IMPORTANT HEALTH PLANNING COMMITTEES IN INDIA

Item	Bhore Committee, 1943	Mudaliar Committee, 1962	Chadha Committee, 1963
Official name	Health Survey and Development Committee	Health Survey and Planning Committee	Special Committee on the Preparation for entry of National Malaria Eradication Programme (NMEP) into the Maintenance Phase
Appointed on	October 1943	12 June 1959	10 April 1963
Chairperson	Sir Joseph Bhore	Dr. Lakshmanaswamy Mudaliar	Dr. MS Chadha
Purpose/ Scope	Make a. A broad survey of position regarding health conditions and health organization in British India b. Recommendations for future development	Assessment of developments in field of medical relief & public health since Bhore Committee Report Review of 1st & 2nd Five Year Plan Health Projects Make recommendations for future plan of health development in India	Study the req. related to a. PHCs planning & priority acc. to needs of Maintenance Phase of NMEP b. staffing pattern for NMEP and how to utilise NMEP staff post eradication status
Key observations	1937 Crude Death Rate: 22.1/1000 population Estimated that ≥50% mortality was preventable Poor quality of health-related statistics High mortality, wide prevalence of disease due to inadequate provision of protective, preventive, curative health services to people Inadequacy of existing medical & preventive health organizations: Dr-Pop Ratio: 1/6300 pop; Bed-Pop Ratio: 0.24 beds/1000 pop.	1956-61 Crude Death Rate: 21/1000 population Expenditure on health decreased from 5.9% (1st 5YrPlan [FYP]) to 4.25% (3rd 5YrPlan) of total budget Bed-Pop Ratio: 0.4/1k pop. Life expectancy at birth 42 years (approx.); 61 Medical Colleges as against 43 Medical Colleges proposed by Bhore Committee (in 10 years after publication of Bhore Committee Report)	Wide variations in malaria situation & control. Re-emergence likely unless eradicated globally
Major Recommendations	Establishment of a **National Health Service** with integration of preventive and curative services **Short Term Plan**: 1 PHC/40k pop. Each PHC to have 2 MO, 4 PHN, 1 Nurse, 4 Midwives & trained dais each, 2 each Sanitary inspectors & Health Assistants, 1 Pharmacist, 15 Class IV staff **Long Term (3 Million) Plan**: Proposed for district with pop of 3 million. 1 PHC (75 beds)/ 10-20k pop; 1 Secondary Hospital (650 beds)/ 15-25 PHCs; District Level Hospitals (2500 beds); Modify medical education to produce social physicians; Increase Bed-Pop Ratio to 1.03 beds/1k Pop by end of 10 years.	Consolidation of advances made in first two FYPs **Strengthening of District Hospitals** **Each PHC not to serve >40,000 population** Improve quality of care provided by PHCs **Constitution of All India Health Service (IAS pattern)** Integration of medical & health services (as recommended by Bhore Committee) Regional organizations in each state to supervise 2-3 District Medical/ Health Officers	**Basic health workers to work as Multipurpose workers (MPW) [1/10k pop.]** **Establish sub-centres: min. 1/10k pop.; ideally 1/5k pop**. **PHC to have microscope, lab technician** General health services to be responsible for maintenance phase of NMEP

IMPORTANT HEALTH PLANNING COMMITTEES IN INDIA

Item	Mukerji Committee, 1965	Jungalwalla Committee, 1967	Kartar Singh Committee, 1973
Official name	Mukerji Committee, 1965	Committee on Integration of Health Services	The Committee on Multipurpose Workers (MPW) under the Health and Family Planning Programme
Appointed on	31 December 1965	1964	28 October 1972
Chairperson	Mr. Mukerji	Dr. N Jungalwalla	Mr. Kartar Singh
Purpose/ Scope	To review what changes are necessary in staffing pattern, financial provisions, etc. due to IUCD gaining prominence in the Family Planning Programme	To examine various problems including service conditions; elimination of private practice	To study & make recommendations on: The structure for integrated services at the peripheral & supervisory levels The feasibility of having multipurpose, bi-purpose workers in the field The training req. for such workers The utilization of mobile service units under FP programme for integrated national, public health & FP services operating from taluk level
Key observations	Great shortage of staff for Family Planning (FP) Programme Drs are reluctant to take up FP duties Training, infrastructure lacking/deficient	Non-practice allowance should be reasonable and realistic to prevent private practice	Generally, 1 PHC/80k-110k or more There are wide disparities in staffing; wide variation in pay scales between states Community leaders unhappy with many workers visiting homes under individual programmes, prefer single visit FP, malaria, smallpox workers feel ability to provide treatment for minor ailments during field visits will increase acceptability in community Poor performance of peripheral workers largely due to inadequate supervision
Major Recommendations	**Delink FP activities from other activities** Strengthening of District FP Bureaus Provision of FP Allowance to Drs Training in FP methods (should be provided)	**Unified cadre** **Common seniority** **Recognition of extra qualifications** **Equal pay for equal work** **Special pay for specialized work** **No private practice** **Good service conditions**	**Having multipurpose workers is desirable & feasible** **Integrate vertical programmes at all levels** **Create new job description and designations:** **ANM→Health Worker (Female)** **Male MPW→Health Worker (Male)** **Supervisors→ Health Supervisor (Male/Female)** **1 Health Supervisor/ 4 Health Workers** **1 PHC/6 Sub-centres (3100 pop each) [1PHC/50k pop.]** **Impact**: Many vertical progs. suffered as MPWs were unable to do work previously done by dedicated staff. Resurgence of malaria. Resentment from dedicated staff as they were used for general health activities.