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History of Health Policies in India: An Evaluation

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ABSTRACT: Healthcare delivery is a continuous and dynamic process. The growth of healthcare delivery system and its structure in India is basically a result of the various committe4es, schemes and policies formulated from time to time.. Some of the major committees and schemes on health are discussed in this article. An attempt is made to historically trace the evolution of health policy making in India in the context of the development of the health sector. The current scenario is reviewed and future directions for policy initiatives are suggested.
Key words: Health Policy, epidemic, eradication, morbidity, mortality

I. INTRODUCTION

Modern medicine and healthcare were introduced in India during the colonial period. This was also a period that saw the gradual destruction of the pre-capitalist modes of production. Institutionalized healthcare delivery system was nonexistent during that time. Practitioners who were not formally trained but who were the inheritors of a caste-based occupational system provided traditional healthcare from their homes.

A brief historical overview of health conditions in the pre independent India is necessary to understand the development of healthcare services after independence as there is a noticeable continuity in the pattern of development of healthcare services and policies from the colonial period into free India.

Fevers, typhoid, cholera, dysentery, smallpox, diarrhea rheumatism were endemic. Epidemics were perennial. Mortality rate was very high. Sanitary conditions were pathetic. Filth, stagnant water, damp and foul ditches, lack of drainage, poor ventilation and polluted drinking water were keeping the morbidity levels high. Whatever medical concern and attention was there had a racial and urban bias, with urban areas inhabited by Europeans receiving the major chunk of medical services.. If the measures taken in these areas were also woefully inadequate, one can imagine the plight of the rest of the country.

It was under these conditions that in the midst of world war-II, in 1943, a 'Health Survey and Development Committee' under the chairmanship of Sir Joseph Bhore was formed by the British Government.

II. BHORE COMMITTE (1946)

The Bhore Committee submitted its report in 1946, marking a watershed in the making of health policy and health planning in India. It is, in fact, the most comprehensive health policy and plan document ever prepared in India. It drew a detailed plan of a National Health Service for the country, which would provide a universal coverage to the entire population free of charges through a comprehensive state run health service in minute detail.

The Committee made the observation that if the Nation's health is to be built, the health program should be developed on the foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of patients.

The Bhore Committee not only identified the problems that existed in Indian health system but also recognized vast rural-urban disparities in the health service distribution for the first time and hence designed its plan keeping in mind the rural areas. It provided a wide framework to develop a National Health Service.

i. Guiding Principles of the Committee

- ❖ No individual should be denied to secure adequate medical care because of the inability to pay.
- ❖ Facilities for proper diagnosis and treatment should be provided
- ❖ Health program must lay special emphasis on preventive work
- ❖ Medical relief and preventive healthcare should be provided to the vast rural population.
- ❖ Health services should be located close to the people to ensure maximum benefit to the community.
- ❖ Doctor should be a social physician protecting the people.

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❖ Medical services should be free to all, without distinction

ii Major observations of the Committee
The Committee stated that health and development are interdependent. It found that the health status of the country as indicated by various indicators was poor.
➢ Mortality rates were very high.
➢ Life expectancy at birth was about 27 years
➢ Incidence of communicable diseases was very high
➢ Many of the health problems were preventable
➢ Improvement in other sectors impacting on health will also lead to improvement in health like water supply, sanitation improvement, nutrition, elimination of unemployment

iii Recommendations of the Committee
❖ Integrated preventive and curative services at all administrative levels.
❖ Minimum ratio of 567 hospital beds, 62 doctors, 151 nurses per 1,00,000 Population was to be maintained
❖ The committee visualized the development of PHCs in 2 stages: 1) A sho0rt term measure, 2) A long term program

1. Short term measure
A PHCs for every 40000 population
➢ PHCs to be manned by 2 doctors, 4 Primary Health Nurse (PHN) , 2 Midwives,1 Nurse, 4 trained dais, 2 sanitary inspectors, 2 health assistants, 1 pharmacist and 15 other class IV employees.

2. Long term program
It consists of health care system in 3 tiers
➢ A primary health unit for every 10-20 thousand population with 75 beds.
➢ Secondary unit with 650 bedded hospital.
➢ District unit with 2500 bedded hospital.
The Bhore Committee initiated the concept of integrated development and comprehensive health care. The Idea of primary healthcare in a three tier pattern was also introduced The recommendations of Bhore Committee and the availability of preventive and curative medical technology laid the foundation for the evolution of hospital-based public health system in India (David .A, 2012; Anjurtupi L. K, 2013).

III. SOKHEY COMMITTEE (1948)

The National Planning Committee was formed by the then Congress president Subhas Chandra Bose nine years before independence, in 1938, with a mission to set social and economic goals to facilitate planned development through National plans. Several subcommittees were set up to explore various aspects of the National economy. One of the subcommittees thus appointed was on National Health under the chairmanship of S.S. Sokhey. Its report was published in 1948 two years after the Bhore Committee submitted its report.
The following are some of its major resolutions:
❖ India should adopt a form of health organization, in which both curative and preventive functions are suitably integrated and administered through one agency.
❖ The preservation and maintenance of the health of the people would be the responsibility of the State.

IV. HEALTH SURVEY AND PLANNING COMMITTEE (1961)

The Health Survey and Planning Committee was set up by Government of India with Dr. A Lakshmanswamy Mudaliar as chairman in 1959 to evaluate the progress made in the first two five-year plans and to make recommendations for improvement of health services.

Its report highlighted some of the achievements in health indicators such as reduction in death rates, increase in the longevity, control of communicable and epidemic diseases. It admitted that basic health facilities in India had not reached even half of the population of our nation. It found that rural areas especially had very little or low access to primary healthcare centers and the condition of the secondary and district hospitals was the same as that of PHCs. Further, it identified a vast rural and urban disparity in health infrastructure facilities and also in health resources.

Hence, the Committee made the following recommendations:
❖ Existing PHCs should be strengthened before establishing new ones. Priority should be given to PHC consolidation before attempting expansion).
❖ PHCs should provide preventive, promotive and curative services.
❖ Strengthen sub-divisional and district hospitals.
❖ Improve the service conditions of doctors and other medical personnel in order to attract them to rural areas.
❖ Creation of All India Health Services.

However, The GOI without paying serious attention to the recommendations of the committee increased the number of the PHCs rather than consolidating the existing ones.

V. CHADHA COMMITTEE (1963)

Late 50's and early 60's, were the years when the central and state governments were grappling with malaria eradication. There was an attempt to integrate the Malaria Eradication Program (NMEP) with general health services in the country consisting of Sub-Centers, PHCs, and district level organizations. In order to implement the program effectively, the central government appointed a Committee To study the arrangements necessary for the maintenance phase of the NMEP headed by Dr. M.S. Chadha.

It suggested the integration of health and family planning services and its delivery through one male and female multipurpose worker per 10,000 population. Further, it recommended that the services of the extension educator should be utilized for all the national health programs.

VI. MUKHERJEE COMMITTEE (1965)

In order to review the 'Staffing Pattern and Financial Provision under Family Planning (FP)' a committee headed by Shri. Mukherjee was formed twice, in 1965 and again in 1966. By then there was a growing realization that the Family Planning Camp which was thought to give a permanent and lasting solution to population control was not yielding the desired results. Therefore, the committee suggested that the newly invented Intra Uterine Contraceptive Device (IUCD) be used as a temporary method of birth control.

The committee further recommended:

- Introduction of target fixation, payment for motivation and incentives to acceptors.
- Reorganization of the FP program into a vertical program like Malaria.
- Addition of one more health visitor per PHC who would specifically supervise the ANMs for the targets of FP program.
- Need to improve the quality of care provided by the Primary Health Center.
- Retaining of private practitioners for a fee of Rs. 100 per-month for 6 hours.

VII. JAIN COMMITTEE (1966)

Jain committee was set-up in 1966 to review the working of different hospitals and central health services. It made an attempt to devolve and decentralize medical care with an aim to strengthen district hospital facilities. It suggested the integration of medical and health services at the district level with both responsibilities to be vested in the Civil Surgeon/ Chief Medical officer. But unfortunately the recommendations of this committee that the curative services of hospitals at the rural level be strengthened, was not taken seriously (Duggal, 2002).

VIII. JUNGALWALLA COMMITTEE (1967)

Jungalwalla Committee was set up in 1964 to:

❖ Study the problems of the health services
❖ Integrate the health services
❖ Improve the Service conditions and
❖ Eliminate Private practice by doctors working government hospitals

It submitted its report in 1967 making the following major recommendations:

❖ Integration from highest to lower level in health services.
❖ Integration of preventive and curative services.
❖ Integration of medical services and public health by rotation of personnel.
❖ Integration of health services with 3 main components: 1. Methods of delivery 2. Their organization and 3. The personnel providing these services and their administration

Kartar Singh Committee (1973)

The tremendous variations in the categories of manpower requirements posed problems in terms of providing integrated services under various national health programs. Hence a committee was appointed in 1972 under the chairmanship of Kartar Singh to look into "Multipurpose Workers under Health and Family Welfare Program".

It made the following recommendations:

❖ Conversion of uni-purpose workers, including ANMs, into multi-purpose male and female workers.
❖ The population served by each pair of male and female multi-purpose workers should be 10,000 to 12,000.

Shrivastava Committee (1975)

To devise a suitable curriculum for training a cadre of health assistants and suggest steps to reorient the the medical education to suit the national needs anmd priorities, a committee to be called as 'Group on Medical Education and Support Manpower' was set up under Shrivastava in 1974. The committee proposed to rectify the dearth of trained manpower in rural areas.

Major recommendations of this committee are:

❖ Creating a cadre of village based health auxiliaries called the Community Health Workers.

❖ Organization of an economic and efficient program of health services to the first level referral Centre, viz., the PHCs.

❖ The creation of a National Referral Services Complex by the development of proper linkages between the PHCS and higher level referral and service centers.

❖ Establishment of 'The Medical and Health Education Commission' for planning and implementing the reforms needed in health and medical education on the lines of University Grants Commission (UGC).

The acceptance of the recommendations of the Shrivastav Committee in 1977 led to the launching of the Rural Health Service.

Krishnan Committee (1982)

Krishnan committee, set up in 1982, was a landmark in improving urban health services. It worked out an implementation program for provision of primary healthcare in urban areas. The salient recommendations of the committee included

❖ The establishment of a health-post run by a doctor, a Public Health Nurse, 4 Auxiliary Nurse Midwives, 4 Multipurpose workers and 25 Community Health workers for a population of 50,000.

❖ The health-post staff should reach out to the community and involve the community in the implementation of the primary health care program (Pardeshi. G and Kakrani. V, 2006).

Mehta Committee (1983)

Dr. Shantilal J.Mehta led 'The Medical Education Review Committee'. Hence it came to be known as Mehta Committee. Part I of the report deals with medical education in all its aspects and Part II of the report specifically deals with the lack of availability of health manpower data in India.

It made the following recommendations:

❖ Training and development of auxiliary personnel and paraprofessional personnel.

❖ Basic and induction training in public health management.

❖ Establishment of Universities of Medical Sciences and Medical and health Education Commission.

National Health Policies

Apart from the above committees, National Health Policies have provided directions to the development of health structure and functions in India. National Health Policy is an initiative by the Central Government to strengthen the health system in India. This initiative shapes various dimensions of health sector like disease prevention, promotion well-being via cross-sectoral actions, health investments, promoting human resources, making use of technological advancements in healthcare and more.

National Health Policy, 1983

The Joint WHO - UNICEF international conference in 1978 at Alma-Ata (USSR) issued a declaration which became a major milestone of the twentieth century in the field of public health. It identified primary healthcare as the key to the attainment of the goal of "Health for All" around the globe. It called on the governments of all countries to formulate National Health Policies according to their own circumstances and to launch and sustain primary healthcare as a part of national health system

It was only after the Alma-Ata declaration that the first NHP was formulated in India in 1983. It had as its goal access to primary healthcare for everyone in India by the year 2000 thirty-six years after independence. It continued till 2002.

The policy emphasized on preventive, promotive public health and rehabilitation dimensions of healthcare. The policy emphasized the need for establishing comprehensive primary healthcare services to reach the population in even the remote areas of the country. It aimed to initiate phased, time-bound program for setting up a well-dispersed **network of comprehensive primary healthcare 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. It envisaged the concept of **Health volunteers** having appropriate knowledge, simple skills and requisite technologies; It encouraged the 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 decentralized level. It tried to develop an integrated net-work of evenly spread **specialty and super-specialty services;** encouragement of such facilities through private investments for patients who can pay, so that the burden on public facilities is limited to those entitled for free use. It suggested the development of an effective Health Information System.

NHP 1983 resulted in some noteworthy successes over time to some extent such as the eradication of Smallpox. Total Fertility Rate and Infant Mortality Rate dropped substantially. Yet, in

spite of its better results, there was an increase in 'life-style' diseases like diabetes, cancer and cardiovascular diseases. The country witnesses a higher incidence of macro and micro malnutrition, especially among women and children during the time the policy was in force.

Bajaj Committee (1987)

In 1986 The Ministry of Health and Family Welfare (MoHFW), GOI appointed a committee on Health Manpower Planning, Production and Management with Prof. J. S Bajaj as its chairman.

The recommendations of the committee were:

❖ To formulate a national policy on education in Health services.

❖ Prepare curriculum for school teachers.

❖ Utilize the services of Indian System of Medicine.

❖ Continuing education program for the health personnel.

Expert Committee on Public Health System (1995)

The Ministry of Health and Family Planning, GOI constituted an expert committee on public Health System in 1995 headed by Prof. J. S. Bajaj who was a member of the Planning Commission at that time. The committee was set up to

- review the public health system in India, and particularly to focus on the quality of surveillance of epidemics and control strategies;
- the effectiveness of health schemes, institutional arrangements and
- the role of state and local authorities in improving the public health system;
- the status of primary health centers and sub-centers in rural areas (especially their ability to respond to outbreaks of disease, and
- The capability of the existing Health Management Information System to provide intelligence for surveillance, prevention and remedial action.

The report made recommendations and suggested an 'Action Plan for Strengthening of Public Health System'. It found that India was facing a resurgence of most communicable diseases and needed to drastically improve diseases surveillance in the country.

National Commission on Macroeconomics and Health (2005)

National Commission on Macroeconomics and Health was set up in 2005 under the chairmanship of P. Chidambaram. It addressed many critical issues confronting the health sector such as inequitable access to basic services for the poor, the inefficiencies in the system resulting in waste and suboptimal utilization of existing resources, the poor quality and declining values, ethical norms.

Some of its important Recommendations are as follows:

❖ Public spending should increase from 1.2% to 3 % of Gross Domestic Product (GDP).Undertake community-based research to arrive at more credible estimates of disease burden.

❖ Strengthen the mechanism for enforcement of laws related to quality assurance, disease surveillance and public health measures, and quality of education, and drug and food safety. Constitute an independent regulation to assess and monitor quality aspects of AYUSH practice.

❖ Medical Council Act and Nursing Council Act should be amended to allow for civil society representation in the council and make them work effectively.

❖ Constitution of Expert Group to work out the modalities of how to mobilize the additional resources generated through taxation to health sector and within what time period.

❖ In order to meet the growing demand for physicians; the number of medical colleges and nursing schools has to be increased.

❖ Task force consisting of knowledgeable and eminent people and representing all stakeholder groups be constituted to detail out the issues, the operational plans and financial implications.

Thus, a number of committees were set-up from time to time in pre-independence and post-independence period by the Government of India. Each committee starting from Bhore Committee to National Commission on Macroeconomics and Health looked into the issues of the healthcare administration and has given recommendations regarding various health problems and issues in India. The recommendations made by the above committees contributed in developing the public health system in our country as we find today. Unfortunately many of the recommendations made by these committees could not be implemented largely due to non-availability of resources and also to a certain extent due to varying perceptions by the implementing agencies and stakeholders.

National Health Policy, 2002

A revised National health policy for accomplishing better healthcare and unmet goals was brought out in 2002 by government of India. It attempted to optimize the broad-based availability of health services to the citizen of the country based on realistic considerations of capacities. It set up a new

framework for the accelerated achievement of the public health goals in socio-economic constraints prevailing in the country. It endeavored to achieve an acceptable standard of good health of Indian Population. It pursued decentralization of public health system by upgrading infrastructure in existing institutions. It aimed to ensure a more equitable access to health services across the social and geographical differences and inequalities in India. The policy welcomed the participation of the private sector in all areas of health activities primary, secondary and tertiary health care services; but recommended regulatory mechanisms and accreditation of private sector for the conduct of clinical practice.

The policy gave primacy for prevention and first line curative initiative. It gave prominence to rational use of drugs. It prioritized increased access to Traditional systems of Medicine. Further, it suggested enhancement of financial resources available for health by increasing the health sector expenditure from the existing 0.9% to 2% of GDP. Further it attempted to raise the existing 15% of central government grants to 25% of total health spending by 2010.

The Policy recognized the catalytic role of empowered women in improving the overall health standard of the country and recommended to meet the specific requirements of women in a more comprehensive manner.

The policy observed that child labor and substandard working conditions are causing occupational related ailments and suggested periodic health screening for high risk associated occupations.

It suggested a social health insurance scheme for health service to the needy. It urged standard protocols in day-to-day practice by health professionals. It recommended tele-medicine in tertiary care services.

NHP 2002 envisaged the strengthening of Food and Drug administration in terms of laboratory facilities and technical expertise.

It recommended the establishment of Statutory Professional Council for monitoring and regulating paramedical training institutions that had come up in the country.

As there was an uneven realization of health indices across rural and urban areas, in order to overcome the social inequalities NHP 2002 set an increased allocation of 55percent total public health investment for the primary health sector and 35 percent for secondary sector and 10 percent for tertiary Sector.

Though NHP 2002 was a continuation of NHP 1983, it shifted the focus to primary healthcare by adopting it as the main strategy through decentralization, bringing in the access to healthcare, encouraging private sector participation and bringing in indigenous and traditional health systems, it tried to raise the public expenditure on health.

NHP 2002- A critique

The National health policy is an eloquent document. Hence it is rather difficult to critique it. It is silent on the concept of comprehensive and universal healthcare in contrast, the NHP 1983 had said: 'India is committed to attaining the goal of "Health for All by the Year AD 2000", through the universal provision of comprehensive primary health care services.' The policy thus departs from the fundamental concept of the NHP 1983 and the Alma Ata Declaration. It is also conspicuously silent on the village health worker. the first contact in the primary healthcare system. By its silence, the NHP 2002 provides a framework for the dismantling of the entire concept of primary healthcare. Importantly, the section on policy prescriptions in the NHP 2002 is silent on the content of the primary healthcare system.

The policy refrains from speaking about the population control program, which the health movement has long held to constitute a major drain on primary healthcare.

Other important concerns are either ignored or referred to only in passing. The policy has a four-line section on women's health, without spelling out any specific proposals. It is silent on child nutrition despite the fact that half the children below 5 years of age are malnourished in India.

The NHP 2002 does not recognize the need to create a system of medical education oriented to the needs of primary care, and instead is biased towards urban specialist-based healthcare.

Further, there is no mention of the necessity to initiate and sustain research on public health but speaks about 'frontier areas' of medical research.

The policy, in tune with the trend of Liberalization, Privatization and Globalization, its prescriptions relate to encouragement of the private sector and legitimization of privatization of the healthcare delivery system.

The Policy document recommends a welcome increase in public health expenditure from the present 0.9% of GDP to 2% in 2010. However, the quantum suggested is too little and falls far short of the 5% of GDP that has been recommended by the World Health Organization long ago.

The NHP 2002 is eloquent on community participation, but its prescriptions are 'top-down'.While it is justifiably critical about the public

health system, there is no criticism of the ills of the unregulated private medical care system, though reference is made to the need to develop regulatory norms.

SUMMARY

India's healthcare system is fragmented, characterized by both public and private providers and offering multiple systems of medical care. The policy initiatives related to eradicating regional and economic inequalities in health have certainly improved the various health indicators related to achieving the millennium Development Goals. However, it must be realized that health is not the concern of health sector alone. It is impossible to effectively plan for healthcare without considering the circular relation between health and the other socio-economic factors. The contours of the national health policy have to be evolved within a fully integrated planning framework and effectively implemented, providing universal comprehensive primary healthcare services relevant to the actual needs and priorities of the community.

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