CHAPTER I
INTRODUCTION

Development is a process of enlarging people's choices. Such choices tend to be very wide-ranging from basic ones like an option to stay healthy, acquire knowledge to greater social, economic and political freedom including the opportunities to be creative and productive, enjoy personal self-respect and be assured of human rights. At all levels of development, however, three most essential choices for the people are to lead a long and healthy life, acquire knowledge and have access to resources needed for a decent standard of living. The goal of all development efforts is to raise the level of well-being of all the citizens of a state or country. Earlier, per capita income was regarded as the sole indicator of economic welfare. This has been increasingly questioned in recent years and the emphasis has now shifted to alternative measures of development. It is argued that development is not only the growth in income, wealth or consumption but also the expansion of human capabilities. Human development has two sides—one is the formation of human capabilities such as improved health, knowledge and skills, another is to make people use their acquired capabilities for productive purposes, for leisure or being active in social, cultural and political affairs (UNDP, 1985).

Health evokes different images for different people. One person might think of well equipped hospitals, beautifully dressed nurses and smiling staff, others might think of shelter, food, safe drinking water and a secure job that ensures all of above. But it all depends upon where a person stands in the society. The holistic perspective of health takes into account not only existing technologies and organization but it also underlines the importance of social determinants that contribute to people’s well being—such as food availability and nutritional status of population, drinking water supply, education, housing, employment and last but not the least the status of women. People’s health can be defined as an outcome of the interplay of socio-economic, cultural, political and technological forces. This outcome varies depending on gender, class stratification and regional factors.

Health as conceived by World Health Organization (WHO) is a “state of physical, mental and social well being and not merely the absence of disease or
infirmity”. According to Amartya Sen, health contributes to a person's basic capability to function, to choose the life he/she has reason to value (Sen, 1985). Health is not just an attribute of individuals; it is also a reflection of the social environment in which an individual experiences life. How a society values and understands health will determine in great part how the individuals in society experience health. Even more, it will determine what society and individuals can do about health—how health will be measured and how the society’s medical care services will be evaluated. Health, in other words, is thought to be influenced by relative income, suggesting that levels of health can be regarded as a signal of the socio-economic development within which people live, as well as to how rich or poor the society is on an average. Inequality can affect health through a variety of social factors, such as access of life opportunities, levels of social cohesion and psycho-social explanations, such as hopelessness, lack of control, isolation, and chronic stress (Kawachi, 1999). Poor health, in turn, further contributes to these social factors, draining social capital and creating conditions where sections of a society trapped in a cycle of self-reinforcing social exclusion. On a macro level, health is a major cornerstone of economic development, while at the micro level, health is essential to ensure that people can achieve a more ‘economically productive life’. Increasingly, research is showing that a healthy population is an engine for economic growth. This new thinking supplements and to a certain extent re-aligns, the traditional justification of spending on health, which is rooted in humanitarian and equity arguments.

Health is an important factor in the formation of human resource development which plays a vital role in improving the qualities of human beings who are the active agents of economic development. Improving the qualities of human agents contributes to labour productivity, allocative and entrepreneurial ability. Health improvement also enhances the quality of human resources in addition to food and better shelter, especially in underdeveloped countries. Ill health causes a great loss of output and therefore any measure taken up to improve health raises the productivity of labour and also total output. Improvement in health promotes learning, reduce absenteeism, improve stamina and increase output. Therefore, better health would contribute in improving the economic status of the poor and for expanding total output.
In health process, individual concerned is not the only actor. The other actors include households, hospitals, community, medical industry, governments, markets and various agencies. These actors act both independently and jointly. Thus, the health process may be considered an interaction of the individual with surrounding institutions and environment. There is indeed a vicious circle present in developing countries like India which is as follows:

Thus, this vicious circle needs to be broken in the interests of the growth of an economy and for the promotion of welfare of the people. With rapid improvement in health particularly of poor this “vicious circle of poverty” can be converted into “virtuous circle of prosperity”.

Health is man’s greatest possession. In terms of resources, for socio-economic development, nothing can be considered of higher significance than the health of the people. An investment on health is an investment on human resource development. But in order to ensure that the health programmes move as scheduled, and to bring about the requisite effort and direction in the wide-ranging health activities and in the government machinery itself, it is necessary to indicate the framework of health policy. The success of health plan depends on numerous factors, among which the choice of current policy is crucial. The term “health policy” is defined as an expression of goals for improving health situations.
The health system in India consists of a public sector, a private sector, and an informal network of providers of care operating within an unregulated environment, with no controls on what services can be provided by whom, in what manner and what costs and no standardized protocols to help measure the quality of care. There are wide disparities in access, further worsened by the poor functioning of public health system. The Health Survey and Development Committee, known as Bhore Committee (1946) was established by the Indian government as the first policy statement on health in independent India. In India the evolution of health system can be categorized into 3 distinct phases:

**Phase I (1947-1983):** During this period, health policy was based on 2 principals-

a) none should be denied care for want of ability to pay;

b) that it was the state’s responsibility to provide health care to the people.

**Phase II (1983-2000):** When the first national health policy of 1983 articulated the need to encourage private initiative in health care service delivery, while at the same time expanding access to primary health care.

**Phase III (Post-2000):** which is witnessing a further shift that has the potential to profoundly affect the health sector in three important ways:

a) The desire to utilize private sector resources for addressing public health goals;

b) Redefining the role of the state from being only a provider to a financier of health services as well;

c) Liberalization of the insurance sector to provide new avenues for health financing.

The health system in India comprises of two broad categories, namely public and private sector. The public sector system comprises of the health system created, run and maintained by the central and state governments. Public health programmes are concerned mainly with preventive, promotive and rehabilitative aspects giving importance to primary health care. Public health services in India produce public goods of incalculable benefit for facilitating economic growth and poverty reduction. These services are both pro growth as well as pro poor as they are self targeted towards the poor, who face the maximum exposure to disease. In the private sector,
health care expenditure is made by households, voluntary organizations, and non-government organizations.

At the time of independence the status of public health was low as shown by high rates of infant, under five mortality rates, high fertility rates, low life expectancy etc. It reflected the general state of social sector and underlined low literacy rate, a larger segment of population below the poverty line subjected to hunger and malnutrition, indicating poor quality of human existence.

Health care is financed primarily by state governments and state allocations on health are affected by many fiscal stresses. During 2008-09, government expenditure on health in India was about 1 percent of GDP which was very low. Efforts in eleventh plan are to increase the total expenditure at the state and centre to at least 2 percent of GDP. Further, this plan is going to experiment with different systems of Public Private Partnerships (PPP’s). The results from the National Health Accounts (NHA) for the year 2001-02 showed that the total health expenditure in the country was Rs. 105734 crore, accounting for 4.6 percent of the GDP. Out of this, public health expenditure constituted Rs. 21439 (0.94 percent), private health expenditure constituted Rs. 81810 crore (3.58 percent) and external support 2485 crore (11percent). If it is looked from the financial allocation point of view then the allocation of health sector over the past decades indicated that the public expenditure on health (through the central and state governments), as a percentage of total government expenditure has declined from 3.12 percent in 1992-93 to 2.99 percent in 2003-04. Similarly, the combined expenditure on health as a percentage of GDP has also marginally declined from 1.01 percent of GDP in 1992-93 to 0.99 percent in 2003-04. In nominal terms, per capita public health expenditure increased from Rs. 89 in 1993-94 to Rs. 214 in 2003-04 (GOI, 2005).

Public health expenditure and investment in India had increased substantially since independence but this has not been enough to secure a minimum decent standard of healthcare service in the country. This social sector had been neglected by government since first five year plan. The health sector’s allocation was Rs. 98 crore for the first plan (5.6 percent of total), 226 crore (4.84 percent of total) for second and 2.63 percent of total for the third plan, Rs. 140 crore for the annual plans (2.12 percent of total), Rs. 336 crore for fourth plan (2.13 percent of total),761 crore for fifth plan
(1.93 percent of total), Rs. 221.4 crore for sixth plan (1.83 percent of total), Rs. 3393 crore for seventh plan (1.69 percent of total), Rs. 75.76 crore for eighth plan (1.75 percent of total). Thus, the allocations to the health sector are declining over the planning periods. India spent 0.9 percent of GDP on public health sector programs as compared to an average of 2.2 percent GDP spent on health by lower income countries (Market Rules, 2007). Meanwhile, India’s total health expenditure as a percentage of GDP is 4.8 percent of which 75 percent is private health expenditure. Thus India ranks 171 out of 175 countries in percentage of GDP spent on public sector health and ranks 17 in spending within the private sector. While most of the expenditure on India’s health system is in private sector, still more people rely on public health services (NSS, 60th Round, 2004). Besides declining expenditure, the sector has been plagued with instances of inefficiencies at several levels resulting in waste, duplication and suboptimal use of scarce resources. All these factors combined have had an adverse impact on the health sector’s ability to provide health care services to the poor. There was also gradual decline in the proportion of funds released to states by central government and the states were themselves under fiscal stress. This resulted in sharp reduction in capital investments in public hospitals, low priority to public hospitals and preventive and promotive care and inefficiencies in the allocation under national health programmes. In India where private health care tends to be too expensive for the common citizen, especially the poor, public health systems tend to suffer from inadequate resources and poor service delivery. Reforms of the public health system include the introduction of user charges to respond to the challenge of augmenting resources and removing inefficiency in public health service delivery system. User charges enhanced the stake of the user and improve accountability. Furthermore, such user charges often recovered only a part of the cost of operation and maintenance of the health service delivery system and are only fraction of the corresponding charges under private health care. Below poverty line users were normally exempted from payment of such charges. Free public health care services often involved a lot of non-financial costs such as waiting time, lack of access and inadequate facilities such as hospital beds, equipments and medicines. The funds collected by way of user charges are meant to be utilized for improving the quality of services in health facilities such as maintenance of hospital buildings, improving the cleanliness and hygiene, minor repairs and construction works,
purchase of medicines, maintenance and repair of equipment and improving facilities for the patients and the attendants. Thus, user charges definitely improve the quality of health services and financial sustainability in health care system.

Since, health is a state subject; the implementation aspect is the responsibility of states. But for one reason or the other they were not able to cope with the demand for health services. Inadequate resource availability in the states affected the policy implementation. The outlay in health and health-related sectors have been increasing over the five year plans. Public spending on health is inequitable across the states, as health care in India is linked with the economic capacities of the states. States that have improved their health status more than others are those with higher levels of per capita income. Furthermore, the allocation of health resources by the centre was also favored to the rich states. During 2005, it was found that there were wide disparities in the per capita expenditure on health care (medical, public health and family welfare) with Uttar Pradesh at the lowest level with Rs. 34.62 and Punjab at the highest level with Rs. 83.49 (Reddy, 1994). Further, the ratio of per capita spending on public health between highest and lowest state was 7:1. The private sector was not coming forward to provide health care at affordable cost. The net result was that health care is becoming highly inaccessible and unaffordable to the poor. The problem is that it was not just more financing that is required for health care, but additional financing for things that significantly contributed to improving the people’s health status. This meant that a reorientation of health care expenditure is needed.

Eighteenth October, 1943 marked a watershed in health policy making and health planning in India. It was a great historical moment. In the midst of Second World War and in succession to the Quit India movement the Government of India announced the appointment of the Health survey and Development Committee under the chairmanship of Sir Joseph Bhore. The terms of reference of this Committee were simple:

a) Broad survey of the present position in regard to the health conditions and health organization

b) Recommendations for future development (Bhore, Joseph, 1946)

The Bhore committee further recognized the vast rural urban disparities in the existing health services and hence based its plan with specifically rural population in
mind. Stated in terms of a ratio to a standard unit of population the minimum requirement recommended by the Bhore Committee was:

a) 567 hospital beds per 100000 population  
b) 62.3 doctors per 100000 population  
c) 150.8 nurses per 100000 population

What existed at that time (1942) were:

a) 24 beds per 100000 population  
b) 15.87 doctors per 100000 populations  
c) 2.32 nurses per 100000 population

In contrast what existed in UK at that time was:

a) 714 beds per 100000 population  
b) 100 doctors per 100000 population  
c) 333 nurses per 100000 population

It was concluded that the health care facilities that existed in India at the time of Bhore Committee were embarrassingly inadequate. In fact, most of these were in urban areas and largely in enclaves of the British civil administration and Cantonments.

**HEALTH SECTOR AND FIVE YEAR PLANS IN INDIA**

With the end of colonial rule in India the population of the country expected a radical transformation of the exploitative social structure that the British rule had nurtured and consolidated. The new rulers mouthed a lot of radical jargon and even put it in writing in the form of First Five year document and other more specific documents for various sub sectors of the economy.

The First Five year Plan describes the central task of planning as the problem not of merely re-channeling economic activity within the existing socio-economic framework; that framework has itself to be remolded so as to enable it to accommodate progressively those fundamental urges which express themselves in the demand for the right to work, the right to adequate income, the right to education and to a measure of insurance against old age, sickness and other disabilities. The Directive Principles of State Policy enunciated in Articles 36 to 51 of the constitution made it clear that for the attainment of these ends, ownership and control of the
material resources of the country should be distributed so as to best sub serve the common good, and that the operation of the economic system should not result in the concentration of the wealth and economic power in the hands of few. It is in this larger perspective that the task of planning was envisaged (Planning commission, GOI, First five year plan, 1951).

However our post colonial history was a witness to the rapid dilution of these progressive principles, objectives and resolutions. The state’s plans and policies had in no way made a significant impact on redistribution of resources for a common good. On the contrary, the policies and plans had helped in strengthening of inequalities.

It was in 1983 that India adopted a formal or official National Health Policy. Prior to this, health activities of the state were formulated through the Five year plans and recommendations of various Committees. Each plan period had a number of schemes and every subsequent plan added a few and dropped a few.

In the 1950’s and 1960’s the entire focus of the health sector in India was to manage epidemics. Mass campaigns were started to eradicate various diseases. Separate country wide campaigns with a techno-centric approach were launched against malaria, smallpox, tuberculosis and leprosy. Cadres of workers were trained in each of the vertical programmes.

During the first two five year plans the basic structural framework of public health care delivery system remained unchanged. Urban areas continued to get over three-fourth of the medical care resources whereas rural areas received special attention under the Community Development Program (CDP). The CDP was failing even before the second five year plan began. The government’s own evaluation reports admitted to this failure.

To evaluate the progress made in the first two plans and to draw up recommendations for the future path of development of health services the Mudaliar Committee was set up in 1959. The report of the committee recorded that the disease control programmes had some substantial achievements in controlling certain virulent epidemic diseases. Malaria was considered to be under control. Deaths due to malaria,
cholera, smallpox etc were halved or sharply reduced and the overall morbidity and mortality rates had declined. The death rate had fallen to 21.6 percent for the period 1956-61. The expectation of life had risen to 42 years. This committee further admitted that the basic health facilities had not reached at least half the nation. The Primary Health Care program was not given the importance it should have been given right from the start. There were only 2800 PHC’s existing by the end of 1961. Instead of the irreducible minimum in staff recommended by the Bhore Committee, most of the PHC’s were understaffed, large numbers of them were being run by ANM’s or public health nurses in charge (Mudaliar Committee, 1961). The fact behind this was that the doctors were moving into private practice after training at public expense. The emphasis given to individual communicable diseases programme was given top priority in the first two plans. But primary health centres through which the gains of the former could be maintained were given only tepid support.

The Third Five year plan launched in 1961 discussed the problems affecting provision of PHC’s and directed attention to the shortage of health personnel, delays in the construction of PHC’s buildings and staff quarters and inadequate training facilities for the different categories of staff required in the rural areas (Planning Commission, GOI, 1961). While the third plan gave serious consideration to the need for more auxillary personnel no mention was made of any specific steps to reach this goal. Only lip service was paid to the need for increasing auxillary personnel but in actual training and establishment of institutions for these people and inadequate funding became constant obstacle. On the other hand, the proposed outlays for the new medical colleges, establishment of preventive and social medicine, completion of All India Institute of Medical Sciences and schemes for upgrading departments continued to remain high. The urban health structure continued to grow and its sophisticated services and specialities continued to multiply. The third plan gave serious consideration for suggesting a realistic solution to the problem of insufficient doctors for rural areas and for that a new short term course for the training of medical assistants was instituted and after these assistants had worked for five years at a PHC they could complete their education to become full fledged doctors and continue in public service. The Medical council and the doctor’s lobby opposed this and hence it was not taken up seriously.
The fourth plan that began in 1969 with a three year plan holiday continued on same lines as the third plan. In fact, the fourth plan is probably the most poorly written plan document. It does not even make a passing comment on the social, political and economic upheaval during the plan holiday period. (1966-1969). These three years of turmoil brought about significant policy changes on economic front which was ignored in fourth five year plan. It lamented on the poor progress made in the PHC programme and recognized the need to strengthen it. It pleaded for the establishment of effective machinery for the speedy construction of buildings and improvement of the performance of PHC’s by providing them with staff, equipment and other facilities. For the first time PHC’s were given a separate allocation. It was reiterated that PHC’s base would be strengthened along with sub divisional and district hospitals, which would be referral centres for the PHC’s. The importance of PHC’s was stressed to consolidate the maintenance phase of the communicable disease programme. Further, during this period water supply and sanitation was separated and allocations were made separately under the sector of Housing and Regional Development.

It was in the fifth plan that the government ruefully acknowledged that despite advances in terms of infant mortality rate going down and life expectancy going up, the number of medical institutions, functionaries, beds, health facilities etc were still inadequate in rural areas. This showed that the government had recognized that the urban health structure had expanded at the cost of rural sectors. This awareness was clearly reflected in the objectives of the fifth five year plan which were as follows:

1) Increasing the accessibility of health services to rural areas through the Minimum Needs Programme (MNP) and correcting the regional imbalances.

2) Referral services to be developed further by removing the deficiencies in district and sub-division hospitals.

3) Intensification of the control and the eradication of communicable diseases.

4) Affecting quality improvement in the education and training of health personnel.
5) Development of referral services by providing specialists attention to common diseases in rural areas.

Major innovations took place with regard to the health policy and method of delivery of health care services. The reformulation of health programmes was to consolidate past gains in various fields of health such as communicable diseases, medical education and provision of infrastructure in rural areas. An Integrated Package approach was launched in the rural areas. The plan further envisaged that the delivery of health care services would be through a new category of health personnel which were to be specially trained as multipurpose health assistants.

The Kartar Singh Committee in 1973 recommended the conversion of uni-purpose workers including Auxiliary Nurse Midwives (ANM’s) into multipurpose male and female workers. It recommended that each pair of such worker should serve a population of 10000 and 12000. Hence, the multi-purpose worker (MPW) scheme was launched with the objective of retraining the existing cadre of vertical programme workers and the various vertical programmes were to be fully integrated into primary health care package for rural areas. (Kartar Singh Committee, 1973)

Another major innovation in the health strategy was launched in 1977 by creating a cadre of village based health auxiliaries called the Community Health workers. These were part time workers selected by the village, trained for 3 months in simple promotive and curative skills both in allopathy and indigenous systems of medicine. The programme was started in 777 selected PHC’s. This scheme was adopted on the recommendations of Srivastava Committee which was essentially a committee to look into medical education and manpower support. The committee pointed out that the over emphasis on the provision of health services through professional staff under state control has been counter productive. On the other hand, it was devaluing and destroying the old traditions of part time semi-professional workers, which the community used to train and proposed that certain modifications can continue to provide the foundation for the development of the national programme of health services in our country.

The sixth plan was to a great extent influenced by the Alma Ata Declaration of Health for All by 2000 AD and the Indian Council of Social Science Research
ICSSR) and by Indian Council of Medical Research (ICMR) report (ICMR-ICSSR, 1980: Health for All). The plan conceded that there was a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and highly trained doctors which was availed mostly by the well to do classes. It was also realized that it was this model which was depriving the rural areas and the poor people of the benefits of good health and medical services. The plan emphasized the development of a community based health system. The strategies advocated were:

a) Provision of health services to the rural areas on priority basis.
b) The training of large cadre of first level health workers selected from the community and supervised by medical officers of PHC’s.
c) No further linear expansion of curative facilities in urban areas.

This plan and the seventh plan too, like the earlier ones made a lot of radical statements and recommended progressive measures. But whatever new schemes were introduced, the underprivileged got worse off and already privileged got better off. However, the sixth and seventh plans no longer talked of targets, now their keywords were efficiency and quality and the means to realize them was the privatization. Privatization is the global characteristic of 1980’s and 1990’s and has made inroads everywhere.

The sixth and seventh plan stated clearly… "the success of the plan depends on the efficiency, quality and texture of implementation…. A greater emphasis in the direction of competitive ability, reduced cost and greater mobility and flexibility in the development of investible resources in the private sector flexible prices to revive investor interest in the capital markets".

The National Health policy of 1983 was announced during the sixth plan period. The NHP in light of the Directive Principles of the Constitution of India recommended, “Universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford.” Providing universal health care as a goal was a welcome step because this is first time after the Bhore committee that government was talking of universal comprehensive health care.
The salient features of 1983 health policy were:

a) It was critical of the curative – oriented western model of health care.

b) It emphasized preventive, promotive and rehabilitative primary health care approach.

c) It recommended a decentralized system of health care, the key features of which were low cost and community participation.

d) It called for an expansion of the private curative sector which would help reduce the government’s burden.

e) It sets up targets for achievement that were primarily demographic in nature.

During the decade following 1983 NHP, rural health care received special attention and a massive program of expansion of primary health care facilities was undertaken in the sixth and seventh five year plans to achieve the target of one PHC per 30000 population and one sub centre per 5000 population. This target has been more or less achieved, though a few states lag behind. The present paradigm of health care development has in fact raised inequities.

The seventh five year plan accepted the National Health Program (NHP) targets. It recommended that development of specialities and super specialities need to be pursued with proper attention to regional distribution and such development of specialized and training in super specialities was encouraged in the public and private sectors (Planning commission, GOI, VIIth Five year plan) This plan also talks of improvement and further support for urban health services, biotechnology and medical electronics and non-communicable diseases. The special attention was also given to cancer, AIDS, heart diseases.

On the eve of eighth plan the country was passing through a massive economic crisis. The plan got pushed forward by two years. But despite this no new thinking went into this plan. Infact, keeping with the selective health care approach, this plan adopted a new slogan-instead of “Health for all by 2000” it emphasized on “Health for the Underprivileged”. Simultaneously, it continued the support to privatization. In accordance with the new policy of the government to encourage private initiatives, private hospitals and clinics were supported subject to maintenance of minimum standards.
The Ninth five year plan by contrast provides a good review of all programs and has made an effort to strategize on achievements attained. In its analysis of health infrastructure and human resources the ninth plan suggested the consolidation of Primary Health Centres (PHC’s) and Sub-Centres (SC) and assured that the requirements for its proper functioning were made available and positioned it as an important goal under the Basic Minimum Services program. During this plan a committee to review public health was set up. It was called Expert Committee on Public Health systems. This committee made a thorough appraisal of public health programs and found that it was facing a resurgence of most communicable diseases and there was a need to drastically improve disease surveillance in the country. It also proposed to set up at district level a strong detection cum response system for rapid containment of any outbreaks that may occur.

On the eve of tenth plan, the focus was on:

1) Reorganization and restructuring the existing government health care system at the primary, secondary and tertiary care levels with appropriate referral linkages. These institutions were responsible for taking care of all the health problems and for delivering services to the people residing in rural and urban areas.

2) Evolving, implementing and monitoring transparent norms for quality and cost of care in health care centers.

3) Improving content and quality of education of health professionals so that all the health personnel had the necessary knowledge, attitude, skills, programme and people orientation to effectively take care of the health problems and improve the health status of the people.

4) Improving inter-sector coordination.

5) Appropriate policy initiatives were taken to define the role of public, private and voluntary sectors in meeting the growing health care needs of the population at affordable cost.
In the eleventh plan document following priority areas for the health system has been identified:

1) Impact of public private partnership in health on the public health services, state finances and to bring equity in access through these PPP’s.
2) Impact and modalities of health insurance should be taken into consideration.
3) Issues of health access in urban areas, health problems of urban poor, the migrants, homeless street and working children should be taken into consideration.
4) Health care in the situations of violence and conflict.
5) Gender issues in disease prevalence, access to health care and education.
6) Nursing research to be undertaken by the nursing as well as social science and bioethics institutions in India.
7) Studies on the innovation, diffusion, use and misuse of medical technologies, research on their relevance, their misuse and irrational use, the additional financial burden on the users due to their misuse. Such studies should cover prescription practices to the new medical technologies such as genetics, assisted reproduction, organ donation and transplantation.
8) Audit of research that is whether research is justified and relevant.

ROLE OF WORLD HEALTH ORGANIZATION (WHO) IN THE PROMOTION OF HEALTH

During the post war period, a significant development has occurred in the field of the establishment of a pivotal International Organization. This organization was commonly known as United Nations (UN). When the UN charter had been framed, attention was being framed initially on the problems of peace and security in the country. In the Yalta conference it was decided to create an Economic and Social Council as an integrated part of the new international organization to deal with the rapidly emerging social and economic problems. The important agency influencing directly or indirectly the promotion of health is World Health Organization. But other organs are also there like United Nations Development Programme, United Nations International Children's Emergency Fund (UNICEF), World Food Programme etc. and special agencies are Food and Agriculture Organization (FAO), International Labour Organization (ILO) etc. which also influence the health. Thus, there is a great
need of coordinated effort by the UN system to produce the desired output. Coordination may be achieved through collaboration in working for some cause or cooperation—the sharing of a joint task by two or more parties; often it includes both modes of action. Health and disease has no political or geographical boundaries. Disease in any part of the world is a potential danger to other parts. “Nothing on earth is more dangerous than international disease” is marked by Paul Russell. The problems of international health are more pressing today as the world becomes smaller.

**MILLENNIUM DEVELOPMENT GOALS AND HOW THEY RELATE TO INDIA**

At the Millennium Summit held at UN in September 2000, 189 countries reaffirmed their commitment to working towards a world in which sustaining development and eliminating poverty was given highest priority. Out of eight MDG’s, eight targets and eighteen indicators were directly related to health. India is committed to achieve these targets by 2015. The goals were as follows:

Goal 1: Eradicate extreme poverty and hunger.
Goal 2: Achieve Universal Primary Education.
Goal 3: Promote Gender equality and empower women.
Goal 4: Reduce Child Mortality.
Goal 5: Improve Maternal Health.
Goal 6: Combat HIV/AIDS, Malaria and other diseases.
Goal 7: Ensure Environmental Sustainability.
Goal 8: Develop a global partnership for development.

Targets and Indicators relating to health are:

**Target 4 a:** Reduce by two-thirds the mortality rate among children under 5.
   4.1 Under Five Mortality Rate.
   4.2 Infant Mortality Rate.
   4.3 Proportion of one year old children immunized against measles.

**Target 5 a:** Reduce by three quarters the Maternal Mortality Ratio.
   5.1 Maternal Mortality ratio.
   5.2 Proportion of births attended by skilled health personnel.
Target 5 b: Achieve by 2015, Universal Access to Reproductive Health
   5.3 Contraceptive and prevalence rate.
   5.4 Adolescent birth rate.
   5.5 Antenatal care coverage.
   5.6 Unmet need for family planning.

Target 6 a: Halt and begin to reverse the spread of HIV/AIDS.
   6.1 HIV prevalence among population aged 15-24 years.
   6.2 Condom use at last high risk sex.
   6.3 Proportion of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS.
   6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years.

Target 6 b: Achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it.
   6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs.

Target 6 c: Halt and begin to reverse the incidence of malaria and other major diseases.
   6.6 Incidence and death rates associated with malaria.
   6.7 Proportion of children under 5 sleeping under insecticide treated bed nets.
   6.8 Proportion of children under 5 with fever who are treated with appropriate anti malarial drugs.
   6.9 Incidence, prevention and death rates associated with TB.
   6.10 Proportion of TB cases detected and cured under directly observed treatment short course.

While UNDP is not a specialized expert agency on health, they used their role as coordinator of UN Development System to support the mandates of other agencies.

In India health sector reforms are taking place under the broad umbrella of Structural Adjustment Program (SAP) which is termed as the New Economic Policy (NEP). The two major aspects of SAP are privatization and globalization. Aim of
privatization and globalization is to improve access and to enhance the quality of social services by supporting India’s health sector reform initiatives. Due to liberalization, advanced techniques, instruments and medicines in the field of health sector are available now in India also. Further, India is now producing advanced equipments which have effectively reduced the cost price of items and drugs.

**NEED OF THE STUDY**

As health is a global issue and has to be high on the agenda of all the countries whether rich or poor. In the Indian context, the impact of development and changes in the health sector are quite divergent and unsatisfactory, in spite of the fact that there have been voluminous advances in health sector in India. Yet the fact remains that more than twenty percent of the Indian population still lives in abject poverty. Such a cohort of the population remains deprived of even two square-meals a day; does not have an access to safe drinking water, suffers from malnutrition; lives under sub-humane conditions; and is subjected to illiteracy. All such curses lead to infections diseases and, therefore, to poor health. The extent of access to and utilization of health care varied substantially between states; this is to large extent is responsible for substantial differences between states in health indices of the population. Moreover, inadequate allocation of public health resources and its inequitable spread across different states have resulted in inequitable health status.

Keeping these facts in mind, a need was felt to study inter-state disparities in health status and public health expenditure in India and across its states and further to study other crucial aspects of health with respect to the major Indian states, since no such investigation appears to have been undertaken in the recent past.

**SPECIFICALLY, THE OBJECTIVES OF THE STUDY ARE:**

1) To measure the nature and level of inter-state disparities in health status in India;

2) To examine the growth of public health expenditure of India and measure its trend overtime;

3) To examine the relationship between health status and public health expenditure over time and between the states;
4) To identify the main determinants and to develop a composite index of health status among the states;
5) To examine the public health system and health related policies over time in India;
6) To give conclusions and policy implications to improve health status in India.

HYPOTHESES OF THE STUDY

In the light of above mentioned objectives, the study attempted to test the following hypotheses:

1) There exist inter-state disparities in India in the health status, but these have declined overtime.
2) The states with higher per capita health expenditure have experienced relatively better health status.
3) Effect of public health policies on the health status continues over a longer period.

PLAN OF THE STUDY

Present study has been divided into nine chapters. First chapter is about the overview of the health status, public health expenditure and public health system in India. Second chapter reviews the studies relating to health in India. Third chapter deals with data base and methodology. It lists the different sources of data and methodology used for carrying out the study. Fourth chapter measures the nature and level of inter-state disparities in health status in India. Fifth chapter examines the public health expenditure and measure its trends overtime. Sixth chapter examines the relationship between health status and public health expenditure and measure its trend over time and between different states. Seventh chapter identifies the main determinants and have developed a composite index of health among states. Eighth chapter examines the public health system and effect of health reforms over time observed in India. Ninth chapter, that is the last chapter of the study, gives the summary and conclusions from the study making suggestions for the development of health status in India.