Health Policy and Planning in India

Component-I (A) – Personal Details

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Component-I (B) Description of Module

Items	Description of Module
Subject Name	Social Work
Paper Name	Fields of Practice in Social work
Module Name/Title	Health Policy and Planning in India
Module Id	
Pre-requisites<Expected to know before learning this module>	Basic understanding about Public health, Government policies on health
Objectives	• To understand various Health Planning in India and Role of Various committee • To learn about Five Year Plans and Health in India • Understand Health Policies in India- past and present
Key words	Health policy, planning, five year plans, role of various committees, Health Policies in India- past and present

HEALTH POLICY AND PLANNING IN INDIA

This module consists of the following:
1.Health Planning in India- Role of Various committee
2. Five Year Plans and Health
3.Health Policies in India- past and present

Introduction

Health and health care development has not been a priority of the Indian state. This is reflected in two significant facts. One, the low level of investment and allocation of resources to the health sector over the years – about one percent of GDP with clear declining trends over the last decade. And second the uncontrolled and very rapid development of an unregulated private health sector, especially in the last two decades (Duggal R, 2000).

The first health policy of 1983, came in after 35 years of Independence. This also reflects the poor concern of state towards health. However, there was a distinct policy and strategy for the health sector. This was reflected through the Five Year Plans of the Central government.

Despite the fact that health is a state subject, at the state government level there is no evidence of any policy initiatives in the health sector. The Central government through the Council of Health and Family Welfare and various Committee recommendations has shaped health policy and planning in India. It has directed this through the Five Year Plans through which it executes its decisions. The entire approach has been program based. The Centre designs national programs and the states have to just accept them. The Centre assures this through the fiscal control it has in distribution of resources. So, essentially what is a state subject the Centre takes major decisions. However, it is important to note that this Central control is largely over preventive and promotive programs like the Disease Control programs, MCH and Family Planning, which together account for between half and two-thirds of state budgets. Curative care, that is hospital and dispensaries, has not been an area of Central influence and in this domain investments have come mostly from the state's own resources(Ibid).

Health Planning in India- Role of Various committees

National Health Planning is defined as

'The orderly process of defining community health problems, identifying unmet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible

and proposing administrative action to accomplish the purpose of the proposed programme ' (Park K, 2005).

Health Planning in India has been based on the suggestions of various committees which have been formed right from the time of independence. These committees were formed by the Govt. Of India from time to time to review the existing health situations and recommend measures for further action. The recommendations of these committees have shaped the formulation of various five year plans which forms the back bone of health policy in India. Let us know more about these committees.

The first committee constituted to understand the existing health condition of the nation was the **Sokhey Committee**. This was a sub committee on Health of the National Planning Committee set up by the Indian National Congress in 1938. Most members of this committee were part of the freedom struggle. This came up with the following findings:

a. Environmental sanitation is low in most parts of the country.

b. Prevalence of malnutrition & under nutrition

c. Health services inadequate to meet the needs of people.

d. There was a high prevalence of diseases like Malaria, TB, Cholera, Small Pox, enteric fevers, dysenteries, tetanus and diptheria.IMR & MMR was high. Medical services were scattered and inadequate, not only in number but the kind of medical care they delivered.

The recommendations made by this committee were integration of preventive and curative function, maintenance of peoples health is a states responsibility; need for training large number of health workers in practical community and personal hygiene, first aid, simple medical treatment; and one health worker for every 1,000 population. Hence their main recommendation was community health worker scheme and Integration of ayurvedic and unani system with state health system after giving them training.

Another important committe that was appointed by the Government of India in 1943, was **Bhore Committee** also known as the *Health Survey and Development Committee* with Sir Joseph Bhore as the Chairman. The committee put forward the proposal for the comprehensive development of a National Program for Health Services for the country. The main recommendations of this committee were:Integration of preventive and curative

services at all administrative levels and development of Primary health centres in two stages.

Short term measure: Each PHC in rural areas should cater to a population of 40,000/-. Secondary health centre should provide supervisory and coordinating role. Each PHC should have 2 medical officers,4 public health nurses, one nurse, four midwives, four trained dais, 2 sanitary inspectors,2 health asisstants, one pharmacist and 14 other class IV employees.

Long term measure: Setting up of Primary Health Units (75 bedded) for a population of 10,000-20,000. Secondary units should have 650 beds and District Hospitals should have 2,500 beds. Ther should be changes in Medical Education. A social physician should undergo compulsary three months training in Preventive and Social Medicine.

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. It's plan was for the district as a unit.The recommendations made by this committee laid the foundation of the present day rural health services in our country. The present structure of health services in rural India is based on the recommendation of the Bhore committee.

Some other committess which were formed in subsequent years to take stalk of the existing health needs of the country and make suggestions for the formulations of health programs were The Mudaliar Committee (1959), Chadah Committee (1963), Mukherjee Committee (1965), Jugalwalla Committee (1967), Kartar Singh Committee (1973) and Shrivastav Committee (1975). Each of these committees made their own specific recommendations which helped in shaping the heath services in the country. While the Mudaliar committee talked about strengthening of the services provided by the PHC, the Chadah committe recommended the creation of Multipurpose workers who would take care of all the work related to basic health care, family planning and vigilance work for Malaria. The Mukherjee committee on the other hand talked about delinking Malaria from family planning work. Jugalwala committee recommended integration of health services, for which the Kartar Singh committee put emphasis on Multi purpose workers. This committee recommended that each PHC should be divided into 16 subcentres for a population of 3,000-3,500.Each subcentre to be staffed by one male and one female health worker.One male health supervisor to supervise 3-4 male health workers and one female health supervisor for 3-4 female health workers. Doctor incharge of PHC should be responsible for overall charge of all health workers and supervisors. The recommendation of Kartar Singh was accepted by GOI in 5th Plan, based on

which the present day rural health structure has been created. The Shrivastav Committee made a very important recommendation, which was that Primary Health should be provided within the community itself through a band of workers from within the community so that health of people is placed in their hands. “ Peoples health in peoples hand”. This recommendation was accepted in 1977 and a rural health scheme was launched (Park K, 2005).

Based on the recommendation of these committees health programs were formulated in the various five year plans and budget for the same was allocated.

Five Year Plans and Health

The first five year Plan (1951-56) focussed on control of communicable diseases, education training and research, family Planning, water supply and sanitation and setting up of PHCs. The activities initiated in the first plan continued in the secon plan (1956-61) with a lot more emphasis on water supply, sanitation and control of communicable diseases. The emphasis of the third plan (1961-66) was on preventive Public Health Services (Water supply & sanitation) and control of Communicable diseases.Family Planning program was launched with a focus on Population Control. The Fourth Plan (1969-74) focussed on Strengthening of PHC’s. High priority was given to preventive health services, control of malaria, TB, leprosy, trachoma and eradication of small pox. Family Planning received a huge chunk of resources. The fifth plan (1974-79) saw launching of several schemes related to health. The Family Planning was integrated with nutrition and immunization of children under the Minimum needs program which aimed at providing minimum preventive health services integrated with family planning, nutrition and immunization. Sanitation & Drinking water program was launched and Integrated Child Development Scheme (ICDS) was launched in 1975. Multipurpose workers scheme began in 1971. Community Health guide scheme was introduced in 1977.

Emergency was declared in 1975. Congress government focussed on family planning. Forced vasectomy was done in vasectomy camps which lead to large scale deaths. This met mass opposition. The govt. changed from congress to Janta Party. This lead to a shift from family planning to infrastructure building from sixth plan (1980-85) onwards. In the mean time the International conference on Public Health took place in Alma Atta, Kazakistan which was a major milestone in the field of public health. India too participated in this conference and

became a signatory to the Alma Atta declaration committing to provide Health for All by 2000 AD. To realise this goal the First ever Health Policy was formulated in 1983 with a goal to provide Health for All through primary health care. All this happened during the sixth plan period (1980-85) which focussed on infrastructure building, community involvement and universal primary health care to all sections of the society. The seventh plan (1985-90) focussed on decentralised planning and peoples involvement in health planning. The Panchayati Raj institutions played a key role in health planning.

Another significant shift in the health sector happened during the eighth plan (1992-97) perid with the globalisation and coming in of the Structural adjustment program (SAP). Cuts were introduced in the welfare sector especially in health and education. To cope up with the fund crunch,new measures were introduced in the health sector like introduction of user fee, privatisation of government run institution and public private partneships. The cost of health care rose with the coming of the private sector, making quality health care inaccessible to the masses. The ninth plan (1997-2002) focussed on consolidation of PHCs and Subcentres. State specific strategies on health were evolved. Focus was given on urban health issues-providing primary health services in urban slums. The National Population Policy 2000 and the National Health Policy 2002 were launched. Besides other things the policy clearly demarcated role of the private and public sector in health care provisioning. While the government should provide primary level care, the public sector should provide secondary and tertiary level care.

The Tenth Plan (2002-2007) focussed on improving the health status of the population by optimizing the coverage and quality of care by identifying and rectifying the gaps in infrastructure and management. Policy like National Rural Health Mission was launched in 2005 to realise this goal. The focus was on improving the accessibility of health services in rural areas and reducing IMR &MMR. The eleventh five (2007-2012) year plan saw the launching of the National Urban Health Mission in 2014, the two were clubbed together and known as the National Health Mission. Twelvth Five Year Plan (2012-2017) saw the launching of the National health policy 2017. A brief description of these policies are provided in the section below.

Health Policies in India

1. National health policy 1983

The main objective of this policy is to achieve the goal of 'health for all by 2000'. It 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.' This policy was critical of the curative-oriented western model of health care. It emphasized upon a preventive, promotive and rehabilitative primary health care approach. It recommended a decentralised system of health care, the key features of which were low cost, deprofessionalisation (use of volunteers and paramedics), and community participation.

Post National Health Policy rural health care received special attention and a massive program of expansion of primary healthcare facilities in rural areas was undertaken in the 6th and 7th Five Year Plans to achieve the target of one PHC per 30,000 population and one subcentre per 5000 population. This target has more or less been achieved, though few states still lag behind. Hence, this policy's main focus was infrastructure building. The policy favoured privatization of curative care at a cost which the people can afford. Advocates for curative services by private sector and preventive and promotive services by the Public Sector. This is mainly because the state suffers from resource crunch.

National Health Policy 2002

This policy aims to provide acceptable standard of good health amongst the general population of the country.It aims to increase access to decentralized Public health systems by establishing new infrastructure in the existing institutions. It focusses on providing equitable access to health services. Primacy is given to preventive and first line curative initiative at Primary Health level. As mentioned earlier, the policy clearly demarcated the roles of the Private and Public Sector. Public sector to provide primary level care, private sector to provide secondary and tertiary level of care.

This policy focusses on diseases contributing to the disease burden like TB, Malaria, blindness, HIV/AIDS. Policy lays great emphasis upon the implementation of public health programmes through local self government institutions. It also advocates for the use of generic drugs and vaccines for cost effective public healthcare.

The policy envisages the setting up of an organized urban primary health care structure. A two tiered structure was suggested where the primary centre is the first tier covering a population of one lakh with a dispensary providing an OPD facility and essential drugs, to

enable access to all the national health programmes. Second tier of the urban health organization would be provided at the level of the government general hospital where reference is made from primary centre.

3.National Rural Health Mission, 2005

Was launched under the mandate of National Common Minimum program (NCMP) of the UPA govt. It is operational since 2005-06 with special focus on 18 states- Bihar, Jharkhand, MP, Chhattisgarh, UP, Uttaranchal, Orissa, Rajasthan, Assam, AP, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Himachal Pradesh and J&K.

The policy proposes to increase the expenditure in health sector from 0.9% of GDP to 2-3 % of GDP over the next five years with main focus on primary healthcare. It also aims to achieve IMR of 30 per thousand live births, maternal mortality of 100 per 100 thousand live births and total fertility rate of 2.1 by the year 2012. It utilizes Public Private Partnership as an essential tool for achieving the above mentioned goal.

Some of the salient features of the policy are as follows:

- Bridge gap in rural health care services through a cadre of accredited social health activist (ASHA) and improved hospital care.

- Decentralization of program to district level to improve intra and intersectoral convergence and affective utilization of resources.

- To provide an overarching umbrella to the existing programs of Health & Family Welfare including RCH II, Malaria, Blindness, Iodine deficiency, Filaria, Kala Azar, TB, leprosy.

- Intersectoral approach to health planning. Pays emphasis to sanitation & hygiene, nutrition and safe drinking water as basic determinants of good health at district and village level.

- Builds greater ownership of the program among the community through involvement of PRIs, NGOs and other stakeholders at national, state and sub district levels.

- Innovative Programs like Janani Suraksha Yojana, Janani Shishu Surakhsa Karyakram, Community Based Monitoring, Village Health Sanitation Committee.

4. *National Urban Health Mission,2014*

Launched in February 2014 the policy aims to meet health needs of the urban poor,

particularly the slum dwellers by making available to them essential primary health care services. This will be done by investing in high-caliber health professionals, appropriate technology through PPP, and health insurance for urban poor. The policy aims to reduce the IMR and MMR in urban areas. It proposes to create one Urban Primary Health Centre (U-PHC) for every fifty to sixty thousand population, one Urban Community Health Centre (U-CHC) for five to six U-PHCs in big cities,one Auxiliary Nursing Midwives (ANM) for 10,000 population and one Accredited Social Health Activist ASHA (community link worker) for 200 to 500 households. NUHM entails to cover all cities with a population of more than 100,000. It would cover 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 on sites.

NRHM and NUHM are clubbed together and known as the National Health Mission.

5. National Health Policy, 2017

Launced in March 2017, the policy aims to improve health status through concerned policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitatibe services provided through the public health sector with focus on equality

(http://www.mohfw).

The policy aims to acheive universal health coverage by providing primary health care by utilising the existing infrastructure and by collaborating with the non-governmental sector. It also aims to acheive improved access to secondary and tertiary services through a combination of public hospitals and private care providers, especially the not for profit providers.

In terms of budget the policy envisages to increase the government spending in health from 1.15% of GDP to 2.5% of GDP by 2025, which is hardly any increase considering the long time span. It talks about reduction of out of pocket expenditure, but doesnt specify any specific strategy to acheive the same.

This policy is being criticised as it does not clearly define the role of the state in strengthening the public health system and providing equitable, affordable and quality care to all. Instead it relies heavily on private and voluntary sectors to fulfil it.

Conclusion

Health policies in India have been formulated and revised from time to time. They do have good programs to reach out to the bpl and those living in the interior rural areas. However, the implementation of these programs remain poor, mainly due to corruption and poor governance at the local level. Partnership with NGO's to enhance the outreach of the program often doesn't work due to the corrupt nature of the NGOs.

As stated earlier, the commitment of the state towards public health is low and this is well reflected in the health policies. All these policies talk about providing accessible and affordable health care to the masses, but then these are just statements in the policy documents and no concrete effort is made to translate these into action. The low budgetary allocation on health is a reflection of the poor commitment of the state to public health. India's public spending on health is one of the lowest in the world, at 1.15 percent of the GDP, this is much below the global average of 5.99 percent. More and more responsibility of public health is being passed to the private sector which is costly and unaffordable to the masses. This has also led to a very high out of pocket expenditure, which constitutes 64 per cent of the total health expenditure, pushing 7 percent of the population into poverty (NSSO, 71st round). As a result the majority are suffering from poor health.