

Health Sector Reforms from Indian Perspective

Dr. Bhakti Mahindrakar (Tatuskar)

UGC-Post Doctoral Fellow, Dept of Studies in Economics, Akkamahadevi Women's University, Vijayapura, Karnataka (India)

ARTICLE DETAILS

Article History

Published Online: 10 November 2018

Keywords

Health, socio-economic

*Corresponding Author

Email: [bstatuskar\[at\]rediffmail.com](mailto:bstatuskar[at]rediffmail.com)

ABSTRACT

Health is the most important socio-economic aspect of every individual's life. It is usually termed as "Health is wealth." Health is not only a base towards a happy life of an individual, but also essential for creative activities in the economy. The entire developmental phase of a person depends upon his rational ability, snooping and practical thinking, but all these qualities depend on his good health. Hence, to meet these necessitates of the healthy citizens and society, health services are outcome for the government. Health of an individual can be considered as important social asset. Present paper attempts to check the role of Government in health sector reforms, to study the various Committees and Recommendations of health sector and to offer appropriate suggestions towards improvement of health sector in India. During independence, the Indian health care system was characterized by low level of public expenditure on health care, poor quality in health care services. Reforms in the health sector have better addressed the need for increasing public spending on health care, focus on preventative health care, ensuring greater access to BPL community, and significantly has improved the productivity of public expenditure. The paper has evaluated the introduction of many health programmes initiated from Bhore Committee of 1946 to Ayushman Bharat 2018, health policies in India have been formulated and revised timely.

1. Introduction

Health is the most important socio-economic aspect of every individual's life. It is usually termed as "Health is wealth." Health is not only a base towards a happy life of an individual, but also essential for creative activities in the economy. The entire developmental phase of a person depends upon his rational ability, snooping and practical thinking, but all these qualities depend on his good health. Hence, to meet these necessitates of the healthy citizens and society, health services are outcome for the government. Health of an individual can be considered as important social asset. WHO defines health as "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition". Further WHO explicate health as, "A state of complete physical, mental, and social well-being and not merely an absence of disease or infirmity". In recent years, it has been further enlarged to include ability to lead a socially and economically productive life" with this background the present paper intends to study Government health sector reforms from Indian perspective and to offer appropriate suggestions.

2. Objectives

- To check the role of Government in health sector reforms.
- To study the various Committees and Recommendations of health sector.
- To offer appropriate suggestions towards improvement of health sector.

3.3. Evolution of government health policies in India

3.1. Health Planning

Health Planning in India is a vital part of socio-economic planning in the country. The guidelines for national health planning were provided by a number of committees dating back to Bhore Committee in 1946. These committees were appointed by Government of India from time to time to review the existing health situation and recommend measures for existing health situation. A focus primary health care by Alma Ata Declaration and the National Health Policy of the government provided a new track towards health planning in India. To attain Health for all by the year 2000 is the goal of Indian national health planning.

3.2. Bhore Committee, 1946

The Government of India in 1943 appointed the Health Survey and Development Committee with Sir Joseph Bhore as Chairman, to survey the existing position regarding the health conditions and health organization in the country and to make recommendations for the future development. The Committee which had among its members some of the pioneers of public health, met regularly for every two years and submitted its report into four volumes in 1946. The Committee for the first time presented inclusive proposals meant for the development of a National Health Service programme. The Committee noticed and pointed that, "If health of the country should be strong, preventive health programme should be prioritized.

Major Recommendations:

- i. Integration of preventive and curative services at all administrative levels.
- ii. The Committee visualized the development of primary health centers with following:

- Each primary health centre in the rural areas for 40,000 population secondary health centre to be established.
 - Two medical officers, 4 trained dais, 4 midwives, 1 nurse, 2 sanitary inspectors, 2 health assistants and 15 other class four employees were recommended.
- iii. Major changes in medical education which includes three months training in preventive and social medicine to prepare "social physicians".
 - iv. under 'Three million plan' setting up primary health units with 75 bedded hospital for each 10,000 to 20,000 population and secondary units with 650-bedded hospitals, again regionalized around district hospitals with 2500 beds.

3.3. Mudaliar Committee, 1962

In 1959, the Government of India appointed another Committee known as "Health Survey and Planning Committee" popularly known as the Mudaliar Committee under the Chairmanship of Dr. A.L. Mudaliar to survey the progress made in health sector as per Bhore Committee's report and to make recommendations for future development and expansion of health services.

Major Recommendations:

- i. Strengthening district hospital with specialist services.
- ii. Regional Deputy or Assistant Directors each to supervise two or three district medical and health officers.
- iii. Each primary health centre not to serve more than 40,000 populations.
- iv. To improve the quality of health care provided by the primary health centres.

3.4. Chadah Committee, 1963

In 1963, a Committee was appointed under the chairmanship of Dr. M.S. Chadah, Director General of Health Services to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme. The Committee recommended that the "vigilance" operations in respect of the National Malaria Eradication Programme should be the responsibility of the general health services that is primary health centres at the block level.

Major Recommendations:

- i. One basic health worker per 10,000 populations.
- ii. These workers were "multipurpose" workers to look after additional duties of collection of vital statistics and family planning, in addition to malaria vigilance.
- iii. The Family Planning Health Assistants were to supervise 3 or 4 of these basic health workers.

3.5. Mukerji Committee, 1965

A Committee known as "Mukerji Committee", 1965 under the Chairmanship of Shri Mukerji, Secretary of Health, reviewed the strategy for the family planning programme. It was observed that the basic health workers could not perform effectively as a multipurpose worker.

Major Recommendations:

- i. Separate staff for the family planning programme and assistants to just undertake family planning duties. The basic health workers were to be utilized for the other purposes than family planning.
- ii. Separating the malaria activities from family planning.

3.6. Mukerji Committee, 1966

Health burden was felt of malaria, family planning, smallpox, leprosy, trachoma etc due to paucity of funds, the matter was discussed in Bangalore under the Chairmanship of the Union Health Secretary, Shri Mukerji. The Committee focused on block level basic health services and higher level of administration.

3.7. Jungawalla Committee, 1967

Towards the significance and urgency of integration of health services, and exclusion of private practice by government doctors, a "Committee on Integration of Health Services" under the Chairmanship of Dr. N. Jungawalla was appointed and it submitted its report in 1967.

Major Recommendations:

- i. common seniority
- ii. recognition of extra qualifications
- iii. equal pay for equal work
- iv. no private practice
- v. good service conditions

3.8. Kartar Singh Committee, 1973

In 1972, "The Committee on Multipurpose Workers under Health and Family Planning" was appointed under the Chairmanship of Kartar Singh, Additional Secretary, Ministry of Health and Family Planning.

Major Recommendations:

- i. Present Auxiliary Nurse Midwives to be replaced by the newly designated "Female Health Workers" and the present day Basic Health Workers, Malaria Surveillance Workers, Vaccinators, Health Education and Family Planning assistants were to be replaced by "Male Health Workers".
- ii. Areas of malaria and smallpox were targeted.
- iii. One primary health centre for a population of 50,000.
- iv. Each primary health centre with one male and one female health worker should be divided into 16 sub-centers for the population of 3000 to 3500 depending upon topography and means of communications.
- v. A male health supervisor to supervise the work of 3 to 4 male health workers and a female health supervisor to supervise the work of 4 female health workers.
- vi. The doctor in charge of a primary health centre should charge all the supervisors and health workers in his respective areas.

3.9. Shrivastav Committee, 1975

The Government of India in the Ministry of Health and Family Planning set up a "Group on Medical Education and Support Manpower" popularly known as the Shrivastav Committee in November 1974.

Major Recommendation:

- i. Health Assistants to serve as a link between the qualified medical practitioners and the multipurpose workers.
- ii. Creation of bands of Para-professional and semi-professional health workers from within the community itself such as, school teachers, postmasters, gram sevaks to provide simple, promotive, preventive and curative health services as per the requirement.
- iii. Development of a Referral Services Complex by establishing proper linkages between the PHC and higher level referral and service centres like taluka/tehsil, district, regional and medical college hospitals.
- iv. Establishment of a Medical and Health Education Commission for planning and implementing the reforms in health and medical education under the University Grants Commission.

3.10. Rural Health Scheme, 1977

The most important recommendation of the Shrivastav Committee was that primary health care should be provided within the community itself through specially trained workers so that the health of the people is placed in the hands of the people themselves.

Major Recommendations:

- i. Involvement of medical colleges in the total health care of selected PHC's with the objective of reorienting medical education to the needs of rural people.
- ii. Reorientation training of multipurpose workers engaged in the control of various communicable disease programmes into uni-purpose workers. This Plan of Action was adopted by the Joint Meeting of the Central Council of Health and Central family Planning Council held in New Delhi in April 1976.

3.11. National Health Policy-2002

The Ministry of Health and Family Welfare, GoI, developed a National Health Policy in 1983 towards the goal of 'Health for all by the year 2000'. Since then a lot of development was noticeable. To translate the above objectives into reality, the Health Policy has laid down specific goals to be achieved by year 2005, 2007, 2010 and 2015.

3.12. National Rural Health Mission 2005

The launch of the National Rural Health Mission (NRHM) in April, 2005 was a crucial step taken towards equitable, affordable and quality health care and priority was given to decline of child and maternal mortality rate, population stabilization and gender and demographic balance.

The policy proposes to increase the expenditure in health sector from 0.9% of GDP to 2-3 % of GDP over the next five years with main focus on primary healthcare. It also aims to achieve IMR of 30 per thousand live births, maternal mortality of 100 per 100 thousand live births and total fertility rate of 2.1 by the year 2012. It utilizes Public Private Partnership as an essential tool for achieving the above mentioned goal.

Goals of NRHM:

- i. To reduce Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- ii. Universal access to public health services like; women health, child health, water, sanitation and hygiene, immunization and nutrition
- iii. control and prevention of communicable and non-communicable and endemics
- iv. Access to integrated comprehensive primary health care
- v. Population stabilization, gender and demographic balance
- vi. Revitalize local health traditions and mainstream Ayurveda, Yoga & Naturopathy Unani, Siddha and Homoeopathy (AYUSH)
- vii. Promotion of healthy life styles.

3.13. National Urban Health Mission, 2014

Launched in February 2014 the policy aims to meet health needs of the urban poor, particularly the slum dwellers by making available to them essential primary health care services. The policy aims to reduce the IMR and MMR in urban areas. It proposes to create one Urban Primary Health Centre (U-PHC) for every fifty to sixty thousand population, one Urban Community Health Centre (U-CHC) for five to six U-PHCs in large cities, 1 Auxiliary Nursing Midwives (ANM) for every 10,000 population and 1 Accredited Social Health Activist ASHA for every 200 to 500 households. NUHM entails to cover all cities with a population of more than 100,000.

Note: NRHM and NUHM are clubbed together and known as the National Health Mission.

3.14. National Health Policy, 2017

Launched in March 2017, the policy aims to improve health status through concerned policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on equality. The policy aims to achieve universal health coverage by providing primary health care by utilizing the existing infrastructure and by collaborating with the non-governmental sector. It also aims to achieve improved access to secondary and tertiary services through a combination of public hospitals and private care providers, especially the not for profit providers.

In terms of budget the policy envisages to increase the government spending in health from 1.15% of GDP to 2.5% of GDP by 2025.

3.15. Ayushman Bharat: A National Health Mission 2018

"Ayushman Bharat Initiative" is also termed as Modicare or Pradhan Mantri Jan Arogya Yojana launched on February 1, 2018, by the Hon'ble Prime Minister Mr. Narendra Modi comprised two schemes:

- i. Developing 1.5 lakhs (0.15 million or 150,000) health and wellness centers across the country to provide universal health-care coverage
- ii. National Health Protection Scheme which should cover over 10 crores poor families (approximate 50 crores or 500 million of beneficiaries) providing up to 5 lakh rupees per annum per family for secondary and

tertiary hospitalization, making it the world's largest state-funded health program.

This masterstroke initiative intends improve the access to quality health services and help fulfilling Modi's stated goal to build a new India by 2022 supplementing its economic progress.

4. Suggestions

1. Expand and execute nationalized principles for assessment by which doctors, nurses and pharmacists are able to perform service.
2. Revise the curriculum in medical, nursing, pharmacy and other schools that train healthcare professionals, so that they too are trained in the new paradigm.
3. To maintain appropriate doctor patient ratio.
4. Developing a healthcare system which will dedicatedly work for providing medical help in less time especially in rural areas.
5. Increase in government health care expenditure to minimum of 5 percent.
6. More research should be encouraged in Indian Medicine (AYUSHN) system.
7. Organizing free health checkup campaign in rural areas.

8. Creating awareness about communicable and non-communicable as how to avoid and control.
9. Initiate transparency by accreditation of hospitals and health care providers.
10. The government should appoint a commission which makes recommendations for the healthcare system and monitor its performance.

5. Conclusion

During independence, the Indian health care system was characterized by low level of public expenditure on health care, poor quality in health care services, with adverse effects on the health status of citizens; a lack of focus on preventative health care. Reforms in the health sector have better addressed the need for increasing public spending on health care, focus on preventative health care, ensuring greater access to BPL community, and significantly has improved the productivity of public expenditure. The paper has evaluated the introduction of many health programmes initiated from Bhole Committee of 1946 to Ayushman Bharat 2018, health policies in India have been formulated and revised timely. Many schemes / programs have helped BPL to afford expensive treatment through Public Private Partnership (PPP) model but still few loopholes are noticed those should be controlled. Further priority should be given to rural healthcare.

References

1. <http://www.mohfw>.
2. Benedict, C., S. Gupta, I. Karpowicz, and S. Tareq, 2010, —Evaluating Government
3. Employment and Compensation, II Technical Notes and Manuals (Washington:
4. International Monetary Fund).
5. Lu C., M.T. Schneider, P. Gubbins, K. Leach-Kemon, D. Jamison, C.J. L. Murray, 2010,
6. Public Financing of Health in Developing Countries: A Cross-National Systematic
7. Analysis, Lancet Vol. 375: pp. 1375–87.
8. Gol (2018), —High Level Expert Group Report on Universal Health Coverage for India Submitted to the Planning Commission, Government of India, New Delhi http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf
9. Government of India, Ministry of Finance, Government of India, Economic Survey 2010–11, New Delhi, available at: <http://indiabudget.nic.in/survey.asp>
10. Government of India, Ministry of Health and Family Welfare (MHFW), 2018, Report of the National Commission on Macroeconomics of Health (New Delhi: Government of India).