CHAPTER VIII

ECONOMIC REFORMS AND HEALTH SECTOR IN INDIA

For several decades, public sector reforms have been premised on the assumption that improving the ability of the government to manage its business will lead to improved social and economic position of the country. The Indian economy grew at a comparatively low rate of growth of 3.5 percent from 1950 to 1980. The plethora of procedures, permits, bureaucratic controls and protectionist policies created under import substitution strategy (ISS) along with other factors landed us into economic crisis of 1991 which was reflected in macroeconomic mismanagement of the economy judged from parameters such as high fiscal deficit, high balance of payment deficit, double digit inflation, low forex reserves etc. An attempt was made to resolve this crisis through the introduction of stabilization and structural adjustment programme (SAP)/ economic reforms. One of the important planks of the stabilization measures is the compression of public expenditure and that of SAP is raising efficiency and international competitiveness.

It is apprehended that any economic reform package that especially relates to compression in public expenditure will adversely affect the vulnerable sections of the society as this will lead to reduction in social sector spending. The experience of many developing countries which have embarked upon a process of macroeconomic reforms during the last 20 years shows that the accentuation of reforms lead to reduction in public spending on basic services and programs directly related to social sector development or human resource development (Gupta and Sarkar, 1994). Even the European countries which have experienced reforms have had diverse experiences with respect to the social impact of reforms (Panchamukhi, 2000). It is from this angle a study of impact of economic reforms on public health expenditure which is a component of social sector expenditure in India becomes important. During the 1970’s “growth with social justice” was the popular slogan. But from 1980’s onwards that is from the onset of reforms the slogan of “equity with stabilization and SAP” appears to be more relevant.
Social infrastructure is as critical for human resource development as physical infrastructure. The Human Development Report 2004 of UNDP had ranked India 127th out of 177 countries with an HDI of 0.595. At these levels, India’s positions is lower than that of several newly industrialized countries (NIC’s) such as those of south-east Asia like Indonesia and Malaysia and also lower than countries like China and Sri Lanka. It is worth mentioning that the low per capita income of the country does not mean low level of human resource development. With limited funds and their proper allocation substantial improvement in human capital can be secured. Even Sri Lanka and China with low per capita incomes have secured higher levels of human resource development and their development efforts were initiated at about the same time as India. One of the principal reasons for India’s low ranking is poor achievement in social sector especially public health. The experience of “miracle economies” of South East Asia provides eloquent testimony to the fact that the real wealth of nation lies not in material resources but in human resources.

In this chapter an attempt has been made to examine trends in public health sector over-time.

Firstly, it is important to examine the trends in aggregate expenditure of the central government in the 1981-1991 and during 1991-2001 as they have implications for the health sector. Public health budget constitute a critical source for health equity in any society. If health indicators show gross inequities then it is evident that public investment in health is also grossly inadequate. The prime cause of underdevelopment of health and health-care is inadequate allocations to health in government budgets. Data from across the world provides clear evidence that across the low and middle income countries over 5.6 billion people have to finance health-care using the most inequitable method of out-of-pocket expenditure, often through borrowings and sale of assets, for over half their health expenditure (World Health Report, 2008). This is so because in these countries public health budgets do not commit adequate resources.

A key aspect of stabilization programme is to reduce the government’s fiscal deficits. Fiscal adjustments during the reform period have been brought about by reducing public investment (that is capital expenditure) rather than by revenue expenditure (Table 8.1).
Table 8.1

Government’s Revenue and Capital Expenditure on Public Health
(as percent of aggregate expenditure)

<table>
<thead>
<tr>
<th>Period</th>
<th>Revenue Expenditure</th>
<th>Capital expenditure</th>
<th>Aggregate expenditure as percent of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Non plan</td>
<td>Total</td>
</tr>
<tr>
<td>1991-92 to 2000-01</td>
<td>14.02</td>
<td>63.78</td>
<td>77.80</td>
</tr>
</tbody>
</table>


Table 8.2

Combined (Revenue and Capital) Expenditure of Centre and States on Public Health (percentages of aggregate expenditure)

<table>
<thead>
<tr>
<th>Sector</th>
<th>1981-82 to 1990-91</th>
<th>1991-92 to 2001-02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health</td>
<td>10.97</td>
<td>11.32</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance, GOI, Various issues.

Thus, the share of public health expenditure increased marginally from 1981-82 to 2001-02.
Table 8.3

Central Plan and Non Plan Outlay on Public Health

(percentages of aggregate expenditure)

<table>
<thead>
<tr>
<th>Sector</th>
<th>1981-82 to 1990-91</th>
<th>1991-92 to 2001-02</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Non Plan</td>
</tr>
<tr>
<td>Public Health</td>
<td>1.07</td>
<td>0.23</td>
</tr>
</tbody>
</table>

Source: Government of India, Budget Papers and Expenditure Budget, Vol. 1, various issues

Table 8.4

Total Health Expenditure (Centre and State)

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenditure (in Rs crore)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-81</td>
<td>943 (0.8)</td>
</tr>
<tr>
<td>1989-90</td>
<td>3767 (0.92)</td>
</tr>
<tr>
<td>1990-91</td>
<td>4508 (0.88)</td>
</tr>
<tr>
<td>1991-92</td>
<td>4888 (0.83)</td>
</tr>
<tr>
<td>1992-93</td>
<td>5621 (0.89)</td>
</tr>
<tr>
<td>1993-94</td>
<td>6218 (0.79)</td>
</tr>
<tr>
<td>1994-95</td>
<td>6920 (0.73)</td>
</tr>
<tr>
<td>1995-96</td>
<td>7880 (0.73)</td>
</tr>
<tr>
<td>1996-97</td>
<td>9231 (0.72)</td>
</tr>
<tr>
<td>1997-98</td>
<td>10544 (0.76)</td>
</tr>
<tr>
<td>2001</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Note: Figures in brackets indicated percentage of expenditure on health

Source: Central Statistical Organization, 2000
It is evident from the tables that capital expenditure as a proportion of total government expenditure (revenue and capital) has declined from 33.39 percent in the pre-reform period to 20.67 percent in post reform period. As a proportion to aggregate expenditure, whole capital plan expenditure has been drastically reduced from 20.98 percent to 10.80 percent and non plan expenditure has come down marginally from 12.41 percent to 9.87 percent. At the same time the revenue expenditure in total expenditure has registered an increase from 67.12 percent to 77.80 percent. The overall trend has been one of the reducing capital plan and non plan expenditure which does not auger well both for raising production capacity of the economy and for maintaining of existing schemes.

India became independent in 1947. For the first time in India’s long history, a democratic regime was set up with its economy geared to a new concept, the establishment of a “welfare state”. The burden of improving the health of people and widening the scope of health measures fell upon the national government. The Bhere Committee’s reports and recommendations became the basis for most of the planning and measures adopted by the national government. The significant events in the history of public health since India became free are as follows;

1948

Ministries of Health were established at the Centre and States. The Post of Director General, Indian Medical Service, and of Public Health Commissioner with the Government of India were integrated in the post of Director General of Health Services who is the principal advisor to the Union Government on both medical and public health matters. This example was followed by many states. The Post of Surgeon General, the Director of Public Health and Inspector General of Hospitals were integrated in many states in the post of Director of Health Services

1949

a) India joined the World Health Organization as a member state.
b) The Employees State Insurance Act, 1948 was passed.
c) The report of the Environmental Hygiene Committee was published.
1950

a) The Constituent Assembly adopted the Constitution of India on 26 November, 1949. Article 246 of the Constitution of India covers all the health subjects; these have been enumerated in the seventh schedule under three lists-State, Concurrent and Union List. Article 47 of the Constitution under the Directive Principles of State Policy states “That the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among the primary duties”.

b) The post of Registrar General of India was created in the Ministry of Home Affairs.

c) The South East Asia Regional Office of the W.H.O. was established in New Delhi.

d) The Indian Research Fund Association was reconstituted into Indian Council of Medical Research.

1951

The Constitution came into force in 1950 and India became a republic. The Planning Commission was set up by Government of India, which set to work immediately for drafting the first five year plan.

1952

The beginning of first five year plan, with a total outlay of Rs 2356 crore. A sum of Rs 140 crore (5.9 percent) was allotted for health programmes. The B.C.G. vaccination programme was launched in the country.

1953

a) The Community Development Programme was launched on 2 October, 1952 for the all-around development of rural areas. Provision of medical relief and preventive health services were part of the programme.

b) The Central Council of Health was constituted with the Union Health Minister as Chairman and the Health Ministries of the states as Members to coordinate health policies between the Central and state governments. Primary Health Centres were set up.
1954

a) The National Malaria Control Programme was commenced as part of the first five year plan.
b) The National Extension Service Programme was started in various states as a permanent organization for rural development.
c) A nation wide family planning programme was started.
d) A committee was appointed to draft a model Public Health Act for the country.

1955

a) Contributory Health Service Scheme (Central Government Health Scheme) was started at Delhi.
b) The Central Social Welfare Board was set up.
c) The National Water Supply and Sanitation Programme was inaugurated.
d) The National Leprosy Control Programme was started.
e) The Prevention of Food Adulteration Act was passed by Parliament.

1956

a) The National Filaria Control Programme was commenced as a part of the First Five year plan.
b) The Central Leprosy Teaching and Research Institute was established at Madras.
c) A Filaria Training Centre was established at Emaculum, Kerala.
d) The Hindu Marriage Act prescribed the minimum age for marriage-18 for boys and 15 for girls.
e) National TB sample survey commenced.

1957

a) The Second five year plan (1956-61) was launched with an outlay of Rs 4800 crore, out of which Rs 225 crore (5 percent) were earmarked for health programmes.
b) The Model Public Health Act was published.
c) The Central Health Education Bureau was established in the Union Health Ministry.
d) Director, Family Planning was appointed in the Union Health Ministry.
e) The Demographic Training and Research Centre was established in Bombay.
f) The Tuberculosis Chemotherapy Centre was established in Madras.
g) The Trachoma Control Pilot Project was established.

1958

a) Influenza pandemic swept the country.
b) The Demographic Research Centres were established in Calcutta, Delhi and Trivandrum.

1959

a) The National Malaria Control Programme was converted into National Malaria Eradication programme.
b) The National Development Council endorsed the recommendations made by the Balwantrai Mehta Committee on Panchayati Raj. A three-tier structure of local self governing bodies from the village to the district was recommended for dispersal of power and responsibilities in the future.
c) The National TB Survey was completed.

1960

a) The Mudiliar Committee was appointed by the Government of India to survey the progress made in the field of health since submission of Bhore Committee’s report and to make recommendations for future development and expansion of health services.
b) A Central Expert Committee was appointed to study the problems of cholera and small pox in India, which recommended measures for their eradication.
c) Rajasthan was the first state to introduce Panchayati Raj.
d) The Nutrition Research Laboratory at Coonoor was shifted to Hyderabad.
1961
a) The School Health Committee was constituted by the Union Health Ministry to assess the present standards of health and nutrition of school children and suggest ways and means to improve them.
b) A National Nutrition Advisory Committee was constituted to tender advice regarding the nutritional policies to be adopted by the government.
c) Pilot projects for the eradication of smallpox were initiated.
d) Vital statistics were transferred to the Registrar General of India, Ministry of Home Affairs, from the Directorate General Health Services.

1962
a) The Third Five Year Plan (1961-1966) was launched with an outlay of Rs 7500 crore out of which Rs 342 crore (4.3 percent) were provided for health programmes.
b) The Report of the Mudaliar Committee was published.
c) The Central Bureau of Health Intelligence was established.

1963
a) The Central Family Planning Institute was established in Delhi by amalgamating the Family Planning Training Centre and Family Planning Communications and Action Research Centre.
b) The National Smallpox eradication programme was launched.
c) The School Health programme was initiated.
d) The District Tuberculosis programme was formulated.

1964
a) The Applied Nutrition Programme was launched by the Government of India with aid from UNICEF, FAO and WHO.
b) The National Institute of Communicable Diseases was inaugurated.
c) The Chadha Committee established a norm of one basic health worker for every 10,000 population.
d) A Drinking Water Board was set up.
1965

a) The National Institute of Health Administration and Education was opened in collaboration with the Food Foundation.

b) A committee was set up by the Union Government under the Chairmanship of Shantilal Shah, to study the question for legalizing abortions.

1966

a) Director, Indian Council of Medical Research, recommended Lippes Loop as safe and effective for a mass programme.

b) Reinforced Extended Family Planning Programme was launched.

1967

a) A Committee of Health Secretaries under the Chairmanship of Mukherjee, Secretary, Ministry of Health, Government of India was constituted to look into the minimum additional staff required for the primary health centres to take over the maintenance work of malaria and smallpox.

b) The Minister of Health was also appointed Minister for Family Planning.

c) A separate department of Family Planning was constituted in the Union Ministry of Health to coordinate family planning programme at the Centre and the States.

d) The population Council started the International Postpartum family Planning Programme in 25 hospitals in 15 countries. Two of these hospitals were located in India-Delhi and Trivandrum.

1968

a) The Madhok Committee was constituted to review the working of the National Malaria Eradication programme and recommended measures for improvement.

b) A Small Family norm Committee was set up to recommend suitable incentives to those accepting the small family norm and practicing family planning.

c) The Central Council of Health recommended the levy of a health cess on patients attending hospitals 1) a minimum charge of 10 paise per patient and 2) A minimum charge of 25 paise per day of hospital stay.
(i) The Small Family Committee’s report was submitted.
(ii) A Bill of Registration of Births and Deaths was passed by the Parliament.
(iii) The Government of India appointed the Medical Education Committee to study all aspects of medical education in the light of national needs and resources.

1969

a) The Fourth Five year plan (1969-74) was launched with an outlay of Rs. 16774 crore, out of which Rs. 840 crore were allocated to health and Rs. 315 crore to family planning.
b) The name of the Nutrition Research Laboratories was changed to National Institute of Nutrition.
c) Comprehensive legislation for control of river water pollution from domestic and industrial wastes was drafted to be introduced into Parliament.
d) The Central Births and Deaths Registration Act (1969) was promulgated.
e) The Report of Medical Education Committee (1969) was submitted. The Committee recommended that (1) the total period for MBBS Course should be four and half year and one year for internship, which should include posting in a rural centre for a period of at least 3 months. (2) The medical teaching and training should be oriented to produce a basic doctor that is a doctor conversant with the basic health problems of rural and urban communities and who is able to play an effective role in preventive and curative health services.

1970

a) The Drugs (Price Control) Order, 1970 was promulgated.
b) All India Hospital (Post-Partum) Family Planning Programme was started.
c) The Population Council of India was formed in April 1970.
d) Chittaranjan Mobile Hospitals (mobile-training-cum-service unit) was installed on the birth centenary of late C.R. Dass on 5 Nov, 1970. The scheme envisages attachment of a mobile hospital to a suitable medical college in each state.
e) The Registration of Births and Deaths Act, 1969 came into force from 1 April.
f) The name of the Demographic Training and Research Centre, Bombay was changed into International Institute for Population studies.

1971

a) The Family Pension Scheme (FPS) for industrial workers came into force.
b) The Medical Termination of Pregnancy Bill, 1969 was passed by Parliament.
c) An expert committee was appointed by the Government of India to draft suitable legislation on air pollution.

1972

a) The Medical Termination of Pregnancy Act came into force on April 1, 1972.
b) National Service Bill passed. It authorizes the Government to compel medical personnel below 30 years of age to take up work in the countryside.
c) The National Nutrition Monitoring Bureau was set up under the Indian Council of Medical Research with headquarters at the National Institute of Nutrition, Hyderabad. Regional units have also been established in the States.

1973

a) The National Programme of Minimum Needs was incorporated in the Fifth five year plan. A provision of Rs 2803 crore was made for this programme, which covered elementary education, rural health, nutrition, rural roads and water supply, housing, slum improvement and rural electrification.
b) The Government envisaged a scheme for setting up 30 bedded rural hospitals; one such hospital for every 4 primary health centres.
c) The Kartar Singh Committee submitted its report recommending the formation of a new cadre of health workers designated “Multi-purpose Health Workers” for the delivery of health, family planning and nutrition services to the rural communities, who will replace in course of time the basic health workers, family planning health assistants, auxiliary-nurse-midwives etc.

1974

a) The Fifth five year plan was launched on April 1, 1974 with a total outlay of Rs 53411 crore of which Rs 37250 crore were in the public sector and Rs
16161 crore in the private sector. A sum of Rs 796 crore were allotted to health, and Rs 516 crore to family planning.

b) Reports of the “Second In depth Evaluation Committee” and the “Consultative Committee of experts” on the National Malaria Eradication Programme were submitted. Both the Committees suggested a “revised strategy” for malaria control.

c) The United Nations designated 1974 as World Population Year.


1975

a) India became smallpox free on 5 July, 1975.

b) The country embarked on a scheme of “Integrated Child Development” from October 2, 1975. A high powered national Children’s Welfare Board was set up.

c) The Group on Medical Education and Support Manpower (Shrivastav Committee) submitted its report.

1976

a) Indian Factories Act of 1948 amended.

b) The Prevention of Food Adulteration Amendment Act 1975 came into force on 1 April, 1976.

c) The equal Remuneration Act, 1975 was promulgated providing for equal wages for men and women for same work of similar nature.

d) The Union Health Ministry announced a new Population Policy.


f) National Programme for Prevention of Blindness was formulated.

1977

a) Eradication of smallpox declared in April by the International Commission.

b) National Institute of Health and Family Planning formed.

c) Rural Health Scheme was launched. Training of Community health workers was taken up.
d) Revised Modified Plan of Malaria eradication was put into operation.
e) The 42nd Amendment of the Constitution made “Population Control and Family Planning” a concurrent subject.
f) WHO adopted a goal of Health for all by 2000 A.D.

1978

a) Bill on Air Pollution was introduced in the Lok Sabha.
b) Parliament approved the Child Marriage Restraint (Amendment) Bill, 1978 fixing the minimum age at marriage 21 years for boys and 18 years for girls.
c) The Charter for Health Development in South East Asia was finalized and endorsed.
d) Declaration of Alma Ata underlined the primary health care approach.

1979

a) World Health Assembly endorsed the Declaration of Alma Ata on primary health care.
b) The Offices of family welfare and National Malaria Eradication Programme were merged and named as Regional Office for Health and Family Welfare.

1980

a) On May 8, 1980, smallpox was officially declared eradicated from the entire world by World Health Assembly.
b) Sixth five year plan (1980-1985) was launched.

1981

a) The 1981 census was taken.
b) WHO and Member Countries adopted the Global strategy for Health for All.
c) Report of the Working Group on Health for All, set up by the Planning Commission, was published.
d) India is committed to the goal of providing safe drinking water and adequate sanitation for all by 1990, under the International Drinking water Supply and Sanitation Decade 1981-1990.
e) The Air (Prevention and Control of Pollution) Act of 1981 was enacted.
1982

a) The New 20 Point Programme was announced.
b) The Government of India announced its National Health Policy.

1983

a) India launched a National Plan of Action against avoidable disablement, known as “IMPACT India”.
b) National Leprosy Control Programme to be called National Leprosy Eradication Programme.
c) Medical Education Review Committee submitted its report.
d) National Health Policy was approved by Parliament.

1984

a) Bhopal Gas tragedy, the worst ever industrial accident in history occurred on the night of Dec 23 taking a toll of atleast 2500 people and no fewer than 50,000 affected.
b) The Workmen’s Compensation (Amendment Act) 1984 came into force from 1 July.


1985

a) Seventh five year plan (1985-1990) was launched.
b) Universal Immunization Programme was launched.
c) A separate department of Women and Child Development was set up under the newly created Ministry of Human Resource Development.

1986

a) The Environmental Protection Act, 1986 promulgated.
b) 20-point plan restructured.
c) Parliament voted Mental Health Bill.

1987

a) New 20 point programme was launched.
b) Indian Standards Institution (ISI) renamed: Bureau of Indian Standards.
c) A World-wide “safe motherhood” campaign was launched by World Bank.
d) National Diabetes Control programme and National AIDS Control Programme initiated.
e) The Factories Amendment Act 1987 operated-with provisions to protect employees exposed to hazardous processes.

1989

Blood Safety Programme was launched. The ESI (Amendment Act) 1989 operated- Modifications in dependant, employee, family, factory and seasonal factory definitions and provisions in original Act.

1990

Control of Acute Respiratory Infection (ARI) Programme initiated as a pilot project in 14 districts.

1991

India stages the last decadal census of the century.

1992

a) Eighth five year plan (1992-97) was launched.
b) Child Survival and Safe Motherhood Programme (CSSM) was launched on 20th August.

1993

Revised National Tuberculosis Programme introduced as Pilot Project in the country.

1994

a) Return of plague after 28 years of silence.
b) The Panchayati Raj Act came into force with all states completing the process of legislation.
1995

a) ICDS renamed as Integrated Mother and Child Development Services (IMCD).
b) The legislation on “Transplantation of Human Organs” was enacted to regulate the removal, storage and transplantation of human organs for therapeutic purposes and for prevention of commercial dealings in human organs.
c) Expert Committee on Malaria submitted its report and recommended guidelines for Malaria Action Plan.

1996

a) Pulse Polio Immunization, the largest single day public health event took place on 9th December, 1995 and 20th January 1996. The second phase of PPI was conducted on 7th December 1996 and 18th January, 1997.
b) Family Planning Programme made target-free from 1 April, 1996.

1997

a) Reproductive and Child Health Programmes launched.
b) Ninth five year plan launched.

1998

a) National Family Health Survey-2 undertaken covering 90,000 women aged 15-49 years.
b) National Malaria Eradication Programme renamed as National AIDS Control Programme.

1999

a) Phase 2 of National AIDS Control Programme became effective.
b) National Policy for older persons announced.
2000

b) Declared guinea worm free country.
c) Signatory to UN Millenium Declaration.
d) National Commission on Population constituted.

2001

a) India stages first census of the century.

2002

a) National Health Policy, 2002 was announced.
c) Tenth five year plan started. There was emergence of SARS.

2003

b) National Vector Borne Disease Control Programme approved as umbrella program for prevention of vector borne diseases viz. malaria, filarial, Kala-Azar, dengue and Japanese encephalitis.

2004

a) Vande Mataram scheme launched.
b) Revised programme of Nutritional Support to Primary education (Mid-day meal scheme) launched.
c) Low osmolarity oral rehydration salt replaces the existing formulae.
d) Integrated Disease Surveillance Project launched.
2005

a) RCH 2 launched.
b) Janani Suraksha Yojana launched.
c) National Rural Health Mission launched.
d) Indian Public Health Standards for Community Health centres formulated.
e) India achieved leprosy elimination target by the end of 2005.
f) National Plan of Action for Children 2005 formulated.

2006

a) WHO releases new pediatric growth chart based on breast-fed children.
b) Ban on child labour as domestic servant.
c) National Family Health Survey-3 conducted.
d) Ministry of Women and Child Development carved out of the Ministry of Human Resources and Development.

2007

a) Eleventh five year plan launched.
b) Indian Public Health Standards for Primary Health centres and sub centres formulated.
c) Maintenance and Welfare of Parents and Senior Citizens Bill 2007 passed.

2008

a) Non-Communicable Disease Programme as pilot project launched on 4 Jan.

HEALTH SYSTEM IN INDIA

India is a Union of 28 States and 7 Union territories. Under the Constitution of India, the States are largely independent in matters relating to the delivery of health care to the people. Each state, therefore, has developed its own system of health care delivery, independent of the central government. Health services are designed to meet the health needs of the community through the use of available knowledge and resources. It is not possible to define a fixed role for health services when the socio-economic pattern of one country differs from another. The health services are delivered by the health system which constitutes the management factor and involves
organizational matters. Two main themes have emerged in recent years in the delivery of health services: a) First, that health services should be organized to meet the needs of entire populations and not merely selected groups. Health services should cover the full range of preventive, curative and rehabilitation services. Health services are now seen as part of the basic social services of a country.

b) Secondly, it is now fully realized that the best way to provide health care to the vast majority of the underserved rural people and urban poor is to develop effective “primary health care” services supported by an appropriate referral system. The social policy throughout the world was to build up health systems based on primary health care, towards the policy objective of Health for All by 2000 A.D.

Community participation is now recognized a major component in the approach to the whole system of health care treatment, promotion and prevention. The stress is on the provision of these services to the people- representing a shift from medical care to health care and from urban population to rural population. The Central responsibility consists mainly of policy making, planning, guiding, assisting, evaluating and coordinating the work of the State Health Ministries, so that health services cover every part of the country, and no state lags behind for the want of the services. The health system in India has three main links that is Central, State and Local or peripheral.

At the Centre

The official “organs’ of the health system at the national level consists of:

2) The Directorate General of Health Services and

At the State Level

Historically, the first milestone in State health administration was the year 1919, when the states (then known as provinces) obtained autonomy, under the Montague- Chelmsford reforms, from the Central Government, in matters of public health. By 1921-22, all the States had created some form of public health organization. The Government of India, Act 1935 gave further autonomy to the states.
The health subjects were divided into three groups: federal, concurrent and state. The “state” list which became the responsibility of the state included provision of medical care, preventive health services and pilgrimages within the state. The position has largely remained the same, even after the new constitution of India came into force in 1950. The State is the ultimate authority responsible for all the health services operating within its jurisdiction.

At present there are 28 States in India, with each state having its own health administration. In all the states, the management sector comprises the State Ministry of Health and a Directorate of Health.

**At the District Level**

The principal unit of administration in India is the district under a collector. There are 614 (year 2007) districts in India. Within each district again, there are six types of administrative areas:

a) Sub-division  
b) Tehsils  
c) Community Development Blocks  
d) Municipalities and Corporations  
e) Villages  
f) Panchayats

Most districts in India are divided into two or more sub divisions, each under the charge of an Assistant Collector or Sub Collector. Each division is again divided into tehsils, in charge of Tehsildar. Since the launching of the Community development Programme in India in 1952, the rural areas of the district have been organized into Blocks, known as Community Development Blocks, the area of which may or may not coincide with tehsil. The Block is a unit of rural planning and development, and comprises approximately 100 villages and about 80,000 to 1,20,000 population, in charge of a Block Development Officer. Finally, there are the village panchayats, which are institutions of rural local self-government.
The urban areas of the district are organized into the following institutions of local self-government:

1) Town area committees- (in areas with population ranging between 5000 and 10,000)
2) Municipal Boards- (in areas with population ranging between 10,000 and 2 lakhs)
3) Corporations (with population above 2 lakhs)

The Town area committees are like panchayats. They provide sanitary services. The Municipal Boards are headed by a Chairman/President, elected usually by the members. The term of the Municipal Board ranges between 3-5 years. Corporations are headed by Mayors. The councillors are elected from different wards of the city. The executive agency includes the Commissioner, the Secretary, the Engineer and the Health Officer. The activities are similar to those of the municipalities, but on a much wider scale.

**Panchayati Raj**

The Panchayati Raj is a three-tier structure of rural local self-government in India, linking the village to the district. The three institutions are:

a) Panchayat-at village level
b) Panchayat Samiti- at the block level
c) Zilla Parishad-at the district level

They all contribute towards the functioning of public health.

**LEVELS OF HEALTH CARE**

There are three levels of health care services; these levels represent different types of care involving varying degrees of complexity

1. **Primary level care**

It is the first level of contact of individuals, the family and the community with the national health system, where primary health care (essential health care) is provided. As a level of care, it is close to the people, where most of their health
problems can be dealt with and resolved. In the Indian context, primary health care is provided by the complex of primary health centres and their subcentres through the agency of multipurpose health workers, village health guides and trained dais. Since India opted for “Health for All” by 2000 A.D., the primary health care system has been reorganized and strengthened to make the primary health care delivery system more effective.

2. **Secondary level care**

The next higher level of care is the secondary (intermediate) health care level. At this level more complex problems are dealt with. In India, this kind of care is generally provided in district hospitals and community health centers which also serve as first referral level.

3. **Tertiary level care**

The tertiary level is more specialized level than secondary level care and requires specific facilities and attention of highly specialized health workers. This care is provided by the regional or central level institutions, e.g. medical college hospitals, All India Institutes, Specialized Hospitals and other Apex Institutions.

A fundamental and necessary function of health care system is to provide a sound referral system. It must be a two way exchange of information and returning patients to those who referred them for follow up care. It will ensure continuity of care and inspire confidence of the consumer in the system. For a large majority of developing countries (including India) this aspect of health system remains very weak.

**THE MILLENNIUM DEVELOPMENT GOALS**

In September, 2000 representatives from 189 countries met at the Millennium Summit in New York, to adopt the United Nations Millennium Declaration. The goals in the area of development and poverty eradication are now widely referred to as “Millennium Development Goals” Governments have set a date of 2015 by which they would meet the MDG’s, that is eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality, improve maternal health, combat HIV/AIDS, malaria and other communicable diseases, ensure environmental sustainability and develop a global partnership for development.
### Table 8.5
Health Related Millennium Development Goals in India

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Eradicate extreme poverty and hunger</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: Halve the proportion of people who suffer from hunger between 1990 and 2015</td>
<td>1990</td>
<td>53.4</td>
</tr>
<tr>
<td>a) Prevalence of underweight children (under five years of age)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>53.4</td>
<td></td>
</tr>
<tr>
<td>2000-07</td>
<td>43.0</td>
<td></td>
</tr>
<tr>
<td>b) Proportion (percentage) of population below minimum level of dietary energy consumption</td>
<td>1991</td>
<td>25</td>
</tr>
<tr>
<td>2000-02</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td><strong>Goal 2: Reduce Child Mortality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</td>
<td>1990</td>
<td>112</td>
</tr>
<tr>
<td>a) Under-five mortality rate (probability of dying between birth and age birth and age 5)</td>
<td>1990</td>
<td>112</td>
</tr>
<tr>
<td>b) Infant mortality rate</td>
<td>1990</td>
<td>80.0</td>
</tr>
<tr>
<td>2007</td>
<td>54.0</td>
<td></td>
</tr>
<tr>
<td>c) Proportion (%) of one year old children immunized for measles</td>
<td>1990</td>
<td>32.7</td>
</tr>
<tr>
<td>2004</td>
<td>56.0</td>
<td></td>
</tr>
<tr>
<td><strong>Goal 3: Improve Maternal Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate</td>
<td>1990</td>
<td>420</td>
</tr>
<tr>
<td>a) Maternal Mortality ratio</td>
<td>1990</td>
<td>420</td>
</tr>
<tr>
<td>2003</td>
<td>301</td>
<td></td>
</tr>
<tr>
<td>b) Proportion (%) of births attended by skilled health personnel</td>
<td>1990</td>
<td>89</td>
</tr>
<tr>
<td>2004</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td><strong>Goal 4: Combat HIV/AIDS, Malaria and other diseases</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Target: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) HIV prevalence among young people. 15-24 years age group</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2001 (M)</td>
<td>0.22</td>
</tr>
<tr>
<td></td>
<td>2001 (F)</td>
<td>0.46</td>
</tr>
<tr>
<td>15-49 Years age group</td>
<td>2003</td>
<td>0.9</td>
</tr>
<tr>
<td>b) Condom use in high risk population.</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2001 (M)</td>
<td>51.2</td>
</tr>
<tr>
<td></td>
<td>2001 (F)</td>
<td>39.8</td>
</tr>
<tr>
<td>c) Ratio of children orphaned/non orphaned</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2001</td>
<td>NA</td>
</tr>
<tr>
<td>Target: Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Malaria death rate per 100,000 in children (0-4 years of age)</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2000</td>
<td>6</td>
</tr>
<tr>
<td>b) Malaria death rate per 100,000 (all ages)</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>2.9</td>
</tr>
<tr>
<td>c) Malaria prevalence rate per 100,000</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>14</td>
</tr>
<tr>
<td>d) Proportion (%) of 5 population under age in malaria risk areas using insecticide –treated bed nets</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2002</td>
<td>NA</td>
</tr>
<tr>
<td>e) Proportion (%) of population under age 5 with fever being treated with antimalarial drugs</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2003-07</td>
<td>8</td>
</tr>
<tr>
<td>f) Tuberculosis death rate per 100,000</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>28</td>
</tr>
<tr>
<td>g) Tuberculosis prevalence rate per 100,000</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>299</td>
</tr>
<tr>
<td><strong>Goal 5: Ensure Environmental Sustainability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target:</strong> Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Proportion of population using biomass fuel.</td>
<td>1990</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>70.8</td>
</tr>
<tr>
<td><strong>Target:</strong> Halve by 2015, the proportion of people without sustainable access to safe drinking water.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Proportion (%) of population with sustainable access to an improved water source, rural.</td>
<td>1990</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>86</td>
</tr>
<tr>
<td>b) Proportion (%) of population with sustainable access to an improved water source (urban).</td>
<td>1990</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>96</td>
</tr>
<tr>
<td><strong>Target:</strong> By 2020 to have achieved a significant improvement in the Lives of at least 100 millions slum dwellers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Proportion (%) of urban population with access to improved sanitation.</td>
<td>1990</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>52</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Goal 6: Develop global partnership for development</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target:</strong> In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries</td>
</tr>
<tr>
<td>a) Proportion (%) of population with access to affordable, essential drugs on a sustainable basis.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Source:** www.unmillenniumproject.org.
Table 8.6
Achievements during Plan Periods

<table>
<thead>
<tr>
<th>Indicators</th>
<th>First Plan (1951-1956)</th>
<th>Tenth Plan (2002-07)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Primary Health Centres</td>
<td>725</td>
<td>22370</td>
</tr>
<tr>
<td>b) Subcentres</td>
<td>NA</td>
<td>145272</td>
</tr>
<tr>
<td>c) Community Health Centres</td>
<td>NA</td>
<td>4045</td>
</tr>
<tr>
<td>d) Total beds</td>
<td>125000</td>
<td>914543</td>
</tr>
<tr>
<td>e) Medical Colleges</td>
<td>42</td>
<td>270</td>
</tr>
<tr>
<td>f) Annual admissions in medical colleges</td>
<td>3500</td>
<td>30408</td>
</tr>
<tr>
<td>g) Dental colleges</td>
<td>7</td>
<td>205</td>
</tr>
<tr>
<td>h) Allopathic Doctors</td>
<td>65000</td>
<td>767500</td>
</tr>
<tr>
<td>i) Nurses</td>
<td>18500</td>
<td>928149</td>
</tr>
</tbody>
</table>

Source: Various Reports of Planning Commission.

This table showed the achievements during the past 60 years of planned development in the public health sector.

POLICIES RELATING TO PUBLIC HEALTH SECTOR IN INDIA

1. Health Planning

Health Planning in India is an integral part of the national socio-economic planning. The guidelines for national health planning were provided by a number of committees dating back to Bhore Committee in 1946. These committees were appointed by Government of India from time to time to review the existing health situation and recommend measures for existing health situation.

The Alma Ata Declaration on primary health care and the National Health Policy of the government gave a new direction to health planning in India, making primary health care the central function and main focus of its national health system. The goal of national health planning in India was to attain Health for all by the year 2000.
2. **Bhore Committee, 1946**

The Government of India in 1943 appointed the Health Survey and Development Committee with Sir Joseph Bhore as Chairman, to survey the then existing position regarding the health conditions and health organization in the country and to make recommendations for the future development. The Committee which had among its members some of the pioneers of public health, met regularly for 2 years and submitted in 1946 its famous report which runs into four volumes. The Committee put forward for the first time comprehensive proposals for the development of a national programme of health services for the country. The Committee observed “If the nation’s health is to be built, the health programme should be developed on a foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of patients.” Some of the important recommendations of the Bhore Committee were:

a) Integration of preventive and curative services at all administrative levels.

b) The Committee visualized the development of primary health centres in two stages: 1) as a short-term measure, it was proposed that each primary health centre in the rural areas should cater to a population of 40,000 with a secondary health centre to serve as a supervisory, coordinating and referral institution. For each PHC, two medical officers, 4 trained dais, 4 midwives, 1 nurse, 2 sanitary inspectors, 2 health assistants and 15 other class four employees were recommended.

d) a long term programme (also called the three million plan) of setting up primary health units with 75 bedded hospital for each 10,000 to 20,000 population and secondary units with 650-bedded hospitals, again regionalized around district hospitals with 2500 beds.

e) Major changes in medical education which includes three months training in preventive and social medicine to prepare “social physicians”.

Although the Bhore Committee’s recommendations did not form part of a comprehensive plan for national socio-economic development, the Committee’s
report continues to be a major national document and has provided guidelines for national health planning in India.

3. Mudaliar Committee, 1962

By the close of the second five year plan (1956-61), a fresh look at the health needs and resources was called for to provide guidelines for national health planning in the context of the five year plans. In 1959, the Government of India appointed another Committee known as “Health Survey and Planning Committee” popularly known as the Mudaliar Committee (after the name of Chairman, Dr. A.L. Mudaliar) to survey the progress made in the field of health since submission of the Bhore Committee’s report and to make recommendations for future development and expansion of health services.

The main recommendations of the Mudaliar Committee were:

a) Consolidation of advances made in the first two five year plans.
b) Strengthening of the district hospital with specialist services to serve as central base of regional services.
c) Regional organizations in each state between the headquarters organization and the district in charge of a Regional Deputy or Assistant Directors-each to supervise two or three district medical and health officers.
d) Each primary health centre not to serve more than 40,000 populations.
e) To improve the quality of health care provided by the primary health centres.
f) Integration of medical and health services as recommended by the Bhore Committee and
g) Constitution of an All India Health Service on the pattern of Indian Administrative Service.

4. Chadah Committee, 1963

In 1963, a Committee was appointed by the Government of India, under the chairmanship of Dr. M.S. Chadah, the then Director General of Health Services to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme.
The Committee recommended that the “vigilance” operations in respect of the National Malaria Eradication Programme should be the responsibility of the general health services that is primary health centres at the block level. The Committee also recommended that the vigilance operations through monthly home visits should be implemented through basic health workers. One basic health worker per 10,000 populations was recommended. These workers were envisaged as “multipurpose” workers to look after additional duties of collection of vital statistics and family planning, in addition to malaria vigilance. The Family Planning Health Assistants were to supervise 3 or 4 of these basic health workers. At the district level, the general health services were to take the responsibility for the maintenance phase.

5. **Mukerji Committee, 1965**

Within a couple of years of implementation of the Chadah Committee’s recommendations by some states, it was realized that the basic health workers could not function effectively as multipurpose workers. As a result the malaria vigilance operations had suffered and also the work of the family planning programme could not be carried out satisfactorily. This subject came up for discussion at a meeting of the Central Health Council in 1965. A Committee known as “Mukerji Committee”, 1965 under the Chairmanship of Shri Mukerji, the then Secretary of Health to the Government of India, was appointed to review the strategy for the family planning programme. The Committee recommended separate staff for the family planning programme. The family planning assistants were to undertake family planning duties only. The basic health workers were to be utilized for purposes other than family planning. The Committee also recommended delinking the malaria activities from family planning so that the latter would receive undivided attention of its staff. The recommendations were accepted by the Government of India.

6. **Mukerji Committee, 1966**

As the states were finding it difficult to take over the whole burden of the maintenance phase of malaria and other mass programmes like family planning, smallpox, leprosy, trachoma etc due to paucity of funds, the matter came up for the discussion at a meeting of the Central Council of Health held in Bangalore in 1966. The Council recommended that these and related questions may be examined by a
Committee of Health Secretaries, under the Chairmanship of the Union Health Secretary, Shri Mukerji. The Committee worked out the details of the Basic Health Service which should be provided at the block level, and some consequential strengthening required at higher levels of administration.

7. **Jungalwalla Committee, 1967**

The Central Council of Health at its meeting held in Srinagar in 1964, taking note of the importance and urgency of integration of health services, and elimination of private practice by government doctors, appointed a Committee known as the “Committee on Integration of Health Services” under the Chairmanship of Dr. N. Jungawalla, Director, National Institute of Health Administration and Education, New Delhi to examine the various problems including those of service conditions and submit a report to the Central Government in the light of these considerations. The report was submitted in 1967.

The Committee defined “integrated health services” as: a) a service with a unified approach for all problems instead of a segmented approach for different problems.

a) medical care of the sick and conventional public health programmes functioning under a single administrator and operating in unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time.

The Committee recommended integration from the highest to the lowest level in the services, organization and personnel. The main steps recommended towards integration were:

a) common seniority  
b) recognition of extra qualifications  
c) equal pay for equal work  
d) no private practice  
e) good service conditions

The Committee while giving sufficient indication for action to be taken was careful neither to spell out steps and programmes nor to indicate a uniform integrated
set-up but left the matter to the States to work out the set up based on the experience of West Bengal, Punjab and Defence Forces. The Committee stated that “integration should be a process of logical evolution rather than revolution”.

8. Kartar Singh Committee, 1973

The Government of India constituted a committee in 1972 known as “The Committee on Multipurpose Workers under Health and Family Planning” under the Chairmanship of Kartar Singh, Additional Secretary, Ministry of Health and Family Planning, Government of India. The terms of reference of the Committee were to study and make recommendation on:

a) The structure for integrated services at the peripheral and supervisory role.
b) The feasibility of having multipurpose, bi purpose workers in the field.
c) The training requirements for such workers.
d) The utilization of mobile service units set up under family planning programme for integrated medical, public health and family planning services operating in the field.

The Committee submitted its report in September 1973. Its main recommendations were: a) that the Present Auxiliary Nurse Midwives to be replaced by the newly designated “ Female Health Workers” and the present day Basic Health Workers, Malaria Surveillance Workers, Vaccinators, Health Education Assistants and the Family Planning Health Assistants to be replaced by “ Male Health Workers”.

b) The programmes for having multipurpose workers to be first introduced in areas where malaria is in maintenance phase and smallpox has been controlled and later to other areas as malaria passes into maintenance phase or smallpox controlled.

a) For proper coverage, there should be one primary health centre for a population of 50,000.
b) Each primary health centre should be divided into 16 sub-centres each having a population of about 3000 to 3500 depending upon topography and means of communications.
c) Each sub-centre to be staffed by a team of one male and one female health worker.
d) There should be a male health supervisor to supervise the work of 3 to 4 male health workers and a female health supervisor to supervise the work of 4 female health workers.

e) The present day lady health visitors to be designated as female health supervisors and

f) The doctor in charge of a primary health centre should have the overall charge of all the supervisors and health workers in his area.

The recommendations of the Kartar Singh Committee were accepted by the Government of India to be implemented in a phased manner during the Fifth Five year plan.

9. **Shrivastav Committee, 1975**

The Government of India in the Ministry of Health and Family Planning had in November 1974 set up a “Group on Medical Education and Support Manpower” popularly known as the Shrivastav Committee. :

a) To devise a suitable curriculum for training a cadre of health assistants so that they can serve as a link between the qualified medical practitioners and the multipurpose workers, thus forming an effective team to deliver health care, family welfare and nutritional services to the people.

b) To suggest steps for improving the existing medical educational processes as to provide due emphasis on the problems particularly relevant to national requirements and

c) To make any other suggestions to realize the above objectives and matters incidental thereto.

The Group submitted its report in April, 1975. It recommended immediate action for:

a) Creation of bands of Para-professional and semi-professional health workers from within the community itself (e.g. school teachers, postmasters, gram sevaks) to provide simple, promotive, preventive and curative health services needed by the community.
b) Establishment of two cadres of health workers, namely-multipurpose health workers and health assistants between the community level workers and doctors at the PHC.

c) Development of a Referral Services Complex by establishing proper linkages between the PHC and higher level referral and service centres viz taluka/tehsil, district, regional and medical college hospitals and

d) Establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of the University Grants Commission.

The Committee felt that by the end of the sixth plan, one male and one female health worker should be available for every 5000 population. Also, there should be one male and female health assistant for two male and two female health workers respectively. The health assistants should be located at the subcentre, and not at the PHC.

10. Rural Health Scheme, 1977

The most important recommendation of the Shrivastav Committee was that primary health care should be provided within the community itself through specially trained workers so that the health of the people is placed in the hands of the people themselves.

The basic recommendations of the Committee were accepted by the Government in 1977, which led to the launching of the Rural Health Scheme. The programme of training of community health workers was initiated during 1977-78. Steps were also initiated for the

a) Involvement of medical colleges in the total health care of selected PHC’s with the objective of reorienting medical education to the needs of rural people.

b) Reorientation training of multipurpose workers engaged in the control of various communicable disease programmes into unipurpose workers. This Plan of Action was adopted by the Joint Meeting of the Central Council of Health and Central family Planning Council held in New Delhi in April 1976.

A Working Group on Health was constituted by the Planning Commission in 1980 with the Secretary, Ministry of Health and Family Welfare, as its Chairman, to identify, in programme terms, the goal for Health for All by 2000 AD and to outline with that perspective, the specific programmes for the sixth five year plan. The Working Group, besides identifying and setting out the broad approach to health planning during the sixth five year plan, had also evolved fairly specific indices and targets to be achieved in the country by 2000 AD.

12. National Health Policy-2002

The Ministry of Health and Family Welfare, Govt. of India, evolved a National Health Policy in 1983 keeping in view the national commitment to attain the goal of Health for all by the year 2000. Since then there has been significant changes in the determinant factors relating to the health sector, necessitating revision of the policy, and a new National Health Policy-2002 was evolved.

The main objective of this policy was to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to decentralized public health system by establishing new infrastructure in the existing institutions. Over-riding importance would be given to ensure a more equitable access to health services across the social and geographical expanse of the country. Primacy will be given to preventive and first line curative initiatives at the primary health level. The policy was focused on those diseases which are principally contributing to disease burden such as tuberculosis, malaria, blindness and HIV/AIDS. Emphasis was laid on the rational use of drugs within the allopathic system. To translate the above objectives into reality, the Health Policy has laid down specific goals to be achieved by year 2005, 2007, 2010 and 2015. These are as given in below table. Steps are already under way to implement the policy.

The large public health infrastructure that brought modern medicine to the masses after independence and implemented the malaria and smallpox programmes in the 1950’s and 1960’s declined in functional quality over the years. The primary level services grew in the 1960’s and 1970’s largely by the impetus and funds of the
<table>
<thead>
<tr>
<th>Goal</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Eradicate Polio</td>
<td>2005</td>
</tr>
<tr>
<td>b) Eliminate Leprosy</td>
<td>2005</td>
</tr>
<tr>
<td>c) Eliminate Kala-Azar</td>
<td>2010</td>
</tr>
<tr>
<td>d) Achieve zero level growth of HIV/AIDS</td>
<td>2007</td>
</tr>
<tr>
<td>e) Reduce mortality by 50 percent on account of TB, Malaria and other vector and water-borne diseases.</td>
<td>2010</td>
</tr>
<tr>
<td>f) Reduce prevalence of blindness to 0.5 %</td>
<td>2010</td>
</tr>
<tr>
<td>g) Reduce IMR to 30/100 and MMR to 100/lakh</td>
<td>2010</td>
</tr>
<tr>
<td>h) Increase utilization of public health facilities from current level to less than 20 percent to more than 75 percent.</td>
<td>2010</td>
</tr>
<tr>
<td>i) Increase health expenditure by government as a percentage of GDP from the existing 0.9 percent to 2 percent.</td>
<td>2010</td>
</tr>
<tr>
<td>j) Increase share of central grants to constitute at least 25 percent of total health spending.</td>
<td>2010</td>
</tr>
<tr>
<td>k) Increase state share health spending from 5.5 percent to 7 percent of the budget</td>
<td>2005</td>
</tr>
<tr>
<td>l) Further increase to 8 percent of the budget</td>
<td>2010</td>
</tr>
</tbody>
</table>

**Source:** www.mohfw.nic.in
vertical, single disease control programmes and the family planning programme. This detracted from their delivery of comprehensive services and the quality of care, a trend that has only escalated over the 1980’s and 1990’s. The private sector grew alongside the public, but until the mid 1980’s public institutions led the private in terms of reaching unserviced regions and in expertise and technology.

During the 1990’s there has been stagnation in the number of rural public health institutions and beds in public hospitals with a decrease relative to population. Simultaneously, there has been an increase in beds in private hospitals. The National Sample Survey data shows that respondent perceptions of not accessing care due to financial constraints increased from 10 percent to 20 percent in rural areas and from 15 percent to 25 percent in urban areas from 1986 to 1996. The rate of untreated ailments increased by 40 percent. Also, the poor still resort to the public services for more of their secondary and tertiary level care than do the better off (Iyer and Sen, 2000).

Presently there is a large public health infrastructure that provides 20 percent of outdoor and 45 percent of indoor curative services and 45 percent of indoor curative services, preventive services through single disease vertical programmes and family planning services at community level. It also maintains surveillance for diseases, regulates medical research, education, production and use of drugs etc. The private sector is also gigantic but restricted to medical care, providing 80 percent of outdoor consultations and 55 percent of indoor care. This unregulated private sector includes a range of service providers- the non formal practitioner, the general practitioner formally trained in modern medicine, the nursing homes and polyclinics with groups of doctor-proprietors and the hospitals with small or big corporate structure (Ashraf, 2002).

Also to be considered for public health system analysis are the 25990 public institutions of indigenous systems of medicine and homeopathy (ISM and H) which constitute about 13 percent of all health care institutions but get only 0.75 percent of the allocation on health. This is despite the fact that these alternative systems are being increasingly sought after globally due to limitations of modern medicine.
Vertical programmes that have received major attention and funds with support from international and national health planners, need to be examined for their effectiveness. Crude death rate remained stagnant and actually increased in several states- the less developed ones like Rajasthan, Orrisa and several north-eastern states as well as more developed ones like Andhra Pradesh, Maharashtra and Tamil Nadu. While Rajasthan, Uttar Pradesh, Kerala and Tamil Nadu registered a decline in the prevalence of pulmonary tuberculosis and malaria, states such as Madhya Pradesh, the north eastern states and more developed ones like Andhra Pradesh and Karnataka registered an increase for these diseases with dedicated vertical programmes. The limited outcome of these programs is even more serious since as NHP-2002 recognises “each disease program is extremely expensive and difficult to sustain”.

The Pulse Polio campaign and the Hepatitis-B vaccination drive respectively target lameness in children and chronic liver disease in adults. However, a major proportion of lameness in children is due to water-borne viruses other than the polio virus or a neurological syndrome of unknown cause. Major cause of cirrhosis of the liver is alcoholism and malnutrition. Vaccination drives tend to create false promises, divert attention from basic underlying causes and create demand for medical technology that has marginal benefit, at best. This technology – fixation transfers itself to curative technologies as well.

The mass application of medical technology through strategies not suited to local epidemiological, social or health services context may even be potentially dangerous. Public health analysis have argued that the new strategy for tuberculosis control is likely to increase resistance to anti-tuberculosis drugs in India where it was low in early 1990’s when this strategy was adopted. It has also been argued that the Pulse Polio strategy may lead to pockets of high resurgence of paralytic polio. Such socially marketed programmes also provide legitimacy for the irrational use of medical technology at mass level.

Some tough moves towards an Indian model of reforms in the health services are necessary if dream to become world class in health sector are to be achieved. Merely increasing funding for the current programmes will do little to improve health if the structure, content and functioning of the public services are not revamped.
While restructuring the health services, lessons learnt from the reforms of the 1990’s should be heeded. We need to set priorities and the most cost-effective ways to address them, ensuring that issues of quality are not undermined in the name of cost cutting and feasibility. Optimal criteria for quality will have to be set.

The goal of strengthening primary health care requires effective and affordable comprehensive primary level health care services becoming accessible and user-friendly for all sections and in all regions of the country with back-up referral to equally appropriate and user friendly secondary and tertiary level public hospitals. Two approaches exist for the primary level: one focuses on vertical single disease control programmes (for TB, malaria, leprosy, AIDS) and the RCH/ family planning programme. The second focuses on the general health services that deal with all health problems comprehensively.

Overall, there has been a neglect of the general health services that cater to the immediate felt needs of people at primary level. The financial resource at its disposal has been less than one-fourth of the 15 percent of budgetary allocation envisaged in the blueprint adopted at the beginning of planned health service development in independent India (Bhore Committee Report, 1948). There has also been a top-down development oriented from the common people and their realities; the very anti thesis of the vision of primary health care. This has increased since the mid 1990’s. The vertical programs are becoming almost synonymous with primary health care, while the general health services are allowed to deteriorate. If the general health services are to be strengthened the following measures appear to be necessary and feasible.

There needs to be clarity on the proportion of attention to be given to the family planning program, the general health services and disease control programmes. A review of all vertical programmes to evaluate the strategy of each and take concrete steps towards their integration into the general health services with a time-bound plan, could lead to the entire 2-3 percent of GDP being allocated for the general health services. The dilemma is that international funds have always come tagged to such vertical programmes. If in the name of primary health care we continue to focus on the vertical programmes, it only means more of the same. If the government cannot
generate adequate finances from within the country must it not insist on “untagged” funds for health with international funders?

Strengthening existing public sector services of ISM and H through increased funding and promotion of research is another dimension for strengthening primary health care. Results of several experiments are available to build upon for this integration of all available knowledge into a home to hospital continuum of the health service system.

The functioning of the public sector general health services at primary, secondary and tertiary levels can be improved by:

1) Strengthening health analysis and planning capacities at district levels.
2) Rationalizing the existing infrastructure and personnel through a block, district and state level restructuring with linkages between the three levels of care.
3) Ensuring adequate supply of essential drugs and basic equipment.
4) Improving health personnel functioning through administrative measures to support persons providing conscientious service and to discipline those who provide poorly or engage in unethical practice, then linking this to social checks.
5) A review of medical education so as to strengthen the understanding of public health issues and rational therapeutics.

A critical section of leaders of the profession, policy makers and administrators do not believe it worthwhile to attempt improving morale and quality of performance of health personnel. The public sector professional has been demonized and the services presented in the worst light possible. It needs to be recognized that the management structure in the public sector has been distorted by the transfer and posting raj as well as by vertical programmes and campaigns that arise in an adhoc manner. The blame is however put on the public sector health personnel, painting them black being a favourite pastime of those who do not face the overcrowded OPD’s or the emergency cases with little equipment or drugs to deal with them, with a majority of the patients being poor. Economists currently add to this by projecting staff salaries as some kind of wasteful expenditure in a service sector. The solution offered is to shift the onus of provision of services to the private sector.
and NGO’s so as to avoid the central issue- that of improving functioning of existing health care infrastructure. The National Health Policy-2002 wants to leave it to the community. The only measure it envisages is to ensure an adequate supply of drugs so that the community perceives its stake in the public services and therefore, builds pressure. The other mechanism often suggested for community controls is to give Panchayati Raj Institutions authority over health care personnel, but attempts to implement this have been effectively countered by technical health professionals.

One basis for the perception of better quality services in the private sector has been better use of state of art technology. A rough comparison of proportion of doctors engaged in malpractice and commissions from labs and chemists also showed up the public sector in a better light than the private. Weakening of public health services and of state controls in the economy has limited the possibility of formal regulation of the private sector.

Even 2-3 percent of India’s GDP is not enough for the public sector to provide comprehensive health services to all of its citizens. Therefore, the imperative for the private services will remain. The issue is what kind of private sectors should the government promote –the informal providers that the poor access most easily, formally trained generalist private practitioners who are a varied group and cater to different classes, or the corporate sector that does not cater to the poor even when it avails of government subsidies. Informal providers often lack sufficient training and even the qualified medical practitioners indulge in irrational overuse of diagnostic tests, drugs and procedures. Services provided by these formal and informal private general practitioners accessed by the poor need to be strengthened by upgrading their knowledge and skills for rational management.

If we attempt to become world class through promotion of private, for-profit hospitals and medical tourism, we have to take an entirely different trajectory for health service development. Quality of service gets equated with high cost institutions. Supported by the dominant medical mindset that sees medical technology as the panacea for all ills, hi-tech state of the art medical facilities, short waiting time and commercial management approaches are hallmarks of their quality and efficiency.