POLICY AND PLANNING

Policies provide the framework for the accomplishment of intended objectives. Davis states that a policy is basically a statement either expressed or implied of those principles and rules that are set up by executive leadership as guides and constraints for the organisation's thought and action. Its principal purpose is to enable executive leadership to relate properly the organisations work to its objectives. The importance of policies is that they establish the overall boundaries for action by individuals or groups within an organisational framework. Ishwar Dayal aptly states that policy formulation refers to that aspect of administration which is concerned with defining the objectives and determining the choices of action. Decision making refers to the process by which this policy is determined. Policy formulation thus encompasses decisions which are aimed not at the solutions of transitory problems, but has a long term perspective and affect the destinies of communities at large or of an identifiable group very to a substantial measure.

This is more true in the governmental context or in the area of public policy-making. Apart from influencing a large or a substantial portion of the population or an entire nation, public policy involves the formulation, combination and assimilation of a wide range of activities, a number of decision-making levels and a substantial quantum of resources.

In a developing country like India, two major areas that call for urgent attention in the field of public policy making are (i) improvement in the acquisition and integration of knowledge and information and (ii) development of the skills of the personnel involved in policy-making. Both these areas gain significance in the field of policy making for social welfare activities. Hence the primary corollary for policy making is 'Planning'. Planning provides the policy with a time oriented framework and various possible feedback effects on policy. Above all, it provides policy making with instruments for dialogue, co-ordination, mobilisation of resources and continuity of action.

Laswell enunciates four points of policy making, which stress -

1) a crucial role of an information base;

2) creation of greater facilities for communication between researchers, policy advisers and decision makers;
3) time orientation, wherein the past and the future were to be viewed as segments of a single continuum; and

4) the relationship between policies and values.

Further, Laswell contends that a vital sphere with regard to policy-making is the dimension of contextuality. The decisions of the policy makers must not be only directed towards alternative policies concerning the same goal, but also priorities among competing goals. The scope of contextual analysis is considered by four basic factors.

1) the availability of resources, professional manpower and the time schedule for reaching policy decisions.

2) the general complexity of the environment within which the policy matter acts, in terms of the political, organisational and socio-economic characteristics.

3) the nature of the different means by which the policy is implemented.

4) the feasibility analysis which involves an assessment of possibilities, whether an idea

can be approved and carried out successfully. The important components of the feasibility analysis include (a) political feasibility which involves getting approval for a policy from the highest point of public authority, (b) economic feasibility which concerns the availability and the adequacy of various physical resources to implement the policy and (c) technological feasibility, which along with the previous components, involves the availability of the technical know-how, skills and machinery.\(^5\)

Hence, this chapter discusses the health policy and the process of planning for health in Tamilnadu with reference to the national context and also certain important issues with regard to the institutions and legislations related to health planning, especially in terms of primary health care.

**Essentials of Health Policy in a Developing Country:**

Health planning bears certain special characteristics in a developing country like India. Chief among them is the large public health sector and the enormous involvement of the public services in this area. The principal aim of the health policy in such a context is to secure fundamental change in the health

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status of the people, in order to enhance their physical, social and economic standards. This includes areas such as medical education, health institutions, health coverage, medical research, choice of the system of medicine, the nature and extent of interactions between these and other areas of social welfare. Secondly, India like most third world countries, possesses a limited budget to spend in the health sector and is sharply constrained by the number of health workers who have been able to be trained in the past as well as the relatively low level organisational and administrative capacity. It is critical for health planners in such circumstances to keep closely in mind the fact that the great advances in the state of health achieved in the industrialised countries have stemmed largely from factors other than the provision of curative medical services. The provision of clean water supply, generally improved hygienic standards, improved educational possibilities, better housing and the like during late nineteenth and early twentieth centuries all made their important contributions to improved standards of health. This also implies the need for a holistic approach in health planning. The very dramatic fall in the levels of mortality and morbidity which preceded the development of potent modern drugs bears ample testimony to this fact.


7. ibid., p.4.
This leads to the third correlate if the health policy in a country should be oriented in rural 'versus' urban terms or prevention 'versus' curative terms, although the two viewpoints are closely correlated. The fundamental issue in this case is the nature and degree of the 'prevention' and 'cure' mix. To start with it is difficult to mount effective preventive health campaigns, especially in rural areas in the absence of an efficient health infrastructure. Moreover, the technological requirements of eradicating or seriously reducing the incidence of certain specific diseases requires a combined curative and preventive approach. There is also the fact that a number of preventive activities are already built into the functions of a properly operating and staffed curative institutions, or, to an even greater degree in the rural health centre. Thus the development of preventive programmes must accompany the growth of rural services, but for purpose of analysis and of political and administrative action, a planning effort should be specifically directed toward getting medical and health services to the mass of rural people than concentration on the more specialised and narrow concept of preventive versus curative services.

A special difficulty in planning the health sector in a developing context is that although it is quite possible to measure health inputs in terms of money, buildings, and manpower, there is yet no convenient methodology for measuring the output
of improved health itself in response to those inputs. The adequacy of health statistics also have a long way to go. It then becomes necessary to make additional use of output as measured in terms of the volume and type of services offered and used as the next best available indicators of health. Thus, Gish states that the volume, type and utilisation of these services constitute at the present time in most third world countries, the best available proxy for measuring the output of health itself. 8

Fourthly, a vital element of the health planning is that it should lead to a definite reduction in regional disparity and an optimum level of equitable distribution of the health services, i.e., services spread more widely throughout the country rather than being concentrated in a few cities. It would thus be taken as axiomatic to health care planning in virtually all developing countries that the thinner the spread of any given volume of resources, provided the essential minimum is provided in any one location, the greater the return in terms of better health or at least the lessening of morbidity and mortality. 9 This follows from the relatively widespread distribution of population combined with poor transport and the fact that only a simple

9. ibid., p.3.
technology is required to prevent and treat a great majority of medical cases to be found in the Third World. This refers to the application of 'primary health care' in a developing milieu, especially in the rural areas. Of course, there is a minimum level of 'thinness' below which it is not possible to go if the efficiency is to be achieved within a health delivery system and the appropriate level to be aimed for in any specific situation is a matter of experience and research.

This is naturally followed by another crucial index of the health delivery system, namely, 'accessibility.' It should be resolved by all health planners whether they should plan for the entire population of the nation, or region and district or for a restricted group or area such as urban and semi-urban centres. For, a health services geared to the needs of a population as a whole should guarantee easy and quick accessibility to these services by the entire population including the remote rural based one, such as design is quite different from that which is characterised by the creation of large specialist hospitals located in urban settings and capable of handling the most difficult medical problems of those fortunate enough to reach the institution. Experience in many parts of the developing world shows that such institutions cater to needs of only the urban community and that too in the immediate vicinity.
This is a serious misuse of scarce health and medical resources and health planners should consciously direct their efforts to improve and increase the health facilities available to the population in the more remote rural areas. Thus the greater problem is likely to be the insufficiency of appropriate preventive programmes that could be implemented by most ministries of health, given their deficient rural infrastructure and relative lack of concentration on such programmes.

Lastly and perhaps the most significant aspect of health planning is the 'finance.' The size of the budget, evidently becomes the most important determinant of the volume of the capital and manpower development that can be permitted for health during the course of the plan period. In most developing countries - India being no exception - the curative services take the great bulk of the health budget with the smaller facilities and preventive services taking a relatively minor part. If this situation is to be balanced, the first priority in the sharing of the budget should be given to the development of the preventive services and the rural health infrastructure needed to provide them. This issue is complicated by the fact that many preventive activities will be carried out within the context of existing health facilities, particularly the smaller rural units, without coming under the separate budget items of
'prevention.' This is coupled with the fact that major areas of preventive and promotive work do not and need not necessarily fall under the jurisdiction of the Ministry of Health, for example provision of safe drinking water, housing, food supply and several others.

The next priority area for budgetary consideration is the 'free provision of health services.' An inevitable feature of most developing nations including India is that a great majority of the population especially in the rural areas exist below the poverty line. And a major objective of the health policy is that no individual should be deprived of the health facilities or medical services on grounds of his not being able to afford it. It may be noted that the costs of management of health sector falls into two categories of control over supply and demand. The control of supply is primarily a question of the properly planned and equitable allocation of facilities based on a standardised budget. The other aspects of control of expenditure has to do with limiting the demand for health services. In many countries such control is exercised through the charging of fees, in others demand is controlled by the supply of services or a mixture of the two. But fee charging usually has the effect of making the distribution of health services specially inequitable.
Certain factors, however, favour the charging of fees. Besides raising revenue it increases the efficiency of the services by reducing their over-utilisation and increasing the cost consciousness of both the providers and recipients of the service. Further it leads to a more balanced distribution of services through imposition of selective charges thereby counter-balancing the over-utilisation of services by those with easy geographic approach. However, this creates a possibility of excluding from health care some one in need, but incapable of meeting the expenses. This is indeed a problematic factor and far outweighs the advantages of a 'changed' system in a developing milieu.

Apart from these essential correlates of the health planning system, if a country's health service is to be geared to cater to the entire populace, it should be developed in accordance with its disease pattern and the possibility of acting upon those diseases.10 This involves an effective machinery and system to marshall and classify a broadbased and an accurate 'data' or 'information' base. Health statistics constitute the most essential ingredient in not only assessing the disease pattern but also a vital component in framing the outlines of the health plan.

10. Oscar Gish, op.cit., p.11.
In contrast to the relatively large volume of work which goes into disease statistics is the situation with regard to economic, financial and health manpower data as well as the utilisation of health service facilities by different sections of the population. The following is a summary check list of the most important data required for the making of national health plans.

A. Economic and Financial:

1. Total expenditure by Government

2. Total expenditure by private sector —
   - Voluntary agencies
   - Insurance schemes
   - Occupational health
   - Private practice

3. Division of total expenditure —
   - Government and private
   - Type of facility or programme
   - Urban and rural
   - Curative and preventive
B. Facilities:

1. Number of in-patient days - 
   Average length of hospital stay

2. Number and type of preventive procedures

3. Recurrent costs of health facilities - 
   Drugs, food, salaries, others.

C. Manpower:

1. Number and type of training institutions.

2. Cost per unit, wastage rates from training

3. Numbers of different categories of health workers.

D. Disease and demographic:

1. Main disease and their geographic incidence

2. Statistics of disease control and eradication measures.

3. Catchment areas for health services and schemes.

4. Data on nutrition standards.\(^1\)

While gaps in disease statistics need not deter the development of health services, as it is unlikely that any

\(^1\) Oscar Gish, op.cit., pp.12, 13.
country would lack even the basic data so as to prevent development, it must be stressed that the aims of the health machinery should be to possess minimum levels of data, directed to the pre-requisites necessary for the making of a viable health plan.

Thus the health policy and the planning structure in India and especially in Tamilnadu, are viewed from these perspectives, so as to gain clear insights in this area and to suggest modifications, changes or an alternative strategy if and wherever it is deemed necessary. India was an important British colony and the evolution and development of the country, particularly in the sphere of welfare issues, is in no way mean to the British rule and administration themselves notwithstanding their imperialistic motives. Thus the discussion of the health policy and planning spans two major eras of the country's history namely the pre-Independence and the post-Independence periods.

Pre-Independence Period:

The core of the health policy during this period was directed towards protecting and safe-guarding the life and health of the British military contingents. The health policy in the early nineteenth century hardly had any 'civil' content about it.¹²

Practical exigencies, however, necessitated the spread of certain health facilities to the community, albeit in a restricted manner. Hence the credit to the British who provided all the foundations and the infrastructural frameworks for modern, scientific public health services, especially in the area of preventing and eradicating certain dreadful communicable diseases.

However, it may be noted that historically, the indigenous system of medicine was well developed in this country. There were the three major systems, Ayurveda, the Hindu medical system; Unani, the Islamic system and the Siddha which can be considered to be a specialised branch of Ayurveda. The allopathic system of the western medicine, based on which the British organised the health system, out of convenience and expediency ignored the indigenous belief systems, life styles, health care institutions and practices which formed an organic unity.

Thus the existing model of health care services has evolved over the last century and a half and some of its major features are rooted in the circumstances of its origin and growth. It may be reiterated that these services began with provision of health care to overseas personnel located in India, mostly in towns and cities. Later on they were extended to the upper and middle classes of the Indian society who acted as intermediaries and

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interpreters between the rulers and the ruled. It was believed that the improvement in the health status of the people at the top layers of society would naturally trickle down to the lower layers in due course and even the concept of a direct large scale programme to improve the health status of the common man was not accepted. The main features of the colonial health policy, thus were urban bias, and elite orientation.

The British administrators were possessed of a strong 'curative' predilection and established hospitals and dispensaries, trained doctors, nurses and other personnel according to their needs. Later on, as a first move towards community health, the health policy was directed towards improving environmental sanitation in towns and cities and immunisation against communicable diseases to some extent. But these areas neither enjoyed prestige nor financial support when compared to the curative ones.

The health planning structure was quite meagre, as most curative activities was in the hands of private practitioners. The first step towards the improvement of the sanitation of the 'native' community was the institution of the Public Health Committee in 1864 based on the recommendations of the Royal Commission which functioned between 1859 and 1863. This Committee for the first time conducted a thorough survey of the health

needs of all the Presidencies including Madras. This resulted in the appointment of 'Sanitary Commissioners' in the three Presidencies of Madras, Bengal and Bombay in 1864. This was the first time an exclusive public health functionary was appointed, whose duties among other things were to advise and assist the Governments of the Presidencies in all matters relating to public health and to exercise constant invigilation on the sanitary conditions of the population. A most significant health policy decision was made in April 1869, when the Sanitary Commissioner who was till then with the military department, was transferred to civil department.

In 1868, an important public health move was made with the reorganisation of the vaccine department. Vaccination provided one of the vital preventive measures and in 1875 vaccinators were transferred to the local fund boards in recognition of the localised needs of the community. In 1878, the health policy began to take cognisance of the 'preventive' element of public health by transferring the mainly preventive service of the Vaccination Department to the control of the Sanitary Commissioner.


16. ibid., p.2.

17. ibid., p.3.
The Royal Commission in 1863 had drawn pointed attention to the absence of all informations with regard to vital statistics of the general population. In 1865 the first attempt was made to register the mortality of the people in the Madras Presidency through the Sanitary Department. This culminated in the enactment of the 'Birth and Death Registration Act' in 1873. The year 1880 witnessed the passing of the 'Vaccination Act' and the appointment of the 'Plague Commission' to survey and devise methods to control and eradicate one of the most menacing diseases at that time. Seven years later in 1887, the 'Epidemic Diseases' Act was passed. Thus, the latter part of the nineteenth century witnessed a spurt of significant activities and legislation which established well the importance and urgency of community and preventive health activities.

The most significant health activity of the twentieth century was the constituting of the 'Malaria Board' in 1911, in the Madras Presidency, to combat what was perhaps the most pernicious communicable disease in the country. In 1915, the Presidency Pilgrim Committee was established in Madras headed by the Sanitary Commissioner. The report of this Committee is considered to be a classic even today.

The year 1922 proved to be a watershed in the history of public health administration. The Government of India Act 1919 transferred the subject of sanitation and Public Health to the Provinces under the Minister in-charge of local self-government. The title of the Sanitary Commissioner was changed to Director of Public Health and the sanitary department came to be termed as the Public Health Department. By now the health policy makers had begun to realise the importance of local involvement and decentralisation in the sphere of public health. In 1923, a complete self-contained Public Health staff working under the District Boards was established and the framework for eradicating and controlling communicable diseases was also drawn. 19

1923 to 1930 witnessed quite a flurry of activities in the area of public health in terms of establishing more local health institutions and personnel such as Health Officers and Sanitary Inspectors and enhancing their training. A noteworthy fact is that the health administration in the Madras Presidency was so well organised that a health team of the League of Nations which visited the Presidency in 1928 highly commended it, especially the anti-malaria work.

With the introduction of provincial autonomy under the Government of India Act, 1935. The health ministries in the

States were made more fully responsible for health policy and administration. The most noted landmark after this Act in evolution of health policy was the enactment of the 'Madras Public Health act 1939'. It was a most comprehensive health Act and the first of its kind in India. Containing several detailed provisions that are essential for the advance of public health, the Act remains a class by itself till date and serves as an important guideline in shaping health policies all over the country. The Drugs Act was enacted in 1940 as a Central Legislation to manufacture, purchase and monitor the distribution of important drugs and medicines.

The first attempt in planning at the national level was made in 1938 with the establishment of the National Planning Committee (NPC) under the Chairmanship of Jawaharlal Nehru and it began to function since 1939. This Committee appointed a number of sub-committees, the important of which was the Sub-Committee on National Health under the Chairmanship of Col. S.S. Sokhay. This sub-committee presented an interim report in 1940 and the main report in 1946. Though several resolutions were passed by the National Planning Committee based on these reports, no concrete actions were taken to further the public health activities on comprehensive lines.

The next major and perhaps the most important development which made and is continuing to make a telling impact on the growth of public health in the country is the appointment of the 'Health Survey and Development Committee' in 1943 under the Chairmanship of Sir Joseph Bhave. The Report of this Committee was published in four volumes in 1946 and remains till today the fountain head of health policy and programmes in India. One of the noteworthy features of this report was the almost accurate forecasts of the health situation it made in terms of health manpower and institutions at various levels of health administration.

The committee, after making a thorough, objective and comprehensive analysis of almost all aspects of health and its related fields suggested a pattern for the health infrastructure needed both at the central, state and local levels. Above all it presented an extensive outline for the 'future health plan' of the country. The committee stated unequivocally that no health plan or proposal could be viewed unilaterally, i.e., it identified health as an inextricable component of the overall social network and recommended that any improvement in the health conditions could be brought only through a multi-sectional approach.

It further emphasised that the provision of effective means for the early detection and prevention of epidemic and communicable diseases must take a very high place in the organisation of
public health measures, while improvement in nutritional standards must form the basic objective in drawing the health plan. The committee observed that nutrition in this context involves not merely a properly balanced diet, but a quantitatively adequate one.22

The committee also enunciated certain fundamental objectives desirable in formulating plans for the national health service. These included the following:

1. The services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;

2. These services should be placed as close to the people as possible, in order to ensure their maximum use by the community which they are meant to serve;

3. The health organisation should provide for the widest possible basis of co-operation between the health personnel and the people;

4. In order to promote the development of the health programme on sound lines the support of the medical

and ancillary professions such as those of dentists, pharmacists and nurses, is essential; provision should, therefore, be made for enabling the representatives of these professions to influence the health policy of the country;

5. In view of the complexity of modern medical practice, from the standpoint of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute 'group' practice, should be made available;

6. Special provisions should be required for certain sections of the population, e.g., mothers, children, the mentally deficient, etc.

7. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it; and

8. The creation and maintenance of as health an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation is essential.23

Thus till 1947, the health system in the country was operating on a limited scale, in the sense that there was neither a uniform and a comprehensive infrastructure nor a well established policy. The Bowra Committee, however, provided a firm foundation for the future of the health system by presenting an objective picture of the then prevalent conditions and appropriate suggestions and above all the framework for policy making and planning.

**Post-Independence Period:**

When India attained independence in 1947, it began to experience conspicuous changes in almost all of its socio-economic and politico-cultural spheres. Though in several areas the vestiges of the colonial rule inevitably continued to exist, the newly independent nation embarked on new experiments and methods in nation-building. The most significant development was the recognition and impetus given to the spheres of policy-making and planning through a federal planning commission to achieve socialist democracy. It was mainly in recognition of the need for a consolidated comprehensive and a uniform policy and plan in all areas of national reconstruction and for equitable distribution of all available resources. The most important purpose was to forecast and project future needs and thereby lead to greater preparedness in facing them.
As observed in the introduction, the local aspect in the health sphere was well comprehended in India even in 1919, when after the Mont-Ford Act, health, sanitation and vital statistics were handed over to the provincial governments. Still there was not adequate clarity regarding the distribution of authority between the Centre and State covering health issues. The situation did not improve much even after the enactment of the 'Government of India Act 1935.'

However, after Independence, when the Constitution of India was framed in 1951, all activities of national importance were classified into three categories with well-delineated areas of operation under the Central, State and concurrent lists. Health was again made an exclusive 'State' subject and included in the State list. The constituent Assembly expressly justified this move by stating that the nature of health care delivery depended largely if not entirely not only on the disease pattern of a particular area which again was influenced by several factors including geographic and climatic, but also on the locally prevalent habits, customs, culture and traditions. It was thus inevitable that the promotion of health should be in keeping with the local needs and problems of a particular area. Therefore, the norms and dictates of decentralisation necessitated health becoming a State subject.24

Nevertheless, the Central Government continued to provide invaluable guidance and suggestions to the States in all health matters and plays a pivotal role in initiating, financing, co-ordinating and consolidating several health schemes and plans. Despite health being a well-extended State subject, it is not easy in certain issues to determine whether the functions implied under specific items in each list have a direct or indirect bearings on health. This is evident from the table below wherein the items bearing direct and indirect relations with health under all three lists are provided:

<table>
<thead>
<tr>
<th>Direct Health Items</th>
<th>Indirect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pilgrimage to places outside India</td>
<td>Shipping, navigation on inland waterways declared by law as National Waterways.</td>
</tr>
<tr>
<td>2. Port quarantine, including marine hospitals</td>
<td>Airways and air navigation regulation and organisation of air traffic and aerodrome.</td>
</tr>
<tr>
<td>3. Inter-State navigations</td>
<td>Carriage of passengers and goods by railways, sea or by air (These items are directed towards the regulation of health requirements and control of infection)</td>
</tr>
</tbody>
</table>
State List:

1. Public health and sanitation hospitals and dispensaries

2. Pilgrimage within India

Concurrent List:

1. Lunacy and mental deficiency including mental institutions

2. Adulteration of food stuffs and other goods.

3. Drugs and Poisons

- Regulation of labour and safety in mines and oil field.
- Production, manufacture, transport, purchase and sale of intoxicating liquors.
- Relief of the disabled and unemployable.
- Burials and burial and cremation grounds.
- Market and Fairs.

Economic and Social Planning

- Social security and social insurance.
- Vital statistics including registration of births and deaths.
4. Legal, medical and other professions.

5. Prevention of the spread from one state to another of infectious or contagious diseases or pests affecting man, animals and plants.

In keeping with the dictates of the welfare state, health was given significant importance and the very concept of health and the nature of planning its delivery, acquired new dimensions and a new orientation.

Values, ends and means:

These new perspectives and changed perceptions of the concept and meaning of health brought quite an evident transformation in the very basic aspects of the health policy in terms of the values, ends and means for health care delivery, in the context of an independent and a developing milieu. Despite the retention and continuation of the pre-colonial British system of allopathic medicine and certain methods and ideas, the overall value framework of health policy was given a new turn.
The health values were oriented to the norms, cultural patterns and predominantly to the economic conditions of the majority of the population. As such the major value that influenced the post-Independence policy was that health services should be divested of its elitist orientation in terms of the population served and urban orientation in terms of geographic distribution. Thus equitable distribution of health and basic medical facilities to all the people especially the rural population constitutes the principal value promise. This principle was enshrined in the directive principles of State policy of the Indian Constitution which states that "the State shall regard the raising of the level of nutrition and standard of all its people and improvement of public health as its primary policy."

Further, in keeping with the Bhopal Committee recommendations, which made a thorough analysis of the economic conditions of especially the rural population and the economic feasibility, health services were to be provided free of cost, at least for the first ten years. This policy component was greatly influenced by the National Health Services of the U.K.

27. Report of the health Survey and Development Committee, op.cit., p.1
The Health policy also recognised the inadequacy of the curative, western oriented hospital based health system in a country like India. These services were either overutilised by a particular section or were under-utilised due to financial and other material constraints on the part of majority of the population. The policy realised the need for a simplified, accessible system that could be within reach - physically and economically - of the common man. These values formed an intensive part of the overall policy of social welfare development of the Government of India under the socialist ideology of the Congress regime, which constituted the core of the planning procedure. This included an integrated development to eliminate poverty and inequality, to spread education and to enable the poor and under-privileged groups to assent themselves.\textsuperscript{28} The health development policy was integrated conveniently with this larger programme of overall social development in such a way that the two were to become mutually self-supporting.\textsuperscript{29}

Thus the basic ends of this policy were -

a) to integrate the development of the health system with the overall plans of socio-economic and political transformation.

\textsuperscript{28} Health for All: An Alternative Strategy, op.cit., p.10.

\textsuperscript{29} For instance, the nutritional component of the health programme will get good support in programmes of increased food production.
b) to ensure that each individual has immediate access to adequate health facilities and is provided with an environment which is conducive to health and adequate immunisation, where necessary;

c) to combine the best elements in the tradition and culture of the people with modern science and medical technology; and

d) to integrate promotive, preventive and curative functions and to establish a democratised and decentralised health structure and motivate maximum community participation in the delivery of health care.

The primary means of achieving these ends were a consolidated and centralised system of planning and programming through the planning commissions at the Centre and the States. And the Five Year Plans were an important means of implementing these goals. The Government adopted the 'Inductive percolative process' whereby the State was to initiate and mobilise the health policy, resources and the relevant institutions and let the services and the machinery percolate to the community levels. Thus the community participation was to be induced from the governmental
level to and altered to percolate gradually to the grass-roots. The government recognised fully the need to develop a practical approach in making essential or primary health care universally accessible to individuals and families in the community in an acceptable and affordable manner and with their full participation. A self-reliant population with minimum dependence on the official health machinery was the ultimate aim of the health policy. This was sought to be achieved through a network of rural health units which provided a package of preventive, curative and promotive services. These units combined the benefits of the curative clinical services with those of eradicating and preventing the occurrence of diseases, through the services of appropriately trained para-medical and auxiliary personnel who would establish a personal rapport with the local community.

Several institutions and organisations came to be established to serve as staff agencies to provide invaluable data and health information.

**Indian Council of Medical Research (ICMR):**

Amongst such post-colonial institutions, the Indian Council of Medical Research constituted an important one. Medical Research is indispensable in understanding and combating diseases

in the tropical Indian conditions by augmenting the knowledge of their basic causative and propagative factors. The ICMB came into existence in 1950 as the Central Medical Research Organisation as recommended by the More Committee. It actually substituted the Indian research Fund Association.

The ICMB adopted two broad directions in the field of research, these were applied research for the solution of outstanding current problems in the field of medicine, public health and allied fields and secondly fundamental research in these areas. The major objectives of the Council are to prosecute, coordinate and assist research in communicable diseases, to finance investigations and research projects, to exchange information with other institutions engaged in similar activities and to prepare and publish reports of research work, papers and periodicals to grant fellowships. Besides the Council maintains eight permanent units all over the country to conduct research and studies in various areas of public health and medicine, namely,

1. The National Institute of Nutrition, Hyderabad.
2. The Virus Research Centre, Pune.
3. The Primary Chemotherapy Centre, Madras.
4. The Cholera Research Centre, Calcutta.
5. The Indian Registry of Pathology, New Delhi.
7. The Institute of Research in Reproduction, Bombay, and
8. The Central Malima Institute of Leprosy, Bombay. 31

The ICWR serves as an apex body assisting in planning organisation, implementation and coordination of medical research in the country.

The Central Council of Health is another key agency involved in shaping the health policy at the federal level. Established in August 1952 in pursuit of the decisions made at the Health Ministers' Conference in 1950, the Council is headed by the Union health minister and consists of Health Ministers of all the States.

The major functions of the Council are to consider and recommend broad lines with regard to matters concerning health in all its aspects such as the provision of remedial and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research.

a) to make proposals for legislation in fields of activity relating to medical and public health and laying down the pattern of health development for the country as a whole;

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Geeal S.L., health Care Administration, Policy Making and Planning, sterling Publishers, New Delhi, 1980, p.36.
b) to make recommendations to the Central Government regarding distribution of available grants-in-aid for health purposes to the States and to review periodically the work accomplished in different areas through the utilisation of these grants-in-aid and to establish any organisation or organisations invested with appropriate functions for promoting and maintaining co-operation between the Central and State health administrations.  

The Council, thus was the first institution at the national level to provide a definite policy framework for health administration and also a vital means for co-operation between the Centre and States on matters of health.

These and other institutions along with the Planning Commission led to the country embarking on an elaborate and a comprehensive long-term planning strategy based on socialist and democratic principles. This initiated the 'Five Year Plans' in 1951. These plans denote the phased implementation of the National Health Policy in accordance with the prevalent national, regional and local needs, circumstances and conditions as analysed.

by the Planning Commission. Health being entirely a State subject, the Central Five Year Plans act more as trend-setters in the formulation of health policies and planning schemes. However, several health programmes especially for the eradication of communicable diseases are centrally sponsored and implemented by the States. An the plan allocation for these projects play no mean role in influencing health policies and priorities at the State level. The validity of these plans and other health projects are bolstered by the recommendations and proposals made by expert health committees consisting of eminent specialists and administrators in health, medicine and other related fields. These committees supply the governments and the planning machinery valuable information based on sound technical knowledge, experience and meticulous research, on which the details of policy measures may be constructed.

Health and the Five Year Plans:

Starting from 1951, there have been six Five Year Plans, interspersed with three annual plans from 1966 to 1969. The Janata Government tried a short experiment with the rolling plan during Sixth Plan period from 1976-83. However, after the Congress resumed power, it has indicated its desire to prepare a new plan for 1980-85.
**First Five Year Plan: 1951-56**

The First Plan devoted an entire chapter to health and was strongly influenced by the Shore Committee report of 1946. It made a thorough study of the health conditions and the health status of the people in India along with a comparative analysis of the health conditions obtaining in some of the developed countries, especially the U.K. The plan identified important areas which needed prompt attention and listed all the factories that accounted for the low level of health in the country, based on a region-wise analysis. These included among other things lack of hygiene, environmental sanitation conducive to healthful living, low resistance due to inadequate diet, prevalence of malnutrition, lack of proper housing, safe water supply and disposal of human waste and the lack of adequate medical care, lack of adequate general and health education, limited resources in terms of money, men and material. It also recognised that facilities for medical education were extremely inadequate and incommensurate with the health problems. Based on these findings the plan laid down the following priorities as major components of the health policy:

1. provision of water supply and sanitation;
2. control of malaria;
3. Preventive health care for the rural population through health units and mobile units;
4. Health services for mothers and children;
5. Education, training, and health education;
6. Self-sufficiency in drugs and equipment; and
7. Family planning and population control.

This indicates that the plan took a comprehensive view of the health conditions. Though the plan recognised the importance of rural based preventive health, it continued to lay greater emphasis on the hospital based clinical spheres. A discomfiting feature of the plan is the paucimonious plan outlay of 5.8% for the health sector.33

**Second Five Year Plan: 1956-1961**

The Second Plan adopted much the same strategy as the first. This plan, however, mentioned for the first time the need for institutional facilities at the local levels to serve as bases from which services could be rendered to the people in the immediate vicinity and the surrounding areas. The plan reiterated the need to step up the family planning programme and other supporting programmes and emphasised the development of technical man-power through appropriate training programmes. Above all

33. First Five Year Plan, Planning Commission, Government of India, New Delhi, 1951.
the Second Plan made a strong plea in favour of enhancing the environmental hygiene. But the plan outlay for health was reduced to 4.9\%.\textsuperscript{34}

**Third Five Year Plan: 1951-1966**

This is about the most significant of the plans, which vehemently impressed upon the health structure the importance of rural and primary health care. It clearly identified the major problems in the effective delivery of primary care which included shortage of trained health personnel, delays in the construction of buildings and residential quarters for the staff and inadequate training facilities for the different categories of staff required in the rural areas.

In order to strengthen the primary health, the plan suggested a single cadre of health personnel for urban and rural areas with a compulsory period of rural services before crossing the efficiency bar. It further stated that this period should be taken into consideration for promotion and higher qualification.

By way of motivating the medical personnel to serve in the rural areas, the plan stated that scholarships to students should be coupled with an obligation to serve in rural areas for a

\textsuperscript{34} Second Five Year Plan, Planning Commission, Government of India, New Delhi, 1961.
stipulated period. The most significant contribution made by the plan was to recommend that the services of qualified and properly trained graduates in the indigenous systems of medicine should be utilised at the Primary Health Centres and the sub-centres. Thus the third plan was completely oriented to the provision of effective primary health care.35

Certain important committee reports were also submitted during this period. These include —

The Health Survey and Planning (Mudaliar) Committee, 1962:

The Government of India instituted this Committee to survey the progress made in the field of health since the submission of the Bhore Committee recommendations in 1946 and to make recommendations for future development and expansion of health services.

The Mudaliar Committee found the quality of primary health care inadequate and stressed the need to strengthen the existing PHCs before new ones could be created. It also stressed the need to strengthen sub-divisional and district hospitals so that these could function effectively as referral centres. The main recommendations of the Mudaliar Committee were —

a) Consolidation of advances, efforts and achievements made during the first two Plan periods in the field of health.

b) Equipping district hospitals with specialist services.

c) Regionalisation of health services, i.e., setting up regional structures between the State and District headquarters.

d) Limiting the coverage of the PHC to a population of 40,000.

e) Improving the quality of care provided by the PHC.

f) Integration of medical and health services as suggested by the Shree Committee, and

g) Constitution of an All-India Health Service on the pattern of Indian administrative Service.36

Chadah Committee, 1963:

This Committee studied the effectiveness of the National Malaria Eradication Programme, especially the 'maintenance phase' and suggested the PHCs should take up full responsibility for malaria vigilance operations and recommended the appointment of basic health workers to conduct the vigilance operations at the rate of one worker for 10,000 population.

1) Integration of organisations and personnel in the field of health from the highest to the lowest levels in the service through -

a) a unified cadre;
b) common seniority;
c) recognition of extra qualifications;
d) equal pay for equal work;
e) special pay for specialised work; and
f) abolition of private practice.

The Committee did not spell out steps and programmes for the integration recommended by it, but left it to the States to work out the details. It however defined the integrated services as -

a) Service with a unified approach for all problems; and

b) Medical and conventional public health programmes being integrated under a single administration and operating in a unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time. 37

Fourth Five Year Plan, 1969-74:

During the Fourth Plan, efforts were made to strengthen the primary health care structure in the rural areas for undertaking preventive and curative health services and for strengthening the maintenance phase of the eradication programmes. The Mudaliar Committee recommendations constituted its base and the plan incorporated the following activities:

a) to provide an effective base for health services in rural areas by strengthening the Primary Health Care Centres;

b) to strengthen sub-divisional and district hospitals in order to provide effective referral services for the PHCs; and

c) to expand the medical and nursing education and to train the para-medical personnel with a view meet the minimum technical manpower requirements. 38

Kartar Singh Committee, 1973:

This Committee on 'Multipurpose workers under Health and Family Planning was constituted to study and make recommendations
on the structure for integrating health services at the periphery and supervisory levels and the feasibility of training and appointing multi-purpose and bi-purpose workers in the primary health field.

The Committee recommended the 'Male and Female Health Workers Scheme' to replace the services of uni-purpose workers at the PHC. It further emphasised that, for proper coverage, there should be one primary health centre for a population of 50,000 and 15 sub-centres for each PHC each covering a population of 3,000-3,500 depending on topography and means of communication.

It suggested a staff pattern of a team of one male and female health workers for each sub-centre with one male and one female health supervisor for 3 to 4 health workers. And that the medical officer in-charge of the PHC should have overall charge of all the supervisors and health workers in his area.39

Fifth Five Year Plan, 1974-78:

The Fifth Plan formulated a new strategy through the 'Minimum Need Programme.' The primary objective of this programme was to provide a package of basic public health facilities

integrated with family planning, nutrition for vulnerable groups such as women, children and lactating mothers. Besides, the plan reiterated the need to enhance the usual health services by intensifying the control and eradication of communicable diseases, increasing the accessibility of the health services, developing the referral services and correcting regional imbalances.

The plan, however, increased the coverage of the PHC to a population of one lakh and that the sub-centres to 10,000. It recommended the provision of drugs at the rate of Rs.12,000 to each PHC and Rs.2,000 to each sub-centre. It, however, suggested that one is every 4 PHCs should be upgraded to the status of a 30-bedded rural hospital with specialised services in surgery, medicine, obstetrics and gynaecology. The minimum needs programme along with the training of multi-purpose health workers and vigorous pursuit of the goals of control and eradication of communicable diseases was to constitute the core of the health plan structure. 40

In 1977 October, the draft Sixth Five Year Plan by the then Janata Government, which wanted to completely re-orient the health plan in accordance with the relevant rural needs of the people. The draft established a landmark by launching the

'Community health Volunteer' scheme. This was based on the concept of community participation, wherein a volunteer is selected from the local village community, is trained in the fundamentals of public health for three months and is provided with a health kit. He has to serve a unit of the village consisting of a population of 1,000.41 This was not, however, uniformly implemented and Ramilnawu especially did not implement this proposal.

Shrivastava Group Report, 1975:

Also known as the 'Group of Medical Education and Support Manpower', it made a thorough examination of various health reports and papers including the recommendations made by as many as 12 conferences and committees. It recognised one of the vital aspects of primary health care when it stated that the rural health services should be based on the local conditions, limitations and potential. It suggested for the first time the idea of selecting health workers from the local community which later emerged as the 'Community Health Volunteer' scheme. It also emphasised the importance of maintaining strong links on the part of all the district medical and health institutions in order to strengthen the referral services.

Sixth Five Year Plan, 1980-85:

when the Congress Government was restored to power at the Centre it drew the draft of the Sixth Plan. This plan again attempted a comprehensive review of the health conditions in the country with special focus on the rural areas and drafted a wide-ranging plan to enhance the health conditions. An important aspect of the sixth plan is that it incorporated the World Health Organisation's global objective of 'Health for All by 2000 A.D.' which was adopted at the Alma-Ata International Conference on Primary Health Care in 1978 at U.S.S.R. India was one of the signatories.42

It reemphasised the need to strengthen the primary health complex through a co-ordinated approach involving all social welfare activities by increasing and expanding the services of trained para-medical personnel to meet the rural health needs. It, however, stressed the importance and urgency of enhancing community participation and health awareness if the Alma-Ata Objective was truly to be realised by the end of the Century.43

Thus the draft national health policy prepared by the Union Ministry of Health and Family Welfare envisages a shift from the

present hospital based, disease oriented approach to one of making best use of knowledge and expertise of technical experts in health and all the related fields.

The following are the salient features of the draft National Health Policy:

a) eradication and control of communicable diseases in the country;

b) provision of an adequate infrastructure for primary health care in the rural areas and urban slums;

c) use of all available methods of health education and wide-spread dissemination of health and family welfare information;

d) use of knowledge from different systems of medicine for promoting quick and safe relief from sickness and debility at the cheapest possible cost;

e) re-orientation of medical education, in keeping with the needs of the community and provision of greater material and child health coverage;
1) improvement of health conditions by setting up a changing sanitary-cum-epidemiological stations;

2) ensuring that coverage of all segments of population with preventive services;

3) creation of self-sustaining system of health security so that individual income is not adversely affected during periods of illness,

4) imparting of medical education in a medium which is an integral part of the nation's culture and life-style to remove the western concepts associated with foreign dispersion which are major factors preventing the people from understanding the true and proper role which medicine plays in the development of healthy community; and

5) use of knowledge from traditional and modern systems of medicine in an effort to develop a composite system of medicine.44 (see Appendix II for details of the National Health Policy).

While a constructive programme of development based on deep insight and prescient planning is evident in the five year-

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44. Draft National Health Policy, Ministry of Health and Family Welfare, Government of India, New Delhi, 1980. Also vide Appendix II for details of the National Health Policy.
plans, the absence of commensurate financial allocation is a matter of concern. Contrary to the increasing plan involvement in enhancing the rural health structure, the plan outlay have been gradually and perceptibly declining as is evident from the table below:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Centre</th>
<th>Centrally sponsored</th>
<th>State</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>13.80</td>
<td></td>
<td>87.1</td>
<td>100.9</td>
<td>4.98</td>
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<tr>
<td>Second</td>
<td></td>
<td></td>
<td></td>
<td>146.00</td>
<td>4.58</td>
</tr>
<tr>
<td>Third</td>
<td>14.86</td>
<td>3.46</td>
<td>205.57</td>
<td>229.03</td>
<td>2.60</td>
</tr>
<tr>
<td>Fourth</td>
<td>53.50</td>
<td>176.50</td>
<td>203.53</td>
<td>433.53</td>
<td>2.14</td>
</tr>
<tr>
<td>Fifth</td>
<td>75.78</td>
<td>177.50</td>
<td>543.20</td>
<td>796.00</td>
<td>2.13</td>
</tr>
<tr>
<td>Sixth</td>
<td>21.98</td>
<td>124.50</td>
<td>134.63</td>
<td>281.11</td>
<td></td>
</tr>
</tbody>
</table>

Health Planning in Tamilnadu:

To a large extent, the general health policy throughout India is almost uniform, Tamilnadu being no exception. This was due to the strong influences of the Central planning structure.

political factors and the intimate connection between political and economic development. Political forces play a dominant role in shaping the health policy and planning strategy through resource allocations, manpower policy, choice of technology and degree of accessibility of health services to the population.

The post-Independence milieu in Tamilnadu experienced the Congress regime for two decades from 1947 to 1967. Having adopted a socialist stance, the country was possessed of one of the most elaborate governmental central and regional, planning systems. The avowed policy of the Health ministry in Tamilnadu from the time of inception was the provision of medical and health services throughout the state free of cost specially in the rural areas, through a network of governmental institutions. One of the characteristic features of the health policy, which is varying degree have been maintained by successive governments is the strong prediction towards the hospital based curative services. Table II shows the percentage of revenue expenditure on public health and medical services from 1955 to 1967 and proves the widening gap between curative and preventive services.

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage on Public Health</th>
<th>Percentage on Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1955</td>
<td>1.1</td>
<td>5.9</td>
</tr>
<tr>
<td>1956</td>
<td>1.2</td>
<td>1.3</td>
</tr>
<tr>
<td>1957</td>
<td>1.3</td>
<td>6.2</td>
</tr>
<tr>
<td>1958</td>
<td>1.2</td>
<td>6.4</td>
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<tr>
<td>1959</td>
<td>2.3</td>
<td>6.1</td>
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<tr>
<td>1960</td>
<td>3.1</td>
<td>5.4</td>
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<td>1961</td>
<td>2.1</td>
<td>6.3</td>
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<td>1962</td>
<td>1.7</td>
<td>5.1</td>
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<tr>
<td>1963</td>
<td>1.7</td>
<td>6.7</td>
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<tr>
<td>1964</td>
<td>1.9</td>
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<tr>
<td>1965</td>
<td>1.5</td>
<td>4.2</td>
</tr>
<tr>
<td>1966</td>
<td>2.1</td>
<td>6.0</td>
</tr>
</tbody>
</table>

The Government of Tamilnadu, expressly stated that the major policy of the Ministry of Health in the State, in accordance with the National Health Policy would be to shift the

emphasis from the hospital based, disease oriented approach depending heavily on sophisticated technology to an approach where the attitudes and skills and training of the health personnel would be in line with the needs of common man and where the facilities available would be easily accessible and equitably distributed in physical, social, cultural and financial terms. Primary health which came as a practical approach in making essential care universally available to individuals and families in the community was incorporated as a major policy.\(^4\) The objectives of the Department of Public Health were directed towards the improvement of the sanitary conditions and the control and eradication of communicable diseases and expansion of the primary health structure through the construction of more PHCs.\(^5\) The Dravida Munnetra Kazhagam (DMK) which defeated the Congress and formed the ministry in 1967 was a regional party. However, the social welfare policies of the Congress and the DMK remained the same. In the sphere of public health remained unchanged and committed to the principles of primary health care. The Ministry reiterated the primary objectives of the health department to improve the environmental sanitation and to control and eradicate communicable diseases.\(^6\) However, the difference in


spending between the health and medical services was marginally reduced. The Tamilnadu State Planning Commission in 1972 appointed a 'Task Force on Health, Family Planning and Sanitation' to prepare a perspective plan for health in Tamilnadu from 1972 to 1984. The Committee spelt out as the major health policy of the state, the improvement of the health of 50 percent of the population which was not covered till then, through an integrated administration of primary health care, nutrition and family planning at the village level. This would involve —

a) the improvement of health and medical services;

b) the promotion of nutritional status of the vulnerable segments of the population according to a system of priorities;

c) strengthen campaign for family planning and health education; and

d) provision of safe and adequate water supply and satisfactory sanitary facilities.  

The present AIADMK which is an offshoot of the DMK took reign of government in the state in 1977 and merely echoed the established health services which reach to the rural families.  


The curative trend, however, continued at the operational level, as is evident from the budgetary allocations continuing to favour the medical services. Table III shows the percentage of revenue expenditure for the two branches of health services since 1967.

### Table III

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage on Public Health</th>
<th>Percentage on Medical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>2.1</td>
<td>6.0</td>
</tr>
<tr>
<td>1968</td>
<td>2.2</td>
<td>6.1</td>
</tr>
<tr>
<td>1969</td>
<td>2.1</td>
<td>5.9</td>
</tr>
<tr>
<td>1970</td>
<td>2.3</td>
<td>5.2</td>
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<tr>
<td>1971</td>
<td>2.2</td>
<td>6.0</td>
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<tr>
<td>1972</td>
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<td>1981</td>
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<td>6.1</td>
</tr>
<tr>
<td>1982</td>
<td>3.0</td>
<td>6.2</td>
</tr>
</tbody>
</table>

The health ministry and the health secretariat are the major policy making institutions in the state, and the major guidelines for health policy are provided by the Central health policies. Though there is a State Planning Commission in Tamilnadu, it is not as active and powerful as the Union Planning Commission. The Task Force on Health was the only expert body ever to be appointed at the State level to analyse the situation and present a comprehensive health policy for Tamilnadu. There are no specific staff agencies (barring the Health Secretariat) to assist the Health Ministry in policy making. Thus policy making and planning procedures emanate directly from the Health and Family Welfare Ministry. More often the ministry depends on the advice of the doctors in the different health and medical directorates in matters of technical and specialist nature.

The principal shortcoming of the health policy, both at the Union and the State levels is, that while the policy in spirit advocates the rural oriented preventive aspects of health planning, in practice, the emphasis gets shifted to urban oriented hospital based curative structure of delivery of medical services. Thus an inexorable hiatus is created between the policy and the implementation process.

Though the general policy for health has successfully identified the major health problems, the element of highly
centralised policy making and planning process, to be a serious drawback. The staff agencies mentioned earlier provide sufficient data and information though at the highest and generalised levels, on all areas of health service development. There are, however, a number of areas in which more localised and community-oriented information are needed, such as the creating ways of improving the registration of births and deaths or with regard to health facilities, the problem of increasing the outreach of hospital services, which is connected to that of an appropriate balance between the volume and size of the most basic rural facility (the sub-centre) and the middle level facility (the primary health centre) and the relationships between these rural facilities and the hospitals.

However, the policy can never make any headway in practice, unless it is bolstered by commensurate resources, especially financial. The major constraint in the area of health planning is the meagre budgetary allocation, which by itself is inadequate besides being coupled with a disparate distribution between public health and curative services with the latter consuming almost 75% of the health budget. This situation provides greater prestige and a stronger organisational structure to the curative services in terms of hospitals, equipment, specialists and high technology.
A related problem is that of the integration or the lack of it amongst the various branches of health and medical services and medical education. It may be observed that while the constant refrain of the health policy after independence has been that the curative and preventive services should be integrated and that the medical educational system should be orientated to the health needs problems and demands of such an integrated pattern, all these have been functioning in a detached and a compartmentalised manner. This is more a problem of planning the organisational structure. In other words the planning and the implementing process have provided neither the infrastructure nor adequate personnel to implement the health policy, especially the primary health part of it. A case in point is that the coverage of the PHC and sub-centre is still much larger (about one lakh and more for PHC and 10,000 and above for a sub-centre) than what is deemed appropriate by the expert committees.

The corollary to this problem is the absence of integration between the health policy and the overall socio-economic planning and development, as vehemently advocated by the Bhore Committee even in 1946. Health is still viewed from an isolated perspective and this causes even the some of most effective health measures to disintegrate without making any substantial contribution to either to the enhancement of the health status or the general social development of the community.
Thus, the absence of integration both at the micro and macro levels is partly attributed to the inadequate planning machinery at the state level. The Health Ministry being the only important apex policy-making and planning body does not possess an exclusive planning unit that can co-ordinate all the branches of the health services, with decentralised local units to provide follow-up and feedback facilities. It could also co-ordinate its services and efforts with other allied ministries and services. Another important aspect is co-ordinating the efforts of non-governmental private and voluntary agencies involved in health activities. Such a planning unit should be organised independently of other ministerial divisions and directly responsible to the Ministry's senior functionaries, thus in fact becoming its planning arm. It should have direct responsibility for the formulation of the annual development (capital) plan and the long-term plans. It should take part in the planning of the recurrent budgets of the ministry which, in turn, necessitates direct involvement with the manpower budget which is the single most important development (74%) of the recurrent budget. The planning unit could have at its disposal a mass of administrative data and vital health statistics and information produced all over the state. A consolidated health information system forms the very core of policy making for health, which in its present state leaves much to be desired.
Health planning at present relies too much on medical doctors who do not have adequate public health training and often tend to have little regard for normal socio-economic or other planning procedures. The problem of applying economic and financial criteria to the health sector is particularly difficult because of the special nature of the services provided. Thus the composition of the planning unit should consist of skilled public health experts, statisticians, economists, sociologists along with the medical experts. The next essential factor is the information content and the data available to the health planners. The present availability of data for health planning is insufficient in terms of high and general policy formulation and in the area of sophisticated medical technology. Despite the existence of a large number of statistical and other organisation both at the Union and the State levels, the health information system has not been designed scientifically and sometimes leads to generation of superfluous data. A great shortcoming of the planning system in the State is the absence of adequate generation and assimilation of local and gross-root level health information with the general health policy. Thus a 'data base' with sufficient field units and which can at a given point in time consolidate and integrate all the relevant information concerning all the health aspects should be available and form an inseparable component of the health machinery.
Lack of effective communication amongst various units of planning and planning personnel is an important reason for lack of integration at the organisational levels. Policy making and planning are a continuous process and the health planning machinery should establish effective channels of communication with governmental and non-governmental agencies in formulating the health policy. At present though several institutions, private, public and quasi-governmental are involved in several health projects, there is not sufficient exchange of information or ideas either at the policy making or at the field levels. Policies thus tend to conform with conventional planning and out-dated information.

Continuity of health policy in terms of gradual implementation of the policies and planning is also a need of the hour. The Five Year Plans have periodically spelt out different projects and strategies in accordance with the exigencies or priorities that seemed necessary at the time of the policy making. This resulted in inadequate resources, shortage of the most needed para-medical and auxiliary health personnel and the infrastructural facilities. Health policies like in the "east should be oriented to a specific time schedule and each plan and the projects it recommends must have bearings on the evaluation of the previous ones and thereby depending on the results proceed with future plans.
Finally a major problem in this area is the relation between policies and the prevailing values. It has been stated the indigenous value, and the health systems has been almost ignored in the policy making. The vital issue in this regard is the influence given to the Indian system of medicine in the general health policy. Though allopathic medicine has the universal appeal backed by authenticity and credibility of scientific experiment, it is alien to the Indian value system and so are certain curative and preventive practices based on it. It has no roots in the cultural and traditions of the people. Yet indigenous system also suffers certain disadvantages such as limited experimentation, tedious treatment process and lack of means for mass production. It, therefore, has been pushed to the giddiness.

The health planning machinery instead of making platitudinal policy announcement regarding the indigenous system, should identify those areas of the system whose efficacy have been proven and adopt those methods that could easily and effectively reach out to the people. As part of the drugs policy, the manufacture of indigenous medicine that have been scientifically analysed should be undertaken on a commercial scale. An important step in this direction would be to enhance research work on extensive scale to validate and popularise the indigenous system of medicine.