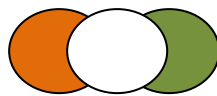


Post Graduate Certificate Course in Health System and Management - 2013



Module 1: Chapter 4

Various Health Committees



**Indian Association of Preventive and Social Medicine
Gujarat Chapter**

Health Planning in India

Learning objectives

The students should be able to:

1. Describe the contribution of Bhore committee towards health planning in India
2. Describe various health committees in post-independence era.
3. Describe the recommendation of various health committees

The guidelines for national health planning were provided by a number of committees. These committees were appointed by government of India from time to time to review the existing health situation & recommend measures for further action. A brief review of recommendations of these committees is given below.

In 1940, the resolution adopted by the National Planning Committee based on the **Sokheys Committee's** recommendations recommended integration of preventive and curative functions and the training of a large number of health workers. Bhore committee constituted in 1943 laid the framework on which the health care was eventually built in the independent India. The health care in India has since moved from bureaucratic government based top down approach to decentralized community based bottom- up system after the Panchayati Raj came into being. This model was long ago propagated by the Father of the nation "Mahatma Gandhi".

Bhore Committee (1943-1946)

During pre independence era, to improve the preventive, promotive and curative health services of country, a National Planning Commission was set up by the Indian National Congress in 1938. The rulers of that time, the British Empire realised the importance of Public Health and instituted the 'Health Survey and Development Committee,' in the year 1943 under the chairmanship of Sir Joseph Bhore. The committee was tasked to survey the then health conditions and health organisations in the country, and to make recommendations for future development. The committee submitted its report in 1946. The integration of preventive, promotive and curative health services and establishment of Primary Health Centres in rural areas were the major recommendations made by this committee.

Important recommendations of the Bhore Committee

1. Integration of Preventive, Promotive and Curative services at all administrative levels.
2. The development of Primary Health Centres for the delivery of comprehensive health services to the rural India. Each PHC should cater to a population of 40,000 with a Secondary Health Centre (now called Community Health Centre) to serve as a supervisory, coordinating and referral institution.
3. In the long term (3 million plan), the PHC would have a 75 bedded hospital for a population of 10,000 to 20,000.

4. It also reviewed the system of medical education and research and included compulsory 3 months training in Community Medicine.
5. Committee proposed the development of National Programmes of health services for the country.

The details of the **Long term plan** recommended by Bhore Committee are as follows:

The district health scheme, also called the three million plan, which represented an average districts population was to be organized in a 3-tier system within a period of 30 to 40 years. At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health service at its headquarters and of supervising the work of these primary units. The headquarters of the district will be provided with an organization which will include, within its scope, all the facilities that are necessary for modern medical practice as well as the supervisory staff who will be responsible for the health administration of the district in its various specialized types of services.

Primary Unit

Every 10,000 to 20,000 population (depending on density from one area to another) would have a 75-bedded hospital served by six medical officers including medical, surgical and obstetrical and gynaecological specialists. This medical staff would be supported by 6 public health nurses, 2 sanitary inspectors, 2 health assistants and 6 midwives to provide domiciliary treatment. At the hospital there would be a complement of 20 nurses, 3 hospital social workers, 8 ward attendants, 3 compounders and other non-medical workers. Two medical officers along with the public health nurses would engage in providing preventive health services and curative treatment at homes of patients. The sanitary inspectors and health assistants would aid the medical team in preventive and promotive work. Preferably at least three of the six doctors should be women. Of the 75 beds, 25 would cater to medical problems, ten for surgical, ten for obstetrical and gynaecological, twenty for infectious diseases, six for malaria and four for tuberculosis. This primary unit would have adequate ambulatory support to link it to the secondary unit when the need arises for secondary level care. Each province was given the autonomy to organize its primary units in the way it deemed most suitable for its population, but there was to be no compromise on quality and accessibility.

Secondary Unit

About 30 primary units or less would be under a secondary unit. The secondary unit would be a 650-bedded hospital having all the major specialities with a staff of 140 doctors, 180 nurses and 178 other staff including 15 hospital social workers, 50 ward attendants and 25 compounders. The secondary unit besides being a first level referral hospital would supervise, both the preventive and curative work of the primary units.

The 650 beds of the secondary unit hospital would be distributed as follows: Medical 150, Surgical 200, Obs. & Gynae 100, Infectious Disease 20, Malaria 10, Tuberculosis 120, and Paediatrics 50. Total 650.

District Hospital

Every district centre would have a 2500 beds hospital providing largely tertiary care with 269 doctors, 625 nurses, 50 hospital social workers and 723 other workers. The hospital would have 300 medical beds, 350 surgical beds, 300 obs. & gynae beds, 540 tuberculosis beds, 250 pediatric beds, 300 leprosy beds, 40 infectious diseases beds, 20 malaria beds and 400 beds for mental diseases. A large number of these district hospitals would have medical colleges attached to them. However, each of the three levels would have functions related to medical education and training, including internship and refresher courses.

This document laid the utmost emphasis on primary health care; it needs no emphasis that primary health care was later on recognised as the key strategy to achieve Health for All (HFA) by 2000 during Alma-Ata conference. The Bhore committee model was based on the allopathic system of medicine. The traditional health practices and indigenous system of medicine prevalent in rural India, which had great influence and were part of their socio-cultural milieu were not included in the model proposed by Bhore committee. The approach was not entirely decentralized but had a top down approach. However it provided a ready-made model at the time of independence and thus was adopted as a blue print for both health policy and development of the country.

Post Independence Era:

With the beginning of health planning in India and first five-year plan formulation (1951-55), **Community Development Programme** was launched in **1952** for the all-round development of rural areas, where 80% of the population lived. Community Development was defined as "a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance upon the community's initiative". The Community Development Programme was envisaged as a multipurpose programme covering health and sanitation (through the establishment of primary health centres and sub-centres) and other related sectors including agriculture, education, transport, social welfare and industries. Each Community Development Block (CDB) comprised approximately 100 villages with a total population of one lakh. For one CDB, one Primary Health Centre was created. (11)

By the close of second five year plan (1956-61), "Health Survey and Planning Committee", The **Mudaliar Committee (1961)**, was appointed by the Government of India to review the progress made in the health sector after submission of Bhore committee report. The major recommendation of this committee report were:

- a. to limit the population served by primary health centres to 40,000 with the improvement in the quality of health care provided by these centres.
- b. Strengthening of the district hospitals with specialist services to serve as a central base of regional services.
- c. Regional organisations in each state between headquarter organisation & the district incharge of a Regional deputy or assistant directors each to supervise 2 or 3 district medical & health officers.
- d. Constitution of an All India Health Service on pattern of Indian Administrative Service.

The **Chaddah committee (1964)**, recommended provision of one basic health worker per 10,000 population for vigilance operations through monthly home visits under national malaria eradication programme. These workers were envisaged as multipurpose health workers to look after additional duties of collection of vital statistics & family planning. The family planning health assistants were to supervise 3 or 4 of these basic health workers.

In a short time after implementation of MPHW scheme it was realised that malaria vigilance operations & family planning program could not be carried out satisfactorily. A committee known as **Mukerjee committee** was formed in **1965** & it recommended separate staff for Family planning activities so that malaria activities could receive undivided attention of its staff.

The **Jungalwalla Committee** in **1967** gave importance to integration of health services & elimination of private practice by government doctors. Integrated health services were defined as "a service with a unified approach for all problems instead of a segmented approach for all different problems". Care of the sick & various public health programmes functioning under a single administrator. The committee recommended:

- | | |
|---------------------------------------|-------------------------------------|
| a. Unified cadre | d. Equal pay for equal work |
| b. Common seniority | e. Special pay for specialised work |
| c. Recognition of extra qualification | f. No private practice |

The **Kartar Singh Committee** on Multipurpose workers in **1973** laid down the norms about health workers. For ensuring proper coverage the committee recommended, one primary health centre to be established for every 50,000 population. Each primary health centre to be divided into 16 sub-centres each for a population of 3,000 to 3,500. Each sub-centre to be staffed by a team of one male and one female health worker. The work of 3-4 health workers to be supervised by one health assistant. The doctor in charge of the PHC should have the overall charge of all supervisors & health workers in his area.

The **Shrivastav Committee** on Medical Education and Support Manpower in **1975** suggested:

- A. Creation of bands of Para-professional and semi-professional health workers from within the community (e.g. school teachers, post masters, gramsevak, etc.) to provide simple health services needed by the community.
- B. the development of a "Referral Service Complex" by establishing linkages between the primary health centre and higher level referral and service centres, viz taluka/ tehsil, district, regional and medical college hospitals.
- C. establishment of a medical & health education commission for planning & implementation of reforms needed in health & medical education on the lines of university grant commission.
- D. One male & female HW should be available for every 5000 population.
- E. The Health Assistants for every two HWs should be located at SC & not at PHC

Following the suggestions of the Shrivastav committee report, **Rural Health Scheme** was launched in **1977**, wherein training of community health workers, reorientating medical education (ROME) training of multipurpose workers, and linking medical colleges to rural health was initiated. It was based on principle "*placing people's health in people's hands*". Also to initiate community participation, the Community Health Volunteer-Village Health Guide (VHG) Scheme was launched. The VHG was to be a person from the village, mostly women, who was imparted short term training and small incentive for the work.

Shivaraman Committee health report

A Committee on Basic Rural Doctors was framed under the guidance of Shri Shivaraman, then member of planning commission. The committee recommended establishment of countrywide cadre of basic rural doctors consisting of trained paraprofessionals to extend comprehensive health care delivery to rural community.

Bajaj Committee health report 1986

An expert committee for 'health manpower planning, production and management' was constituted under the chairmanship of Dr JS Bajaj, then member of planning commission, to tackle the problem of health manpower planning, production and management. Important recommendations of the Bajaj committee are:

1. Recommended for Formulation of National Health Manpower planning based on realistic survey.
2. Educational Commission for health sciences should be developed on the lines of UGC.

3. Recommended for National and Medical education policy in which teachers are trained in health education science technology.
4. Uniform standard of medical and health science education by establishing universities of health sciences in all states.
5. Establishment of health manpower cells both at state and central level.
6. Vocational courses in paramedical sciences to get more health manpower.

Krishnan Committee Health Report 1992

The committee under the chairmanship of Dr Krishnan reviewed the achievements and progress of previous health committee reports and also made comments on shortfalls. The committee address the problems of urban health and devised the health post scheme for urban slum areas. The committee had recommended one voluntary health worker (VHW) per 2,000 population with an honorarium of Rs 100. Its report specifically outlines which services have to be provided by the health post. These services have been divided into outreach, preventive, family planning, curative, support (referral) services and reporting and record keeping. Outreach services include population education, motivation for family planning, and health education. In the present context, very few outreach services are being provided to urban slums.