From Bhore Committee to National Rural Health Mission: A Critical Review

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Abstract

This review article describes the Bhore Committee to National Rural Health Mission.

INTRODUCTION

Sir Joseph Bhore Committee or Health Survey and Development Committee[1] was constituted in 1946. It was guided by lofty principals as 'nobody should be denied access to health services for his inability to pay' and that the focus should be on rural areas. Following the acceptance of report of Bhore Committee by rulers of newly independent country, a start was made in 1952 to setup primary health centers to provide integrated promotive, preventive, curative and rehabilitative services to entire rural population, as an integral component of wider Community Development Programme. In 1952, India was the first country to launch a national programme emphasizing family planning to stabilize the population at a level consistent with the requirement of national economy. The convulsive political changes that took place in the 1970s impelled the Central Government to implement the vision of Sokhey Committee[2] of having one Community Health Worker for every 1000 people to entrust 'people health on people's hand'. India has come quite close to Alma Ata Declaration on Primary Health Care made by all countries of the world in 1978[3]. The Declaration included commitment of governments to consider health as fundamental right; giving primacy to expressed health needs of people; community health reliance and community involvement; Intersectoral action in health; integration of health services; coverage of entire population; choice of appropriate technology; effective use of traditional system of medicine; and use of only essential drugs. In 1982, Government made a major move in health politics by coming up very sharply against the health work done in the country in last 35 years. National Health Policy was thus formed in 1982[4] to make architectural corrections in health care system. National Health Policy gave a general exposition of the policies which require recommendation in the circumstances then prevailing in health sector. The Universal Immunization Programme (UIP) was launched in 1985 to provide universal coverage of infants and pregnant women with immunization against identified vaccine preventable diseases. From the year 1992-93, the UIP has been strengthened and expanded into the Child Survival and Safe Motherhood (CSSM) Project. It involves sustaining the high immunization coverage level under UIP, and augmenting activities under Oral Rehydration Therapy, prophylaxis for control of blindness in children and control of acute respiratory infections. Under the Safe Motherhood component, training of traditional birth attendants, provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies are being taken up. In 1997, Reproductive and Child Health (RCH- Phase1) programme was launched which incorporated child health, maternal health, family planning, treatment and control of reproductive tract infections and adolescent health. RCH Phase-2 (2005-2010) aims at sector wide, outcome oriented program based approach with emphasis on decentralization, monitoring and supervision which brings about a comprehensive integration of family planning into safe motherhood and child health. There is a differential approach for Empowered Action Group (EAG) and non-EAG states with improved ownership among states with dedicated structural arrangements to improve program management.

The National Rural Health Mission (2005-2012)[5] is a major undertaking by United Progressive Alliance Government to honor its commitments under common minimal programme. The political commitment to rural health and access to primary health care that the CMP articulated was itself a

matter of considerable cheer. NRHM is also strategic framework to implement the National Health Policy 2002. It has adopted key guidelines given in National Health Policy 2002, e.g. equity, decentralization, involving Panchayati Raj Institutions (PRIs) and local bodies in owning primary health care management, strengthening primary health care institutions and suggestions for generating alternate source of financing. The NRHM subsumes key national programmes, namely, Reproductive and Child Health-2 (RCH-2), National Disease Control Programmes and Integrated Disease Surveillance Project. The mission covers the entire country, with special focus on 18 states, which have relatively poor infrastructure. These include all 8 Empowered Action Group (EAG) states viz. Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Uttranchal, Chattisgarh and Jharkhand ; 8 North East States besides Jammu and Kashmir and Himachal Pradesh.

NRHM lists a set of core and supplementary strategies to meets its goals of reduction in IMR and MMR; universal access of public health services such as women health, child health, water, sanitation and hygiene, immunization and nutrition; prevention and control of communicable and non communicable diseases; access to integrated comprehensive primary health care; population stabilization; revitalization of local health tradition and mainstreaming AYUSH; and promotion of healthy lifestyles.

These set of strategies are

Core Strategies-

- Train and enhance capacity of Panchayati Raj Institutions to own, control and manage public health services.
- Promote access to improved health care at household level through female health activist (ASHA)
- Setting up Village Health Committee to develop health plan for each village
- Strengthening sub-centers through untied fund and provision of 30-50 bedded CHC per lakh population for improved curative care to Indian Public Health Standards (IPHS)
- Integrating vertical health programmes at all levels
- Technical support to National, State and District Health Mission in preparation of District Health Plan
- Strengthening capacities for data collection, assessment and review for evidence based planning and empowering health care institutions for preventive health care.
- Promoting non-profit sector particularly in underserved areas.

Supplementary Strategies-

- Regulation of Private Sector to improve equity, and ensure availability of quality services at reasonable cost
- Foster public- private partnerships for achieving public health goals
- Mainstreaming AYUSH and thus revitalizing traditional health systems
- Reorienting medical education to support rural health issues
- Risk pooling and social health insurance to provide health security to under-privileged population

It has been observed that health care system has expanded considerably over last few decades but quality of services are not upto the mark. Hence Indian Public Health Standards[6] are being introduced in order to improve quality of health care delivery. At present these standards are applied only to Community Health Centers (CHC) but subsequently standards for SC and PHC shall also be developed. These set of standards are lesser resource intensive as compared to already existing Bureau of Indian Standards for 30 bedded hospitals.

There are few concerns that emerge from reading of mission documents. The first concern is that there is no systematic analysis of previous policies and no major lessons seem to have been learnt from the past. It does not appear to analyze why Primary Health Care approach was never implemented effectively and the goals for ‘Health for All by 2000' has not been met. There seems to be no analysis for the fact why Community Health Volunteer scheme failed before launching ASHA.

The second concern relates to influence of globalization-privatization framework on the mission. The mission seems

to be privatization friendly and there is a very strong influence of RCH programme (with major funding from World Bank and other international agencies). While RCH forms one of the key component of mission, the disproportionate influence may not be healthy for integrated strengthening of rural health systems.

The third concern is related to appointment of Accredited Social Health Activist (ASHA) in a village. The selection criteria include educational level upto eight class which may impose a bias against women from disadvantaged groups which despite forming majority in her village is denied the post because of less formal education. Moreover, unless the other levels of health system such as PHCs and CHCs are substantially improved, their services upgraded and staff made responsive, ASHA would not be able to make much headway in her task as an activist i.e. mobilizing people and facilitating their access to health services as a right. Further, the amount of work expected from ASHA, with maximum compensation of Rs. 83 per month, cannot be very significant.

The fourth concern is regarding adoption and operationalization of Indian Public Health Standards for CHCs and that all the National Health Programmes should be delivered through CHCs. Although a step in forward direction, these changes may weaken the institution of PHC and focus on specialized medical care services at CHC level. With CHC being further away for most people (than a PHC), communities will be increasingly pushed to access local practitioners (largely unqualified) or reach CHC with complications.

The NRHM claims to integrate various national health programmes. But these integrative strategies are limited to RCH and family welfare programmes with no intention of touching three major disease control programmes (Malaria, AIDS, TB), that has been verticalised as a part of Millennium Development Goals (MDG) linked to market needs of large pharmaceutical industries.

For mission to achieve its goals, the growing. Urban population constitutes nearly third of national population and growing urban population needs to be included in the scope at three times the national population growth rate. Health status and access of RCH services of slum dwellers are poor. Lack of sensitization among service providers, weak coordination among various stakeholders, unorganized public sector infrastructure and poor living environment further compounded problem of urban poor. Existing policies need to be improved to make them more urban poor friendly, practicable and measurable.

The setting up of NRHM is seen as yet another political move by the UPA government to make another promise to the long suffering rural population to improve their health status. It adopts a very simple approach to a highly complex problem. Nevertheless, the strategies of NRHM are based on sound management principals and an attempt has been made to overcome shortcomings of similar previous schemes. In addition, there is a prerequisite to allocation of funds to states requiring signing of Memorandum of Understanding with Government of India, stating the agreement to the policy framework of NRHM and timeliness and performance benchmarks against identified activities. The state shall also commit to devolute powers to PRIs and decentralization of programme to district levels.

One will hope and wish that increased awareness and collective power of the people along with detailed guidelines and standards provided in the mission, NRHM will be implemented in letter and spirit to bring sea change in our primary health care system and benefits the disadvantaged segments of population.

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