Health Committee

SWRK4021

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Bhore Committee

- Constituted by pre independent GOI
- - Under Sir Joseph William Bhore, Indian Civil Servant
- Formed in 1943
- “Health Planning and Development Committee

Bhore Committee Report

Submitted in 1946
Runs into 4 volumes
Volume I A survey of the State of the Public Health and the existing health organisation
Volume II Recommendations
Volume III Appendices
Volume IV Summary

The Bhore Committee (1943-1946)

During pre independence era, to improve the preventive, promotive and curative heath services of country, a ***National Planning Commission was set up by the Indian National Congress in 1938.*** The rulers of that time, the British Empire realised the importance of Public Health and instituted the 'Health Survey and Development Committee,' in the year 1943 under the chairmanship of **Sir Joseph Bhore**.

The committee was conducted the survey the about health conditions and health organisations in the country, and to make recommendations for future development.
The committee submitted its report in1946. The **integration of preventive, promotive and curative health services** and establishment of **Primary Health Centres in rural areas** were the major recommendations made by this committee.

Important recommendations of the Bhore Committee

- Integration of Preventive, Promotive and Curative services at all administrative levels.
- The development of Primary Health Centres for the delivery of comprehensive health services to the rural India. Each PHC should cater to a population of 40, 000 with a **Secondary Health Centre (now called Community Health Centre)** to serve as a supervisory, coordinating and referral institution.
- In the long term (3 million plan), the PHC would have a 75 bedded hospital for a population of 10,000 to 20,000.

It also reviewed the system of medical education and research and included compulsory 3 months training in Community Medicine.

Committee proposed the development of National Programmes of health services for the country.

The details of the **Long term plan** recommended by Bhore Committee by different level as: follows:

Primary Unit – PHC, First Tier
Secondary Unit- CHC, Second Tier
District Hospital, Third Tier

Primary Unit: Primary Health Centre

- Every 10,000 to 20,000 population (depending on density from one area to another)
- would have a 75-bedded hospital
- Served by Six Medical Officers including medical, surgical and obstetrical and gynaecological specialists.
- This medical staff would be supported by 6 public health nurses, 2 sanitary inspectors, 2 health assistants and 6 midwives to provide domiciliary treatment.
- At the hospital there would be a complement of 20 nurses, **3 hospital social workers**, 8 ward attendants, 3 compounders and other non-medical workers.

The Two medical officers along with the public health nurses would engage in providing preventive health services and curative treatment at homes of patients.

The sanitary inspectors and health assistants would aid the medical team in preventive and promotive work. Preferably at least three of the six doctors should be women.

The 75 beds,
25 would cater to medical problems,
10 for surgical,
10 for gynaecological,
20 for infectious diseases,
6 for malaria and four for tuberculosis.

This primary unit would have adequate ambulatory support to link it to the secondary unit when the need arises for secondary level care. Each province was given the autonomy to organize its primary units in the way it deemed most suitable for its population, but there was to be no compromise on quality and accessibility.

Secondary Unit- Community Health Centre

The secondary unit would be a 650-bedded hospital having all the major specialities with:
a staff of 140 doctors,
180 nurses and , 178 other staff including
15 hospital Social Workers, 50 ward attendants and
25 compounders.

The secondary unit besides being a first level referral hospital would supervise, both the preventive and curative work of the primary units.

Note: The 650 beds of the secondary unit hospital would be distributed as follows: Medical 150, Surgical 200, Obs. & Gynae 100, Infectious Disease 20, Malaria 10, Tuberculosis 120, and Paediatrics 50. Total 650.

District Hospital

- Every district centre would have a 2500 beds hospital providing largely tertiary care with 269 doctors, 625 nurses, **50 Hospital Social Workers** and 723 other workers. The hospital would have 300 medical beds, 350 surgical beds, 300 obs. & gynae beds, 540 tuberculosis beds, 250 paediatric beds, 300 leprosy beds, 40 infectious diseases beds, 20 malaria beds and 400 beds for mental diseases.

  A large number of these district hospitals would have medical colleges attached to them. However, each of the three levels would have functions related to medical education and training, including internship and refresher courses.

Recommendations

- 3 months training in preventive and social medicine to prepare 'SOCIAL PHYSICIANS'
- Special emphasis on preventive work (Integration of curative and preventive services)
- Village Health Committee consisting of 5 to 7 individuals for procuring the active participation of the people in the local health programme.
- Inter-sectoral Coordination

This document laid the utmost emphasis on primary health care; it needs no emphasis that primary health care was later on recognised as the key strategy to achieve Health for All (HFA) by 2000 during Alma-Ata conference.

The Bhore committee model was based on the allopathic system of medicine. The traditional health practices and indigenous system of medicine prevalent in rural India, which had great influence and were part of their socio-cultural milieu were not included in the model proposed by Bhore committee.

Post Independence Era:

- With the beginning of health planning in India and first five-year plan formulation (1951-55), **Community Development Programme** was launched in **1952** for the all-round development of rural areas, where 80% of the population lived. Community Development was defined as "a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance upon the community's initiative". The Community Development Programme was envisaged as a multipurpose programme covering health and sanitation (through the establishment of primary health centres and sub-centres) and other related sectors including agriculture, education, transport, social welfare and industries. Each Community Development Block (CDB) comprised approximately 100 villages with a total population of one lakh. For one CDB, one Primary Health Centre was created. (11)

Constituted in 1959 By GOI Under Dr. A Lakshmanswamy Mudaliar, 1961
Vice Chancellor, Madras University Health Survey and Planning Committee"

- Consolidation of 1st to 5 yr plans
- Strengthening DH to serve as central base for specialist services
- Regional organisation between headquarters and regional **DD and AD**
- PHC - 40,000 population
- 1 Basic Health Worker per 10,000 population
- Improve secondary services
- Integration of Medical and Health services
- All India Health Service
- By the close of second five year plan (1956-61), "Health Survey and Planning Committee", The **Mudaliar Committee (1961)**, was appointed by the Government of India to review the progress made in the health sector after submission of Bhore committee report. The major recommendation of this committee report were:

to limit the population served by primary health centres to 40,000 with the improvement in the quality of health care provided by these centres.

Strengthning of the district hospitals with specialist services to serve as a central base of regional services.

Regional organisations in each state between headquarter organisation & the district incharge of a Regional deputy or assistant directors each to supervise 2 or 3 district medical & health officers.

Constitution of an All India Health Service on pattern of Indian Administrative Service.

Chadha Committee **(1964)**
(Dr. M.S. Chaddah)

- A committee of health administrators and malariologists reviewed the National Malaria Eradication programme and recommended that a special Committee should study in detail the preparations that are to be made for the entry into the maintenance phase and formulate a plan.
- Constitued in 1963
- By GOI
- Under Dr. MS. Chadha, Director General of Health Services

The **Chaddah committee (1964)**, recommended provision of one basic health worker per 10,000 population for vigilance operations through monthly home visits under national malaria eradication programme. These workers were envisaged as **multipurpose health workers to look after additional duties of collection of vital statistics & family planning.** The family planning health assistants were to supervise 3 or 4 of these basic health workers.

Mukharji Committee 1965
Shri B. Mukharji

- Following the Central Family Planning Council meet at Madras
- Constituted in 1965
- Headed by Shri Mukerji, Secretary, Ministry of Health and Family Planning

In a short time after implementation of Multiple Health Worker (MPHW) scheme it was realised that malaria vigilance operations & family planning program could not be carried out effectively.

A committee known as **Mukerjee committee** was formed in **1965** & it recommended separate staff for Family planning activities so that malaria activities could receive undivided attention of its staff.

Kartar Singh Committee 1973

- Meeting of the Central Family Planning Council 1972
- By GOI
- In 1972
- "The committee on Multipurpose workers under Health and Family Planning"
- Kartar Singh, Addl. Sec., MOHFP
- Report in 1973

Multipurpose workers - feasible and desirable

Re-designation

ANMs replaced by **FHW**s

BHW, Malaria surveillance workers, vaccinators, FPHAs replaced by **MHW**s

LHV designated as FH supervisor

To be first introduced in malaria maintenance phase areas and small pox controlled areas

Clearly spelt out the job functions of HWs and Supervisors

The **Kartar Singh Committee** was framed on Multipurpose workers in **1973** which laid down the norms about health workers. For ensuring proper coverage the committee recommended,

- One Primary Health Centre to be established for every 50,000 population.
- Each primary health centre to be divided into 16 sub-centres each for a population of 3,000 to 3,500.
- Each sub-centre to be staffed by a team of one male and one female health worker.
- The work of 3-4 health workers to be supervised by one health assistant. The doctor in-charge of the PHC should have the overall charge of all supervisors & health workers in his area.

The **Shrivastav Committee** on Medical Education and Support Manpower in **1975** suggested:

Creation of Pay bands of Para-professional and semi-professional health workers from within the community (e.g. school teachers, post masters, gramsevak, etc.) to provide simple health services needed by the community.

- the development of a "Referral Service Complex" by establishing linkages between the primary health centre and higher level referral and service centres, viz taluka/ tehsil, district, regional and medical college hospitals.

establishment of a medical & health education commission for planning & implementation of reforms needed in health & medical education on the lines of university grant commission.
One male & female HW should be available for every 5000 population.

The Health Assistants for every two HWs should be located at SC & not at PHC

Following the suggestions of the Shrivastav committee report, **Rural Health Scheme** was launched in **1977**, wherein training of community health workers, reorientating medical education (ROME) training of multipurpose workers, and linking medical colleges to rural health was initiated. It was based on principle *"placing people's health in people's hands".* Also to initiate community participation, the Community Health Volunteer-Village Health Guide (VHG) Scheme was launched. The VHG was to be a person from the village, mostly women, who was imparted short term training and small incentive for the work.

Bajaj Committee health report 1986

- Recommended for Formulation of National Health Manpower planning based on realistic survey.
- Educational Commission for health sciences should be developed on the lines of UGC.
- Recommended for National and Medical education policy in which teachers are trained in health education science technology.
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- Uniform standard of medical and health science education by establishing universities of health sciences in all states.
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- Establishment of health manpower cells both at state and central level.
- Vocational courses in paramedical sciences to get more health manpower

Krishnan Committee Health Report 1992

The committee address the problems of urban health and devised the health post scheme for urban slum areas. The committee had recommended one voluntary health worker (VHW) per 2,000 population with an honorarium of Rs 100. Its report specifically outlines which services have to be provided by the health post. These services have been divided into outreach, preventive, family planning, curative, support (referral) services and reporting and record keeping. Outreach services include population education, motivation for family planning, and health education. In the present context, very few outreach services are being provided to urban slums.

Other Notable Committees Sokhey Committee (1947)

- prescribing standards of dietary and nutrition for all classes of population;
- consideration of the nature and incidence of the various epidemic which take a heavy toll of life, and suggestion of ways and means for guarding against theses scourges;
- investigation into the volume and causes of infant mortality, as well as mortality among women; and suggestion of ways and means of reducing such mortality;
- provision of the necessary health units, comprising physician, nurses, surgeons, hospitals and dispensaries, sanatoria and nursing homes;
- health insurance;
- medical training and research;
- compilation of vital statistics, including those of birth and death rates;
- cultivation of the necessary drugs and production of medicines to preventive or curative aid, scientific and surgical appliances and accessories of the national Health Services

Chopra Committee (1948)

- promotion of indigenous and modern medicine through integration in education and multi-disciplinary research

Mehta Committee (1957)

- Balwant Rai Mehta

To assess performance of Community Development Programme started in 1952

- concluded programme was a failure due to lack of local initiative

Renuka Roy Committee (1960)

- **School Health committee**
- recommended promotion of preventive care through schools, provision of mid day meals, health education as part of curricular and integration of school health and primary health network

Jain Committee (1966)

- to **review the working of different hospitals and central health services**

Krishnan Committee (1982)

- headed by S.V. Krishnan
- to **study health services in urban areas** and cities

Mehta Committee (1983)

Dr. Shantilal J. Mehta, Chairman

"Medical Education Review Committee"

Bajaj Committee (1987)

Prof. J.S. Bajaj, Professor of Medicine

HEALTH MANPOWER PLANNING, PRODUCTION AND MANAGEMENT

- Procedures relating to admissions to under-graduate courses
- Procedures relating to admissions to the post-graduate course
- Duration of the under-graduate course and Internship
- Duration of the post-graduate courses and thesis
- Review of the Residency Scheme
- Measures to bring about overall improvement in the under-graduate and post-graduate education

Report of the National Commission on Macroeconomics and Health (2005)

- Under chairmanship of P. Chidambaram, Finance Minister and Dr. Anbumani Ramadoss, Health Minister
- promoting equity by reducing household expenditure on total health spending and experimenting with alternate models of health financing;
- restructuring the existing primary health care system to make it more accountable;
- reducing disease burden and the level of risk;
- establishing institutional frameworks for improved quality of governance of health;
- investing in technology and human resources for a more professional and skilled workforce and better monitoring

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Thank you