CHAPTER 3

HEALTH CARE ECONOMICS – CONCEPT, DEVELOPMENT, GROWTH AND CONSTRAINTS WITH REFERENCE TO THE INDIAN ECONOMY

“If we could give every individual the right amount of nourishment and exercise, not too little and not too much, we would have found the safest way to health.”

~ Hippocrates

3.1 Health - Conceptual Background

Health is an intricate, multi-faceted concept and thus, is quite complex to be defined precisely. The universal observation about health refers to the absence of illness due to physiological and other deficiencies. The narrowest definition of health states it just as the ‘absence of disease’ while a wider definition of health, considers not merely the absence of disease but also looks ‘health as the achievement of a total spectrum of personal, physiological, psychological, and even societal goals’.

The constitution of the World Health Organization’s (WHO) has defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The WHO definition of health indicates a clear shift away from previous narrow and functional definitions of health to a more holistic view, where the focus is on the health of an individual or community and not just with the physical and the mental status. This characterization of health brings in a more holistic concept which links health with social and economic interactions.

This definition of health tends to focus on the ideal rather than the actual, since it assumes the notion of an absolute, i.e. the ‘complete well-being’ of an individual,

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rather than examine the relationship of the individual with their social environment.\textsuperscript{104} Health or well-being has a range and cannot be in terms of an absolute quantity. According to researchers, it is important to define health in terms of various health indicators such as life expectancy, infant mortality, crude death rate, etc.\textsuperscript{105} In other words, it is necessary to consider the Human Development Index (HDI), which is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and having a decent standard of living.\textsuperscript{106}

Human Development Index includes life expectancy where it assesses the health dimension as one of the components, to assess quality of human life in an economy. Many developing countries have lower life expectancy rates due to high infant and child mortality rates compared to those in developed countries. Studies show that improving health depends on the twin goals of “adding years to life” and at the same time “adding life to years”. In other words, to improve the health care needs of a population it is necessary to increase the life expectancy and at the same time improve the quality of life by reducing the impact of diseases and disabilities.

The four general goals of the Health for All policy\textsuperscript{107} are as follows:

a. Adding years to life by increasing life expectancy i.e. a decline in premature deaths,
b. Adding health to life by reducing disease and disability i.e. a decline in chronic diseases and health problems,
c. Adding life to years by helping people achieve good health i.e. increase functional capacity to help them use their full physical, mental, and social potential, and
d. Ensuring equity in health by reducing health disparities between countries and between population groups within countries.

A number of factors including ‘health care’ may influence this state of health. In fact, health determinants are often dependent on the level medical care and access, income,

poverty, level of education, age, sex, race, marital status, environmental pollution, access to clean water, sanitary and housing conditions as well as certain personal behaviour like smoking habits, exercise etc. Thus, health status is often used to explain wages, productivity, school performance, fertility and the demand for medical care.

3.2 Significance of Good Health

Human resources are a country’s most precious endowment and the success of any development strategy is directly proportional to the extent to which human resources is developed in terms of education, health and well-being. Health has a great significance from the economic point of view. A literate, healthy population is an asset for an economy while an ailing and illiterate population often seen as a liability. From an individual point of view, health performs dual functions. On the one hand, good health is a valuable asset in itself, and on the other hand, it helps to generate further wide-ranging social benefits, as good health can generate more income in labour market. The inter-relationships between health and nationwide development are intricate and is a two-way phenomenon with health being both influenced by and influencing economic development.

The World Development Report 1993\(^\text{108}\) stresses good health as a vital part of well-being and strongly justified health expenses on purely economic grounds. According to the Report, improved health contributes to economic growth in four ways:

(1) Good health helps to decreases production losses caused by workers’ illness;
(2) It also permits the use of natural resources that were previously totally or nearly inaccessible due to disease;
(3) It can also encourages and increases the enrolment of children in schools and makes them capable of learning; and
(4) Furthermore, it makes alternative uses of resources that would otherwise have to be spent on medical care and treatment.

In fact, the economic gains are relatively greater for the poor people, who typically suffer most from ill health and who stand to gain the most from the development of under-utilized natural resources. The improved health and nutrition programs can help to accelerate economic development of a country. Improved health of the populace plays a key role in fuelling economic development, as it may increase productivity or efficiency of the labour force leading to greater output and reduced costs of production. Better health conditions may help to open new regions of a country for settlement and subsequent development and at the same time it can also serve to bring changes in attitudes towards achievement and entrepreneurship, as well as spur economic growth. This linkage has a significant importance in encouraging entrepreneurship in poor countries.

3.3 Good Health – A Fundamental Right

Health is a fundamental human right essential for the exercise of other human rights. The right to health simply means that every individual has the right to the utmost achievable standard of physical and mental well-being which also includes access to all medical services, adequate food, safe drinking water, decent housing, sanitation, healthy working conditions and clean surroundings. The right to health means that governments must ensure conditions in which all its citizens can be as healthy as possible and this requires provision of conditions that range from ensuring availability of health services, healthy and safe working conditions, adequate housing and nutritious food. The right to health has been incorporated and enshrined in international and regional human rights treaties as well as national constitutions all over the world. There are different perspectives on the importance of health and on to the possible roles of the state in promoting it. Health is viewed as a right, as a consumption good and even as an investment.\(^\text{109}\)

a) Health as a Right\(^\text{110}\)

Health is viewed by some as a right, comparable to justice or political liberty. Indeed, the WHO constitution states that ‘... the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of


race, religion, political belief, economic or social condition’. The state is held responsible to ensure health care access; its role is comparable in ensuring equal justice and will be predominantly concerned with issues of equity in health and health care.

**b) Health as Consumption Good**

Yet another view about health perceives it as an important individual objective that is not comparable with justice, but with material aspects of living and this view leads to the belief that health is ‘consumption good’. Here, the role of the administration, has no particular responsibilities in the support of health, and might be limited to ensuring that the adequate quality health care is provided.

**c) Health as an Investment**

A third view of health considers it is essential, as it largely affects the productive ability of the labor force. Health is an important factor affecting the productivity of a workforce and any type of illness may affect the overall productivity, either through absenteeism or by lowering productivity through its debilitating effects. So, investment in health can help to increase the productivity of the workforce.

The right to health is a fundamental part of human rights and helps to lead a life of dignity. The preamble to the Constitution of the World Health Organization (WHO), states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.

The importance of health as a fundamental right is clearly brought out under Article 25 of Universal Declaration of Human Rights, that states that every individual has the right to a satisfactory standard of living, sufficient for the health and well-being of both the individual as well as of his family, together with food, attire, accommodation, health care and necessary social services. It also includes the right to security in the case of redundancy, illness, disability, widowhood, old age or

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other lack of livelihood in circumstances beyond his control. Article 25 also emphasizes that motherhood as well as childhood are permitted to special care along with assistance and all children, whether born in or out of wedlock, shall benefit from the same social protection.

3.4 Health – A Fundamental Right as per the Indian Constitution

Fundamental rights refer to a charter of rights contained within the Constitution of India, which guarantees civil liberties to all Indians to lead their lives in peace and harmony as citizens of India. The various fundamental rights recognized by the Indian constitution are:

1. Right To Equality
2. Right To Freedom
3. Right Against Exploitation
4. Right To Freedom Of Religion
5. Cultural And Educational Rights
6. Right To Constitutional Remedies
7. Right To Life
8. Right To Education
9. Right To Information

India pledged along with other WHO member Nations, ‘Health for All by the Year 2000’ at Alma-Ata in 1978; and in the same year signed the International Covenant for Economic, Social and Cultural Rights – Article 12 in which the State is obliged to achieve the highest attainable standard of health for its population. Improvement in the health status of the population has been one of the major thrust areas for the social development programmes of the country. However, the health scenario in India is abysmal and health care continues to be out of the main focus and is persistently neglected despite the recent changes in economic policy.

Although, the Constitution of India does not directly provide for the right to health as a fundamental right, it directs the State to take necessary measures to improve the condition of health care of the people. Thus, the preamble to the Constitution of India, among other things, seeks to secure for all its citizens, justice – social and economic by providing a framework for the achievement of the objectives laid down in the
preamble and it has been further amplified and elaborated in the Directive Principles of State Policy.

Directive Principles of State Policy, are directives to the State and are non-justiciable and are not enforceable in any court of law for non-fulfilling these directives. The Constitution guarantees some fundamental rights as having a bearing on health care. Article 21 states that “No person shall be deprived of his life or personal liberty except according to the procedure established by law.”

According to the Directive Principle of State Policy laid down in the Constitution, raising the nutritional levels, the standard of living and the improvement of public health are among the most important duties of the state. The Government of India has tried to achieve this objective through improvement in the access to and utilization of health services in the country with special focus on under-served and underprivileged segments of the population.

The Constitution of India has provisions regarding the right to health by the constitutional directives contained in articles 38, 39 (e) (f), 42, 47 and 48A in Part IV of the Constitution of India. Article 38 of the Indian Constitution imposes liability on the State to secure a social order for the encouragement of welfare of its citizens and hence public health is mandatory and so is the need. Article 39(e) is related to look after the health of the workers. Article 41 imposed duty on State to public aid essentially to the ill and disabled. Article 42 makes provision to protect the health of the newborn and mother through maternity benefits.

Under the Article 47 of the Directive Principle of State Policy, it is the primary duty of the state to improve public health, secure justice, provide humane condition at work, extension of sickness-old age-disablement-maternity benefits were also contemplated. Further, the State’s duty includes prohibition of consumption of intoxicating drinking and drugs that are injurious to health. Article 48A ensures that

114 Ibid.
the State shall attempt to protect and impose a pollution free environment for good health.\textsuperscript{115}

Along with the State, the Panchayat, Municipalities are legally responsible to improve and protect public health. Article 243G says “that the legislature of a state may endow the panchayats with necessary power and authority in relation to matters listed in the eleventh Schedule.”\textsuperscript{116} The entries in this schedule having direct relevance to health are as follows: 11 – drinking water, 23 – health and sanitation including primary health centers, dispensaries and hospitals, 24 – family welfare, women and child development, and 26 – social welfare including welfare of the disabled and mentally challenged.

Article 243-W finds place in part IX-A of the Constitution titled “The Municipalities” and the entries in this schedule with relevance to health are as follows: 5 – water supply to be used for domestic, industrialized and commercial purpose, 6 – Public health, sanitation conservancy and solid waste management, 9 – safeguarding the interest of weaker sections of society, including the handicapped and mentally retarded, 16 – essential statistics which includes the registration of births and deaths, and 17 – regulation of slaughter-houses and tanneries.\textsuperscript{117}

3.5 Health Economics

Economics is the study of ‘how scarce resources are allocated among alternative uses to satisfy human wants.’ Today, health economics is an emergent area in the discipline of economics. Health economics can be defined as the application of economic theories, tools and concepts of economics as a discipline to the topics of health and health care.\textsuperscript{118}

The study of Health Economics looks at the allocation of insufficient resources for the improvement of health and to get the utmost value for money by ensuring clinical effectiveness along with cost effectiveness in health care provision. It studies issues related to efficiency, effectiveness, value and behavior in the production and consumption of health and health care as well as studies both resource allocation within the economy to the health sector and also within the health care system to the various health care activities and people.

Health Economics is an applied field of study that allows for the systematic and precise examination of the problems faced in promoting health for all. This field of study through the application of the various economic theories relating to consumer, producer and social choice, aims to understand the behavior of individuals, health care providers, public and private organizations, and governments in decision-making.119

Health economists use mathematical models, by combining data from biostatistics and other related fields for supporting medical decision-making. The study of economics focuses on utilizing inadequate resources and the application of health economics reflects the need to obtain maximum value for money and also cost-effectiveness of the health care policies.120

3.5.1 Scope of Health Economics
The scope of ‘health economics’ as a discipline makes an attempt to understand the relationship between health status and productivity, financial aspects of health care services like allocation and distribution of scarce resources, economic decision-making in health and medical care institutions, planning of health development and such other related aspects etc. Health Economics can be used to directly inform the government on the best course of action with regards to regulation, of national health packages, defining health insurance packages and other national health programs which can have an impact on the health of a society.

The scope of health economics includes the following distinct topics, viz:
1. Factors which determine health like socio-economic, cultural and environmental.
2. Scope and significance of health which establish the impact of health on the development of the nation.
3. Demand for health care which deals with the demand for health care in a society.
4. Supply for health care deals with the supply for health care in a society.
5. Micro economic evaluation at treatment level which deals with deals with the tool to ascertain the effectiveness of the treatment.
6. Market equilibrium which shows the equilibrium of the five distinct markets involved in handling health care viz- health care financing market, physicians and nurse service market, institutional service market, input factor market etc.
7. Planning, budgeting and monitoring mechanism which cover the individuals or the society’s planning for health and health care as well as the financial commitment.
8. The four types of formal economic evaluation which refers to the assessment of the health aspects that considers the following concepts.\textsuperscript{121}

(1) \textbf{Cost Minimization Analysis}
In cost minimization analysis, the consequences of two or more interventions being compared are equivalent. The analysis therefore focuses on costs alone, and the cheapest option is chosen.

(2) \textbf{Cost Effectiveness Analysis}
Cost effectiveness analysis is used in health economics to compare the financial costs of therapies whose outcomes can be measured purely in terms of health effect.

(3) \textbf{Cost Utility Analysis}
Cost utility analysis is similar to cost effectiveness analysis in that there is a defined outcome, by which we measure the outcomes of the medical treatment in a composite of both length and quality of life. However, cost–utility analysis in relation to health outcomes is measured in terms of survival and quality of life. The most frequently used measure is the Quality adjusted life-year (QALY). Benefits are measured based on impact on length and quality of life to produce an overall index of health gain, which is valued between 0 – worst health and 1 – best health are combined it with the time-length in that state.

(4) Cost Benefit Analysis
Cost benefit analysis attempts are made to value all the costs and benefits of an intervention are expressed in monetary terms. If the benefits are less than the costs then the intervention is considered acceptable.

3.5.2 Significance of Health Economics
Good health affects an individual’s ability to enjoy life to the fullest, their ability to contribute to their family’s well-being as well as to be a productive member of the workforce, and also earlier in life, their ability to be productive in school. Generally, the consumption of personal health care services tends to be much higher as an individual become older, than for the younger adults. The impact of health economics is felt not only within the discipline of economics but also outside the field.

The demand for health care is a ’derived demand’, as it is derived from the state of health and awareness about significance of good health among the population of the country. Factors like increasing population, changing lifestyles, increasing number of untreatable diseases, ageing population or ever-increasing life expectancy etc. have increased the demand for health care services. Yet, at the same time, the resources to meet the escalating demand for health care services are scarce in supply. This has inevitably lead to increasingly widening gap between the demand for and supply of health care services in the economy.

Health economics is governed by a simple theoretical concept that of cost effectiveness or achieving ‘value for money’ which implies either a desire to achieve a preset objective at least cost, or a desire to maximize the benefit to the population of patients served from a limited amount of resources. This requires services to be evaluated for ‘cost-effectiveness.’

Health care economics is concerned with the scarcity in the health care markets which are typically analyzed as: Health care financing market, Physician and Nurses’ services market, Institutional services market, Input factors markets and Professional education market.122 The World Development Report

(WDR) of 1993 views health as a basic human right and stresses the need of providing cost effective health care for the poor and which can contribute towards alleviating poverty.\(^{123}\) Health economics is fast becoming a subject of noteworthy significance, particularly in the developing countries which primarily have low human development index because of the following reasons:

(i) An economic climate where resources are exceedingly insufficient and decisions on priorities are critical yet complicated;
(ii) A growing approval among health professionals and policy-makers that the discipline of health economics and economists can help them plan policies and make decisions;
(iii) The increasing development of the sub-disciplines of health economics; and
(iv) The growing interest among economists and others in applying their economic skills to health issues.\(^{124}\)

3.6 Concept of Public Health

Public health as defined by Winslow\(^{125}\) states that ‘it is the science and art of preventing disease, prolonging life and promoting physical and mental health efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health’.

Public Health is defined as ‘the science of looking after the safety and improving the well-being of communities through education, promotion of healthier lifestyles, policy making and research for preventing both disease and injury as well as detection and control of infectious diseases.’\(^{126}\) Overall, public health is concerned with

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protecting the health of the entire populace. Public Health refers to all designed measures (both public and private) to avoid disease, encourage health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire population, and not just on individual patients or diseases.\textsuperscript{127} Thus, public health is concerned with the total system and not only the eradication of a particular disease.

Public health is a multi-dimensional entity, where health service is only one input into the comprehensive health of the population. It also includes public distribution systems of food, clean drinking water, sanitation etc.\textsuperscript{128} The three main public health functions are concerned with:

- The assessment and monitoring of the health of communities and populace at risk and also to recognize health issues and priorities,
- The public policies formulation that is designed to solve, known health problems and priorities, both at local and national levels, and
- To assure that all populace have access to appropriate and cost-effective care, including health promotion and disease prevention services.

Public health research and programs improve health for the entire population by ensuring sanitation, clean and safe drinking water supply, containing outbreaks of infectious diseases, informs policy-making and help to remove disparities in access to health care. Public health is basically populace-based and plays a vital role in disease prevention efforts, in the developing world as well as in developed countries, by utilizing the services of local health systems and non-governmental organizations. The main focus of public health intervention is to improve health and quality of life through prevention and treatment of disease and other physical and mental health conditions. According to Walley et al. (2001), Public health deals with ‘health of the whole population of the society.’ In fact, Public health shares the same ideals as Primary Health Care. These are easily remembered as the four A’s and is as follows:

1. Affordable. 2. Acceptable. 3. Accessible. 4. Appropriate.\textsuperscript{129}

A large number of factors affect the evolution of health care arrangement in a society and these include the level of socio economic inequalities, reach of health services, quality and cost of care etc. Besides health care arrangements, there are many other factors which play a vital role in determining the health status of individuals. These include poverty, unemployment, gender inequality, lack of access to the basic minimum social services etc.\textsuperscript{130}

Nations should invest in maximizing the number of ‘Healthy Life Years’, described as “a year of physical, mental and social well-being; not just the absence of disease or infirmity”. In times of recession and increased competition, “healthy individuals and healthy populations can create a competitive advantage through increased productivity, reduced health care costs and overall higher levels of well-being.”\textsuperscript{131} Individuals nurture ‘virtuous cycles of health’ – recurring cycles of events increase the beneficial effect of the next – that fuel health and growth by living these healthy years.

Countries that focus on the well-being and prevention of illnesses will receive a greater return on their investment than those focusing on health care and treatment. In order to create healthier populations, economies should increase their investments, very often as the advantages of investing tends to produce a healthy population. This result enormously outweighs the investment made. Such investments need to be part of any ‘population health strategy’ and economies can no longer see health as a ‘cost’, but rather as an ‘investment’. Investments in health leads to health-enabling environments, healthy pregnancies, balanced childhood nutrition, adequate vaccinations, minimum level of education/health literacy, healthy body weight, sense of self-efficacy, and high compliance rate with treatment. The result is healthier and a more productive population which become the foundation of sustainable economies.

Investment in health and education can augment the quality of human resources and their productivity. The Indian government will have the perfect opportunity to start a virtuous cycle of health by increased investment in health as this will improve

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productivity, enable greater consumption and boost economic growth, and at the same time such health care reforms can protect Indians from out-of-pocket expenditure burden, create 15 million additional health services jobs by 2025 and allow the country to emerge as a global hub for innovative, low-cost health products and services.132

3.7 Health Expenditure and its Significance

Adequate health care is a fundamental necessity for human well-being in order to realize their potential and ability to learn, work, and achieve their full potential. Thus, health care financing is important for two reasons – first, it determines the availability of health care as well as who has access to it and second, it dictates the degree of financial protection offered against catastrophic illness costs.

‘Health Financing’ relates to all health and health-related expenditures and is a critical component of health systems. Health financing is concerned with the generation, allocation and usage of financial resources in health systems. The resources consumed by the health sector are provided by the government (central and peripheral), by state donors, by employers (directly or through insurance schemes), by charities, by private donors and by users of health services.133

Health care financing under a very narrow perspective pertains only to the mobilization of funds for health care. Under this broad definition, health care financing covers the following three issues: first, mobilization of funds for health care: second, allocation of funds to the regions and population groups and for specific types of health care: and third, mechanisms for paying health care.134 Health Expenditure is defined on the basis of their main or principal purpose of improving health, regardless of the primary function or activity of the entity to provide or pay for


the associated health services. Health services are financed through private expenditure or public expenditure or external aid/resources. ‘Private Expenditure’ includes voluntary payments by individuals or employers. ‘External sources’ refer to the external aid which comes through bilateral aid programme or international non-governmental organizations. Even with substantial increases in domestic health expenditure, increased external financial flows will be necessary for many of the low-income countries for a considerable period of time.

‘Public Expenditure’ includes all expenditure on health services by the Central, State and Local government and also through services, which are paid for by taxes or compulsory health insurance contributions either by employers or insured persons or both. ‘Public Health Expenditure’ consists of recurrent and capital spending from the government (central and local) budgets, external borrowings and grants (including donations from international agencies and non-governmental organizations), and social (or mandatory) health insurance funds.\

‘Health Financing’ refers to not just raising monetary resources for health but also includes the issues of ‘who is asked to pay’, ‘when they pay’, and ‘how the money raised is spent’. Therefore, the three critical areas of health financing are:
1. Raise sufficient money for health;
2. Remove financial barriers to access and reduce financial risks of illness;
3. Make better use of the available resources

A good health financing system raises adequate funds for health, in ways that ensure people can use the needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for these services. It also provides incentives for the providers and users to be efficient. A strong health care system is an important milestone in a country’s growth journey – from a developing to a developed nation. Financing systems for universal health coverage needs to be specifically designed to provide all people with access for needed health services

(including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective and also to ensure that the use of these services does not expose the user to financial hardship. ‘Health Financing Policy’ focuses on how to move closer to universal coverage with issues related to:
(i) How and from Where to raise sufficient funds for health;
(ii) How to overcome financial impediments that exclude many poor from accessing health services;
(iii) How to provide an equitable and efficient mix of health services.137

Health care expenditures of a developing nation like India assumes greater implication especially with the low per person spending on health and insufficient public expenditure which result in one of the highest proportions of private out-of-pocket expenses in the world.138 Currently, in many countries the health expenditure levels are still below the critical minimum levels for providing at least a minimal set of health services. Thus, the challenges for many poorer countries, is to increase the level of health funding to provide and make accessible health services of sufficient quality to its underprivileged population. At the same time the challenges faced by many richer countries, is to protect the existing levels of health expenditure, while responding to the challenge of ageing populations and cost pressure from technological advances. In fact, these are challenges faced by many other poorer nations also.

3.8 Indian Health Care Sector

India, the seventh largest country by area, the second-most populous country and the most populous democracy in the world, is a land of many widespread diversities and disparities. Life in India, with a population of 1.21 billion out of which 26.1 per cent is below the poverty line, is rife with many challenges - high income disparity, lack of basic infrastructure and the incidence of diseases.139 As a result, delivery of quality

affordable health care is an enormous challenge. An analysis of the current health care profile of India indicates the gaps, deficiencies and anomalies in terms of public health care service outreach, available resources, infrastructure and affordability as well as government expenditure, when compared to other developing nations.

### 3.8.1 Phases in the Development of the Indian Health Care Sector

Present Indian health care infrastructure has progressed in an evolutionary manner, over the last few decades after the Indian independence. India’s Health System can be categorized into three distinct phases:

- The first phase, from 1947-1983, India’s health policy was to be based on two wide principles: (i) that none of the Indian population should be deprived of care for want of ability to pay, and (ii) that it was the state’s responsibility to provide health care to the people.

- The second phase from 1983-2000, saw the development of first National Health Policy of 1983, which expressed the need to promote private initiative in health care service delivery as well as to expand access to publicly funded primary health care. This phase witnessed an expansion of rural health facilities for providing primary health care and the implementation of National Health Programmes (NHPs) for disease control under vertically designed and centrally monitored structures.

- The third phase, post-2000, is witnessed a further shift and broadening of focus to address vital issues affecting the health sector in the country in three important ways such as public-private partnership, liberalization of insurance sector to provide new avenues for health financing, and redefining the role of the government as a financier of health services as well.

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3.8.2 Health Care Infrastructure System and Delivery in India

The structure of India’s health care system is multi-faceted, composed of various types of providers, who practice different systems of medicine and facilities, and within different ownership structures. 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. This consequently means no controls on what services can be provided by whom, in what manner, and at what cost, and no uniform protocols to help assess the quality of care. There are wide disparities in access, further worsened by the poor functioning of the public health system.\(^{142}\)

Health care delivery in India is carried out through both the public and private health care service providers. The public health care sector in India is made of a network of a) Primary health care centers and sub-centers b) Hospitals health centers, Community health centers, Rural hospitals, District hospitals, Specialist hospitals, Teaching hospitals c) Health Insurances schemes like Employees State Insurance Scheme, Central Govt. Health Scheme d) Other agencies like Defence Services and Railways. Whereas the Private Health care Sector constitutes of a) Private Hospitals, Polyclinics, Nursing homes and Dispensaries b) General practitioners and clinics. Along with the sectors there are also other indigenous medical systems like Ayurveda, Siddi, Unani, Homeopathy, voluntary Health Agencies and NGOs.

The Indian ‘Public Health System’ is made of a set of state-owned health care facilities funded and controlled by the government, while some of these are controlled by Central Government agencies, others are under the State Governments of India. The Ministry of Health & Family Welfare is the governmental ministry which controls the Central Government interests in these health care institutions, and consequently most of the treatments in these institutions are either fully or partially subsidized. As health is a state subject, most states follow a similar pattern of health care administration and management. Consequently, the overall organizational structure and systems of public health care provision are quite similar across the country. This common planning framework is largely a legacy of a common history of

British colonial rule that laid the fundamentals of the health care bureaucracy. Further, the fiscal transference of resources is determined by the Central Government and this is done through Plan Schemes or Programme, which are usually consistent across states.

Under the Indian Constitution, the States are given chief authority over majority aspects of health care, including public health and hospitals. Public health financing is done by all the three levels of government – Central, State and Local. The Central Government devises wide-ranging health policies and plans under the direction of the Ministry of Health and Family Welfare. The Central Government and individual States share responsibility on items of national importance, including disease control, medical education, the medical profession, and state budgets. As a health is a State subject, a major proportion of spending 64 per cent is at state level, with the centre spending about 31 per cent and the MOHFW spends only 21 per cent of the total amount.143

The Central Government ministries like the Ministry of Health and Family Welfare (MOHFW), Ministry of Labour and Employment (MOLE), Ministry of Railways (MOR) and Ministry of Defence (MOD) are responsible for health care.144 The Ministry of Health and Family Welfare, devises the health policy and is responsible for all government family planning programs in India. This agency is comprises of three departments: the Department of Health, Department of Family Welfare, and Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH).145 The Department of Health deals with health care which includes awareness campaigns, immunization campaigns, preventive medicine, and public health. Bodies under the administrative control of the Department of Health are as follows:

1. Medical Council of India
2. Dental Council of India
3. Pharmacy Council of India

4. Indian Nursing Council
5. All India Institute of Speech and Hearing (AIISH), Mysore
6. All India Institute of Physical Medicine and Rehabilitation (AIIPMR), Mumbai
7. Hospital Services Consultancy Corporation Limited (HSCC)
8. Food Safety and Standards Authority of India
9. Central Drugs Standard Control Organization
10. National Health Programmes
   - National AIDS Control Programme (AIDS)
   - National Cancer Control Programme
   - National Filaria Control Programme
   - National Iodine Deficiency Disorders Control Programme
   - National Leprosy Eradication Programme
   - National Mental Health Programme
   - National Programme for Control of Blindness
   - National Programme for Prevention and Control of Deafness
   - National Tobacco Control Programme
   - National Vector Borne Disease Control Programme (NVBDCP)
   - Pilot Programme on Prevention & Control of Diabetes, CVD and Stroke
   - Revised National TB Control Programme
   - Universal Immunization Programme

The Department of Family Welfare is accountable for all aspects concerning family welfare, particularly in reproductive health, maternal health, pediatrics, information, education and communications; cooperation with NGOs and international aid groups; and rural health services. The Department of Family Welfare is responsible for:
   - 18 Population Research Centres (PRCs) at six universities and six other institutions across 17 states
   - National Institute of Health and Family Welfare (NIHFW), South Delhi
   - International Institute for Population Sciences (IIPS), Mumbai
   - Central Drug Research Institute (CDRI), Lucknow
Indian Council of Medical Research (ICMR), New Delhi: founded in 1911, it is one of the oldest medical research bodies in the world

The Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) is concerned with Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homoeopathy, and other alternative medicine systems. The department was established in March 1995 as the Department of Indian Systems of Medicines and Homoeopathy (ISM&H). In addition to the above departments there are a number of autonomous institutions under the Ministry of Health & Family Welfare which conduct research in various specific areas. Their innovative efforts provide impetus to the Health & Family Welfare programme at different levels. The following autonomous institutions under it also conduct research in various specific areas:

- Indian Council of Medical Research (ICMR)
- Research Activity under RCH Programme
- Indian Medical Association (IMA)
- Central Drug Research Institute, Council of Scientific and Industrial Research (CDRI), Lucknow

3.8.3 Need for Investment in Public Health for Economic Growth

The last 150 years has witnessed a global transformation in human health that has led to people living longer, healthier, more productive lives. While having profound consequences for population size and structure, better health has also boosted rates of economic growth worldwide. Health expenditure consists of all expenditures for medical care, prevention, promotion, rehabilitation, community health activities, health administration and regulation and capital formation with the predominant objective of improving health. It also includes expenditures on health-related functions, such as medical education and training, and research and development.

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The initial beneficiaries of improved health care investments are often the most vulnerable group: ‘children’. Healthier children have higher school attendance rates along with improved cognitive development, and a longer, healthier life span. This makes investment in education more attractive and further productive in the longer run. Increasing longevity levels in developing countries has opened a new incentive for the current generation to save — which can have remarkable effects on national saving rates. This can also increase foreign direct investment, as it is seen often seen that foreign investors shun environments where the labor force suffers a heavy disease burden.

Health improvements can encourage economic performance but ill-health issues can also adversely affect economic performance and send it in the reverse direction. There is a scope for vicious circles, as when health declines it sets off impoverishment and further ill-health. People in developing countries suffer from far higher rates of infectious diseases than people in the developed world. Many developing countries face the dual burden of disease, with communicable diseases like AIDS, tuberculosis, malaria along with major childhood infections and maternal mortality, presenting formidable challenges to be faced simultaneously. At the same time, non-communicable diseases, such as heart disease and chronic lung disease, already pose huge and rapidly growing threats as populations continue to age. Such diseases result in a massive waste of human capital as prime-age workers fall sick. Such high-morbidity and mortality environment deters investments in education and creation of human capital that may have a little pay-off. High mortality rates may reduce investment and saving rates that are likely to be affected and this may impact the economic development of the country.

The mobilization and strengthening of human resources for health has been neglected in many countries, but remains a key ingredient in combating health crises in some of the world’s poorest countries, and for building sustainable health systems. Public health investments are crucial not only in their own right but also because they to break away from the poverty-trap faced by many developing countries. In a country

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like India with vast and divergent health needs and also with constraints like shortfall in the availability of health infrastructure, health financing accordingly assumes great importance in the architecture of the health system. A desirable health financing system is one which not only reduces the ‘Out Of Pocket’ (OOP) expenditure on health care but also lessens the probability of any financial impoverishment while meeting health care needs.

### 3.8.4 Trends in Health Expenditure in India

Health financing is the most decisive of all determinants of a health system as the type of financing describes the structure of the health system, the behaviour of different stakeholders as well as the quality of outcomes. The Central Government spends on health and provides grants-in-aid to State Governments, which has a major responsibility for incurring health expenditure.\(^{150}\) In addition to this expenditure the State Governments also incur health expenditure directly out of the resources available with them. The State Government’s health expenditure includes transfers to rural and urban local bodies for health spending. Alongside, the local bodies incur health expenditure from the resources available with them. The sum total of health expenditure by each of these three tiers of the government provides an estimate of public spending on health, in India.

‘Public Health’ being a State subject the sector is financed primarily by the State Governments and is financed through general tax and non-tax revenue resources as the cost recovery from the services delivered has been negligible. As a result, resource allocation to this sector is influenced by the general fiscal situation of the State Governments. The severe fiscal strain during the late 1980s enforced the State Governments to bring in austerity measures and the soft sectors such as health were targeted for expenditure reductions. During the early 1990s, reform measures were initiated at the Centre fiscal transfers to states, which were compacted leading to reductions in the health sector allocation.

In order, to understand the level of public expenditure on health in India, it is necessary to study and compare the health expenditure in India with international

standard of spending. Savedoff (2007), in his study argued that a country should spend at least around 5 per cent of GDP on health to achieve better health outcomes. India’s health care allocation is significantly low when compared to the global, developed nations and other similar emerging economies like Sri Lanka, China, and Thailand. One of the reasons contributing to India’s poor health status is its low level of public spending on health, which is one of the lowest in the world. According to WHO’s World Health Statistics (2007), India ranked 184 among 191 countries in terms of public expenditure on health as a per cent of GDP.

Public health care expenditure by the health departments of Central and State Governments progressively increased from 0.22 per cent in 1950-51 to 1.05 per cent during the mid-1980s, and stagnated at around 0.9 per cent of the GDP afterwards. India currently spends only 1.2 per cent of its GDP on public health care whereas the total Indian health spending was about 4.1 per cent of GDP in 2008–09. This is comparatively less to other developing countries which normally spend between 3-5 per cent of their GDP on health care delivery. The ratio is not only low when compared globally, but it is very low when the trend is studied over the years. Even this amount of health expenditure which combines the private and government spending is appallingly low when compared to other nations. In fact, though studies statistics show that 4.1 per cent of the GDP is spend on health, the fact is that 70 per cent of it is from people’s own pockets or private spending, meaning that the government spends barely 1 per cent on health. While public spending on health care is low, the out-of-pocket (OOP) expenditure by households has been large. The high OOP expenditure puts an ever-increasing financial burden on the poorer sections of the population. The private sector spends in India is more than double that of the

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government spends which suggests that it’s the absence of government health care which forces individuals to spend money out-of-pocket. This results in pushing the poor further into debt and poverty-trap.

3.9 Evolution of National Health Planning in India
Health as a state of complete physical, mental and social well-being is essential for leading a productive life, without disease or infirmity. Provision for health should be considered a fundamental human right and attainment of the highest level of health is a most important social goal, therefore, national health planning is considered as socio-economic planning. The strong links between poverty and ill-health often affects the economic development of a country. The health of a nation is an essential component of development, vital to the nation’s economic growth and internal stability. Thus, assuring a minimal level of health care to the population is a critical component of the development process.

3.9.1 Ancient Public Health Care in India
The experience and concern in health care development and primary health care in India dates back to the Vedic period, in the Indus-Valley Civilization as far back as 3000 B.C. There is historical evidence of well-developed environmental sanitation programmes such as underground drains, public baths in the cities etc. Health and measures used for maintaining hygiene were different in various periods of Indian history. For example, the use of public baths and highly developed water systems during the early Indus valley civilization were not matched by peoples from the successive civilizations.157

3.9.2 Health during the Colonial Period
Modern medicine and health care were introduced in India during the colonial period and charted the same pathway followed by the British. In colonial India, public health efforts were focused largely on protecting British troops, civilians and army quarters. During the middle of the 18th century, the British Government in India established medical services which were primarily meant for the benefit of the British nationals, armed forces and a few privileged civil servants. Sanitation was given the highest

priority and efforts were focused on early detection and control of infectious diseases like cholera and plague. The restrictions of public health efforts to British civilians and military became a major constraint as the vast majority of the native Indian population was denied access to the Western medicine and cure. At the time of Independence, majority of Indian masses remained deprived of the dividends of these medical efforts. Only 3 per cent of the households in India had access to toilets, while clean water, drainage systems and other waste disposal services were utterly lacking.

Many native systems of medicine were entirely neglected and lost their significance in maintaining health. Health care services which were available only in general hospitals located in big cities and commercial centers were largely curative in nature. Later on, some preventive measures were adopted for the control of epidemics and dispensaries were opened in some remote villages. Yet, the health planning and medical education adopted was unrelated to the health needs of the native population and resulted in a strong bias towards Western medicine. This lead to the blind acceptance of sophisticated contemporary medicine meant for a few sections of the society and neglect of the critical interests of the large majority.

3.9.3 Post-Independence Scenario

When the British left India in 1947, they left behind a country mired in dismal poverty. Health care services in India were utterly inadequate, mostly urban-based and basically curative in nature at the time of Independence in 1947. Majority of the population, especially the poor and those residing in rural areas, did not have access to modern health facilities and as a result the morbidity and mortality rates was very high with people in low-income groups having life expectancy of just about 27 years during that time period.

Since Independence, improvement in the health status of the population has been one of major thrust areas in social development programmes of India. Keeping in view the constitutional obligations, the Government of India planned several approaches for the health care delivery. Health policy making and health planning of a nation is its strategy for controlling and optimizing the social uses of its health knowledge and health resources. The basis for organization and planning of health services in India was based on the recommendations and guidance provided by the ‘Health Survey and
Development Committee’ (Bhore Committee) in 1946. It was proposed to establish one Primary Health Centre (PHC) for each community development block (CDB). At that time, the operational responsibilities of the PHC were to cover medical care, control of communicable diseases, maternal and child health (MCH), nutrition, health education, school health, environmental sanitation and the collection of vital statistics. Each PHC had three Sub-centres, being looked after by a trained midwife for providing MCH services.

Subsequently, over the past three decades the health services organization and infrastructure have undergone wide-ranging changes and expansion in various stages, following the review by a number of expert committees, i.e. the Mudaliar Committee (1961), the Mukherjee Committee (1966), the Kartar Singh Committee (1974) and the Shrivastava Committee (1975). The various committees of experts appointed by the Indian government from time to time have rendered positive contribution in advising the government about different health issues faced by the people. The reports of these committees have formed an important basis of health planning in India. The Indian Government appointed various committees on different occasions to assess the current health status, existing health infrastructure and available resources that was required. Progressive changes were then introduced into the programme over the various five-year plan periods. These national health reports were of vital importance as they served as historical landmarks in the history of National Health Planning of India.

3.9.3.1 National Health Committees

A number of policy initiatives were initiated and committees were set-up to recommend appropriate steps for all-round development of the health sector, and programmes were implemented to improve the health situation in the country. The different National Health Reports by the various Health committees in India, and their significant contributions made by them are listed below:

(A) Bhore Committee (1946)
(B) Mudaliar Committee (1962)


(C) Chadda Committee (1963)
(D) Mukherjee Committee (1965)
(E) Jungalwalla Committee (1967)
(F) Kartar Singh Committee (1973)
(G) Shrivastav Committee (1975)
(H) V Ramalingaswami Committee Report (1981)
(I) Bajaj Committee Report (1986)
(J) Krishnan Committee Report (1992)

(A) The Health Survey & Development Committee (Bhore Committee), 1946

The Bhore Committee, which was appointed by the Government of India in October 1943, to make a survey of the existing position with regard to health conditions and health organization as well as to make recommendations for future developments, found that they had to confine themselves mainly to statistics of ill-health and death, in the absence of data on positive health.  

The Committee’s report brought out the low state of public health, as reflected in the high mortality and morbidity predominantly among mothers and children. The report stressed that this was preventable as it was primarily caused by the absence of environmental hygiene, inadequate nutrition and lack of preventive and curative health services as well as intellectual co-operation from the people themselves. The report highlighted the wide prevalence of unhygienic conditions in urban and rural areas and also stated that the provision for protected water supply and drainage was totally inadequate. The report emphasized that “If it were possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through malnutrition and preventable morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about.”


(B) The Mudaliar Committee, 1962
The Mudaliar Committee (1962) known as the “Health Survey and Planning Committee”, headed by Dr. A. L. Mudaliar, Vice-chancellor of the then Madras University, was appointed in 1959 to evaluate the performance of the health sector since the submission of Bhore Committee report. The committee found that the conditions in Primary Health Centres (PHCs) were unsatisfactory and recommended that it is necessary to see that the already established PHCs be fortified before new ones were opened; the report also advised strengthening of sub-divisional and district hospitals, and emphasized that a PHC should not be made to provide for more than 40,000 of the population. It also stated that the curative, preventive and promotive services should be provided at the PHC; and it also recommended that the erstwhile Indian Medical Service should be replaced by a newly created All India Health Service.

(C) The Chadda Committee, 1963
This committee was appointed under chairmanship of Dr. M.S. Chadda, the then Director General of Health Services, to advise about the necessary arrangements for the maintenance phase of National Malaria Eradication Programme (NMEP). The committee’s recommendations suggested that the vigilance activity in the NMEP should be carried out by basic health workers (one per 10,000 population), who would function as multipurpose workers and would perform, in addition to malaria work, the duties of family planning and vital statistics data collection under supervision of family planning health assistants. In fact, the very scope of the committee was restricted to malaria eradication.

(D) The Mukherjee Committee, 1965 and 1966
The Mukherjee committee was headed by the then Secretary of Health Shri. Mukherjee, was appointed in 1965 to review the performance in the area of family planning. The committee also recommended delinking the malaria activities from family planning and incorporation of a separate staff for the Family Planning Programmes. The basic health workers were to be utilized for purposes other than

family planning. Multiple activities of the mass programmes like family planning, small pox, leprosy, trachoma, NMEP (maintenance phase), etc. were making it difficult for the states to undertake these effectively because of shortage of funds. A committee\textsuperscript{164} of state health secretaries, headed by the Union Health Secretary, Shri Mukherjee, in 1966 was set up to look into this problem of shortage of funds. The committee worked out the details of the Basic Health Service, and recommended that these services should be provided at the Block level and also some consequential strengthening that was required at higher levels of administration.

(E) The Jungalwalla Committee, 1967
This committee, known as the ‘Committee on Integration of Health Services’\textsuperscript{165} was set up in 1964 under the chairmanship of Dr. N Jungalwalla, the then Director of National Institute of Health Administration and Education (currently NIHFW). It was asked to look into various problems related to integration of health services, abolition of private practice by doctors in government services, and the service conditions of Doctors.

(F) The Kartar Singh Committee, 1973
This committee, headed by the Additional Secretary of Health and titled the “Committee on multipurpose workers under Health and Family Planning”\textsuperscript{166} was constituted to form a framework for integration of health and medical services at peripheral and supervisory levels. Its main recommendations were the amalgamation of peripheral workers into a single cadre of multipurpose workers to ensure proper coverage. Also, it recommended the organizational change with respect to Primary Health Centres (PHCs) and Sub Centres (SCs) - one PHC to be established for every 50,000 population. Further, each PHC to be divided into 16 sub-centres each to cater to a population of 3000 to 3500. Each sub-centre was to be staffed by a team of one male and one female health worker.

(G) The Shrivastav Committee, 1975
This committee known as “Group on Medical Education and Support Manpower” was set up in 1974, to decide upon steps required (i) to re-orient medical education in accordance with national needs & priorities and (ii) to develop a core curriculum for health assistants, to function as a link between medical officers and MPWs. The committee recommended the following steps as immediate action for:
1. Creation of bonds of para-professional and semi-professional health workers from within the community itself.
2. Establishment of three cadres of health workers namely – multipurpose health workers and health assistants between the community level workers and doctors at PHC.
3. Establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of University Grants Commission. The acceptance of the Shrivastava Committee recommendations led to the introduction of the Rural Health Service in 1977.

(H) The V. Ramalingaswami Committee Report, 1981
Soon after the Alma Ata conference, a joint panel was commissioned by Indian Council of Social Science Research (ICSSR) and Indian Council of Medical Research (ICMR) in 1980, under the chairmanship of Dr. V. Ramalingaswami. This Committee was appointed to study the problems of both health and medical care in India to help evolve a viable alternative. The 1981 report of Study Group, ‘Health for All: An alternative strategy’ was submitted after a detailed study of the problem over a period of three years. This report still remains a landmark document for providing alternative health care system to all Indians in a practical, humane, culturally acceptable readily accessible, affordable and highly cost-effective manner utilizing the available knowledge and technology from all sources as well as be accountable to the people it served.

(I) The Krishnan Committee Report, 1982
The committee headed by Dr Krishnan,\textsuperscript{169} reviewed the achievements and progress of previous health committee reports and also made comments regarding the shortfalls and deficiencies faced by the Indian Health care system. On the basis of suggestions of the Krishnan Committee, under the Revamping scheme in 1983, the Government started four types of Urban Health Posts (UHP) in ten States and Union Territories with a prerequisite of setting them in slums or in the vicinity of slums, to provide outreach, primary health care, and family welfare and MCH services.

(J) The Bajaj Committee, 1986
An ‘Expert Committee for Health Manpower Planning, Production and Management’\textsuperscript{170} was constituted in 1985 under Dr. J.S. Bajaj, the then professor at AIIMS. The major recommendations of this Expert Committee were: the formulation of national medical & health education policy; preparation of national health manpower policy; establishment of health science universities in various states, union territories and establishment of health manpower cells at central and state levels.

3.10 Health Care Objectives and Initiatives under India’s Five Year Plans
In the early years after Independence, India was faced with the situation of acquiring and accumulation of capital in the private sector through large scale investments in capital goods industry, infrastructure and financial services. Rapid industrial growth was the keyword and this policy unfortunately gave rise to the neglect of the social sectors like health and education which were already low priority areas.

The Indian Government, through the ministry of health and family welfare along with other related agencies, play a vital role in development of health, through strengthening health systems and generation of human, financial and other resources. The aim is to help the various health systems to achieve their goals of improving health, reducing health inequalities, securing equity in health care, financing and responding to the population needs.


Improvement in the health status of the population has been one of the major key areas for the social development of the country, which was to be achieved through improving the access to the utilization of health services with special focus on the underserved and underprivileged segments of the population. Over the last five decades, India has built up a vast health infrastructure and manpower at the primary, secondary and tertiary care in the government, which are manned by the professionals and para-professionals.\textsuperscript{171} The people have become aware of the benefits of health related technologies for prevention, early diagnosis and effective treatment for a wide variety of illness an accessed available treatment. In the last many years, technological advances and improvement in access to health have brought about a steep decline in mortality.\textsuperscript{172} Yet, in many states, there is a marked disparity in health indices of the population, which can be attributed to the extent of access to and utilization of health care services across districts and segments of the society.

3.10.1 National Health Policy and Plans

Ever since India achieved Independence, the Government has taken several measures to improve the health of its citizens. India started the process of planned economic development with the First Five year Plan on April 1, 1951. The basic objectives of planning in India can be grouped under four heads: (1) Growth, (2) Modernization, (3) Self-reliance, and (4) Social justice. Each Plan is both an assessment of the past and a call for the future.

A health policy is an expression of what the health care system should aspire to be, so that it can meet the health care needs of the people. The health policies adopted by the government earlier could be explained in terms of priorities fixed for the various aspects of health and the objectives, which it sought to achieve. Since health is an important contributing factor in the utilization of manpower, the Planning Commission of India gave considerable importance to health programmes in the five-year plans as a tool for socio-economic development. It was not until 1983 that India adopted a formal or official National Health Policy. Prior to that health activities


of the state were formulated through the Five year Plans and recommendations of various Committees.

The first Five Year plans were brought in by the Indian government with the noble objectives of improving the health standards for the Indian population by adopting various programmes like self-sufficiency in medical drugs and equipment, Family Planning and population control, new programmes for the control of communicable diseases like malaria, filaria, tuberculosis, leprosy etc. Education and training facilities for medical and para-medical personnel and other health functionaries were also instituted and expanded. The broad objectives of the health programmes during the five-year plans have been to control and eradicate major communicable diseases; population control; strengthening of basic health services through establishment of primary health centers and also the development of health manpower resources. The details of different Five Year plans and their objectives are listed below:

**The First Five Year Plan (1951-56)**
The First Five Year Plan which was launched in 1951 mainly focused on development of the primary sector, and seven broad areas: irrigation and energy, agriculture and community development, transport and communications, industry, social services, land rehabilitation, and for other sectors and services. Post-independence, the health standards of the people in India were disturbing and there were constant dangers of epidemics and other communicable diseases. This was the result of lack of hygienic environment conducive to healthy living, low resistance due to lack of adequate diet and poor nutrition, lack of proper housing, safe water supply, sanitation and the lack of medical care, curative and preventive. These were accentuated by the lack of general and health education and low economic status. The First plan had a programme with the following priorities like provision of water supply and sanitation, control of malaria, health services for mother and children, education, training and health education, self-sufficiency in drugs and equipment, family planning and population control.

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The Second Five Year Plan (1956-61)
The Second Five Year Plan was a continuation of the First one and aimed at expanding the existing health services along with the universal aims of the various health programmes. It intended to develop existing health services, to bring them gradually more within the reach of all the people and also to promote a progressive improvement in the national health level. The Second Plan followed an economic development model known as the Mahalanobis model and developed by the Indian statistician Prasanta Chandra Mahalanobis in 1953. The Second plan was particularly focused on the development of the public sector and on expanding the existing scheme of primary health centre network to cover the rural population spread over a vast geographical area. During the Second plan, top priority was given to the eradication of communicable disease like malaria, small-pox etc.176

The Third Five Year Plan (1961-66)
The Third Five Year Plan, launched ‘family planning programme’ as an integral part of the health plans to educate and persuade the people, especially the rural population, to accept the small family norm. It also considered the problems faced by the PHCs, like the shortage of health personnel, inadequate training facilities for the different categories of staff required in the rural areas etc. The Mudaliar Committee's recommendation regarding consolidation of PHCs was ignored and during this plan period there was further increase in the numbers of the PHCs, yet their condition remained the same as before. It also laid greater emphasis on preventive public health services as well as eradicating and control of communicable diseases. The specific objectives of the Third plan were improvement of environmental sanitation, especially rural and urban water supply, organization of institutional facilities for providing health services and for the training of medical and health personnel; along with provision of services such as maternal and child welfare, health education and nutrition etc.

The Fourth Five Year Plan (1969-74)
The Fourth Five Year Plan commenced in 1969 after a three year plan holiday and continued on the same lines as the Third plan without any major change in the policy

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approach towards the health care services. It further pushed the concept of family planning programme as an integral part of the health plans by promoting contraceptives like IUD and sterilization. During this plan, efforts were made to provide an effective base for health services in rural areas by strengthening the primary health centres. These centres were to provide preventive and curative health services, take over the maintenance phase of communicable diseases control programmes for malaria and small-pox and become the focal points for a nation-wide family planning programme. Medical as well as nursing education and training of para-medical personnel were expanded to meet the minimum technical man-power requirements.

The Fifth Five Year Plan (1974-79)
The Fifth Five Year Plan, realizing the failure of coercive methods to control population stressed on health, family planning and nutrition as a component of the Minimum Needs Programme along with eradication of poverty. The government recognized that inspite of improved health indicators, rural health facilities in terms of hospital beds, skilled manpower etc. was inadequate. The recommendations of the Kartar Singh Committee in 1973 stressed on the need to the convert single purpose workers, including Auxiliary Nurse Midwives (ANMs), into multipurpose male and female workers (MPWs) with the objective to retrain the existing cadre of vertical programme workers and to fully integrate into the primary health care package for rural areas. During this plan, Expanded Programme of Immunization (EPI) was introduced in 1978 with the objective of reducing mortality and morbidity due to diphtheria, tetanus, whooping cough, polio, and tuberculosis among children and expectant women. The major objectives of the fifth plan with regard to health were to increase accessibility of health services in rural areas, to improve the quality and providing the necessary rural orientation to the medical and para-medical personnel.

The Sixth Five Year Plan ((1980-85)
Under the Sixth Five Year Plan, which was based on the Shrivastav Committee Report-1975, rural health schemes were given priority at the expense of urban

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super-specialty hospitals. At the same time the family planning programme was greatly expanded to include family welfare programme. This plan was to a great extent influenced by the Alma Ata declaration of – Health for All by 2000 AD, and ‘Health for All: An Alternative Strategy’ the study report of Indian Council of Social Science Research’s (ICSSR) and Indian Council of Medical Research (ICMR) report. The plan also emphasized that no further linear expansion of curative facilities in urban areas unless it was deemed necessary and India brought out its first official National Health Policy (NHP) in 1983 and the various national programmes like the National Malaria Eradication Programme, the National Programme for Control of Leprosy, Tuberculosis, etc. have also helped to reduce mortality and morbidity.\footnote{Sixth Five Year Plan: Health. Retrieved October 23, 2013, from The Planning Commission Government of India, http://planningcommission.gov.in/plans/planrel/fiveyr/6th/6planch22.html}

**The Seventh Five Year Plan (1985-90)**

The Seventh Five Year Plan recommended the development of specialties and super-specialties as well as also emphasized on improvement of urban health services, biotechnology and medical electronics along with enhanced support for population control activities. Primary health care was to be further augmented in the Seventh plan. In the overall health development programme, emphasis was be laid on preventive and promotive aspects plus on organizing effective and efficient health services which are comprehensive in nature, easily and widely available, freely accessible, and generally affordable by the people. However, many studies have observed that though the rural infrastructure is in place in most areas, these were under-utilized due to poor facilities, inadequate supplies, absence of medical personnel, lack of medicines etc.

**The Eighth Five Year Plan (1992-97)**

Due to the fast changing political situation at the centre, the Eighth Five Year Plan could not take off in 1990, and the plans for the years 1990–91 and 1991–92 were treated as Annual Plans. The Eighth Five Year Plan got pushed forward, due to the massive economic crisis faced by the country. The National Health Policy (1983) reiterated India's commitment to attain ‘Health for All (HFA) by 2000 A.D’ and chose to emphasize Health for the Underprivileged and also simultaneously continued to support privatization. It affirmed on the effective delivery of health care services
through education, training and appropriate orientation towards community health of all categories of medical and health personnel. The Eighth plan emphasized on ensuring that health facilities are easily accessible to the entire population.\(^{180}\) Under ‘Health for All’ (HFA) paradigm it stressed on focusing on high-risk vulnerable groups, i.e. mothers and children, and also the underprivileged segments within the vulnerable groups. It emphasized on the community based systems reflected in planning of infrastructure, with about 30,000 populations as the basic unit for primary health care. Accordingly, a vast network of institutions at primary, secondary and tertiary levels was established.

**The Ninth Five Year Plan (1997-2002)**

During the Ninth Five Year Plan further efforts were carried out to improve the health status of the population by optimizing coverage along with quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs. The Ninth plan emphasized the need to promote economic and social growth, by offering strong support to the social sectors of the country in an effort to achieve the complete eradication of poverty. It analyzed the existing health infrastructure and human resources and states that consolidation of PHCs and SCs, as well as ensuring the availability of its requirements for its proper functioning is an important goal under the Basic Minimum Services program. As it is difficult to find physicians to work in PHCs and CHCs, one of the suggestions under the plan to improve public health care facilities was by creating part-time positions to be offered to local qualified private practitioners and/or offer the PHC and CHC premises for after office hours practice against a rent. During the Ninth plan, health manpower planning was to be linked to the needs and demands of health services. The plan also stressed on the need for increasing accountability and responsiveness to the health needs of the people by raising the utilization of the Panchayati Raj institutions in local planning and monitoring. Available local and community resources were to be used to improve the operational efficiency and the quality of services and to ensure that the services were made more responsive to the user’s needs.

The Tenth Five Year Plan (2002-2007)

The Tenth Five Year Plan of the nation recognized that the development objectives need to be defined in terms of increase in GDP and also in terms of human well-being. The Tenth plan indicated the dismal picture of the health services infrastructure and acknowledged that the public health system is grossly short of defined requirements. The plan emphasized the need to invest more on building good primary-level care and referral services by restructuring and developing the health infrastructure, especially at the primary level. The major focus of the plan was to fully implement the structural and functional health sector reforms initiated in the Ninth plan, to improve efficiency of the existing health care system and intended to achieve the national average levels in respect of all the critical indicators of quality of life\textsuperscript{181} and strong emphasis was put on human development; and for family welfare, the following targets have been indicated: a) reduction population growth, b) reduction of maternal mortality ratio, c) reduction of infant mortality rate, d) exploring alternative systems of health care financing including health insurance so that essential, need based and affordable health care is available to all and e) reorganization and restructuring the existing government health care system among the other objectives.

The Eleventh Five Year Plan (2007-2012)

The approach of the National Eleventh Five Year Plan was “Towards Faster and More Inclusive Growth”, under which not only a growth target but also a number of quantifiable and observable socio-economic targets relating to employment generation, school drop-out rates, infants’ mortality, maternal mortality, under-nutrition among children, anemia among women and girls, provision of clean drinking water for all and improving child sex ratio for age group 0 to 6 years were specified\textsuperscript{182} One objective of the Eleventh plan was to achieve good health for people, especially the poor and the underprivileged.\textsuperscript{183} In order to achieve this, a comprehensive approach was planned that encompasses individual health care, public


health, sanitation, clean drinking water, access to food, knowledge of hygiene and feeding practices.

The plan aimed to facilitate convergence and development of public health systems and services and importance was to be given to reducing disparities in health across regions and communities by ensuring access to affordable health care. The Eleventh plan sought to correct the imbalance which stemmed from deficiencies in the public sector by increasing the share of Public Expenditure on Health in the Centre and States taken together from less than 1.0 per cent of GDP in 2006-07 to 2.0 to 3.0 per cent of GDP to be achieved over a period of time.

The Twelfth Five Year Plan (2012–2017)
India's health indicators are not improving in tandem with other socio-economic indicators. Good health care is perceived to be either unavailable or unaffordable.\(^\text{184}\) While the Twelfth Five Year Plan must re-strategize to achieve faster progress towards the seven goals stated under the Eleventh plan, it must also define its health care strategy more broadly. The NRHM has focused heavily on child birth and pre-natal care. It must however expand to a more comprehensive vision of health care, which includes service delivery for a much broader range of conditions, covering both preventive and curative services.

- Making Universal Essential Health Care operational.
- Ensuring Essential medicines for all.
- Building Health Information and disease surveillance (for Communicable and Non-Communicable diseases).
- Integrating AYUSH in health research, teaching and practice

Other pioneering management reforms within health delivery systems will be encouraged with a view to improve efficiency, effectiveness and accountability. Programmes/schemes will be evaluated on the basis of outcomes rather than outlays. While preventive health care is much cheaper than curative care, it has so far not received the attention it deserved. But most significantly, families and communities must be empowered to create an environment for healthy living. The Twelfth Five-Year Plan must break the vicious cycle of multiple deprivations faced by girls

and women because of gender discrimination and under-nutrition. Ending the gender based inequities, discrimination and violence faced by girls and women, they must be accorded the highest priority and these needs to be done in several ways such as achievement of optimal learning outcomes in primary education, interventions for reducing under-nutrition and anemia and promoting menstrual hygiene in adolescent girls as well as providing maternity support.

3.11 National Health Policies and Programmes in India

Health policy of a nation is basically its strategy for controlling and optimizing the social uses of its health knowledge and health resources. Important health programmes have been undertaken by the Government of India for the control and obliteration of communicable diseases, improvement of sanitation, hygiene and water supply, elevating the levels of nutrition, population-control etc. National Health policy addresses the urgent need to improve the performance of health systems.

1. National Health Policies (NHP 1983)

The first National Health policy of 1983 was in direct response to the commitment to the Alma Ata declaration to achieve ‘Health for All by 2000’. The National Health Policy (NHP) was endorsed by the Parliament of India in 1983 and updated in 2002. It accepted that health was central to national development and had a focus on access to health services; especially for rural populations. The first National Health Policy in 1983 aimed to achieve the goal of ‘Health for All’ by 2000 AD, through the provision of comprehensive primary health care services. NHP-1983 emphasized the need for providing primary health care with special emphasis on prevention, promotion and rehabilitation. The main goal was to achieve an acceptable standard of good health for the general population and emphasized the creation of an infrastructure for primary health care; close co-ordination with health-related services and activities (like nutrition, drinking water supply and sanitation); the dynamic involvement and participation of voluntary organizations; the provision of crucial drugs and vaccines; qualitative improvement in health and family planning services; the provision of

adequate training; and medical research aimed at the common health problems of the people.\textsuperscript{186}

2. **National Population Policy, 2000: Health Related Components**

The National Population Policy was announced in the year 2000, with a comprehensive policy framework for family planning along with maternal and child health goals, objectives and strategies. The immediate intention of the Policy was to tackle the unaddressed and unmet requirements of contraception, health care infrastructure and health workforce as well as to provide integrated delivery for basic reproductive and child care services, with medium term objective of bringing Total Fertility Rate to replacement level by 2010 through vigorous implementation of inter-sectoral operational strategies. The long term objective of National Population Policy was to achieve a stable population by 2045 at a level consistent with requirements of sustainable economic growth, social development and environmental protection.

3. **National Health Policy (NHP), 2002**

Nearly twenty years after the first health policy, a Second National Health Policy, was presented in 2002. This is the second such policy adopted by the Government after a gap of nineteen years. This National Health Policy recognized as the noteworthy successes in health sector since the implementation of the First NHP 1983, like the eradication of small-pox and guinea worm, the near eradication of polio and the progress towards the elimination of leprosy and neonatal tetanus. The policy was framed to attain public health goals.\textsuperscript{187} One of the most important features of this policy is the improvement of education and training in addition to the incorporation of appropriate technology to assure high quality affordable care. A high priority was accorded to research in areas of national and epidemiological importance and futuristic concerns.

The main objective of the revised National Health Policy, 2002 was to achieve an acceptable standard of good health among the general population of the country and


\textsuperscript{187} National Health Policy 2002 (India), Ministry of Health and Family Welfare, Government of India, New Delhi 2002
also to set goals to be achieved by the year 2015. Important health programmes were started for controlling or eradicating communicable diseases, improvement of sanitation, raising the nutritional standards, control of population etc.\textsuperscript{188} The government launched a large number of programmes and schemes to address the major concerns and eventually bridge the gaps in existing health infrastructure and provide accessible, affordable, equitable health care. The details of the various National Health Programmes in India are as follows:

1. **National Rural Health Mission (NRHM)**

The NRHM provides an overarching umbrella to the existing health and family welfare programmes and was launched in 2005 to improve accessibility to quality health care for the rural population, bridge gaps in health care, facilitate decentralized planning in the health sector, and bring about inter-sectoral convergence.\textsuperscript{189} Better infrastructure, availability of manpower, drugs and equipment, along with augmentation of health human resources in health facilities at different levels have led to improvement in health care delivery services and considerable gains in health status in terms of increased life expectancy, reductions in mortality and morbidity etc.

2. **Janani Suraksha Yojana (JSY)**

The main aim of Janani Suraksha Yojana (JSY) launched in 2005 was to bring down the Maternal Mortality Rates by promoting institutional deliveries conducted by skilled birth attendants. In addition, Janani Shishu Suraksha Karyakram (JSSK), a new initiative which entitles all pregnant women delivering in public health institutions to an absolutely no expenses delivery, covering free delivery including Caesarean, free drugs, diagnostics, blood and diet and free transport from home to institution including during referrals, is also in operation.\textsuperscript{190}

3. **National Programme for Control of Blindness (NPCB)**

Under National Programme for Control of Blindness, various measures like eye care, refractive error correction, cataract surgery are common procedures for achieving


suggested goals under the programme. The national programme was launched in 1976 as total centrally sponsored programme.

4. National Guinea Worm Eradication Programme
After the successful eradication of small-pox, India took steps to eradicate guinea worm in the country which was causing incapacitation to the individuals who are unable to perform their regular work, resulting in economic and production loss to the patient and family. These types of diseases manifest in rural area where there is inadequacy of safe drinking water.

5. National Water Supply and Sanitation Programme
National water supply and sanitation programme commenced in the year 1954 with a view to provide safe and wholesome water to the population of the country and to provide adequate drainage facilities for the entire urban and rural population of India. India proposed the healthy related investment in the sector of water supply and sanitation during first, second and third five year plans of ₹ 11, ₹ 74 and ₹ 110 crores respectively.

6. National Tuberculosis Control Programmes
Soon after Independence, India visualized the burden of existing tuberculosis problems in the country and took necessary measures to combat the disease. The suffering from this social disease was the most significant determining factor in the progress of developmental activities. During the period of 1950 and 1960 the modern principles of the diagnosis and treatment were established in the country. The mass BCG vaccination and National Tuberculosis Survey of 1955-58 led the country to take up the modified strategies for the control of tuberculosis. It aimed at reduction of tuberculosis using the available resources and within the given span of time.

7. National Polio Eradication Programme
India plays a significant role in polio eradication because of its huge under-five child population. After the 1988 World Health Assembly Meet, the goal of polio eradication was adopted globally. The incidence of polio in India was high before the National Immunization Programme. Oral polio vaccine was introduced in India in 1979. Three doses of OPV at monthly intervals starting at six weeks of age and an
additional dose at one month after the primary series was followed. Pulse polio immunization (PPI), is an unique approach towards polio eradication where all children in the country are simultaneously administered OPV on a fixed day, repeated after 4 weeks to ensure that the wild virus of strain get replaced by the harmless and protective strain.

8. Reproductive and Child Health Programme
In April 1988, Government of India implemented the reproductive and child health programme which is popularly known as Reproductive and Child Health Programme (RCH). It is reoriented and refocused version of the family welfare programme which is integrated with child survival and safe motherhood along with involvement of men. In 1998, ICMR set up a task force in male reproductive health, so that equal emphasis could be given to Male Reproductive health. Thus, RCH is implemented to address women's reproductive health needs and women centered gender sensitive services are organized and implemented. The concept of reproductive health include family planning, maternal and child health, safe abortion, effective control of STD and RTI, prevention and management of infertility, care of adolescent health etc.

9. Child to Child Programme
This programme centered on the innovative, activity-oriented approach to create awareness among 6 to 14 year-old children to distribute important health care messages, making them more equipped to take better care of their siblings and spread the messages in the family, community, society and nation. This helps to bring about a general overall awareness and subsequent improvement in the health status of children.

10. National AIDS Control Programme
National AIDS control programme dates back to 1985 when the Government of India constituted a Task Force to tackle the problem of AIDS and to control its spread in the country. This programme was launched in 1987 both for the service of diagnostic and treatment as well as also for research in specified aspect of AIDS in India. In the beginning the AIDS screening focused only on risk groups like sex workers and blood donors. However, currently it includes AIDS education activities.
11. National Vector Borne Disease Control Programme
A National Vector Borne Disease Control Programme was been launched to control and prevent vector-borne diseases such as malaria, dengue, chikungunya, Japanese encephalitis, kala-azar, and lymphatic filariasis in the country. Of these six diseases, kala-azar and lymphatic filariasis have been targeted for elimination by 2015. 191

12. National Leprosy Eradication Programme
During the pre-independent period, leprosy in India was treated by the 152 institutions both charitable and NGOs. Based on the recommendations of expert committee, India launched leprosy control programme in the country in 1955. During the first five year plan its objective was controlling the disease by domiciliary sulphone drug treatment. Subsequently, the centrally sponsored scheme has been brought in with more emphasis on high endemic areas.

13. National Anti-Malaria Programme
In the early British period, malarial control activities were seen in the port areas, plantations and cantonments. Up to 1936, only anti-larval measures were found to be used in malaria control. In 1946, large scale activities like DDT spray was taken up to control the spread of Malaria. In 1953, the National Anti-Malaria Programme was launched with an objective of reducing malaria morbidity in highly malaria-prone areas of the country. In 1958, NMEP was launched with the objective of the reducing parasite reservoir in human beings, reducing the transmission in the community and to eradicate malaria within time schedule. In accordance with the project planning, NMEP was carried out in four phases namely the preparatory phase, the attack phase, consolidation phase and maintenance phase.

14. National Filaria Programme
The National Filaria control Programme was launched in 1955 and the following measures were taken in the programme:

- Delimitation of the problem in hitherto un-surveyed area.
- Control in the urban areas through recurrent anti-larval measures and anti-parasitic measures by filarial control units.

- Providing drugs through primary health care delivery system in rural areas of endemic states.

15. National STD Programme
Since the earlier nomenclature of sexually transmitted diseases was venereal disease, the programme was started as National Venereal Disease (VD) control programme in 1949. Initially it started as a pilot project and in 1955, the Planning Commission of India, recommended laboratory services and VD clinic at district levels. In 1957, DGHS started a central VD organization for an effective implementation of VD control activities. The centre established 5 regional training centres in different parts of country. Located at district hospitals, there are 504 STD clinics functioning in the country.

16. National Yaws Eradication Programme
Yaws is the most common of these infections, occurring mainly in poor communities in warm, humid tropical regions of Africa, Asia, Latin America and Western Pacific. Yaws is transmitted primarily through skin contact with an infected person. A single skin lesion develops at the point of entry of the bacterium after 2-4 weeks. If left untreated, multiple lesions appear all over the body. Although rarely fatal, yaws can lead to chronic disfigurement and disability. Overcrowding, poor personal hygiene and poor sanitation facilitate the spread of the disease. In 1952, India took steps to initiate mass campaign against yaws in endemic districts and by 1964, remarkable reduction of yaws allowed to discontinue the mass campaign measures.

17. National Surveillance Programme for Communicable diseases
During the nineties, India suffered from severe epidemics of communicable diseases and this lead to the systematic process of reporting of various diseases of public health importance and as and when and where they occur, the designated agency responsible for taking effective interventional steps would come into existence. Thus in 1997, India initiated National CD surveillance programme to prevent and combat epidemics.

18. National Nutritional Programme
Government of India has initiated many nutritional programmes to overcome malnutrition and deficiencies in the community. They are 1) to improve the overall
nutritional status, 2) to overcome specific deficiencies and, 3) to help achieve better nutrition through indirect schemes. The Applied Nutrition programme launched in 1963 with the assistance of UNICEF aimed at a) production of protective foods, b) health education for their consumption and c) improvement by self-effort of the community. Supplementary feeding programme was launched in 1970 by the Department of Social Welfare and Ministry of Human Resources and the main beneficiaries were pregnant and lactating women, preschool children between the ages 0-6.

19. National Cancer Control Programme
Changing life-styles and longevity are added factors for the increase in the cancer problem in the country. Given the increasing number of cases the country initiated the National Cancer Control programme in 1975-76 with the major objective of equipping a premier cancer institution in India.

20. National Iodine Deficiency Disorder Control Programme (NIDDCP)
The Government of India launched a 100 per cent centrally assisted National Goiter Control programme in 1962, to control the problem associated with Iodine deficiency such as still births, mental retardation, abortions etc. The objectives of the programmes were to survey and assess the magnitude of Iodine deficiency, supply of iodized salt instead of common salt and also do a resurvey for understanding the impact after 5 years.

21. National Mental Health Programme
Since 1920, India has taken steps to rename the mental sick treatment to mental hospital which was previously known as mental asylums. Since 1952, psychiatric units have been set up in all big hospitals and medical colleges. A multi-pronged strategy to raise the awareness about issues of mental health and providing accessible and affordable treatment, removing ignorance, stigma and shame attached to facilitate inclusion and acceptance for the mentally ill.192

22. National Diabetes Control Programme
The Indian Government has taken steps to initiate the National Diabetes Control Programme during the Seventh Five Year Plan after understanding that Diabetes is a major problem of health. The major objectives were to identify high risk group, reduce the risk by health education, early diagnosis and prompt treatment, prevent diabetes-related health complications etc.

23. National Family Planning (Welfare) Programme
This programme was introduced to impact the growth of population by averting millions of births annually. In 1952, India launched the world’s first national program emphasizing family planning to the extent necessary for reducing birth rates ‘to stabilize the population at a level consistent with the requirement of national economy’. Since then, the family planning program has evolved and the program is currently being repositioned to not only achieve population stabilization but also to promote reproductive health and reduce maternal, infant & child mortality and morbidity.193

24. Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)
The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) aims at correcting regional imbalances in the availability of affordable/reliable tertiary health-care services and augmenting facilities for quality medical education in the country. Funds has been earmarked under the PMSSY, which aims at (i) construction of 6 AIIMS-like institutions in the first phase at Bhopal, Bhubaneswar, Jodhpur, Patna, Raipur, and Rishikesh and in the second phase in West Bengal and Uttar Pradesh, (ii) up-gradation of 13 medical colleges in the first phase and 6 in the second phase.194

25. Tertiary Health Care Infrastructure Development/ Up-gradation:
To strengthen government medical colleges, land requirement norms and infrastructural requirements for opening new medical colleges have been revised. However, to further the increase in the availability of doctors, it is proposed to set up new medical colleges attached to district hospitals and strengthen and upgrade

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existing ones to add 16,000 new MBBS seats during the Twelfth Plan period. In order to meet the shortage of nurses, a scheme is under implementation for opening of ANM schools and general nursing and midwifery (GNM) schools in districts where there are no such schools.

26. Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)  
The Indian system of medicines is also being developed and promoted by involvement/integration of the AYUSH system in national health care delivery through an allocation of ₹990 crore Plan outlay in 2012-13. India is one of the first nations to launch so many national level health programmes for the health development of the country.

3.12 Impact of Disease Burden in India  
India today, is the seventh-largest in the world by nominal GDP and the third-largest by purchasing power parity (PPP) and has the potential to grow larger and more equitably and to emerge to be counted as one of the developed nations of the world.

Today, the Indian economy is considered as one of the world's fastest growing major economies. Despite rapid economic growth, health care in India has always been wanting for funds with successive governments keeping a tight rein on public expenditure. The gaps in health outcomes continue to widen. India, a country where 45 per cent of Disability Adjusted Life Years (DALYs) are caused by non-communicable diseases (NCDs), epitomizes the definition of 'double burden of disease’, where communicable causes of premature death and disability co-exist alongside growing burdens from non-communicable causes. This dual burden of communicable and non-communicable diseases was largely driven in India, which is the largest country in the region.

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The Country Cooperation Strategy brief of the World Health Organization (WHO) shows that India accounts for 21 per cent of the world’s global burden of disease.\textsuperscript{198} India carries a dual burden of communicable diseases (an estimated 315 million Indians suffer from tropical diseases) and a non-communicable diseases (NCD) epidemic (its contribution to mortality will increase from 53 per cent in 2008 to 73 per cent by 2030).\textsuperscript{199} The Planning Commission estimated that health problems push 39 million people every year into poverty; 47 per cent and 31 per cent of hospital admissions in rural and urban India respectively are financed by loans and asset sales; and 30 per cent in rural India and 20 per cent in urban areas go untreated due to financial constraints.\textsuperscript{200}

Non-communicable diseases are responsible for 60 per cent of deaths in India and accounts for 40 per cent of hospital stays and 35 per cent of outpatient visits. Since expenditure on public health in India is less than 1 per cent of GDP – which is among the lowest in the world – patients and their families bear the burden of the cost. The World Health Organization (WHO) says this pushes an estimated 2.2 per cent of Indians into poverty each year.\textsuperscript{201}

Therefore, it is clear that the onset of disease needs to be averted and if and when it occurs it should be treated promptly. For policies to ensure this, it is necessary that India has an evidence-based understanding of the extent of disease burden, the population groups that are the most vulnerable, and what interventions are needed to avert premature death or needless suffering. Non-Communicable Diseases are associated with three types of economic costs or impacts: social welfare, macroeconomic costs and microeconomic impacts. Social welfare impact represents the value that individuals place on optimal health, and can be estimated by the individuals’ responses to the trade-off between money and health. Macroeconomic impact represents the broader economic output for the nation and is estimated by

\textsuperscript{201} Murukutla, N. (2015, July 14). In Poor Health. The Indian Express.
NCD-related changes in productivity and per capita gross domestic product (GDP). Microeconomic impact reflects NCD-related individual and household costs, consumption patterns and income changes.²⁰²

### 3.13 Challenges Faced by the Health Care Sector in India

The public health system in our country has various limitations or drawbacks. The principal challenge for India is the building a sustainable health system. As such, health care in India is tangled in a vicious cycle of low public investment and unfortunate health outcomes.

Among the main constraints faced by Indian health care sector are lack of infrastructure and manpower along with inaccessibility and expensive nature of health care services. The deficiency of qualified medical professionals is one of the key challenges facing the Indian health care industry. India’s ratio of 0.7 doctors and 1.5 nurses per 1,000 people is drastically lower than the WHO average of 2.5 doctors and nurses per 1,000 people. The situation is aggravated by the concentration of medical professionals in urban areas, which have only 30 per cent of India’s population. Many patients, especially those living in rural and semi-urban areas, are still receiving services from unqualified practitioners. The industry needs an additional 1.54 million doctors and 2.4 million nurses to match the global average.²⁰³

The World Health Organization guidelines state that there should be 3.5 beds per 100, but the total bed density in India is 1.3 per 1000 which is way below the expected norms. Underutilization of existing resources further compounds the problem of meager infrastructure as utilization of public sector health care facilities remain low, as per Rural Health Statistics, NHRM. The U.S. has one bed for every 350 patients while the ratio for Japan is 1 for 85. In contrast, India has one bed for every 1,050 patients. To match bed availability to the standards of more developed nations, India needs to add 100,000 beds this decade, at an investment of $50 billion.²⁰⁴

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WHO National Accounts shows that India’s health care expenditure has grown in at a much slower rate than the country’s GDP. In per capita terms adjusted for purchasing power, India’s public expenditure on health is $43 a year, compared with $85 in Sri Lanka, $240 in China, and $265 in Thailand. In terms of GDP, India spends only 1.2 per cent, a rate that has not budged in more than a decade and is one of the lowest in the world which is low in comparison to those of 1.5 per cent in Sri Lanka, 2.7 per cent in China, and 3 per cent in Thailand.²⁰⁵

Only 22 per cent of the population in rural areas and 19 per cent in urban areas use government facilities for out-patient care. Even for in-patient care, only around 42 per cent in the villages and 38 per cent in the cities utilize government facilities. Complaints are common about distant locations, inconvenient hours, high staff absenteeism and the insensitivity of many health workers.²⁰⁶ According to the World Health Organization (WHO), just 33 per cent of Indian health care expenditures in 2012 came from government sources and the remaining private spending. India’s low spending has put the financial burden on individuals. Due to the high medical expenses, many families are driven into the poverty trap every year.²⁰⁷

Yet another issue is the conceptualization and planning of all health programmes which is centralized and the approach towards disease control and prevention is fragmented and disease-specific rather than comprehensive. As a result of this fragmented disease specific approach (where each and every disease are isolated from each other) rather than decentralized comprehensive health care approach using locally relevant strategies have added to woes of the public health care system in India.

The result of selective, patchy narrow focused strategies and lack of resources have made the health system unaccountable, disconnected to the public health goals, inadequately equipped to address people's growing expectations and inability to


²⁰⁷ Ibid.
provide financial risk protection to the poor. Access to medical care continues to be challenging and elusive due to locational reasons, bad roads, unreliable functioning of health facilities, transport costs and indirect expenses due to wage loss etc. making it easier to seek treatment from local private doctors and/or quacks. This explains the gross underutilization of the existing health infrastructure at the primary level contributing to avoidable waste.208

Most of the health care infrastructure is based on population norms rather than habitations leading to issues of accessibility, acceptability, and utilization. Along with these issues there is the problem of inadequate resources which lead to non-availability of essential consumables and non-consumables. The lack of availability of human resources at various levels of health care and where they are available, the patient-provider interactions are beleaguered with many problems, in addition to waiting time for consultation and treatment. Another limitation of the public health care system is the lack of proper system for of monitoring, evaluation, and feedback. Public health system also suffers from the issue of quality standards which results in underutilized or dysfunctional health infrastructure.

Thus, the three greatest challenges faced by India’s health care system are lack of accessibility, availability and affordability and the reasons for this failure can be attributed to three broad factors: poor governance and the dysfunctional role of the state; lack of a strategic vision; and a weak management.

3.14 Conclusion

‘The existing state of public health in the country is so unsatisfactory that any attempt to improve the present position must necessarily involve administrative measures of such magnitude as may well seem to be out of all proportion to what has been conceived and accomplished in the past.’ This statement by Bhore Committee holds true even today, and bring out the abysmal state of affairs in the Indian health care sector today. Since Independence, the health sector in India has seen many remarkable improvements, in terms of life expectancy at birth, birth and death rate and infant

mortality rate etc. Yet, the present health situation in India is certainly not satisfactory and is much below that of developed countries which are the consequence of unhygienic and insanitary conditions, defective nutrition, inadequacy of the existing medical and preventive health organization as well as lack of health education.

The achievements of the public health sector made during the eighties in improving health outcomes was undermined by the economic crises of 1991 and the subsequent economic reforms which followed under the Structural Adjustment Programme (SAP) strategy or economic policies for developing countries promoted by the World Bank and International Monetary Fund (IMF). As a result of these strategies, public investment in the health sector has declined and this is seen by significantly reduced capital expenditures as well as no further expansions in the public health infrastructure. In India, the public health expenditure is found to be low as compared to the total health expenditure. A large share of public health facilities is concentrated in urban areas. Private health facilities are largely uncontrolled and unregulated.

Indian health care sector is a study of contrasts – where on the one hand there are super-specialty world class hospitals that cater to the rich and medical tourists and on the other hand there are hospitals with terrible infrastructure, lack of medical staff and equipment for the larger poor population. With rising health inequities and issues it is necessary to frame health policies that aim at reducing inequities and regional imbalances in the health sector as well as strengthening the primary health care network all over the country.

One of the many concerns of any nation is the improvement of its public health system through financial packages along with programme strategies that aim to correct regional imbalances. Public health system will be strengthened through addressing these imbalances and shortcomings. It will have to be the main focus of any prudent health policy. In order, to change the existing situation in the public health care sector, the government needs to bring in a radical transformation by increasing the public health care expenditures. This step is necessary to resolve the problem of inadequate infrastructure, their lack of proper maintenance and replacement along with deficiency of the medical staff.
Public health care system in India needs to be revamped with appropriate stress on strategic vision which translates into effective health-related policies and its implementation along with efficient governance and proficient management of available resources.