

# HEALTH PLANNING In INDIA

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# Introduction

- Health and health care development has not been a priority of the Indian state.
  - low level of investment and allocation of resources to the health sector
  - unregulated private health sector

- The Central government has shaped health policy and planning in India.
  - through the Council of Health and Family Welfare and various Committee recommendations
- At the state government level there is no evidence of any policy initiatives in the health sector.

# BHORE COMMITTEE, 1946

- The most comprehensive health policy and plan document ever prepared in India was the '**Health Survey and Development Committee Report**' popularly referred to as the Bhole Committee.
- This committee was appointed in 1943 with Sir Joseph Bhole as its Chairman.
- It made comprehensive recommendations for remodelling of health services in India.

# Objectives:

1. The services should make adequate provision for the medical care of the individual in the **curative** and **preventive** fields and for the active **promotion** of positive health;
2. These services should be placed as **close to the people** as possible, in order to ensure their maximum use by the community, which they are meant to serve;
3. The health organization should provide for the widest possible basis of **cooperation** between the health personnel and the people;
4. Provisions should be made for enabling the representatives of **medical and auxiliary professions** to influence the health policy of the country.

5. **“Group” practice**, should be made available
  - In view of the complexity of modern medical practice, from the standpoint of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute;
6. **Special provision** will be required **for certain sections** of the population, e.g. mothers, children, elderly etc.,
7. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it and
8. The creation and maintenance of as **healthy** an **environment** as possible in the homes of the people as well as at work.

# Recommendations

1. Integration of preventive and curative services of all administrative levels.
2. Major changes in medical education which includes three months training in preventive and social medicine to prepare “social physicians”.

### 3. Development of Primary Health Centres in 2 stages :

#### a) Short-term measure – One primary health centre

- for a 40,000 population.
- 2 doctors, 1 nurse, 4 PHN, four midwives, four trained dais, two SI, two HA, one pharmacist and 15 class IV employees.
- Secondary health centre provide support, coordinate and supervise PHC.

#### b) A long-term programme (also called the **3 million plan**) of setting up

- primary health units with 75 bedded hospitals for each 10,000 to 20,000 population and
- secondary units with 650 bedded hospital, again regionalised around district hospitals with 2500 beds.



- In the fifties and sixties the entire focus of the health sector in India was to manage epidemics.
- Mass campaigns were started to eradicate the various diseases.
  - These separate countrywide campaigns with a technocentric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera.
  - Cadres of workers were trained in each of the vertical programmes.

- The policy of going in for mass campaigns was in continuation of the policy of colonialists who subscribed to the percepts of modern medicine that health could be looked after if the germs which were causing it were removed.
- But the **basic cause** of the various diseases is social, i.e. inadequate nutrition, clothing, and housing, and the lack of a proper environment. These were **ignored**.

- National programs were launched to eradicate the diseases.
  - The NMEP was started in 1953 with aid from the Technical Cooperation Mission of the U.S.A. and technical advice of the W.H.O. Malaria at that period was considered an international threat.
  - The tuberculosis programme involved vaccination with BCG, T.B. clinics, and domiciliary services and after care. The emphasis however was on prevention through BCG. These programmes depended on international agencies like UNICEF, WHO and the Rockefeller Foundation for supplies of necessary chemicals and vaccines.
- The policy with regard to communicable diseases was dictated by the imperialist powers as in the other sectors of the economy.

- During the **first two Five Year Plans** the **basic structural framework** of the public health care delivery system remained unchanged.
- Urban areas continued to get over three-fourth of the medical care resources whereas rural areas received "special attention" under the Community Development Program (CDP). History stands in evidence to **what this special attention meant.**
- The CDP was failing even before the Second Five Year Plan began.

# MUDALIAR COMMITTEE, 1962

- This committee known as the “**Health Survey and Planning Committee**”, headed by Dr. A.L. Mudaliar, was set up in 1959:
  1. To assess the performance in health sector since the submission of Bhore Committee report.
  2. To evaluate the progress made in the first 2 plans and
  3. To make recommendation for the future path of development of health services.

- The report of the committee recorded that the disease control programmes had some substantial achievements in controlling certain virulent epidemic diseases.
- This committee found the conditions in PHCs to be unsatisfactory.
  - Most of the PHC's were understaffed, large numbers of them were being run by ANM's or public health nurses in charge.

# Recommendations

1. Consolidation of advances made in the first two five years plans.
2. Strengthening of the district hospitals with specialists services to serve as central base of regional services.
3. Regional organizations in each state between the headquarters organization and the district in charge of a Regional Deputy or Assistant Directors – each to supervise 2 or 3 district medical or health officers.
4. Each PHC not to serve more than 40000 population.
5. To improve the quality of health care provided by PHC.
6. Integration of medical and health services.
7. Constitution of an All India Health service on the pattern of Indian Administrative Services.

- The **third Five Year Plan launched in 1961 discussed the problems** affecting the provision of PHCs, and directed attention to the shortage of health personnel, delays in the construction of PHCs, buildings and staff quarters and inadequate training facilities for the different categories of staff required in the rural areas.
- Ignoring the Mudaliar Committee's recommendation of consolidation of PHC's this plan period witnessed a rapid increase in their numbers but their condition was the same as the Committee had found at the end of the second plan period.



- In case of the disease programme due to their vertical nature there was a huge army of workers.
  - The delivery of services continued to be done by special uni-purpose health workers. Therefore in the same geographical area there was overlapping and duplication of work.

# CHADAH COMMITTEE, 1963

- This committee was appointed under chairmanship of Dr. M.S. Chadah, to advise about the necessary arrangements for the maintenance phase of National Malaria Eradication Programme.
- Recommended the integration of health and family planning services.

- The committee suggested that the vigilance activity in the NMEP should be carried out by basic health workers who would **function as multipurpose workers:**
  - one per 10,000 population,
  - would perform, in addition to malaria work, the duties of family planning and vital statistics data collection
  - under supervision of family planning health assistants.

# MUKHERJEE COMMITTEE, 1965

- The recommendations of the Chadah Committee, when implemented, were found to be impracticable
  - the basic health workers, with their multiple functions could do justice neither to malaria work nor to family planning work.
- The Mukherjee committee headed by the then Secretary of Health Shri Mukherjee, was appointed to Review the Staffing Pattern and Financial Provision under Family Planning.

# Recommendations

- 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 utilised for purposes other than family planning.
- Delink the malaria activities from family planning so that the latter would received undivided attention of its staff.

# MUKHERJEE COMMITTEE, 1966

- Due to shortage of funds, it was difficult for the states to undertake multiple activities of the mass programmes effectively
  - E.g family planning, small pox, leprosy, trachoma, NMEP (maintenance phase), etc. were making.
- 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 at the Block level, and
  - Some consequential strengthening required at higher levels of administration.

# JUNGALWALLA COMMITTEE, 1967

- This committee, 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 NIHFWS).
- 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 :-
  - a) A service with a **unified approach for all problems** instead of a segmented approach for different problems.
  - b) Medical care and public health programmes should be put under charge of a **single administrator** at all levels of hierarchy.

- Following steps were recommended for the integration at all levels of health organisation in the country
  1. Unified Cadre
  2. Common Seniority
  3. Recognition of extra qualifications
  4. Equal pay for equal work
  5. Special pay for special work
  6. Abolition of private practice by government doctors
  7. Improvement in their service conditions



- The **4th Plan which began in 1969 continued** on the same line as the 3rd plan.
- It lamented on the poor progress made in the PHC programme and recognized again the need to strengthen it.
- It pleaded for the establishment of effective machinery for speedy construction of buildings and improvement of the performance of PHCs by providing them with staff, equipment and other facilities.

# KARTAR SINGH COMMITTEE, 1973

- This committee, 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.

# Recommendations

- a) Various categories of peripheral workers should be amalgamated into a single cadre of multipurpose workers (male and female).
  - i. ANM → MPW(F)  
Basic health workers → MPW(M)  
LHV → Female health supervisor.
  - ii. The work of 3-4 MPWs was to be supervised by one health supervisor.
- b) One PHC should cover a population of 50,000.  
It should be divided into 16 sub centres, each to be staffed by a male and a female health worker.

# SHRIVASTAV COMMITTEE 1975

- This committee was set up in 1974 as "**Group on Medical Education and Support Manpower**" to determine steps needed to:
  - (i) reorient medical education in accordance with national needs & priorities;
  - (ii) develop a curriculum for health assistants who were to function as a link between medical officers and MPWs.

# Recommendations

1. Creation of **bands of paraprofessional and semi professional** health workers from within the community itself e.g. school teachers, postmasters etc.
  2. Establishment of two cadres of health workers between the community level workers and doctors at PHC namely – **multipurpose health workers and health assistants.**
  3. Development of a “**Referral Services Complex**” by establishing proper linkage between PHC and higher referral services.
  4. Establishment of a **Medical and Health Education Commission** for planning and implementing the reforms needed in health and medical education on the lines of University Grants Commission.
- Acceptance of the recommendations of the Shrivastava Committee in 1977 led to the launching of the Rural Health Scheme.

- In the **5th Plan**, the government ruefully acknowledged that the number of medical institutions, functionaries, beds, health facilities etc, were **still inadequate in the rural areas** despite advances in terms of infant mortality rate going down, life expectancy going up,
- The urban health structure had expanded at the cost of the rural sectors.
- Major innovations took place with regard to the health policy and method of delivery of health care services.
- Increasing the accessibility of health services to rural areas through the **Minimum Needs Programme (MNP)** and **correcting the regional** imbalances.

- The 6<sup>th</sup> Plan was to a great extent influenced by the Alma Ata declaration of Health For All by 2000 AD (WHO, 1978) and the ICSSR - ICMR report (1980).
- The plan conceded that "there is a **serious dissatisfaction** with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed of mostly by the well to do classes.
- It is also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services“
- The National Health Policy of 1983 was announced during the Sixth plan period.

- The **7th Five Year Plan recommended** that "development of specialties and super-specialties need to be pursued with proper attention to regional distribution" and such "development of specialised and training in super specialties would be encouraged in the public and the private sectors".
- This plan also talks of improvement and further support for urban health services, biotechnology and medical electronics and non-communicable diseases.
- Enhanced support for population control activities also continues.
- The special attention that AIDS, cancer, and coronary heart diseases are receiving and the current boom of the diagnostic industry and corporate hospitals is a clear indication of where the health sector priorities lie.



- On the eve of the **Eighth Five Year Plan** the country went through a massive economic crisis.
- The Plan got pushed forward by two years. But despite this no new thinking went into this plan.
- Infact, keeping with the selective health care approach the eighth plan adopted a new slogan – instead of Health for All by 2000 AD it chose to emphasize Health for the Underprivileged.
- Simultaneously it continued the support to privatization.

- During the Eighth Plan resources were provided to set up the Education Commission for Health Sciences, and a few states have even set up the University for Health Sciences as per the recommendations of the **Bajaj committee report**.

# BAJAJ COMMITTEE, 1986

- An "**Expert Committee for Health Manpower Planning, Production and Management**" was constituted in 1985 under Dr. J.S. Bajaj, the then professor at AIIMS.
- Major recommendations are :-
  1. Formulation of National Medical & Health Education Policy.
  2. Formulation of National Health Manpower Policy.
  3. Establishment of an Educational Commission for Health Sciences (ECHS) on the lines of UGC.
  4. Establishment of Health Science Universities in various states and union territories.
  5. Establishment of health manpower cells at centre and in the states.
  6. Vocationalisation of education at 10+2 levels as regards health related fields with appropriate incentives, so that good quality paramedical personnel may be available in adequate numbers.
  7. Carrying out a realistic health manpower survey.

- During the 8th Plan period a committee to review public health was set up. It was called the **Expert Committee on Public Health Systems**.
- This committee made a thorough appraisal of public health programs and found that we were facing a resurgence of most communicable diseases and there was need to drastically improve disease surveillance in the country.

- The **9th Five Year Plan** by contrast provides a good review of **all programs** and has made an effort to strategise on achievements hitherto and learn from them in order to move forward.
- There are a number of innovative ideas in the ninth plan.
- Reference is once again being made to the Bhore Committee report.
- Another unique suggestion is evolving state specific strategies because states have different scenarios and are at different levels of development and have different health care needs.
- The Ninth Plan proposes to set up at district level a strong detection come response system for rapid containment of any outbreaks that may occur.

- On the eve of the 10th Plan, the **draft National Health Policy 2001** has been announced.

# **NATIONAL HEALTH POLICY IN INDIA**

- It was not until 1983 that India adopted a formal or official National Health Policy.
- Prior to that health activities of the state were formulated through the Five year Plans and recommendations of various Committees.

# National Health Policy 2002

## Objectives:

- Achieving an acceptable standard of good health of Indian Population,
- Decentralizing public health system by upgrading infrastructure in existing institutions,
- Ensuring a more equitable access to health service across the social and geographical expanse of India.



# NHP 2002, Objectives.....

- 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.
- Emphasizing rational use of drugs.
- Increasing access to tried systems of Traditional Medicine

# Goals – NHP 2002

Eradication of Polio & Yaws	2005
Elimination of Leprosy	2005
Elimination of Kala-azar	2010
Elimination of lymphatic Filariasis	2015
Achieve of Zero level growth of HIV/AIDS	2007
Reduction of mortality by 50% on account of Tuberculosis, Malaria, Other vector and water borne Diseases	2010
Reduce prevalence of blindness to 0.5%	2010
Reduction of IMR to 30/1000 & MMR to 100/lakh	2010
Increase utilization of public health facilities from current level of < 20% to > 75%	2010

Establishment of an integrated system of surveillance, National Health Accounts and Health Statistics	2005
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

## **BHORE COMMITTEE**

### **FIVE YEAR PLAN**

**FIRST (1951-1956)**

**SECOND (1956-1961)**

**MUDALIAR COMMITTEE**

**THIRD (1961-1966)**

**CHADAH CO MUKHERJ JUNGALWALLA COMMITTEE**

**FOURTH (1969-1974)**

**KARTAR SINGH COMMIT SHRIVASTAV COMMITTEE**

**FIFTH (1974-1979)**

**SIXTH (1980-1985)**

**NATIONAL HEALTH POLICY 1983**

**SEVENTH (1985-1990)**

**EIGHTH (1992-1997)**

**BAJAJ COMMITTEE**

**NINTH (1997-2002)**

**TENTH (2002-2007)**

**NATIONAL HEALTH POLICY 2002**

**ELEVENTH (2007-2012)**

**TWELFTH (2012-2017)**

**THANKS**