Health Policy is our concern too!

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Health policies are dynamic. They are moulded by several forces operating at the local, regional, national and international levels. They are influenced by social, economic and political factors. Policies in the non-health sector, such as agriculture, irrigation, industry etc also affect health. Whether recognized or not, health and related policies greatly affect health work. They affect nurses, multipurpose workers, doctors and all allied health professionals working in rural and urban, health centres and hospitals. More importantly, they affect patients and the population in general. This could be for better or for worse! Therefore health policies concern all of us!

‘A policy can be defined as a broad statement of goals, objectives and means that creates the framework for activity. Policies often take the form of explicit written documents, but they may also be implicit or unwritten’ (4). National Health Policies are guiding principles for efforts by the health sector of the State or Government.

Health Policies in Post Independent India

Independent India evolved health policies and plans with inputs by expert committees, the Planning Commission, the Central Council of Health and Family Welfare and the Ministries of Health and Family Welfare at the centre and states. A brief review of the major policies follows.

The Bhore Committee Report (1946) which initiated this phase, gives detailed findings and conclusions of a two year process. This was the working of the Health Survey and importance of preventive health work’ if the nation’s health is to be built’. It set forth a bold vision of a country-wide system of primary health centres, secondary hospitals and district hospitals. However, almost fifty years later, we have yet to achieve fully the recommendations of this group.

Since this landmark report, other expert committees too submitted reports. They deal with different aspects of the development of health services in India. The main reports are highlighted in Box – 1.

Mudaliar Committee, 1962 - Health Survey and Planning Committee.
Chadha Committee, 1963 - Maintenance phase of National Malaria Eradication Programme; Basic Health Workers.
Mukherji Committee, 1965 - Review of strategy of Family Planning Programme
Mukherji Committee, 1966 - Details of Basic Health Services
Jungalwalla Committee, 1967 - Integration of health Services
Kartar Singh committee, 1973 - Multipurpose Workers under Health and Family Planning
Srivastav Committee, 1975 - On Medical Education and Support Manpower
Several national health programmes were developed to address special problems like different communicable diseases, nutritional problems, mental health etc. The concept of Primary Health Centre with sub-centres covering a defined population as part of the Community Development Programme was accepted. The first Primary Health Centre started in 1952. Taluk and District level hospitals were developed. So also specialist and medical college hospitals.

Subsequently, 1977 saw the launching of the Rural health Scheme. This included the:

- Training of community health workers;
- Reorientation of medical education to meet the needs of the majority, underserved rural population; and
- The reorientation of multi-purpose workers.

The common thread throughout has been the expressed need to make health a reality for the entire population of the country. This was to fulfill Article 23 of the Constitution of India, which “aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising of the level of nutrition, the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of the workers, men and women, especially ensuring that children are given opportunities and facilities to develop in a healthy manner”. This Constitutional statement could be taken as the overall goal of national health effort.

**Alma Ata (1978) Health For All**

In 1978, India was a signatory, along with all other nation states, to the now famous Alma Ata declaration of the World Health organization. The stated goal has since been Health for All by 2000 A.D., with Primary Health Care as its main strategy. Equity in health status of people, globally or within countries, was accepted as being vitally important. Primary Health Care (PHC) was defined by the Alma Ata Conference as “essential health care made universally accessible to individuals and acceptable to them, through their full participation, at a cost the community and country can afford”. Key underlying principles of PHC are:

- Equitable distribution of health services/equitable access to health services;
- Community participation;
- Inter-sectoral coordination; and
- Use of appropriate technology.

A working group of the Indian Council for Medical Research and the Indian Council for Social Science Research, in 1981, brought out an important document, “Health for all An Alternative Strategy”. This stressed the need for a people based health care system. It also recognized that poverty is a major cause of ill health in India. The urgent need for social justice in health and health care was reinforced. This document was used in formulating the Sixth Five Year Plan.
National Health Policy (1982)

The National Health Policy was brought out government in 1982 and passed by Parliament in 1983. It reviewed progress made thus far, analysed the prevailing health situation and identified key areas for the health effort in the future. It emphasized –

- Again the preventive, promotive, public health and rehabilitative aspects of health work and the need for country-wide comprehensive primary health care services;
- The need for a decentralized system of health care; and
- Maximum community and individual self – reliance and participation.

A time framework for the achievement of specific goals was laid down (see Box – 2).

BOX 2 NATIONAL HEALTH POLICY GOALS FOR HEALTH AND FAMILY WELFARE

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Indicator</th>
<th>1990</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.</td>
<td>Infant Mortality Rate</td>
<td>87</td>
<td>60</td>
</tr>
<tr>
<td>02.</td>
<td>Perinatal Mortality Rate</td>
<td>--</td>
<td>30-35</td>
</tr>
<tr>
<td>03.</td>
<td>Crude Death Rate</td>
<td>10.4</td>
<td>9</td>
</tr>
<tr>
<td>04.</td>
<td>1-5 year Mortality Rate</td>
<td>15.2</td>
<td>10</td>
</tr>
<tr>
<td>05.</td>
<td>Maternal Mortality Rate</td>
<td>2.5</td>
<td>&lt; 2</td>
</tr>
<tr>
<td>06.</td>
<td>Low Birth Weight Babies (% &lt; 2,500 gms)</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>07.</td>
<td>Life Expectancy: Female</td>
<td>57.1</td>
<td>64.0</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>57.6</td>
<td>64.0</td>
</tr>
<tr>
<td>08.</td>
<td>Crude Birth Rate</td>
<td>27.0</td>
<td>21.0</td>
</tr>
<tr>
<td>09.</td>
<td>Annual Growth Rate</td>
<td>1.66</td>
<td>1.20</td>
</tr>
<tr>
<td>10.</td>
<td>Family Size</td>
<td>3.88</td>
<td>2.3</td>
</tr>
<tr>
<td>11.</td>
<td>% mothers receiving AN care</td>
<td>60-75</td>
<td>100</td>
</tr>
<tr>
<td>12.</td>
<td>% deliveries by trained attendants</td>
<td>80</td>
<td>100</td>
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</table>


The Sixth Five Year Plan and the 20 point programme gave shape to ways by which the national health Policy and its goals could be achieved.

The Eighth Plan (1992-97)

Coming to the present and the future, it is useful to look at the Eight Five Year Plan covering the period the period 1992-97. It states that ‘the most significant goals for the plan” are: improvement in the level of living, health and education of people, full employment; elimination of poverty and a planned growth in population. This includes the building up and strengthening of peoples participatory institutions; the provision of safe drinking water and primary health facilities to all. Health in its assessment forms part of the total development effort.

Health and population control are listed as two of the six priority objectives of this Plan. Special note should be made that in the Eighth Plan Document “Health for the Underprivileged” is to
be “promoted consciously and consistently”, through community based health systems. This is seen as the key strategy for Health for All.

The Plan document states that “The structural framework for the delivery of health programmes must undergo a meaningful reorientation in a way that the underprivileged themselves become the subjects of the process and not merely its objects. This can only be done through emphasizing community based systems. Such systems must provide the base and basis of health planning ….. The ethos and culture of the communities must provide the scaffolding for such community based systems”.

A major role is envisaged for practitioners of Indian systems of medicine. There is an intention to move more strongly from curative medical care towards building positive health. Preventive and promotive methods and practices would get greater emphasis. This includes meditation, yoga and other traditional practices.

Need for further analysis

This quick review covers the major governmental statements regarding health policy in India. The documents referred to are the explicit policies. However a deeper analysis of several factors is necessary to assess how effectively the policies are followed up and implemented. We could look for instance at:

- The total budget allocation, its trend over time and its rural-urban distribution;
- The availability and quality of government health services, geographical and social accessibility and the utilization of services;
- The quality and relevance of training in health sciences, the distribution of health personnel; and
- The recognition and support given to indigenous systems of medicine;

Ground Realities

Studies reveal continued disparities and inequalities. The total health budget allocation has been decreasing over the decades in terms of percentage of total budget (from 5.9% in first Plan to 3.7% in Seventh Plan). There is a major urban-rural difference in budget allocation. This is reflected in the services. In Kerala (KSSP Study, 1991) 75% of hospital beds and 66.6% of doctors were urban based. Only 5% of the budget is allocated the Indian Systems of Medicine and Homeopathy though a large proportion (approx. 50%) of trained medical personnel are in this sector. The utilization of government health services is relatively poor e.g., 5.6% in rural Maharashtra (Malshiras Study, FRCH, 1993) and 15-20% in rural Karnataka (1992-93). Inadequate coverage of the urban poor by basic mother and Child Health care has been recently reported from Delhi. Performance of national health programmes are also below par as shown by evaluations, e.g., of the Family Welfare Programme (stagnant birth rates) and the national TB Control programme (ICORCI, 1987). These are just some illustrative examples. There continues to be a disproportion to doctors. There are inadequate numbers of dentists, pharmacists, physiotherapists and other allied health professionals. The urban rural disparity also persists here. Questions of relevance of training to community needs and community health problems are
being raised e.g., CHC medical education study. The mushrooming of the ‘private sector’ in the training of health professionals is also taking place with insufficient social and professional accountability.

There realities could be said to reflect implicit, unstated policies that also govern the actual functioning of health services. They are not a negation of the several real achievements in this field made by the country so far. The studies are however an important pointer to the need to understand ground realities and their underlying forces more deeply. While the present system could and should be improved, much could be learnt from alternative approaches, that have been tried at various levels by voluntary health organizations. A constructive and critical spirit can support the further evolution of health policies and services, so that health for the underprivileged becomes a reality.

Could policies be more data based in the future?

Data from the decadal census, the National Sample Survey, the Sample Registration Scheme and from various research organizations provide us with indicators of the health status of the population. While there is an overall improvement occurring, disparities, between states and even districts are very evident. This is indicated in Box 3.

**BOX 3 HEALTH INDICATORS IN DIFFERENT STATES**

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>25.60</td>
<td>8.70</td>
<td>70</td>
<td>62.23</td>
<td>3.70</td>
</tr>
<tr>
<td>Bihar</td>
<td>32.90</td>
<td>10.60</td>
<td>75</td>
<td>57.00</td>
<td>4.40</td>
</tr>
<tr>
<td>Gujarat</td>
<td>29.50</td>
<td>8.90</td>
<td>72</td>
<td>61.49</td>
<td>3.90</td>
</tr>
<tr>
<td>Harayana</td>
<td>31.80</td>
<td>8.50</td>
<td>69</td>
<td>61.97</td>
<td>4.60</td>
</tr>
<tr>
<td>Karnataka</td>
<td>27.80</td>
<td>8.10</td>
<td>71</td>
<td>63.31</td>
<td>3.60</td>
</tr>
<tr>
<td>Kerala</td>
<td>19.00</td>
<td>5.90</td>
<td>17</td>
<td>73.80</td>
<td>2.40</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>36.90</td>
<td>12.50</td>
<td>111</td>
<td>54.71</td>
<td>4.60</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>27.50</td>
<td>7.30</td>
<td>58</td>
<td>64.30</td>
<td>3.50</td>
</tr>
<tr>
<td>Orissa</td>
<td>29.90</td>
<td>11.60</td>
<td>123</td>
<td>55.15</td>
<td>3.80</td>
</tr>
<tr>
<td>Punjab</td>
<td>27.60</td>
<td>7.80</td>
<td>55</td>
<td>65.30</td>
<td>3.50</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>33.10</td>
<td>9.40</td>
<td>83</td>
<td>58.69</td>
<td>5.50</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>22.40</td>
<td>8.70</td>
<td>67</td>
<td>60.80</td>
<td>2.80</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>35.70</td>
<td>12.00</td>
<td>98</td>
<td>49.64</td>
<td>5.60</td>
</tr>
<tr>
<td>West Bengal</td>
<td>27.30</td>
<td>8.10</td>
<td>63</td>
<td>59.53</td>
<td>3.70</td>
</tr>
<tr>
<td>INDIA</td>
<td><strong>29.90</strong></td>
<td><strong>9.60</strong></td>
<td><strong>80</strong></td>
<td><strong>59.10</strong></td>
<td><strong>4.30</strong></td>
</tr>
</tbody>
</table>

**SOURCE:** Eighth Five Year Plan (1992-97), Vol. 1
Differences by social class are also increasingly being studied. This data has to be used more effectively and translated through policies and plans into strategies for action. Information, in an understandable form, also needs to be made more available to the public. To respond meaningfully to diverse health problems and needs, and equally importantly, as a crucial democratic step towards putting people health into people’s hand, the planning process needs to be decentralised.

Decentralization = a possible future scenario

The current debate on the recent Panchayat Raj bill raises important issues. The need for decision making power and for greater social and financial control at the village/mandal level over development, health and education is being expressed. How will this intermesh with the more centralized, bureaucratic system that has developed in the health sector? How can the interests of the less powerful and less articulate sections of society be safeguarded and promoted? How will conflicts of interest between professional groups, powerful groups and the emerging peoples consciousness through the process of decentralization be resolved? And what are the actual steps that need to be taken? There are no ready-to-use packages or easy solutions to these questions.

Micro-level experiments and projects by voluntary groups, using participatory methods, have been effective in evolving policies and strategies that not only provide low-cost health care responsive to peoples’ needs, but also improve health status.

Larger level planning at the State, district and national level, are also necessary. Here, a possibility is to use an optimum mix. This would include time tested methods, an epidemiological approach; provision of vision and broad directions; allowing much flexibility; promoting and strengthening local initiative and capacities in the management of health problems and issues. Progressive equitable improvement in health and quality of life, and accountability and social justice in health care would be indicators of effective policies.

Can we contribute?

At the level of individuals and groups of hospitals, health centres and health/development projects, there are policies that determine the direction of work. Staff members could collectively review the policies at regular intervals. Are priority disease problems/health issues being addressed? What is or criteria for deciding what is considered ‘priority’? Can the national health policy be discussed? Are there specific regional/local problems that need to be addressed? Do we interact adequately with the governmental health system? Can people be involved more in the process of decision making? The process goes on.

Of course the most crucial part of a policy, is its implementation. Could we be sentinals regarding the implementation of national health policies which are essentially our health policies? Could we create greater awareness among people about the various policies and programs. Could we create also help the health system to be more functional? Health Policy then is certainly our concern too!
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