Overview of Health Policies and Programmes

Ritimoni Bordoloi

KKHSOU

Introduction

- The first comprehensive health policy and plan document prepared in India was “Health Survey and Development Committee Report” under the chairmanship of J Bhore in 1946.
- Terms of reference of this committee were-one, broad survey of the present position in regard to health conditions and health organisation in British India and two, recommendation for future development.
- Bhore committee had long and short term plans for health service delivery structure and emphasized –equal access to health care irrespective of the ability to pay, rural areas to be the focus of the service, provision of comprehensive preventive and curative services and cooperation of the people by the health service system.
- Expected 15 percent of the total government expenditure on health.

- Alma-Ata declaration 1978-primary health care approach adopted internationally.
- It focused on comprehensive services which are accessible, affordable and acceptable to the people along with inter-sectoral collaboration for improving health status of the people.
- In the pre-colonial period in terms of health-has three characteristics-first it was considered a social responsibility and thus state and philanthropic intervention was highly significant, - second, services were provided free to all who availed them or accesses. Caste, class and occupation had limited the access; third-most of these facilities were located in the town projecting a clear urban bias.

- During colonial period hospitals and dispensaries were mostly state owned or state financed. However, private health sector existed in large measures as individual practitioners
- In 1881 census recorded 108751 male medical practitioners- of these 12620 were classified as physicians and surgeons (qualified doctor of modern medicine and 60678 as unqualified practitioners (ISM)
- During the colonial time the private health sector was fairly large and well established –in 1938 about 40,000 private doctors reported to be active.
- During 1941-42, 47254 RMP (Registered Medical Practioner) (17654 graduates and 29870 licentiates) were in India and of these about 13000 were in government agencies and rest in private sector.
- After the economic liberalisation in 1991, social security has evolved under the concept of a welfare state where health care is one of the prominent elements and thus health becomes as basic right of the citizen.

- In India till 1983 there was no formal health policy statement – policy and committees as part and parcel of the planning process providing most of the inputs for the formulation of the health programmes.
- The NHP 1983 was adopted during the sixth plan period.
- It was curative-oriented western model of health care
- Emphasised a preventive, promotive and rehabilitative primary health care approach
- Recommended a decentralised system of health care, the key features were low cost, de-professionalisation (use of volunteers and paramedics) and community participation.
- Called for an expansion of the private curative sector which would relive the burden of the government.

Fall out of NHP 1983:

- The rural health care system was not able to provide even the epidemiological base what the NHP 1983 recommended
- Expansion of the private health sector was phenomenal-riding high on state subsidies in the form of medical education, soft loan to set up medical practice
- NHP 1983 did not reflect ground realities adequately and present paradigm raised inequity-so need of making primary health care a reality and accessible to all.

- Eight 5 year plan adopted a new slogan –instead of health for all by 2000. Emphasised was given on health for the underprivileged.
- 9th Plan –reference was made to the Bhore Committee report and to contextualise present scenario in the recommendations that the Bhore Committee had made. This plan also showed concern for urban health care, especially the absence of primary health care and complete reliance on secondary and tertiary health care even for minor ailments.
- Since 8th and 9th plan child survival and safe motherhood acquired seriousness and presently transformed into RCH Programme.

- On the eve of the 10th plan-the draft of NHP 2002 was announced- includes all that indicative of a progressive health policy-talks of integration of vertical programmes, strengthening of infrastructure, filling the gap of availability of doctors by introducing short term training for basic services, decentralization of health care delivery by PRIs, setting up national disease surveillance system, regulation of private practice etc.

- NHP 2002 did not mention the NHP 1983 goal of universal, comprehensive and primary health care services, but acknowledge that public health care system is grossly inadequate of defined requirements.

- The main aim and objective of NHP 2002 is to achieve an acceptable standard of good health among the general population of the country.

- NRHM which is a comprehensive health care approach, launched in 2005, covering all the schemes for promoting health (please visit the website for detail information)
- There are some other challenges like Formation of Human Capital, Inclusive Growth where human beings are projected as productive in terms of economic development. Thus, maintaining good health is the prerequisite for human development.
- Again, India is set to reach the Millennium Development Goals (MDG) with respect to maternal and child survival. The MDG target for Maternal Mortality Ratio (MMR) is 140 per 100,000 live births by 2015.

- The latest National Health Policy 2015 addresses the urgent need to improve the performance of health systems, this National Health Policy is a declaration of the determination of the Government to leverage economic growth to achieve health outcomes and an explicit acknowledgement that better health contributes immensely to improved productivity as well as to equity. (Millennium development goals and commitment of all the nations for maintaining the better health)
- The goal of the policy is -The attainment of the 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.

- The draft national health policy proposes the following formulation- “the Center shall enact, after due discussion and on the request of three or more States (using the same legal clause as used for the Clinical Establishments Bill) a National Health Rights Act, which will ensure health as a fundamental right, whose denial will be justiciable. States would voluntarily opt to adopt this by a resolution of their Legislative Assembly. States which have achieved a per capita public health expenditure rate of over Rs 3800 per capita (at current prices) should be in a position to deliver on this- and though many States are some distance away- there are states which are approaching or have even reached this target.” Such a policy formulation/resolution we feel would be the right signal to give a push for more public health expenditure as well as for the recognition of health as a basic human right, and its realization as goal that the nation must set itself.

Institutional set up of Public Health

- Sub-centres
- Primary Health Centre (PHC) (30 bedded hospital)
- Community Health Centre (30 bedded hospital)
- Sub district/ Sub divisional Hospital (31-100 bedded)
- District Hospital (100-500 bedded)

In the public sector, a sub-centre is the most peripheral and first point of contact between the primary health care system and the community. For improving the living standard, in the field of rural health, the objective was to establish: one sub-centre for a population of 5000 people in the plains and 3000 people in the tribal and hilly areas, one PHC for 30000 population in plains and 20000 population in the hilly and tribal area and one CHC/Rural Hospital for a population of one lakh.

(Please go through the guidelines provided by Indian Public Health Standard in 2012)

Disparities in health outcomes: Indicator , India

	Total	Rural	Urban	% differential
• TFR (2012)	2.4	2.6	1.8	44% difference
• IMR (2012)	40	44	27	63% difference

Disparities in Health

Indicator	States with Good Performance	States with greater challenges
TFR (2012)	HP (1.7), Punjab (1.7), Tamil Nadu (1.7) and West Bengal (1.7)	Bihar (3.5), UP(3.3), Rajasthan (2.9), MP(2.9)
IMR (2010)	Kerala(12), Tamil Nadu(21), Delhi(24), Maharashtra(24)	Madhya Pradesh (54), Assam (54), Orissa (51), Rajasthan (47)
MMR(2010-12)	Kerala (66), Maharashtra (87), Tamil Nadu (90), Andhra Pradesh (110)	Assam (328), Uttar Pradesh /Uttarakhand (292), Rajasthan (255), Odisha (235)

- In case of the MMR, Assam has the highest number followed by Uttar Pradesh. In Assam, the MMR fell from 328 per 100,000 live births in 2010-12. It is not possible for a woman to deliver at home to get the comprehensive health care for the mother and the child. This is one of the primary reasons for such high maternal mortality in the state. In Assam, 22.4 percent was recorded as institutional delivery whereas 77.5 percent was recorded as home delivery in 2005-06 (India Human Development Report 2011). These can be seen as serious concerns for the state.

Investment in Health Care

- The Government spending on healthcare in India is only 1.04% of GDP which is about 4 % of total Government expenditure, less than 30% of total health spending.
- The National Health Policy 2002 articulated in the 10th, 11th and 12th Five Year Plans, and the NRHM framework was the decision to increase public health expenditure to 2 to 3 % of the GDP. Public health expenditure rose briskly in the first years of the NRHM, but at the peak of its performance it started stagnating at about 1.04 % of the GDP.

- The National Health Policy 2015 accepts and endorses the understanding that a full achievement of the goals and principles as defined would require an increased public health expenditure to 4 to 5% of the GDP.

- It would be ambitious if India could aspire to a public health expenditure of 4% of the GDP, but most expert groups have estimated 2.5 % as being more realistic. At such levels of expenditure, “purchasing,” would have to be mainly from public providers for efficient use of resources with purchasing from private providers only for supplementation.
- In this regard, we can cite an example of the improvement of health in Sri Lanka where One third of the Sri Lankan population live on less than two dollars a day, but the country’s MMR is among the lowest in the world. Now 96 percent deliveries are attended by skilled birth attendants, and 90 percent births take place under proper health care. This has been possible because public health services are provided free of cost. Now in Sri Lanka, almost every household lives less than 1.5 km away from the nearest health centre.

Thank You