W.P.: 313

Working Paper

IIM
WP-313

INDIAN INSTITUTE OF MANAGEMENT
AHMEDABAD

PLANNING AND IMPLEMENTATION OF HEALTH, FAMILY PLANNING & NUTRITIONAL SERVICES—CERTAIN PROBLEMS AND ISSUES

By

T. J. Ramaiah

W P No. 313
February 1980

WP313
WP
1980
(313)

The main objective of the working paper series of the IIMA is to help faculty members to test out their research findings at the pre-publication stage.

INDIAN INSTITUTE OF MANAGEMENT
AHMEDABAD

PLANNING AND IMPLEMENTATION OF HEALTH, FAMILY PLANNING & NUTRITIONAL SERVICES- CERTAIN PROBLEMS AND ISSUES

by

T.J.RAMAIAH*

Abstract

This paper discusses the major problems of planning and implementation that confront the development of comprehensive health services in India. The problems are categorised into four major groups, viz., those pertaining to decentralisation and integation largely dependent upon higher echelons of the organisation, including political; those relating to managerial processes; and those pertaining to the recipients of services and the interphase between the community and the health services organisations. The same are discussed in the national perspective, without specific reference to any particular state. A number of issues are raised to stimulate thinking and discussion.

-o-o-

During the last nearly 30 years of planned development, there has been a massive growth of health, family planing and nutritional services in India in terms of their organisational set up, physical facilities, their geographical spread, health services activities, population coverage etc. The basic philosophy, strategy for development and plans for facilities and services for their short and long term development were provided by the Health Survey and Development Committee[1] (1946). In its implementation, after Independance as an integral part of the movement of Community Development Blocks, Primary Health Centres (PHC) emerged as focal points for delivery of comprehensive health, family planning and nutritional services in rural areas. Each primary health centre with its three sub-centres (later increased to six to eight) was to cater to a population of about 80 to 100 thousand and a sub-centre for every ten thousand population. Over the last 28 years of planned development, a vast organisational structure came into being with 5,353 primary health centres and 39,012 subcentres in rural areas, each primary health centre complex having

* Public Systems Group, Indian Institute of Management, Ahmedabad.

1. Governemtn of India, Min. of Health (1946), Report of the Health Survey & Development Committee, Government of India Press, Calcutta.

been staffed by 40 to 60 health workers.

During the same period, there has been a phenomenal growth of other health care institutions such as hospitals, dispensaries, educational and training facilities for different categories of health functionaries, urban family welfare centres etc. with the Governmental concern for the menace of communicable diseases, a number of vertical programmes for control/eradication of Malaria, Filaria, Small-pox (now eradicated), Tuberculosis, Leprosy, Trachoma, Goitre, Sexually transmitted diseases, Cholera, came into being. To arrest the alarming growth of population, a National Family Welfare Programme was launched. To improve the nutritional status and in turn the health status and general well-being of the population, particularly so of the weaker and vulnerable segments of the population, a number of nutritional programmes such as Applied Nutrition Programme, Mid-day Meals Programme, Special Nutrition Programme, Integrated Child Development Scheme (ICDS), Balw di Nutrition Programme etc. were launched. More recently, in order to provide a hundred percent coverage of the rural population with Primary Health Care, a massive programme of Community Health Volunteer's Scheme was launched. Appendix I presents a comparative picture of certain important elements of such infrastructural facilities created over the last 30 years.

A substantial amount of thinking and effort has gone into such a development through out its developmental process, the inspiration and motivation for the same can be said to have come through the valued recommendation of a number of expert committees like Health Survey and Planning Committee (1961), Chadha Committee (1966), Mukherji Committee (1967), Srivastava Committee (1975), amongst many others.

However, at aggregate level, its development continued to rest primarily on empirical judgments of "some" key actors in policy process rather than on scientific evidence generated through experimentation and research[2]. As a result, the system has been fraught with a number of problems and issues, inconsistencies and imbalances in planning and implementation of comprehensive health, family planning and nutritional services. The same are discussed in the following pages, classified under four major groups, namely, of decentralization, integration, managerial processes and of community participation.

Decentralization : Planning for Health, Family Planning and Nutritional services (as of others) in India has been centralized to a great extent in Yojana Bhawan, despite a number of mechanisms to involve states, concerned Administrative Ministries of Government of India and the political decision makers through Central Councils of Health and Family Welfare and National Development Council. Some of the important elements in such a process are :

a) Yojana Bhawan, in consultation with the Ministry of Health & Family Welfare initiates the process by preparation of plan guidelines, circulates it to the states for preparation of a Five Year Plan;

b) State Governments prepare draft plans and submit this to the Ministry of Health and Family Welfare/Ministry of Social Welfare;

---

2. Government of India, Ministry of Health & Family Planning (1976). Operations Research for Improved Delivery of Health Services - Report of the Task Force, NIHAE, New Delhi.

c) The Central Ministry forwards the same to Yojana Bhawan along with their own plan (generally, central component).

d) A series of meetings then take place between the concerned parties in Yojana Bhawan resulting in a Draft Plan;

e) The same is discussed by the National Development Council resulting in the final plan document.

What go into the initial drafts submitted by the State Governments is essentially based on the policy decisions taken at Central Councils of Health and Family Welfare and depend to a great extent on the sources of finances, namely, whether a scheme is purely centrally funded, centrally assisted or aided. From the Third Five Year Plan onwards, a new dimension has been added to the general process described above, that is, a number of Working Groups constituted by Planning Commission consisting of experts in the field deliberate on the strategy and priorities whose recommendations become an important input to the Draft Plan. Thus, the process has been highly centralized resulting in[3]

i) adoption a single model of development and delivery of services with little or no flexibility to experiment with new ideas or innovations;

ii) lack of development of resources (talent and skills) at levels below the state level (district and below) to plan strategies and priorities to workout a economic, financial and other implications and to prepare sound project reports, based on the local needs and local resources;

---

3. Government of India, Planning Commission (1964) The Planning Process, Government of India Press, Faridabad.

iii) lack of involvement of enlightened public, public/private institutions and communities and their representatives at large in the preparation of local plans; and

iv) lack of mobilization of local resources (technology and finances) and continued excessive dependance on imported technology and foreign aid.

As a consequence, the problems of phasing of targets and other estimates did not receive enough of study, tended to be unrealistic and hence their realisation has been adversely affected. The plans tended to become rigid while they ought to be flexible and open to change, even under favourable conditions, both in terms of targets and benefits and of cost estimates and financial returns to facilitate introduction of changes/adjustments in their implementation, required called for on account of factors which could not be anticipated at the stage of plan preparation. The examples of such phenomena have been innumerable and the planners who have been associated and involved in the process could count them. The basic questions that come up, therefore, are shall we continue with the present centralized planning process or decentralize it ? If it is to be decentralized, upto what level ? What are the preconditions to facilitate such a decentralized planning process and help sustain the same ? What should be operational mechanisms to ensure that the plans are need-based and local ? Gujarat and Maharashtra have certain decentralized systems of administration of development processes at district level, through Panchayatraj System which, it is given to understand, has facilitated decision-making to make the organisations responsive to the

local needs. It would be worthwhile to examine the characteristics and the systematics processes of the panchayat system to develop the same further.

The solutions to these questions have their deep roots in political philosophy and political thought. It is, however, possible to search for solutions, with initial limited success though, at the operating levels through creation of facilitating environment and conditions.

Integration : The delivery of comprehensive health services (preventive, promotive and curative health, family planning and nutritional services) in an 'integrated' way and development of health services organisations to develop and foster that concept was imbedded into the basic philosophy and strategy initially accepted towards development of health services[4]. With the subsequent addition of a number of vertical programmes, this concept got completely diluted and the development of health services got distorted. It was, however, argued that the infrastructure was not adequate to execute and combat some of the serious health problems in a short period except through vertical programmes designed specially to meet the needs of a problem and would be integrated into the functioning of primary health centres as soon as the problem was brought under control. As a consequence, the development of basic infrastructure suffered and it continued to remain inadequate to

---

4. Tewari, T R , etal (1971), An Exploratory Study of Integrated Health Services in India, National Institute of Health Administration and Education, New Delhi (mimeographed). This is the first and the last major study which explored the issues in integration in their totality in India.

take over a vertical programme when they reached maintainance phase[5]. The examples of the same can be found in the eradication of smallpox and Malaria. Even the vertical programmes did not achieve the desired objectives and goals but continued to consume vast resources (the opportunity costs deserve to be assessed). This led to a committee on multipurpose health worker which deliberated and recommended conversion of the existing health care system based on unipurpose health workers into that of multipurpose health workers[6,7]. While the scheme was accepted in principle, its implementation received serious setbacks because of, again, vertical programmes. Even now, its implementation has been partial. The only State which has implemented MPW scheme in all the districts is Gujarat. This scheme attempted to bring about integration in the roles of peripheral health workers, without commensurate structural and functional changes in the higher echelons of the organisation. While Primary Health Centres have an important role to play in Nutritional Programmes, they continued to remain

---

5. Krishnaswamy Rao, S (1969), Towards new horizons in health administration (mimeographed)

6. Government of India, Ministry of Health and Family Planning (1973), Report of the multipurpose Health Worker Committee (mimeographed).

7. Satia, J K: Morten, David C (1976), Integrated Health care Services for India, Indian Institute of Management, Ahmedabad (mimeographed) - This case discusses the origin and development of MPW scheme, the organisational set up before and after MPW scheme, the perceptions of functionaries and the anticipated problems.

administratively outside the health bureaucracy. While the technical supervision, guidance and control is with PHC Medical Officer and District Medical Officer of Health, administratively the control rests with Block Development Officer. A number of evaluative[8,9,10,11] studies of MPW scheme revealed that while it helped towards role integration of peripheral level, it discouraged team work and perpetuated family-oriented service delivery and communication of the old structure and not the community-oriented approach which is essential for a number of activities under comprehensive health care such as environmental sanitation, nutrition, health education etc.[12]. In reality, the very concept of integrated health services, particularly in relationship to family planning, maternal and child health and nutritional services, has continued to elude application in practice. This experience

8. Maru, R M, Nirmala Murthy and Satia, J K (1976) Multipurpose worker scheme - A study of pilot Implementation in Channi Primary Health Centre, Indian Institute of Management, Ahmedabad (mimeographed).

9. Murthy, N (1977), Multipurpose worker scheme in Singapur Block, RaeBareli, Indian Institute of Management, Ahmedabad (mimeographed).

10. National Institute of Health Administration and Education (1973), Study of District Health Administration, Report of Phase I, NIHAE Report No. 7 (mimeographed).

11. Kumar, P V S (1979), The Family Planning Programme implementation in Rural Andhra Pradesh, Ph.d. Deseertation, Indian Institute of Technology, Bombay (unpublished).

12. Rushikesh Maru (1979), Organisation for Rural Health: The Indian Experience, Indian Institute of Management, Ahmedabad (mimeographed).

raises a number of basic issues on this dimension, namely, what is 'integration', does assigning of all or some related roles to one individual at one level mean 'integration' or should it to be seen in a 'holistic' way accross the total organization (vertically and horizontally) ? What are the essential structural and functional changes/modifications necessary in the total organization to make it work? What are the resultant effects in its relationship to the community organisations? and how to build an appropriate interphase between the two to ensure participation of communities in the delivery of comprehensive health services in an 'integrated' manner? Recent years have seen introduction of certain important schemes such as community health volunteer's scheme and Adult Education Programme. These have introduced individuals who operate at community level but perform closely related activities of health, education and welfare in addition to those already working at that level such as Anganwadi Workers of ICDS, Organisors of feeding centres as a part of supplementary Nutrition Programme, Village Level Workers (VLW) from Agriculture etc. Recognising that health, population, nutrition and development are inseperable parts of the whole which mutually influence and supplement each other[13,14,15],

---

13. Economic and Social Commission for Asia and the Pacific (1977), Report and Selected papers of the Expert Group Meeting on Organisational Aspects of Integrating Family Planning with Development Programmes, Asian Population Studies Series No.36, ESCAP, Bangkok.

14, Ibid (1978), Report on Evaluation of the Role of Population Factors in the Planning Process through Application of Development Models, Asian Population Studies Series No.37, ESCAP, Bangkok.

15. Ibid (1977), Population Growth and Economics Development in Sub-national Areas - Report of an expert group meeting, A.P.S.Series No.40, ESCAP, Bangkok.

how to integrate or develop appropriate interactive linkages and make them operationalise? How to develop a system or help facilitate processes in a system where in each functionary perecives his roles as supportive and contributory to those of others in the larger perspective of development, realises the linkages and works towards their fulfilment? These are questions with serious implications for planning and implementation. While varied experiences exist[16], unique solutions to suit all social and political systems do not exist.

Management: The medical professionals who are entrusted with the primary responsibility of managing health services organisations have been far ill-equipped to perform the job. There has been continued struggle with the self perpetuating role conflict between the practice of medicine on one hand and the practice of administration on the other, leading to many short comings in the management of health organisations, viz. in planning and organising, in supervision and control. Let us examine them.

1. There has been considerable increase (about 500%) in educational facilities for doctors in the country and continued to produce them based on western model of medical education of hospital-based, patient-centred, clinical medicine. The result has been about 72 percent of them are available in urban areas where about 20 percent of the population live and the remaining only 28 percent are in rural areas where bulk of the population (80%) live;[17]

---

16. Rushikesh M Maru, T V Rao, V K Gupta, J K Satia, and G Giridhar (1979), Managing Population and Development Linkages: The Egyptian Experience, Health and Population Unit, Indian Institute of Management, Ahmedabad (mimeographed).

17. Ramaiah, T J (1979), The researches relevant to Health Care Needs and demands, A key note address presented at the National Conference on Medical Education, August 1979, New Delhi.

2. While we have been propounding the urgent need for development of rural health services, the reality was towards strengthening urban areas. If the number of positions created for doctors in the organised health care system is some measure of it, it was estimated that the same in urban institutions during last about 30 years was about three times the corresponding figure in rural health institutions[17].

3. Undue emphasis was given to the production of doctors and to the neglect of other categories of health personnel. As a result, we have created an hour-glass of health manpower situation wherein the doctor-nurse ratio has been 2:1, while it ought to be the reverse[17].

4. While on one hand there has been perceived demand for certain categories health manpower (such as doctors and nurse), paradoxically there also exists unemployment amongst them. In fact, the supply-demand situations have been ill-balanced with no appropriate systems for placement[18,19,20].

---

17. Ramaiah, T J (1979), The researches relevant to Health care Needs and demands, A key note address presented at the National Conference on Medical Education, August 1979, New Delhi.

18. Ramaiah, T J, Bhandari S C(1975), The supply and Demand for Allopathic Medical Graduates, 1978-79, NIHAE Research Report No.27, NIHAE, New Delhi (mimeographed)

19. Kataria, M, Ramaiah T J (1978), The supply and Demand for certain categories of specialist Medical Manpower, National Institute of Health and Family Welfare, New Delhi (mimeographed).

20. Government of India, Ministry of Health and Family Planning (1976) Loc.cit.

5. While the primary health centres are to provide preventive, promotive and curative services wherein preventive and promotive services constitute a bulk of them, the chief of the set up at this level is the doctor, major part of whose training comprises of curative medicine. He is not oriented towards the host of auxiliary and para health professionals work therein. The community education, community health and community approach are things alien to him which infact are his important tasks, functions and philosophies[21];

6. Role conflict, role ambiguity and role overlap are predominant, particularly so in rural health services organisations;

7. Systematic plans for implementation of programmes and projects, activity plans at grass root levels do not exist;

8. Supervision and control are hard to find, while some forms of occasional inspections do exist[21];

9. While different categories of health personnel do spend considerable time of theirs in information gathering, processing and reporting, the available information systems are ill-suited to provide effective feed-back and control[21]; and

10. The intra organisational communication and communication between workers and clients are much to be desired. The health workers in the primary health centres are expected to be a 'team' led by the medical officer which in reality is only notional;

---

21. Ramaiah, T J (1978), A review of researches in rural health services in India (mimeographed)

11. A hierarchy of health organisations exist which are expected to provide different levels of health care services (primary, secondary and tertiary). The effective functioning in terms of being able to provide services to distinct client groups with as little duplication of éffort, depends upon a well planned system of regionalisation of services and referal systems. While much has been said and written on this theme, not even a semblance of the same is in evidence;

12. The available systems for procurement, storage, distribution and dispensing of medicines and drugs; maintainance and repairs of equipment and vehicles are much to be desired. These have led to a paradoxical situation wherein there existed considerable under utilisation of the available facilities on one hand and considerable unmet felt-need on the other[22]. The quality and content of care provided, particularly so by the primary health centres, has been far from adequate[23]. There has been undue emphasis on doctors, hospitals, hospital beds, sophisticated equipment etc, which could do little of lasting good[24]. The questions that the planners and administrators should address

---

22. Banerji, D (1973), Social and Cultural Foundations of the Health Services Systems of India, Jawaharlal Nehru University, New Delhi.

23. Department of International Health, School of Hygine and Public Health, Johns Hopkins University (1975), Functional Analysis of Health Care Needs and Demands, Asia publishing House, Bombay.

24. The Pan American Health Organisation (1977), Health Care means more than doctors, WHO Chronicle, 31, 12: p. 485 - 486

themselves are a) are these problems insurmountable? b) if not, what should be the strategy (ies) and operational designs to bring in innovative management processes to improve the efficiency and effectiveness of health delivery systems?[25]

<u>Community Participation:</u> Health care services are accepted as a basic human right. However, large population groups have little or no access to even the most rudimentary forms of health care. There is a growing recognition that most of the problems discussed earlier arise out of adoption of wrong model of health care which relies heavily on large number of doctors, which is urban and hospital oriented, depending heavily on sophisticated facilities and equipment and which provides and propogates curative care rather than preventive and promotive services. Attendant to these are over professionalisation of medical care and accentuated costs. This has led to search for and experimentation with alternative models of delivery of comprehensive health services. In the wake of such a search was the report[26] of a group on Medical Education and Support Manpower (1975) which made far reaching recommendations, amongst others towards creation of a band of voluntary, part-time health workers selected and supervised by communities and drawn from amongst them to provide primary health care as a supplement to fully trained personnel and not as a substitute for them. The

---

25. Rushikesh Maru, Nirmala Murthy, T V Rao, and J K Satia (1979), Introducing Professional Management in Public Systems: some observations from IIMA's Research on Management of Population Programme, Indian Institute of Management, Ahmedabad (mimeographed).

26. Government of India, Ministry of Health and Family Welfare (1975), Health Services and Medical Education - A programme for Immediate Action, Indian Council of Social Science Research, New Delhi.

community involvement and their participation in the delivery of primary health care services was the basic premise of their recommendations. This has led to the launching of community health volunteer's (CHV) scheme in 1977 by Government of India. There has been a global recognition for development of such systems[27]. A number of evaluative studies[28,29,30,31,32] have been undertaken of the CHV scheme, implemented in India. The findings of these studies, which are in general complementary, provided a valuable understanding of the scheme in terms of its functioning, strengthes and weaknesses that pertain to managerial aspects of the scheme such as procurement and supply of inputs, training of trainers and of CHVs etc., an important but major concern expressed was pertaining to community participation and involvement in the scheme. The success of this scheme or any other social service

---

27. World Health Organisation (1978), Primary Health Care, Report of the international conference on Primary Health Care, Almaa-Ata, 1978. This conference not only provided a declaration on 'Health for all' by 2000 A.D. but also provided an outline of the approach in the context of role of Primary Health Care in and for development, its operational aspects and national strategies and international support for the same.

28. National Institute of Health & Family Welfare and others (1978), An Evaluation of Community Health Worker's Scheme- a colloborative study. Tech. Report 4, NIHFW, New Delhi.

29. Bose, Ashish etal (1978), An Assessment of New Rural Health Scheme and suggestions for improvement. Institute of Economic Growth, New Delhi (mimeographed).

30- Vohra, H R, Ramaiah T J, Rao, K G (1978) Dynamics of selection of community health workers - a study in four northern states of India, NIHFW, New Delhi (mimeographed).

31. Kumudini Dandekar and Vaijayanti Bhate (1978), Maharashtra's Rural Health Services Scheme - An evaluation, economic and political weekly, Vol.XIII. No.50, pp.2047-2052

scheme depend to a great extent on the degree of community participation they have been able to achieve. Some of the basic questions that arise in this contact are what is community participation and involvement ? How to go about designing systems that elicit it? How to operationalise such systems? What are the preconditions for their acceptance/success? The participation and involvement has been brought about in the CHV scheme to some extent only in the selection of CHVS. However, in the field of health, we have had a number of experimental projects[33] operating at the village level which aimed at provision of primary health care services to the rural population. While these projects differ from each other on many a dimension, they however, attempted to bring about community particpation through adoption of different models. These models are based on local self reliance, people's active participation in social and economic development activities, community decision making in selection of workers, local contribution in cash, facilities, manpower, logistic support, construction and maintenance of facilities etc.

---

32. National Institute of Health & Family Welfare and others (1979), Repeat evaluation of community Health Volunteers' Scheme-1979, A collaborative study, Vols. I & II, NIHFW, 1979, (mimeographed)

33. Indian Council of Medical Research (1976) Alternative Approaches to Health Cafe - Report of a symposium jointly organised by ICMR & ICSSR, ICMR, New Delhi.

The Harriet Benson Memorial Hospital Project, Lalitpur in U.P. brought about community involvement through provision of physical facilities by the village for the VHW clinics, village health committees, selecting the VHWs from among the community and payment of honorarium to VHWs by the village panchayats. The comprehensive rural health project of Jamkhed attempted to bring about active community involvement through the integration of health care delivery with economic development activities like irrigation facilities, tube-well digging making of roads, farming etc. The Mandve Project in Maharashtra also attempted to bring about the community involvement wherein health is seen to be an integral part of economic development programmes and social participation in health is attempted through economic activities such as cultivation of land etc. As against these, we have the well known health cooperatives in Kerala which are based on community involvement wherein the people contribute for the services and they manage the cooperatives. These are only some examples. These models clearly indicate that there does not exist a single unique model for community participation and involvement to be used for the whole country. The levels of literacy, the social and economic conditions of the people, their paying capacity, their perceived health needs and the priority of health needs amongst other social and economic needs of families and communities etc. play significant role in eliciting their involvement and its sustainance[34]. In addition, their perception of the benefits derived and the extent to which the governmental inputs in the scheme are seen to be the incentives also matter.

---

34. Rushikesh M Maru (1978), Approaches to community Participation in Population Programmes of India and Egypt. Indian Institute of Management, Ahmedabad, (mimeographed).

What has been presented in the proceeding pages is a critical analysis of the total developmental process of health, family planning and nutritional services in India leading to the identification of problems and issues in their planning and implementation in a national perspective. The attempt is neither to decry the system nor to discount the achievements, but only to provide a framework within which to look for meaningful solutions which are viable, system-wide and help towards achievement of the goals of health for all and suited to our social and economic mileau. The four dimensions discussed are complementary to each other, together lead towards development of system(s) which is sensitive and responsive to the needs. We have been able to add many tasks which have themselves been undergoing many changes and therefore, the need for development of decentralized and integrated systems with appropriate managerial process is imperative. It is, however, to be recognised, not as a constraint but as a reality, that unique solutions do not exist for any one problem and each development administrator has to look for such solutions specific tp a given geographical area through diagnosis and experimentation.

Appendix I

Growth and Development of Infra-structure for Health, Family Planning and Nutrition Services during 1950-51 1971-72 and 1977 All India.

Category	1950-51	1971-72	1977
1. No.of Hospitals and dispensaries	8,600	14,438	15,257
2. No.of PHCs	0	5,195	5,353
3. Number of subcentres	0	32,218	39,012
4. Urban Family Welfare centres	0	-	1,937
5. Hospital beds	113,000	298,304	391,738*
6. No.of Medical colleges	30	99	106
7. No.of Health & Family Welfare Training centres	0	-	46
8. No.of Nursing Institutions - General Nursing	-	263	309*
- ANM's	-	315	337*
- LHV's	-	19	23*
9. Annual Admissions to Medical colleges	2,500	12,526	13,561*
10. Annual Admissions to Nursing Institutions			
-General Nursing	6,100	19,665	20,642*
-ANM's	163	11,002	9,690*
-LHV's	92	1,333	1,841*
11. St8ck of Doctors	59,000	138,000	185,000
12. Stock of Nurses	17,000	77,824	-
13. No.of Mobile services units under Family Welfare programme	0	-	191
14. No.of CHVs	-	-	105,000

* for 1974.

Sources : 1. Government of India, Ministry of Health and Family Welfare (1979), Family Welfare Programme in India year Book (1977-78), Mass Mailing Unit, Dept. of Family Welfare, New Delhi.
2. National Institute of Health & Family Welfare (1977), Health Sector of India - An overview, NIHFW, New Delhi.