REVIEW OF GOVERNMENT POLICIES AND PROGRAMMES FOR DEVELOPMENT OF HEALTH SERVICES IN INDIA

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ABSTRACT

Good health plays a substantial role in economic growth. Studies on the role that health plays in Economic growth from more than a century of history in currently developed countries confirm this as well. Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals possess, which has intrinsic value (being healthy is a very important source of well-being) as well as instrumental value. In instrumental terms, health impacts economic growth in a number of ways. For example, it reduces production losses due to worker illness, it increases the productivity of adult as a result of better nutrition, and it lowers absenteeism rates and improves learning among school children. Health also allows for the use of natural resources that used to be totally or partially inaccessible due to illnesses. India is currently spending only 1.2 per cent of its GDP on publicly funded health care. This is considerably less than most other comparable countries. Total Indian health spending is conventionally estimated at a little over 4 per cent of GDP. The public health care system has been strengthened since the start of the 21stcentury by initiatives such as the National Rural Health Mission (NRHM). But it is still suffering from significant limitations in areas such as the (free) provision of essential medicines to the 400-600 million poorest Indians. Keeping in the view the importance of health services in economic development, this paper will focus on the current status of health system in India and review the government policies and programmes especially in the Twelfth Five Year Plan.

KEY WORDS: Economic Growth, Health Services, Government Policies and India

I. INTRODUCTION

'Health' a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, is a precondition to the realization of human potential and for attainment of happiness. Thus, health is both a social and an economic good. It is fundamental to one of the main inputs (Human capital) for economic development. Along with financial, intellectual, social, and political capital, development schemes rely on skilled, healthy individuals as workers and as consumers. Poor health and illness generate an economic burden to individuals, companies, and regions. An unhealthy population generates costs in preventable health care expenditures, higher premiums from insurance companies and healthcare costs to business, and greater public expenditures on Medicaid and Medicare. These expenditures come at the expense of other investments. The public sector forgoes critical investments in education, transportation, housing and other infrastructure, social services etc. Businesses experience opportunity costs and may have to sacrifice expansion and capital investment. Businesses want to locate in regions with healthier populations because their costs are lower and productivity is higher. Furthermore, unemployment and low-income are among the leading determinants of poor health.Unemployment is consistently linked with higher rates of illness, injury, and premature mortality. Thus, health is both a social and an economic good. The Directive Principles of State Policy in the Constitution of India mandate **'improvement of public health'** as one of the primary duties of the State. The Central and State Governments have been taking proactive steps to promote health of the people by creating a network of public health care facilities, which provide free medical services, and also proactively control the spread of diseases.

This paper is divided into four sections. Section II will focus on the evaluation of health policies during five year plans in India, section III will highlights the objectives and government policies in twelfth five year plan. The section IV will conclude the study with policy implications.

II. EVALUATION OF HEALTH POLICIES DURING PLANNING IN INDIA

India's current health policy originated in the national building activities that occurred during independence in 1947 and in the philosophy behind the government of India's 1946

report on the 'Health Survey and Development Committee' referred to as the Bhore Committee Report.

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(Banerji, 1985).

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. DDT spraying operations was one of the most important activities of the programme. 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 policywith regard to communicable diseases was dictated by the imperialistpowers as in the other sectors of the economy. Along with financial aidcame political and ideological influence. Experts of various internationalagencies decided the entire policy framework, programme design, andfinancial commitments etc.

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). The CDP was failing even before the Second Five Year Plan began. The governments own evaluation reports confessed this failure.

To evaluate the progress made in the first two plans and to make recommendation for the future path of development of health services the **Mudaliar Committee** was set up in 1959. The report of the committee recorded that the disease control programmes had some substantial achievements in controlling certain virulent epidemic diseases. The

Mudaliar Committee further admitted that basic health facilities had not reached atleast half the nation (Batliwala, 1978).

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 (FYP III, 657). The Third Five Year Plan highlighted inadequacy of health care institutions, doctors and other personnel in rural areas as being the major shortcomings at the end of the second Five Year Plan (Ibid, 652). The allocation patterns continued to belie the stated objectives and goals of the overall policy in the plans. The urbanhealth structure continued to grow and its sophisticated services and specialties continued to multiply. The 3rd plan gave a serious consideration for suggesting a realistic solution to the problem of insufficient doctors for rural areas "that a new short term course for the training of medical assistants should be instituted and after these assistants had worked for 5 years at a PHC they could complete their education to become full fledged doctors and continue in public service" (FYP III, 662). The Medical council and the doctors lobby opposed this and hence it was not taken up seriously.

The **Fourth Five Year Plan** which began in 1969 with a 3 year plan holiday continued on the same line as the third 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 (ibid, 390). For the first time PHCs were given a separate allocation. It was reiterated that the PHC's base would be strengthened along with, sub divisional and district hospitals, which would be referral centers for the PHCs. The importance of PHCs was stressed to consolidate the maintenance phase of the communicable diseases programme. FP continued to get even a greater emphasis with 42% of health sector (Health + FP) plan allocation going to it (FYP IV, 1969, 66). It was also during this period that water supply and sanitation was separated and allocations were made separately under the sector of Housing and Regional development(ibid, 398-414).

It was in the **FifthFive Year Plan** that the government ruefully acknowledged that despite advances in terms of infant mortality rate going down, life expectancy going up, the number of medical institutions, functionaries, beds, health facilities etc, were still inadequate in the rural areas. This shows that the government acknowledged that the urban health structure had expanded at the cost of the rural sectors (FYP V, 1974, 234).Major innovations took place with regard to the health policy and method of delivery of health care services. The reformulation of health programmes was to consolidate past gains in various fields of health such as communicable diseases, medical education and provision of infrastructure in rural areas. This was envisaged through the MNP which would "receive the highest priority and will be the first charge on the development outlays under the health sector (Ibid, 234). It was an integrated packaged approach to the rural areas. The plan further envisaged that the delivery of health care services would be through a new category of health personnel to be specially trained as multi-purpose health assistants. However, the infrastructure target still remained one PHC per CDP Block.Another major innovation in the health strategy was launched in 1977 by creating a cadre of village based health auxiliaries called the **CommunityHealth Workers**. Family Planning, which started with an insignificant outlay in the 1st plan, was now taking the single largest share in the health sector outlay.

The **Sixth Five Year Plan** was to a great extent influenced by the Alma Ata declaration of **Health for All by 2000 AD** (WHO, 1988) 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". (Draft FYP VI, Vol. III, 1978, 250) The plan emphasized the development of a community based health system. The plan emphasized that horizontal and vertical linkages had to beestablished among all the interrelated programmes, like water supply, environmental sanitation, hygiene, nutrition, education, family planning and MCH. The **National Health Policy (NHP)** in light of the Directive Principles of the constitution of India recommends "Universal, comprehensive primary health care services which are relevant to the actual needs and priorities

of the community at a cost which people can afford" (MoHFW, 1983, 3-4). Providing universal health care as a goal is a welcome step because this is the first time after the Bhore Committee that the government is talking of universal comprehensive health care. But the 1983 NHP did not reflect the ground realities adequately. The tasks enunciated in the policy were not sufficient to meet the demands of the masses, especially those residing in rural areas. "Universal, comprehensive, primary health care services", the 1983 NHP goal, is far from being achieved.

The **Seventh Five Year Plan** accepted the NHP advice that "Development of specialties and super-specialties need to be pursued with proper attention to regional distribution" (FYP VII, 1985, II, 273) and such "development of specialised and training in super specialties would be encouraged in the public and the private sectors" (Ibid, II, 277). This plan also talks of improvement and further support for urban health services, biotechnology and medical electronics and non-communicable diseases (Ibid, II. 273-276). Enhanced support for population control activities also continues (Ibid, II. 279-287).

During 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. 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 (FYP VIII, 322). Simultaneously it continued the support to privatization, “In accordance with the new policy of the government to encourage private initiatives, private hospitals and clinics will be supported subject to maintenance of minimum standards and suitable returns for the tax incentives.” (ibid, 324).

The **NinthFive Year Plan**provides a good review of all programs and has made an effort to strategies on achievements hitherto and learn from them in order to move forward. There are a number of innovative ideas in the ninth plan. It is refreshing to see that reference isonce again being made to the Bhore Committee report and to contextualise today’s scenario in the recommendations the Bhore Committee had made. (FYP IX, 446) In its analysis of healthinfrastructure and human resources the Ninth Plan said that consolidation of PHCs and SCs and assuring that the requirements for its proper functioning were made available is an important goal under the Basic Minimum Services

program. Thus, given that it was difficult to find physicians to work in PHCs and CHCs the Plan suggests creating parttime positions which could be offered to local qualified private practitioners and/or offer the PHC and CHC premises for after office hours practice against a rent. Also it suggested putting in place mechanisms to strengthen referral services. (ibid, 454).The Ninth Plan also reviewed population policy and the family planning program. In this review too it went back to the Bhore Committee report and said that the core of this program was maternal and child health services. In the midst of all this the **National Population Policy** was announced with a lot of fanfare in the middle of 2000.

As with the earlier plans, **Tenth Five Year Plan** thrust was to improve the quality of life of the people within the overall development philosophy of Gross National Happiness (GNH). (FYP-X)Major Health Sector Targetswere to

- Reduce IMR to 20 per thousand live births
- Reduce U-5 MR to less than 30 per thousand live births
- Reduce MMR to less than 100 per hundred thousand live births
- Enhance Life Expectancy to more than 70 years
- Sustain access to Safe Drinking Water to greater than 95%
- Improve access to Safe Sanitation to greater than 97%
- BHTF funds to reach 30 Million US$
- Improve proportion of population within 3 hrs walking distance of a health facility to more than 90%

The Tenth Plan aimed at providing essential primary health care, particularly to the underprivileged and underserved segments of our population. It also sought to devolve responsibilities and funds for health care to PRIs. However, progress towards these objectives has been slow and the Tenth Plan targets on MMR & IMR have been missed. Accessibility remains a major issue especially in areas where habitations were scattered and women & children continue to die en route to hospitals. Rural health care in most states is marked by absenteeism of doctors/health providers, low levels of skills, shortage of medicines, inadequate supervision/monitoring and callous attitudes. There were neither rewards for service providers nor punishments for defaulters. As a result, health outcomes in India were adverse compared to bordering countries

The **Eleventh Five Year Plan** noted that although the percentage of total expenditure on health in India as a percentage of GDP was around 5 per cent, (which is roughly comparable to other developing countries), there was a disproportionally high reliance on private, particularly household's out of pocket, expenditure. This reflected a critical imbalance in the healthcare system, which stemmed from deficiencies in the public sector's capacity to deliver basic healthcare. The private sector too was characterised by wide variations. At one end of the spectrum were private hospitals with world class facilities and personnel offering services,which were competitively priced compared to similar services abroad, but remained beyondthe capacity of most Indians. At the other end, there was an unregulated private sector whichwas more affordable, but offered services of varying quality, often by under-qualifiedpractitioners (FYP-XI).

The Eleventh Plan had set six health outcome indicators as time-bound 'goals'. These included

- lowering maternal mortality
- lowering malnutrition among children,
- lowering anemia among women and girls,
- lowering fertility rate
- lowering infant mortality
- Raising the child sex ratio.

There has been progress on all these fronts, except child sex ratio, the goals have not been fully met. Low public spending on health (1% of GDP), high out-of-pocket payments (71%) leading to impoverishment, high levels of anemia (56% among ever-married women aged15-45 years) reflect in high levels of malnutrition among children (wasting 22.9%, stunting44.9%), high infant mortality (47/1000 live births) and maternal mortality (212 per 1 lakhlive births). India trails in health outcomes behind its South Asian neighbours like Sri Lankaand Bangladesh, which have a comparable per capita income. Large variations within thecountry suggest that the health status of disadvantaged groups is even worse. Public health expenditure is likely to reach 1.4 per cent of GDP (and including drinking water & sanitation 1.8 per cent of GDP) by the end of Eleventh Plan. It should be raised to 2.5 per cent of GDP by the end of the Twelfth Plan.

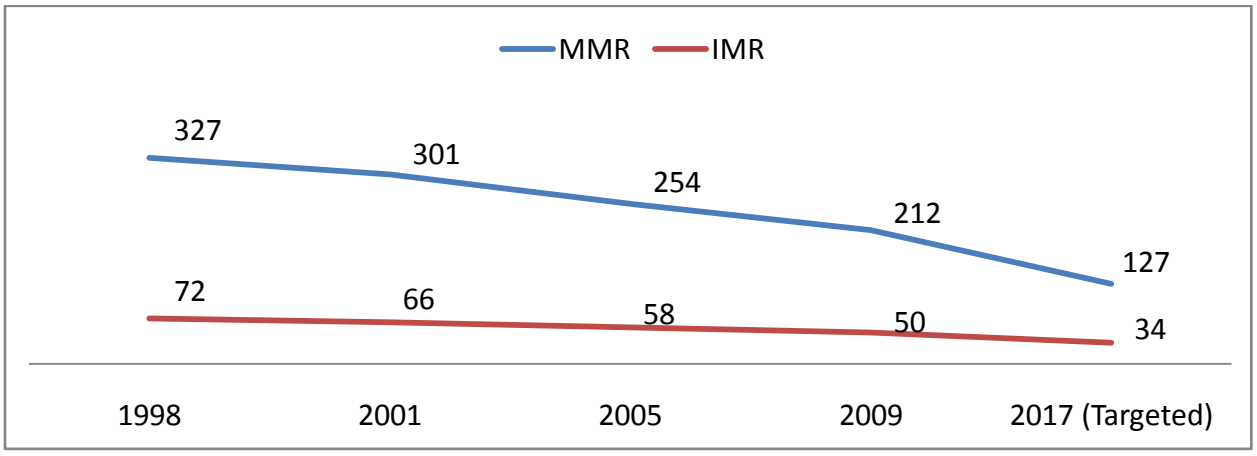
III HEALTHCARE IN TWELFTH PLAN

More specifically, the national health outcome goals, which are meant to reflect the broader commitments during the Twelfth Five Year Plan,are as following:

1. **Reduction of Maternal Mortality Ratio (MMR):** India is projected to have an MMR of 149 by 2015 and 127 by 2017. An achievement of the Millennium Development Goal (MDG) of reducing MMR to 109 by 2015 would require a further acceleration of historical rate of decline. At this accelerated rate of decline, the country can achieve an MMR of 75 by 2017.

2. **Reduction of Infant Mortality Rate (IMR):** India is projected to have an IMR of 38 by 2015 and 34 by 2017. An achievement of the MDG of reducing IMR to 27 by 2015 would require an even further acceleration of historical rate of decline. If this accelerated rate is sustained, the country can achieve an IMR of 19 by 2017.

FIGURE 1:MATERNAL MORTALITY RATIO (MMR) AND INFANT MORTALITY RATE (IMR)

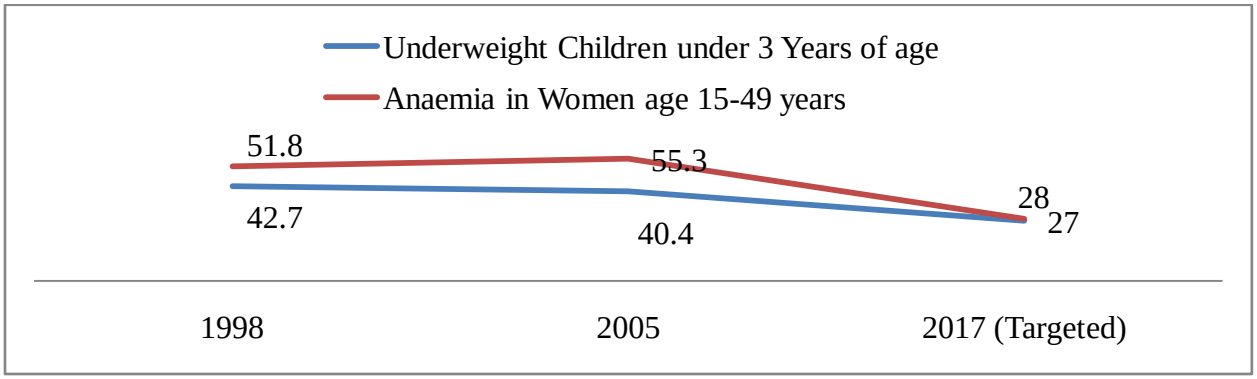


3. **Reduction of Total Fertility Rate (TFR):** India is on track for the achievement of a TFR target of 2.1 by 2017, which is necessary to achieve net replacement level of unity, and realize the long cherished goal of the National Health Policy, 1983 and National Population Policy of 2000. Stagnant TFR over the last two years is, however, a matter of concern.

FIGURE 2: TOTAL FERTILITY RATE

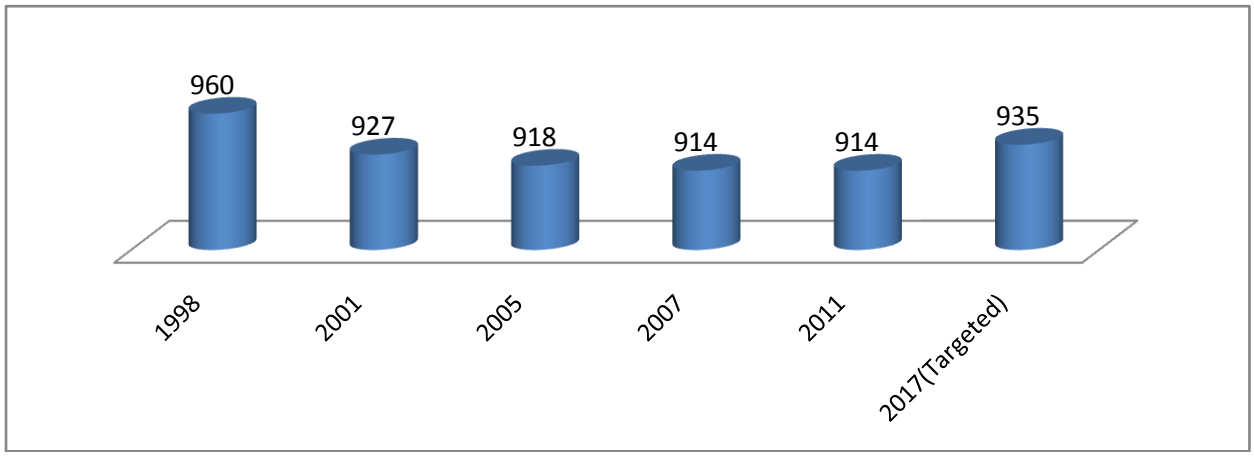
4. **Prevention and Reduction of Underweight Children under 3 Years:** At the current rate of decline, the prevalence of underweight children is expected to be 29% by 2015, and 27% by 2017. An achievement of the MDG of reducing undernourished children under 3 years to 26% by 2015 would require an acceleration of this historical rate of decline. If this accelerated rate is sustained, the country can achieve an under 3 child under-nutrition level of 23% by 2017.
5. **Prevention and Reduction of Anemia among Women Aged 15-49 Years:** The prevalence of anemia has shown a rising trend (58.8% in 2007, DLHS), which needs to be reversed and steeply reduced to 28%, which is half the current levels, by the end of the 12th Plan.

FIGURE 3: UNDERWEIGHT CHILDREN AND ANEMIA IN WOMEN



6. Raising child sex ratio in the 0-6 year age group from 914 to 935.

FIGURE 4: CHILD SEX RATIO



7. Prevention and reduction of burden of diseases – Communicable, Non-Communicable (including mental illnesses) and injuries.
8. Reduction of households' out-of-pocket expenditure from 79% to 50% of total health care expenditure.

TOWARDS COMPREHENSIVE HEALTH CARE

To help define appropriate strategies for the Twelfth Plan, the Planning Commissionconstituted a High Level Expert Group on Universal Health Coverage under the Chairmanship of Prof. K Srinath Reddy. Their recommendations are an important input in defining a comprehensive health strategy for the next ten years. While the Twelfth Plan must re-strategise to achieve faster progress towards the goals listed above, it must also define its health care strategy more broadly. Its main strategies are as follows:

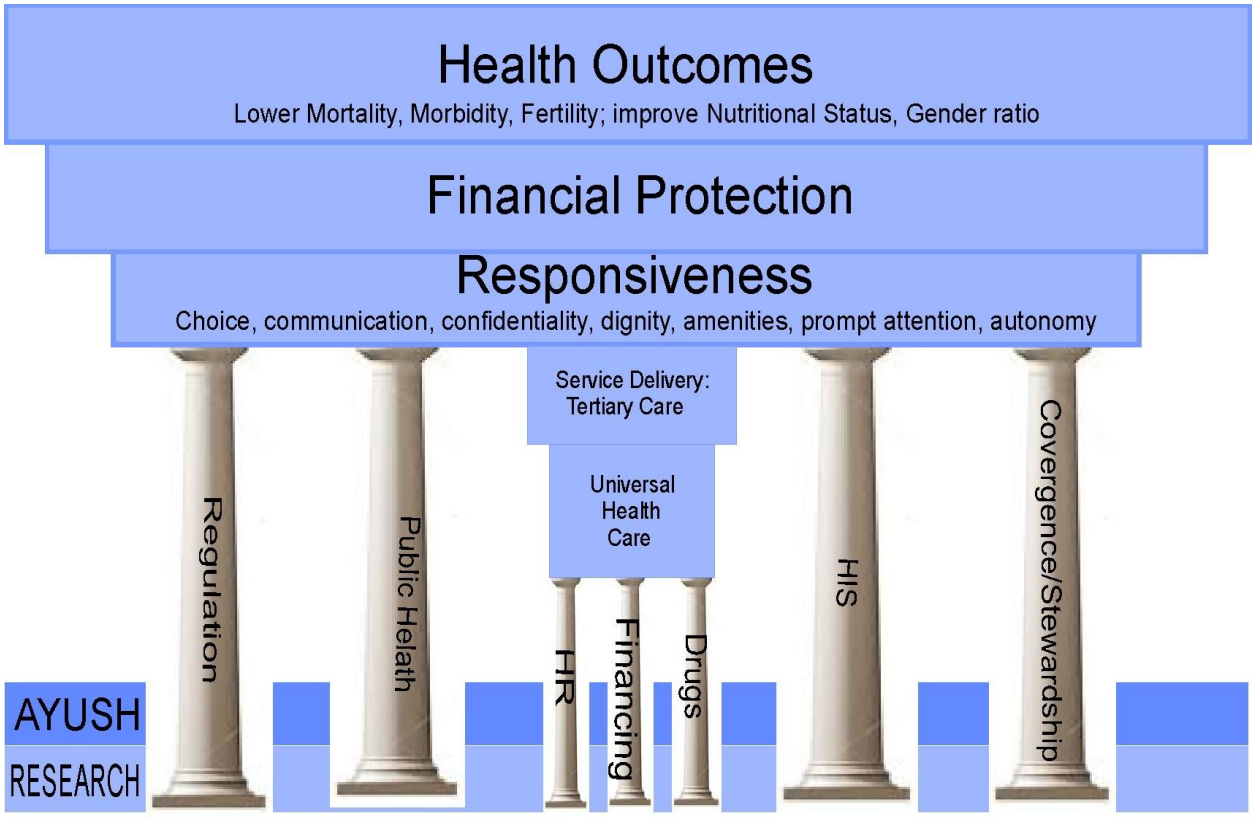
- ✓ The Twelfth Plan will prioritize convergence among all the existing National Health Programs under the NRHM umbrella, namely those for Mental Health, AIDS control, Deafness control, Care of the Elderly, Information, Education and Communication, Cancer Control, Tobacco Control, Cardio Vascular Diseases, Oral health, Fluorosis, Human Rabies control, Leptospirosis.
- ✓ Other innovative management reforms within health delivery systems with a view to improve efficiency, effectiveness and accountability will be encouraged.
- ✓ An accountability matrix will be devised in order to improve the health related goals articulated in the current Plan. The matrix will define the responsibilities of functionaries of the Health, Women and Child Development, and Water and Sanitation departments at

the Block and habitation levels. Definite roles and accountabilities will also be assigned to Civil Society Organizations. Processes like real time data collection, community-based validation, and medical audits to ensure quality, cost-effectiveness and promptness of healthcare will be introduced.

- ✓ While preventive health care is much cheaper than curative care, it has so far not received the attention it deserved. Existing frontline health educators and counselors should play a lead role in compiling and disseminating preventive health practices to every nook and corner of the country. The state should play a lead role in building a culture of familiarity and knowledge around public health by involving Panchayati Raj Institutions (PRIs), Rogi Kalyan Samitis, Village Health, Sanitation and Nutrition Committees, Urban Local Bodies (ULBs) and the available cadre of frontline health workers, through innovative use of folk and electronic media, mobile telephony, multimedia tools and Community Service Centers. But most importantly, families and communities must be empowered to create an environment for healthy living.
- ✓ The Twelfth Plan must break the vicious cycle of multiple deprivations faced by girls and women because of gender discrimination and under-nutrition. This cycle is epitomised by continued deterioration in the sex ratio in the 0-6 year age group, revealed by the Census 2011; by high maternal and child mortality and morbidity, and by the fact that every third woman in India is undernourished (35.6 per cent have low Body Mass Index) and every second woman is anaemic (55.3 per cent). Ending gender based inequities, discrimination and violence faced by girls and women must be accorded the highest priority and these needs to be done in several ways such as achievement of optimal learning outcomes in primary education, interventions for reducing under- nutrition and anaemia in adolescent girls and providing maternity support.
- ✓ The Twelfth Plan must make children an urgent priority. This will involve *convergence* of Health and Child Care services. At present, Health and Child Care services to 83 Crore Rural Indians residing across 14 lakh habitations, 6.4 lakh villages and 2.3 lakh Gram Panchayats are provided, rather independently, through a network of around 11 lakh AnganwadiCentres (AWCs) of the Women and Child Development Department and 1.47 lakh Sub-Centres of the Health Department.

- ✓ Often, women attending AWCs with their children have to travel long distances to avail primary health care. While there is a case for expanding the network of AWCs to all habitations, even more urgent is the need to create a direct reporting relationship between AWCs and Sub-Centres so that interventions are better synergized, resources are optimized, while women and children attending AWCs continue to get health and nutritional services under one roof.
- ✓ The Twelfth Plan should aim at locating a Health Sub-Centre in every Panchayat and an AWC in every habitation their formal inter-linkage being a must for integrating the delivery of health, nutrition and pre-school education services. Through this approach, at least one ASHA would get positioned in each AWC; and at least one Auxiliary Nurse Midwife (ANM) / Health Worker (Female) would be available for a cluster of AWCs within every panchayat.

FIGURE 5: HEALTH SYSTEMS FOR THE 12TH PLAN



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Source: Twelfth Five Year Plan

HEALTH INFRASTRUCTURE

One of the major reasons for the poor quality of health services is the lack of capital investment in health for prolonged period of time. The National Rural Health Mission had sought to strengthen the necessary infrastructure in terms of Sub-Centres, Primary Health Centres and Community Health Centres. While some of the gaps have been filled, muchremains to be done. According to the Rural Health Statistics (RHS), 2010, there is shortage of 19,590 sub-centres; 4,252 PHCs and 2,115 CHCs in the country.It is essential to complete the basic infrastructure needed for health delivery in rural areas by the end of the Twelfth Plan. This will require substantial Plan assistance to the states for infrastructural development including upgrading existing PHCs and CHCs to IPHS norms, building Labour rooms and Operation Theatres, which are critical to reducing Maternal mortality and also building new PHCs.

The status of Human Resources for Health (HRH) has improved during the 11th Five yearplan period, however much more needs to be done. The density of doctors in India is 0.6 per1,000 and that of nurses and midwives is 1.30 per 1,000, representing jointly 1.9 health workers per 1,000. While no norms for Health Human Resource have been set for the country, if one takes a threshold of 2.5 health workers (including midwives, nurses, and doctors) per 1,000 population, there is shortage of health workers. Furthermore, because of a skewed distribution of all cadres of health workers, the vulnerable populations in rural, tribal and hilly areas continue to be extremely underserved. The Twelfth Plan must therefore ensure a sizeable expansion in teaching institutions for doctors, nurses and paramedics (FYP XII).

KEY ELEMENTS OF A ROBUST HEALTH

- ✓ National Health Programmes
- ✓ Health Information Systems
- ✓ Convergence with other Social Sector Programmes
- ✓ Public Health Management
- ✓ Strengthening Tertiary Care
- ✓ Human Resources for Health
- ✓ Regulation of Food, Drugs, Medical Practice and Public Health
- ✓ Promoting Health Research

- ✓ AYUSH – Integration in Research, Teaching and Health Care
- ✓ Inclusive Agenda.

IV. CONCLUSION AND POLICY IMPLICATIONS

We can conclude that the Central and State Governments have been taking proactive steps to promote health of the people by creating a network of public health care facilities, which provide free medical services, and also proactively control the spread of diseases.Butthe health care system in the India suffers from inadequate funding. There are several structural problems too like:

- The lack of integration between disease control and other programmes in the social sector.
- Sub-optimal use of traditional systems of Medicines, weak regulatory systems for drugs as well as for medical practice.
- Poor capacity in public health management.
- Lack of integration between disease control and other programmes in the social sector.
- Lack of human resources is responsible for inadequate provision of health service
- Skewed distribution of all cadres of health workers, the vulnerable populations in rural, tribal and hilly areas continue to be extremely underserved.

We need to overcome these problems. Policies should be made by keeping into account these problems in our health services and then the policies should be effectively implemented. With this a sound health system also requires the active participation of communities in preventive and promotive health care. The solution for satisfying the health needs of the people does not lie in the health policies and plans but it is a question of structural changes in the political economy that can facilitate implementation of progressive health policies.

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