

## Origin and Evolution of Primary Health Care in India

### Pre-Alma Ata Declaration Period

Primary Health Care is a vital strategy that remains the backbone of health service delivery. India was one of the first countries to recognize the merits of Primary Health Care Approach (PHC). PHC was conceptualized in 1946, three decades before the Alma Ata declaration, when Sir Joseph Bhore made recommendations that formed the basis for organization of basic health services in India. The Bhore Committee report laid emphasis on social orientation of medical practice and high level of public participation. The salient features of this committee are presented in the Box 1.1

#### Box 1.1 : The Bhore Committee: Salient Recommendations

1. Integration of preventive and curative services at all administrative levels
2. Short Term- Primary Health Centres for 40,000 population
3. Long Term (Three million Plan)- Primary Health Centres with 75 beds for each 10,000-20000 population
4. Formation of Village Health Committee
5. Provision of Social Doctor
6. Inter-sectoral approach to health services development.
7. Three months' training in preventive and social medicine to prepare social physicians.

Source: Report of the Health Survey and Development Committee, Government of India: New Delhi; 1946.

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 subcentres) 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.

By the close of second five year plan (1956-61), "Health Survey and Planning Committee", The **Mudaliar Committee**, 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 was 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. Also, Provision of one basic health worker per 10,000 population was recommended.

The **Jungalwalla Committee** in 1967 gave importance to integration of health services. Integrated health services were defined as "a service with a unified approach for all problems instead of a segmented approach for all different problems". The committee recommended integration from the highest to lowest level in the services, organization and personnel.

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 **Shrivastav Committee** on Medical Education and Support Manpower in 1975 suggested creation of bands of Para-professional and semi-professional health workers from within the community (e.g. school teachers, post masters etc.). It also recommended 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.

Following the suggestions of the Shrivastav committee report, **Rural Health Scheme** was launched in 1977, wherein training of community health workers, reorientation training of multipurpose workers, and linking medical colleges to rural health was initiated. 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. An Illustration of rural health care system in India is presented in Box 1.2.

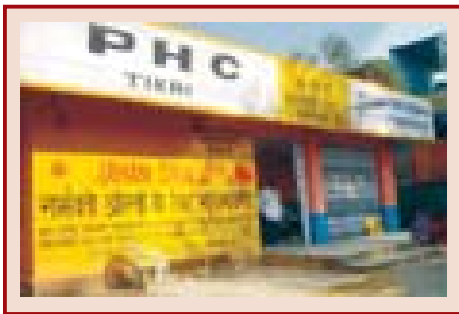


Photo Credit : NRHM Photo Gallery

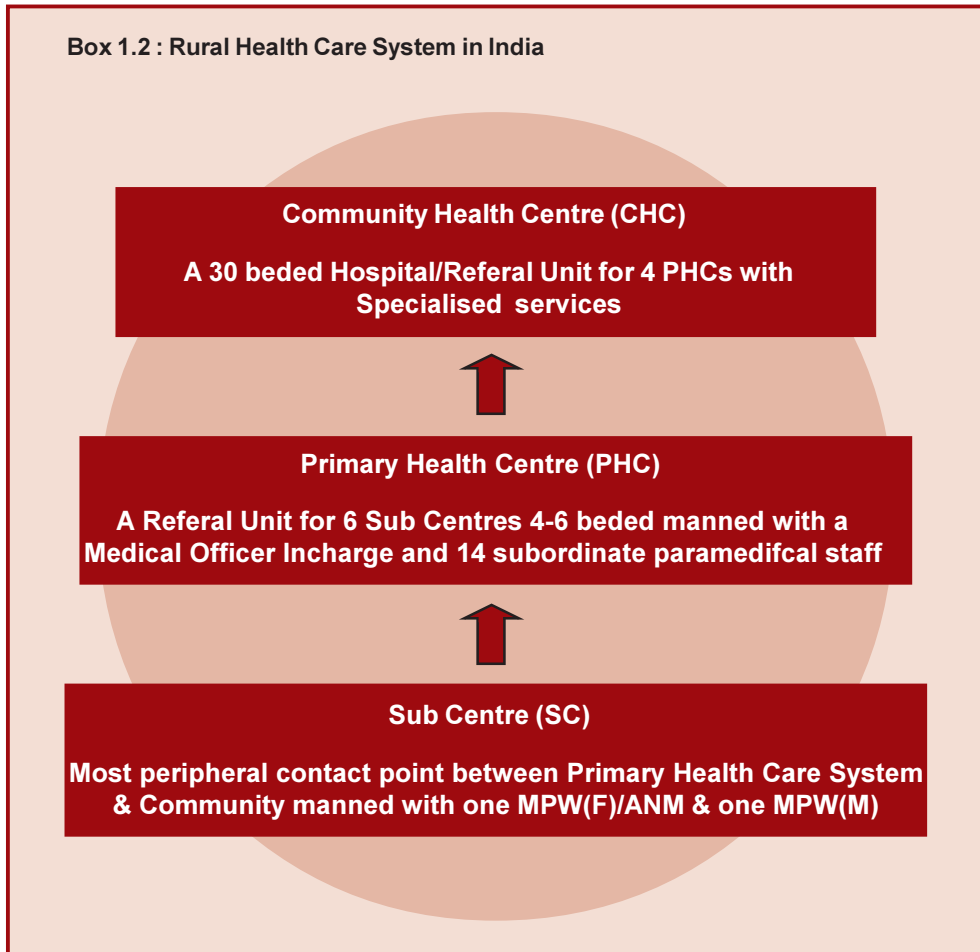


Photo Credit : NRHM Photo Gallery

## **Alma Ata Declaration and Beyond**

The Alma Ata declaration of 1978 launched the concept of Health for all by year 2000. It was signed by 134 governments (including India) and 67 other agencies. The declaration advocated the provision of first contact services and basic medical care within the framework of an integrated health services.

**Box 1.2 : Rural Health Care System in India**



Source: Rural Health Statistics, Ministry of Health and Family Welfare, Government of India, New Delhi, 2007.

The declaration asserted *"PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."*

Several critical efforts outlined Government of India's commitment to provide health for all of its citizens after Alma Ata Declaration. The Report of the Study Group on **"Health for All - An Alternate Strategy"** commissioned by ICSSR and ICMR (1980) argued that most of the health problems of a majority of India's population were amenable to being solved at the primary health care level through community participation and ownership. The report recommended the formulation of a comprehensive national health policy through an inter-sectoral approach that includes environment, nutrition, education, socio-economic, preventive, and curative dimensions. The Report of the Working Group on **"Health for All by 2000 AD"**, also examined the contextual issues in providing health care. The report set out health targets to be achieved by 2000 AD for which existing health services and manpower had to be increased substantially.

The responsibility of the state to provide comprehensive primary health care to its people as envisioned by the Alma Ata Declaration led to the formulation of India's **1<sup>st</sup> National Health Policy (NHP)** in 1983. The major goal of policy was to provide of universal, comprehensive primary health services. The policy emphasized the role that could be played by private and voluntary organizations working in the country to support government for integration of health services.

A selective approach as an "interim" measure to the long-term process of comprehensive primary health care implementation was introduced in many countries, including India. Led by Walsh and Waren (1979), it was argued that resource constraints made it "not possible" to achieve the Alma Ata goals within the committed time limit. Thus, the focus shifted from the development of health systems and infrastructure for primary health care and ensuring health equity to several vertical interventions based on technical justifications and cost-effectiveness analysis. UNICEF also suggested its selective approach

of GOBI-FFF (Growth monitoring, oral rehydration therapy, breast feeding, immunization, female literacy, family planning, food supplements for pregnant women) for improving child survival.

By the turn of the millennium, despite some gains in health outcomes and vast improvements in the availability of health infrastructure through a three-tier network, India had yet to achieve most of the goals enshrined in its first national health policy.

The **National Population Policy (NPP)** was announced in the year 2000, the overarching policy framework for family planning and maternal and child health goals, objectives and strategies. The immediate Objective of NPP was to address the unmet needs of contraception, health care infrastructure, and health personnel, and to provide integrated delivery for basic reproductive and child care services. It envisaged development of one-stop integrated and coordinated service delivery at the village level for basic reproductive and child health services through a partnership of the government with voluntary and non-governmental organizations.

Nearly twenty years after the first health policy, the **II<sup>nd</sup> National Health Policy (2002)** was presented. The NHP 2002 recognized the noteworthy successes in health since the enunciation of the first NHP in 1983. These successes included the eradication of small pox and guinea worm, the near eradication of polio, and progress towards the elimination of leprosy and neonatal tetanus. The NHP sets out a new policy framework to achieve public health goals in the socio-economic circumstances currently prevailing in the country. The approach aims at increasing access to the decentralized public health system by establishing new infrastructure in deficient areas and upgrading the infrastructure of existing institutions. It sets out an increased sectoral share of allocation out of total health spending to primary health care. The major goals of NHP 2002 are presented in the Box 1.3.

**Box 1.3 : National Health Policy 2002.**

<b>Major Goals to be achieved by</b>	<b>Year</b>
Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kala Azar	2010
Eliminate Lymphatic Filariasis	2015
Achieve zero level growth of HIV/AIDS	2007
Reduce mortality by 50% on account of TB, Malaria, other vector and water borne diseases	2010
Reduce prevalence of blindness to 0.5%	2010
Reduce IMR 30/1000 and MMR 100/lakh	2010
Increase utilization of public health facilities from <20% to >75%	2010
Establish an integrated system of surveillance, national health accounts and health statistics	2005
Increase health expenditure by Govt. as a % of GDP from existing 0.9% to 2%	2010
Increase share of central grants to constitute at least 25% of total health spending	2010
Increase the state sector health spending from 5.5% to 7% of the budget	2005
Further increase to 8% of the budget	2010

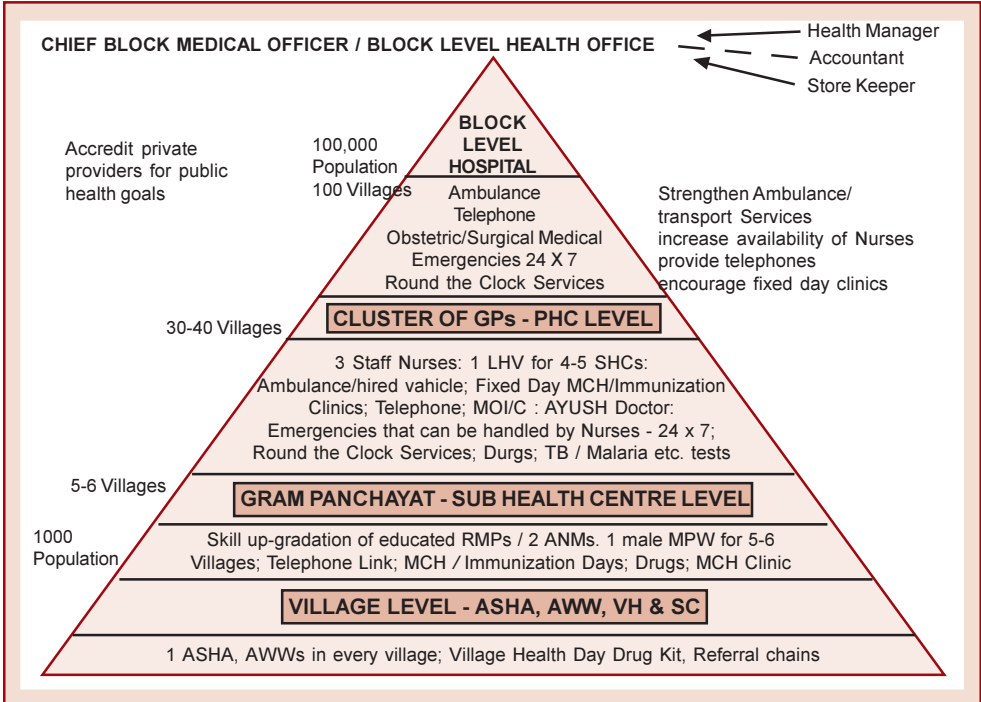
Source: National Health Policy-2002 Ministry of Health and Family Welfare, Government of India, New Delhi.

More recently (2005), the Government of India has launched the **National Rural Health Mission (NRHM)**, with the goal of improving the availability of and access to quality health care by people, particularly in rural areas. The Mission envisages a synergistic primary health care approach for decentralized health planning and implementation at the village and district level. The mission was made operational from April 2005 throughout the country with special focus on 18 states having weak demographic indicators and infrastructure. The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to the poor and vulnerable sections of the community. It reaffirms the political

will to increase public health fund allocation to 2-3% of GDP from existing allocation of 0.9% of GDP.

NRHM is visualized as an architectural correction of the Indian public health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country. It envisages appropriate health personnel to be placed at different levels starting from village level in fully functioning health centers with adequate linkages amongst different levels. An Illustrative Structure model is depicted in Figure 1.1 showing health structures functioning at different levels with a set of key health personnel performing adequate functioning in coordination with others sectors.

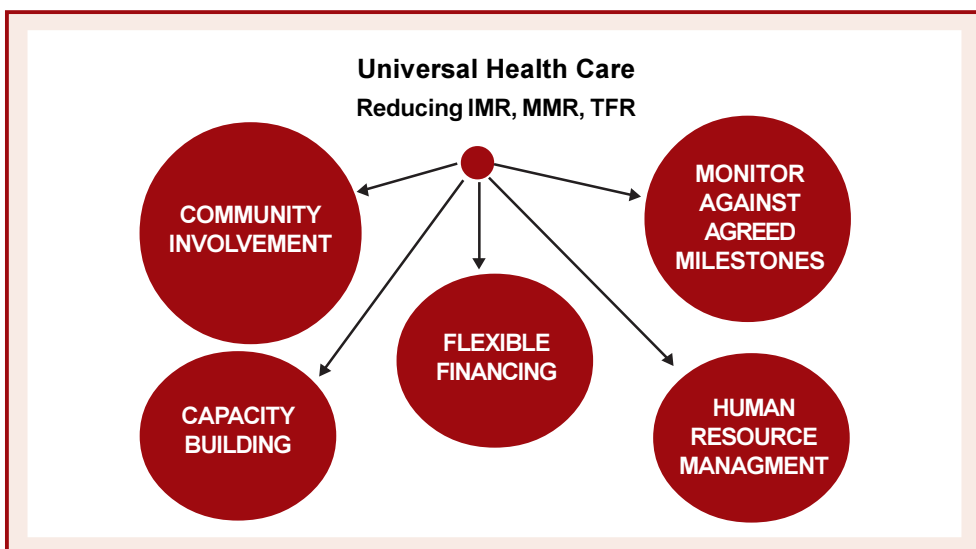
**Figure 1.1 : NRHM - Illustrative Structure**



Source: NRHM, Framework for Implementation, 2005-12, Ministry of Health and Family Welfare, Government of India, New Delhi.

NRHM has as its key components as provision of a female health activist in each village; a village health plan formulation through a local team headed by the health and sanitation committee of the Panchayat; strengthening of rural hospitals for effective curative care and making them measurable and accountable to the community through Indian Public Health Standards (IPHS); integration of vertical health and family welfare programmes; strengthening of primary health care through optimal utilization of funds, infrastructure and available manpower. NRHM works on five key approaches- communitization emphasizing community involvement, flexible financing for increased monetary autonomy at different levels, capacity building to empower multiple stakeholders for efficient health delivery and human resource management to generate more manpower and equipping health personnel with adequate multiple skills. (Figure1.2). The strategies proposed in NRHM are illustrated in Box 1.3.

Figure 1.2 : NRHM Goals & Approaches



Source: NRHM, Framework for Implementation, 2005-12, Ministry of Health and Family Welfare, Government of India, New Delhi.

### **Box 1.3 : Strategies under National Rural Health Mission**

#### **Core Strategies under Mission:**

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the village level worker (Accredited Social Health activist- ASHA)
- Health plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through better human resource development, clear quality standards, better community standards, better community support and an untied fund to enable local planning and action and more Multipurpose workers
- Strengthening existing Primary Health Centres through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.
- Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (Indian Public Health Standards defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels)
- Preparation and implementation of an inter-sector district health plan prepared by district health mission, including drinking water supply, sanitation, hygiene and nutrition.
- Integrating vertical health and family welfare programmes at national, state, district and block levels.
- Technical support to national, state and district health mission, for public health management.
- Strengthening capacities for data collection, assessment and review for evidence base planning, monitoring and supervision.
- Formulation of transparent policies for deployment of human resource for health.
- Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in underserved areas.

#### **Supplementary Strategies under Mission:**

- Regulation for Private sector including the informal Rural Medical Practitioners (RMPs) to ensure availability of quality service to citizens at reasonable cost.

- Promotion of public private partnerships for achieving public health goals.
- Mainstreaming Indian system of medicine (AYUSH) revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of medical care to medical ethics.
- Effective and visible risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

