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Health Policy Issues in Jharkhand

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National Health Programmes: Policy Issues

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Background

Health, being a basic human right and development issue, has been considered an integral component of the development process and means to improve the quality of life of the people in India. Soon after independence, health care services based on the concept of comprehensive health care were started as a part of community development programmes. A vast network of health institutions (primary health centres and sub-centres) was created to reach people with health services. Primary health centres (PHCs) are the key mechanisms to provide a gamut of services such as medical care, control of communicable diseases, reproductive and child health (RCH) services, environmental sanitation, school health services, health education, and implementation of various national health programmes. While developing the health services, major consideration was given to accessibility and availability of services; promotive and preventive health care; vulnerable sections of the population, namely women and children; and, most important, involvement of people through community participation.

Both the crude death rate (CDR) and infant mortality rate (IMR) are high, and the high incidence and prevalence of communicable diseases such as malaria, plague, cholera, smallpox, typhoid, and tuberculosis (TB) are responsible for a large number of deaths in the country. In the given situation, the Government of India launched several vertical national health programmes against major communicable diseases. Special programmes were also launched to address some nutritional problems and population control (family planning).

It was considered that a single-purpose, mass campaign approach involving a unified, single line of command would be the most effective mechanism for controlling diseases and reducing deaths, thus "softening" the huge task of improving health and protecting lives.

Major national health programmes included:

* National Malaria Eradication/Control Programme
* National Smallpox Control/Eradication Programme
* National Cholera Control Programme
* National Filaria Control Programme
* National Leprosy Control Programme
* National Trachoma Control Programme
* Guinea Worm Eradication Programme
* National Goiter Control Programme
* National Family Planning Programme
* Applied Nutrition Programme
* National Water and Sanitation Programme

These programmes were generally initiated in collaboration with bilateral or international agencies that provided assistance in the form of funds, technical assistance, equipment, and technology. To begin with, all of these programmes were fully centrally aided/assisted and were to be implemented by the states through the network PHCs.

The vertical health programmes yielded rich dividends. Over the past five decades, significant gains have been achieved. The CDR has decreased from 27 to 9.6 per 1,000 people and the IMR from 140 to 80 per 1,000 live births. Life expectancy has increased from 32 to 62 years of age. Smallpox has been completely eradicated; no cases of human plague have been reported since 1968, with the exception of a rumoured epidemic in the late 1990s; incidence of malaria and related deaths have been reduced to significantly lower levels; and there have been no major epidemics of communicable diseases. Nutrition problems such as endemic goitre have also been effectively reduced.

The trend favouring the vertical model of programme implementation to deal with specific problems continues because results are, thus far, encouraging. Several new programmes have been launched according to this implementation design.

Key Constraints

Over the many years since their implementation, the nature and nomenclature of these programmes, objectives, and strategies have undergone changes or revisions. These changes have been subject to availability of financial support, changing epidemiological behaviour of the particular health problem, continuation of interests and commitments of international donor agencies, political commitment, altered priorities, and infrastructure and organisational changes in the health

system. Some of the key constraints in effective implementation of national health programmes include the following:

Lack of Ownership by the States

Generally, the national health programmes have been perceived as programmes of the Government of India's Ministry of Health and Family Welfare (MOHFW) because they were planned at the central level and funds were disbursed by the MOHFW. States had no role in the planning process. Programmes had "straight jacket" designs and components that were applied to all states; the specific needs of states were not addressed.

Lack of Integration of National Health Programmes in the Health Systems

Most of the national programmes were conceived as vertical health programmes with a single chain of command. The implementation design envisaged single-purpose programme officers, supervisors, and health functionaries at various levels, with no linkage to the existing state health systems. The national health programmes remained isolated from the mainstream. This design influenced the ownership and the efficiency of programme implementation and coordination. Several national health programmes could not make any significant dent in morbidity and mortality. The glaring example was the National TB Control Programme. Forty years after its inception, the prevalence and incidence of TB remained unchanged, and the disease continued take a heavy toll of life until recently, when the programme was revised.

In the initial phase of the post-independence era, the vertical programmes were relevant and had the desired impact on the health of the people. The National Malaria Eradication Programme, National Smallpox Eradication Programme, and Guinea Worm Eradication Programme were great successes. However, there was major organisational restructuring in 1975 to change from single to multi-purpose functioning. The National TB Control Programme was not restructured and thus maintained its vertical character, whereas programmes such as malaria control were brought under the multi-purpose approach and integrated into the existing health system. The National Malaria Control Programme faced several problems, but was sustained because of its integration with the health system.

Lack of Funding

Ironically, most of the vertical programmes were centrally funded for a significant period time, but the states were subsequently asked to share programme expenditures. Financial constraints, such as funding shortages and problems with

funding flows, became a major issue in efficient implementation of the national health programmes, other constraints notwithstanding. The states had become dependent on the MOHFW for funds and because they could not generate their own funds to support the programmes, they continued to seek central funding. Financial support for the programmes was also severely affected when external grants dried up; the programmes had been funded mostly by external agencies for their initial phases and for a limited, subsequent period.

Poor Implementation Mechanism

Programmes, though technically sound, were not effective in bringing desired changes because of poor implementation. The states were unable to develop adequate health infrastructures and chronically suffered from the shortage of health manpower. Roles and responsibilities of institutions at various levels and of personnel were not clear. The functionaries lacked the training to develop the competence and skills necessary to perform required tasks.

Inadequate Monitoring and Feedback

Since the MOHFW controlled programmes, monitoring at the state and district level was reduced to compilation and onward transmission to a higher level—ultimately to the MOHFW. The state, although expected to monitor the programmes, could not organise a system of monitoring of information, analysis, and decision-making. Feedback from the MOHFW to states and districts was limited. As a result, programmes were unguided.

Poor Community Participation

Involvement of people and communities in planning and implementation remained marginal throughout the process. The role of information, education, and communication (IEC) remained undermined, as communication was never given importance but rather, was considered irrelevant in a "technically-oriented" health programmes. Competence in communication planning and management was not present nor was there a positive attitude. Communication still remains a major constraint in effective implementation and utilisation of programmes and services.

Lack of Inter-sectoral Coordination

Because the national health programmes were considered the domain of the medical community and the responsibility of the health department, health planners and administrators did not coordinate with other departments and sectors. Other sectors were not involved in programme implementation, and the social dimension of health was never given high priority.

Donor Priorities

As stated, the national health programmes were supported by external agencies. The programmes were designed based on experience and expertise in other countries; thus the approaches were not necessarily appropriate to Indian conditions and populations. The programmes were also driven by the priorities of donor agencies. Continuing donor interest and funding determined the sustainability of the programmes.

Goals of the National Health Policy 2002

The MOHFW has announced the new National Health Policy 2002 (NHP 2002). While the new policy retains the fundamental underlying principles and approach of the National Health Policy 1983, the NHP 2002 also focuses on newly emerging issues in health care. These include health sector reforms in health system organisation and health care financing, health and demographic transitions, advances in health technology, rising costs of health care, globalisation and the changing international economy, and people's rising expectation for better quality of care. The NHP 2002 has set long-term goals to be achieved in both the current and the next decade.

The National Health Policy 2002 Goals
(To be achieved 2000–2015)

* Eradicate Polio and Yaws	2002
* Eliminate Leprosy	2005
* Eliminate Kalazar	2010
* Eliminate Lymphatic Filariasis	2015
* Zero Growth of HIV/AIDS	2007
* Reduce mortality (TB, Malaria, and other vector-borne and water-borne diseases	2010
* Reduce prevalence of blindness (0.5%)	2010
* Reduce IMR to 30/1,000 and MMR to 100/100,000 live births	2010
* Increase utilisation of public health facilities (20% to 75%)	2010
* Establish integrated system of surveillance, national health accounts (NHA), and health statistics	2005
* Increase health expenditure by government from 0.9 to 2.0 percent of GDP	2010
* Increase share of Central Grants to constitute at least 25 percent of total health spending	2010
* Increase state sector health spending to 7 percent	2005

More than half of the listed goals are related to specific health problems or communicable diseases. Can these goals be achieved through vertical programmes? Do we have alternatives to the vertical programmes? To achieve these policy goals, the following basic realities have to be realised:

- Programme success and a continuous flow of intended benefits largely depends on an effective and efficient delivery system to provide quality services to the satisfaction of the beneficiaries, which is something health care services in India have been lacking to a great extent.
- Another key component for programme and service sustainability is adequate maintenance of physical and organisational infrastructure. This is an often neglected component, and provisions are rarely made for it in programme planning and budgeting.
- Roles and responsibilities of personnel and health institutions at various levels in the organisation often lack clarity, and scant attention is given to intra-organisational coordination and linkages.
- Self-reliance is further strengthened by enabling an institution to build its own capacity rather than providing a "top feed."
- Above all, and most relevant to health programme sustainability, is the continued interest and commitment of donor agencies, willingness of the governments, and firm support from politicians and the people.

Policy Issues in National Health Programmes

The NHP 2002 aims to achieve an acceptable standard of good health among India's general population. The approach to achieve this aim would include increasing access to the public health system by establishing a new infrastructure and upgrading the existing one and ensuring more equitable access to health services across the geographical and social expanse of the country.

The NHP 2002 has accorded a central role to national health programme implementation, keeping in mind the aforementioned constraints. The central government, with active participation of the states, will play a key role in designing national programmes, provide adequate financial resources, provide requisite technical support, and conduct monitoring and evaluation activities.

The NHP 2002 emphasises state governments' ownership of the national programmes. Because health is a state subject, states will develop need-specific strategies for priority areas. Although the funding source would mainly be the central government, states will have autonomy in utilising funds to implement the programmes.

The policy states that autonomy is to be given to the states; programme implementation at the state and district levels will be done by autonomous state and district-level bodies for greater flexibility.

Integration of health programmes with the health care delivery system will be promoted and strengthened. The programmes will be gradually merged under a single field administration. The policy also recommends that vertical programmes for control of major diseases like TB, malaria, and HIV/AIDS continue as vertical programmes until moderate levels of prevalence are reached. This recommendation also includes RCH and the Universal Immunisation Programme.

While the policy elements outlined above directly address policy issues related to national health programmes, the NHP 2002 announced policy measures that would strengthen national health programmes and improve their efficiency. Some of the key elements include the following:

* Increasing sectoral outlay to primary health care, of total health spending to 55 percent.
* Increasing central government health sector expenditure from 5.2 to 6 percent of the GDP. The states would increase health expenditure from 5.5 to 8 percent of the budget by 2010.
* Developing norms for health care professionals and institutions.
* Increasing the role of IEC in health care services.
* Emphasising health research, raising expenditure on research from 1 to 2 percent by 2010.
* Setting up a national disease surveillance network.
* Increasing the role of the private sector in health care.

Lessons for Jharkhand

Jharkhand is a newly created state with a predominantly tribal population. While the state is rich in natural resources, the geographic terrain poses serious challenges to health care access and availability. Since the state came into existence only recently, it has a great opportunity to create new organisational structures and systems. The state can avail itself of the general lessons of public health and the learning experiences of the country and states implementing various national health programmes over the last 50 years. The announcement of the NHP 2002 provides opportunities for policies to be implemented in the state. Some of the key policy initiatives that can be undertaken by Jharkhand include the following:

* Create an organisational structure that is effective. The state may consider creating a decentralised organisation with clearly defined roles and responsibilities, flexibility, and autonomy at various levels.
* Integrate various national health programmes into the state health systems in the process of creating an organisational structure.
* Develop a human resource development policy to meet the manpower requirements of the state health systems. The state may take this opportunity to plan human resources to meet the shortage of staff by

streamlining the recruitment, transfer, promotion, and capacity building of various categories of health officials and functionaries at different levels.

* Create a system and process for efficient fund allocation and utilisation, as indicated in the NHP 2002. More than half of the funds would be allocated to primary health care. This is an opportunity for the state to seek more funds for primary health care and rationalise resources by integrating national health programmes into primary health care.
* Develop infrastructure and support facilities at health institutions at various levels. The NHP 2002 provides a unique opportunity and ground for policy wherein development of infrastructure and capacity could become a part of the strategy for strengthening health care systems.
* Donors have shown a keen interest in the development of the state; identify priorities and create opportunities and an enabling environment for donor and external funding agencies to invest in the development of a health care system with long-term and sustainable goals.