ROLE OF GOVERNMENT IN HEALTH CARE SYSTEM

The present chapter describes the institutionalisation of health care system by the Indian government. The chapter explains how various incremental steps have been taken in the form of various committees and policy documents from the British times to present so as to improve the lives of people. The chapter has been divided into four sections. The first section explains how health care is analysed in relation to sanitation and describes the evolution of health policy. The second section examines the relationship between polity, society and health by underlining the role played by the state actors, especially the role of political parties in relating health to the overall development agenda and it focuses on how health has been examined within national planning perspective. The third section focuses upon recent policy initiatives with regard to the state’s commitment to the overall well-being of the citizens. The fourth section provides detailed description of organisational health structure at the state level (Punjab) and the implementation of various national level health programmes in the State along with detailed description of working of the satellite hospitals and slum area dispensaries within Amritsar.

SECTION -I

2.1 PUBLIC MODE OF HEALTH CARE

Sanitation, health and medicine constituted the three pillars of health policy. As early as 1837 Sir James Ronald Martin raised the issue of sanitary practices to safeguard the British from tropical diseases. This led to the formulation of town planning strategies keeping in mind climatic theory of disease causation. Eventually residential spaces such as cantonments, civil lines and hill stations were designed for Europeans and elites separating them from the masses. Hence the process of residential segregation came into being. This system brought in other measures such as formation of municipalities near the cantonments as early as 1871. Thus the process of municipalities emerged which was guided by municipal act accompanied by a process of notifications of notifying areas. The issue of health was given paramount importance for certain sections of the population in towns and cities. For performing this role advisory position of
Sanitary Commissioner was created. The overall curative health was taken care of by the Civil Surgeon of respective districts (Ramasubban, 2008:89-92).

The advent of local self-government could be traced to reforms brought in by Lord Ripon in 1882. This brought into focus how to manage civic affairs such as to control epidemics, fires and stench of drains which could affect the European and Indian middle classes. Forty years later Mortgage-Chelmsford Reforms of 1919 brought in education, public parks and health within the ambit of Indian control. Further to resolve the issue of sanitation improvement trust came into being in large cities like Bombay and Calcutta. Those days housing schemes meant for the poor were not availed because of high rental cost, thus forcing the poor to move in to the slums. It was translated into action with coming of planning practices having link to managing the whole cities rather than confining to sanitary reform etc. (Chaplin, 2011:59).

The outbreak of plague epidemic from 1896-1905 in the Bombay presidency led to first ever public intervention by the government. The intervention included fumigation, quarantine measures as well as forced house searches which harassed the general public. In 1898 the first improvement trust came into existence, with the purpose improving sanitary conditions, decreasing congestion to avoid overcrowding which lead to break out of epidemics. On the issue of urban governance collisions between municipalities and improvement trust were noticed due to similar nature of roles as well as functions (Spodek, 2013:57). The colonial government went ahead to carry out small-pox vaccination just to test efficacy of western medicine over the natives. During religious fairs sanitary steps at public level were taken up in order to supervise these arrangements. Some provinces formed committees for this very purpose. However, the steps undertaken were a miniscule due to the vastness of the nation and Britishers own preoccupation with war issues (Ramasubban, 2008:89-95).

In 1936 British officer A.P. Hume prepared a blueprint to relieve congestion in old Delhi. It stated that congestion was not only confined to the houses where occupancy per house was very high. Congestion also dealt with housing structures on the land. The areas of meanest type, having unsanitary lanes and dwellings, were termed as slums which were considered a menace for public health. The report further led to the
formation of improvement trust as a statutory body to look into matters relating to planning de-congestion of the city and the managing of public lands (Priya, 1993:825). However, these improvement trusts largely worked for the betterment of city areas having affluent class often marginalizing the poor. Thus improvement trust went to sanitise the city by adopting strategies of removing the slums. Thus the interest of the poor was often ignored. Such a system continued even after partition. The government went on to accommodate fifty per cent increase in the population of Delhi by creating large housing structures which they failed to do for native poor residents (Ibid.: 826).

Public health initiatives have been taken by sanitary personnel by filling up the tanks to get rid of mosquito menace. The civil engineers ensured that water and sewerage lines were laid to serve the populations in civil lines and also collected taxes for services rendered to them (Spodek, 2013:57). Often slums were designated with references such as sore spots, blighted spots, meanest type needed to be eradicated, burnt, cleared in various policy documents (Priya, 1993:829). The pre independence initiatives were largely urban centric not catering to the needs of the rural population.

2.2 EVOLUTION OF HEALTH POLICY

The British government in India set up Health Survey and Development Committee in the year 1943 headed by Sir Joseph Bhore to evaluate health conditions and make recommendations for future course of action. This committee came into being in 1943 as part of British efforts to reinforce the idea that British would stay back and do lot for improvement of masses (Hammer et al., 2007:4049). The Indian State since independence have tried to follow certain frame work which was put in place by Bhore committee report. A committee was formed for *Integration of Health Services* in 1967. Integration stood for putting the things together, within health paradigm it meant combining administrative structures, functions and mental attitudes into single entity (Government of India, 1967:2-3). Over a period of time various incremental steps have been taken up by the government at the centre which includes eradication of smallpox in the mid 1970s, developing an expanded immunisation programme in 1978 for immunisation of children at early stages of life. Within this programme newer vaccines have been incorporated from OPV in 1979, TT vaccine for pregnant mothers in 1983 measles vaccine in 1990s. Lately they have added hepatitis B and Japanese encephalitis
A working group was set up to oversee the reorganisation of family welfare and primary care services in urban areas in 1982. It was of view that poor and lower middle class people have been forced to live in unhygienic conditions and crowded areas. They have been more likely to fall ill because of existing conditions. As such they have been prone to infectious diseases for which they needed a health post which should be at a nearby distance from their home. As large numbers of families have been working in slums for earning their livelihood convenience of meeting at requisite time was important for communication and counselling as well as immunisation or pulse polio drives which sometimes required door to door visits (Government of India, 1982:1-5). Further on, National Health Policy came into being in 1983 which laid emphasis upon the goal of health for all by the year 2000. There was a need for reorganisation of the health care infrastructure accompanied by revamping of education and training component of medical and health personnel. With the adoption of a National Health Policy in 1983, the 73rd and 74th Constitutional Amendments devolving power to local institutions in 1992, the National Nutrition Policy in 1993, the National Health Policy 2002 and the National Policy on Indian System of Medicine and Homoeopathy and Drug Policy in 2002 articulated the issue of good health which could be possible by delivery through the decentralised health system (Government of India, 2002:21). A recent attempt by the state was the national common minimum programme which has urban infrastructure, water, health, employment agriculture etc. as priority areas. To follow certain policy guidelines government has brought national rural health mission so as to provide better health care at primary level and achieve universal health coverage (UHC) in the villages (Sahoo, 2010:499). (For further reference on Health committees see annexure: 1).

SECTION II

2.3 POLITY, SOCIETY AND HEALTH

In order to comprehend the domain of health it is important to throw light on the discourse between polity and society which is ever evolving and undergoing a change. For a society to be termed just, democracy and development should go hand in hand. The Indian state after its formation was largely driven by force of socialism along with
British Fabianism. The state on its part was providing free social services based on three pillars enshrined in the constitution that of rights, entitlements and social justice.

Taking these into consideration the state prompted a large number of welfare functions by adopting a set of fundamental rights which provided sense of equality and liberty to its citizens. At the same time the set of the directive principles of the state policy had provisions for the welfare of weaker sections in terms of poverty alleviation and health care (Sahoo, 2010: 490).

The political institutions must ensure proper delivery of resources which is essential for progress of society. The political eras through which country has passed over a period of time has been of mixed ones with initial euphoria of Nehruvian era followed by gradual decline in years to come. The Indian leadership tried to achieve objectives linked with national integration and economic development where the state was guided by welfarism along with public sector led industrial development (Sharma, 2013: 170).

After India’s independence two approaches have been recognized: one was of community development programmes. The issues of nutrition and environmental sanitation have been underlined not only for individuals but also for community at large. The key steps which have been taken included initiating education on nutrition and sanitary issues, creation of women instructors for carrying out family planning activities and child welfare measures. It also involved creating workforce for paramedical work. The other approach was technocratic model governed by the state build enterprises. Its three embodiments have been industrial growth, scientific development supplemented by higher education. The socialism encouraged by Nehru had its reflection in cohesive policy followed by him for betterment of public sector in comparison to private sector. A Nehruvian model of development followed the inward economic path (Nayyar, 2007: 30 and Ramasubban, 2008: 95-96). In line with this argument the government got aid from bilateral and multilateral agencies to carry out immunisation campaigns. It was anticipated that any political and economic development can be possible only when endemic diseases are eradicated. For Nehru the principle of modernity was linked to state making and the state was identified as main
instrument of change. It was largely thought that there was a need to rebuild the social structure to overcome social inequalities and out-of-date value system. For this very purpose article 37-51 and 55 revealed the state obligation for public health, justifiable delivery of produces and right to beneficial employment. The directive principles were seen as instruments to foster the idea of economic democracy and social justice.

The Constituent assembly on 20 August 1947, brought three lists with the set of entries for each. The central list had 87 subjects, the state list had 57 items and the concurrent list 36 entries. The concurrent list eventually falls in-centre perview. Health was declared a state subject. However article 229 was inserted as a tool by the centre to pass on the state matters with the agreement of a particular state (Hewitt, 2008:43-50).

In reality the state and society relationship at provincial level was facilitated through local elites from dominant sections of society. In politics and bureaucracy they had their say which often led to circumstances in which reformist plan was often appropriated by middle classes (Ibid., 2008:67). It has been observed that the social elites manipulated with utilitarian reforms to such an extent that the genuine recipients were excluded from the whole process in spite of the state intension to deliver to the masses. The state and society relationship was covered by multiple layers of power structures which varied from place to place. The state policies of social redistributive justice required creation of new institutions so as to empower locals which led to contestation between various groups. Thus new pattern of cemented hierarchies emerged where economic and religious cultural forms were exhibited. On the whole the state policies were concerned with subsidies in agriculture or industrial development. Hence social sector was largely ignored in early years of independence (Hewitt, 2008:71-72). This was further taken up by Indira Gandhi though she slowly wavered from this approach as the international economic environment had greater influence upon her (Nayyar, 2007:30). Mrs. Gandhi alleged that the state had failed on socio-economic front because of vested interests of political parties at the regional level. As a result she encouraged more vigorous involvement of the government at the central level. She lamented that the state led bureaucracy had often over looked the interest of the poor sections (Hewitt, 2008:84).
By 1969 Indira Gandhi went all the way to appease poor sections of the society by initiating 10 point programme along with nationalization of banks as one of its poll planks. In 1971 Indira Gandhi raised the slogan of *Garabi hato* as an ideological weapon to get people vote. In order to give credibility to the core brought the state commitment for the welfare of poor as confined within directive policy. For improvising the socialistic credentials of congress party a 20 point programme was also pursued with great vigour and determination (Hewit, 2008:128).

During emergency forcible policies on family planning have been followed against weaker sections and minorities living in slums of New Delhi promising those who underwent vasectomy with certain incentives. The criminalization of politics during this time period brought in issue of how to remain in power without delivering. Thus governance system was weekend to a great extent (Chaplin, 2011:61). By the early 1980s there was an attempt to make paramedical workers into multipurpose health workers. They were trained to carry out vertical campaigns in eradication of diseases or meeting out family planning targets. The essence of integration in Indian sense was equated with various kinds of health carrying work much to opposite of international concept of integration which wanted health to be part of developmental agenda. Moreover lack of coordination at unified ministerial levels was often taken as hindrance towards improving health care goals (Hammer *et al.*, 2007:4053).

By 1982 Congress started promoting private market oriented strategies which were further adopted by Rajiv Gandhi. The national government failure to address the needs of the poor often led to populist measures adopted by regional level governments to gain popular votes in state elections. This altered the conditions of urban infrastructure which further deteriorated often affecting further who have been living in slums. Technocracy was given precedence over mass politics as a result of which the government did not pursue any substantial public policy. Moreover central initiatives often lacked orientation due to ignorance of specific local and regional dimensions (Hewitt, 2008:169-173).

Later on Rajiv Gandhi brought in private sector to the core of the economy. The liberalisation was finally introduced by Narshima Rao administration (Nayyar,
However the post 90's pro-liberal logic has greatly halted welfare measures. In fact some scholars have stated it as demise of socialism in Indian politics. The class character of the state is pro rich as it facilitates neo-liberal logic so as to create wealth for the elites at the cost of the poor. The reforms have led to the emergence of two India's: one ushering an era of content and happiness the other of dismay struggling and despair among the poor (Sahoo, 2010:494).

Under Atal behari Vajpayee when National Democratic Alliance (NDA) came to power the proposal was mooted to create AIIMs like facilities in six states that is Orissa, Bihar, Uttaranchal and Rajasthan, Madhya Pradesh and Chhattisgarh at the second Pravasi-samelan in New Delhi by then the Union minister for health Smt.Sushma Swaraj she retreiated that the government was bound to provide quality health care (http://www.rediff.co.in/news/2004/jan/10pbd4.htm:NP). A committee was constituted under the chairmanship of R.A. Mashelkar which recommended serious penalties for those who manufactured spurious drugs thus harming the health of citizens. Even, National Health Policy 2002 was launched which dealt with achieving appropriate standards of health for general population. This policy document tried to cover all aspects related to health care from outlays to delivery mode and to health care of women (Government of India, 2002:7-11). Even political parties like Bhartiya Janta Party came along a long way to identify with underprivileged but in reality what it had done for the poor was far from reality as its slogan of India shining was middle class oriented rather than having anything for the poor (Chaplin, 2001:63). Thus health sector was prioritised as required by various political leaders and their regimes. International organisations like World Health Organisation have defined health “as a state of complete physical, mental and social well-being not merely absence of disease or deformity.” The state has legitimate role to protect poor urban residents from adverse situations which occur because of change in economic forces operating at market level (Nayyar, 2007:23).

Apart from this developing countries have initiated a series of reforms related to the health sector. In order to prevent the onslaught of infectious diseases which have been responsible for higher mortality rates among the infants, mother and population in general health related measures similar to immunisation programmes have been carried
out. To focus on public health issues support from other ministries have been acknowledged from time to time for instance water supply, sewerage, sanitation, and drainage etc (Ramasubban, 2008:87).

The health system functioning has not been spared by over indulgence of bureaucrats and politicians which has been a regular feature of governance since 70s. The health system suffers from administrative unconcern as issues of accountability, efficiency and quality have led to poor services. There has been overall decay of public health as inter-sectorial programmes are being run by different ministries at the central level (Ibid.:96-97). Upto some extent the capabilities of Indian state to distribute resources have been hampered by the proprietary classes such as bureaucrats, politicians, big businessmen and rural elite. These groups have tried to capture opportunities as well as patronage from the government. The resources meant for social development and other programmes have declined due to ever-increasing subsidies, concessions etc. (Sharma, 2009:359). This fact has been highlighted ever by Atul Kohli in his work "The State and Poverty in India". The process of liberalization having economic fare brought in the federal market economy replacing the Nehruvian model of socialist development (Ibid.:363). Sahoo has pointed out that over a period of time there has been a gradual decline in social expenditure meant for social development (Sahoo, 2010:490).

2.4 PLANNING AS AN EXERCISE

In India planning as an exercise has been taken up so as to create socialistic pattern of society. The setting up of planning commission brought into focus how far financial mechanism can be used to pursue national health concerns. In planning commission decision making has been in the hands of economists and bureaucrats. The medical professionals and its pressure groups did not have full participation as stakeholders in achieving health goals. The bureaucrats often adhered to decisions made by international circuit of elite medical professionals. They have been the ones who often quoted appropriate models of health care but have been too ignorant about health structure in the actual working sphere. The international funding mechanisms have been technical exercises often executed in concrete reality (Hammer, 2007 :4053). Under the
public health provision factors such as clean water, sanitation accompanied by immunisation coverage along with gender relations influenced child mortality. The Indian state on its part tried to eradicate diseases like smallpox, cholera, malaria, blindness etc. Planning has largely helped in creating primary health care services instead of large multi-purpose hospitals. After Independence, the national family planning programme was entirely funded by the centre which started off in the year 1952. On the recommendations of smallpox and cholera committee in 1958 national smallpox eradication programme came into existence which led to hiring of 20,000 vaccinators for this purpose. In 1983 the Government of India announced the National Health Policy. In order to understand the institutionalization of health programme one has to glance at the planning process to decipher the situation (Sagar, 2006:18-19). The urban sector is a state subject but very less initiatives has been undertaken by the states on their own. All policy pronouncements at the central level have been largely followed. The health policies have emerged in its present form because of two reasons: one by following the colonial legacy which underwent a change in the 80’s along with coming of the 74th amendment act giving more power to local bodies to manage urban affairs. Secondly raised aspirations of the middle classes to be served better by the municipal authorities. The urban policy focus has been on larger metropolitan cities whereas small towns have largely left out which are growing on their own (Shaw, 1996:224). The modernist ideas have been part of the policy due to the participation of planners and architects for creating a better urban environment. Urban issues came in limelight through the process of institutional hold up during second five year plan. The third plan went ahead with the notion of balanced development between various categories of towns as well as between rural and urban areas. For converting these issues into reality, planning legislations along with master city plans have been propagated. However planning exercise had its pitfalls as in order to create ‘good cities’ for a small group of elites masses interests had been largely ignored. The plans also brought into attention the issue of financial buildup for corporations. This was ensured by way of levying taxes and stamp duties on land transactions in the cities (Ibid.:226).

Slums have been prioritized as early as 1972-73 when, Calcutta Municipal Corporation allocated 40 crore to develop slums and later on the government at centre
level intiated a programmes at providing minimum services in slums of 11 cities having population of eight lakh and above.

In the seventh plan the community participation and the need for private initiatives to cater to the basic services has been emphasised (Shaw,1996:228). The poor people residing in slums faced neglect at the hands of bureaucracy in various capacities. It has been observed that the state health budget are largely used by the non poor, even if it is meant for the poor it hardly reaches them through the health providers at primary level (Devarajan and Shah, 2004:909). The well functioning democratic society does not ensure that the poor get benefits of better services. The poor may not be aware about the services meant for them. The public issues may not dominate during voting and they may vote just on caste or class lines. Sometimes politicians ignore its constituency’s minorities making them to run for their money because of discrimination (Ibid.:912).

Hence it was only after the eighties that the government looked at health through human angle and not merely an indicator related to basic statistics of population and health. It has been aptly reflected in a series of changes in policy documents, intentions and the multiple sector approach which has been followed till now.

Thus the government through its five year plans has given priorities to various sectors like health and urban affairs. However, the policies are oriented towards being mere incremental programmes without taking into essence the social, political economic concerns behind their making. In India policies are meant to be just stop gap arrangements (Shaw,1996:224). (See annexure:1 for further reference about health within planning perspective).

**SECTION III**

**2.5 PRESENT SCENARIO OF HEALTH SECTOR AT NATIONAL LEVEL**

India is having a federal structure whereby the constitution of India allocates social services to the respective states who in turn are helped by the centre in terms of provision for economic services. However there are regional variations in terms of provision for basic services as revenue generation varies across the states. This issue of
imbalance assets is resolved by the centre in the form of specific grants which are given to the states in running centrally sponsored health programmes, even planning commission makes state plan schemes to tide over the fiscal imbalance. It is the responsibility of the state government to provide health services, as per the state list in the seventh schedule. The states handle health services such as public health, sanitation, hospitals and dispensaries whereas issues of population control and family planning (entry 20A) mental deficiencies and lunatic treatment under entry 16 fall in the gambit of the concurrent list. All institutions of national importance are run by the central government (Rao, 2012:5).

2.5.1 Basic Indicators of Health

Infant mortality rate (IMR) stood at 47 per 1000 live birth in 2009 and maternal mortality ratio (MMR) has been found to be 212 in 2007-2009. Other health indicators show that more than 68.4 per cent of expecting mothers had undergone three antenatal check-up from mere 49.8 per cent as in 2007-08. The percentage levels in the case of institutionalised delivery have increased from 47 per cent to 72.9 per cent. The per cent of fully immunised children increased by five per cent from 54 to 61 during 2008-2009. The IMR declined from 58 in 2005 to 44 per 1,000 live births in 2011 while MMR declined from 254 in 2004-06 to 212 per 100,000 live-births in 2007-09 and TFR from 2.9 in 2005 to 2.5 in 2010 (SRS bulletin, 2012a:NP). About 28 million pregnancies occur along with an estimated 56,000 maternal deaths in India every year. There is need to overcome the regional disparities that exist in the country with the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa and Assam contributing to more than two-thirds of the MMR burden. Thus starting of NRHM paid dividends, as there was a decline of 37 per cent in the annual rate of IMR from 2005 onwards till 2011. Similar trends have been witnessed in MMR levels 22 per cent between 2005-2008. While higher rate of decline has been noted at TFR levels i.e. 47 per cent between 2005-10. In 2009, immunisation against vaccine-preventable diseases among one-year olds for BCG immunisation coverage stood at 87 per cent, polio 67 per cent, measles 71 per cent and Diphtheria, Tetanus and Pertussis 66 per cent respectively. Inspite of these intiaitives there are huge inter-state disparities which can be found in health status as in case of Kerala (74 years) and Madhya Pradesh.
(56 years) is an average life expectancy. Thus there is a gap of 18 years with regard to life expectancy. (See annexure:1 for further reference about basic health indicators).

In 2010, there have been 2.3 million cases of TB have been in India. The number of HIV infected persons have been 2.5 million. Every year more than 1.5 million malaria cases are reported and occurrences of acute diarrhea have been found to be a major problem among children below five years of age. Diseases like dengue and Chikungunya have recently emerged due to malfunctioning of our public health system. Large number of diabetics cases have been reported which is a major cause of blindness, kidney dysfunction, heart attacks and amputations. The per centage of pregnant women who experienced delivery and post-delivery complications have been 61 per cent and 35 per cent respectively in 2008. Only about 18 per cent of women received full antenatal care. A target of 25/1000 for IMR and MMR requires improvement i.e. 100/100,000 live births for MMR has been prescribed by the 12 Five Year plan document by the end of 2017 (Government of India.2013c.Ministry of Health and Family Welfare:NP).

*The State of the World’s Children* 2012, which reflect the malnutrition status in different countries of the World. The underweight children under five years in India have been 43 per cent. In Asia they have been 27 per cent, in Africa 19 per cent and 20 per cent in sub Saharan Africa. In world there have been 16 per cent children who are malnourished below five years of age. India ranked 67 out of 84 countries in Global Hunger Index 2010. Child health is a serious issue as 42 per cent of the world’s stunted children reside in India and under-nutrition affects about 22 per cent of population and these issues have been related to the Millennium Development Goals (MDGs) 4 and 5. This constitute other major challenges the government has to met within stipulated time period.

The National Family Health Survey-3 (NFHS-3), 2005-06, points out that in India 42.5 per cent children under 5 years have been underweight and 69.5 per cent have been anaemic. The report entitled *Infant and Child Mortality in India-Levels, Trends and Determinants* published by NIMS-ICMR and UNICEF recently reveal that 188 children under-five have been dying every hour in India and the country witnessed
16,55,000 deaths of under-five children in 2011. The states of Punjab and Himachal Pradesh in North India, Kerala and Tamil Nadu in the South, Maharashtra in the West, West Bengal in the Eastern part of India are likely to achieve MDG-4 target of U5MR below 39 by 2015. The key socio-economic determinants does have a bearing on Infant and child mortality rate. It has been observed that Infant mortality rate among children born to illiterate mothers has been consistently higher than those born to mothers with some education. The woman having more than twelve years of education have lower rate in comparison to those who have been illiterate(Government of India. Ministry of Woman and Child Development, 2013d:NP).

All the above stated issues have a high cost in economic terms. The economic loss amounted to US$ 53.8 billion per year, which was roughly 6.4 per cent of India’s GDP in 2006 and equivalent to US$ 48 per person per year (Government of India, 2012c:17-22). Human development report 2013 reveals Indias ranking as 136 on Human development Index. The per centage of urban population was 31.6 per cent based on 2011 census. On this basis India ranking was 161 out of 194 Nation States. On the issue of public spending on health which was 1.2 per cent of GDP. India ranked 182 along with two countries i.e. Bangladesh and Azerbaijan. This ranking was based on health spending’s which have been available for 190 countries. (for further reference see annexure: 1 about basic health indicators).

2.5.2 Financial outlays on Health Sector

The Indian State commitment to overall well being of its citizens gets reflected in budget 2012-2013. Priorities have been well defined as Ministry of health and family welfare has been allocated Rs. 37,330 crore, from this total amount Rs. 21,239 crore has been meant for new national health mission which combines the existing rural mission with proposed one Urban mission, thus there is an increase of 24.3 per cent over the revised estimates. An amount of Rs 4,727/- crore has been kept for medical education, training and research. Similarly Rs 1,069/- crore have been allocated for AYUSH (Ayurveda, Unani, Siddha and Homeopathy). To safeguard the health of the aged population, National programme for the health care of the elderly is being implemented in 100 selected districts of 21 States. For this very purpose Rs 150/- crore has been
allocated for eight regional geriatric centre’s so to develop as departments. Further to provide the best level tertiary care to Indian citizens in various parts of the country six AIIMS-like institutions have been started. The hospitals attached to the colleges would be functional in the 2013-14. A sum of Rs 1,650 crore is being allocated for these institutions(http://budget.nic.in:NP).

2.5.3 Health Sector Initiatives

The latest initiative is the High Level Expert group (HLEG) on UHC constituted by the Planning Commission of India in October 2010. Within the 12th year plan health has been examined by using wider perspective that entails issues related to nutrition, food supply and determinants of health. The government initiatives in providing basic services is reflected in figures as population having access to drinking-water sources has increased from 72 per cent to 88 per cent. With respect to Urban this per centage has increased from 90 per cent to 96 per cent. The figures for sanitation for the year 2008 show that there has been marginal increase in per centage levels from 49 per cent to 54 per cent. The issue of poverty also emerges as one of determinant of health as 42 per cent of population by 2005 was living on less than US$ 1.25 a day purchasing power parity. Thus health systems need to be understood along with these concerns especially taking into account inter-sectoral actions, along various dimensions be finance, manpower and services rendered keeping in mind the expectations of the citizens which are often sidelined (Government of India, 2012c :5).

A nation-wide Information, Education and Communication (IEC) campaign has been launched against malnutrition by President of India at Vigyan Bhawan on 19th November 2012. Ministry of Woman and Child Development through its extensive coverage is providing breast feeding which is essential for infants and young children to reduce infant mortality. In order to improvise child rearing practices Village Health and Nutrition Days (VHNDs) are being observed. In order to incorporate “Health for All” not mere as rhetoric but functional aspects the government had underlined following measures such as Scaling up of public expenditure on Health, Focus upon strengthening the primary health care, Availability of free generic medicines in public health
institutions. Further expansion of human resources for health by setting up more medical colleges, nursing colleges and Para-medical institutions, and Strengthening the drug regulatory system within the 12th Five Year Plan period. (Government of India, 2012d. Ministry of Women and Child Development:NP). In fact all these programmes are being constantly monitored and assessed through multiple monitoring mechanisms (Government of India, 2012e. Ministry of Health and Family Welfare:NP).

Apart from MCH care services along with UIP programme which have been discussed above certain other measures have been underlined in the 12th Five Year Plan so that people can have access to a defined essential range of medicines and treatment at an affordable price. These include health services for adolescents which include components of Adolescent Reproductive and Sexual Health (ARSH) Clinics, WIFS (Weekly Iron-Folic Acid Supplementation with deworming).

The state has evolved measures to combat communicable diseases such as Malaria, Kala-azar, filarial, Dengue, Japanese Encephalitis and Chikungunya, Tuberculosis and Leprosy etc. Three key issues are involved with regard to communicable diseases: one is that of control, followed by free investigation and treatment. In case of non-communicable disease: cataract surgery for blindness control, along with the free cornea transplant, glaucoma/diabetic retinopathy and free spectacles for children are some measures. Apart from these carrying out family planning activities comprise free services providing information, giving contraceptives and other family planning interventions. The Mother and Child Tracking System (MCTS) have been put in place to reach out to every pregnant woman for proper care during pregnancy and to every child for proper vaccination. Under this system data entry of more than 3.5 crore women and 2.7 crore children has been done so far (Government of India, 2013b:NP).

The funds allocated under the National Health Mission and Family Welfare for the 12th Five Year Plan is Rs. 193405.71 crore, which inter-alia includes the following categories. It is important to describe and analyse the initiatives at the state level. Hence government has prioritised health issues by initiating schemes/programmes that includes the Integrated Child Development Services (ICDS), National Rural Health
Mission (NRHM), Mid-Day Meal Scheme, Rajiv Gandhi Schemes for Empowerment of Adolescent Girls (RGSEAG) namely SABLA, Indira Gandhi Matritva Sahyog Yojna (IGMSY) as direct targeted interventions. Besides, indirect Multi-sectoral interventions include Targeted Public Distribution System (TPDS), National Horticulture Mission, National Food Security Mission, Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), Nirman Bharat Abhiyan, National Rural Drinking Water Programme etc. Thus nutrition is the foremost issue which is complex, multi-dimensional and inter-generational in nature. It cannot be resolved single-handedly.

Apart from the above stated initiatives, social and economic determinants of health like drinking water, sanitation, nutrition, education, women empowerment, poverty etc. are important to reduce infant and child mortality which are being taken up by different ministries (Government of India. Ministry of Health and Family Welfare, 2012b:NP).

The delivery of health services in India is by both the public sector and the private sector. However, contesting issues related to health care remain as such in spite of various initiatives both taken at the state and the central level. In spite of all these processes of elaborate planning and health programmes what we achieve is reflected in W.H.O report 2005 which gives dimension of health scenario of India in relation to China, Indian government spends 4.8 per cent expenditure as part of its GDP on health. The corresponding figure for China is 5.8 per cent (World Health Organisation 2005, Government of India.2008.: 66-70). Government role is important not only in providing health care but also regulating it. The governments in low income countries spend half of what is actually needed to be spent i.e. they spent 27 instead of spending US$ 54 as per the study by Stenberg and others in 2010. The National Commission on Macroeconomics and Health identified the “unfinished agenda” of health care by insisting upon enhancing government expenditure. The present estimates show that centre and states combined allocation to health sector is mere four per cent of total public spending. The country's per capita health spending was US$ 45 in 2009 which also remains among the five lowest in the world. The key areas which are to be addressed include financial outlays meant for medical, public health and family welfare.

Within the framework of Indian Constitution, in directive principles of State Policy stress is laid upon ‘improvement of public health’ which is primary duty of the
State. During the Eleventh five year plan very less amount has been spent on health, one (1) per cent of GDP. There is a high variance in the quality of service available in the public sector. On the other hand, large number of patients come from abroad to seek health care at private institutes and hospitals.

The emergence of any form of illness especially among poor strata leads to higher out of pocket expenditure which is equal to or greater than 40 per cent of a household’s non-subsistence income (Government of India, 2012c:6). The high out of pocket expenditure on health reflects low level of public spending on health which ultimately affects the poor people. This is four times higher than what is spent in public arena (Rao, 2012:1-4). In fact the question of affordability in terms of medicines is a challenge for many in India. About 71 per cent of the citizens have been forced to pay high out-of-pocket payments. About 72 per cent of private expenditure on health goes on medicines alone. Thus government has taken major decision to distribute of free generic drugs to patients seeking healthcare in public facilities which can only bring down out-of-pocket expenditure hence making public healthcare affordable.

The private sector has been playing a prominent role in relation to participation of man power and infrastructure related services within the health sector. It has been estimated that 80 per cent of doctors, 26 per cent of nurses, 49 per cent of beds and 78 per cent of ambulatory services and 60 per cent of in-patient care comes through the private sector. Thus a stronger health care delivery initiative by the government in binding these private players along with public intuitions is necessary for meeting the health goals (Government of India, 2012c:15). The National Health Accounts study carried out in 2009 revealed that those who seek health care at government facility often spend money to buy medicines from pharmacies, has to pay for laboratory tests and often face the persistent informal fees. Financial constraints had the bearing on health care as about twenty per cent people in urban areas did not access health care. As per NSSO study health Infrastructure and manpower constraints also affect delivery of services. It is somewhat better in urban areas than in rural areas (1.3 versus 0.39 doctors, 4.2 versus 1.18 total health workers, 1.59 versus 0.41 nurses and midwives). For instance at infrastructure level (0.6) hospital beds per 1,000 inhabitants are available. However the lack of clinical and maintenance/support staff, which makes
nearly 50 per cent of beds in the public sector is non-functional. It is estimated that 15,097 hospitals i.e. 68 per cent and 6,23,819 total beds i.e. 37 per cent in the country are in the private hospitals often located in urban areas (Government of India, 2012c:9-14).

While delivering his speech at FICCI organized seminar on the theme, *Universal Healthcare: Dream or Reality* 28-August-2012 the President stated that at the National level, *the estimated economic loss for India due to deaths caused by all the diseases in 2005 was 1.3 per cent of its GDP as per WHO study. With an increase in the number of non-communicable diseases, this loss is apprehended to increase to 5 per cent of GDP by 2015 if it is not checked. Therefore, a healthcare coverage that assures access to medicines and treatment at affordable prices is an objective, essential for the full utilization of the human resource capacity and one to which India is committed to achieve* (W.H.O,2005:NP).

Government plans to enhance expenditure on health from the current level of 2.5 per cent of GDP by 2017 i.e. the end of 12th Plan and 3 per cent by 2022 i.e. at the end of 13th Plan. From pharmacists to the doctors, from industry to drug manufacturers, from medical insurance to management of hospitals and running of primary health centre’s, all have a role in the success of the health system. Health coverage has to follow curative, interventionist as well preventive approach in healthcare. This is equally important as the number of those suffering from diabetes and cardio-vascular diseases have been on the rise in indian society (Government of India, 2012g:NP).

2.6 GAPS IN HEALTH AGENDA

2.6.1 Public Spending on Health

Some of above the stated problems could be linked to India’s public spending on health. India spends less than one per cent of its GDP on health. Its neighbouring countries like Sri Lanka spends 1.8 per cent of GDP, figures for China are close to 2.3 per cent. Among European nations prominent being UK, Spain, Germany, Italy, they spend 6.5-8 per cent of their GDP on healthcare. America has one of the highest spending above seven per cent. These differences become more obvious once per capita indicator is taken as the marker of health spending. India spends US$43 per head,
whereas its counterparts like Sri Lanka invest US$87, and China spends US$ 155 respectively (Anonymous, 2012a:NP). The World Health Statistics 2012 by World Health Organisation (WHO) reveals similar story that the per capita total expenditure on health for India is US$ 44 (at average exchange rate) as compared to total expenditure on health in respect of some select developing countries. Thus this has a bearing on health care outcome of respective countries.

For health to be linked to overall socio economic development, former PM of India Manmohan Singh stated that the total government health expenditure should be to tune of 2.5 per cent of GDP by the end of the Twelfth Plan. At present juncture it is 1.4 per cent. However, health being a State subject the outlay’s by respective states would be crucial for achieving this in reality. He underlined at the National Conference of the Jawaharlal Nehru National Urban Renewal Mission on December 2009 that 21st century for most of the developing countries, will bring in change from a primarily rural to a mainly urban economy. This change which has been at slower pace in case of India but will speed over the next 20 years, the urban population might well double. In order to face this challenges concrete measures need be adopted within governance structure at every level in an efficient and coordinated manner (Government of India, 2009:NP). For this very reason government on its part has initiated JNUURM whose main focus has been providing basic services like water supply, sewerage, drainage, solid waste management, improvement of slums and construction of houses for the urban poor. To carry out this endeavour Ministries of Urban Development and Housing and Urban Poverty Alleviation have approved projects for which the Central Government has committed assistance of Rs 55,625 crore and buses for urban transport worth Rs. 1,03,462 crore (Government of India, 2013a:NP.). However to carry out JNNURM municipal reforms must be put in place across cities. At the same time measures should be effectively introduced so as to improve the financial health of our municipalities. However this has not occurred in cities like Amritsar due to corrupt practices and lack of political will by the Municipal corporation in case of Amritsar city (Sharma et al., 2012:101-102).

Some amount of critical insights have been given by noted academicians for various maladies which affect our health system and basic infrastructure in cities. At
Indian Science Congress which was recently held at Kolkatta in February 2013. The former Prime Minister Manmohan singh reiterated that India’s future largely depends by overcoming the principle of social exclusion which could be possible only through enhanced growth in basic social services, such as health and education for all. These changes must be accompanied by food, energy, security and growth in the Indian economy (Government of India, 2013a:NP).

Amartya Sen mentioned that half of Indian households do not have toilets and of half of India’s children being malnourished. *India is the only country in the world that is trying to have a health transition on the basis of a private healthcare that doesn’t exist.* The State of public health care is much precarious that 80 per cent of the population is forced to seek private health care while delivering a talk at the Kolkata Literary Festival (Singh, 2013:Indian Express). According to a former director-general, National Council for Applied Economic Research stated that public health services component within national health policies have been sidelined.

The undue emphasis on single-focus programmes has eroded away the very essence of public health systems. These programmes had their genesis from malaria eradication programme launched in the year 1958. The intentions have been good but over a period of time restricted government approach to identify public health programme with these diseases based programmes only. The state governments must re-start separate services for public health having distinction from medical care, each with its own budget and workforce. At national level initiatives taken by the state of Tamil Nadu can be implemented. In Tamil Nadu separate directorate of public health represented by professionals and public health managers. These managers have first hand experience of working in both the rural and the urban areas. Moreover with its own budget, and with legislative underpinning they are able to work better in an independent manner. This public health system comprises of workforce which includes both non-medical specialists and labourers (Rao,2010:NP).

2.6.2 Shortage of Manpower

Even at times the human resources meant for health care are lopsided as often new graduates end up in private sector. The bureaucratic hurdles at the senior level
force large number of practitioners to leave government practice and look for other alternatives. According to an official’s working as director of NRHM stated that “MBBS graduates are clearly not interested in rural areas (Mudur, 2010:NP).

The shortage of manpower in health sector is one of the main reasons for dismissal health indicators. This was stated by Parnab Mukherjee President of India while addressing the convocation of King George Medical University (KGMU) Lucknow. He stated that there have been only 1.9 health workers in India per 1,000 persons. The density of doctors in India is only 0.6 per 1,000 persons and that of nurses and midwives is 1.3 per 1,000, thus this scenario depicts acute shortage of healthcare professionals (Anonymous, 2012b:NP). Similar accounts have been given by Dr Samlee Plianbangchang, WHO’s Regional Director for South-East Asia. He was of the opinion that “Countries in the South-East Asia Region have mere 23 health workers (doctors, nurses and midwives) per 10,000 population which is considered the minimum health workforce needed to achieve 80 per cent coverage of essential health interventions. He stated that lack of access to health-care providers was more adverse in the South-East Asia Region than in African Region of WHO (Government of India, 2012c:NP).

2.6.3 Policy Issues

However, a lot needs to be done as certain programmes could not start reasons best known to the government officials. The issues related to universal health coverage, free supply of medicines in government facilities and National Urban Health Mission have been the prominent ones. The regulatory bill cannot be implemented due to technical glitch as the parliamentary standing committee on health returned it seeking redrafting for inclusion of all stakeholders on board and providing sufficient powers to existing regulators. Similar instances have been observed with regard to bill on the National Commission for Higher Research in Health (NCHRH) which was proposed in the wake of corruption in the MCI and other health sector regulators.

In order to replace Mental Health Act of 1987 a bill was prepared on mental health which could not be passed as there have been reservations on the part of social justice ministry and disability rights activists as the present bill was against the very spirit of UN Convention on rights of persons with disabilities which India has ratified in
October 2007. The states on its part failed to address the issue related to unregulated clinical trials by pharmaceutical giants.

On disease front in order to confront higher deaths due to dengue and Japanese encephalitis the cabinet passed a comprehensive plan involving crores. There have been 227 cases of dengue related deaths in 2012 in comparison to 110 deaths in 2011. The central government has introduced national pharmaceutical pricing policy and made a listing of 348 essential drugs under price control paving way for cheaper drugs (Anonymous, 2013:NP). All these regulations do convey state intentions to improvise health of its citizens.

For proper functioning of health care system steps have been taken during twelfth five year plan to prepare suitable public health cadre. To oversee the overall functioning of the health system human resources need to be recruited. There is an effort on the part of the state to merge all existing schemes under NRHM by 2013-2014. Other measures which can ameliorate the existing health system include passage of The Clinical Establishments (Registration and Regulation) Act, 2010 and setting up of National Centre for Disease Control whose main aim is to strengthen Public health laboratories (PHL) at District and State level (Anonymous, 2013:NP).

SECTION IV

2.7 HEALTH SECTOR SCENARIO AT PUNJAB LEVEL

The first sub section of this section deals with the organisational structure of health care system. This have been divided into four levels as it is there in other states of India. The second sub section of this section describes the overall performance of National level health programmes. The third sub section provides a detailed description of health services which are available in Amritsar city. It brings into account the working of public health care and private health care facilities. Thus the prevailing ground realities have been explored with regard to the working of the satellite hospitals in sample slums of Amritsar.
2.7.1 Government Level

The state Department of Health and Family Welfare, under the Ministry of Health & Family Welfare, guides and supervises the Health and Family Welfare Programmes in the state. The overall responsibility for running the administration and implementing the programmes lies with principal secretary to the government, Health & Family Welfare department. To carry this load of work the principal secretary is given assistance by three secretaries, one joint secretary and one under secretary.

2.7.2 Directorate Level

At the Directorate level, the programmes of Health & Family Welfare are implemented, supervised and co-ordinated by the Director of Health and Family Welfare. In the year 1991, a new Directorate of Social Insurance was set up for the implementation of the ESI (Medical benefit) scheme. There are three Directors i.e. one Director Health Services, one Director Family Welfare and one Director ESI.

Various Health and Family Welfare Programmes are looked after by one Additional Directors, two Joint Directors, seven Deputy Directors including Malaria, one Joint Controller (F&A) and a number of other officers belonging to various specialties.

STRUCTURE OF HEALTH CARE SYSTEM IN PUNJAB

Source: http://pbhealth.gov.in
2.7.3 District Level

At the District level the Civil Surgeon is in charge of the health activities. Each Civil Surgeon is supported by a team of programme officers designated as District Family Welfare Officer, Assistant Civil Surgeon, District. Health Officer, District Immunisation Officer, District TB/Leprosy Officer. In addition, other officers like Mass Media Education and Information Officer, Assistant Controller (F&A) etc. also join hands to implement various programmes.

2.7.4 Block Level

At the block level, Senior Medical Officer is in charge of the Primary Health Centre. He is assisted by one of the two Medical Officers, one male and one female. Dental Surgeon is also part of the Health Management in some of the block level PHCs. Multipurpose Health Supervisor (Male), Multipurpose Health Supervisor (Female) and Block Extension Educator assist them to supervise the delivery of health services at the peripheral level where Multi Purpose Worker (Male) and Multi Purpose Worker (Female) provide services of primary health care to the people, on their door-steps.
2.7.5 Primary Level (Preventive & Curative Care)

- **Sub-Centre:** There are 2951 Sub-centres (each for a population of approximately 5000 manned by one Male and one Female Health worker). This is the first contact point with the masses. The manpower deployed there supports in implementation of following programmes given below:

  (i) Universal Immunisation Programmes (TT for pregnant mothers, BCG, DPT, Polio, hepatitis-B & Measles).

  (ii) Maternal & Child Health (Antenatal Check up, Institutional Delivery & Post Natal Check Up).

  (iii) Family Planning: Counselling/Motivation,

  (iv) Management of diarrhea especially in infants.

  (v) Health Education i.e. educating the community about the various available services.

  (vi) Control of Acute Respiratory Infection especially in infants.

  (vii) Identifying women requiring help for medical termination of pregnancy and refer them to the nearest approved institution.

  (viii) Health Survey.

- There are 1186 Subsidiary Health Centres/Dispensaries, each for the population of 10,000, having staff of one Medical Officer, one Pharmacist, one Sewadar and one Sweeper. Through these institutions, all the above programmes along with curative health care (OPD) are being implemented.

- There are 432 Primary Health Centres for every 30,000 population having staff of one Medical Officer, one Pharmacist, one Staff Nurse, one Laboratory technician, one Sewadar and one Sweeper. Four bedded institutions providing curative and preventive health care.

- There are 143 Community Health Centres for every 1,00,000 population with bed strength of 25/30 beds PHC/CHC providing promotive, preventive and curative health care (http://punjabgovt.nic.in).
2.7.6 Secondary Level (Curative Care)

Under Secondary Level health care services, all types of curative treatment for various diseases is provided. All types of surgeries and other interventions are being carried out apart from by-pass and transplantations, which are being carried in the tertiary level institutions (Medical Colleges). In these institutions, all the preventive health care services and other disease control are being taken care of.

- 62 secondary level hospitals in the state
- There are 22 District Hospitals having bed range of 50-400 beds, these hospitals are situated in all the districts.
- There is one Special Hospitals for Children in Bathinda having 100 beds.
- There is one Special Mental Hospital at Amritsar having 400 beds, which has been reconstructed recently and is functioning under the name & the style of “Institute of Mental Health” Amritsar.
- 39 Sub-Divisional Hospitals are there having bed range of 50-60 beds.

Curative, preventive and promotive services are provided at 2280 Medical Institutions in the state (Government of Punjab, 2013:35-38). All the health indicators in Punjab are better than All India. Life Expectancy at birth is 69.3 years (66.1), Infant Mortality Rate per 1000 live birth is 28 (42), Birth Rate per 1000 population is 15.9 (21.6) (Economic Survey: 2013-2014). Total fertility rate 1.8(2.5), Maternal Mortality Rate per I000 population is 172(212).

The basic indictors in the state of Punjab are as follows: birth rate is 16.6 for the state of Punjab while for urban population it is 15.6 per thousand population. The death rate for the state of Punjab is 7.0 whereas in urban Punjab it is 5.8 per thousand population. Infant mortality rate is 34 per thousand population for the state of Punjab and for urban Punjab it is 28 per thousand population (Government of Punjab, 2011:401).

The State is served by large number of health institutions in the public sector. The maximum number of government hospitals are located at Amritsar and Patiala i.e. six each. There are 54 community centres in Punjab. In the whole of Amritsar one Community health centre is serving the Urban population. There are 21 primary health
centres located in urban areas of the state. In Amritsar five primary health centres have been converted into the satellite hospitals.

There are 122 dispensaries catering to urban population out of which seven are located in Amritsar city. The state has 259 health institutions at the city level across twenty cities of Punjab. Amritsar has fourth largest network of 20 health institutions in the public sector after Jalandhar (28), Ludhiana (25) and Patiala (22) (Government of Punjab, 2011:402).

The number of beds existing in public hospitals in the state have been 10,444 out of which 2,351 have been in Amritsar. At the state level the number of registered medical personnel have been 22,162 doctors; 31,907 Midwife; 43,969 Nurses and 47,677 Dais. At district level these figures have been as follows 2484 doctors, 2805 midwife, 4221 nurses and 6909 dais. The number of beds per thousand have been 1.5 in Amritsar district.

At the state level number of family planning sterilizations was 93853 out of which tubectomy numbers have been 76982 whereas vasectomy numbers have been around 16871. The number of mothers covered under nutritional anemia programme in Punjab have been 75.8 per cent in 2010-2011. The expectant mothers undergoing tetanus toxoid doses have been around 78.6 per cent. The number of infants covered between the age of two years having (D.P.T.) immunisation have been 95 per cent and the children between age of (3-8 years) covered under (D.T.) have been 59.2 per cent (Government of Punjab, 2011:403-416).

The state government allocated Rs 3,443 crore in the budget, against an outlay of Rs 1,369 crore in the last year’s budget. The state has been given Rs 107 crore as an incentive by the centre for reducing infant mortality rate. The budget includes assertion that all essential medicines will be given free to both indoor and out-door patients (The Tribune, 2013:NP). The budget outlays and expenditure under two sectors Health and Family welfare and DRME (Directorate of Research and Medical Education) is given below in table 2.1.
Table 2.1: Health and Medical Education (Outlay & Expenditure)

<table>
<thead>
<tr>
<th>Sector</th>
<th>2012-2013</th>
<th>2013-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outlay (crore)</td>
<td>Expenditure</td>
</tr>
<tr>
<td>Health and family welfare</td>
<td>259</td>
<td>263</td>
</tr>
<tr>
<td>DRME</td>
<td>138</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>397</td>
<td>285</td>
</tr>
</tbody>
</table>

* 30% increase in outlay over the last year

**Source:** Government of Punjab, Annual Plan 2013-2014: 35.

Table 2.2: Health Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Targets</th>
<th>Amritsar</th>
<th>Punjab</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMR 2012</td>
<td>12th Plan 16, MDG : 20</td>
<td>N. a</td>
<td>28</td>
<td>42</td>
</tr>
<tr>
<td>MMR 2007-2009</td>
<td>12th Plan : 78, MDG : 83</td>
<td>N. a</td>
<td>172</td>
<td>212</td>
</tr>
<tr>
<td>Child Sex Ratio(0-6)years</td>
<td>12th Plan: 950</td>
<td>826</td>
<td>846</td>
<td>914</td>
</tr>
<tr>
<td>TFR 2010</td>
<td>12th Plan: 1.7</td>
<td>N. a</td>
<td>1.8</td>
<td>2.5</td>
</tr>
</tbody>
</table>


This table provides us with information on basic indicators related to health and what has been achieved at the district, state and national levels. In the state of Punjab various National Programme being implemented by the Director Health & Family Welfare which are discussed below as it provides us with the background to understand the utilization pattern of health services which is examined in chapter fourth dealing with health profile of slum dwellers in Amritsar.

2.8 NATIONAL HEALTH PROGRAMMES (See annexure : 1 for further reference about performance of National health programmes in Punjab).

2.8.1 Malaria Programme

This programme was launched in the year 1958. The number of malaria cases reported in 2007 have been 2017 and this has increased to 2660 in 2011. The number of
deaths reported due to malaria have been three. For treating malaria Anti Malaria drugs are distributed to fever cases through drug distribution centre (DDC) in the village of Punjab free of cost. The DDC’s do not collect blood slides but administer drugs to fever cases. In order to control vector spread out the spray operations are commence from 15 May onwards and last till 30th September every year. Amritsar is one of 13 cities of Punjab where Urban Malaria Scheme has been implemented by carrying out Anti Larval Operations regularly at weekly intervals.

Dengue is caused by Aedes Aegpti mosquito. The mosquito is a domestic breeder. The number of dengue cases have shown sudden increase from 253 to 3921 for the period 2005-2011. The number of casualities reported have been 51. The department of Health and Family Welfare has a curative, preventive and educative role to prevent and control dengue fever. Special dengue wards are reserved in hospitals for free of cost treatment of dengue cases. To overcome its spread the public is made aware through news papers and pamphlets to prevent stagnation of water in their houses and in the surrounding areas.

Japanese Encephalitis: In 2010 two cases of acute encephalitis syndrome have been reported. They have been reported among the migrant population living in the state.

Kala Azar, Filaria, Chikungunya and Swine Flu: There is no problem of Kala Azar, Chikungunya & Filaria in Punjab State. One case of chikungunya was reported in 2010. Swine flu: 46 cases have been reported from Punjab out of which 14 died as on December 31st 2011 (NHP, 2011:53-54)

Water Borne Diseases: To provide the potable drinking water to the people in the state water samples are taken by the Civil Surgeon office and are sent to the State Laboratory for testing at regular intervals.

2.8.2 National Leprosy Eradication Programme

There have been a total number of 849 cases in 2007 which reduced to 603 by May 2013. The prevalence rate is 0.25/10,000 population. for its treatment multi Drug Therapy (MDT) has been used this is supplied free of cost by the World Health
Organisation (WHO) through government of India and is made available up to PHC level by the District Leprosy Officers.

2.8.3 National Mental Health Programme

National Mental Health Programmes was launched in 1982 in view of the magnitude of mental illness in the country and availability of infrastructure and trained manpower in India.

NMHP has 3 components, namely:

(1) Treatment of Mentally ill
(2) Rehabilitation
(3) Prevention and promotion of positive mental health.

District Mental Health Programmes (DMHP)

The central Government launched the District Mental Health Programmes (DMHP) at the national level in 1996-97. District Muktsar was selected for DMHP as a pilot project with Department of Psychiatry, Govt. Medical College Amritsar as a nodal institute for this programmes in 1996-97. The scheme started in the year 2002-03. Training has been provided to 47 senior medical officers, 137 paramedicals and 225 anganwadi workers. As per census 2001 data number of persons suffering from mental disorders have been 2,42,892 for major disorders and 11,14,460 for minor disorders (NHP, 2011:113).

2.8.4 National Programme for Control of Blindness

National Programmes for Control of Blindness (NPCB) was launched in the State in 1976 with 100% central assistance and infrastructure was developed in the state in a phased manner and has been covered under Non-Plan Scheme. The Cataract Surgery coverage was 110% in the year 2005-06 and 107% in the year 2006-07.

2.8.5 Revised National TB Control Programme

Tuberculosis is a major public health problem. The main source of infection is untreated sputum of the positive patients living in the community. Total TB cases has shown a decline from 37297-17030 for the time period between 2008-2013. (for further
reference see annexure 2.4). It was initiated in 1962 as a decentralised programmes and it was started in the State of Punjab in 1966. Recognising the shortcoming of National TB Control Programmes & the unexpected increase in the TB incidence, Government of India with the support of WHO and Swedish International Development Agency (SIDA) undertook a detailed evaluation of NTCP in 1992. A new approach “Revised National TB Control Programmes” was adopted. At present there are 57 TUs (TB Units), 283 DMCs (Designated Microscopy Centres) and 13129 DOTS Centres in the state of Punjab.

2.8.6 National Cancer Control Programme

The District Cancer Control Programme in seven districts of the state namely Patiala, Hoshiarpur, Bathinda, Mukatsar, Mansa, Faridkot& Sangrur have been submitted to GOI, for approval and funding (Rs. 22 lakhs for each district per year for the duration of 3-5 years). A Super Specialty Cancer Hospital will be set up under Public Private Partnership in the premises of Civil Hospital Bathinda at an approximate cost of Rs. 55 to Rs. 60 crore. Punjab Health Systems Corporation and Punjab Infrastructure Development Board (PIDB) have been directed to prepare the necessary background documentation for inviting “Expression of Interest”. The state has enacted Cancer and Drug Addiction Treatment funding Act 2013. A sum of Rs 300 crore should be mobilized every year by levy on sale/allotment of properties, construction works undertaken by the Government and its agencies and increase in VAT on tobacco products. A sum of Rs 1.50 lakh has given from CM Cancer relief fund to 7513 patients assisted since 2011 (`70 Cr). The state has set up cancer treatment facilities in medical colleges and two district hospitals. The cancer wings will be created at the cost of Rs 300 crore ‘in all three government medical colleges Amritsar, Patiala and Faridkot as well as at district headquarters in Sangrur and Bathinda respectively. The state also plans to establish five drug de-addiction centres in view of rising drug menace among youth in Punjab (The Tribune, 2013:NP), (Government of Punjab, 2013:NP).

2.8.7 School Health Programme

School Health Programme is an important component of total health care delivery system in the state, which helps in keeping close watch on the health of school
going children. Under this programme, medical check-up of all Government/private primary and middle school students of are carried out by the school health teams. In order to reduce morbidity among school children. Health education is imparted to the school children and their teachers. School health programme has been implemented within the state of Punjab in all 19,973 government and government aided schools comprising 27,79,645 students. All students of government and government aided schools are examined twice a year by Registered medical officer/Medical officer. Even anganwari children are also examined. Any child who is suffering from any diseases is treated free of cost by Punjab health system corporation hospitals. Till date 2052 children having heart ailments have been referred to PGI Chandigarh and other tertiary hospitals for treatment and 1081 children have been operated upon at the cost of Rs. 947.55 lakhs. Three hundred forty eight (348) children suffering from cancer have been referred to PGI Chandigarh, MDOCH Ludhiana, CMC Ludhiana for their treatment sum of Rs. 417. 36 lakhs have been spent on them. For treatment of thalassemia 166 cases have been referred to various thalassemiac societies in Punjab and Rs. 13.28 lakh have been spent on them till June 2013 (Source: Right to Information Act 2005, Health Education Department Punjab, 2013).

2.8.8 Intensive Dental Health Care Programme

Dental diseases are mainly due to the lack of awareness among the people about the prophylactic, interceptive and curative treatment available in the existing infrastructure of the Dental Health Care Services in the State. It was also noticed that the Dental Surgeon population ratio was 1:30000 in the urban areas. But the ratio in the rural areas is 1:1.19 lakhs. The Punjab Govt. has launched Intensive Dental Health Care Programmes for school children, school teachers and general public, which is first of its kind in the country. To reach the far-flung areas of each district one mobile Dental Clinic Van has been for providing interceptive and curative treatment to the people at their doorstep.

2.8.9 The Persons with Disabilities According to Act, 1995

Based on the 2001 census, 1.7 per cent of Punjab's Population is suffering from disability in vision, speech, hearing, movement and mental state. Disability rate in
Punjab is lower than that of the country which is 2.1 per cent. The total disabled population of Punjab is 4,24,523 (Source: Registrar general of India, as given in National health profile 2011:117).

2.8.10 Maternal and Child Care

Family Welfare department provides ante-natal, natal and postnatal services. From the year 2005-06, under National Rural Health Mission, Government of India has emphasised on institutional deliveries and the care of new born. The main stress is upon to reduce maternal mortality rate and infant mortality rate. The state government launched **Balri Rakshak Yojna** a state funded scheme, for promotion of cause of the girl-child. Incentive is paid for adopting terminal method of sterilization after the birth of one or two girl children @Rs. 500/- and Rs. 700/-respectively. 162 beneficiaries have already been registered.

2.8.11 Tobacco Control Programme

The National health profile report 2011 gives data with respect to the state of Punjab. The percentage of men who have been found to be smoking have been 20.9 where as per centage of women have been 0.5 per cent. Under the category of those who chewed tobacco based products the per centage of men have been 33.8 per cent whereas women numbered 0.8 per cent as on 2005-2006 falling in the age group of 15-49 years, (NHP, 2011:112). The Cigarette & other Tobacco products (Prohibition of Advertisement & Regulation of Trade & Commerce, Production, Supply distribution) Act, 2003 was implemented in India w.e.f. 1st May, 2004 and in the state of Punjab from 25th June, 2004.

2.8.12 Drug-Addiction

The State Government has launched the campaign against drug menace in the state. It has been decided to establish 20 Drug De-addiction Treatment Centres (DDTC) of 10 beds & 20 Beds strength in 50 bedded and 100 bedded hospitals during the year 2007-08 & 2008-09. Ten (10) such DDTC at Civil Hospital Taran Taran, Gurdaspur, Faridkot, Ferozepur, Ajnala, Badal, Mansa, Moga, Nawan Shahr and Rupnagar have been planned during 2007-08 at the cost of RS. 165.0 lakh (Source: www. pbhealth.gov.in)
There are certain bureaucratic hurdles which have often been reported for non implementation of centrally sponsored health programme. The political announcements by the state level functionaries in the field of health care have lead to the loss of 6.64 crore (Vasudeva, 2012: Indian Express). Over a period of time wrong priorities have further affected the health system to large extent as become known as during financial year 2012 an amount of 8 crore budget was assigned to directorate of health. Out of this 8 crore 5.4 crore was spend on buying laboratory equipments and chemicals rather than buying necessary medicines. The money which was required as per demanded by PHCs for buying medicines was 20 crore. However 2 crore which was left also lapsed as no timely initiative was taken by directorate to order medicines. Thus higher amount of corruption is involved in this process of buying medicines and of medical equipments under different heads (Sethi, 2012:NP).

2.9 HEALTH CARE SERVICES IN AMRITSAR

Health services is an important aspect for a community. These services are being carried out by large number of government and privatised institutions. These are shown in Map 2. which show location of Public Health Care facilities located in Amritsar city. and Map 3. show public health care Facilities within Sample Slums.

Figure 2.1: Organisational Structure of Health Care Services in Amritsar (At Urban Level) Source: (Government of India, 2012:14).
2.9.1 Public Health Care Services in Amritsar

At the national level Health structure has been categorized into two types on the basis of its location. In the rural areas, there is a three-tier system which has been described above in figure 2.1 (a sub-centre per 5,000 population staffed with a male and a female worker, a primary care (PHC) centre per 30,000 population with a medical doctor and paramedical staff, and a community health centre (CHC), per 100,000 population with 30 beds and basic specialists). The urban areas have a two-tier system: a basic health post for every few thousand population, wherever it exists and an urban health centre/urban family welfare centre per 100,000 population attached to a general hospital. Both of these are being followed in the same manner at the state level and city level also (Government of India, 2012:14).

In Amritsar city, there are three government-run medical institutions. These public health institutions provide both preventive and curative care and are easily accessible to all social groups whether they can afford or not.

**Figure 2.2: Government run medical institutions in Amritsar (Tertiary level)**

- Punjab Government Dental College & Hospital Amritsar
- TB & Chest Disease Hospital Amritsar
- Shri Guru Teg Bahadur Hospital, Amritsar

Amritsar also houses the six special public health institutions. The three existing at hospital level and three at dispensary level. These special institutions include medical facilities offered at E. S. I Police, Jail, Cantonment. They have two hundred beds in all.

The number of patients accessing medical care as out-patients in public institutions have been 1,56,69,677 out of which 81,19,620 have been females and rest 74,50,051 have been males in 2010. In 2009, the maximum count of out-patients accessing health care system have been suffering from diseases of respiratory system, followed by digestive system, Skin and subcutaneous tissue system followed by abnormal laboratory and
clinical findings, blood and blood forming diseases last being infective and parasitic
diseases. The state has large number of AYUSH institutions which are 630 in number.
The city of Amritsar has 25 institutions in total offering AYUSH services.

All the Eighty Eight Subsidiary Health Centres are working in seven blocks of the
district respectively. There are two Community health centres situated at Ajnala and
Baba Bakala respectively. There are six slum area dispensaries which are located in
areas such as Logarh, Bhagtanwala, Gawal-mandi, Kot khalsa, Basant Avenue and
khazana Gate. All these Slum area dispensaries work as clinically urban dispensaries.
Apart from these there are six revamping centres operating in areas such as Haripura,
Kangra Colony, Jodhnagar, Gopal Nagar, Basant Avenue and Kot khalsa respectively.

Thus there are eleven dispensaries in Amritsar city, which include five satellite
hospitals which are located at the periphery of the city in all directions. In Mustafabad
Bhai Daya Singh Memorial, Kala-Ghanpur Bhai Himmat Singh Memorial, In Ranjeet
Avenue Bhai Dharam Singh Memorial, In fatehpur Bhai Sahib Singh Memorial and In
Bhagtanwala Bhai Mohkam Singh Memorial. These urban health post are equivalent to
primary health centres. However, as they have been upgraded with three doctors each
along with supporting staff they are called as the satellite hospitals. They are meant to
provide health facilities to people at their door steps. (See Map 2: Location of Public
Health Care Facilities in Amritsar City)

Within the city health facilities are broadly categorised under two separate
heads: one comes under the jurisdiction of Directorate of health services this include
civil hospital and eleven dispensaries. The other comes under medical education and
research to which government hospital at district level is attached. The health facilities
which come under the directorate of health services are supported by the following staff
that comprise of 52 doctors working at civil hospital and dispensaries within
corporation limit. The number of doctors serving the satellite hospitals along with
dispensaries are 21 in total. Thus within a satellite hospital three doctors are serving
which includes one specialist (gynaecologist), one medical officer having M.B.B.S.
degree and one dental doctor.
They are supported by supporting staff such as nurses which are 108 in total. These nurses tend to perform three shifts in a day i.e. morning, evening and night. They are also supported by reliever staff during duty hours. In order to run the operations in smooth manner they are in turn supported by Lady health volunteers and Auxiliary Nurse midwife. All three of them are performing multi-dimensional roles.

The nurses are working as supervisory staff providing nutritional care, preparing daily reports and updating charts on regular basis. The lady health volunteer assist in promoting family planning methods among eligible couples and carrying out immunisation schedule for infants. Under one LHV four ANMs are working who carry out the field work related to various national health programmes. In fact all of them carry out basic medication such as vaccination and assisting doctors in carrying out minor surgeries. These ANMs are described by new nomenclature such as MFPW and FFPW.

The nurses working in Public health care facilities undergo training under various modules such as nursing administration, handling of biomedical waste and thoracic surgery, basic monitoring activities etc. These health workers which includes Nurses ANMS and LHV are essential backbone of health care initiatives at National and Community levels. They are the ones who are burdened with carrying out
Reproductive Child Health programmes, Expanded Programme of Immunisation and essential Primary health care (Khan, 2011:28)

**Figure 2.4: Diagram depicting Pharmacist cadre in Satellite hospital/SLAD**

Within the health system pharmacists play an important role in dispensing medicines to the patients prescribe by the doctor. At the same time drug choice (patented), telling precautions as well side effects of various medicines to the patient concerned. However they have a grudge against lack of promotional avenues as it is there in case of doctors and nurses who entail multiple level career structures. They are 30 pharmacists in total serving various health facilities in the city.

**Figure 2.5: Diagram depicting Laboratory cadre in satellite hospital/SLAD**

For carrying out requisite clinical procedures to detect infections within body fluids Laboratory technician play decisive role from preparing slides to taking appropriate quantity of samples. They apply proper dosage of chemicals to detect any foreign body or basic body indicators and salts etc. There are 25 laboratory technicians working under different designations to provide reports to patients on time.

For upkeep of the health facilities safai karamcharis are also performing their roles. They are 50 in number. There are very few chowkidars to provide security for health personnel especially nursing cadre who are serving the health facility during odd
duty hours. In order to access the basic services various prices have been fixed for facilities such as Ultrasound 150/-, X-Ray 40/-, ECG 25/-, Minor Surgery 50/- and OPD charges 2/- etc.

Figure 2.6: Organisation Structure of health professionals in Satellite Hospitals

2.9.1.1 Working of Satellite Hospitals (Maps 4,5,6, howing depiction of Health Care Facilities in Notified Slum)

Bhai Sahib Singh Memorial Satellite Hospital

Patients visiting satellite hospital at Fatehpur are not only from the slums but also from nearby villages depending upon the nature of treatment they require. The location of public health care facility along with private practioners RMPs is shown in Map 4. The specialist doctors include gynaecologist’s and doctor of medicine. The doctors are supported by auxiliary staff comprising of Staff nurses (9), Laboratory technicians (2), and the pharmacist.

The number of patients which availed treatment from the facility during the field study have been 1213. Out which 605 have been new and 608 have been old O.P.D patients. Numbers of expectant mothers visiting facility have been around 20-25 in a month on an average. Over a period of time sixty two slides have been tested for malaria however none was found to be malaria positive.

Those having major health issues are referred to Guru Nanak hospital. According to doctors as the stray dogs are menace the cases of animal bites are also
referred to district hospital. Some cases of tuberculosis have been reported for which they get medicines from district hospital the registry is maintained for such cases.

The laboratory is well equipped with basic instruments such as centrifugal machine, Microscope and calorimeter etc. Within the laboratory following test are carried out HB, BT, CT, TLC, DLC and Urine. The laboratory is equipped with essential equipments like Disposable destroyer, Centrifugal machine and Microscope. In fact they don’t have photo calorimeter These satellite hospitals are having two shifts i.e. morning and evening from (8 a.m to 2 p.m) and (2 p.m to 8 p.m) respectively. This hospital lacks physical infrastructure as it does not have any land line connectivity with other hospitals. It is difficult to locate this hospital as no signboards have been installed on the main road to guide the patients to hospital. The hospital does not dispose of their biomedical waste in a right manner. The post of dental surgeon has been lying vacant for some time. The staff employed here grapples with the problem of lack of medicines and cleanliness of surroundings (Gill:2012a NP). (Maps 4,5,6, howing depiction of Health Care Facilities in Notified Slums of Fatehpur, Bharariwal and Angarh)

**Bhai Daya Singh Memorial Satellite Hospital**

It is located in Mustafa bad area next to batala road here two doctors are serving. The qualification of doctors is as follows: one is having M.B.B.S. degree serving as medicine doctor, the other doctor is having M.D. Gynaecology. Following auxillary staff is running the clinic comprising off Staff nurse (4) (2 regular + 2 contractual under NHRM), Pharmacists (4), ANM (3), LHV(1).

The number of patients accessing this facility number around 1200 new and 800 old O. P. D patients respectively during field visit. During the field study the doctors working at Mustafabad satellite hospital stated that 67 institutionalised deliveries had taken place during one year. The majority of expectant ladies have been below 25 years of age as per records made available to the researcher.

Among the adult population respiratory tract infections and arthritis is often reported. Among children problems of E.N.T. (wax in ears), dental carries, malnourishment, anaemia and worm infestification are often diagnosed. Seven cases of
measles have been reported during past one month. No new infection of polio virus have been reported. Some cases of addiction which do turn up are referred to de-addiction centre established in the district hospital. This satellite hospital caters to large chunk of local plus migratory population. About six quacks are operating in this area.

The pharmacist who are working at satellite hospital stated that avenues of promotions’ are very less in their career. Over a span of their career they get rarely any promotions. They have two gardes: pharmacist grade II and grade I. Thus they are disappointed a lot as there cadre lacks promotional avenues which is not in case of doctors and nurses who avail multiple level promotions in their career structures. Thus they cannot become chief pharmacist as vacancies are less, this fact is also stated in studies such as one by (Martinez and Martineau, 1998:351).

With neo liberal policies of the government health sector has also been affected. Earlier i.e. prior to 2006 doctors have been the provider of medicines as CSO office was directly supplying them. The rate of medicines have been quite less (one pack of cotton cost was available for Rs 20/- , CPM cost was Rs-10/- and pack of 500 paracetamol cost 75 rupees only. The requisite details which have been recommended by medical officer working at SLAD or satellite hospital was send by the civil surgeon office. However, the prices have undergone a change after the formation of Punjab health system corporation. The role of civil surgeon office is negligible now as medicines and medical equipments are directly supplied from PHSC Mohali “whatever they feel desirable is send without keeping into account the requirement”. There have been instances when ortho related lumber belts have been supplied which are lying unused as there is no post of Orthopaedician at Satellite hospital. The government strategy to follow family planning targets get spoilt as people are orthodox in certain ways in using such methods thereby the packets of condoms which lie unused are generally thrown into water channel’s to make it believe they have been utilized. Moreover in certain cases the ANMS show sterilizations performed on those woman who have reached menopause, so as to get money for targets achieved by LHV and patients both. There is acute shortage of essentials medicines as doctors have to spend from there own pocket. The medicines and kit which are supplied by Directorate of health services Mohali are not required as there is no paediatrician to recommend there utilization. However, there is
an angle of corruption which is often labelled on district and state level health officials by staff during personal interview. This point gets validated by the coverage also in local daily (Gill, 2014: NP).

ANMs are burdened with lot of responsibility as they have to maintain not only registers but also have to regularly and update them. For implementing various national programmes ANMs make periodic visits in the field. ANMs are assisted by LHV. The school health programme is being carried out in three schools of the area. Every Wednesday is observed as Maternal and child health day and immunisations are also carried out. ANM does office work maintaining registers, in the morning and at noon they start their work in the field as one ANM has to roughly cover population of 15,000.

They have cold chain facility for keeping injections but due to frequent power cuts there is a problem. They have apprised the civil surgeon office about this problem so that inverters could be fixed to overcome this problem. They have trained birth attendant who often gets Rs.200 per delivery as honorarium. However during researcher visit it was found that she had been deployed to prepare tea for the staff.

In order to ensure proper keep and maintenance of the premises three safai karamcharis have been deputed, as they have to report for morning, evening and night duties. According to the patients accessing this facility is a nightmare as it lacks proper approach i.e. no metalled road is there and during rainy seasons it is difficult to even come to this place. Patients during informal talk with the researcher reported that the behaviour of the lady doctor is not appropriate. She hardly treats poor patients.

The ANM who has been working at this health facility for some time now. stated that during her career span of twenty years. She had undergone various health training modules. These include SBA (skilled Birth attendant) whose duration was one and half month training at the civil hospital. During this training they are taught about placement of child in the womb, sensations perception, artificial respiration and cleaning of infants throat. In CCT (Child Care Training) which is generally of one week duration issues related to dehydration, skin diseases and vaccinations have been generally examined. ANMs are also given training for administering DOTS treatment for tuberculosis. ANM also given training for treating mental illness patients with
compassion. Chronic illness such as cancer and AIDS have also been dealt in various training modules.

There are two LHVs one which is recruited by directorate of health services. The other LHV is working on contract but on deputation from NRHM. These LHVs are having strain relations at work place due different qualifications and perks but same job profile. The LHV working on permanent post draws a Rs.23,000 salary per month who has post graduate diploma from MFHW division whose duration was one and half year. whereas The LHV under NRHM are medical graduates who are drawing salary of 8000/- only.

**Bhai Himmat Singh Memorial Satellite Hospital**

This is located in Kala Ghanapur it houses ESI dispensary and Satellite hospital two facilities operating from the same premises. The location of public health care facility along with private practitioners RMPs is shown in Map 7. ESI takes into requirements of those employees who are working in an industry and they do possess smart card. The majority of these workers suffer from ailments like hypertension, diabetes, thyroid, backache, gastro-entities, fever, skin ailments and water borne diseases. The average number of patients in a day hovered around 150-200 respectively. The patients suffering from serious ailments are referred to ESI Majitha road.

The satellite hospital located in Kala Ghanapur area have an average patient turnout of fifty. The number of patients which have accessed this facility prior to researcher visit have been 1217 in total comprising of old O.P.D (441) and New O.P.D cases (776) respectively.

The majority of the patients come to seek treatment for general ailments, for immunisation and antenatal check-up. Following auxillary staff is running the satellite hospital comprising off Staff nurse (4), Pharmacists (2), ANM (3), LHV(1). There have been presently two doctors working in the satellite hospital and one post of doctor was lying vacant as noted during field visit. In this health facility three pharmacists are working, according to them as per demand they get medicines directly from the directorate. The laboratory technician stated that nil cases have been reported for malaria as per test conducted out in the laboratory during rainy season. To upgrade their
knowledge in dealing with patients and using proper techniques from time to time they have attended training programmes three times for malaria, once each for Tuberculosis and Aids respectively at various stations in Punjab and Chandigarh.

The nurses also maintain an maternal child health report in which immunisation schedule of mother is given prenatal and post natal and essential immunisation meant for new born child from birth up-to five years of age. The CMO of the satellite hospital has to send weekly, monthly and yearly reports to Civil surgeon office. These district level reports are compiled and then send off to directorate of health Services Mohali. The nurse performing their job state that the satellite hospital lack requisite medicines so sometimes they have to contribute jointly to purchase essential medicines which are always in short supply. They have to work in night shifts for which there is no security available be it chowkidar or any male employee. There is no one to assist them at night. For running operation theatre to carry out normal deliveries at the satellite there is a need for power backup. Out of pocket expenditure is done by nursing staff to carry out basic work. Later on they reimbursed from medical fund available at the disposal of Medical officer. In all there are five nurses, one for every shift and one act as reliever for the others. As there are three shifts in 24 hour two nurses are there on night duty.

ANM stated that on an average seven to eight cases come for delivery. The cases which have complications are referred to government hospital maternity wing. ANM regularly maintain contacts with those mothers who are expecting by making periodic visits to their home and telling them about personal hygiene and treatment to be followed. ANM play a proactive role in providing family planning counselling to both husband and wife. ANMs perform family counselling role to convince young couples to follow family planning or to undergo sterilizations. For ANMs it becomes difficult to convince male members as there are certain inhibitions to talk about reproductive systems across sex.

There are hardly any male health volunteers which can be deputed for this job. During their area visits ANMs came across teenage pregnancies but onley one in ten asked them the ways to terminate their pregnancies. Reproductive tract infections are also reported by woman to ANMs. ANMs also monitor HIV positive cases if they come
to them for counselling. Study indicate that ANMs and LHV\s have to cover large populations as a result of this their performance deteriorates. Study indicate home visit by ANMs does have positive influence over MCH indicators (Bhattacharji et al., 1986:237).

ANM working at satellite hospital have attended weekly seminars on topics such as Environmental management and health care, RTI, HIV/AIDS, child immunisation, Vaccine keeping, birth time problems etc. In order to have proper rapport with the patients in the field they also undergo seminar on B.C.C. (Behaviour and Communication Change) whose focus is on family welfare, nutrition practices, breast feeding etc.

The School health programme is run by the satellite hospital. Under this programme, medical check-up of all Government/private primary and middle school students are carried out by the school health teams. Under this programme children of are provided Ferro-sulphate (Iron tonic) and for deworming (albanzedol solution from NRHM urban component). Pulse polio campaign has been regularly taken up since fifteen years. Recently migratory population has been identified as a target as per health department directives, for which three times in a circle polio drops have been administered. As per RTI act 2005 following information with regard to National programme for control of blindness has been made available on district health society. In the year 2007-08 Rs. 2,49,525 was spend on medicines and consumables which has been enhanced to Rs. 5,88,972 during 2012-2013. There have been instances when MHW takes patient to main hospital for carrying out family planning procedures but there doctors don’t behave in an cordial manner. In certain cases when ANMs take the eligible couples after much persuasion to civil hospital for sterilization operations doctors are not available. The doctors are burdened with multiple duties due to stringent working hours. Moreover due to frivolous issues sometimes the operation cases are rejected without discussing it with MHW accompanying eligible couples.

ANMs mention that for patient coming at night hours we have to administer medicine to induce or prolong labour pains so that case could be dealt in the morning by gynaecologists. However, due to anxiety on the part of expectant ladies family members
often call Dai which is available locally within the area. hence, the delivery of the case which was earlier to be performed in institutionalised setting is performed at home. These shortcoming in the system need to be looked up seriously as sated BY ANMS and LHV.

The reasons for undergoing Dai based home delivery largely relates to illiteracy, mother in law pressure because of social-cultural considerations. There are certain myths related to food intake during time of pregnancy by referring to cold and hot foods which lady must abstain to keep in good health without taking into account medical advice. This problem results in large number of women having anaemia and resulting in Low Birth weight babies.

Throughout the year to remain in touch with health of the people the staff at health centres have to celebrate days and weeks related to number of diseases and health in practices in day today life. Thus they are quite overburdened to meet their professional requirements and expectations.

During informal talk with staff at satellite hospital it came to researcher notice that inorder to avoid performing night duty the doctor have initiated friendly approach towards Trained birth attendant (dais in particular). TBAs are performing evening duty for which they get field travel allowance of Rs 280/- when they go along with ANMs to perform the cases.

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There are two class IV employees one each :working in morning and evening shifts. This Satellite hospital surfers from poor state of affairs as foul smell comes from nearby surroundings and tall grass grows has grown in its compound. The employees on their own have contributed from their pocket to built wall to separate it from village pound (Gill, 2012b:NP). There is an operation theatre but its theatre light is not functioning properly. Its operationalization requires an attendant also. According to doctors the seepage of waste water into the hospital premises had made problems more acute. The building has not only been affected but also costly medical equipment’s are being spoilt.

In spite of repeated reminders to civil surgeon office and to the area councillor and corporation. No effective steps have been taken till now. Some problems are there as laboratory does not have blood grouping kit which is required not only for expectant ladies but for others also. (Map 7, showing depiction of Health Care Facilities in Notified Slums of kalaghanupur )

**Bhai Dharam Singh Satellite Hospital**

This is located in Ranjeet Avenue it caters to middle and lower middle class patients apart from patients from Nangli and Gumtala areas. About 60-70 patients daily
visit the OPD. Normal deliveries are carried out on an average 50 in number. This hospital have facilities of dental surgeon and ophthalmologist apart from two doctors of medicine and gynaecologist. This hospital is lot cleaner in comparison to others.

**Bhai Mokham Singh Satellite Hospital**

It is situated near Satkatri Bagh does witness large rush of patients on an average 30 deliveries are carried out here in amonth. In its premises immunisation centre is run for new born children and Dots treatment is being provided to TB patients. The Satellite hospital does have a dental surgeon which provides treatment to patients by giving them medicines. The requisite furniture and equipment’s required for treating patients is lacking. There are testing facilities available at this satellite hospital as laboratory is there with two technical assistants. The OPD witness huge rush of patients everyday 200-250 daily. All these five Satellites however lack facilities for caesarian section.

**2.9.1.2 Slum Area Dispensaries: Gopal Nagar and Chhehrata**

**Slum Area Dispensary (SLAD): Gopal Nagar**

The slum area dispensary which is situated in Gopal Nagar is located in low lying area because of recent raising of road level. The condition of dispensary is pitiable one with two rooms and old furniture the walls are not painted properly and roof plasters are falling off.

The staff comprised of one doctor, one pharmacist, three ANMs, one class four employee and one Sweeper only. The doctor posted out there has been serving the centre since last four years not many improvements have come by be it people perception about institutionalised deliveries as according to doctor the dais of the area become self-proclaimed doctors by arguing with patients that when they can have normal deliveries at home why they need to visit health centre. According to doctors large number of youngster’s are hooked to habit forming drugs but there is problem of disclosure, at same time there are behavioural problems related to addiction majority of them are unemployed and daily wagers. Trained dais has been provided with necessary medical kits so as to have safe deliveries.
The doctor state that the ANM have to ensure three antenatal care visits which implies having administered tetanus toxoid vaccination twice plus to check proper growth and position of foetus. Apart from that the expectant mothers are provided Iron, folic acid and calcium dosage as nutrition element. The number of cases have C-section are 5 to 10 per cent of the total cases handled. Only two to three per cent cases have been of still births. Over a period of time staff of clinic carries out house to house survey to identify eligible couples which require family counselling but also require treatment for any reproductive system related problem. Generally for kids programmes to overcome Iron deficiency and worm infestation are carried out.

The problems of field staff are immense as they when walk through the narrow streets they are eve teased by anti-social elements who generally passed lewd comments related to their nature of work. As they have O.P.D only so they don’t have any post of staff nurse at health centre.

With respect to slum area dispensary Gopal nagar this caters to populace of 30642. They tend to promote institutionalised deliveries also at same time Dai of the area has been trained to ensure community participation and self-awareness with regard to institutionalised delivery. The immense paper work and periodic visits to civil surgeon office and civil hospital does disturb their daily routine. (Map 8, showing depiction of Health Care Facilities in Notified Slums of Ganda singh wala).

**Slum Area Dispensary (SLAD): Chherata**

The slum area dispensary is situated in Chherata area and is located on GT Road opposite to entry point of Gahnupur. The dispensary is functioning since 1992 in a government building have verandah and four rooms along with the bathroom. three rooms are in bad shape as no maintenance is given by government staff which is working there spends from their own pocket especially to carry out cleansing operations and as well maintaining the green space. This dispensary also covers a population of 31,000 from 6443 households. The total staff working in this dispensary includes one medical officer who is graduate having MBSS degree. The doctor is supported by staff comprising of LHV and ANM. There is one post of Pharmacist which is lying vacant.
The doctors himself dispense the medicines to the patient. During last year 513 deliveries occurred in this area. The birth rate of this area is 16.5/1000. about nine cases of still birth have been reported. The staff reported that number of institutionalised deliveries have been high comparative to other areas as population is educated and motivated.

There have been eight trained dais working in this area. They are not of much help as generally they don’t follow the instructions which have been given to them. ANMs have been helped by link workers or the ASHA workers. They have been the ones who bring mother from the area for EIP, cater to family planning need among eligible couples. The nexus of the dais is so strong that they charge 5000/- rupees for normal birth. In those families have been there is high illiteracy dais made them believe that if they go to government healthcare sytem the delivery would be Caesarian one. The family planning success rate per eligible couple is 30 per cent as 1314 cases have been covered under Tubetocomy and vasectomy.

The dispensary had proper infrastructure for keeping of medicines as ICE line refrigerator was there. Everday patient load is 45-50 patients daily, on immunisation days numbers tend to increase. The LHV and ANM staff have been overstrechced as they not only to make reports make monthly registars but aslo to perform Field work. The doctors in a week is awy for two or three days for emergency duties. so patients often end up complaining of what is the fun when doctor is away The staff also has to celebrate health days by organising meetings in there areas such as one related to safe girl child programmesmeeme or do matter distribution of ORS solution to counter the spread of Diahorrea in rainy season.

The scenario describes above has also been substantiated by (George, 2010:21-30) which describes how health professionals have to compete within the system with gender specific roles vis-a-vis the male health workers. They have to face the wrath of people who often complain of poor services being given to them. These front health professionals have to face the health system inbuilt insufficiencies which are by product of bureaucratic interference this is one of the leading reason for sorry state of affairs. These health workers make effective decisions considering the environmental
constrains so as to provide requisite health care to people. The complaints by LHV, ANMs with regard to working conditions is deplorable as field work is often carried out by them whereas male workers just perform supervisory jobs often look for way out to earn money for wherever it is possible.

Health professionals also state that social construction of public health care system by private providers especially RMPs have created disregard among poor patients. The poor patients are often made to belief that instant injections by Private practioners are more fruitful in overcoming disease than simple medicines dispensed at Public health care facility. From the above description about working of Satellite hospital reveals that as per W.H.O standards there is acute shortage of health professionals in sample slums. The number of physicians available per thousand population is 0.00014 and 0.00015 in sample slums in which Satellite hospitals are situated. The nursing staff available per thousand population is 0.0006 for both the slums. The number of pharmacist available per thousand population hovers between 0.0007-0.0015 whereas the number of Laboratory technicians available to serve the areas is 0.00015. Thus there is larger inadequacy in terms of health professionals available to serve these sample slums as a result of which large number of private health providers runs there private hospitals ,clinics and shops to meet the health needs of the sample slums.

2.9.2 Private Health Care Facilities

The private health care is provided by large number of institutions which are one hundred fifty in number. These can be classified on the basis of treatment given. In all there are three super speciality hospitals, followed by hundred hospitals, twenty three nursing homes and twenty four clinics offering diagnostic, ENT, dental digestive and other services.

The growth of private institutions in health care occurred mostly during late seventies in urban areas of states like Punjab which witnessed prosperity due to green revolution. The entry of corporate entities into health care sector has been of late nineties occurrence which could be attributed to the emergence of mushrooming middle class and its demand for special care led to genesis of private entities. The private sector
generally offers curative health services for which they have drawn price structure keeping in mind the ability of people who can afford to pay (Baru, 1998: 215-219).

These private hospitals got certain concessions from the state government in the form land allocated to them, export duties have been lessened for high end technologies. Several business conglomerates entered the fray such as Escorts Fortis which is located next to Verka bye pass in Amritsar. This hospital attracts the larger upper and middle classes who have slowly moved away from health services offered in public sector. The cost of treatment is enormous symbolically they try to redefine quality of health care which has gone missing from public health sector due to higher patient load, inadequate infrastructure and the doctors self has become more important than their professional goals. Hence crisis loom in public health services at tertiary level of health care which is lesser than at what is felt by those who are accessing health care at lower levels of hierarchy.

Within private health sector in Amritsar the doctors of repute and credibility become brand ambassdors for these private hospitals. The greater clinical expertise as catering to different kind of cases the doctors who had earlier stints in government hospitals are most sought after. These serving doctors who cannot sustain political pulls and pressures sometimes are stressed out and seek better avenues in the private health care system. The retired doctors also works as consultants with numerous hospitals often getting paid high apart from getting pensions they are able to secure their livelihood and pass their time in constructive manner. Some of reputed private hospitals in Amritsar are as follows :-

Medicity hospital is located on GT road near Khandwala. There are three hospitals which are located in vicinity to each other Harpreet Hospital opposite Khalsa College caters to maternity related cases apart from general medicine. Beri Maternity Hospital, Gumber eye hospital followed by Navpreet hospital which has Ortho, ENT, Kidney specialist offering their services. Just Opposite to Navpreet hospital across the main road there is located Sukhbir Hospital which gets large number patients from slums of Kala Ghanupur. Infact it has been observed during field study that in RMP shops which have been running successfultly in slums private hospitals address along
with phones numbers are pasted on walls. The RMPs refer patients to these private doctors and get commission per patient. Thus this has become a lucrative trade in health services.

Amandeep hospital caters to large number of accidental victims who have suffered causalities in road accidents. It is 200 beded hospital. It is located on GT Road near police station. Ohri hospital and Saini heart care centre opposite to Harkrishan Public School is situated on GT road. This description does describe hospitals which serves every ones pocket depending on nature of services rendered which are curative in nature. During field study respondents in slums of Kala Ghanupur do mention some of names of the hospitals mentioned above which they utilised for treatment in emergency cases.

Similarly people who are residing in slums of Ganda Singh Wala visit private hospitals located on Majitha road and nearby localities such as Janta hospital, Bhandari, Bajwa hospital and Naresh grover hospital and Bawa Ortho hospital. Even in case of Fatehpur and Bharariwal people often referred that if any emergency conditions aroused they visited nearby Mahajan super-speciality hospital located near gate khazana. Hence, health care services are offered both in public and private spheres however the private sector is too big and has many of unregulated faces which we came across as RMPs in slums who are running poly clinics and shops which are found at every street and corners of different mohallas and colonies in Amritsar city.

It has been assumed that welfare measures slowly and steadily bring about equity in the society. Thus welfare approach often have been accompanied by actual development of health sector in India. Health related measures have been eclipsed with mantra of economic growth. The economic model which was followed within health sector has been mixed one, eventually led to growth of public sector along with market interests. These reasons have been enough for emergence of unregulated private sector. Thus we can adopt Pritchett idea of stating India as “Failing State” the reason being active in taking initiatives but yet weak in implementing policy decisions (Walton, 2010:87). Hence the State in spite of adopting appropriate policies in health care lack proper implementation which have been seen in the chapter above due to lack of intentions and logistical reasons. (Kohli, 2010:60). Thus this chapter builds the frame
work to examine health care utilization and perception among the slum dwellers. It is important to examine how far these state interventions which are at made both at the policy level and institutional level do affect the state of health which is available to the slum dwellers in the fourth and fifth chapters.

End Notes:

Satellite Hospital: These refer to slum are dispensaries which have been upgraded by providing three doctors and nursing staff along with LHV and ANMs. These provide facility for OPD as well as IPD. They have been provided 8-10 beds. There is laboratory for basic pathological test. They act as referral units for curative care. The Status is PHC.

British Fabianism: Theories of economic and Social reform advocated by socialist organisation which was founded in England in 1884 that favoured gradual spread of socialism by peaceful means.

State: refers to central government and state of Punjab implementation of policies programmes and plans in wider interest of the public.

MCH: Under this programme the pregnant mothers are registered in the first trimester and given Iron and Folic Acid Tablets to prevent anaemia. Injection of Tetanus toxoid is also given to pregnant mothers to prevent tetanus. Women are also advised about diet during pregnancy and lactation. Efforts are made to promote institutional deliveries.

Sample Slums: The proportion of SC population which was less than 10 percent was found in Ward no.1 having slums of Kala-Ghanupur, between 20-40 per cent ward no.47 having slum of Ganda Singh Wala and above 60 percent Ward no.59 having slums of Fatehpur, Bhraraival and Angarh have been enlisted.

School Health Programme: Under this programme fifty two tablets of folic acid per child per year are provided in schools to prevent anemia i.e. one tablet per week. For de-worming two tablets of albendazole per child per year are distributed in all schools. At the interval of six months, Children with refractive errors are provided with free spectacles. The children who are suffering from heart ailments, cancer and thalassemia are treated free of cost at super specialty hospitals (PGI Chandigarh, DMC, CMC and
Mohan Dai Oswal Cancer Hospital (MDOCH) Ludhiana, Fortis hospital, Silver Oaks Hospital and IVY hospital Ajitgarh.

**Blood Component Separators:** They have been installed at Ropar, Hoshiarpur, Pathankot, Ludhiana, Jalandhar, Bathinda and Ferozepur Hospitals and Medical colleges at Patiala and Amritsar to diagnose dengue.

**DOTS:** Directly Observed Treatment Short course Chemotherapy. Under this programme the State Government is also providing facility of free X-ray examination. Medicines are given free of Cost to all the TB patients. Medicines are provided in patient-wise boxes, which are earmarked for every patient. The essential element of **RNTCP**, based on the WHO model include political commitment, passive case finding, diagnosis by sputum microscopy, treatment under direct observation, effective patient education to maintain patient adherence, a secure un-interrupted supply of drugs, individual patient registration, follow up and outcome evaluation by health department.

**OPD:** Out patient department refers to universal immunisation programmesmeeme is part and parcel of RCH since 1997. At present pentavalent vaccine against diphtheria, pertussis, tetanus, Hepatitis B and Haemophilus influenza type B infection have been introduced in two southern states kerala and Tamilnadu.

**Disability:** Under the PWD act 1995 disability covers issues related to following:

a) Blindness

b) Low vision

c) Leprosy cured

d) Hearing impairment

e) Locomotor Disability

f) Mental Retardation

g) Mental illness

The disabilities mention above have been included in order to enable the persons suffering from disabilities to derive certain benefits/concessions provided by the State
Govt./U.T. Administrations/Central Ministries/Departments and Local Authorities. The authorised certifying authority will be a medical board at the district level, sub-divisional level and block level. The board will consist of the Chief Medical Officer/ Senior Medical Officer at the sub divisional level, civil hospital and another specialist in specified field viz. Eye Surgeon, ENT Surgeon, Orthopaedic Surgeon and Psychiatrist. The category wise detail is as follows of disabled population in Punjab based on 2001 census. Mentally Disabled: 63,808; Visually Disabled: 170,853; Hearing Impairment: 17,348; Speech Disabled: 22,756; Locomotor Disabled: 149,758.

**Neoliberal:** It refers to an ideology of self reliance upon market forces and reducing state interventions and expenditure to minimum.

**Maternity Home:** It provides health facilities in urban areas which provide indoor services for institutionalised deliveries. They have less than 30 beds.

**Polio Virus Vaccines**

**OPV:** stands for oral poliovirus vaccine developed by Albert Sabin. It is generally supplied as mixture of three types of VPV(vaccine polio virus) called trivalent OPV.

**IPV:** stands for inactivated poliovirus vaccine developed by Jonas Salk. It is given through injection as it is culturrally made non infectious and mixed.

**Cold Chain:** It refers to a system of storing and transporting vaccines at recommended temperatures from the point of manufacture to point of use.

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