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Evolution of Population and Health Policies in India

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BACKGROUND

India is currently the second most populous country in the world. According to the current population trends, there is every probability that it will become the most populous country of the world by the year 2040. The massive size of the population and its rate of growth has been a matter of serious concern in India right since Independence. Health and population related issues have always been on the priority of the development agenda of the country. There is ample evidence to suggest that this concern and the policies evolved to address these concerns have led to the creation of a vast network of public health and family welfare services delivery system which, at least theoretically, covers the entire country. It is also true that the expansion and extension of health and family welfare services in the country have contributed, often substantially, in improving the health status of the population and in bringing down the population growth rate. At the same time, it is also true that the achievements in the field of health and population in India, particularly after Independence, have somewhere fallen short of expectations.

In this paper, we discuss, at some length, the evolution of health and population policies in India in the context of health and population transition that the country has witnessed since Independence. It may be remarked here that although issues related to the health of the population and population growth are closely linked, yet the evolution of health policy as well as the population policy in India have virtually followed independent paths. This independent evolution of health and population policies in India appear to be logically correct as the determinants of health of the people are radically different from the determinants of population growth, although health of the people has an affect on the growth of the population and patterns of population growth have implications to the health of the people. This interrelationship between the health outcomes and patterns of population growth, structure and distribution have often been advocated as the basis for adopting an integrated approach to addressing health and population issues facing the people and for formulating integrated health and population policies. The experience, however, suggest that the integration of health and population issues either at the policy level or at the implementation level has tended to ignore aspects of health and population beyond the interrelated ones. It is worth pointing out that the health and population issues which are interrelated, are essentially a subset of the much broader spectrum of health of the people as well as a complex dimension of the patterns of population growth, structure and distribution. As such, the integrated approach to health and population policy evolution as well as delivery of health and family welfare services tend to neglect the health issues and population concerns beyond the interrelated subset and, therefore, has only a limited impact.

EVOLUTION OF HEALTH POLICY IN INDIA

Although, evolution of the concepts and principles of health care in India dates back to times immemorial, yet, systematic evolution of health care delivery system in India had begun only during the colonial period. Before the British rule in India, the concepts and principles of health care in India were rooted primarily in *Ayurveda* which means the "science of life." *Ayurveda* is widely believed to have evolved during the *Vedic* period. References to diseases, herbs and herbal cures can be found in all the four *Vedas*, especially in the *Rig Veda*. The *Atharva Veda* has many hymns eulogising herbs. *Ayurveda* is also one among the few traditional systems of medicine that contains a sophisticated system of surgery. It is one of the oldest systems of health care in the world dealing with both preventive and curative aspects of the health of an individual in the most comprehensive manner and presents a close similarity with the concept of health propounded by the World Health Organisation, which asserts that 'health is a state of complete physical, social and mental well being and not merely the absence of disease and infirmity (WHO, 19). However, little is currently known about the evolution of *Ayurveda* as the health care system to meet the health needs of the people. It is, however, a fact that, even today, *Ayurveda* is preserved by the majority of the Indian people as the tradition to live longer and healthier.

Although, Ayurvedic practices had become the part and parcel of the life of every India during the medieval period, yet, there is little evidence of the evolution of public health care delivery system during this period. The practice of *Ayurveda* was largely an individual prerogative, although there were supposedly institutions for training in *Ayurveda* throughout the country. Meeting the health needs of the people, during this period, did not appear to be the state priority. One reason may be the fact that the practice of *Ayurveda* had become the way of life and there appeared little necessity for state intervention. The second reason, on the other hand, may be the fact that India, during that period, was divided into a large number of princely states at that time and there was little political stability.

During the colonial rule, efforts to evolve a health care delivery system for the Indian masses followed two divergent paths. The first path was followed by the colonial powers. It consisted of imposing the western allopathic system of medicine and health care over *Ayurveda*. This attempt of the colonial powers may also be seen as a part of the exercise of establishing dominance of the western society and culture over the centuries old Indian tradition and Indian way of life.

The second path was followed by the nationalist forces during the colonial rule. The nationalist movement advocated revival of *Ayurveda* as the system of medicine for the Indian masses. After Independence, there have been

attempts to evolve an integrated system of the delivery of health care to the people comprising of western allopathic system and *Ayurveda* as well as other systems of medicine like Unani, Siddha and Homeopathy.

Evolution of the Health Care System during the Colonial Period

The first reference to health care delivery system during the colonial period dates back to 1859 when a Royal Commission was constituted to enquire health of the army in India. This Commission recommended measures not only for the army but also for the civil population. The recommendations put forward by the Commission were the basis for establishing Commissions of Public Health in the provinces of Madras, Bombay and Bengal in 1864. However, most of the recommendations of these Commissions remained unimplemented as there was no comprehensive policy towards preventive health services.

The first thought to evolve public health care delivery system in India could be made only after the outbreak of Plague in 1896. The Plague Commission was constituted to enquire the outbreak of the disease recommended the need for strengthening public health care delivery system and establishment of laboratories for research. However, measures taken to implement these recommendations remained small, confined mostly to the urban areas. At the same time, Government of India transferred the responsibility of meeting the health needs of the people to Provincial Governments under the Government of India Acts, 1919 and 1939.

The first substantive attempt to evolve a comprehensive public health care delivery system in India could be made only in 1943 when a Health Survey and Development Committee, popularly known as Bhore's Committee was appointed by the Government of India to make:

(a) A broad survey of the present position in regard to health conditions and health organisations, and

(b) Recommendations for future development.

The Committee submitted its report in 1946 and India became Independent in 1947. Recommendations of the Committee, therefore, became the basis for the evolution of the public health care delivery system in Independent India.

The nationalist forces, on the other hand, pushed *Ayurveda* as the health care system for Indian masses. The first reference to any activity related to the promotion of *Ayurveda* dates back to 1827 when classes in Ayurvedic Medicine were started in the Government Sanskrit College, Calcutta. These classes were however discontinued by the British in the year 1933. In 1916, Members of the Imperial Legislative Councils pressed the Government to accept *Ayurveda* as the basis for the development of public health care delivery system and for developing the system on scientific basis so as to increase its usefulness. This

pressure resulted in the constitution of one man Komar Commission to make investigation in the indigenous system of medicine in the year 1917. In 1920, the Indian National Congress demanded Government patronage for *Ayurveda* and Provincial Governments began to grant assistance for the development of *Ayurveda* based health care delivery services. The State and Central Governments appointed several committees to suggest ways and means of rehabilitating this time tested system in the service of the people and to promote *Ayurveda* following modern scientific parameters and methods. In 1921, Mahatma Gandhi inaugurated Ayurvedic and Tibbia College in Delhi which was followed by establishment of an Ayurvedic College in the Benaras Hindu University by Pt. Madan Mohan Malviya. The increasing pressure of the nationalist forces to recognise *Ayurveda* as the system of health care for the people also forced the British government in 1940 to enforce the Drugs and Cosmetics Act for Ayurvedic/Siddha/Unani medicines also.

The Health Survey and Development Committee constituted under the colonial rule also recognised the contribution of *Ayurveda* in meeting the health needs of the people of the country but conspicuously failed to make any recommendation for its further development and expansion. However, the Chopra Committee recommended in 1946 that the indigenous and the western systems of medicine should be combined to evolve an integrated system of health care delivery so as to effectively meet the health needs of the people.

Evolution of Public Health Care Services Delivery System in Independent India

The evolution of the public health care delivery system in India since Independence has been guided by different committees constituted by the Government of India from time to time. These Committees were constituted in a purely ad-hoc manner with very limited institutional support. As there has been little congruence between the recommendations put forward by these Committees. At the same time, the recommendations put forward by these Committees were never implemented by the Government in a comprehensive manner. The ad-hoc approach of constituting committees and the piece-meal approach of accepting and implementing the recommendations set forward by the committees so constituted appear to have resulted in a lack of long-term vision in the evolution of the health policy. This lack of long-term vision in the evolution of the health policy is reflected in the development of the public health care delivery system in the country. One fall out of this ad-hoc approach is that there has been little institutionalisation of health policy evolution within the public health care delivery system in India. The systems approach to health policy evaluation is still missing in the country. Table 1 presents a synopsis of the recommendations put forward by various committees.

Some of the salient features of the evolution of the health policy for the development of public health care delivery system in India are as under:

1. There has been little integration of the indigenous system of medicine (especially *Ayurveda*) and the western allopathic system of medicine. Both the systems of health care have evolved almost independent to each other. As the result, there has been lot of duplication of the efforts.
2. There has been sheer lack of data necessary for health policy evolution and for planning and development of the public health care delivery system. There has been little attempt to develop the health related data base that facilitates evidence-based policy making and health situation assessment.
3. Recommendations of almost all the committees constituted in the Independent India virtually followed the framework laid down in the first Health Survey and Development Committee constituted during the colonial rule. There has rarely been an attempt to evolve an alternative model of health care delivery to the people.
4. Following the approach adopted in the first Health Survey and Development Committee report, almost all committees focussed on the development and strengthening of health infrastructure - hospitals, health centres, manpower, etc. Psycho-social and behavioural aspects of health and health care have virtually been ignored by almost all Committees.
5. Although, health is a state subject in the Indian Constitution, yet there has been little effort to evolve state specific public heath care delivery system that can address the health care needs specific to the state. The constituent states of India have almost entirely depended on the initiatives taken by the central government for the evolution of the health care delivery system.
6. There is little regulation of the health care delivery services either in the public or in the private sector. There is virtually no in-built mechanism to ensure the quality of health care services either in the public or in the private sector.
7. There has been little attempt to project the future health needs of the country in the context of future population growth, projected changes in the structure and distribution of the population as well as transition in the health status of the population.

The implications of the ad-hoc approach for the evolution of the health policy are evident when one compares the transition in the health status in India with that in China. At the time of Independence, the health status of the people of China was very similar, even poorer, to the health status of the people in India. However, China has achieved some astounding successes in improving

the health status of its people through a systematic evolution of the health policy and its effective implementation. India, by contrast, lags way behind China in terms of the health status of the people. The reason is that a systematic, evidence-based approach to health policy evolution has always been lacking and many recommendations of the numerous ad-hoc committees constituted for suggesting ways for improving the health of the people were not accepted by the government for one reason or the other. Often these Committees were constituted at such a short interval that there was little time for critically examining the operational feasibility of the recommendations put forward. Moreover, the recommendations were adopted by the government in a piece meal fashion with the result that the comprehensiveness of the recommendations is hardly visible at the implementation stage. The health policy makers in India are not clear even today about what should be the health care delivery system for the Indian masses. Should it be the indigenous system of *Ayurveda* or should it be the western allopathic system or should it be a mix of the two. The broad consensus is that the public health care delivery system should be the mix of the indigenous and the western system of medicine. However, there has rarely been any systematic and concerted attempt to integrate the two systems of health care delivery. They continue to exist and function in isolation to each other.

EVOLUTION OF POPULATION POLICY IN INDIA

Concern about population, especially, about population growth as it affects the social and economic development and welfare of the people was not a serious issue before Independence, although there were some passing reference about the need to control population growth in the context of the Great Bengal Famine and the Plague epidemic. Although, India adopted a population policy and launched an official population control programme way back in 1952, yet a serious thought to the implications of rapid population growth could be given only after 1961 population census which confirmed a very rapid increase in the population of the country during the decade 1951-61.

Population policy in India has a history now lasting more than 50 years. During this period, official approach towards addressing population related issues and concerns has undergone evolutionary ups and downs with frequent shifting of the policy focus vis-à-vis population issues and concerns. However, population issues and concerns, especially how to curb the rapid growth of population, has always remained and continues to be at the centre stage of the social and economic development agenda of the country.

The official stand about population and related issues in the context of social and economic development and the well being of the people has always been an integral part of social and economic development planning in India as reflected from different Five-year Development Plans. The provisions made in

different Five-year Development Plans continue to be the basis for population stabilisation efforts in the country even today. There were only two occasions when the population policy was formulated outside the framework of development planning. The first was in the year 1976 and the second was in the year 2000. Table 2 presents a synoptic view of the concerns about population and related issues in different Five-year Development Plans.

India was the first country in the developing world to officially recognize the role of population in social and economic development processes way back in 1951. This recognition was embedded in the First Five-year Development Plan and highlighted the urgency of the problem of population control as a result of the decline in the death rate (Government of India, 1952). The Plan document specifically stressed the need of reduction in the birth rate to the extent necessary to stabilize the population at a level consistent with the requirements of the national economy. Family limitation or spacing of children was also recognised as necessary to secure better health of the mother and better care and upbringing of children. As such, the First Five-year Development Plan incorporated a programme of family limitation and population control. It was also suggested that since family planning had direct relevance to the health of the people, especially women and children, family planning should be a part of the public health programme.

By all accounts, the official statement about population and population related issues way back in 1950s was progressive in wisdom and proactive in approach that was unparallel in the world at that time. The basis of the statement was India's concern about the health of its people and not population growth as the average annual population growth rate in India during the period 1941-51 was just around 1.3 per cent per year, the same as the average annual population growth rate during the period 1931-41. Birth limitation and birth spacing through the use of modern family planning methods was recognized as "a step" towards improvements in health and well being, especially of mothers and child, necessary to bring down the death rate. At the same time, population control effects of family planning were also acknowledged but only over a period of time. In the immediate context, the emphasis, clearly, was on the health effects of family planning.

Since the First Five-year Development Plan, population control and family planning (family welfare after 1977) has always got a reference in all the Development Plans implemented in India, although under varying contexts. However, these statements lack a consistency over the period of time except that population control through fertility reduction is a national necessity. Table 2 presents a consolidated summary of population related statements and policy objectives in different Five-year Development Plans. For example, the health context of family planning that was highlighted in the First Five-year Plan was

replaced by the need of regulating India's population from the dual standpoint of size and quality is of the utmost importance to national welfare and national planning in the Second Five-year Development Plan. The role of population in development was further emphasized in the Third Five-year Development Plan which stated that stabilising population over a reasonable period must be at the very centre of the planned development. Probably and so obviously, this emphasis on population stabilisation was the result of a very rapid increase in population growth during the decade 1951-61 when the average annual population growth rate increased to almost 2 per cent per year compared to just around 1.3 per cent per year during 1941-51. The concern for the rapid population growth continued during the Fourth, Fifth and Sixth Five-year Development Plans in which the family planning programme was accorded the highest priority. For example, the Sixth Five-year Development Plan stated that the developing countries, like India, with large populations could not afford to wait for development to bring about a change in the attitudes of couples to limit the size of families as the process of development itself is stifled by population growth and emphasized for universal adoption of family planning to reduce the birth rate. However, the Eighth Five-year Development Plan again highlighted the development context of population growth and argued that rapid population growth required that the economy should also grow at a more rapid rate to protect already low level of per capita availability of food, clothing, housing, employment and social services. As such, the Plan recognised population control as an overriding concern in the development process as high population growth rate continued to be one of the major problems facing the country. A high population growth rate meant that the economy had to grow faster to protect already low level of per capita availability of food, clothing, housing, employment and social services, etc.

The Ninth Five-year Development continued to highlight population control through fertility reduction as a major development challenge. However, the Plan argued that main reason for high fertility was high infant mortality leading to high unwanted fertility, and large unmet need of contraception. Improving health, especially of children and women was argued to be a prerequisite for reducing fertility through lowering the persistent high unwanted fertility. The Tenth Five-year Development continued to emphasize upon the health aspects of fertility reduction.

The inconsistency in the approach to addressing population issues is also reflected in the inconsistency in population related objectives and goals set in different Five-year Development Plans. During the First Five-year Development Plan, the objective of population control was to reduce the birth rate. However, in the Sixth Five-year Development Plan, a very ambitious goal of achieving the net reproduction rate of one was fixed to achieve population

growth in realisation of the fact that it was difficult to reduce the birth rate without a parallel reduction in the death rate. Since the Sixth Five-year Development Plan, issues related to improvements in mortality, especially infant, child and maternal mortality, starting gaining ascendancy over issues related to reduction in fertility. Efforts to intensify mortality reduction efforts were boosted further with the introduction of the Universal Immunisation Programme in the Seventh Five-year Development Plan and Child Survival and Safe Motherhood Programme in the Eighth Five-year Development Plan in which family planning was conceived as one of the interventions to bring down infant, child and maternal mortality. The Child Survival and Safe Motherhood Programme was replaced by the Reproductive and Child Health Programme during the Ninth Five-year Development Plan the focus shifted further away from family planning and fertility reduction. The drift away from family planning was almost complete during the Tenth Five-year Development Plan which has no reference to fertility reduction, although it has a reference to population stabilization. The National Rural Health Mission launched in the year 2005 is also conspicuously silent about fertility reduction, a total reversal of the official policy during the First Five-year Development Plan. Fertility reduction in India has now appears to be relegated to a residual limbo in the national development planning process despite the fact that fertility in the country and in many of its States remains well above the replacement level.

In addition to the official statements about population control and family planning imbedded in the Five-year Development Plans, there have been two policy announcements about population outside the development planning framework. The first was in the form of National Population Policy 1976 which argued that if the future of the nation was to be secured, and the goal of removing poverty to be attained, the population problem would have to be treated as the problem of topmost national priority and commitment. The 1976 policy also stressed that simply waiting for education and economic development to bring about a drop in fertility was not a practical solution. It argued that the very increase in population made economic development slow and more difficult to achieve. The time factor was so pressing, and population growth so formidable, that the country had to get out of the vicious circle through a direct assault as a national commitment.

The Statement of National Population Policy, 1976, however, remained effective for a very short duration of just about one year only. With the new government coming to the office after the 1977 general elections, major provisions of the 1976 policy were denounced. It was categorically stated that there would be no pressure of any kind for accepting family planning to regulate fertility. There was clear message that family planning was to be promoted purely on voluntary basis.

The Karunakaran Committee appointed by National Development Council of Planning Commission in 1993 proposed the formulation of a National Population Policy to take a long term holistic view of development, population growth and environmental protection and to suggest policies and guidelines for formulation of programmes and a monitoring mechanism with short, medium and long term perspectives and goals. The First full-fledged National population policy was announced in the year 2000, on the basis of report prepared by the Expert Group headed by Dr. M.S. Swaminathan. The policy had taken into account the Plan of Action recommended by International Conference on Population & Development, Cairo, 1994. Based of these recommendations, a number of actions were already initiated like Target free approach as well as Community Needs Assessment approach. The ultimate objective of the National Population Policy 2000 is to population stabilisation in the country by the year 2045. In order to achieve this objective, the policy aims at reducing the total fertility rate to the replacement level by the year 2010 and maintaining it at the replacement level beyond 2010 as the intermediate goal. Lastly, in order to achieve the replacement fertility by the year 2010, the policy aims at addressing the unmet needs in terms of family planning, health care infrastructure and health personnel. The Policy also supported the commitment of government to provide integrated service delivery for reproductive and child health care based on voluntary and informed choice and consent of citizens without any incentive and disincentive (Government of India, 2000).

Salient features of the evolution of the population policy in India, since Independence, can be summarised as under:

2. Although the preamble of different Five-year Development Plans have repeatedly highlighted the role of population factors in the social and economic development planning processes, population stabilisation efforts have always been conceptualised and implemented within the narrow perspective of health. Beyond health aspects of population growth, structure and distribution have rarely been recognised in the development planning process in India.

4. The conceptualisation of population issues and concerns within the narrow perspective of health has resulted in the emergence of family planning, especially, sterilisation as the only way to address population issues and concerns. This may be true at the time of Independence when fertility rates were very high and were the main cause of rapid population growth in the context of declining fertility. The situation is changing now as both fertility and mortality are decreasing for quite some time and are no longer dominant factors in population growth. It has been estimated that nearly 60 per cent of the future population

growth in India will be result of population momentum resulting from age structure effects on the birth rate and the death rate. Population stabilisation efforts need to be attuned to this new reality.

6. Declining fertility and mortality has also induced changes in the age structure of the population that has implications for social and economic development. Incorporating the changes in population age structure in both population policy and the development policy is an issue that has consistently been ignored in the evolution of population policy.

8. The population policy in the country has always followed the techno-medical approach towards population stabilisation. Psycho-social and behavioural aspects of reproductive behaviour have always been neglected in the quest to achieve population stabilisation.

10. Despite the fact that concerns about population in India are now more than 50 years old, there has been little attempt to develop a comprehensive population and development data base, especially at the district and grass roots levels that can facilitate examination of population and development inter-linkages.

12. Implementation of the population policy largely remains the government activity with little involvement of the people and their organisations in population stabilisation efforts, despite the fact that it has repeatedly been asserted that population stabilisation efforts can succeed only when they are conceptualised and implemented as a people's programme.

13. Population stabilisation has become a politically sensitive issue because of the way population stabilisation efforts have been implemented. There has been little effort at the policy level to address this political sensitiveness.

IMPACT OF HEALTH & POPULATION POLICIES

The various health and population policies put in force from time to time have influenced successive Governments to create a vast three tier system of health and family welfare services delivery in the country. Although the goals set under the various policies could not be achieved within the stipulated time frame, yet there has been a significant reduction in number of health & population indicators. However, there are a large differentials in the achievement by States. While, the southern and western States of India have made significant progress across all indicators, the success has been partial in the northern, eastern and north eastern States. The crude birth rate, which was recorded at 40.8 per 1000 in 1951, has declined to 23.8 in 2005, as per the estimates available from the Sample Registration System (SRS). The crude death rate, which was recorded at 25.1 per 1000 in 1951, has declined to 7.6 in 2005. Infant mortality rate has come down from 146 in 1951-61 to 58 in 2005.

CHALLENGES IN HEALTH AND POPULATION POLICY EVOLUTION

The first major challenge to health and population policy evolution in India is to reinvigorate the policy environment. The current policy environment can at best be described as ad-hoc in organisation and discrete in operation. There is a pressing need to institutionalise the policy environment so that the policy evolution process becomes a continuous process. This means that policy evolution should not be limited to just issuing pious policy statements in the form of National Health Policy and National Population Policy. Rather, policy statements should be followed up with detailed implementation plans at the national, state and below state levels and putting in place mechanism for the monitoring and evaluation of the implementation of the policy. Developing a monitoring and evaluation system, it may be pointed out, will also facilitate the creation of the much needed population and development database which is quite essential for policy evolution. Obviously, the policy evolution institutions should function independent of the policy execution institutions.

Indicators	Past level	Current level
Crude Birth Rate (per thousand population)	40.8 (1951)	23.8 (2005)
Crude Death Rate (per thousand population)	25.1 (1951)	7.6 (2005)
Infant Mortality Rate (per thousand live births)	146 (1951-61)	58 (2005)
Maternal Mortality Ratio (per 100000 live births)	437 (1992-93)	301 (2001-03)
Total Fertility Rate (per woman)	6.0 (1951)	3.0 (2003)
Life Expectancy at Birth (in years)	(1951)	(2001)
Male	37.1	63.87
Female	36.1	66.91

The second issue is a rethinking about the integration of health and population policies. It may be stressed here that the determinants of health are radically different than the determinants of population growth, structure and distribution, although there are some common elements in the two. These common elements constitute only a small sub-set of the determinants of health as well as determinants of population, growth, structure and distribution. Any health policy or any population policy, therefore, should go beyond this common sub-set of determinants of health and population. This is a major challenge as health and population in India has always been discussed and

debated within the extremely narrow techno-medical perspective. Social and cultural aspects of health seeking behaviour as well as psycho-social issues related to the reproductive behaviour have either remained neglected in the health and population policy evolution or they have been addressed in the techno-medical context only. A multi-dimensional approach to health as well as to population is needed.

The third issue is the implementation of multi-dimensional health policy as well as population policy because the public administration system in India is a compartmentalised one with the responsibility of public functions distributed between different departments of the government in a very rigid manner.

Table 1
Key recommendations of different committees constituted for the evolution of the health care system in India.

Bhore's Committee (1946)	• No individual should lack access to medical care because of inability to pay for it. • Special emphasis should be placed on preventive methods and on communicable diseases. • Health services should be as close to the people as possible in order to ensure maximum benefit to the community to be served. • There should be one primary health unit for every 10-20 thousand population with 75 beds, 6 doctors and 6 public health nurses. • There should be one 650-bed hospital for around 300 thousand population and one 2500-bed district hospital. • 15 per cent of the government expenditure should be devoted to health care.
Pharmaceutical Enquiry Commission (1953)	• Intensive research in indigenous drugs of *Ayurveda*.
Dave Committee (1955)	• Develop uniform standards for Ayurvedic Education.

Udupa Committee (1958)	• Integrated system of medicine to meet the health needs of the people. • Need for training in Siddha and Ayurvedic system of medicine
Mudaliar Committee (1961)	• One primary health centre for every 40 thousand population. • One bed for every 1000 population. • One doctor for every 3000 population. • There should be one 50-bed basic speciality hospital in each Taluka. • One medical college for every 5 million population. • No integration of systems of medicine.
Jain Committee (1966)	• One bed for every 1000 population. • One 50-bed hospital in every taluka (sub-district) in the country. • Enhancement of maternity facilities at each level of the public health care delivery system in the country. • Health insurance for larger population coverage. • User charges against the delivery of health services.
Kartar Singh Committee (1974)	• Integration of all health programmes. • Retraining of health workers as multipurpose workers. • A team of one male and one female health worker at the sub-centre level (3000 population). • One primary health centre for every 50 thousand population. • One health supervisor for every four health workers.

Srivastava Committee (1975)	• One male and one female health worker for every 5 thousand population. • One health assistant for every two health workers. • One additional doctor and nurse at every primary health centre for strengthening the maternal and child health services. • Increase in the public expenditure on drugs at the primary health centre level. • Compulsory national service of two years at PHC by every doctor between 5th and 15 years of career. • Establishment of medical and health education commission. • Integration of west and indigenous systems of medicine.
Joint Panel of Indian Council of Medical Research and Indian Council of Social Sciences Research (1980)	• A village health unit per 1000 population with one male and one female health worker. • One sub-centre for every 5000 population with one male and one female health worker. • One 30-bedded community health centre per 100000 population with 3 specialists and 6 general duty medical officers. • A district health centre for every 1 million population and a specialist centre for every 5 million population. • The expenditure on health services to be increased to 6 per cent of the gross domestic product.
National Health Policy (1983)	• Provision of universal, comprehensive primary health care services. • Involvement of private practitioners and non-government organisations. • Training of village-based workers in simple health care skills. • Evolution of decentralised system of health care and establishment of referral systems. • Establishment of nation wide chain of epidemiological stations. • Encourage private investment in health sector.

National Health Policy (2002)	• Achieve an acceptable standard of good health. • Equitable access to decentralised public health system. • New infrastructure in deficient areas. • Upgrading of infrastructure in existing institutions. • Increase in aggregate public health investments. • Primacy to preventive and first level curative activities at the primary health centre level. • Rational use of drugs. • Increased access to indigenous system of medicine.
National Rural Health Mission (2005)	• Architectural corrections in health care services. • Increase in public spending on health from 0.9 per cent of the gross domestic product around 2005 to 2-3 per cent by 2012. • Decentralisation of the public health care delivery system. • Building community capacity to manage, own and control grass roots level health care services.

Table 2
Population policy objectives and population policy contexts as stated in different Five-year Development Plans in India

Plan	Policy Context	Policy Objectives
First 1951-56	Family limitation or proper spacing between children is a necessary and desirable goal in order to secure better health of the mother and better care and upbringing of children.	Reduction in the birth rate to the extent necessary to stabilize the population at a level consistent with the requirements of the national economy.
Second 1956-61	The problem of regulating India's population from the dual standpoint of size and quality is of the utmost importance to national welfare and national planning.	Further development of family planning on systematic lines. Continuous study of population problems. Constitution of Central Board of family planning and population problems.
Third 1961-66	Stabilising the growth of population over a reasonable period must be at the very centre of planned development.	Family planning has to be undertaken, not merely as a major development programme, but as a nationwide movement which embodies a basic attitude towards a better life for the individual, the family and the community.
Fourth 1969-74	Family planning should be treated as the programme of highest priority.	Reduction in the birth rate.
Fifth 1974-79	In order to reduce the gap between the birth rate and the death rate, it is necessary that the decline in the birth rate is accelerated through large scale family planning efforts.	Reduction in the birth rate.

Plan	Policy Context	Policy Objectives
Sixth 1980-85	It is almost axiomatic that social and economic development can in the long run bring about fall in the fertility rate. However, developing countries, such as India, with large populations cannot afford to wait for development to bring about a change in the attitudes of couples to limit the size of families as the process of development itself is stifled by population growth.	Reduce the net reproduction rate to one by 1996 for the country as a whole and by 2001 in all states.
Seventh 1985-90	Same as the Sixth Plan.	Reduction in the birth rate, death rate and infant mortality rate. Increase in the couple protection rate and antenatal care. Universal immunization coverage
Eighth 1992-97	High growth rate of population continues to be one of the major problems facing the country. It means that the economy has to grow faster to protect already low level of per capita availability of food, clothing, housing, employment and social services. Population control assumes an overriding concern.	Containing population growth through reduction in the birth rate and the infant mortality rate.
Ninth 1997-2002	Reduction in the population growth is recognized as the priori objectives. The current high rate of growth is due to large size of population in the reproductive age group, higher fertility due to unmet need of contraception and high unwanted fertility due to high IMR.	Meet all felt needs of contraception. Reduction in the desired levels of fertility through reduction in infant, child and maternal mortality.

Plan	Policy Context	Policy Objectives
Tenth 2002-07	Same as Ninth Plan	Reduction in infant mortality rate and maternal mortality ratio. Reduction in the decadal growth rate of population.