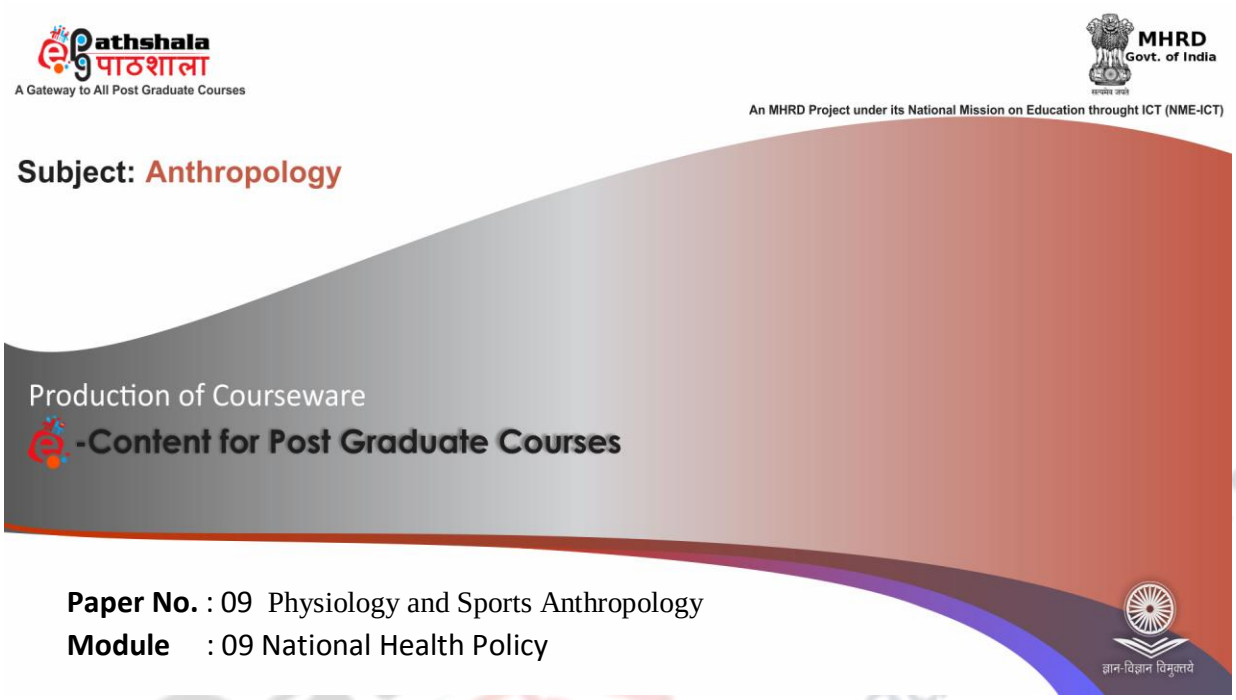

Paper No. : 09 Physiology and Sports Anthropology
Module : 09 National Health Policy

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Subject Name	Anthropology
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Learning Objectives

After studying this module:

- You would able to understand the evolution and development of National Health Policy.
- You would able to learn different Committees and their recommendations.
- You would be able to learn the provisions of National Health Policies.

1. Introduction: Different Committees on Health

Every state must have its health policy to guide the state to make proper health provisions of its citizens. But in case of India, the health policy was much delayed as the first National Health Policy was adopted in the year 1983. Before the launch of NHP, several committees on heath were formed. Some of the committees were formed even before independence such as Sub-Committee on Health under the National Planning Committee and Bhore Committee. The important Committees on heath before the first National Health Policy are:

- Bhore Committee 1946
- Mudaliar Committee 1959
- Chadah Committee 1963
- Mukerji Committee 1965
- Mukerji Committee 1966
- Jungalwalla Committee 1967
- Kartar Singh Committee 1973
- Srivastav Committee 1975

2.1 Bhore Committee 1946

The Bhore Committee is known as 'Health Survey and Development Committee'. It was appointed under the chairmanship of Sir Joseph Bhore in 1943 and submitted its report in 1946. It was the most comprehensive studied report and made from the micro level. There were two major objectives:

- To review the health situation and health organizations in British India; and
- To recommend the future development of Indian health system

Recommendations

1. Integration of preventive and curative health care services at all administrative levels. No individual should lack access to medical care and fail to secure the adequate health care because of inability to pay for it.
2. Development of Primary Health Centres (PHC) in two stages :
    i. Short-term measure: one PHC for 40,000 population and each PHC to be manned by two doctors, one nurse, four nurses, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacist and fifteen class IV staffs. Secondary health centre was also envisaged to provide support and supervise functioning of PHC.
    ii. A long-term programme (three million plan) of setting up primary health units with 75-bedded hospitals for each 10,000-20,000 population and secondary unit with 650-bedded hospital, again regionalised around district hospital with 2500 beds.
3. As much medical relief and preventive health care as possible should be provided to the vast rural population of the country.
4. Health service should provide all consultants, laboratories, and institutional facilities for proper diagnosis and treatment and health programme must lay emphasis on preventive work.
5. All diagnosis and treatment services should be available in the public health facilities.

6. Major changes in medical education which includes three months training in preventive and social medicine to prepare "social physicians".
7. Suitable housing, safe drinking water, and sanitary surroundings.

The committee was instrumental in bringing about public health reforms related to peripheral health centres in India. Though most of the recommendations were not implemented at the time, the committee was a trigger to the reforms that followed. It required the implementation of structural changes in the then health system, and had they been implemented they would have radically altered health care access and health status of the Indian masses, especially the 80 percent population residing in rural areas (Duggal, 2005).

2.2 Mudaliar Committee 1962

After India's independence, the first two decades were mainly spent on managing and fighting the rampant epidemics like malaria, cholera and smallpox. It was also realized that major resources of public health services have been spent only in the urban areas while maximum population resides in rural areas. Also, the recommendations of the Bhore Committee could not be implemented in real sense. For this, the GoI has appointed "*Health Survey and Planning Committee*" was formed under A.L. Mudaliar in 1959.

The then Minister of Health said that "the principles enunciated by the Bhore Committee are as valid today as they were at that time and now twelve years of development necessitates today a resurvey of the whole field of the health" (Mudaliar Committee Report, 1961). The main objectives were:

- To make the evaluation in the field of medical relief and public health since the submission of the Bhore Committee's report;
- To review the first and second Five year Plan health projects; and
- To make recommendations for development and expansion of health services.

Main recommendations:

1. Provision of one PHC per 40,000 populations.
2. The staffing pattern of earlier or existing PHCs should be upgraded as per the Bhore Committee recommendations.
3. Strengthening of Sub-Divisional and District Hospitals (DH) after the PHCs.
4. At least one bed per 1,000 and one doctor per 3,000 population and at least one 50-bed basic hospital for each sub-division.
5. There should be one 500-bed DH and one medical college per 5 million populations.
6. No integration of systems of medicine. Central government should control communicable diseases.
7. All India Health service should be created to replace the erstwhile Indian Medical service.

2.3 Chadha Committee, 1963

The GoI has appointed another committee in 1963 under the chairmanship of Dr. M.S. Chadha to advise about the necessary arrangements for the maintenance phase of National Malaria Eradication Programme (NMEP). The objectives of this committee were:

1. To give the details of requirements related to PHCs, their planning, the necessary priority required as per the needs of NMEP maintenance phase; and
2. To analyse the staffing pattern required for PHCs and the manner in which technical and supervisory staffs of NMEP should be utilized after the eradication of Malaria.

Recommendations:

- The vigilance operations in respect of NMEP should be the responsibility of the general health services (PHCs at block).
- The basic unit to have effective control over communicable diseases and provide preventive health care.
- One basic health worker per 10,000 population and should be redefined as MPW who will have do additional duties of collection of vital statistics and FP.
- A Medical Officer (MO) trained in Malaria is required to assist the District Health Officer (DHO) who also work as District Epidemiological Officer and investigate cases, supervise the programmes and take remedial actions under the supervision of DHO.
- The Family Planning Health Assistants should supervise 3-4 MPWs.
- To establish the medical institutions particularly the dispensaries and PHCs planned during the third five year plan.

2.4 Mukherji Committee, 1965

The recommendations of the Chadha Committee, when implemented, were found to be impracticable because the basic health workers, with their multiple functions could not do justice either to malaria work or to the FP work. As a result, both the programmes -Malaria and FP programmes suffered largely. The Mukherjee committee was appointed to review the performance in the area of FP programme.

Recommendations:

1. To de-link the Malaria activities from FP and separate staffs for FP programme.
2. Separate FP cell at the state health directorate level which would work as executive agency for the implementation of FP programmes.
3. This FP cell at the state would be looked after by a Joint Director (FP) and receive all the support from other officials in the implementation of the FP programme.
4. The FP Assistants were to undertake family planning duties only.
5. The basic health workers were to be utilized for the purpose other than FP.

2.5 Mukherji Committee, 1966

Multiple activities of the mass programmes like FP, Small Pox, Leprosy, NMEP etc. were difficult to implement by the States due to paucity of funds. A committee of state health secretaries, headed by the Union Health Secretary – Shri B. Mukerji was set up to review the staffing pattern of the PHC and to recommend the minimum staffs of various categories required at different levels within the district so as to provide an integrated health service.

Recommendations:

1. One basic health worker for 10,000 populations in normal areas but in difficult and sparsely distributed population, number of health workers may be increased proportionately.
2. A health inspector for 4 basic health workers. The existing sanitary inspector should focus more on the environmental sanitation.
3. A leave and training reserve of 5% of total basic health workers should be provided.
4. Technical staffs such as doctors should be relieved of the administrative work.
5. A medical officer should be dedicated only to NMEP.
6. District level health organizations should be gradually strengthened by adequately staffed and it should be headed by a Chief Medical Health Officer.
7. Strengthening PHED for preventive health care at the district level.
8. A Medical Superintendent for the District Hospital.
9. Proper buildings for the office and residence at the PHC and sub center levels.
10. Adequate emphasis on the continuing training to the medical and Para-medical staffs.

2.6 Jungalwalla Committee, 1967

Jungalwalla Committee, known as "Committee on Integration of Health Services", was appointed in 1964 under the chairmanship of Dr. N. Jungalwalla to assess various problems related to integration of health services, abolition of private practice by doctors in government services, and the service conditions of doctors. The committee defined "integrated health services" as:

1. A service with a unified approach for all problems instead of a segmented approach for different problems; and
2. Medical care and public health programmes should be put under charge of a single administrator at all levels of hierarchy with due priority for each programme obtaining at a point of time.

Recommendations:

1. Integration of health services, organization and personnel from top to bottom level.
2. Inter-independence between Central, State and local Governments in health matters including the programmes.
3. District level health organizations should be strengthened properly to undertake comprehensive health work on regionalized basis.
4. A PHC is a paramount institution and M O must be in complete administrative control.
5. Integration of services will not be effective unless all MOs are brought in one cadre and improvement in their service conditions.
6. Common seniority and equal pay for equal work and special pay for special work.
7. Abolition of private practice by government doctors.

2.7 Kartar Singh Committee, 1973

This committee, known as "Committee on Multi-Purpose Workers (MPW) under Health and FP programmes" was constituted in 1972 to study**:**

- The structure for integrated services at the peripheral and supervisory levels.
- The feasibility of MPW and their training requirement.
- Utilization of 'mobile service units' set-up under FP Programme for integrated medical, public health and FP services operating in the field.

Recommendations:

1. Various categories of peripheral workers should be integrated into a single cadre of MPW (male and female).
2. The erstwhile ANMs were to be converted into MPW (F) and the Basic Health Workers, Malaria Surveillance Workers, Vaccinators, Health Education Assistants (Trachoma) and the FP Health Assistants to be replaced by MPW (M).
3. The work of 3-4 male and female MPWs was to be supervised by one health supervisor (male or female respectively).
4. The existing LHVs were to be converted into female health supervisor.
5. One PHC should cover a population of 50,000 and it should have at least two doctors.
6. A PHC should be divided into 16 sub-centres (one for 3000 to 3500 populations) and each sub-centre to be staffed by a male and a female health worker.
7. The doctor in-charge of PHC should have the overall charge of all the supervisors.
8. Training of female health workers in the Five Year Plan and number of ANM training should be increased particularly where the states have acute shortage.

2.8 Shrivastav Committee, 1975

The Ministry of Health and Family Planning, Government of India has set up a 'Group on Medical Education and Support Manpower' in 1974 under the chairmanship of Dr. J.B. Shrivastav. The group submitted its report in April 1975. The main objectives were:

1. To devise suitable curriculum for training of Health Assistants conversant with basic medical aid, so that they can serve as a link between qualified medical practitioners and the MPWs,
2. To suggest steps for improving the existing medical educational processes, and
3. To make any other suggestions to realize the above objectives and related matters

Recommendations:

1. Creation of para-professional and semi-professional health workers from within the community (e.g. teachers, postmasters) to provide simple, promotive, preventive and curative health services to the community.
2. Establishment of 3 cadres of health workers namely – MPW and health assistants between the community level workers and doctors at PHC.
3. Development of a "Referral Services Complex" by establishing proper linkages between the PHC and higher level referral centres.

4. Establishment of a Medical and Health Education Commission for planning and implementing the reforms on the lines of UGC.
5. Involvement of medical colleges in the health care service delivery of selected PHCs with the objective of reorienting education to the needs of rural people; and
6. Reorientation of MPWs engaged in the control of various communicable disease programmes into uni-purpose workers.

The recommendations of the Committee were accepted by the Government of India in 1977, which led to the launching of the Rural Health Scheme.

Before the launch of NHP in 1983, a joint panel of ICMR and ICSSR was also formed which suggested: a village health unit per 1000 population with one male and one female health worker; one Sub-center per 5000 population with one male and female health worker; one 30-bed CHC per 100,000 population with 6 general doctors and 3 specialists; a DH for every 1 million population and a specialist center for every 5 million population; no further expansion of medical education and drug production but only their rationalization and reorientation; and 6 percent of GNP must be ultimately spent on Health Care Services.

2. National Health Policy, 1983

The Constitution of India directs the State to raising the level of nutrition and the standard of living of its people and the improvement of public health among its primary duties, securing the health and strength of the workers, men and women, and children. To achieve this, the country should have a broad policy and detailed guidelines. But our country did not have any such policy until 1983.

NHP-1983 consists of 20 paras and an appendix setting the goals for health and family welfare programmes. India is also a signatory of Alma Ata Conference of WHO which committed to attaining the goals of "Health for all by the year 2000 AD" through the universal provision of comprehensive primary health care services. The attainment of this goal requires a thorough overhauling of the existing approaches to the education and training of medical and health personnel and the recognition of the health services infrastructure. It is also necessary to secure the complete integration of all plans for health and human development with the overall socio-economic development process. The salient features of NHP-1983 are:

- It emphasized on preventive, promotive and rehabilitative health care approach and provision of universal and comprehensive primary health.
- Involvement of private practitioners and NGOs to expand coverage of and access to services.
- Decentralised health care, low cost, de-professionalisation (use of volunteers and paramedics), and community participation and establish a referral system.
- Establish a nationwide chain of epidemiological stations.
- Encourage private investment in health sector to reduce government burden.
- The need of National Population Policy for stabilizing the population because it is most important component.

- Changes in curriculum and training of medical and health personnel and provides guidelines for the production of health personnel on the basis of manpower requirement.
- Programmes to provide mental health care as well as medical care and the physical and social rehabilitation of mentally retarded, deaf, blind, physically disabled, infirm, and the aged.
- Priority to the people residing in the tribal, hill and backward areas as well as endemic disease affected populations and the vulnerable sections of the society.
- Doctors should be given compensatory non-practice allowances.
- Integrate Indigenous and other systems of Medicine.
- Priority areas are:
    - Nutrition,
    - Prevention of food adulteration,
    - Water supply and sanitation,
    - Environmental Protection,
    - Immunization Programme,
    - Maternal and Child Health services,
    - School Health Programme,
    - Occupational Health Services.
- Health Information System for appropriate decision making and programme planning.
- More industries to produce quality drugs, vaccines, biomedical equipment, etc., with special reference to Malaria, TB, leprosy, blindness, etc. Productions of Indigenous and herbal medicines should be encouraged.
- Effective health insurance schemes should be started in the states and central level.
- Existing health legislation to be reviewed and making them suitable for better delivery of health care.
- Inter-sectoral coordination of various efforts and timely monitoring and reviews of progress.

Selected health and demographic targets to be achieved by 2000 in the NHP are as follows:

Table -1: Indicators selected to achieve the goal in National Health Policy

Indicator	Goal 1990	Goal 2000	Achievement 2000
1. Crude Birth Rate/ 1000 population	27.0	21.0	26.1
2. Crude Death rate/ 1000 population	10.4	9.0	8.7
3. Infant Mortality Rate/ 1000 live births	87	< 60	70
4. Perinatal Mortality Rate		30-35	46
5. Maternal Mortality rate/1000 live births	2-3	< 2	4
6. Life Expectancy at birth 96-2000 Male	57.6	64	62.4
96-2000 Female	57.1	64	63.4
7. Couple Protection Rate	42.0%	60.0%	46.2%
8. Natural Growth Rate	1.56	1.20	1.93
9. Net Reproductive Rate	1.17	1.00	1.45
10. Family Size		2.3	3.1
11. ANC (any)		100%	67.2%
12. Blindness, Incidence	0.7	0.3	
13. Leprosy % of disease arrested out of total	60	80	
14. Under 5 Mortality Rate		10	9.4
15. Low Birth Weight Baby		10%	26%
16. Immunization			

TT (Pregnant, Children)	100%	100 %	83 %
OPV	85	85	87%
BCG	80	85	82%
DPT	85	85	87%
Fully Immunized	80	85	56%

It may be observed that most of the goals set for 1990 and 2000 except death rate and a few vaccinations could not be achieved. The reasons may be- over ambitious goals, inefficiency in implementation and routine monitoring and evaluation of programmes. Beside this, the emphasis of NHP-1983 was also on the preventive and promotive health care and the suggestion for involvement of private players in curative health. Health depends on many factors such as: education, economy, nutrition, occupation, environmental conditions, agriculture, land reforms and social structure. Unfortunately NHP narrows down its direction to only provisions for the physical infrastructure of health. This policy has identified priority areas but not much work is being done.

NHP also advocates for the community participation, but it fails to ensure their participation as most of them still prefer to choose private health facilities. Decentralised planning, implementation and control are not much emphasized in the NHP which may lead to poor acceptance of programmes at the state and community level (Duggal, 2005).

3. National Health Policy- 2002

The Government of India has revisited its previous NHP and came up with new policy in 2002. The aim was to achieve an acceptable standard of good health, decentralization of the health facility, equitable access, increase in the investment, identification of national problem like malaria, TB, blindness, etc. The objectives are:

- Acceptable standard of good health of Indian population.
- Decentralizing public health system by upgrading infrastructure in existing institutions.
- Equitable access to health service.
- Enhancing contribution of private sector on the affordable price.
- Emphasizing rational use of drugs.
- Increasing access to Traditional Medicine.

Major goals to be achieved by NHP 2002 can be broadly classified into the following:

- Reducing morbidity and mortality
- Increasing public health facilities
- Increasing public health spending

Table -2: Goals of NHP-2002

Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kala-Azar	2010
Eliminate Lymphatic Filariasis	2015
Achieve Zero level growth of HIV/AIDS	2007
Reduce Mortality by 50% on account of TB, Malaria, other Vector & Water Born diseases	2010
Reduce 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 <20% to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics	2005
Increase health expenditure from 0.9% to 2.0% of GDP	2010
Increase share of Central grants to Constitute at least 25% of total health spending	2010
Increase State sector health spending from 5.5% to 7% of the budget	2005
Further increase to 8%	2010

Policy Prescriptions of NHP-2002

Financial Resources:

- Health sector investment to increase to 6% of the GDP by the year 2010.
- Existing 15% of central government contribution is to be raised to 25% by 2010.

National Health Programmes

- To optimize the utilization of public health infrastructure at primary level, gradual convergence of all health programmes under a single field administration.
- Vertical programme for control of major diseases to be continued till achievement of moderate levels of prevalence.
- Scientific designing of public health projects, suited to the local situation.

Public Health Infrastructure

- Revival of public health by providing some essential drugs through decentralized health system.
- Frequent in-service training to health personnel.
- Increase in public expenditure by reasonable user charges.

Extending Public Health Services

- Expanding allopathic, Ayurvedic and Homeopathic practioners as well as trained paramedical manpower of allopathic to the underserved areas through simplified recruitment procedures for contract employment.
- A mandatory two year rural posting before awarding graduate degree.

Role of Local Self Government Institutions

- Implementation of health programmes through local self-government institutions by 2005.
- Decentralizing the implementation of the programmes including mental health services for ameliorating the more common categories of disorders.

Education of Health Care Professionals

- Setting up of a Medical Grants Commission to address uneven distribution of medical and dental colleges.
- Need-based and skill oriented syllabus and more practical training to doctors.
- A periodic skill-upgradation of health professionals through Continuing Medical Education.

Norms for Health Care Personnel

- ***Indian Medical Council Act*** and Indian ***Nursing Council Act*** provide statutory norms for doctors and nurses which should be introduced urgently.
- To raise the proportion of Postgraduate seats.

Nursing Personnel

- The need for an improvement in ratio of nurses and doctors/beds.
- The need for training courses for super specialty nurses required for tertiary care institutions.

IEC

- Need of an IEC policy for maximising the dissemination of information.
- Priority to school health programmes which aim at preventive and promotive health care.

Health Research

- One percent of the total health spending on health research by 2005.
- Medical research would be focused on new therapeutic drugs and vaccines for tropical diseases, such as TB, malaria and sub-types of HIV/AIDS.

Role of Private Sector

- Suitable legislation for regulating minimum infrastructure and quality standards in medical institutions/clinical establishments.
- Co-option of the non-governmental practitioners in the national disease control programmes so as to ensure that standard treatment protocols

Role of Civil Society

- The disease control programmes should earmark not less than 10 percent of the budget.
- Simplify procedures to enhance the government-civil society interface.

Women's Health

- Highest priority of the central government to the programmes related to women's health.
- Review the staffing norms of the public health to meet the specific requirements of women.

In addition to this, the Policy also laid emphasis on National Disease Surveillance Network from the lowest level of public health administration to the central government and a contemporary code of ethics to be notified and implemented to ensure that common patient is not subjected to irrational or profit-driven medical regimens.