Health Care Approach in India, 1978-2015: A Historical Analysis

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Abstract

Beginning with the Primary Health Care Approach of the Alma Ata in 1978 and having reached up to the Universal Health Care through the insurance in 2015 is marked by a 180 degree shift in India's health policy paradigm. The primary health care approach "Health for All" was emanated, in the declaration of the Alma Ata, on the basis of the role of state (health is a state subject) in health policy and development. The National Health Policy of 1983 was endorsed along with the commitment of achieving the goal of health care for all by 2000. In the first three decades, after the independence, the need of health planning and development was accomplished through the five year plans led to the realization of the needs of formulating health policy. Under the umbrella of health policy, it was assumed that, an integrated and comprehensive approach towards the development of health services, medical education and medical research will be better served. Neoliberal economic policy of 1990's made way of the appearance of the health policy of 2002 which formalized a market led growth of the health system in India as an official policy. This policy preference has been further sought to be consolidated through the latest draft National Health Policy 2015.

Introduction

After the independence of India three models of development were recognized in health sector; Nehruvian and the Bhore Committee perspective of international standard, Hindu Mahashava perspective of revival of ancient canonical tradition (not like Chopra Committee recommendation) and the people centered and pluralistic development model of Gandhi and the Sokhey Committee.[1] Although there were differences in recommendations but all those models recognized the primacy of western biomedicine. Nehruvian model of international standard through the Bhore Committee was chosen as the vision of health service development in independent India where two other models were not incorporated.[2] In the development of top-down approach the state adopted technology based health service and the Gandhian approach was sidelined. After more than half a century lot of health service infrastructures were in place in both public and private sectors.

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Pharmaceuticals industries, medical instruments and skilled manpower were well absorbed in the sector. In the flow of time health plan and policies were changed responding to the need of time and context. Private sector overtook the public sector and eventually India is now in the map of medical tourism for the developing countries for better treatment and a good choice of the developed countries for a lower rate in medical service comparing their expenditure in health service.

In the following sections we discuss the shifts in India's health policy paradigm and the forces shaping the same since the beginning of the WHO's Primary Health Care initiative of 1977. The implications of these changes for the common Indian people are also discussed.

Comprehensive Health Care and Primary Health Care Approach of Alma Ata

Notion of comprehensive health care is as old as it was seen in early twentieth century in England, even in the USA. The movement came out at a time when people demanded to provide universal health service to them. From the Bandung Conference of 1937 the idea of primary health infrastructure and integrated health service was evolved.[3] The Bhore Committee talked about the infrastructure and gave an independent plan for welfare state of India where free medical service to all without distinction was incorporated.[4] The International Conference on primary health care held on 6-12 September 1978 in Alma Ata, USSR articulated the necessity to protect and promote the good health of all the people of the world.[5] 'Health for All by 2000' - slogan was incorporated as the perspective view. Three key ideas of the declaration were- appropriate technology, criticism of elitism and health and development.[6] It presented the following approaches for primary health care;[7]

It is a practical approach of making necessary and commonly reachable health care services to the persons and families of a community in a suitable and affordable manner. In many countries this approach has been developed over time through the way of practicing both positive and negative activities. Universally accessible health care has some developmental and social dimensions which influence the entire health system functions. The shape of primary health care is determined through the improvement of the standard of life and maximum welfares of health to the highest number; and these targets are achieved with the acceptance of wider responsibility and active participation of communities and individuals to health. Healthier population can contribute more in socio-economic development and such development additionally facilitates the health. So, mutually supportive

primary health care and community labors for socio-economic development are more likely to be successful. Within the harmony of health sector and other socio-economic sectors the health sector performs the best and therefore, a harmony within the health sector through backing primary health care from all other levels is needed.

Used methods, equipment, techniques and drugs in health sector are needed to be proved the worthy and affordable. This is important in the primary health care because there is a tendency of using technologies in hospital but it is less appropriate in front-line care. Technical capacity of provider and goal of primary health care make it more significant of having appropriate technology available. Community health workers are giving primary health care but their required skill and training are different from one country to another. Whatever their skill level is, it is more significant to understand the need of communities for services. This understanding capacity will make the way of gaining confidence of the people. In this case service provider should reside in the same community where service takers are living.[8]

Selective Primary Health Care

Selective Primary Health Care (SPHC) was developed from the larger concept of primary health care focusing on major infectious diseases based on prevalence, morbidity, mortality and feasibility of control. In the Bellagio Conference of 1979 this new concept was established on the ground of criticism against the primary health care approach of Alma Ata by the international agencies specially the Rockefeller Foundation.[9] The Rockefeller Foundation, the World Bank, the UNICEF and the World Health Organization were the main performer of the SPHC. The major component of the SPHC were; a) For children, over 6 months old, measles and DPT vaccination, b) For pregnant women, to prevent neonatal tetanus, tetanus toxoid, c) Encouraging mother for long term breast-feeding, d) Chloroquine treatment in malaria prone areas, e) Oral rehydration salts in case of diarrhea.[10] Targeting the children and pregnant women the UNICEF sanctioned the selective primary health care concept known as GOBIFF in 1982.[11]

- G: Growth chart monitoring for child development
- O: Oral rehydration salts, widespread availability
- B: Breast-feeding promotion
- I: Immunization of all children against diphtheria, pertussis, measles, tetanus, poliomyelitis and tuberculosis
- F: Food supplement for young children and pregnant women
- F: Family Planning for birth control

Comprehensive to Selective Primary Health Care

Contradiction regarding Comprehensive Primary Health Care (CPHC) began immediately after the declaration of Alma Ata arguing its idealistic and political nature, cost in implementation and unattainability.[12] It was formally accepted that the principles of the Alma Ata was not conducive to the market oriented economy of the capitalist countries. Bisht made an argument that widespread view regarding primary health care was something applicable for the developed countries not for developing countries due to scarcity of resources but nobody calculate the real economic cost and benefits of the universal health care of Alma Ata.[13] D. Banerji argued that the claim of cost-effectivity of the SPHC than the CPHC was not convincingly proved with evidence; furthermore, program designing of the SPHC was not proved both epidemiologically and socially as more effective program.[14] So, it is clear that primacy was given to principles of the CPHC which is more inclined to the socialist view and contrary to the capitalism.

Philosophy of comprehensive primary health care (CPHC) and selective primary health care (SPHC) was quite different in nature and application. The CPHC was based on people participation in program designing, implementation and evaluation. It emphasized on people, not predetermined system and it highlighted social control over health service. On the other hand, the SPHC adopted dictatorial approach selecting the diseases and its preventing components. Accessibility of selective health care denies the accessibility to unselected health care. In other words when particular diseases are selected for caring then people who are sufferer of unselected health diseases have no access to the health which implies the necessity of purchasing of non-access services.[15] In this case poor people are more vulnerable in access of proper treatment.

National Health Policy

The WHO defines health policy as the decisions, plans and actions which are taken for the achievement of specific health care goal within a society. It defines the vision for future targeting the short and medium term. It outlines priorities and expected roles of different group and builds consensus and informs people.[16] Role of the policy formulation for whole health sector is appeared as the organizational section for applying knowledge regarding health and disease. It includes surveillance and monitoring, research and education, analysis and policy formulation for priority problems, maximizing infrastructure and technologies, manpower development and deployment in all the sectors of health

service. Public, private, NGO, indigenous system of medicine and primary, secondary and tertiary levels of health care, drugs quality control, production and regulation are related to the policy of health sector.[17] India got three national health policies (1983, 2002, 2015 draft) for planning and development in health sector.

National Health Policy of 1983

The draft of the National Health Policy (NHP) 1983 came in public domain in 1979 with two major viewpoints, a) inspiring the people for handling the health problems through their own ways, b) health technologies are put under the control of people themselves that mean technology will be placed under the regulation of people not technology will regulate people.[18] Debabar Banerji pointed out some broad approaches of the NHP 1983 like; a) primary health care service through structured support of paramedics, volunteers, auxiliaries and equipped multipurpose workers, b) Building up effective community participation and individual self-reliance, c) primary health care through efficient referral system, d) Sanitary cum epidemiological stations across the country to handle the poor health conditions, e) providing specialist treatment in the centers based on necessity, f) first priority to backward section of people.[19]

The National Health Policy of 1983 was started with the reference of the constitution of India that it envisioned the establishment of a new social order on the basis of equality, freedom, justice and dignity of the individual.[20] From the National Health Policy 1983 some points are mentioned below;

- It proposed the restructuring of health services with the following approaches
- Private and voluntary sector workers' efforts would be integrated with the government effort
- Standard quality of health workers' training would be crucial importance to the success of the comprehensive health care approach
- Ensuring the individual self-reliance and effective community participation
- The effective establishment of referral system
- Nation-wide establishment of a chain of sanitary cum epidemiological stations
- Curative centers should be related to the population and maximization of its use
- For reducing governmental expenditure planned program would be developed by public and private medical professionals, moreover, support to the voluntary agencies to work in the health field.

- Encouragement of private investment in the government set up for ensuring the adequate care to the poor section and affluent section by paying clinics
- Well-coordinated program for the mental health care
- First attention would be given to tribal, backward and vulnerable sections of society.
- Adequate mobility of personnel at all level of functioning
- For confirming all the initiatives organized efforts are required
- Private Practice by Government Functionaries: The policy prescribed the private practice of government professional in the government service against non-practicing allowance.

Analysis of the National Health Policy 1983

Statement of the National Health Policy(NHP) of 1983 began with citing some words from the constitution of India which are mostly related to the rights of human beings, so, the NHP signifies the health as an individual human right. Objectives of the policy was set up considering the point of upholding the dignity of human through solving the backward linked problems of malnourishment and malnutrition, special concentration to the vulnerable section of population like children and women. Health needs were assumed to be fulfilled within 2000 through the comprehensive health care which was prescribed by the declaration of Alma Ata in 1978. Moreover, emphasizing on integration of the plans, the policy paved the way of how the goal will be achieved.

The NHP clearly pointed out the existing situation and way out the solution through building up self-reliance and developing awareness of individual.[21] The analysis of the NHP is subtracted in the following para;

> The hospital-based disease, and cure oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, especially those residing in the urban areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of health care. The existing approach, instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems.[22]

In the 1980's conceptual paradigm was shifted from comprehensive health care to selective health care where Washington Consensus doctrine and five year plans of India constituted the way of shifting. The Washington Consensus was a neoliberal economic doctrine accepted the international institution, developing countries and donors since 1989. It advocated the reduction of government intervention and liberalization of

finance, trade and monetary system. Characteristics of the doctrine were privatization, free-trade, liberalization and de-regulation.[23] The sixth five year plan (1980-1985) was influenced by Alma Ata Declaration and it gave high priority to the development of primary health care located to the people as close as possible. The seventh five year plan (1985-1990) gave emphasis on the improvement of the quality of services, people's involvement and community participation, involvement of voluntary organization and urban health service. The eighth five year plan (1992-1997) emphasized on the development of urban health service as per the recommendation of Krishnan Committee. Strengthening secondary and tertiary health care was emphasized to support the urban health center. The ninth five year plan (1997-2002) integrated the vertical program in horizontal. The tenth five year plan defines the essential health care service only for those who are below poverty line.[24] Thus comprehensive primary health care was diluted to urban health and essential health care up to 2002. Amid this development the second National Health policy was endorsed with the message of neoliberal economy.

National Health Policy 2002

The National Health Policy 2002 was started with revisiting of the National Health Policy 1983 and presenting the existing situation regarding health in India with a comparison of last half a century.[25] Major points of the policy are mentioned below.

a. Objectives

The main objective of the policy is to achieve an acceptable standard of good health amongst the general population of the country. It emphasized on establishing new infrastructure and upgrading the existing infrastructures. It gave importance on ensuring more equitable access to health service across the country. It also emphasized on the substantial increase of the central government's contribution. It expected the strengthening capacity of public health administration at the state level for rendering effective service delivery. It also expected the enhancement of private sector in providing health services to the affluent section of population. Importance will be given to first line curative measures and prevention at the primary health level by increasing sectoral share of distribution. Rational use of drugs within the biomedicine would be emphasized and access to traditional medicine would be ensured. Within the broad objectives the National Health Policy 2002 bounded the time to achieve the goals of different indicators.

b. Programs

National health program should be designed considering the socio-economic diversity of India. Funding of central government would be continued to run the broad based public health initiatives. Central government would deal with the technical and managerial expertise for large scale public health program and program implementation under the state government. Vertical program for particular disease remarked as extremely expensive and difficult to sustain, in this situation, it proposed only vertical program for those diseases which have possibility of elimination or eradication within foreseeable time period.

c. Urban Health

Public health services are very poor in the urban areas, to expand the existing services there is no uniform organizational structure. Moreover, people are forced to avail the health care through out of pocket expenditure. The NHP-2002 addressed the need of minimum standard of broad base health service facilities for the unserved urban population.

d. Role of the Private Sector

Private sector mainly contributes in the secondary and tertiary level care. The policy addressed the issues of the comprehensive information system and the establishment of regulatory mechanism for ensuring the standard of private diagnostic centers, medical institutions and the conduct of clinical practice and delivery of medical services.

Implication of the shift (For the health care needs of poor in India)

At the beginning of twenty first century Government of India adopted the new national health policy in 2002. The World Bank created a document on 'Better Health System for India's Poor' in 2002 and another document namely 'Financing for India's Health Sector' in 1992 which had influence in the policy formulation over the period of time.[26] The National Health Policy implies the following aspects.

- It opens the privatization of medical sector in all the levels and private investments in public sector institutes
- Both population control program and vertical disease control program will run centered on grass-root workers which ultimately undermine the integrated and comprehensive features of public health
- Public sector institutions were de-legitimized through the labelling of inefficiency, laziness and corruption. This allegation was given on the basis of inappropriate measures without any comparative

indication or consideration in reduction of resource allocation.

- Although India was the signatory of the declaration of Primary Health Care of Alma Ata but by the National Health Policy of 2002 it was evaded.
- Subsidies were technically shifted from public sector to private sector.

Reason behind the significant change in policy paradigm, especially from 1990's to the beginning of the twenty first century, was not only the change in world context but the massive alteration in Indian society itself. The emergence of middle class and their demand of advanced hospital service matching with the international standard and establishment of luxurious hospital changed the understanding of the people about the best in hospital care.[27] Super specialty hospital, five star hospital, luxury in health care became the part of standard of health service where medical bureaucracy, grounded in middle class, supported in the trends. Ruling political parties, taking the opportunity of lessening the burden of free health care facility to the people, were able to patronage the health service as a commodity to international market. To cope the global market state took two more initiatives;[28] it worked as an agency for ensuring the facility of private market and parallel worked as buyer of available technologies of health services for the poor section of the society. The withdrawal of welfare seriously impacted the formulation of health sector policy and its application.

National Rural Health Mission (NRHM)

The National Rural Health Mission (2005-2012) envisioned the effective health care to rural people in the country focusing on 18 states those have weak health infrastructure and health indicators. It's mission was to increase the public expenditure on health from 0.9% to 2-3% of GDP. Female health workers in each village were its key component. Through the district plan for health, it aimed at health concerns like sanitation & hygiene, safe drinking water and nutrition would be effectively integrated. It took plan to improve the access of rural population, especially children and poor women to an affordable, accountable, equitable and effective primary health care.[29]

Analysis of the NRHM

The NRHM was the initiative of the Government of India for addressing the health need of rural population, through the application of the programs under the NRHM the health system of India was strengthened. Number of total health worker in the name of Accredited Social Health

Activists (ASHA) reached to 900000, who brought the population closer to the public health services.[30] The NRHM used over 18000 ambulances all over the country for free urgent response to patient transport service which served one million patients monthly. With the addition of more than 178000 health workers and providing cash incentive to the pregnant mothers the destitute women got free care which reduced the institutional gap between patients and health service care. But all the goals of the NRHM was not fulfilled where reduced monetary support was one of the causes. Mission was to increase the health budget but it did not appear according to the plan. India spends only one percent of total GDP in public health whereas China use 3% and the USA 8.3%.[31]

National Health Policy Draft 2015

The National Health Policy Draft 2015 was placed in public domain for feedback, suggestions and comments. Within thirteen years of second health policy the new health policy was prescribed by the Ministry of Health and Family Welfare due to four major contextual changes. Firstly, the health priorities are being changed, there are increasing burden of non-communicable disease. Secondly, the emergence of health care industry with 15% compound annual growth rate. Thirdly, growing expenditure of the health care services is the major contributor of poverty. Fourthly, economic growth increased the economic capacity available. Besides political will for ensuring universal access to affordable health care services, the commitment of health assurance is an important factor behind framing the new health policy.[32]

The policy draft was written on the aspiration of being developed country with the growing Gross National Income and now India possesses sophisticated technologies and knowledge for providing health care to the population. Policy draft observed the huge ill-health, disease, premature death and suffering as unnecessary within in the ability of effective and accessible intervention for prevention and treatment.

It is observed that the health insurance schemes are varied widely in terms of benefit and facilities in the secondary and tertiary care. So, it is proposed that all state level and national health insurances need to be aligned into a single insurance schemes which will reduce the fragmentation. The Rashtriya Swasthya Bima Yojana (RSBY), under the Ministry of Health and Family Welfare, would help the central ministry and state from a single payer system approach. In this way ministry would be able to compare the relative cost of alternative financing through service purchase both from private and public sectors, which is marked as the best decision in the given context.

Conclusion

From the comprehensive primary health care, through government efforts prescribed by the Alma Ata declaration, to the universal health coverage, through insurance prescribed by the National Health Policy Draft 2015, manifest the shift of health policy paradigm in India. These types of shifting in paradigm of health policy are completely divergence of the spirit of India on which it was developed in the 1950's. Inspiration of 1950's was to build a social democratic country encouraging public health sector for the citizens irrespective of their paying ability. This turn in direction was occurred within the health policy paradigm of India due to larger private development context designed by international and national pressure groups. Interestingly, within very limited resources in 1950's, the country committed to its citizens for free health care to all but in 1990s, within flourished economy and strong middle class, the state did not bother to take care of citizens' health specially poor section of the society.

India as a third largest economy of Asia spends only one percent of GDP. It denotes that the health care system is not getting satisfactory attention from the government level. K. Srinath Reddy, President of Public Health Foundation of India opines that if budgetary allocation is not increased, the promise of universal health coverage will not be fulfilled.[33] In spite of rapid economic growth in last two decades adequate budget is not allocated in the public health sector and consequently the poor network of hospital sector and incompetency of public sector in comparison to private are evident these days.

The Alma Ata Declaration covered the values of equity, universality, comprehensiveness and self-reliance integrating socio-economic and political context. It had intellectual and moral obligation to the human. Although it was propagated that the SPHC was less costly and attainable but it's implications to the marginal section of people was not calculated. Government of India endorsed the National Health Policy of 1983 which was more inclined to the Alma Ata. But commercialization and neoliberal economy solicited for the evolvement of private sector in the health service. In the new context of market based economy the Government of India endorsed the National Health Policy of 2002 emphasizing on private sector involvement in health services. In the continuation of the patronization of the private sector, Government again placed the draft of the National Health Policy 2015 in public domain with the ideal of universal health coverage based on insurance which is supportive to the new trend of economy in health care development.

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