An Assessment of Health Policies in India

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Abstract—*The objective of this research is to assess and improve health standard in India. After Independence, India adopted the welfare state approach, which was dominant worldwide at that time. As with most post-colonial nations, India attempted to restructure its patterns of investment. During that time, India's leaders envisaged a national health system in which the State would play a leading role in determining priorities and financing, and provide services to the population. The Health Ministry is authorized agency for formulating and implementing health policy in India. Improvement in the health status of the population has been one of the major thrust areas in social development programs of India since independence. It tries to give long-term solutions for health policies in India.*

Keyword*: Health Standard, Welfare State, National Health System, Health Policies,*

1. INTRODUCTION

After Independence, India adopted the welfare state approach, which was dominant worldwide at that time. As with most post-colonial nations, India too attempted to restructure its patterns of investment. During that time, India's leaders envisaged a national health system in which the State would play a leading role in determining priorities and financing, and provide services to the population.

The Health Ministry is the authorized agency for formulating and implementing health policy in India. Improvement in the health status of the population has been one of the major thrust areas in social development programs of India since independence. The Indian government has set up a number of committees to assess and improve health standards in India. Some of the major committees and their recommendations are follows:

2. BHORE COMMITTEE 1946

Bhore Committee (1946), known as the Health Survey and Development Committee, was appointed in 1943 with Sir Joseph Bhore as its Chairman. It laid emphasis on integration of curative and preventive medicine at all levels.

3. MUDALIAR COMMITTEE 1962

Mudaliar Committee 1962 known as the "Health Survey and Planning Committee", headed by Dr. A. L. Mudaliar, Vice-chancellor of the then Madars University, was appointed in 1959 to assess the performance in health sector since the submission of Bhore Committee report. The committee recommended that:

(1) The committee found the conditions in PHCs to be unsatisfactory and suggested that the PHC, already established should be strengthened before new ones are opened. Government of India (1961), 'Report of the Health Survey and Planning Committee', (Chairman: Mudaliar), Ministry of Health, New Delhi.

(2) The committee also advised strengthening of sub-divisional and district hospitals. It was emphasized that a PHC should not be made to cater to more than 40,000 populations and that the curative, preventive, and primitive services should be all provided at the PHC.

(3) The Mudaliar Committee also recommended that an All India Health Service should be created to replace the erstwhile Indian Medical service.

The concern of the Health Survey and Planning Committee (Mudaliar Committee 1962) was limited to the development of the health services infrastructure and the health cadre at the primary level. It felt the growth of infrastructure needed radical transformation and further investment.

4. CHADDA COMMITTEE 1963

Chadda Committee (1963)66 was appointed under chairmanship of Dr. M. S. Chadha, the then Director General of Health Services, to advise about the necessary arrangements for the maintenance phase of National Malaria Eradication Programme (NMEP). The committee suggested that the vigilance activity in the NMEP should be carried out by basic health workers (one per 10,000 population), who would function as multipurpose workers and would perform, in addition to malaria work, the duties of family planning and vital statistics data collection under supervision of family planning health assistants. Basic health workers should visit house-to-house once in a month to implement malaria eradication activities. The scope of Chadda committee was restricted to malaria eradication.

5. MUKHERJEE COMMITTEE 1965

The recommendations of the Chadda Committee, when implemented, were found to be impracticable because the basic health workers, with their multiple functions could do justice neither to malaria work nor to family planning work. The Mukherjee Committee (1965)67 headed by the then Secretary of Health Shri Mukherjee, was appointed to review the performance in the area of family planning.

The committee recommended separate staff for the family planning programme. The family planning assistants were to undertake family planning duties only. The basic health workers were to be utilized for purposes other than family planning. The committee also recommended delinking the malaria activities from family planning so that the latter would receive undivided attention of its staff.

6. MUKHERJEE COMMITTEE 1966

Multiple activities of the mass programmes like family planning, small pox, leprosy, trachoma, NMEP (maintenance phase), etc. were making it difficult for the Government of India (1963), states to undertake these effectively because of shortage of funds. A committee of state health secretaries, headed by the Union Health Secretary, Shri Mukherjee, was set up to look into this problem. The committee worked out the details of the Basic Health Service that should be provided at the Block level, and some consequential strengthening required at higher levels of administration.

The Committee did not attempt to work out any details of the organisation that would be needed above the district level, i.e. at the Zonal, the State and the Central level. The Committee felt that the State Governments should work out the better methods for the functioning of the health organizations at the Zonal and State levels.

7. JUNGALWALLA COMMITTEE 1967

Jungalwalla Committee (1967), known as the “Committee on Integration of Health Services” was set up in 1964 under the chairmanship of Dr. N. Jungalwalla, the then Director of National Institute of Health Administration and Education (currently NIHFW). It was asked to look into 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.

(2) Medical care and public health programs should be put under charge of a single administrator at all levels of hierarchy.

8. KARTAR SINGH COMMITTEE 1973

Kartar Singh Committee (1973)69, headed by the Additional Secretary of Health and titled the "Committee on Multipurpose Workers under Health and Family Planning" was constituted to form a framework for integration of health and medical services at peripheral and supervisory levels.

9. SRIVASTAV COMMITTEE 1975

Srivastav Committee (1975)70 were set up in 1974 as "Group on Medical Education and Support Manpower" to determine steps needed to:

(1) Reorient medical education in accordance with national needs and priorities.

(2) Develop a curriculum for health assistants who were to function as a link between medical officers and MPWs.

10. WORKING GROUP ON HEALTH FOR ALL BY 2000 A.D. 1981

‘The Working group on health for all by 2000 AD’ under the Chairmanship of Kripa Narain submitted its report in 1981 and based on its recommendations the following health strategy was worked out for the Sixth Plan Period:

(1) Emphasis would be shifted from development of city based curative services and super specialities to tackle rural health problems.

(2) The infrastructure for rural health would consist of primary health centres serving a population of 30000 each, sub-centres serving a population of 5000 each and a trained health volunteers for every 1000 people.

(3) Facilities for treatment in basic specialities would be provided at community health centres at the block level for a population of 1 lakh with a 30 bedded hospital attached and a system for referral cases from the community health centre to the district hospitals would be introduced.

(4) Various programmes under education, water supply and sanitation, control of communicable diseases, family planning, maternal and child health care, nutrition and school health implemented by different agencies would be properly coordinated for optimal results.

(5) Medical and para-medical manpower would be given adequate training for meeting the requirements of a programme of this order and all education and training programmes would be given suitable orientation towards rural health care and finally, the people would be involved and community participation in the health programme would be encouraged. They would be entitled to supervise and manage their own health programmes.

11. THE NATIONAL HEALTH POLICY, 1983

For the first time in the history of free India a very comprehensive health policy was approved by the Parliament in 1983. The National Health Policy, 1983 has clearly admitted the failures of the government in health sector in the past.

The National Health Policy, 1983 attempted to address all these issues. Its main goal was the provision of universal, comprehensive primary health services. It envisaged the integration of a large number of private and voluntary organizations, who were active across the country in the health field, with the government efforts to provide health services. It also recommended a decentralized system of health care and a nation-wide chain of epidemiological stations.

Because of the new Policy, once again, a selective approach to health care became the focus. Verticality was reintroduced as an ‘interim' arrangement and interventions of immunization, oral rehydration, breastfeeding and anti-malarial drugs were introduced. This was seen as a technical solution even before comprehensive primary health care could be realized. UNICEF too came out with its report on the state of the world's children and suggested immunization as the spearhead in the selective GOBI-FF (Growth Monitoring, Oral Rehydration, Breastfeeding, and Immunization, Food Supplements for Pregnant Women and Children, and Family planning) Approach. Once again, programme-driven health policies became central focus of health endeavours of the government.

The subsequent plans emphasised restructuring and developing the health infrastructure, especially at the primary level. The Seventh Plan (1985-90) restated that the rural health programme and the three-tier health services system need to be strengthened and that the government had to make up for the deficiencies in personnel, equipment and facilities. The Eighth Plan (1992-97) distinctly encouraged private initiatives, private hospitals, clinics, and suitable returns from tax incentives. With the beginning of structural adjustment programmes and cuts in social sectors, excessive importance was given to vertical programmes such as those for the control of AIDS, tuberculosis, polio and malaria funded by multilateral agencies with specified objectives and conditions attached. Both the Ninth (1997-2002) and the Tenth Five-Year Plans (2002-2007) start with a dismal picture of the health services infrastructure and go on to say that it is important to invest more on building good primary-level care and referral services.

12. THE NATIONAL HEALTH POLICY, 2002

The National Health Policy, 2002 gives prime importance to ensure a more equitable access to health services across the social and geographical expanse of the country. It calls for a strong primary health network in rural India. Emphasis has been given to increase the aggregate public health investment through a substantially increased contribution by the Central Government. Priority has been given to preventive and curative initiatives at the primary health level through increased sectoral share of allocation.

13. CRITICAL ASSESSMENT OF HEALTH POLICIES

Both the Health Policies of 1983 and 2002 highlight the importance of the role of decentralization but do not state how this will be achieved. The National Health Policy (2002) includes all that is wanted from a progressive document and yet it glosses over the objective of NHP 1983 to protect and provide primary health care to all. The Policy document talks of integration of vertical programmes, strengthening of the infrastructure, providing universal health services, decentralization of the health care delivery system through panchayati raj institutions (PRIs) and other autonomous institutions, and regulation of private health care but fails to indicate how it achieves the goals. It encourages the private sector in the first referral and tertiary health services.

The overview of the plans and policy reports not only throws light on the gap between the rhetoric and reality but also the framework within which these policies and programmes have been formulated. There has been an excessive preoccupation with single-purpose driven programmes. Above all, the spirit of primary health care has been reduced to just primary level care. The health reports and plans mostly concentrated on building the health services infrastructure and even this lacked a sense of integration. Most of the policy reports miss out on the importance of a strong referral system. Instead, there has been more emphasis on building the primary level care and even that has lacked proper implementation. The Bhore committee report and later, the Primary Health Care Declaration discussed the operational aspects of integrating the other sectors of development related to health. The multi-sectoral approach that is much needed and the inter-sectoral linkages that are essential for a vibrant health system have not been well thought out, and there has been no plan drawn out for it later. The outline of plan documents and their implementation have been incremental rather than being holistic. It is important to question whether it is only the low investment in health that is the main reason for the present status of the health system or is it also to do with the framework, design and approach within which the policies have been planned.

The Government initiatives in the public health sector have recorded some noteworthy successes over time. Smallpox and Guinea Worm Disease have been eradicated from the country; Polio is on the verge of being eradicated; Leprosy, Kala Azar, and Filariasis can be expected to be eliminated in the foreseeable future. There has been a substantial drop in the Total Fertility Rate and Infant Mortality Rate. The success of the initiatives taken in the public health field is reflected in the progressive improvement of many demographic/ epidemiological /infrastructural indicators over time.

The National Health Policy (NHP) 1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged, had hoped to provide 'Health for All by the year 2000 AD', through the universal provision of comprehensive primary health care services. In retrospect, it is observed that the financial resources and public health administrative capacity which it was possible to marshal, was far short of that necessary to achieve such an ambitious and holistic goal. Against this backdrop, it was felt that it would be appropriate to pitch the National Health Policy (NHP), 2002. It was expected that the recommendations of NHP-2002 would attempt to maximize the broad-based availability of health services to the citizens of the country.

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13.1 India towards "Right to Health"

John Bryant in his book "Health and the Developing World" published in 1969 remarked that – "Large numbers of the world's people, perhaps more than half, have no access to health care at all, and for many of the rest the care they receive does not answer the problems they have."

The Joint WHO – UNICEF international conference in 1978 at Alma-Ata (USSR) declared that "the existing gross inequalities in the status of health of people particularly between developed and developing countries as well as within the countries is politically, socially and economically unacceptable."

The Alma-Ata conference called for acceptance of the WHO goal of HEALTH FOR ALL by 2000 AD and 'Primary Health Care' as a way to achieve "Health for All".

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.

The Alma-Ata conference defined 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."

13.1.1 Projection of Resource Requirements

Considering the increase in population during Census 2011, the following health care resources are immediately required to meet the increasing demand of health care services. Presently there are over 1.58 million doctors (of which allopathic are 780,000, including over 250,000 specialists), 1.4 million nurses, over 1.5 million hospital beds, 600,000 health workers and about 25,000 PHCs with government and municipal health care spending at about Rs.700 billion (excluding water supply). The increased population immediately requires, from public as well as private sector, the following resources during the financial year 2012-2013 to meet the goal of 'Health for All' by 2020.

14. CONCLUSION

Over the past few decades a number of committees and commissions have been appointed by the Government to examine the issues and challenges affecting the health sector. The earliest committees included the Health Survey and Development Committee (Bhore Committee) and Sokhey Committee. Other main committees in the post-independence period included Mudaliar Committee, Chadha Committee, Mukherjee Committee, Jungalwalla Committee, Kartar Singh Committee, Mehta Committee and Bajaj Committee. Some of the recent committees include the Mashelkar Committee and the National Commission on Macroeconomics and Health.

The approach of most of these committees was fragmented and each one tried to address the issue of health in India from micro perspective. These committees individually addressed the issues such as organization, integration and development of health care services and delivery system, health policy and planning, national programmes, public health, human resources, indigenous system of medicines, drugs and pharmaceutical amongst the others. The Health Policy 1983 proclaimed 'Health for All' by 2000 AD, but it failed to achieve its objective and therefore, the government announced another comprehensive policy – the National Health Policy, 2002. Even this policy did not make much contribution towards health status in India even after a decade of its implementation. The effect of all these is the increasing burden of patients on existing health care infrastructure, mushroom growth of quacks especially on country side and slums in urban areas and large number of private clinics and nursing homes, most of which are beyond the ken of a common man.

The Government of India has announced free medical facilities for population below poverty line. The scheme encompasses public hospitals and selected private hospitals free treatment of major diseases without any charges up to certain limit. However, the government failed to realize the fact that there is excessive pressure on the present health infrastructure in urban as well as in rural areas. In government hospitals, the number of in-patients is so large that many patients have to be accommodated on beds placed on floor in the ward. There is always dearth of basic medicines and equipment. Many government hospitals are understaffed. Again not all private hospitals have been included in the list of hospitals providing free hospitalization. Among those who have been included in the list, many are pack with patients.

Private hospitals function according to certain norms and therefore cannot admit more patients then its installed capacity. Under such circumstances, the dream of providing free hospitalization merely remains a distant dream.

Thus, the piecemeal and half-hearted efforts of the government to provide medical facilities to the patients are not going to provide its citizens their 'Right to Health'. The government needs to give a positive thought to the issue and take concrete measure to resolve problem from the base, i.e. development of infrastructure and necessary facilities and their proper maintenance and replacement. For this, the approach of the government needs a radical change. It has a pathetic record of devoting a mere 1.2 per cent of GDP as public expenditure. To scale up care, that must be raised to at least 2.5 per cent by the end of the 12th Plan, and 3 per cent in the subsequent five years. This can bring about a dramatic reduction in out-of-pocket spending from 67 per cent of total health expenditures today to 47 per cent by 2017 and 33 per cent by 2022.

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