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Editorial

# Gaps in Goals: The History of Goal-setting in Health Care in India

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There are several instances where specific targeted programs and goals have wreaked havoc with the health services system in several countries. After the family planning program and the small-pox eradication drive, the recent case of such diversion happened due to the pulse-polio program. We have sufficient evidence now regarding the distortions the pulse-polio program created in the health services with its uni-focal and intensive drives which affected the total coverage of immunization.[1] The Millennium Development Goals (MDGs) is the new target which is being thrust on the Indian health services although not as directly as some of the earlier targeted activities.[2] When we examine the history of Goal-setting in India which we attempt in this editorial with respect to some select policies, programs and strategies such as the recommendations of the Bhore committee, the family planning program, the Health For All strategies and the RCH program, it is possible to understand the weaknesses in such exercises. However, these experiences could serve as valuable lessons for the health planning process especially given the emphasis on Millennium Development Goals.

## 1. *The first goal-setting: the Bhore committee*

The first goals for the Indian health services were suggested by the Bhore committee (1946) the recommendations of which laid the foundations of the health services in the country.[3] These included both short-term program for two five year plan periods and a long-term program for a distant future. With respect to the primary units, the short-term goal was to set-up Primary Health Centers with coverage of 40000 each with secondary health center as a supervisory institution. In the long run, the committee visualized a PHC to serve a population of only 20000. The functions of the PHC included curative care to both inpatients and outpatients, maternal and child health services including family planning, communicable diseases, school health, environmental sanitation and health education. The Mudaliar committee appointed by the Government of India in 1959 and which submitted its report in 1961 noted that the primary health center program bears no resemblance to that visualized by the Bhore Committee[4]. The committee was of the view that it will not serve any useful purpose to open PHCs without adequate facilities, resources and personnel.[4] It took more than three decades to even achieve something distantly similar to the even short-term goals of the Bhore committee.

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## 2. *Targets and their failure in family planning*

The fate of family planning program is well-known which went through rough roads on a number of occasions. Adoption of a stringent control rather than welfare strategy, excessive use of coercion to achieve targets, use of methods with perceptible side-effects, thrusting targets on the personnel and disturbing the integrated working of the health services for intensive drives etc. etc. are all reasons which created a negative stereotype regarding the program. Failure in achieving the goals of NRR 1 could be attributed to the social determinants which the techno-centric program could not address.

The target-driven approach was only discontinued during the post-Cairo period and largely as a result of the RCH philosophy which advocated a target-free approach for the health workers.

## 3. *Health for All by 2000 AD*

One of the most positive milestones as a policy and perhaps the most negative in terms of its outcome in international health, Health For All (HFA) and the Primary Health Care (PHC) strategies had some major influences on the health services in different countries including India, at least at the level of policies. The joint report of the WHO/UNICEF presented at the conference can be considered as a treatise on social sciences in health although the essence of the report never got translated into concrete actions.[5] The report does not see primary health care as a set of targeted actions or goals but rather as a comprehensive strategy to achieve Health For All. A health system is visualized as consisting of inter-related components from both health and other sectors. The goal of health for all thus can be achieved only by comprehensive actions in coordination with overall development of the society, community participation, self-reliance, decentralization and appropriate organizational strategies.

Government of India appointed a working group on health for all by 2000 AD which submitted its report in 1981. According

to the report, Health for All included provision of a minimum package of health care services to all the segments of the population giving priority to the underprivileged sections of the society[5]. The package included:

1. Health education concerning prevailing health problems and the methods of prevention and control.
2. Adequate food supply to improve nutritional status
3. Protected water supply and sanitary facilities
4. Provision of appropriate health care to vulnerable sections such as children and pregnant women including family planning
5. Prevention of communicable and non-communicable diseases
6. Access to essential medicines and medical care.

Like the Millennium Development Goals, the report identified a number of indicators to be achieved by the year 2000. Evidently, the comprehensive strategy suggested by the WHO/UNICEF Report was largely ignored.

Let us look at the achievement as visualized by the report in this thirtieth year of Alma Ata declaration. Table 1 show that most of the projections of the Health for All (HFA) committee have not been met in 2000. Especially, the Maternal Mortality Rate is extremely high even in 2004. Similarly, the percentage of deliveries conducted by Trained Birth Attendants and the natural growth rate is also considerably lower than that projected by the HFA committee. The poor track record of achieving goals is quite evident and it questions the very basis of target-setting in health care.

**Table 1:** HFA projections and achievements

| Index | 1981<br>HFA report | 1985 | 1990 | 2000 | 2004 |
|---|---|---|---|---|---|
| CDR | 14.1 | 11.8 | 9.7 | 8.5 (9) | 7.5 |
| CBR | 33.2 | 32.9 | 30.2 | 25.8 (21) | 24.1 |
| IMR | 129 | 97 | 80 | 68 (below 60) | 58 |
| MMR | 800 | | 570 | 540^^ (below 200) | 301 |
| Net Reproduction Rate | 1.67 | 2.0 | 1.8 | 1.5 (1) | 1.4 |
| % of Deliveries by TBA | 10-15 | 18.7 | 22.9 | 29.0 (100) | 26.1 |
| Life Expectancy | 52.6 M<br>51.6 F | 55.4 F<br>55.7 M | 57.7<br>58.1<br>(58.0)<br>(57.7) | 61.0<br>62.7<br>(64) | 64.8<br>65.6<br>(2001-06) |
| Natural Growth Rate | 1.9 | 2.11<br>(1.79) | 2.05<br>(1.66) | 1.73<br>(1.26) | 1.66 |

*Projected/targeted figures of the HFA committee in parenthesis*
***Sources:*** *Sample Registration System (Different Years)*
*(^^ National Family Health Survey II (1998-1999)*

4. ***Reproductive and Child Health Program***

The reproductive and Child Health (RCH) program is an example of unrealistic setting of goals. The evaluation report of the RCH –I finds that the project goals were over ambitious in relation to the time available. There was lack of clarity regarding activities which resulted in uni-focal actions. Although the project approach talked about reproductive health and gender equality, it focused more on female sterilization.[6]

It also adopted a uniform package across states without consulting the states and other agencies. It also gave so much emphasis on the target-free approach which was not followed in many states. The lack of training on such an approach negatively affected the process of decentralized planning. Although, the goal of 60% of the District Plans being prepared in a decentralized manner was met although true community consultations was missing in many plans. One of the key goals of the RCH I was to reduce the disparities in RCH between the regions, socio-economic groups, etc. However, comparison of RHS data for EAG states for both the rounds of surveys (Bihar, Chhatisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal) indicate no reduction in disparities in RCH status. Especially with regard to ante-natal care, institutional delivery, safe delivery, full immunization etc. there is an increase in the gap between all India and the EAG states (see Table 2). Despite this experience, the RCH II propose new goals such as increasing Couple Protection Rate, antenatal and immunization coverage, Maternal Mortality etc.

**Table 2:** Goals and the Gap in RCH

| Indicator | Comparison of EAG States with All India Performance | | | | | |
|---|---|---|---|---|---|---|
| | RHS I 1998-99 | | RHS II^ 2002-03 | | Gap (India - EAG) | |
| | India (%) | EAG (%) | India (%) | EAG (%) | 1998-99 | 2002-03 |
| CPR any method | 42.5 | 33.7 | 49.0 | 41.4 | 11.0 | 7.6 |
| Unmet Need | 25.3 | 31.6 | 18.6 | 21.9 | -6.0 | -3.3 |
| Any ANC | 65.3 | 52.7 | 77.2 | 62.7 | 12.6 | 14.5 |
| Institutional Delivery | 34.0 | 19.7 | 46.9 | 24.1 | 14.3 | 22.8 |
| Safe Delivery | 40.2 | 26.7 | 62.1 | 39.4 | 13.5 | 22.7 |
| Full Immunization | 54.2 | 41.8 | 49.5 | 36.6 | 12.4 | 12.9 |
| Home visit* | 14.8 | 9.8 | 6.4 | 4.7 | 5.0 | 1.7 |

*Based on 50% of districts covered in Phase I of Round II^*

*Any Health Worker during 3 months prior to survey **

*Source: http://mohfw.nic.in/NRHM/RCH/Background_new.htm# Accessed 07.12.2010*

## Conclusion

The history of goal-setting in India provides some valuable lessons for the health services development in the country. This suggests that the whole process of goal-setting has to be re-examined. The process has to be realistic based on the epidemiological pattern and the natural history of any specific problem. The reasons for the under achievements in programs evident from the above examples could be multi-dimensional. It indicates organizational weaknesses not just at the time of implementation as is often pointed out but even at the time of planning and programming itself. Failure in implementation could be the result of unrealism and lack of vision at the planning stage. It also means that the complexity of the problem cannot be tackled by targeted interventions based on aggregate data as targeted interventions could lead to techno-centric packages ignoring the larger structural dimensions of the problem. The target-driven programs can also result in intensive, vertical and categorical programs which may distort the comprehensiveness of health services as has happened with the attempt to eradicate polio. The target driven and time-bound approaches could also place unrealistic demands on the existing fragile and crumbling delivery systems in the developing countries. Parallel and disease-specific interventions which may emerge from the need to meet the MDGs could result in '*duplications, distortions, disruptions and distractions*' within the health care system.[7] Another possibility is that selective approaches could be used as an excuse to give fillip to privatization even in extremely important areas like maternity care in rural areas. This is already implemented in India, where the private sector is involved as a part of the Public Private Partnership in maternity care in rural areas in the name of reducing maternal mortality rate which could result in increasing the inequity in health care. Long-term, broader, system-based interventions through an integrated approach could be more cost-effective, result-oriented and beneficial compared to such intensive drives. There is a need for more debate on the managerial strategies in public health especially the system of goal-setting if they are meant to improve the health of the populations.

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