigm that rural and urban areas had different health care needs – that urban populations need curative care and rural populations preventive. In the middle of the 5th Plan a State of National Emergency was proclaimed and during this period (1975-77) population control activities were stepped up with compulsion, force and violence now characterizing the FP program. One of the recommendations included was legislation by state governments for compulsory sterilization. With the end of the Emergency and a new government in power this policy was sent to the freezer.

The National Health Policy and Later Five Year Plans:

The Sixth Plan was to a great extent influenced by the Alma Ata declaration of Health for All by 2000 AD (WHO, 1978) and the ICSSR - ICMR report (1980). The plan conceded that there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed of mostly by the well to do classes. It is also realized that the model which is depriving the rural areas and the poor people of the benefits of good health and medical services. The Sixth and Seventh Five Year Plans state clearly: "the success of the plan depends crucially on the efficiency, quality and texture of implementation is a greater emphasis in the direction of competitive ability, reduced cost and greater mobility and flexibility in the development of investible resources in the private sector flexible policies to revive investor interest in the capital markets.

The National Health Policy (NHP) in light of the Directive Principles of the constitution of India recommends "universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford". Providing universal health care as a goal is a welcome step because this is the first time after the Bhore Committee that the government is talking of universal comprehensive health care. A policy document is essentially the expression of ideas of those governing to establish what they perceive is the will of the people. These may not necessarily coincide for various reasons and influences that impinge upon both the rulers and the ruled. Implementing a policy, especially if it seeks to significantly change the status quo, necessarily requires a political will. Whether the political will is expressed through action depends on both the levels

of contextualization of the electorate and the social concerns of those occupying political office.

During the decade following the 1983 NHP rural health care received special attention and a massive program of expansion of primary health care facilities was undertaken in the 6th and 7th Five Year Plans to achieve the target of one PHC per 30,000 population and one sub-centre per 5000 population. This target has more or less been achieved, though few states still lag behind. However, various studies looking into rural primary health care have observed that, though the infrastructure is in place in most areas, they are grossly underutilized because of poor facilities, inadequate supplies, insufficient effective person-hours, poor managerial skills of doctors, faulty planning of the mix of health programs and lack of proper monitoring and evaluatory mechanisms.

Among the other tasks listed by the 1983 health policy, decentralization and deprofessionalisation have taken place in a limited context but there has been no community participation. This is because the model of primary health care being implemented in the rural areas has not been acceptable to the people as evidenced by their health care seeking behavior. As regards the demographic and other targets set in the NHP, only crude death rate and life expectancy have been on schedule. The others, especially fertility and immunization related targets are much below expectation (despite special initiatives and resources for these programs over the last two decades), and those related to national disease programs are also much below the expected level of achievement. In fact, we are seeing a resurgence of communicable diseases.

With regard to the private health sector the NHP clearly favours privatization of curative care. It talks of a cost that "people can afford", thereby implying that health care services will not be free. Further statements in the NHP about the private health sector leave no room for doubt that the NHP is pushing privatisation. NHP adopts the stance that curative orientation must be replaced by the preventive and promotive approach so that the entire population can benefit . The NHP suggests that curative services should be left to the private sector because the state suffers from a constraint of resources. It recommends, with a view to reducing governmental expenditure and fully utilizing untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage the establishment of practice by private medical professionals, increased investment by non-governmental agencies in establishing curative centers and by offering organized logistical, financial and technical support to voluntary agencies.

The Seventh Five Year Plan accepted the above NHP advice. It recommended that "development of specialties and super-specialties need to be pursued with proper attention to regional distribution" and such "development of specialised and training in super specialties would be encouraged in the public and the private sectors". This plan also talks of improvement and further support for urban health services, biotechnology and medical electronics and non-communicable diseases.

Enhanced support for population control activities also continues The special attention that AIDS, cancer, and coronary heart diseases are receiving and the current boom of the diagnostic industry and corporate hospitals is a clear indication of where the health sector priorities lie.

On the eve of the Eighth Five Year Plan the country went through a massive economic crisis. The Plan got pushed forward by two years. But despite this no new thinking went into this plan. Infact, keeping with the selective health care approach the eighth plan adopted a new slogan – instead of Health for All by 2000 AD it chose to emphasize Health for the Underprivileged. Simultaneously it continued the support to privatization, "In accordance with the new policy of the government to encourage private initiatives, private hospitals and clinics will be supported subject to maintenance of minimum standards and suitable returns for the tax incentives."

During the 8th Plan period a committee to review public health was set up. It was called the Expert Committee on Public Health Systems. This committee made a thorough appraisal of public health programs and found that we were facing a resurgence of most communicable diseases and there was need to drastically improve disease surveillance in the country. The Ninth Plan proposes to set up at district level a strong detection come response system for rapid containment of any outbreaks that may occur. In fact, the recommendations of this committee have formed the basis of the Ninth Plan health sector strategy to revitalize the public health system in the country to respond to its health care needs in these changed times. Also the Plan has proposed horizontal integration of all vertical programs at district level to increase their effectiveness as also to facilitate allocative efficiencies.

Policies During Recent Five Year Plans:

The Ninth Five Year Plan by contrast provides a good review of all programs and has made an effort to strategies on achievements hitherto and learn from them in order to move forward. There are a number of innovative ideas in the ninth plan. It is refreshing to see that reference is once again being made to the Bhore Committee report and to contextualize today's scenario in the recommendations the Bhore Committee had made. In its analysis of health infrastructure and human resources the Ninth Plan says that consolidation of PHCs and SCs and assuring that the requirements for its proper functioning are made available is an important goal under the Basic Minimum Services program. Thus, given that it is difficult to find physicians to work in PHCs and CHCs the Plan suggests creating part-time positions which can be offered to local qualified private practitioners and/or offer the PHC and CHC premises for after office hours practice against a rent. Also it suggests putting in place mechanisms to strengthen referral services.

Another issue of concern is the influence of international agencies in policymaking and program design both within and outside the plans. Right from the First plan onwards one can see the presence of international aid agencies

who with a small quantum of money are able to inject large doses of ideology. It cannot be a coincidence that almost every health program the Indian government has taken up since the first plan has been anticipated by some international donor agency. Whether it was the CDP in the fifties, IUCD and malaria in the sixties or RCH and AIDS in the nineties, most health programs have been shaped through external collaboration. Historically, though there is a qualitative and quantitative difference.

The Tenth Plan was Improvement in the health status of the population has been one of the major thrust areas in social development programmes of the country. This was to be achieved through improving the access to and utilization of Health, Family Welfare and Nutrition Services with special focus on under-served and under-privileged segments of population. The areas of attention in the Tenth Plan include the reorganization and restructuring of existing health care infrastructure, including the infrastructure for delivering ISM&H services, at primary, secondary and tertiary care levels, so that they have the responsibility of serving population residing in a well defined geographical area and have appropriate referral linkages with each other.

There will have to be a continued commitment to provide essential primary health care, emergency life saving services, services under the National disease control programmes and the National Family Welfare programme free of cost to individuals based on their needs and not on their ability to pay. At the same time, suitable strategies will have to be evolved, tested and implemented for levying and collecting user charges from people above poverty line and utilizing funds obtained for improving the quality of health care services.

The vision of the Eleventh Five Year Plan is to end the multifaceted exclusions and discriminations faced by women and children; to ensure that every woman and child in the country is able to develop her full potential and share the benefits of economic growth and prosperity. Success will depend on our ability to adopt a participatory approach that empowers women and children and makes them partners in their own development. The roadmap for this has already been laid in the National Policy on Women 2001 and the National Plan of Action for Children 2005. The Eleventh Plan recognizes that women and children are not homogenous categories; they belong to diverse castes, classes, communities, economic groups, and are located within a range of geographic and development zones.

The gender perspectives incorporated in the plan are the outcome of extensive consultations with different stakeholders, including a Group of Feminist Economists. In the Eleventh Plan, for the first time, women are recognized not just as equal citizens but as agents of economic and social growth. The approach to gender equity is based on the recognition that interventions in favour of women must be multi-pronged. The child development approach in the Eleventh Plan is to ensure that children do not lose their childhood because of work, disease, and despair. It is based on the understanding that the rights of all children, including those who do not face adverse circumstances, must be protected everywhere and at all times so that they

do not fall out of the social security net. Successful integration of survival, development, protection, and participation policies are important for the overall well being of the child.

The Twelfth Plan seeks to strengthen initiatives taken in the Eleventh Plan to expand the reach of health care and work towards the long term objective of establishing a system of Universal Health Coverage (UHC) in the country. This means that each individual would have assured access to a defined essential range of medicines and treatment at an affordable price, which should be entirely free for a large percentage of the population. Inevitably, the list of assured services will have to be limited by budgetary constraints. But the objective should be to expand coverage steadily over time. By 2015, basic medical and health system that covers urban and rural residents will be established; basic medical insurance and basic public health services will be made universally available; the accessibility, quality and efficiency of medical and health services as well as patients' satisfaction will be improved evidently; out-of-pocket payment will be reduced significantly.

The public health service system will be primarily established with clear distribution of work, information exchange, resource sharing, coordination and interaction; it will promote equal access of urban and rural residents to basic public health services. The medical service system covering both urban and rural residents will be primarily established with orderly and reasonable structure; it will provide the people with basic medical services that are safe, effective, convenient and affordable. A multiple tiered medical insurance system that covers both urban and rural residents will be primarily established with the basic medical insurance as the main body, various additional medical insurance and commercial health insurance as supplement; out-of pocket payment will be further reduced. The supply assurance system for drugs and medical devices based on national essential medicine system will be further regulated to ensure that essential medicines are safe, effective, equally accessible and rationally used.

Conclusion:

Structured health policy making and health planning in India is not a post independence phenomena. In fact, the most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946. The Bhore Committee recognized the vast rural-urban disparities in the existing health services and hence based its plan with specifically the rural population in mind. Its plan was for the district as a unit. Two requirements of the district health scheme are that the peripheral units of the organization should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration. The public health service system will be primarily established with clear distribution of work, information exchange, resource sharing, coordination and interaction; it will promote equal access of urban and rural residents to basic public health services.

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