National Health Policy: Progress And Pitfalls

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THE National Health Policy which was approved by the Indian Parliament in1983 marked a beginning to the quest for equity in health expressed as WHO's goal of 'Health for All' by the Year 2000. The policy, hence, aimed at providing a decent level of health for the people of India. Now, well into the last decade of the century, the promises made in the policy are fading out and portraying a gloomy picture, which force us to think if we could achieve the goals set for 2000 A.D. even by the year 2011. This paper makes an attempt to trace the reasons for the dissatisfactory performance and see what lessons can be learnt.

The 1978 International Conference organised by WHO and UNICEF on Primary Health Care (PHC), through its declaration at Alma Ata offered the basis for appropriate action directed towards the internationally accepted goal of 'Health for All by the Year 2000', and the Indian National Health Policy is mainly based on the Primary health care strategy as outlined and agreed upon in the declaration: "Primary health care is essential health care made universally accessible to individuals and acceptable to them through their full participation and at the cost the community and country can afford".

The key elements of Primary Health Care are nutrition; immunisation; first aid; maternal, child health and family planning; sanitation and water supply; supply of essential drugs; control of endemic diseases and health education. All these elements of primary health care are essentially related to each other. These elements are to be achieved through approaches like easy accessibility of services, inter-sectoral action for service integration and community participation.

According to the PHC approach, the promotion of health should be based on action in the socio-economic sphere as well as in the health care sector itself. The former aims to counteract the causes of ill health and to make the development process more likely to contribute in improving people's health. The latter tries to make the existing health services more equitable and effective in relation to the needs of the people. Yet these issues were never operationalised as central features of the strategy, and the existing health delivery approach is essentially technocratic in nature and indeed often paternalistic: health is something to be 'delivered' to the population by health professionals and their assistants.

A decade has almost passed by since this beginning was made, but unfortunately India has not made much progress towards attainment of the goal of "Health for All", which was to be measured by some indicators shown in the table. Despite the reasonable economic growth in the last 10 years, poor housing, lack of sanitation and safe water supply, inadequate dietary intake etc. persist and explain the continuing high incidence of infectious diseases and the elevated infant and maternal mortality rates. The poor performance of the health system relative to the health needs of the country is well known. Two-fifth of the population lacks regular access to health services, which are either inadequate or maldistributed, socially and regionally. The services provided are often over-sophisticated in relation to the most frequent causes of illness and death. Curative care takes up about 90 per cent of the health sector's expenditure, leaving insufficient resources for preventive and promotive activities. In addition, the health services usually operate at a low level of productivity due to a large number of poorly coordinated agencies involved in health care and the ineffectiveness of sectoral planning; many government units are in fact under utilised. Wastage of resources often coexists with shortages elsewhere, such that health units are not properly equipped and staffed.

What's Wrong

A question that arises here is what went wrong? One may argue that resources allocated to achieve the goals laid down in the policy were not sufficient. Although, it is a known fact that social sectors, especially health and education have been neglected in our planning process and have not been given their due recognition. It should however, be accepted that the limited resources allocated were not put to the right use. Moreover, implementation of the primary health care strategy was largely supported by funds received from external donor agencies. In this context a model plan for creation of health facilities and provision of services was developed in order to improve the health satus of people in the backward areas. To implement the Model Plan a number of districts in different States of the country

were selected on the basis of socio-economic and health related "backwardness criteria". It was thought that lessons learnt from this experiment will help to achieve the goal of 'Health for All by the Year 2000'. With financial assistance from bilateral agencies like World Bank, USAID, ODA (UK), DANIDA (Denmark) and UNFPA around 125 districts were selected (which are about one-fourth of the total districts of the country) for special treatment. Some of these district projects have been evaluated by independent organisations and it appears that these projects instead of contributing towards initiating the approaches laid down to achieve the goals of our national health policy merely contributed towards development of physical infrastructure and recruitment of manpower. For example, the number of Sub-Centres and Primary Health Centres which provide health care in rural areas have increased from 84,053 and 10,705 in 1985 to 1,30,390 and 20,531 in 1990, respectively. Similarly, a sizable increase has been noticed in manpower working in the area of health. However, a similar trend was not visible in the quality of health care being provided. For example, the percentage of maternal deaths due to causes related to anemia has declined from 18.9 per cent in 1983 to only 17.8 per cent in 1987. Maternal deaths related to bleeding at the time of pregnancy have infact increased from 23.8 per cent in 1983 to 27.9 per cent in 1987. Further, the percentage of infant deaths due to respiratory infection have increased from 15.1 per cent in 1983 to 18.4 per cent in 1987. Similarly, the incidence of diarrhoea among infants has also increased from 9.5 per cent in 1983 to 10 per cent in 1987. (Year Book, 1989-90, Family Welfare Programme in India, Ministry of Health and Family Welfare, Govt. of India). It is hence felt that resources, although limited were not insufficient so as to hinder the effective implementation of the health policy. It is more likely that the problems lie elsewhere.

Table 1

National Health Policy: Goals Set And Achievements

Indicator	Goals 2000 AD	Current Level
Crude birth rate (Per 1000 population)	21	30.5 (1989)
Crude death rate (Per 1000 population)	09	10.2 (1989)
Infant Mortality rate (Per 1000 live births)	60	91 (1989)
Maternal mortality rate (Per 1000 deliveries)	02	4.5 (1989)
Annual population growth rate (Percent)	1.2	2.1 (1991)
Percentage of total deliveries by trained birth attendants	100	40.50 (1987)
Percentage of pregnant women receiving ante-natal care	100	40-50 (1987)
Couple protection rate (Percentage)	60.0	43.3 (1990)
Life expectancy at birth (Yrs.)		
Male	64	55.6 (1981-86)
Female	64	56.4 (1981-86)

Source: Year Book 1989-90: Family Welfare Programme in India; Ministry of Health and Family Welfare, New Delhi.

Insufficient Understanding

India adopted the strategy outlined at Alma-Ata (in the form of its Health Policy) without a thorough understanding of the issues involved in it. The strategy was imposed on the existing system without analysing whether the system was competent enough to implement the strategy in its true sense. Further, knowing fully well that India was in no position to implement all elements of the primary health care strategy, as noted above, a decision was taken to bring about a break-through in all elements. Instead of this kind of a diffused approach, a concentrated effort should have been followed, by selecting a few vital elements like mother and child health and family planning, immunisation, water supply and sanitation. These important items would have had a greater impact in improving the general health condition. It has been argued that decline in the death rate in Britain from the 18th century onwards had more to do with improvements in hygiene, sanitation and safe water supply than with advances in medical knowledged provision of health care.

It has also been argued that targets set in the health policy were unrealistic to be achieved as noted in the Table. It is, however, felt that targets were not unreasonable but an appropriate mechanism could not be developed to attain them. Some other developing countries like Thailands, Indonesia and Malaysia although far behind India in terms of infrastructure, equipment, etc. when the primary health care strategy was initiated are today far ahead of us as regards the health status of their masses.

It appears that the health programme was not managed properly, even though additional health resources were made available to the health budget from inside or outside the country, very little improvement in primary health care could be achieved. Most health resources go

to providing unnecessary sophisticated curative health care and little money is left for health promotion and disease prevention.

This brings us to the conclusion that the the basic approaches on which the concept of primary health care rests were neglected from the very beginning. These include the universal availability of essential health care to individuals, families and population groups according to need; involvement of communities in planning, delivery and evaluation of such care and an active role for other sectors in health activities.

Lessons

One can learn two important but related lessons from the past experience: First is the necessity to put health in its proper multi-sectoral perspective, which is so much wider than the narrow framework of the health care that has dominated the discussion in the country so far. Many health care professionals—even well meaning ones—have fallen into the trap of 'medicalising' health, which masks the continuing socio-economic determinants of health and disease; and they have thereby contributed to brainwashing the population into believing that health care is a sufficient condition for achieving Health for All. In future, health policy must not be limited to health care organisation, which is only one focus of the former. It must be clarified how and to what extent, the socio-economic determinants of illness will be dealt with in the socio-economic spheres. Health care services will then appear as just one of the measures that must be adopted to promote, protect and restore health.

It may be difficult for those who earn their living by dispensing medical care to accept such an argument, but a critical evaluation of the limits and scope of health care is absolutely essential. Countries that have managed to undertake radical changes in their health systems have often done so without the help of their health care professionals.

Secondly, the national health policy was not submitted for wider social scrutiny and support. Since primary health care is a mechanism of providing health care to the people by the people, community participation stands out as the most important aspect of the PHC strategy. Community participation will accrue only by involving the community in decision making, provision of services and evaluation of the same. For effective community participation, the community should have a stake in the programme. The village health guide scheme which was the first major step taken towards achieving community participation, turned out to be a failure mainly because the community did not have a stake in it, instead, it resulted in an increased degree of Government participation in the programme: Once the Government withdrew funds set-aside for this purpose, the scheme failed in many States. The first step towards attaining community participation is to decentralise the programme and make district the nodal point for implementation of all activities even if the funds may be provided by the Ministry of Health and Family Welfare in Delhi.

Selection

It is thus necessary to select those processes that are most conducive to the provision of health care according to the criteria of equity, cost-effectiveness, acceptability and feasibility. Thus, health care must be placed under wider social control. Most of the existing problems result from the fact that the interests of the consumer elites, and of the producers of health care services and goods, have prevailed over those of the vast majority of the people. The latter have scarcely had a say either in policy making or in controlling the operation of health care sector. The present degree of political and bureaucratic centralisation obstructs the formulation and implementation of alternative health policies appropriate to the different social and regional conditions of the country. An effective decentralisation of health care planning and management is thus necessary if the health policy wishes to achieve Health for All at the earliest.

Decentralisation will automatically result in bringing about a convergence of different departments, agencies, voluntary organisations and local bodies working in the area, to come to a platform for making decisions in collaboration with each other, thus, helping all sections of the society to own the decisions taken and work effectively towards their implementation. It would further avoid duplication of efforts. This in turn will improve the service delivery component and help to enhance accessibility of services available.

The foregoing analysis brings us to infer that the problems are evident and solutions are available. If immediate action is not taken on the above lines, the concept of "Health for All" will not become a practical reality in India. We will continue to be a country groping in the dark in search of an improved health status for our masses. It is because the health situation in India has reached a point where technique alone can contribute little towards finding solutions to the crucial questions that are still unresolved. The recognition of this fact and the democratisation of the health debate, must be top priorities if society is to exercise control over the causes of its health problems and over the health care systems. □

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