

## Primary Health Care in India: Review of Policy, Plan and Committee Reports

**P** RIMARY HEALTH CARE' IS A TERM THAT IS USED EXTENSIVELY WORLDWIDE BY policy-makers. What does this term imply? Is it merely a term or does it hold within it a much wider and deeper significance to the concept of health?

The Alma Ata Declaration in 1978 gave an insight into the understanding of primary health care. It viewed health as an integral part of the socioeconomic development of a country. It provided the most holistic understanding to health and the framework that States needed to pursue to achieve the goals of development. The Declaration recommended that primary health care should include at least: education concerning prevailing health problems and methods of identifying, preventing and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health and provision of essential drugs. It emphasized the need for strong first-level care with strong secondary- and tertiary-level care linked to it. It called for an integration of preventive, promotive, curative and rehabilitative health services that had to be made accessible and available to the people, and this was to be guided by the principles of universality, comprehensiveness and equity. In one sense, primary health care reasserted the role and responsibilities of the State, and recognized that health is influenced by a multitude of factors and not just the health services. It also recognized the need for a multisectoral approach to health and clearly stated that primary health care had to be linked to other sectors. At the same time, the Declaration emphasized on complete and organized community participation, and ultimate self-reliance with individuals, families and communities assuming more responsibility for their own health, facilitated by support from groups such as the local government, agencies, local leaders, voluntary groups, youth and women's groups, consumer groups, other non-governmental organizations, etc. The Declaration affirmed the need for a balanced distribution of available resources (WHO 1978).

Keeping this definition in mind, we now discuss whether this holistic concept has been utilized as a framework to guide policy-makers to develop various health policy documents, health committee reports and the five-year plans since Independence so as to impact on the health system.

After Independence, India adopted the welfare state approach, which was dominant worldwide at that time. As with most post-colonial nations, India too attempted to restructure its patterns of investment. During that time, India's leaders envisaged a national health system in which the State would play a leading role in determining priorities and financing, and provide services to the population.

'If it were possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through malnutrition and preventable morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about' (Bhore Committee Report 1946).

The emphasis of the first health report, i.e. the Health Planning and Development Committee's Report, 1946 (popularly known as the Committee Report) on the role of the State was explicit. It was a plan equivalent to Britain's National Health Service. The Report was based on a countrywide survey in British India. It is the first organized set of health care data for India. The poor health status was attributed to the prevalence

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of insanitary conditions; malnutrition and undernutrition leading to high infant and maternal mortality rates; inadequacy of the existing medical and preventive health organizations; lack of general and health education; unemployment and poverty that produced adverse effects on health and resulted in inadequate nutrition; improper housing and lack of medical care. Intersectoral linkages were well discussed with nutrition, housing and employment as essential precursors for healthy living. It considered that the health programme in India should be developed on a foundation of preventive health work and proceed in the closest association with the administration of medical relief. The Committee strongly recommended a health services system based on the needs of the people, the majority of whom were deprived and poor. It felt the need for developing a strong basic health services structure at the primary level with referral linkages. It also recommended the need to invest in the pharmaceutical sector to develop indigenous capabilities and reduce excessive reliance on multinational companies. India was therefore one of the few developing countries which adopted a health policy that integrated the principles of universality and equity. Community participation and cooperative efforts to promote preventive and curative health work was important to achieve a vibrant health system. The Committee felt that large sections of the people were living below the normal subsistence level and they could not afford to pay for or contribute to the health services. It was decided that medical benefits would have to be supplied free to all at the point of delivery and those who could afford to pay should channel contributions through the mechanism of taxation. Though the report stated that '...it will be for the governments of the future to decide ultimately whether medical service should remain free to all classes of the people or whether an insurance scheme would be more in accordance with the economic, social and political requirements of the country at the time' (Bhore Committee Report 1946), one point was apparent—that no individual should fail to secure adequate medical care, curative and preventive because of the inability to pay for it. They recommended that State Governments should spend a minimum of 15% of their revenues on health activities.

The National Planning Committee (NPC) set up by the Indian National Congress in 1938 under the chairmanship of Colonel S. Sokhey stated that the maintenance of the health of the people was the responsibility of the State, and the integration of preventive and curative functions in a single state agency was emphasized. The Sokhey Committee Report was not as detailed as the Bhore Committee Report but endorsed the recommendations of the Bhore Committee Report and commented that it was 'of the utmost significance' (Banerji 1985).

The objectives of the First (1951-56) and Second Five-Year (1956-61) Plans were to develop the basic infrastructure and manpower visualized by the Bhore Committee. Though health was seen as fundamental to national progress, less than 5% of the total revenue was invested in health. The following priorities formed the basis of the First Five-Year Plan: provision of water supply and sanitation; control of malaria; preventive health care of the rural population through health units and

mobile units; health services for mothers and children; education, training and health education; self-sufficiency in drugs and equipment; family planning and population control. Starting from the first plan, vertical programmes started, which became the centre of focus. The Malaria Control Programme, which was made one of the principal programmes, apart from other programmes for the control of TB, filariasis, leprosy and venereal diseases, was launched. Health personnel were to take part in vertical programmes. However, the first plan itself failed to create an integrated system by introducing verticality.

The concern of the Health Survey and Planning Committee (Mudaliar Committee 1962) was limited to the development of the health services infrastructure and the health cadre at the primary level. It felt the growth of infrastructure needed radical transformation and further investment. Another major shift came in the Third Plan (1961-66) when family planning received priority for the first time. Increase in the population became a major worry and was seen as a hurdle to the development process. Although the broad objective was to bring about progressive improvement in the health of the people by ensuring a certain minimum level of physical well-being and to create conditions favourable for greater efficiency, there was a shift in focus from preventive health services to family planning. During the Fourth Plan (1969-74), efforts were made to provide an effective base for health services in rural areas by strengthening the PHCs. The vertical campaigns against communicable diseases were further intensified.

During the Fifth Plan (1974-79), policy-makers suddenly realized that health had to be addressed alongside other development programmes. The Minimum Needs Programme (MNP) promised to address all this but became an instrument through which only health infrastructure in the rural areas was to be expanded and further strengthened. It called for integration of peripheral staff of vertical programmes but the population control programme got further impetus during the Emergency (1975-77) and most of the basic health workers got sucked into the family planning programme. Meanwhile the Chaddha Committee Report (1963), the Kartar Singh Committee Report on Multipurpose Workers (1974) and the Srivastava Committee Report on Medical Education and Support Manpower (1975) remained focused on giving recommendations on how the health cadres at the primary level should be distributed.

With the widespread disillusionment with vertical programmes worldwide and the need to provide universal health services came the Primary Health Care Declaration at Alma Ata in 1978, which India was a signatory to. The Sixth Plan (1980-84) was influenced by two policy documents: the Alma Ata Declaration and the ICMR/ICSSR report on 'Health for All by 2000'. The ICMR/ICSSR Report (1980) was in fact a move towards articulating a national health policy that was thought of as an important step to realize the Alma Ata Declaration. It was realized that one had to redefine and rearticulate and get back into track an integrated and comprehensive health system that policy-makers had wavered from. It reiterated the need to integrate the development of the health system with the overall plans of socioeconomic and political change.

It recommended that the Government formulate a comprehensive national health policy dealing with all dimensions—environmental, nutritional, educational, socio-economic, preventive and curative. The National Health Policy, 1983 attempted to incorporate all these. Provision of universal, comprehensive primary health services was its goal. A large number of private and voluntary organizations who were active across the country in the health field were to support the Government in its efforts to integrate health services. Evolving a decentralized system of health care and nationwide chain of epidemiological stations were some of the main recommendations.

Once again, a selective approach to health care became the focus when a strong lobby questioning the financial repercussions of the primary health care approach came up. Verticality was reintroduced as an 'interim' arrangement and interventions of immunization, oral rehydration, breastfeeding and antimalarial drugs were suggested (Warren 1988). This was seen as a technical solution even before comprehensive primary health care could be realized. UNICEF too came out with its report on The state of the world's children and suggested immunization as the spearhead in the selective GOBI-FF (growth monitoring, oral rehydration, breastfeeding, immunization, food supplements for pregnant women and children, and family planning) approach (Rifkin and Gill 1986). Programme-driven health policies were once again the central focus.

The plan documents henceforth, emphasized on restructuring and developing the health infrastructure, especially at the primary level. The Seventh Plan (1985–90) restated that the rural health programme and the three-tier health services system need to be strengthened and that the government had to make up for the deficiencies in personnel, equipment and facilities. The Eighth Plan (1992–97) distinctly encouraged private initiatives, private hospitals, clinics and suitable returns from tax incentives. With the beginning of structural adjustment programmes and cuts in social sectors, excessive importance was given to vertical programmes such as those for the control of AIDS, tuberculosis, polio and malaria funded by multilateral agencies with specified objectives and conditions attached. Both the Ninth (1997–2002) and the Tenth Five-Year Plans (2002–2007) start with a dismal picture of the health services infrastructure and go on to say that it is important to invest more on building good primary-level care and referral services.

Both the plans highlight the importance of the role of decentralization but do not state how this will be achieved.

The National Health Policy (2002) includes all that is wanted from a progressive document and yet it glosses over the objective of NHP 1983 to protect and provide primary health care to all. The Policy document talks of integration of vertical programmes, strengthening of the infrastructure, providing universal health services, decentralization of the health care delivery system through panchayati raj institutions (PRIs) and other autonomous institutions, and regulation of private health care but fails to indicate how it achieves the goals. It encourages the private sector in the first referral and tertiary health services.

## Conclusion

The overview of the plans and policy reports not only throws light on the gap between the rhetoric and reality but also the framework within which the policies have been formulated. There has been an excessive preoccupation with single-purpose driven programmes. Above all, the spirit of primary health care has been reduced to just primary level care. The health reports and plans mostly concentrated on building the health services infrastructure and even this lacked a sense of integration. Most of the policy reports miss out on the importance of a strong referral system. Instead, there has been more emphasis on building the primary level care and even that has lacked proper implementation. The Bhore committee report and later, the Primary Health Care Declaration discussed the operational aspects of integrating the other sectors of development related to health. The multisectoral approach that is much needed and the intersectoral linkages that are essential for a vibrant health system have not been well thought out, and there has been no plan drawn out for it later. The outline of plan documents and their implementation have been incremental rather than being holistic. It is important to question whether it is only the low investment in health that is the main reason for the present status of the health system or is it also to do with the framework, design and approach within which the policies have been planned.

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## References

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**Banerji D.** Health and family planning services in India: An epidemiological, socio-cultural and political analysis and a perspective. New Delhi: Lok Paksh; 1985.

**Government of India.** Report of the Health Survey and Development Committee, Vol. II (Chairman: Bhore). Delhi: Manager of Publications; 1946.

**Government of India.** First Five-Year Plan (1951-56) to Tenth Five-Year Plan (2002-2007). New Delhi: Planning Commission of India; 1961.

**Government of India.** Report of the Health Survey and Planning Committee, (Chairman: Mudaliar). New Delhi: Ministry of Health; 1961.

**Government of India.** Report of the Committee of Multi-purpose Workers under Health and Family Planning Programme (Chairman: Kartar Singh). New Delhi: Ministry of Health and Family Planning; 1973.

**Government of India.** Health Series and Medical Education: A Programme for Immediate Action: A Report of the Group on Medical Education and Support Manpower (Chairman: Srivastava). New Delhi: Ministry of Health and Family Planning; 1975.

**Government of India.** Statement on National Health Policy. New Delhi: Ministry of Health and Family Welfare; 1983.

**Government of India.** National Health Policy 2002. New Delhi: Ministry of Health and Family Welfare; 2002.

**Indian Council of Social Science Research (ICSSR) and Indian Council of Medical Research (ICMR).** Health for All: An alternative strategy. Report of a Study Group. New Delhi: ICSSR; 1980.

**Rifkin SB, Gill W.** Why health improves: Defining the issues concerning comprehensive primary health care and selective primary health care. *Social Science and Medicine* 1986;23:559-66

**Warren KS.** The evolution of selective primary health care. *Social Science and Medicine* 1988;26:891-8.

**World Health Organization.** Primary Health Care: Report of the International Conference on Primary Health Care. Geneva: WHO; 1978.