NHPP1: Evolution of Health Policy in India

Quadrant – I

Personal details:

Role	Name	Affiliation
Principal Investigator	Dr. C.P. Mishra	Professor Department of Community Medicine Banaras Hindu University, Varanasi Uttar Pradesh, India
Paper Coordinator	Dr. Davendra Kumar Taneja	Director Professor Department of Community Medicine Maulana Azad Medical College New Delhi, India
Content Writer/Author	Dr. Ranabir Pal	Additional Professor, Department of Community Medicine and Family Medicine All India Institute of Medical Sciences Jodhpur, India
Content Reviewer	Dr. Bratati Banerjee	Professor Department of Community Medicine Maulana Azad Medical College New Delhi, India

Description of module:

Items	Description of Module
Subject Name	Social Medicine Community Health
Paper Name	National Health Policies and Programmes
Module Name/Title	Evolution of Health Policy in India
Module Id	NHPP1
Pre-requisites	Knowledge on health problems and health system in India; knowledge on national policies in general
Objectives	To study about the evolution of National Health Policy
Key words	National Policy; Health

Introduction

The key features of health are inter-individual variability, complexity, and co morbidity, which is why indicators of quality of care, based on single disease models, work less well among the people. The care in health and disease is a major social issue in developed countries. In developing countries like India, diseases are also associated with non-medical risk factors like poverty, family support, social stress, inadequate housing, mental illnesses, and limited options for living arrangement and a huge dependency ratio. The decline in morbidity and mortality rates accompanied by an improvement in life expectancy and child survival rates has resulted in a progressive increase in expectation of life in India. Yet India had its first national health policy in 1983 i.e. 36 years after independence.

The Joint WHO – UNICEF international conference in 1978 at Alma-Ata (USSR) in their declaration called on all the governments to formulate national health policies according to their own circumstances to launch and sustain primary health care as a part of national health system. This conference declared that "Primary health care is essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford." Alma-Ata Declaration called on all the governments to formulate national health policies according to their own circumstances to launch and sustain primary health care as a part of national health system.

Learning Outcomes

Up on completion of this module, the reader should be able to:

- Discuss the evolution of the National Health Policy
- Describe the major points of the Draft National Health Policy 2015

Main Text

1. Pre-independence era

In the pre-colonial period, structured health care delivery had clearly established three characteristics. Firstly, it was considered a social responsibility and thus state and philanthropic intervention was highly significant. Secondly, the services that were provided by these facilities were provided free to all who availed them or had access to them. Caste, class and occupation did however limit access. And thirdly, most of these facilities were located in towns thus projecting a clear urban bias.

The rural areas had to wait till the Government of India Act of 1919 whereby health was transferred to the provincial governments and the latter began to take some interest in rural health care. Rockefeller Foundation is historically very important for development of health care services and health policy in India, especially for rural areas with the ideology that rural areas need only preventive health care and not hospitals and medical care clinics, i.e., they need "Public Health" and not medical care. In 1938 the Indian National Congress established a National Planning Committee (NPC) under Jawaharlal Nehru with the subcommittee on National Health that formulated an interim report incorporating the need for the state to adopt family planning and welfare policies in order to bring about a harmonious order of social economy.

Modern medicine and health care were introduced in India during the colonial period. In 1946 the Report of the `Health Survey and Development Committee' popularly referred to as the Bhore

Committee had innovative proposals that required implementation of structural changes in the then health care system. NPC resolutions were endorsed by the Bhore Committee in their documents.

2. **Post-independence era**

In India until 1982-83 there was no formal health policy statement. The policy was part and parcel of the planning process (and various committees appointed from time to time), which provided most of the inputs for the formulation of health programme designs.

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.

To evaluate the progress made in the first two five-year plans and to make recommendations 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. The Mudaliar Committee also recommended that an All India Health Service should be created to replace the erstwhile Indian Medical Service.

In 1963 the Chadha Committee had recommended the integration of health and family planning services and its delivery through one male and one female multipurpose worker per 10,000 population.

Mukherjee Committee in 1966 reviewed the Staffing Pattern and Financial Provision under Family Planning and indicated that the camp approach had failed to give the family planning programme a mass character with IUCD use, target fixation, payments for motivation and incentives to acceptors with reorganisation of the Family Planning program into a vertical programme with addition of one more Health visitor per PHC who would specifically supervise the ANMs for the targets of this program.

In 1967 the Jain Committee report on Medical Care Services had made an attempt to devolve medical care by recommending strengthening of such care at the PHC and block/taluka level as well as further strengthening district hospital facilities. The Jain Committee also suggested integration of medical and health services at the district level with both responsibilities being vested in the Civil Surgeon/Chief Medical Officer. But recommendations of this Committee, which is the only committee since independence to look at medical care and also for the first time talked about strengthening curative services in rural areas, were not considered seriously. Later on, Minimum Needs Programme (MNP) was introduced by increasing the accessibility of health services to rural areas and correcting the regional imbalances.

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.

Shrivastava committee in 1975 brought another major innovation in the health strategy by creating a cadre of village based health auxiliaries called the Community Health workers.

The National Population Policy was announced in 1977 that reinforced education for health with a core aim of “direct assault on the problem of population rise as a national commitment”. This population policy was later replaced by the National Population Policy 2000 with the objective to address the unmet needs for contraception, health care infrastructure, and health personnel, and to

provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

A National Health Policy was formulated in 1983, and since then there have been marked changes in the determinant factors relating to the health sector. Some of the policy initiatives outlined in the NHP-1983 have yielded results, while, in several other areas, the outcome has not been as expected. The NHP-1983 gave a general exposition of the policies which required recommendation in the circumstances then prevailing in the health sector and stressed the need for providing primary health care with special emphasis on prevention, promotion and rehabilitation.

Suggested planned time bound attention to the following:

i) Nutrition, prevention of Food Adulteration

ii) Maintenance of quality of drugs

iii) Water supply and sanitation

iv) Environmental protection

v) Immunisation programme

vi) Maternal and child health services

vii) School health programme and

viii) Occupational health services.

The noteworthy initiatives under that policy were:-

(i) A phased, time-bound programme for setting up a well-dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves;

(ii) Intermediation through 'Health volunteers' having appropriate knowledge, simple skills and requisite technologies;

(iii) Establishment of a well worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralised level;

(iv)An integrated network of evenly spread speciality and super-speciality services; encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government's facilities is limited to those entitled to free use.

The period after the announcement of NHP-83 has also seen an increase in mortality through 'life-style' diseases- diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem. Another area of grave concern in the public health domain is the

persistent incidence of macro and micro nutrient deficiencies, especially among women and children. In the vulnerable sub-category of women and the girl child, this has the multiplier effect through the birth of low birth weight babies and serious ramifications of the consequential mental and physical retarded growth.

In the National Health Policy 2002 Primary health care was adopted as the main strategy through

- Decentralization
- Equity
- Private sector/indigenous system participation
- Rise in public investment

The objectives were:

•Achieving an acceptable standard of good health of Indian Population,

•Decentralising public health system by upgrading infrastructure in existing institutions,

•Ensuring a more equitable access to health services across the social and geographical expanse of India.

•Enhancing the contribution of private sector in providing health service for people who can afford to pay.

•Giving primacy for prevention and first line curative initiative.

•Emphasising rational use of drugs.

•Increasing access to tried systems of Traditional Medicine

Goals to be achieved by 2015 were:

- 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 Tuberculosis, Malaria, Other vector and water borne Diseases - 2010
- Reduce prevalence of blindness to 0.5% - 2010
- Reduce IMR to 30/1000 & MMR to 100/lakh - 2010
- Increase utilisation of public health facilities from current level of <20% to > 75% - 2010
- Establish an integrated system of surveillance, National Health Accounts and Health Statistics - 2007
- Increase health expenditure by government as a % of GDP from the existing 0.9% to 2.0% - 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 of State sector Health spending from 7% to 8% - 2010

Public health cadre as envisioned in the Eleventh Plan to manage NRHM is not yet in place. The Planning Commissions' High Level Expert Group (HLEG) suggested All India and state level Public Health Service Cadres and a specialised state level Health Systems Management Cadre in order to give greater attention to public health and also strengthen the management of the universal health coverage system. In 12th five years plan it is realised that here is an urgent real need for a dedicated Public Health cadre (with support teams comprising of epidemiologists, entomologists, public health nurses, health inspectors and male Multi-Purpose Workers) backed by appropriate regulation at the state level. The broad mission of public health is to assure conditions (environments) in which people can be healthy. Epidemiology, statistics, sociology, psychology, health economics, health promotion, management and leadership, health systems and policy all contribute to the public health approach. The success of any health system largely depends on the effectiveness, efficiency and equity of public health practices. Like health care system, public health systems in India have weakened and is undervalued, understood and under utilised in relation to its capacity to improve the health and well-being of individuals and populations. Vaccinations, control of infectious diseases, safer food, motor vehicle safety, safer workplaces, fluoridation, and regulation of tobacco are among the public health interventions responsible for improvements in the quality and length of lives. India has a shortfall of public health professionals. Now there is an urgent need to improve the quantity and quality of public health professionals to address the public health issues. The cornerstone of public health practice is prevention, particularly primary prevention, whereby disease and injury do not occur. For providing secondary and tertiary prevention, public health professionals focus on ensuring access to effective clinical care, rather than on providing the care itself. Access to quality health care is essential to secondary and tertiary prevention and therefore, to public health. India has a vast network of health facilities and a good number of institutions for training and research in public health. However, these facilities are usually inadequate, understaffed and short of funds. In India, the distribution of medical colleges, nursing colleges, nursing and ANM schools, paramedical institutions is uneven across the states with wide disparities in quality of education. There is a great confusion in between the public health, community medicine and preventive and social medicine. It continues to be a matter of debate that the faculties of community medicine are clinical teachers or not. Most of the textbooks of medicine do not write any chapter on public health which indicates that the medicine and the public health are on different paths. The teaching faculties of public health or community medicine do not want to be the prominent part of the clinical teaching in the rural and slums of urban areas. While health services systems in the states will always have medical professionals but there is an urgent need for appropriately qualified and experienced professionals with public health degrees to fill gaps in critical areas of preventive and promotive services. So a uniform All India Public Health Service Cadre is the need of hour to improve national health indicators. Enhancing public expenditures on health is likely to have a direct impact on poverty reduction as over 35% of hospitalized persons fall below the poverty line because of hospital expenses.

About 3.9 crores are shifting to below poverty line (BPL) per year because of treatment cost in India (Report by Hindustan Times). All the State governments should consider the practice initiated by Tamil Nadu of creating a separate Directorate of Public Health with a dedicated public health workforce and the practice adopted by states such as Andhra Pradesh, Gujarat, Madhya Pradesh and Odisha of deputing in-service candidates to public health courses to develop public health cadres. Such courses should be made mandatory for all posts with public health responsibilities. Thus, the public health cadre will create an environment that allows the MBBS or others students to make public health of their choice. We can remove the physical shortage of manpower in health institutions at the periphery and can make the referral system and feedback very smooth.

Because of independent public health cadre and their own directorate, the impact is visible on every health program as well as health indicators in Tamil Nadu, which is on the way of continuous success as experienced by experts. Times of India reported that most of the health centres surveyed in Tamil Nadu were found clean, lively and well-staffed. Plenty of medicines were available for free and there were regular inspections. The displayed walls were plastered with charts and posters giving details of

the daily routine, facility available, progress of various programmes and related information. Patients streamed in and out, evidently at ease with the system. New government in the centre under the dynamic and innovative leadership is trying the best to go ahead to place public health at right and result oriented track. Preventive health care strategies can be implemented with much lower cost in comparison to curative and tertiary care strategies. This has been vision of CLEAN INDIA and to give more focus on preventive and promotive health care. Surely and certainly this will improve the country's health indicators and quality of health programmes having the key impact on country's economic growth. The great success of preventive strategies can be seen in the success of making India polio free in the year 2011. "Courage (Physical, Moral, Psychological), Perseverance, Integrity and Intellectual vitality from every citizen of the Country is the key to make the Country's health at the TOP".

Any expectation of a significant improvement in the quality of health services, and the consequential improved health status of the citizenry, would depend not only on increased financial and material inputs, but also on a more empathetic and committed attitude in the service providers, whether in the private or public sectors. In some measure, this optimistic policy document is based on the understanding that the citizenry is increasingly demanding more by way of quality in health services, and the health delivery system, particularly in the public sector, is being pressed to respond. In this backdrop, it needs to be recognized that any policy in the social sector is critically dependent on the service providers treating their responsibility not as a commercial activity, but as a service, albeit a paid one. In the area of public health, an improved standard of governance is a prerequisite for the success of any health policy.

The Alma-Ata international conference defined Primary Health Care as "the essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford." The Government of India was a signatory to Alma-Ata's declaration and committed to providing quality primary health care services to achieve Health for All by the year 2000. Community participation is one of the key principles on which primary health care is established-others being equitable distribution, inter-sectoral coordination, and appropriate technology. In the way of providing primary health care services, the Government of India has made impressive growth in terms of the establishment of primary health care institutions across rural, tribal hard-to-reach sectors. However, shortcomings in the delivery of primary health care services have resulted in lesser utilisation rates and more dependence on private health care service providers. The delivery of health services for the poor people in urban areas and disadvantaged population remains a challenge in India.

Health is directly represented in three of the eight MDGs (Goals 4, 5, and 6), and makes an acknowledged contribution to the achievement of others, in particular, those related to the eradication of extreme poverty and hunger, education, and gender equality. Goal 8 recognizes the need for solidarity by the international community for achieving results.

The NHP, 1983, was a half-hearted attempt to synthesise recommendations of three important earlier committees, the Bhore Committee of 1946 (Government of India, 1946), the Mudaliar Committee of 1962 (Government of India, 1962), and the Shrivastav Committee of 1975 (Government of India, 1975, 1976). The Bhore Committee, 1946, set up before India's independence, concentrated on preventive medicine and tried to link health with social justice. It gave some surprisingly pragmatic directions. The Mudaliar Committee (1962) concentrated on medical education and development of training infrastructure for static medical units. The Shrivastav Committee (1975) urged the training of a cadre of health assistants to serve as links between qualified medical practitioners and multipurpose workers (e.g. school teachers, post masters, gram-sevaks, etc.). While the NHP 1983 reiterated the pious resolution of taking health services to the doorstep of the people and ensuring fuller cooperation of the community, it failed to even declare health care as a fundamental right of the people. The WHO

in its Preamble (1948) states, 'The enjoyment of the highest attainable standard of health is one of the fundamental Rights of every human being without distinction of race, religion, political belief, economic or social condition'. The General Assembly of the UN in its Universal Declaration of Human Rights the same year listed the Right to better living conditions and the Right to Health and Medical Service as vital Articles. But the NHP 1983 of India failed to say so categorically. This, when the Directive Principles of State Policy of the Constitution of India (Part IV) state, 'The State shall regard the raising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties'.

Russia was the first country to give its citizens a constitutional right to all health services. The French Constitution of 1946 'guarantees to all... protection of health'. In 1965-66, the Social Legislation in the United States declared health a human right. The 89th US Congress changed the concept of health maintenance from an individual to a social responsibility by enacting Medicare and Medicaid, and Comprehensive Health Planning from 'the womb to the tomb'. Most nations are continuously planning newer strategies to put the Right to Health and Medical Service into practical use. But both the NHP of India 1983 and 2002, failed to even confer the status of a 'Right' to Health. Both have some worthwhile proposals, no doubt, but the major social thrust and vision to convert their commitment into a Right is still lacking. This is due to poor awareness amongst the planners and bureaucratic circles, lesser demand from a community unaware of its fundamental rights and a medical establishment which seeks to wallow in its short-sighted establishment propagation strategies. While goals of medicine worldwide have changed from curative to preventive, preventive to social, and social to community medicine, India has still to reap the benefits of this philosophy to any significant degree. Community participation in health is an aphorism that still awaits genuine realisation in many countries of the world, notably of the third world. India unfortunately is no exception. This, in spite of the fact that through the framework of the Ninth Five Year Plan (1997-2002), new initiatives were supposed to be taken to achieve the following:

a. Horizontal Integration of vertical programmes;

b. Develop disease surveillance and response mechanism with focus on rapid recognition report and response at district level;

c. Develop and implement integrated non-communicable disease control programme;

d. Health impact assessment as a part of environmental impact assessment in developmental projects.

e. Implement appropriate management systems for emergency, disaster, accident;

f. Screening for common nutritional deficiencies especially in vulnerable groups and initiate appropriate remedial measures;

g. Reduction in the population growth rate was recognised as one of the priority objectives. It will be achieved by meeting all felt-needs for contraceptives and by reducing the infant and maternal morbidity and mortality so that there is reduction in the desired level of fertility

h. Implementation of reproductive and child health programme by effective maternal and child health care, increased access to contraceptive care; safe management of unwanted pregnancies; nutritional services to vulnerable groups; prevention and treatment of RTI/STD; reproductive health services for adolescents; prevention and treatment of gynaecological problems; and screening and treatment of cancers, especially that of uterine cervix and breast.

3. Major points from draft national health policy (DNHP) 2015:

The DNHP states its overall goal as:

The attainment of highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.

4. Major Recommendations:

Primary Care Services and Continuity of Care: to provide "comprehensive set of preventive, promotive, curative and rehabilitative services

Secondary and Tertiary Care Services: a concept of "strategic purchasing," which refers to "the government acting as a single payer—purchasing care from public hospitals and private providers as part of strategic plan for district health systems development."

Infrastructure Development: "From normative approaches in their development to targeted approaches to reach under-serviced areas" wherein "a conscious effort shall be made to identify districts and blocks which have the larger gaps for development of infrastructure and deployment of additional human resources"

Human Resources for Health: A slew of measures have been proposed to enhance the training, retraining, placement, incentives for doctors.

Summary

The Joint WHO – UNICEF international conference in 1978 at Alma-Ata (USSR) in their declaration called on all the governments to formulate national health policies according to their own circumstances to launch and sustain primary health care as a part of national health system. This conference formulated the Alma-Ata Declaration which stated that "Primary health care is essential health care made universally accessible to individuals and acceptable to them, through their full participation and at the cost the community and country can afford."

A National Health Policy was formulated in India in 1983, and since then there have been marked changes in the determinant factors relating to the health sector. Some of the policy initiatives outlined in the NHP-1983 have yielded results, while, in several other areas, the outcome has not been as expected. The NHP-1983 gave a general exposition of the policies which required recommendation in the circumstances then prevailing in the health sector and stressed the need for providing primary health care with special emphasis on prevention, promotion and rehabilitation.

NHP 1983 was modified as the National Health Policy of 2002 where Primary health care was adopted as the main strategy through decentralization; equity; private sector/indigenous system participation and increase in public investment.

A Draft National Health Policy has been prepared in 2015 which states its overall goal as the attainment of highest possible level of good health and well-being, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.

Points to be remember

•Crafting of a National Health Policy is a rare occasion
•Allow our dreams to mingle with ground realities
•Needs are enormous and the resources are limited
•Health needs are also dynamic and keep changing over time
•Had to make hard choices between various priorities
•The ultimate goal is achieving an acceptable standard of good health of people of India
•The commitment of the service providers and an improved standard of governance is a prerequisite for the success of any health policy

Quadrant-III Self-Assessment

Q.1 What were the salient features in health services in India before First National Health policy?

Q. 2 Briefly delineate improvements in National Health policy 2002 from First National Health policy.

Q. 3. First National Health policy was promulgated in 1978 – True/ False [Key: false]

Q. 4. National Health policy 2002 is proposed to be modified in [Key: d]

a. 2020

b. 2018

c. 2016

d. None of the above

Q. 5 National Health policy 2002 has target to reduce prevalence of blindness 0.5% by ---------- [Answer: 2010]

Q. 6. Match the Columns: [Key: A1: B3; A2: B4; A3: B1; A4: B2]

Column A	Column B
1. National Health Policy was first formulated in	1. 2015
2.Second National Health Policy	2. 1962
3. National Health Policy is proposed to be modified in	3. 1983
4. Mudaliar Committee	4. 2002

Quadrant-IV: Learn more/Web Resources/Supporting Materials/Interesting Facts:

Govt. of India. Report of the Health Survey and Planning Committee. New Delhi: Ministry of Health, 1962

NATIONAL HEALTH POLICY – 2002. From: http://mohfw.nic.in/np2002.htm 2/9/2011

Planning Commission of India. High Level Expert Group Report on Universal Health Coverage for India. New Delhi: Govt. of India; 2011.

Planning commission. Twelfth five year plan volume III. New Delhi: Planning Commission GOI; 2012-2017.

Rawat CMS. All India and State Public Health Cadre in India: An Urgent Need of The Hour!!. Ind J Comm Health. 2014; 26(4):322-324.

http://www.who.int/healthsystems/topics/stewardship/en/

National Burden of Disease Studies: A Practical Guide. Edition 2.0. October 2001. World Health Organization. Global Program on Evidence for Health Policy. WHO, Geneva

Whom to Whom? Official Development Assistance for Health. Second Edition 2000-2010. World Health Organization.

World Health Organization: World Health Report, Health systems: improving performance. Geneva: WHO; 2000.

Duggal R. Evolution of Health Policy in India. CEHAT 2001

Krishnan TN: Access to Health and the Burden of Treatment: An international Comparison. In Disinvesting in Health: The World Bank's Prescription for Health. New Delhi: Sage Publications; 1999.