UNIT 14 HEALTH POLICY IN INDIA

Structure

14.0 OBJECTIVES

After studying this Unit, You will be able to:

- understand the meaning of health policy;
- discuss health policy planning in India over a period of time;
- delivery of National Health Programmes; and
- find out the challenges in health policy.

14.1 INTRODUCTION

Health care planning has undergone changes in its structure, personnel and in its access of the populace on the basis of recommendations made by different committees. After independence, India has initiated several policies and programmes and global partnership has been introduced, so far expected results has been not shown, therefore without the realization of the goals of the programme of action of the millennium development which combines clear theoretical thinking with realistic application. Though multi-sectoral approach has been adopted at various stages, but still there is a need to be percolated these aspects in the grass-root through trained and well skilled workers for sustainable impact of health and family welfare programmes. In reality, the vast infrastructure in health care facilities is able to cater only twenty per cent of the population and eighty per cent of the people's health needs are met my private health care provision. Restricted access to health facilities leads to higher incidence of morbidity and mortality. Further, it also forces people to have out-of-pocket

expenses which often lead to indebtedness. In rural areas and poor people in urban areas are victim of the vicious circle of poverty, malnutrition and poor health reinforcing each other.

14.2 MEANING OF HEALTH POLICY

Health policy can be defined as the decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society. According to WHO, an explicit health policy can achieve several things: it defines a vision for the future; it outlines priorities and the expected roles of different groups; and builds consensus and informs people. The policy process encompasses decisions made at a national or state level that affect whether and how services are delivered. Policy is in way national law that support different programmes related to it and make intervention accordingly. When health policy is made, it is followed by the operational policies. Operational policies are the rules, regulations, guidelines, and administrative norms that governments use to translate policies into the field situation whether they are to be delivered.

Health policy can be defined as the decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society.

Check Your Progress I

1) What do you mean by health policy?

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14.3 HEALTH POLICY AND PLANNING IN INDIA JUST AFTER INDEPENDENCE

With the advent of British Rule, every facet of Indian life– including the medical and public health services– was subordinated to commercial, political and administrative interests of the imperial (state) government in the United Kingdom and its representatives in India. However, along with their own, the Britishers also permitted native Indian elite also to avail of modern health care. Keeping in view the constitutional directions aiming at elimination of poverty and ill health, the Government of India, soon after Independence, planned several approaches for health-care delivery. The basis of the health development policy in India was laid in the recommendations of the Health Survey and Development Committees, namely, Bhore Committee as early as in 1946, Mudaliar Committee (1961), Chadah Committee (1963), Mukherjee Committee (1965), Jungalwala Committee (1967), Jain Committee (1968), Kartar Singh Committee (1973), and Srivastava

Committee (1975). Besides the Committees, inputs have been provided by some studies on health policy, which were conducted by the autonomous institutions like the ICSSR and the ICMR. The important recommendations by these committees can be thematically grouped under the following: (a) for improving the existing institutional structure of health care delivery system, (b) to improve the supporting services for a proper and quick delivery of medi-care facilities, and (c) to improve the quality of the delivery system thereby improve the health standard of the masses (Nagla: 1993). Health care planning has undergone changes in its structure, personnel and in its access of the populace on the basis of recommendations made by different committees. Nagla (1993) has highlighted the enormous efforts made by the various committees to chart out the growth of health manpower in India. The works of these committees have, however, been subject to serious data limitations. Information on different categories of health personnel, their priorities and distribution (especially in respect to professionals outside the public sector) has been rather scanty. The various committees and even institutions like the ICSSR/ICMR study group have been focusing on providing expert opinions rather than garnering accurate statistical data. No committee has been able to take into account the contribution of non-governmental health institutions and that of professionals in rendering health care services. Perhaps more importantly, the committees have been unable to assess the health care needs of the people through field surveys and ascertain the extent of utilization of health care institutions and practitioners (Yesudin: 1981). Introduction of economic reforms and liberalization has created space for social insurance schemes introduced by public sector Life Insurance Corporation and by private insurance companies, introducing medical insurance policies. This was the initiation of public-private mix for health-care support in India.

14.4 HEALTH FOR ALL BY THE YEAR 2000 AD

In order to provide minimum basic health facilities, it was resolved by the Health Assembly of the WHO to launch a movement known as "Health for All by the Year 2000 AD". In 1978, the Alma- Ata Conference reaffirmed Health for All as the major social goal of all governments. In 1981, a global strategy for this programme was adopted by the WHO, which was later endorsed by the United Nations General Assembly. India is a signatory to those declarations and has made efforts to extend health facilities to the vulnerable sections of its society.

Health for All has been defined as attainment of "a level of health that will enable every individual to lead a socially and economically productive life" (Government of India: 1982). The concept of "Health for All by 2000 AD implied a substantial change in basic health policies and in the approaches to health care. In order to provide minimum health facilities, the government of India along with state governments increased the allocation to the health sector. A group set up jointly by the ICSSR and ICMR with an alternative strategy to achieve health for all citizens. It suggested certain steps for restructuring the health care service infrastructure based on the principle of promoting the preventive and curative aspects of health. This group felt that, "the growth of health care services in the country has been haphazard and unrelated to the needs of poor and rural people who stand most in need of health care". The group remarked that several assumptions on which present system is based were wrong. For instance, there

was no distinction between planning for health and that for health services so that little or no attention has been paid to the social, economic, political and cultural dimensions of health. The recommendations of the study group were more practical and provided details of health services up to the village level. It emphasized that most common illnesses can be self-cured and need only symptomatic treatment with simple remedies, be it herbal, indigenous or allopathic medicine. The diseases, which are communicable, can be controlled by preventive measures, and can be readily diagnosed and treated with the help of cheap and highly effective drugs. The group, therefore, proposed that primary health services should be extended to the community through a trained and involved community health volunteer preferably male or female, for a population of 1,000. To lift the status of preventive and promotive aspects of medical services, the working group has suggested that greater emphasis be given to departments of preventive and social medicine.

14.5 HEALTH POLICY -1983: AN APPRAISAL

National Health Policy-1983, framed in a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged, had hoped to provide 'Health for All by the Year 2000 AD', through the universal provision of comprehensive primary health care services. The genesis of health sector reforms and its various dimensions are in built in Indian policy instrument and its developmental framework. However, several pertinent issues in health sector reforms have a bearing on our constitutional provisions– like equity, accessibility of poor, efficiency in using resources and inadequacy of resources, gender bias, quality of health care, impact of liberalization etc. It has been observed after analyzing the health policy that the financial resources and public health administrative capacity is inadequate and therefore the set goals for the policy could not be achieved. The main recommendation of NHP is to increase the broad-based availability of health services to the masses on the basis of realistic considerations of capacity.

14.6 NATIONAL HEALTH POLICY-2002

The main objective of the NHP-2002 is to achieve an acceptable standard of good health amongst the people especially the poor people. To make health services available to the people, the decentralization of public health system is targeted. It can be done by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions. Importance was given to the equitable access to the health services across all sections of society and particularly the poor people and people living in remote areas. It was also emphasized that aggregate public health spending will be increased by the central government. In turn, this initiative can strengthen the capacity of the public health administration at the State level to render effective service delivery. In NHP, importance was given to the preventive and first-line curative initiatives at the primary level through increased sectoral share of allocation. The rational use of drugs within the allopathic system is also preferred. Increasing use of generic drugs over the branded drugs is also pushed on particularly in the government health facilities. Access to tried and tested systems of traditional medicine was also ensured.

The total expenditure in health expenditure is around 5.2 per cent of Gross Domestic Product (GDP). However, the between 2012 and 2013 aggregate health spending is expected to reach a rate of 5.5 per cent by 2013. Looking to these figures it is concluded that the expenditure on public health services is very meagre and below from the desirable standard. However, under the Constitutional structure, public health is the responsibility of the States. Under the federal structure it is the states that provide the health services to their population and central government helps them in certain National programmes and national Health initiatives. In NHP-2002 it was proposed that the central government will spend 6 per cent of GDP, with 2 per cent of GDP being contributed as public health investment by the year 2010. However, it is the failure of the government that it has not done what it envisaged in the NHP-2002 (National Health Policy: 2002). To reduce these inequalities and imbalances at inter regional level, rural-urban level, between different economic classes, caste groups, the primary health sector is targeted. Primary health sector has been given importance over tertiary and secondary health sector. The NHP- 2002 also projected that the increased aggregate outlays for primary health sector will boost the existing facilities and also opens the door for new primary health centres and sub-centres according to the norms of such facilities. The policy for the eradication and elimination of disease requires a major role of the central government with the active participation of the State governments. In the public health facilities, the outdoor funding is insufficient. The medical and para-medical personnel are also much less of the prescribed norms. The availability of consumable items is negligible. The equipment in many public health facilities is outdated or obsolescent and unusable. Buildings are in the dilapidated. Some facilities are in the rented accommodations. In the indoor facilities, there is insufficiency of beds, equipment are obsolescent. Availability of essential drugs is minimal and the capacity of facilities is grossly inadequate. Over-crowding is another feature in the public health facilities which results into the steep deterioration of quality of health services delivered to the people. This results into the decreasing use of public health facilities i.e. around 20 per cent. Only less than 20 per cent seek out door patient service and less than 45 per cent avail indoor facilities in the public health facilities. This is the situation in spite of peoples' inability to pay for the private services and results into the out-of-pocket payments. In principle, this Policy welcomes the participation of the private sector in all areas of health activities – primary, secondary or tertiary. The policy is encouraging the private insurance companies for increasing the coverage of secondary and tertiary sector under health insurance packages. In the National Health Framework, the alternative systems of medicine like Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) are also put under one umbrella to have their substantial role in the health care.

14.7 NATIONAL RURAL HEALTH MISSION (NRHM)-2005

National Rural Health Mission was launched in April 2005 in to provide health care to the rural people particularly to the vulnerable section, children and women. The basic aim is to provide comprehensive and integrated health care to the rural masses. In this mission, there is a provision to provide every village with trained

female community health activist, known as Accredited Social Health Activist (ASHA). She works as mediator between the community and the public health system. These ASHA workers would not get any remuneration, rather they would be provided only performance-incentives for promoting universal immunization, referral and escort services for reproductive and child health and other programmes. The Central government has framed this Rural Health Care Mission at policy level, but it is the responsibilities of the State governments to executed and support it.

14.8 NATIONAL HEALTH POLICY: 2017

The basic aim of National Health Policy- 2017 is to improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality. The policy envisages as its goal the attainment of the highest possible level of health and well-being for all at all ages, 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. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery. The policy gives importance to the Sustainable Development Goals (SDGs). The policy aims to draw upon the diverse systems of medicine practiced in India and the different sectors of healthcare provider. The policy acknowledges the need for raising the level of public financing for health and determines to raise it to 2.5 per cent of the GDP by 2025. It affirms that 70 per cent of funding should go to primary healthcare, which is needed for comprehensive care and promotion of well being. Health and wellness Centres are established which connects the family on the basis of family cards. Health and Wellness Centre provides basic health services, referral linkages and perform a gatekeeper function for advanced care. More advanced care is opened for secondary and tertiary level medical centres. 'Fee for service' model is adopted for secondary and tertiary care. 'Capitation mode' of payment will be there for primary care. Expanded institutional capacity, and new courses and cadres are proposed to overcome the shortages of skilled human resources in the health system. Essential drugs and diagnostic are provided free of cost at public facilities.

14.9 AYUSHMAN BHARAT YOJNA

Ayushman Bharat (Long Life to India) was launched in 2018 and renamed as ***Pradhan Mantri Jan Arogya Yojna*** (PMJAY). It proposes to convert 1,50,000 primary health sub-centres into Health and Wellness Centres (HWC). These centres will be redesigned to provide a wide range of essential primary health services close to home and will have both facility-based and community outreach services. It will become a platform for health services related to maternal and child health, communicable and non-communicable diseases, mental health and common disorders. It is proposed that each HWC will serve 5000 persons. A Primary health Centre (PHC) will have six HWCs connected to it. Along with wellness promotion through integration of other systems f medicine, promotion of healthy diets, regular physical activity, yoga, advocacy of tobacco avoidance and substance abuse, vector control, sanitation, hygiene and clean water programmes will be promoted.

Check Your Progress II

1) Summarize the health policy just after independence.

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2) What was the basic goal of Health for All?

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3) What was the goal of National Health Policy of 1983?

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4) What is the main objective of National Health Policy of 2002?

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5) What is National Rural Health Mission?

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6) Give the critical point of National Health Policy of 2017.

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14.10 DELIVERY OF NATIONAL PUBLIC HEALTH PROGRAMMES

It is self-evident that in a country as large as India, which has a wide variety of socio-economic settings, national health programmes have to be designed with enough flexibility to permit the State public health administrations to craft their own programme package according to their needs. Also, the implementation of the national health programme can only be carried out through the State Governments' decentralized public health machinery.

Over the last decade or so, the Government has relied upon a 'vertical' implementational structure for the major disease control programmes. Through this, the system has been able to make a substantial dent in reducing the burden of specific diseases. However, such an organizational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain. Over a long time-range, 'vertical' structures may only be affordable for those diseases, which offer a reasonable possibility of elimination or eradication in a foreseeable time-span.

It is a widespread perception that, over the last decade and a half, the rural health staff has become a vertical structure exclusively for the implementation of family welfare activities. As a result, for those public health programmes where there is no separate vertical structure, there is no identifiable service delivery system at all. The Policy will address this distortion in the public health system.

This policy envisages a key role for the Central Government in designing national programmes with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, NHP-2002 envisages the gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, Malaria, HIV/AIDS, as also the RCH and Universal Immunization Programmes, would need to be continued till moderate levels of prevalence are reached. The integration of the programmes will bring about a desirable optimization of outcomes through a convergence of all public health inputs. The Policy also envisages that programme implementation be effected through autonomous bodies at State and district levels. The interventions of State Health Departments may be limited to the overall monitoring of the achievement of programme targets and other technical aspects.

The Policy envisages that apart from the exclusive staff in a vertical structure for the disease control programmes, all rural health staff should be available for the entire gamut of public health activities at the decentralized level, irrespective of whether these activities relate to national programmes or other public health initiatives.

14.11 CHALLENGES AND MANAGEMENT OF HEALTH CARE

The provision of health under Indian constitution is fall in State subject. Today every state is free to formulate their health programme and strategy. In fact,

India was the first country in the world, who introduce family planning programme in 1952. Since Independence, we have invested lot in the health infrastructure and created 1,45,000 sub centres, 2,3000 Public Health Centres (PHCs) and 3222 Community Health Centres (CHCs). However, this infrastructure is still insufficient for the vast population, as still approximately eighty per cent of the population is receiving health care from the private sector. Poor, access to public health facilities heads to higher incidence of morbidity and mortality.

The poor people have an out-of-pocket expense which often leads to indebtedness. The vicious circle of indebtedness leads to poverty, malnutrition and poor health. They reinforce each other. In India, private households' contribution to healthcare is 75 per cent. Most of these costs are out-of-pocket costs. Private Expenditure on Health (PHE) as a per cent of per capita income has almost doubled since 1961. Private Expenditure on Health has increased at much higher rate than the per capita income over the period of time.

The 'vertical' or; categorical' programmes were not properly conceived, too techno-centric programmes, which are imposed by the western countries over the poor developing countries without understanding of their specificity. International Monetary Fund (IMF), while giving the loans has also imposed certain conditionalities in the form of imposition of international initiative in early phase of 1990s. The Structural Adjustment Programme (SAP) enabled the entry into most important elements of the governance of the country in the form of influencing budgetary allocations in the country. SAP has also given break through to the market of private health sector rapidly. There is a sharp decline in the government's commitment to public health services which is reflected in various plan outlays. India's public Health expenditure in terms of its percentage from the GDP, it is the fifth lowest in the World. Private sector has been provided many subsidies and rebate in the import of medical instruments and for drugs. India has the largest and least regulated private healthcare industry in the world.

The increasing role of the state in delivering health care services and the consequent bureaucratization of health care delivery has created a divergence between governmental goals and targets for collective health status and the individual's efforts to maintain health and well-being. While the lack of governmental health care is found to adversely affect the health status of a population, greater interference of medical services through the government bureaucracy and the rapid diffusion of privatised medical care lead to inequality of health status.

Universalization of health care is at the heart of health policy in India science Independence in 1947. Since then, the country has experienced different models to improve access to health services and ensure universal care to entire population. Despite the proliferation of governmental and private initiatives, the majority of the Indian population still has great difficulty in obtaining appropriate health services. Along problems of spatial distribution of health services, other barriers stand between patients and health care services.

Weaknesses in the public sector are noted across the entire chain of facilities, from sub-centres to medical college hospitals. This has been due to inadequate investment in infrastructure, human resources and equipment, compounded by poor management.

The private sector has flourished due to the void created by the dwindling capacity and competence of the public sector and aided by mismanagement and weak regulatory system. The large corporate hospitals are charging high cost of care and insensitive to human sufferings due to crass commercial considerations.

The models or public-private partnership (PPP) deployed so far have not worked well because of poorly designed contracts, vaguely defined deliverables and inadequately enforced accountability. The dependence on the private sector for service delivery in government-funded health insurance schemes has yielded valuable lessons on how unregulated partnership can lead to unintended consequences of induced demand and unnecessary procedures.

The success or failure of the policy is mainly judged in its equity component. In the framework of equity dimension, a marked emphasis has been given to the expansion and improvement for the primary health facilities including the new concept of provisioning of essential drugs through central funding. The improvement in the health status of the people depends upon the quality of health services. Increase in financial and material input is not only sufficient for improvement in the health status but it also depends on more empathetic and committed attitude in the service providers in the private and public sectors. Ultimately it is the quality of the health services which matters for the enhanced health status. In this backdrop, it needs to be recognized that any policy in the social sector is critically dependent on the service providers treating their responsibility not as a commercial activity, but as a service, albeit a paid one. In the public health sector, an enhanced standard of governance is a prerequisite for the success of any health policy.

Check Your Progress III

1) How vertical programmes are used for the disease control?

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2) Mentions the challenges encountered in health care.

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14.12 LET US SUM UP

This unit briefly summarizes the health policy and planning in India since independence. Health care planning has undergone changes in its structure, personnel and in its access of the populace on the basis of recommendations made by different committees. After independence, India has initiated several policies and programmes and global partnership has been introduced, so far expected results has been not shown, therefore without the realization of the

goals of the programme of action of the millennium development which combines clear theoretical thinking with realistic application. Though multi-sectoral approach has been adopted at various stages, but still there is a need to be percolated these aspects in the grass-root through trained and well skilled workers for sustainable impact of health and family welfare programmes. The infrastructure in health still insufficient for the vast population, as still approximately eighty per cent of the population is receiving health care from the private sector. Poor, access to public health facilities heads to higher incidence of morbidity and mortality. The poor people have an out-of-pocket expense which often leads to indebtedness. The vicious circle of indebtedness leads to poverty, malnutrition and poor health. They reinforce each other. In India, private households' contribution to healthcare is 75 per cent. Most of these costs are out -of- pocket costs.

14.13 KEY WORDS

Health Policy: Health policy is a vision document for the future; it outlines priorities and the expected roles of different groups; and builds consensus and informs people.

Health for All: It has been defined as attainment of a level of health that will enable every individual to lead a socially and economically productive life.

Out-of-Pocket Cost: Individual's inability to pay for the private health services results in out-of-pocket cost.

Fee-for-Service: It means providing payment for each hospitalization which includes medical consultation, procedure or test performed.

Capitation Model: It is a fixed payment for a whole set of health services covering a person or a family in year or any other defined period to cover healthcare costs incurred for a person in a year.

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