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Development of government health policy in India

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Abstract
The public health arena has a multitude of stake-holders comprising doctors, nurses and para-medical personnel, pharmacists, public health professionals, researchers and academics, policy makers, officials from the Ministry of health and family welfare, educational and training institutions in the public and private sectors, non-government organizations and others. The government is the largest medical service provider in India. More than 50% of Indian population depends upon Indian government for their health and wellbeing through government run hospitals, clinics, public health centres, and running medical van. Indian government looks failed in providing a quality medical service to all citizens due to non-inventoryand anti-technology nature. We can trace a common set of problems associated with the public health which is also responsible for failure of different programs and policies. The ministry of health and family welfare (MoHFW) has a vast range of control programs that have been going on for decades. These programs have been revised periodically to incorporate improvements based on past experience and contemporary understanding, but most of the internationally accepted performance indicators seem to indicate that India has performed quite poorly on health indicators and is quite far from achieving its stated goals of universal healthcare access for all.

Keywords: public health, doctors, nurses, para-medical personnel, pharmacists

1. Introduction
The past and the running government programs of health sector reflected several problems. Indian government is facing many problems related to the expansion of health sector. There is common negligence about technologies among health care professionals. The policy makers and service providers do not have access to a quality and reliable data about customers and users resulted in many imaginary and unsuccessful projects. The health professionals in the public health delivery system lack skills, motivation and clarity. Indian experts are now considering IT interventions very useful in the many areas of public health such as vaccine and drug supply, intelligence gathering, water and sanitation, routine health care of maternal and child health, services in emergencies, health care education and training of workers etc. Modern technologies will be more useful in education and training of health care workers. Education will upgrade skills and increase the capacity of workforce.

2. Government Policies
2.1 National Rural Health Mission (NRHM)
In 2005, the government launched its flagship program National Rural Health Mission (NRHM). It is still a fundamental and the largest program for government to provide the accessible healthcare services to all the rural areas. This was established to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. The mission statement from the NRHM document identifies the importance of health for the public and the country. It focuses on the improvement in the basic health care delivery. The plan of action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and distrm-Health management of health programmes, community participation and ownership of assets, induction of management and financial personnel into distrm-Health health system, and operationalizing community health centers into functional hospitals meeting Indian public health standards in each block of the country [1].
The goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. NRHM has several key components such as, provision of a female health activist in each village, preparation of a village health plan through a local team headed by the health and sanitation committee of the panchayat, strengthening of the rural hospital for effective curative care and being made measurable and accountable to the community through publication of the Indian Public Health Standards (IPHS), integration of vertical health and family welfare programmes, optimal utilization of funds and infrastructure at the local level, and Strengthening delivery of primary healthcare in the community etc. NRHM includes some new key components also related to the creation and up gradation of healthcare management systems such as, Sub-Centers (SC), Public Health Centers (PHC), Community Health Centers (CHC), revitalizing and mainstreaming AYUSH, mission flexible pool untied funding, JananiSurakshaYojana (JSY), Accredited Social Health Activists (ASHAs), involvement of Hospital Development Societies (HDS), Rogi Kalyan Samitis (RKS), Village Health and Sanitation Committees (VHSCs), Distrm-Health Health Plans (DHP), integration of vertical health and family welfare programs at national, state, distrm-Health and block levels,

fostering public private partnerships while regulating the private sector, instituting Indian Public Health Standards(IIPHS), funds released for selection and training of ASHAs, untied grants for CHCs, PHCs and SCs, upgradation of CHCs, drug procurement, health camps, annual maintenance Grant for CHCs and PHCs, and RKS Corpus Fund and VHSNC Untied Grants etc.

The objective of this health mission is to provide effective healthcare to rural population throughout the country with a special focus on 18 states, which have weak public health indicators and/or weak infrastructure. These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh. NRHM built the infrastructure like primary health centers and hospitals and health care staff such as doctors, nurses, paramedical staff, and a special female social health activist ASHAs. NRHM has reduced the incidences of several diseases but not as the expected. We can also see the slow performance of NRHM in different states of India. NRHM provided the mobile medical units in all states covers the emergency vehicle provision, where as in Andhra Pradesh and Bihar have entered into contracting PPPs. The successful implementation of PPPs with the state funding and Satyam operating and managing Fixed Day Health Services (FDHS) through more than 75 health vans, the latter has not managed to do so (Kaveri Gill, 2009) [2]. The Bihar state health society admitted that mobile medical units were a particular store point for them. Uttar Pradesh and Rajasthan so far have no system in place at all, though it is in the planning stages. In the non-focus state of Gujarat, Chiranjeevi Yojana is a PPP arrangement introduced across five tribal dominated districts, wherein private gynecologists are empanelled to conduct free institutional deliveries, especially assisted cases, of BPL women. The success story of Gujarat was the result of private practitioners primarily but their too low honorarium led to increased dissatisfaction among them (Venkat Raman and Björkman, 2009) [3]. The TNMSC – Tamil Nadu Medical Services Corporation procures drugs and equipment from reputed manufacturers on the basis of a transparent, open tender system. The distribution takes ground stock in order to assure uninterrupted supply. As an institution, TNMSC is probably representative of the overall excellence of the public health system in the state, by secondary accounts the most superior in the country and akin to developed country systems on numerous dimensions. The public healthcare system in Rajasthan was struck predominantly by the low absolute numbers of those seeking health care. The public health system is more plausible explanation is misidentification of BPL /non-BPL by official counting criteria, as well as large numbers of those just above the poverty line.

2.2 The National Urban Health Mission (NUHM)

The population in urban areas is increasing very fast in uncontrolled way. There is a big difference between urban poor and urban rich in the life style and standard of living. Urban poor have all possible facilities by the government. Existing health and basic services like drinking water, housing, electricity, drainage, sewerage etc., are not accessible to most of the urban poor populations who live in slum or slum like conditions. Poor environmental condition in the slums and high population density makes the urban poor vulnerable to lung diseases like Asthma, Tuberculosis (TB), and vector borne diseases (VBDs). It is observed that cases of malaria, heart disease and diabetes is rising in urban areas and soon will be higher compared to rural areas. amongst the urban poor are twice as high as amongst the other urban residents. Open sewers, poorly built septic tanks, stagnant water in the ambient surroundings serve as ideal breeding grounds for insects. The National Urban Health Mission [4] (NUHM) recognizes the growth of urban areas as well as the growth of the urban poor, especially those living in the slums. NUHM recognizes the deficiency in the existing healthcare infrastructure, the inaccessibility of the health care facilities in the urban areas due to overcrowding of patients, ineffective outreach and referral systems, lack of standards and norms for urban health care delivery system, social exclusion, lack of information, lack of to access the modern health care facilities, and lack of economic resources as serious barriers to effective urban health. NUHM aims to address the health concerns by facilitating equitable access available health facilities by rationalizing and strengthening the capacity of the existing health care delivery system. It proposes to address gaps with the support of nongovernmental organizations. The key strategies in NUHM are communitised risk pooling/insurance mechanism with IT enablement, community participation in planning and management, identification of target groups through distribution of Family/Individual Health Suraksha Cards, monthly health and nutrition day, capacity building of key stakeholders, special provision to include the most vulnerable people, monitoring the quality of services, strengthening existing primary public health systems, and public private partnership for delivery of healthcare services etc. The NUHM programme, though announced with much elaboration, has recently been shelved.

2.3 National Family Health Survey (NFHS)

The National Family Health Survey (NFHS) have been initiated recently, coincided with the acceptance of the UN's millennium development goals to which India is a signatory. In India, the National Family Health Survey (NFHS) [5] has been conducted in three large scale studies in 1992-93, 1998-99 and 2005-06 with a representative sample of families throughout the country by the International Institute for Population Sciences (IIPS). The objective of these surveys is to provide state-wide and nation-wide information on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, utilization and quality of health and family planning services. The NFHS aim to provide vital data on fitness and family well-being needed by the Ministry of Health and Family Welfare and other agencies for policy and program purposes.

The NFHS-1 of 1992-93 collected extensive information on population, health, and nutrition, with an emphasis on women and young children. The International Institute for Population Studies was assisted by eighteen Population Research Centres (PRCs) located in various universities and institutes of national repute and a total of 48 reports comprising state level

and national level reports have been published. The NFHS-2 of 1998-99 covered in 26 states of India at that time. The added focus of this survey was on the quality of health and family planning services, domestic violence, reproductive health, anemia, the nutrition of women, and the status of women. The NFHS-3 of 2005-06 with eighteen research organizations, including five PRCs, being involved conducting the survey in 29 states of India. What must be mentioned here is that these larger surveys have all be done using pen and paper based methods. While this may have been the only option available for field data collection up to NFHS-3, the policy-makers need to be aware that reliable mobile solutions are now available for this critical activity of data collection. It is expected that NFHS-4, whenever it starts, will use modern mobile technologies for data collection. This program has the potential to create maximum impact on service delivery in public health but still have significant technology gaps.

2.4 National Population Register (NPR)

The National Population Register (NPR) [6] is a recent initiative of the Government of India coinciding with the acceptance of the UN's millennium development goals, which provides a comprehensive identity database of the usual residents of the country. It is expected to provide the tools for better targeting of the benefits and services under the Government schemes and programs improve planning and help strengthen security of the country. The process of creating the NPR has been included within the 15th Indian Census. The NPR aims to collect name, date of birth, sex, present address, permanent address, names of parents and spouse etc. of as many as families possible. Once this database has been created, biometrics such as photograph, ten fingerprints and probably Iris information will be added for all persons aged fifteen years and above. All usual residents will be eligible to be included irrespective of their nationality. This will be done through special camps at every village and at the ward level in every town. Each household will be required to bring an acknowledgement-slip given during the enumeration process. One the data is collected it will be verified at the local Panchayat office or the ward office. After the appropriate vetting by the Gram Panchayat or the Ward Committee the authenticated lists will be sent to the Unique Identity Authority of India (UIDAI) for de-duplication and issue of UID Numbers. All duplicates will be eliminated at this stage based on comparison of biometrics. Unique ID numbers will also be generated for every person. The cleaned database along with the UID Number will then be sent back to the Office of the Registrar General and Census Commissioner, India (ORG and CCI) and would form the National Population Register. As the UID system works on the basis of biometric de-duplication, persons above the age of fifteen years will be issued a UID Number whereas for each person below the age of fifteen years the UID Number will be linked to that of the parent or guardian.

2.5 Education and Training Programme [7]

Shortage of staffs is a distressing feature of India's healthcare services. Several initiatives have been taken in the medical education, nursing education and paramedical education, to overcome the shortage of human resources for health. At present there are 154 medical colleges are in government sector and the remaining 180 medical colleges in private sector with annual intake capacity of approximately 41,500 MBBS and 21000 post graduate students. During the academic year 2011-12, new medical colleges were established in the country with increase in the sanctioned seats of old medical colleges. To strengthen the primary health care especially at the Sub Centre level and to meet the growing health challenge it is considered necessary to create a cadre of mid-level health workers. Accordingly, the Ministry of Health and Family Welfare favoured at starting a BRHC course in the country. The Honorable President of India in her address to the Joint Session of Parliament on 4th June, 2009, announced the Government's intention to set up a National Commission for Human Resources for Health (NCHRH) as an overarching regulatory body for health sector to reform the current framework and enhance supply of skilled personnel. There are many steps taken by the government to overcome shortage of doctors, such as:

- Increase in the number of seats in colleges
- Setting up of new medical colleges with relaxation in land requirement in metropolitan and other cities
- Relaxations in bed strength
- Rationalization of infrastructure like institution block, library, auditorium, examination hall, lecture theatres, etc. has been rationalized for optimal use.
- To have common laboratories
- Requirement of hostels and residential quarters
- Registered companies allowed to establish medical colleges
- Increase in intake capacity at MBBS level has been raised from 150 to 250.
- Age limit for appointment of medical faculty raised from 65 to 70 years.
- DNB professionals are eligible for admission.
- Ratio of teachers to students relaxed from 1:1 to 1:2.
- Foreign medical degrees allowed.
- Postgraduate courses in Pre and Para clinical disciplines.
- Teaching experience reduced.
- Financial assistance to State Governments for medical colleges.
- Rural service of doctors encouraged.
- 50% Seats in post graduate diploma courses for medical officers from remote and difficult areas.
- The Central Government is engaged with a proposal for introduction of a Common Entrance Test for admission to medical courses at both Undergraduate and Postgraduate levels.

A Centrally sponsored scheme providing financial assistance of Rupees 2030 crore to high focus States of the country for establishment of 132 ANM and 137 GNM Schools is under implementation. A scheme for establishment of 6 Colleges of Nursing at the sites of AIIMS like institutions at the cost of 120 crores is under implementation. Presently the nurse physician ratio in the country is 1.5:1 as against international norm of 3:1. Current annual training capacity for nurses is 1.75 lakh. Number of registered nurses in the country is 1.70 lakh out of which around 4 lakh are active. There are many steps taken to facilitate reforms in the nursing sector:

1. Student patient ratio has been relaxed from 1:5 to 1:10.
2. The land from 5 acres has been relaxed to construct building of 54,000 sq. ft. for School/College of Nursing and Hostel.
3. Qualification, experience, and retirement of the Nursing Teachers has been relaxed and allowed Sharing of teaching faculty for both Diploma and Graduate Programs.
4. Relaxation for opening M.Sc. (N) program. Super specialty Hospital can start M.Sc. (N) without having under graduate program.
5. Essentiality certificate to open M.Sc. (N) program from State Government is not required for those institution which are already having Indian Nursing Council recognized program like Diploma or Degree.
6. Admission for Nursing allowed for married candidates.
7. Maximum number of 100 seats will be given to those parent hospitals with 300 beds without insisting Medical College.
8. Under the Centrally sponsored scheme of Development of Nursing Services the schemes of training of nurses, strengthening of existing schools of nursing and up gradation of the school of nursing attached to medical college in to college of nursing.

There is no regulatory body governing paramedical professionals except the Pharmacy Council of India (PCI). The Ministry is proposing to create an overarching regulatory body viz. NCHRH, which is aimed to address all such issues related to paramedical education. The government has taken the following various steps to address these issues:

1. To standardize paramedical education across the country, one National Institute of Paramedical Sciences (NIPS) at Delhi and 8 Regional Institutes of Paramedical Sciences (Chandigarh, Lucknow, Bhopal, Hyderabad, Coimbatore, Bhubaneswar, Patna and at an identified location in Maharashtra) are being set up.
2. A scheme of 85 crore as financial assistance is under implementation for Strengthening/ Up-gradation of Pharmacy Institutions across the country to conduct Degree and Postgraduate courses.

2.6 The Global Public Health Intelligence Network (GPHIN)

The web based early warning system GPHIN [8] is a securely gathers preliminary reports related to public health in seven languages on a real time, 24x7 basis. While it currently supports seven languages, additional languages are planned for a future upgrade. It collects raw data by monitoring global media sources, such as web-sites and news feeds, to gather relevant information on disease outbreaks and other public health events and then filtering and analyzing it on a continuous basis. The output is categorized and notifications about public health events that may have serious public health consequences are forwarded to registered users. GPHIN is not free for potential users. Pricing is based on a number of factors such as the type of organization, the number of users and the requirement for customized features.

GPHIN tracks topics such as disease outbreaks, infectious diseases, contaminated food and water, bio-terrorism and exposure to chemical and radio nuclear agents, and natural disasters. It also monitors issues related to the safety of products, drugs and medical devices. It can provide an organization with the information necessary to better respond to emerging health risks around the world. The network is a low-cost, effective early warning instrument for chemical, biological, radiological and nuclear public health threats worldwide, such as public health events to track the domestic and international concern, real-time, 24x7 coverage of media sources from six continents, automated alert function to notify users of public health events, emerging infectious diseases with the other additional features such as public health events, early warning for outbreaks, customized to user needs, cost-effective method of conducting public health surveillance to complement other surveillance activities, and automated search function to quickly identify relevant reports.

3. Conclusion

Government Policies has shaped the healthcare system of the country as a whole and innovation improvisation is a prominent requirement of India to achieve better health for all. The current studies pointed out the lots of good steps undertaken by Government to address the large healthcare challenges. Also, according to our results, we must take into consideration long-term goals for the country to make India a Healthy Nation by designing the better healthcare policy for Nation.

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