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Community Health Nursing-I

Including Environmental Science and Epidemiology

As per the Revised INC Syllabus for BSc Nursing



Bandana
Taranpreet Kaur

Semester V

JAYPEE

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Healthcare Planning and Organization of Health Care at Various Levels

2 CHAPTER

CHAPTER OUTLINE

- Health planning steps
- Health planning in india
- Commissions on health and family welfare
- Five-year plans
- Participation of community and stakeholders in health planning
- Healthcare delivery system in india
- Delivery of health services at subcenter (SC), PHC, CHC, district level, state level and national level
- At the central level/national level in India
- At the state level
- At district level (local or peripheral) subcenter level
- Primary Health Center Level (PHC)
- Community Health Center Level (CHC)
- Sustainable Development Goals (SDGS)
- Primary Health Care
- Primary Health Care in India
- Comprehensive Primary Health Care (CPHC)
- CPHC through SC/Health Wellness Center (HWC)
- Role of MLHP/CHP
- National Healthcare Policies and Regulations
- National Health Policy (1983)
- National Health Policy (2002)
- National Health Policy (NHP) 2017
- National Health Mission (NHM)
- National Health Protection Mission (NHPM)
- Ayushman Bharat
- Universal Health Coverage

LEARNING OBJECTIVES

After studying this chapter, the students will be able to:

- Describe health planning and its steps, and various health plans, and committees.
- Discuss healthcare delivery system in India of various levels.
- Describe SDGs, primary healthcare and Comprehensive Primary Health Care (CPHC).
- Explain healthcare policies and regulations in India.

KEY TERMS

Public health care: The science of protecting and improving the health of people and their communities.
Private sector: The part of a country's economy that is run by individuals and companies, rather than a government entity.
Integrated is intended in this report to encompass the provision of *comprehensive, coordinated,* and *continuous* services that provide a seamless process of care. Integration combines events and information about events occurring in disparate settings and levels of care and over time, preferably throughout the life span.
Comprehensive: Comprehensive care addresses any health problem at any given stage of a patient's life cycle.
Coordinated: Coordination ensures the provision of a combination of health services and information that meets a patient's needs. It also refers to the connection between, or the rational ordering of, those services, including the resources of the community.
Continuous: Continuity is a characteristic that refers to care over time by a single individual or team of healthcare professionals ("clinician continuity") and to effective and timely communication of health information (events, risks, advice, and patient preferences) ("record continuity).
Accessible refers to the ease with which a patient can initiate an interaction for any health problem with a clinician (e.g., by phone

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or at a treatment location) and includes efforts to eliminate barriers, such as those posed by geography, administrative hurdles, financing, culture, and language.
Healthcare services refers to an array of services that are performed by healthcare professionals or under their direction, for the purpose of promoting, maintaining, or restoring health (Last, 1988). The term refers to all settings of care (such as hospitals, nursing homes, physicians' offices, intermediate care facilities, schools, and homes).
Clinician means an individual who uses a recognized scientific knowledge base and has the authority to direct the delivery of personal health services to patients.
Accountable applies to primary care clinicians and the systems in which they operate. These clinicians and systems are responsible to their patients and communities for addressing a large majority of personal health needs through a sustained partnership with a patient in the context of a family and community and for (1) quality of care, (2) patient satisfaction, (3) efficient use of resources, and (4) ethical behavior.
Personal healthcare needs include physical, mental, emotional, and social concerns that involve the functioning of an individual.
Sustained partnership refers to the relationship established between the patient and clinician with the mutual expectation of continuation over time. It is predicated on the development of mutual trust, respect, and responsibility.
Patient means an individual who interacts with a clinician either because of real or perceived illness or for health promotion and disease prevention.
Community refers to the population served, whether they are patients or not. It can refer to a geopolitical boundary (a city, county, or state), to members of a health plan, or to neighbors who share values, experiences, language, religion, culture, or ethnic heritage.

HEALTH PLANNING STEPS

INTRODUCTION

Health planning can be defined as: "a systematic approach to attaining explicit objectives for the future through the efficient and appropriate use of resources, available now and in the future." ***—Green, 2007***

Health planning is a multilevel work which should be a shared task at all levels of the health system. It is often seen that planning is the responsibility of a separate administrative unit. This requires constant interaction between decision makers, managers, and professionals at all levels. This suggests the need for input into planning by decision makers at each health system level with the planning unit performing advisory and facilitator's functions and guiding decisions from a technical perspective. The ultimate decisions would be made by relevant stakeholders, such as community leaders, patients, and health professionals.

Health Planning: The Main Features

The rationale for planning is almost common to planning in all sectors. Some distinctive features to health planning in compare to the other planning are.

- Health is a very labor-intensive sector with the time needed to train a health professional often being several years. As such long-term human resource planning is critical for the health sector.
- A second feature of health planning is the complex power relations between the various sectors involved in or influencing decision-making processes. This includes both external (donors, international agencies) and internal (health ministry, professional associations, civil society) stakeholders. Health planning, because of close links with health policy making, is seen as both a technical and a political process with different groups of stakeholders bringing different agendas into the process. Mechanisms of engagement and the degree of influence of various sectors may vary (for instance, some may impose conditionality, whereas others may use advocacy as the main instrument of influence). Complex interrelationships between different groups of stakeholders can have an impact on the approaches to, and success of, health planning.
- A third characteristic of health planning is the tension between the clinical perspectives (focus on individuals) versus the public health perspective (focus on populations). Planning within the health system needs to find an accommodation between both perspectives.

Health Planning Steps (Fig. 2.1)

- Analysis of the health situation
- Establishment of objectives and goals
- Assessment of resources
- Fixing priorities
- Write-up of formulated plan
- Programming and implementation
- Monitoring
- Evaluation

Which reveals the new health situation, i.e., after the health program has been in place for some time. And the planning cycle continues.

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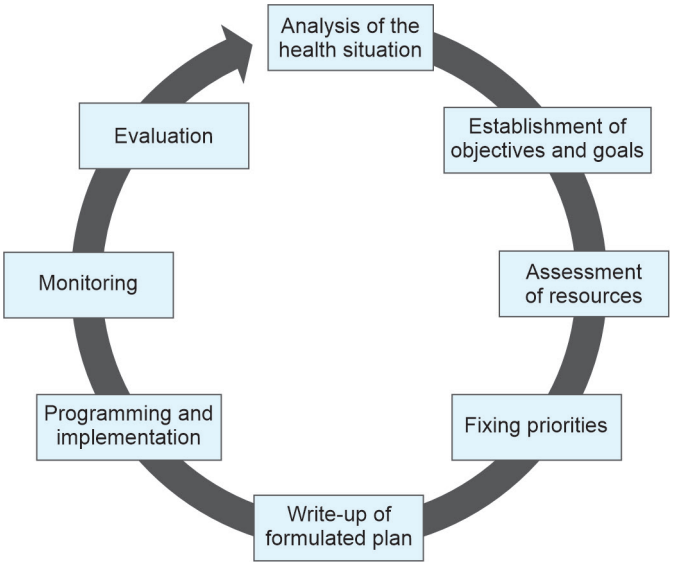


Fig. 2.1: Health planning steps.

Analysis of the Health Situation

The first step in health planning is the analysis of the current situation and other aspects, such as:

- Population statistics—age and sex structure, religion, SES, etc.
- Morbidity and mortality rates
- Morbidity and mortality rates due to the disease under consideration
- Epidemiology and geographic distribution of the disease under consideration
- Existing healthcare facilities
- Technical manpower available
- Facilities for training healthcare staff
- Awareness and attitude of the community regarding the disease, etc.

This analysis helps to determine needs and priorities and help to make the basis of setting goals and objectives.

Establishment of Objectives and Goals

This step is to identify the desirable health issue under consideration. Goals and objectives, establish the standards against which current disease will be compared for assessing the performance of program.

- A plan cannot be implemented efficiently and haphazard wasteful activity will result without clear objectives and goals
- At the central level, the objectives would be more general and with each successive level, the objectives will become more specific.
- Management techniques are usually used to determine objectives, e.g., cost-benefit analysis
- These analysis will assess the feasibility of attaining the desired results in optimum cost and time.
- The objective can be defined like: "To reduce the prevalence to the level of 0.5%".

Assessment of Resources

Any type of planning cannot be think of without resources and the objectives should be made by considering the recourses available.

- The available: Manpower, money, material, skills, knowledge and techniques should be accessed.
- A balance is to be struck between the available resources and the attainment of the objectives.

Fix Priorities

- The resources are usually not enough to attain all the objectives.
- So priority goals should be listed out and resources should be allocated to these.
- Various considerations in fixing priorities can be:
  - In order of magnitude
  - Lower costs needed to achieve the objectives
  - Saving the lives of younger people
  - Political commitments and pressure, etc.
- Once the priority objectives have been decided:
  - Alternative ways of achieving them should be assessed
  - For example, whether vaccination is more cost effective or treatment of the cases? For example, the disease itself may be mild and requiring inexpensive treatment whereas vaccine may need to be imported and very expensive for mass application. Hence, a program for early diagnosis and treatment may be preferred over vaccination for achieving the target prevalence rate.
  - Management techniques for comparing the efficiency of alternative plans may be useful for deciding priority.

Write-up Formulated Plan

- Once priorities are laid out, a systematic plan should be made to attain them.
- All the major steps should be included with the:
  - Resources (input) required for each step
  - The expected outcome (output) and
  - Time period specified for each step
  - Precise guidelines for procedures
  - Fixation of responsibility (identify individual responsible for the execution of each step)

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Programming and Implementation

- Once the plan has been approved it has to be implemented. Implementation requires an effective organization to run the routine procedures and referral. The real shortcomings or impracticalities of the program may be revealed at this stage.
- Main consideration at this stage are:
  - Definition of roles and tasks
  - Selection and training of personnel
  - Organization and communication so that all workers are aware of their responsibility and remain motivated.
  - The involved institutions should work efficiently.

Monitoring

- Monitoring is defined as "the continuous process of observing, recording and reporting on the activities of the organization or project".
- Monitoring refers to the day-to-day follow-up of functioning of program.
- It is to be ensured that the activities are proceeding as planned and are on schedule.
- Immediate corrective action is to be taken in case of deviations.

Evaluation

- Evaluation refers to the assessing the final outcome of the plan.
- Evaluation is in terms of:
  - Degree to which objectives are achieved
  - How efficiently have the resources been utilized (output-input, cost-benefit analysis, etc.)
  - What were the factors responsible for shortfalls
  - Factors responsible for better performance if any
  - Difficulties faced during the implementation of and possible solutions for them
- Based on the results of the evaluation, one of the following decisions may be taken:
  - To continue running the program as the results are satisfactory
  - To make a few changes to overcome inefficiencies and let the program continue
  - To change the objectives as the disease profile has changed due to the effect of the program
  - To abandon the approach and analyze alternative approaches
    - The program failed to achieve the objectives or
    - A new and much more effective technology has been developed for controlling the disease and needs to be incorporated in the program or
    - A new and more dangerous health problem has emerged and the priority needs a change



Planning in its broadest sense includes three steps that are plan formulation, execution and evaluation.

HEALTH PLANNING IN INDIA

Various committees and commissions on health and family welfare and five-year plans: Health planning in India is a complex process. A number of experts have been appointed by government to make various committees and commissions to render their services and advices about different health problems from time to time. The planning process involves several stakeholders, including the government, healthcare providers, and community members. The reports of these committees helps to identify the health needs of the population develop strategies to address those needs, and allocate resources to implement those strategies. Some of these are as follows.

BHORE COMMITTEE (1943–1946)

The Bhore Committee was set up by the Government of India in 1943 under the chairmanship of Joseph William Bhore. This committee was also known as the health survey and development committee. It was a health survey taken by a development committee to assess health condition of India. The committee consisted of pioneers in the healthcare field who met frequently for two years and submitted their report in 1946.

Aim

The major aim of the committee was improvement of public health system in India by conducting survey of existing position regarding the health conditions and health organization in the country and to make recommendations for future development.

Observations by Bhore Committee

- The main observations done by Bhore committee were as follows.
- Health status of the country as indicated by various indicators was poor.
- Mortality rates were very high.
- Life expectancy at birth was about 27 years.
- Incidence of communicable diseases was very high.
- Many of the health problems were preventable.
- Health and development are interdependent.
- Improvement in sector other than health will also lead to improvement in health, such as water supply,

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sanitation improvement, nutrition, elimination of unemployment.

Recommendations

The report was printed in four volumes. It laid out the proposal for a national program of health services in India and also stressed the importance of preventive care in Subject to curative treatment.

Some of important recommendations are as follows:

- Integration of preventive and curative services at all administrative levels.
- Development of primary health centers (PHC) in 2 stages
  - Short-term measure—one primary health center was suggested for a population of 40,000. Each PHC was to be staffed by 2 doctors, one nurse, four public health nurses, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacist and fifteen other class IV employees. The first was established in 1952. Secondary health centers were also envisaged to provide support to PHCs, and to coordinate and supervise their functioning
  - A long-term program (also called the 3 million plan) of setting up primary health units with 75-bedded hospitals for each 10,000 to 20,000 population and secondary units with 650-bedded hospital, again regionalised around district hospitals with 2500 beds.
- Major changes in medical education which included three months training in preventive and social medicine to prepare "social physicians".
- Abolition of the Licentiate in medical practice, etc., qualifications and their replacement by a single national standard Bachelor of Medicine and Bachelor of Surgery (MB BS) degree.
- Creation of a major central institute for postgraduate medical education and research. It was achieved in 1956 with the All-India Institute of Medical Sciences (AIIMS).
- Village health committee to be formed for special attention to diseases, such as malaria, TB, smallpox, leprosy, plague, cholera, venereal diseases, filariasis, mental illness. Special programs for health of mothers and children, environmental hygiene and occupational health for industrial workers.

Guiding Principles Adopted

- No individual should be denied to secure adequate medical care because of inability to pay.
- Facilities for proper diagnosis and treatment.
- Health program must lay special emphasis on preventive work.
- As much medical relief and preventive health care should be provided to the vast rural population.
- Health services should be located close to the people to ensure maximum benefit to the community.
- Doctor should be a social physician protecting the people.
- Medical services should be free to all, without distinction.

Implementation of Bhore Committee Report

The proposals of the committee were accepted in 1952 by the government of newly independent India. Though most of the recommendations of the committee were not implemented at the time, the committee was a trigger to the reforms that followed.

Significance, Importance and Outcomes of Bhore Committee Report

The committee was instrumental in bringing about the public health reforms related to peripheral health centers in India. Primary health centers were built across the nation to provide integrated promotive, preventive, curative and rehabilitative services to entire urban as well as rural population, as an integral component of wider community development program. Initiated the concept of integrated development and comprehensive health care. The three tier pattern of healthcare services started.



Although the Bhore committee's recommendations did not form part of a comprehensive plan for national socioeconomic development, the committee's report continue to be a major national document, and has provided guidelines for national health planning in India.

MUDALIAR COMMITTEE

The Government of India appointed a 'Health Survey and Planning Committee' in 1959 under the chairmanship of Dr AL Mudaliar, to assess the state of the healthcare in India and to measure the progress achieved after implementing the suggestions of the Bhore Committee in 1946. The committee submitted its report in 1962.

The Mudaliar Committee found:

Quality of healthcare provided by the primary health centers was unsatisfactory so there is a great need for strengthening the:

- Existing primary health centers. Before new centers were established.

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- Sub-divisional and district hospitals so that they may effectively function as referral centers.

Main Recommendations

- Consolidate the progress made in first two 5-year plans
- Strengthen the district hospitals with specialists
  - So that they can act as good referral centers and
  - To serve as central base of regional services
- Create a regional administrative level between
  - The headquarters at state level and
  - The district level
  - In charge of a regional level hospitals should be deputy or assistant directors
  - Each of them have to supervise two or three district medical and health officers.
- Each primary health center should cater to a maximum of 40,000 population.
- To improve the quality of health care provided by the primary health centers.
- Integration of medical and health services as recommended by the Bhore Committee.
- Constitution of an All India Health Service on the pattern of Indian Administrative Service (IAS)

The third Five-year Plan launched in 1961 discussed the problems affecting the provision of PHCs, and directed attention to the shortage of health personnel, delays in the construction of PHCs, buildings and staff quarters and inadequate training facilities for the different categories of staff required in the rural areas. Ignoring the Mudaliar Committee's recommendation of consolidation of PHC's this plan period witnessed a rapid increase in their numbers but their condition was the same as the committee had found at the end of the second plan period.

In case of the disease program due to their vertical nature, there was a huge army of workers. The delivery of services continued to be done by special uni-purpose health workers. Therefore in the same geographical area, there was overlapping and duplication of work.

CHADHA COMMITTEE, 1963

Malaria used to be rampant in India in 1950's. It was the greatest handicap in the socioeconomic development of the country. National Malaria Control Programme (later NMEP) was launched in 1953 to control the extremely high levels of Malaria infections.

- **The program was operated in four phases:**
  1. Preparatory phase
  2. Attack phase
  3. Consolidation phase
  4. Maintenance phase: House to house visits to identify fever cases (Vigilance)

  A special organization was established for the first three phases and for the 'Maintenance' phase, the responsibility for the activities was to be passed on to the general health services of the country in 1964.
- **Chadha committee** was appointed by the Government of India in 1963, under the Chairmanship of Dr MS Chadha. Who was working as Director General of Health Services.

Aims

- To study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme.
- **The committee recommended** 'Vigilance' operations under National Malaria Eradication Programme should be the responsibility of the general health services, i.e., primary health centers at the block level.
- Vigilance operations included:
  - Monthly home visits to identify fever cases
  - To be carry out through separate workers
  - The '**basic health workers'.**
  - One basic health worker per 10,000 population was recommended.
- The basic health workers were seen as 'multipurpose workers', i.e.,
  - In addition to malaria vigilance, they have duties of
  - Collection of vital statistics and
  - Family planning
- The Family Planning Health Assistants were—to supervise 3 or 4 of these basic health workers.
- **From the district level upwards:** The **general health services** were to take the responsibility for the maintenance phase.

MUKHERJEE COMMITTEE

The recommendations of the Chadha Committee, when implemented, were found to be impracticable the basic health workers, with their multiple functions could do justice neither to malaria work nor to family planning work.

The Mukherjee committee headed by the then Secretary of Health Shri Mukherjee, was appointed to Review the Staffing Pattern and Financial Provision under Family Planning.

Terms of reference for Mukherjee Committee (1965) were

- In 1965, the ICMR Director pronounced that Lippies Loop was safe.
- So this intrautrine contraceptive device, (IUCD) was introduced into the family planning program and reorganization of the family planning program was needed.

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- Child birth rate was 41 per thousand and was aimed at reducing to 25 per thousand in a period of 10 years.
- To review what additions and changes are necessary as a result of the greatly altered situation due to the IUCD having come in the forefront of the program, in the staffing pattern, financial provisions, etc.

Recommendations of Mukherjee Committee (1965)

- Strengthening of education and publicity efforts and involvement of other organizations
- Strong executive agency in health directorate of each state government to exclusively deal with family planning
- Approved the existing Urban Family Welfare center
- At Rural Family Planning Center—basic health workers to be utilized as multipurpose health workers for general services.
- The family planning assistants were to undertake family planning work without having supervision of basic health workers.
- Delink the malaria activities from family planning so that the latter would received undivided attention of its staff.

Mukherjee Committee, 1966

Following 13th Meeting of the Central Council of Health held at Bengaluru (also called Bangalore) in June, 1966—state finding it difficult to take burden of maintenance phase of malaria and other program, such as smallpox, leprosy, FP, trachoma. It was formed in 1966 by Government of India and headed by Shri B Mukerji, Union Health Secretary.

Terms of Reference of Mukherjee Committee (1966)

To review the staffing pattern of the primary health center complex and to recommend the minimum staff of various categories required at different levels within the district so as to provide an integrated health service capable of fully catering to the needs of the vigilance services in the maintenance phase of National Malaria Eradication Programme, smallpox eradication, tuberculosis, leprosy and trachoma control, etc.

To recommend the pattern of central assistance for the states.

Recommendations of Mukherjee Committee (1966)

- Services to be provided at block level
- Strengthening required at higher level
- Any attempt to give the basic health worker more work under the family planning program would either endanger malaria vigilance work or would need a larger number of basic health workers per block than what the committee has recommended.

JUNGALWALLA COMMITTEE (1967)

Jungalwalla committee is known as the **"Committee on Integration of Health Services"** was set up in 1964 under the chairmanship of Dr N Jungalwalla, who was working as Director of National Institute of Health Administration and Education (currently NIHFW) at that time.

- **The aim of this committee** was to look into various problems related to integration of health services, abolition of private practice by doctors in government services, and the service conditions of doctors.
- The committee defined "integrated health services" as:
  - Service with a **unified approach for all problems** instead of a segmented approach for different problems.
  - Medical care and public health programs should be put under charge of a **single administrator** at all levels of hierarchy.

Recommendations

1. Following steps were recommended for the integration at all levels of health organization in the country.
2. Unified cadre
3. Common seniority
4. Recognition of extra qualifications
5. Equal pay for equal work
6. Special pay for special work
7. Abolition of private practice by government doctors
8. Improvement in the service conditions

- The **4th Plan which began in 1969 continued** on the same line as the 3rd plan.
- It lamented on the poor progress made in the PHC Programme and recognized again the need to strengthen it.
- It pleaded for the establishment of effective machinery for speedy construction of buildings and improvement of the performance of PHCs by providing them with staff, equipment and other facilities

KARTAR SINGH COMMITTEE (1973)

This committee, headed by Chairperson S Kartar Singh the additional secretary of health and family welfare and was titled as the "**Committee on multipurpose workers under health and family planning**" was constituted to form a framework for integration of health and medical services at peripheral and supervisory levels.

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Recommendations

- Various categories of peripheral workers should be amalgamated into a single cadre of multipurpose workers (male and female).
- ANM designated as "female health worker". All basic health workers and surveillance workers, vaccinators, health education assistant and family planning health assistant replaced by "male health worker".
- MPHW introduced in malaria maintenance phase areas and smallpox controlled area.
- PHC population coverage increase up to 50,000 people
- Medical officer of PHC has overall charge of all supervisors and all health workers.
- Lady health visitor designated as female health supervisor.
- It should be divided in 16 subcenters. Each subcenters have given 3000 to 3500 populations. Each subcenter has provided 1 male and 1 female health worker. Then there should be a each male health and female health supervisor to supervise the work of 3 to 4 male/female health worker.

SHRIVASTAV COMMITTEE 1975

This committee was set up in 1974 as "**Group on Medical Education and Support Manpower**" with aim to determine steps needed to:

Reorient medical education in accordance with national needs and priorities;

Develop a curriculum for health assistants who were to function as a link between medical officers and multiple health workers.

Recommendations of Shrivastav Committee

- Creation of **bands of paraprofessional and semi-professional** health workers from within the community itself, e.g., school teachers, postmasters, etc.
- Establishment of two cadres of health workers between the community level workers and doctors at PHC namely—**multipurpose health workers and health assistants**.
- Development of a "**Referral Services Complex**" by establishing proper linkage between PHC and higher referral services.
- Establishment of a **Medical and Health Education Commission** for planning and implementing the reforms needed in health and medical education on the lines of University Grants Commission.

  Acceptance of these recommendations of the Shrivastava Committee in 1977 led to the launching of the Rural Health Scheme.

- In the **5th Plan,** the government ruefully acknowledged that the number of medical institutions, functionaries, beds, health facilities, etc., were still inadequate in the rural areas despite advances in terms of infant mortality rate going down, life expectancy going up,
- The urban health structure had expanded at the cost of the rural sectors.
- Major innovations took place with regard to the health policy and method of delivery of healthcare services.
- Increasing the accessibility of health services to rural areas through the Minimum Needs Programme (MNP) and correcting their goals imbalances.
- The 6th Plan was to a great extent influenced by the Alma Ata declaration of Health For All by 2000 AD (WHO, 1978) and the ICSSR and ICMR report (1980).
  - The plan conceded that there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super-specialization and highly trained doctors which is availed of mostly by the well to do classes.
  - It is also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services.
- The National Health Policy of 1983 was announced during the Sixth Plan period. The **7th Five-Year Plan recommended** that "development of specialties and super-specialties need to be pursued with proper attention to regional distribution" and such development of specialized and training in super specialties would been courage in the public and the private sectors".
- This plan also talks of improvement and further support for urban health services, biotechnology and medical electronics and non-communicable diseases.
- Enhanced support for population control activities also continues.
- The special attention that AIDS, cancer, and coronary heart diseases are receiving and the current boom of the diagnostic industry and corporate hospitals is a clear indication of where the health sector priorities lie.
- On the eve of the Eighth Five-Year Plan the country went through a massive economic crisis.
- The plan got pushed forward by two years. But despite of this no new thinking went into this plan.
- Infect, keeping with the selective healthcare approach the eighth plan adopted a new slogan—instead of Health for All by 2000 AD it chose to emphasize health for the underprivileged.

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Simultaneously, it continued the support to privatization. During the Eighth Plan resources were provided to setup the Education Commission for Health Sciences, and a few states have even set up the university for Health Sciences as per the recommendations of the **Bajaj Committee report**.

BAJAJ COMMITTEE (1986)

An" **Expert Committee for Health, Manpower Planning, Production and Management**" was constituted in 1985 under Dr JS Bajaj, who was working as professor at AIIMS and a member of planning commission committee. The report was submitted in December 1986.

Major Recommendations

- Formulation of National Medical and Health Education Policy.
- Formulation of National Health Manpower Policy.
- Establishment of an Educational Commission for Health Sciences (ECHS) on the lines of UGC.
- Establishment of Health Science Universities in various states and union territories.
- Establishment of health manpower cells at center and in the states.
- Vocationalization of education at 10+2 levels as regards health-related fields with appropriate incentives, so that good quality paramedical personnel may be available in adequate numbers. Carrying out area wise listing of health manpower survey.
- National and medical education policies in which teachers are trained in health education science technology.
- Uniform standard of medical and health science education by establishing universities of health sciences in all states.
- Establishment of health manpower cells both at state and central levels.
- Vocational courses in paramedical sciences to get more health manpower.

During the 8th Plan period a committee to review public health was set up. It was called the **Expert Committee on Public Health Systems.**

- This committee made a thorough appraisal of public health programs and found that we were facing a resurgence of most communicable diseases and there was need to drastically improved is ease surveillance in the country.
- The **9th Five-Year Plan by contrast provides a good review of all programs** and has made an effort to strategize on achievements hitherto and learn from them in order to move forward.
- There are a number of innovative ideas in the ninth plan.
- Reference is once again being made to the Bhore Committee report.
- Another unique suggestion is evolving state specific strategies because states have different scenarios and are at different levels of development and have different healthcare needs.
- The 9th Plan proposes to set up at district level a strong detection come response system for rapid containment of any outbreaks that may occur.
- On the eve of the 10th Plan, the **draft National Health Policy 2001** has been announced.

KRISHNAN COMMITTEE (1992)

Krishnan Committee was formed under the chairmanship of Dr Krishnan reviewed the achievements and progress of previous health committee reports and also made comments on shortfalls. The committee addresses the problems of urban health and devised the health post-scheme for urban slum areas. It reports, in the present context of that time that a very few outreach services are being provided to urban slums. Outreach services include population education, motivation for family planning, and health education. These services have been divided into outreach, preventive, family planning, curative, support (referral) services and reporting and recordkeeping. Its report specifically outlines which services have to be provided by the health post. Committee had recommended one voluntary health worker (VHW) per 2,000 population.

COMMISSIONS ON HEALTH AND FAMILY WELFARE

NATIONAL COMMISSION IN MICROECONOMICS AND HEALTH (2005)

The National Commission on Macroeconomics and Health, included among others, a critical appraisal of the present health system for both in the public and the private sector and suggesting ways and means of further strengthening it with the specific objective of improving access to a minimum set of essential health interventions to all. It was also intended that the commission would look into the issue of improving the efficiency of the delivery system and encouraging public-private partnerships in providing comprehensive health care. National commission was formed under the chairman ship of P Chidambaram, the then Finance Minister and Dr Anbumani Ramadoss, the then Health Minister of India.

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Its overall objective was to assess how increased investments in the health sector impart poverty and economic development. A recommended set of measures designed to maximize the poverty reduction and economic development benefits of health sector development.

Commission Established Six Working Groups

- Health, economic growth and poverty reduction
- International public goods for health
- Mobilization of domestic resources for health
- Health and international economy
- Improving health outcome of poor
- Development assistance and health

Main Objectives of this Commission

- Promoting equality by reducing household expenditure on total health spending and experimenting with alternative models of health financing.
- Reducing disease burden and the level of risk.
- Establishing institutional frameworks for improved quality of governance of health.
- Restructuring the existing primary healthcare system to make it more accountable.
- Investing in technology and human resources for a more professional and skilled work force and better monitoring.



National Commission in Macroeconomics and Health was replaced by NITI Aayog in 2014.

PLANNING COMMISSION OF INDIA (1950)

The Planning Commission of India was a governmental agency established in 1950 to formulate India's Five-Year Plans. It aimed to guide the country's economic and social development. The commission's responsibilities included assessing India's resources, formulating development plans, prioritizing and allocating resources, and monitoring the implementation of plans. It played a crucial role in shaping India's economic trajectory during its formative years. It contributed significantly to the country's growth and development.

History of Planning Commission

- The implementation of the First Five-Year Plan began in 1951, and the successive planning for five years continued until 1965, that is when the India-Pakistan conflict interrupted the process. Due to several factors, such as the depreciation of the rupee, inflation and resource depletion, the planning was disrupted. The fourth five-year plan was finally launched in 1969 after a series of plans from 1966 to 1969.
- The implementation of the 8th Five Year in 1990 plan was delayed due to political reasons. These years were covered with annual plans from 1990-91 and 1991-92. After the economic liberalization of 1992, the eighth plan was introduced. While the earlier plans focused on improving the performance of the public sector. However, following the release of the 9th Five Year Plan of 1999, the focus shifted from heavy industries towards more suggestive planning.
- Planning Commission was under the Prime Minister of India on March 15, 1950, under Prime Minister Jawahar Lal Nehru.
- It was created by the Central Government and did not have any constitutional or legal basis.
- In March 1950, the Government of India established the Planning Commission through a government resolution to improve the standard of living for Indians by effectively utilizing the nation's resources, boosting production, and offering employment opportunities to all sections of India.
- The role of the Planning Commission included making an assessment of all of India's resources, utilizing them efficiently, and setting priorities.
- The first head of the Commission was Pandit Jawahar Lal Nehru.

Composition of Planning Commission in India

- The Prime Minister served as the Chairman of the planning commission and presided over the meetings.
- The Deputy Chairperson was the de facto head of the Commission and held the full functioning role of drafting and submitting drafts of the Five Year Plan to Cabinet Ministers.
- The Deputy Chairperson was appointed for a fixed term by the Central Cabinet. He held the position equivalent to that of Cabinet Minister. Also, he did not have any voting powers.
- Part-time members included some central ministers.
- Finance Ministers and Planning Ministers were ex-officio members.

Functions of the Planning Commission of India

- The primary function of the Planning Commission was to formulate Five-Year Plans. These plans outlined specific targets, strategies, and investments for various sectors.
- The Planning Commission conducted regular assessments of India's resources. This included natural resources, human capital, and financial resources.

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- The Planning Commission played a central role in prioritizing development programs. It allocated resources across various sectors.
- The Planning Commission established monitoring mechanisms to track the progress of Five-Year Plans. It identified bottlenecks and assessed the effectiveness of implemented programs.
- The Planning Commission facilitated coordination and collaboration between various government ministries and departments.
- The Planning Commission encouraged research and innovation in various fields. This involved supporting research institutions, funding research projects, and promoting technology adoption.
- The Planning Commission provided economic advice to the government on various policy matters.
- The Planning Commission aimed to achieve balanced regional development across India. It addressed disparities between states and regions.
- The Planning Commission advocated for the empowerment of marginalized groups. This included women, minorities, and disadvantaged communities.
- The Planning Commission encouraged public participation in the planning process. It recognized the importance of involving stakeholders in decision-making.

Planning Commission: Positives and Achievements

- PC laid emphasis on infrastructure developments and capacity building. As a result, huge investments were made in education, energy, industry, railways and irrigation.
- India became self-sufficient in agriculture and made great progress in capital sector goods and consumer sector goods.
- PC introduced many remarkable concepts, such as nationalization, green revolution, etc., and transformed itself to align with new concepts, such as liberalization, privatization and inclusion.
- Planning commission made great emphasis on social justice, governance, employment generation, poverty alleviation, health and skill development.
- The transformation of India from a poor to an emerging economic power is credited to the orderly and phased manner in which planning was implemented.

Planning Commission: Negatives and Problems

There were many issues with planning methods followed in India. The drawbacks of the planning adopted via PC include:

- No structural mechanism for regular engagement with states.
- Ineffective forum for the resolution of center-state and inter-ministerial issues.
- Inadequate capacity expertise and domain knowledge; weak networks with think tanks and lack of access to expertise outside government.
- Failed to implement land reforms.
- It was a toothless body, was not able to make union/states/UTs answerable for not achieving the targets.
- Designed plans with 'one size fit for all' approach. Hence, many plans failed to show tangible results.
- Weak implementation, monitoring and evaluation.

Needs of Change from Planning Commission

- The contemporary world is governed by constitutional ethos like federalism rather than centralization.
- India's population has almost tripled to 121 Cr, and many of the Indian states are as big as European nations.
- Indian economy has expanded from a GDP of 10,000 crore to 100 lakh crore (at current prices)—i.e., from a poor nation to one of the largest economies. India ranks 3rd in GDP at purchasing power parity, has surpassed Japan and is now standing just below the US and China. The new economy needs institutions which can take India forward in a global competitive environment.
- Cooperative federalism and fiscal federalism will help to meet the diverse needs of different states/UTs in which planning commission had failed drastically. Plans have to be formulated by fulfilling the aspirations of states by tailoring the plans to suit their needs and requirements.
- The share of agriculture in GDP has been drastically decreasing while the share of the service sector to GDP is increasing in India. From 1991, as our economy is liberalized, private firms have been playing a major role in the economy. Today, we are living in a globalized world connected by modern transport, media, communications and networked international institutions and markets. With the increasing levels of development, the aspirations of people have soared from survival to safety and surplus. So governance systems need to be transformed to keep up with the same.
- Change in the economic scenario where the government is supposed to be an enabler rather than a player or provider of first and last.

The Planning Commission which has a legacy of 65 years has been replaced by the **NITI Aayog** in Jan 2015. The replacement seems to be more relevant and responsive to the present economic needs and scenario in the country.

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NATIONAL INSTITUTION FOR TRANSFORMING INDIA (NITI AAYOG)

The NITI Aayog was formed on January 1, 2015. In Sanskrit, the word "NITI" means morality, behavior, guidance, etc. But, in the present context, it means policy and the NITI stands for **"National Institution for Transforming India"**. It is the country's premier policy-making institution that is expected to bolster the economic growth of the country. It aims to construct a strong state that will help to create a dynamic and strong nation. This helps India to emerge as a major economy in the world. The NITI Aayog's creation has two hubs called **"Team India Hub"** and "**Knowledge and Innovation Hub"**.

- Team India: It leads to the participation of Indian states with the Central Government.
- The knowledge and innovation hub: It builds the institution's think tank capabilities.

NITI Aayog is additionally creating itself as a State of the Art Resource Center, with the essential resources, knowledge, and skills that will empower it to act with speed, advance research and innovation, Bestow crucial policy vision to the government and manage unforeseen issues. The reason for setting up the NITI Aayog is that people had expectations for growth and development in the administration through their participation. This required institutional changes in administration and active strategy shifts that could seed and foster substantial scale change.

Objectives of NITI Aayog

- The active participation of states in the light of national objectives and to provide a framework 'National Agenda'.
- To promote cooperative federalism through well-ordered support initiatives and mechanisms with the states on an uninterrupted basis.
- To construct methods to formulate a reliable strategy at the village level and aggregate these gradually at higher levels of government.
- An economic policy that incorporates national security interests.
- To pay special consideration to the sections of the society that may be at risk of not profiting satisfactorily from economic progress.
- To propose strategic and long-term policy and program frameworks and initiatives, and review their progress and their effectiveness.
- To grant advice and encourage partnerships between important stakeholders and national-international think tanks, as well as educational and policy research institutions.
- To generate knowledge, innovation, and entrepreneurial support system through a shared community of national and international experts, etc.
- To provide a platform for resolution of inter-sectoral and inter-departmental issues to speed up the accomplishment of the progressive agenda.
- To preserve a state-of-the-art resource center, be a repository of research on good governance and best practices in sustainable and equitable development as well as help their distribution to participants.
- To effectively screen and assess the implementation of programs and initiatives, including the identification of the needed resources to strengthen the likelihood of success.
- To pay attention to technology improvement and capacity building for the discharge of programs and initiatives.
- To undertake other necessary activities to the implementation of the national development agenda, and the objectives.

Verticals of NITI Aayog

The supportive bodies or verticals of NITI Aayog help in smooth functioning of the requisite tasks by the organization.

NITI Aayog has the following verticals under it:

- Administration and Support Units
- Agriculture and Allied Sectors
- Asprational Districts Programme Cell
- Communication and Social Media Cell
- Data Management and Analysis, and Frontier Technologies
- Economics and Finance Cell
- Education
- Governance and Research
- Governing Council Secretariat and Coordination
- Industry-I
- Industry-II
- Infrastructure—Connectivity
- Infrastructure—Energy
- Micro, Small and Medium Enterprises
- Natural Resources and Environment, and Island Development
- Project Appraisal and Management Division
- Public–Private Partnership
- Rural Development
- Science and Technology
- Social Justice and Empowerment, and Voluntary Action Cell
- Social Sector-I (Skill Development, Labor and Employment, and Urban Development)

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