CHAPTER – 4
CONCEPT OF HEALTHCARE, HEALTH POLICIES AND HEALTH PROGRAMMES: THE INDIAN CONTEXT

4.1 INTRODUCTION
As a signatory to Alma –Ata Declaration in 1978 the Government of India was committed to taking steps to provide Health for All (HFA) to its citizens by 2000 A.D. For this India drafted a “National Health Policy” in 1983. In 2002 another “National Health Policy” has been adopted.

The challenge that exists today in many countries is to reach the whole population with adequate healthcare services and to ensure their utilization. The large hospitals which are chosen for the delivery of the health services has failed in the sense that it serves only a small part of population, that too, within a small radius of a building and the services rendered are mostly curatives in nature. Therefore, it has been aptly said that these large hospitals are more ivory towers of diseases than the centers for delivery of comprehensive healthcare services (Park, 2009: P- 796). Rising costs in the maintenance of these large hospitals and their failure to meet the total health needs of community have led many countries to seek alternative models of healthcare delivery with a view to provide healthcare services that are reasonably inexpensive and have the basic essentials required by the rural population.

A number of models have been developed for the delivery of health care services. One of the simplest models is presented below. This model has the following four components.

a) Health Status and Health Problem
An assessment of the health status and health problems is the first requisite for any planned effort to develop healthcare services. This is also known as the ‘Community Diagnosis’. The data required for analyzing the health situation and for defining the health problems, as in India (Table 4.1), comprise the followings.

i. Morbidity and mortality statistics
ii. Demographic conditions of the population
iii. Environmental conditions which have a bearing on health
iv. Cultural backgrounds, attitudes, beliefs, and practices which affect health.

v. Socio-economic factors which have a direct effect on health

vi. Medical health services available

vii. Other services available.

Table 4.1: Health Problems in India

<table>
<thead>
<tr>
<th>Health Problems</th>
<th>Diseases or Morbidity involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable Diseases Problem</td>
<td>Malaria, TB, Diarrhoeal Diseases, Acute Respiratory Diseases, Leprosy, Filaria, AIDS, Kala-azar, Viral Hepatitis, Japanese Encephalitis, Meningitis.</td>
</tr>
<tr>
<td>Nutritional Problem</td>
<td>Protein Energy Malnutrition (PEM), Nutritional Anaemia, Low Birth Weight, Nutritional Blindness (Esophthalmia), Iodine Deficiency Disorder (Goiter), Lathyriism and Endemic Fluorosis.</td>
</tr>
<tr>
<td>Environmental Sanitation Problems</td>
<td>Lack of Safe Water, Primitive Methods of Excreta Disposal.</td>
</tr>
<tr>
<td>Medical Care Problems</td>
<td>80% of Health facilities in Urban areas, 74% rural population have no H.Fs; Curative services are in urban areas.</td>
</tr>
<tr>
<td>Population Problems</td>
<td>Huge pressure of population creates problems on employment, education, housing, healthcare, sanitation and environment.</td>
</tr>
</tbody>
</table>

Source: Park, 2009

b) Resource

Resources are needed to meet the vast health needs of a community. The basic resources for providing healthcare are:

1. Health Manpower

The term ‘Health Manpower’ includes both professional and auxiliary personnel who are needed to provide the healthcare. An ‘Auxiliary’ is defined by WHO as “technical worker in a certain field with less than full professional training”.

‘Health Manpower Planning’ is an important aspect of community health planning. It is based on a series of accepted ratios as given in the table 4.2.

There is maldistribution of health manpower between rural and urban areas of India as well as among the states. Study shows that in India there is a concentration of doctors (up to 73.6%) in urban areas, where only 26.4% of total population live.

During the past decade many new categories of ‘Health Manpower’ have been introduced. They include village guides, multipurpose workers, technicians, ophthalmic assistants.
Apart from this, Money and Time are important resources for providing health services. Scarcity of money affects all parts of the health delivery system.

Table-4.2: Suggested Norms for Health Personnel

<table>
<thead>
<tr>
<th>Category of Personnel</th>
<th>Norms Suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>1 per 3500 population</td>
</tr>
<tr>
<td>Nurses</td>
<td>1 per 5000 population</td>
</tr>
<tr>
<td>Health Worker (Male and Female)</td>
<td>1 per 5000 population in Plain area</td>
</tr>
<tr>
<td></td>
<td>1 per 3000 population in Tribal and Hilly areas</td>
</tr>
<tr>
<td>Trained Dai</td>
<td>1 for each village</td>
</tr>
<tr>
<td>Health Assistant (Male and Female)</td>
<td>1 per 30000 population in Plain areas</td>
</tr>
<tr>
<td></td>
<td>1 per 20000 population in tribal and Hilly areas</td>
</tr>
<tr>
<td>Health Assistant (Male and Female)</td>
<td>Provide supportive supervision to six health workers (Male and Female)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1 per 10000 population</td>
</tr>
<tr>
<td>Laboratory Technicians</td>
<td>1 per 10000 population</td>
</tr>
<tr>
<td>ASHA (Accredited Social Health Activist)</td>
<td>1 per 1000 population</td>
</tr>
</tbody>
</table>

Source: Park, 2009: P-801

c) Healthcare Services

The purpose of healthcare services is to improve the health status of the people. In the light of HFA by 2000 AD goals had been fixed in terms of Mortality and Morbidity Reduction, Increase in Expectation of Life, Decrease in Population Growth, Improvement of Nutritional Status, Provision of Basic Sanitation, Health Manpower Requirements, and Resource Development and certain other parameters such as Food Production, Literacy Rate, and Reduced Level of Poverty.

d) Healthcare Systems

'Healthcare System' is intended to deliver the healthcare services. In India this is represented by five major Sectors or Agencies which differ from each other by the health technologies applied and by the source of funds for their operation. These five sectors are outlined below.
[1] Public Health Sector

(a) Primary Healthcare in India

Keeping in view the WHO goal of HFA by 2000 AD, the Government of India drafted National Health Policy in 1983 and in 2002. Primary healthcare services are now provided in three levels.

1. **Village Level**- Healthcare must penetrate into the furthest reaches of rural areas and every one should have access to it.

2. **Sub Center (SC) Level**- SC is the peripheral outpost of the health delivery system in rural areas. They are established on the basis of one SC for every 5000 population in general, and one for every 3000 population in the hilly, tribal and backward areas.

3. **Primary Health Center (PHC) Level**- The “National Health Plan (1983)” proposed reorganization of PHCs on the basis of one PHC for every 30000 rural population in the plain area, and 20000 population in hilly and tribal, and backward areas for effective coverage (Government of India, Bulletin on Rural Health Statistics in India, 1996).

(b) Hospitals / Health Centers

i. **Community Health Centers (CHCs)**- As on the 30th June 1996, 2424 CHCs were established throughout India by upgrading the PHC; each CHC covering a population of 80000 to 120000 (one in each CD Block) with 30 beds and specialists in Surgery, Medicine, Obstetric, Gynecology and Paediatric with X-ray and laboratory facilities.

ii. **Hospitals**- Apart from the PHCs, the present organization of health services of the government sector consists of- (a) Rural Hospitals, (b) Sub-divisional Hospitals, and (c) District Hospitals. There was proposal to convert the district hospitals into District Health Centers (GOI, Report of the Working Group on Health For All by 2000 AD, 1981).

(c) Health Insurance

There is no universal health insurance in India till date. Health Insurance is at present limited to industrial workers and their families. The Central Government employs are also covered by the health insurance, under the banner “Central Government Health Scheme”.

(d) Other Agencies

Defence Medical Services under the banner of “Armed Forces Medical Services” provide integrated and comprehensive health services including promotive, preventive and curative
services. The Railway provides comprehensive healthcare services through the agencies of Rail Way Hospitals, Health Units and Clinics.

[2] Private Sector
i. Registered Medical Practitioners (RMPs) - In a mixed economy such as India, private practice of medicine provides a large share of the health services available. The general practitioners constitute about 70% of the medical profession but most of them tend to congregate in the urban areas (Sharma 1976).

ii. Private Institutions - Apart from the RMPs there are many nursing homes, private hospitals, poly clinics, and dispensaries for providing curative services to the economically advanced population of the society.

[3] Indigenous Systems of Medicine
The practitioners of indigenous medicine provide bulk of medical care to the rural people and poorer sections of the urban areas. These systems of medicines are as follows:

i. Ayurvedic System: Studies indicate that nearly 90% of the Ayurvedic physicians serve the rural areas.

ii. Homoeopathy: Homoeopathy is practiced in India since 1810 and at present it provides bulk of medical and healthcare to the rural population.

iii. Unani-Tibb: It continues to be important source of medical relief to the rural population, mainly of Muslim community.

iv. Unregistered Practitioners: Apart from these, Unregistered Practitioners / Quacks play very important role in the rural areas to serve the patients. Even today, a large percentage of rural people fully depend on these Quacks for their survival.

[4] Voluntary Health Agencies
The voluntary agencies occupy an important place in Community Health Programme in India. The voluntary health agencies have been compared to motor trucks which can penetrate the by-ways and the official agencies to “Railways Trunk Lines” which must run on tracks established by law (Park, 2009: PP-813-14).

The major Voluntary Health Agencies in India are as follows:

[5] Health Programmes in India

Since India became independent several measures have been undertaken by the Union Government to improve the health of the people. Prominent among these measures are “National Health Programmes” which have been launched by the Central Government for control/eradication of communicable diseases, improvement of environmental sanitation, raising the standard of nutrition, control of population and improving the rural health.

A brief account of these programmes, which are currently in operation, is presented in the Table 4.3 (Appendix-2) as applicable in the study area.

4.2 MORBIDITY AND DISEASES

Morbidity has been defined as “any departure, subjective or objective, from a physiological well being” (WHO, 1959: Technical Report, Serial No. 164 and WHO, 1968: Technical Report, Serial No. 389, as cited in Park, 2009: P-57). The term is used equivalent to such term as sickness, illness, disability. The WHO expert committee on health statistics noted in its 6th report (WHO, 1959: Technical Report, Serial No. 164 ibid P-57) that the morbidity could be measured in terms of three units, as follows:

a. Persons who were ill;

b. The illness (periods or spells of illness) that these persons experienced; and

c. The duration of these illnesses (days and weeks).

The above three aspects of morbidity are commonly measured by morbidity rates or morbidity ratio, namely— (1) Frequency (2) Duration and (3) Severity. Disease frequency is measured by— (a) Incidence and (b) Prevalence Rate.

Morbidity of the people is generally understood from the diseases of the people which is responsible for the lowering of health. These diseases are classified into the following categories.
4.2.1 Communicable Diseases
There are various types of communicable diseases in India as well as in West Bengal. Among them the notable diseases which play a vital role in the morbidity of people are presented below.

i. Respiratory Infections
The major diseases are- (1) Small Pox, (2) Chicken Pox, (3) Measles, (4) Influenza Diphtheria, (5) Whooping Cough, (6) Meningococcal Meningitis, (7) Acute Respiratory Infection (ARI), and (8) Tuberculosis.

ii. Intestinal Infections
The Major diseases are- (a) Poliomyelitis, (b) Viral Hepatitis, (Hepatitis A and Hepatitis B), (c) Cholera and (d) Acute Diarrhoeal Diseases.

iii. Arthropod-Born Infection
The Major diseases are- (a) The Dengue Syndromes, (b) Malaria, and (c) Lymphatic Filariasis.

iv. Zoones
The major diseases of this group are- (a) Rabies, (b) Japanese Encephalitis, and (c) Plague.

v. Surface Infections
The major diseases of this group are- (a) Tetanus, (b) Leprosy, and (c) HIV-AIDS.

4.2.2 Chronic Non-Communicable Diseases
The Non-communicable diseases of the recent time are playing very crucial role in the morbidity of people. The data of morbidity and mortality are not available properly. The major non-communicable diseases are - (1) Coronary Heart Disease, (2) Hypertension, (3) Stroke, (4) Rheumatic Heart Disease, (5) Cancer, (6) Diabetes, (7) Obesity, (8) Blindness, (9) and Accident.

4.3 NUTRITION AND HEALTH
Nutrition may be defined as the science of food and its relationship to health. It is primarily concerned with part played by the nutrients in the body growth, development and maintenance (Park, 2009: P-526). Good Nutrition means “maintaining a nutritional status that enables us to grow well and enjoy good health” (Park, 2009: P-526). The modern concept is that nutrition is the cornerstone of socio-economic development; and nutritional
problems are not just medical problems, but multifactoral with roots in many other sectors of development such as education, demography, agriculture and rural development.

In the global campaign of health for all, promotion of proper nutrition is one of the eight elements of primary healthcare. Nutrition indicators have been developed to monitor HFA. Greater emphasis is now placed on integrating nutrition into Primary Healthcare Systems, wherever possible, and formulation of "National Dietary Goals" to promote health and nutritional status of families and communities.

4.3.1 NUTRIENTS

Nutrients are organic and inorganic complexes contained in the food. These nutrients may be divided into- (a) Macronutrients like Protein, Fat and Carbohydrate; and (b) Micronutrients such as Vitamins and Minerals.

4.3.1.1 Nutritional Problems in Public Health

There are many problems which affect vast segment of our population. The major ones are, (1) Low Birth Weight (LBW), (2) Protein Energy Malnutrition (PEM), (3) Exophthalmia, (4) Nutritional Anaemia, (5) Iodine Deficiency Disorder (IDD), (6) Endemic Flurosis and (7) Lathyrism.

4.3.1.2 Community Nutrition Programmes in India (Table-4.4)

Surveys conducted by the ‘State Nutrition Division’ and ‘National Nutrition Monitoring Bureau’ (NNMB) under ICMR reveal that Malnutrition and other deficiency disorders are found more in young children and pregnant and lactating mothers. While the progress made in various child survival indicators like IMR, Education, Immunization etc. over the last 50 years is impressive, about two million infants still die each year almost the same number as in 1960 and most of these deaths are preventable. Despite the fact that we have a large buffer stock of food grains, about 53% of children below the age of five years are under nourished (Joshi, 2005).
<table>
<thead>
<tr>
<th>SL No</th>
<th>Name of Nutrition Programmes</th>
<th>Year of Launch</th>
<th>Major Features/Functions/Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mid Day Meal Programme (MDMP)</td>
<td>1961</td>
<td>To attract more children to school and retain them so that literacy improvement of the children could be brought about.</td>
</tr>
<tr>
<td>2</td>
<td>National Goiter Control Programme (NGCP) / &quot;National Iodine Deficiency Disorders Control Programme&quot; (NIDDCP)</td>
<td>1962</td>
<td>Launched in the Conventional Goiter Belt in the Himalayan Region. Later decided to introduce entire edible salt in the country in 1992 in a phased manner.</td>
</tr>
<tr>
<td>3</td>
<td>Vitamin A prophylaxis Programme</td>
<td>1976</td>
<td>To administer single massive dose of an oily preparation of Vitamin A orally to all pre-school children every 6 months.</td>
</tr>
<tr>
<td>4</td>
<td>National Nutritional Anaemia Control Programme (NNACP)</td>
<td>1969</td>
<td>To reduce anaemia among the women of reproductive age and pre school children through distribution of Iron and Folic Acids to pregnant women and young children (1-12 years).</td>
</tr>
<tr>
<td>5</td>
<td>Balwadi Nutrition Programme (BNP)</td>
<td>1970</td>
<td>The Programme is implemented through Balwadi. The food supplement provides 300 Kcal and 10 grams of protein per child 3-6 years per day.</td>
</tr>
<tr>
<td>6</td>
<td>Special Nutrition Programme (SNP)</td>
<td>1970</td>
<td>To improve the nutritional status of the children below 6 years age of age, pregnant and nursing mothers in urban slums, tribal areas and backward rural areas.</td>
</tr>
<tr>
<td>7</td>
<td>Integrated Child Development Service (ICDS) Programme</td>
<td>1975</td>
<td>Pre-school children below 6 years and pregnant and lactating mothers are benefited through the distribution of supplementary nutrition, vitamin A prophylaxis and iron and folic acids.</td>
</tr>
<tr>
<td>8</td>
<td>National Mid-Day Meal Programme (NMDMP)</td>
<td>1995-96</td>
<td>To increase primary school attendance and retention as well as improve the nutritional status and learning achievements of school children, generally in the 6-11 years old age group.</td>
</tr>
<tr>
<td>9</td>
<td>Public Distribution System (PDS)</td>
<td>1997</td>
<td>The poor man's access to the PDS proved extremely limited, particularly in the most poverty stricken state.</td>
</tr>
<tr>
<td>10</td>
<td>Targeted Public Distribution System (TPDS)</td>
<td>1997</td>
<td>Under the TPDS, households of Below Poverty Line (BPL) are given a special identity card to obtain up to 10 kgs of rice or wheat per month at half the issue price.</td>
</tr>
</tbody>
</table>

Source: Park (2009), Joshi (2005), Ramadasmurthy and Ram, (1984), and GOI, 7th Five Year Plan, Vol-2.

4.4 MATERNAL AND CHILD HEALTH (MCH)

In any community, mothers and children constitute a priority group. In number, they comprise 71.14% of the population in the developing countries. In India, women of child bearing age (15-49 years) constitute 22.2% and children less than 15 years of age about
35.3% of the total population. Together they constitute 57.5% of the total population (Park, 2009: P-447). By virtue of the number mothers and children are the major consumers of health services, of whatever form.

The term MCH refers to the preventive, promotive, curative and rehabilitative healthcare for mothers and children. It includes the sub-areas of (1) maternal health (2) child health (3) family planning (4) school health (5) handicapped children (6) adolescent and (7) health aspects of children care in special settings, such as day care (Park, 2009: P-450).

The specific objectives of the programmes are-

1. Reduction of maternal, perinatal, infant and childhood mortality and morbidity;
2. Promotion of reproductive health; and
3. Promotion of the physical and psychological development of the child and adolescent within the family. The ultimate objective of MCH service is life long health.

4.5 HEALTH PLANNING AND MANAGEMENT IN INDIA

‘Health Planning’ is a part of national development planning. Health Planning is necessary for the economic utilization of materials, man power and financial resources. The health planning is to improve the health services.

In this context, national health planning has been defined as “the orderly process of defining community health problems, identifying unmet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible, and projecting administrative actions to accomplish the purpose of the proposed programme.

4.5.1 NATIONAL HEALTH POLICIES (NHP)

(1) National Health Policy - 1983

The Ministry of Health and Family Welfare, Government of India, promulgated a “National Health Policy” in 1983 keeping in view the national commitment to attain the goal of HFA by the year 2000. The Health Policy laid down specific goals to be achieved by 1985, 1990 and then in 2000. Through the frame work of the 7th and 8th Five Years Plans and 20 Point Programmes, steps were taken to implement the policy. Some of them were: (a) To establish one health Sub-center for every 5000 rural population (3000 in tribal and hilly areas) with one
male and female health worker; (b) To establish one Primary Health Center (PHC) for every 30,000 rural population (20,000 in hilly and tribal areas); (c) To establish Community Health Center (CHC) each serving a population of 1 lakh; (d) To train Village Health Guides selected by the community for every village or rural population; (e) To train the Traditional Birth Attendant or Dai in each village; and (f) Training of various categories of other staff e.g. Multi Purpose Workers.

2) National Health Policy - 2002

The Ministry of Health and Family Welfare, Government of India, issued a new National Health Policy-2002, as after 1983 there have been significant changes in the determinant factors relating to the health sector, necessitating revision of the earlier policy.

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Goals</th>
<th>To be Achieved in the year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Eradication of Polio</td>
<td>2005</td>
</tr>
<tr>
<td>2</td>
<td>Eliminate Leprosy</td>
<td>2005</td>
</tr>
<tr>
<td>3</td>
<td>Eliminate Kala-azar</td>
<td>2010</td>
</tr>
<tr>
<td>4</td>
<td>Eliminate Lymphatic Filariasis</td>
<td>2015</td>
</tr>
<tr>
<td>5</td>
<td>Achieve Zero level growth of HIV / Aids</td>
<td>2007</td>
</tr>
<tr>
<td>6</td>
<td>Reduce mortality by 50% on account of TB, Malaria and other vector and water borne diseases</td>
<td>2010</td>
</tr>
<tr>
<td>7</td>
<td>Reduce prevalence of blindness to 0.5 %</td>
<td>2010</td>
</tr>
<tr>
<td>8</td>
<td>Reduce IMR to 30/100 and MMR to 100/lakh</td>
<td>2010</td>
</tr>
<tr>
<td>9</td>
<td>Increase utilization of Public health facilities from current level of &lt;20 to &gt; 75%</td>
<td>2010</td>
</tr>
<tr>
<td>10</td>
<td>Establish an integrated system of Surveillance</td>
<td>2005</td>
</tr>
<tr>
<td>11</td>
<td>Increase health expenditure by Government as a % of GDP from existing 0.9 % to 2.0 %</td>
<td>2010</td>
</tr>
<tr>
<td>12</td>
<td>Increase Share of central Grants to constitute at least 25% of total spending</td>
<td>2010</td>
</tr>
<tr>
<td>13</td>
<td>Increase State sector health spending from 5.5 % to 7% of the budget</td>
<td>2005</td>
</tr>
<tr>
<td>14</td>
<td>Further increase of budget to 8% of the Budget</td>
<td>2010</td>
</tr>
</tbody>
</table>

Source: Prepared by the researcher based on the various sources

The policy mainly emphasised on—

i. Ensuring a more equitable access to health services across the social and geographic expanse of the country;

ii. Preventive and first line curative initiatives at the primary health level;
iii. Controlling the diseases which are principally contributing to disease burden such as TB, Malaria, blindness and HIV/AIDS; and

iv. Rational use of drugs within the allopathic system.

To translate the above objectives into reality Health Policy 2002 has laid down specific goals to be achieved by the year 2005, 2007, 2010 and 2015 (Table-4.5).

**4.5.2 RECOMMENDATION OF DIFFERENT COMMITTEES FOR HEALTH**

The guidelines for National Health Planning were provided by a number of committees dating back to the Bhore Committee in 1946. These committees were appointed by Government of India (GOI) from time to time to review the existing health situation and recommend for further actions. A brief account of the recommendations of these committees, which are landmark in the history of the public health in India, is given below.

1) **Bhore Committee (1946)** - The Government of India in 1943, appointed the Health Survey and Development Committee with Sir Joseph Bhore as chairman to survey then existing position regarding the health condition and health organization in the country and to make recommendation for the future development.

2) **Mudaliar Committee (1962)** - In 1959, the GOI appointed another committee known as “Health Survey and Planning Committee” popularly known as Mudaliar Committee to survey the progress made in the field of health to make recommendations for future development and expansion of health services.

3) **Chadah Committee (1963)** - To study the arrangements necessary for the maintenance of the “National Malaria Eradication Programme” a committee was appointed in 1963 under the chairmanship of Dr. M.S. Chadah, the then Director General of Health Services.

4) **Mukherjee Committee (1965-66)** - Mukherji Committee (1965) was appointed to review the strategy of Family Planning Programme (FPP).

5) **Jung Walla Committee (1967)** - “Committee on Integration of Health Services” under the Chairmanship of Dr. N. Junga Walla recommended integration of health services, organization and personnel.
6) **Karter Singh Committee (1973)** - “The Committee on Multipurpose Workers under Health Planning” under the chairmanship of Karter Singh, recommended the following:

i. The present Auxiliary Nurse Midwives (ANM) to be replaced by the newly designated “Female Health Worker” (FHW) and present day Basic HW, Malaria Surveillance Workers, vaccinators, Health Education Assistants and Family Planning Health Assistant to be replaced by “Male Health Workers” (MHW).

ii. For proper coverage there must be one PHC for a population of 50000.

iii. Each PHC should be divided into 16 Sub-Centers each having a population of 3000 to 3500 depending on the topography and means of communication.

iv. There should be Male Health Supervisor to supervise the work of 3-4 MHWs and Female Health Supervisor to supervise the work of 3-4 FHWs.

v. Doctors in Charge of a PHC should have the overall charge of all supervisors and HWs in his area (Government of India, Report of the Committee on Multi Purpose Worker under Health and Family Planning Programme, 1978).

7) **Shrivastav Committee (1975)** – The Ministry of Health and Family Welfare had in November 1974 set up a group on “Medical Education and Support Manpower” popularly known as the Shrivastav Committee. It recommended immediate action for: (a) Creation of bands of Para Professional and Semi Professional Health Workers, (b) Establishment of 2 cadres of Health Workers namely Multipurpose Health Workers and Health Assistants, (c) Development of “Referral Service Complex”, (d) Available of 1 MHW and 1 FHW for every 5000 population, and (e) Being 1 Male Health Assistant (MHA) and 1 Female Health Assistant (FHA) for 2 MHWs and 2 FHWs (Government of India, Report of Group on Medical Education and Support Manpower, 1975 and Government of India, 1976).

8) **Rural Health Scheme (1977)** - Based on the recommendation of the Shrivastav Committee (1975), the Government of India launched the “Rural Health Scheme” in 1977. The Programme of Training of “Community Health Workers” was initiated during 1977-78.

9) **‘Health for All’ 2000 A.D.** - A Working Group on Health was constituted by the Planning Commission in 1980 with the Secretary, Ministry of Health and Family Welfare, as its chairman to identify the goals for Health for All by the 2000 A.D. and to outline the specific Programme for the 6th year plan.
10) National Rural Health Mission (NRHM) - The Department of Health and Family Welfare, GOI, launched NRHM on 12th April 2005. Following activities were undertaken:

1. Upgradation of PHC and grant money for maintenance;
2. Upgradation of All BPHCs;
3. Upgradation of some of BPHCs into Indian Public Health Standard (IPHS);
4. Monetary help to Sub-centers;
5. Formation of “Rog Katyan Samity” and “District Health Mission”;
6. Procurments of drugs;
7. Engagement of ‘Accredited Social Health Activist’ (ASHA).

11) Reproductive and Child Health (RCH-2) Programme (2005) - The Department of Health and Family Welfare, GOI, launched RCH-2 Programme, a major flagship programme under NRHM in April, 2005. In this RCH-2 Programme thrust has been on schemes related to –

1. Institutional Deliveries,
2. Safe Motherhood,
3. Operationalisation of First Referral Units (FRU),
4. Basic and Comprehensive Emergency Obstetric Care,
5. Strengthening of referral Units,
6. Strengthening of routine Immunization, and
7. Referral Transport for Delivery.

12) National Population Policy 2010

Population policy in general refers to policies intended to decrease the birth rate or growth rate. Statement of goals, objectives and targets are inherent in population policy. In April 1976 India formed its first ‘National Population Policy’ (NPP). It called for an increase in the legal minimum age of marriage from 15 to 18 for females and 18 to 22 years for the males. However for the most part, the 1976 statement became irrelevant and the policy was modified in 1977. New policy statement reiterated the importance of the family norm without compulsion and changed the programme title to “Family Welfare Programme”.

“National Population Policy 2000” was the latest in this series. It reaffirms the commitment of the government towards target free approach in administering family planning services. It deals with women education, empowering women for improve health and nutrition; child survival and health; the unmet needs for the family welfare services; healthcare for the under-served population groups like urban slums, tribal community, hill area population, and displaced and migrant population; adolescent’s health and education; increased participation of men in planned parenthood; and collaboration with NGOs.
The objective of NPP 2000 is to bring the Total Fertility Rate (TFR) to replacement levels by 2000. The long term objective is to achieve requirements of suitable economic growth, social development and environment protection.

It was anticipated that, if the NPP 2000 was fully implemented, in the year 2010 the population will be 1107 million instead of 1162 million projected by the Technical Group of Population Projections. Similarly the anticipated Crude Birth Rate will be 21 per 1000 population, infant mortality rate 30 per 1000 live births, and total fertility rate 2.1.

4.5.3 PLANNING COMMISSION AND HEALTH SECTOR PLANNING

The Government of India set up the “Planning Commission” in 1950 to make an assessment of the material, capital and human resources of the country and to draft developmental plan for the most effective utilization of these resources. Since health is an important contributory factor in the utilization of manpower, the Planning Commission gave considerable importance to health programmes in the Five Year Plans. Health Plan is implemented at various levels e.g. Center, State, District, Block and Village. The broad objectives of health Programme during the five year plans have been- (1) Control and eradication of major communicable diseases; (2) Strengthening of the basic health services through the establishment of PHCs and SCs; (3) Population Control; and (4) Development of health manpower resources. Some of the major health issues of the recent Five Year Plans are outlined below.

(1) Ninth Five Year Plan (1997-2002) - During the Ninth Plan efforts were intensified to improve the health status of the population by optimizing coverage and quality of care by identifying and reflecting the critical gaps in infrastructure, manpower, equipment essential diagnostic reagent and drug.

(2) Tenth Five Year Plan (2002-2007) - During the 10th Plan efforts were on the improvement of health status of population by optimizing coverage quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs.

In the 10th Plan there was continued commitment to provide essential health healthcare, emergency life saving services, services under national disease control programmes free of cost to individuals based on their needs and not their ability to pay. The GOI has set targets
in the 10th Five Year Plan to control certain diseases like HIV/AIDS, TB, Leprosy, Malaria and Blindness etc.

(3) Eleventh Five Year Plan (2007-2012)

The health of a nation is an essential component of development, vital to the nation's economic growth and internal stability. Assuring a minimal level of health care to the population is a critical constituent of the development process.

Considerable achievements have been made over the last six decades in our efforts to improve health standards, such as life expectancy, child mortality, infant mortality, and maternal mortality. Small pox and guinea worm have been eradicated and there is hope that poliomyelitis will be contained in the near future. Nevertheless, problems abound. Malnutrition affects a large proportion of children. An unexpectedly high proportion of the population continues to suffer and die from new diseases that are emerging; apart from continuing and new threats posed by the existing ones. Pregnancy and childbirth related complications also contribute to the suffering and mortality.

The country has to deal with rising costs of health care and growing expectations of the people. The challenge of quality health services in remote rural regions has to be urgently met. Given the magnitude of the problem, we need to transform public health care into an accountable, accessible, and affordable system of quality services during the Eleventh Five Year Plan.

Vision for Health

The Eleventh Five Year Plan will provide an opportunity to restructure policies to achieve a New Vision based on faster, broad-based, and inclusive growth. One objective of the Eleventh Five Year Plan is to achieve good health for people, especially the poor and the underprivileged. In order to do this, a comprehensive approach is needed that encompasses individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene, and feeding practices. The Plan will facilitate convergence and development of public health systems and services that are responsive to health needs and aspirations of people. Importance will be given to reducing disparities in health across regions and communities by ensuring access to affordable health care.
Eleventh Five Year Plan will give special attention to the health of marginalized groups like adolescent girls, women of all ages, children below the age of three, older persons, disabled, and primitive tribal groups. It will view gender as the cross-cutting theme across all schemes.

To achieve these objectives, aggregate spending on health by the Centre and the States will be increased significantly to strengthen the capacity of the public health system to do a better job. The Plan will also ensure a large share of allocation for health programmes in critical areas such as HIV/AIDS. The contribution of the private sector in providing primary, secondary, and tertiary services will be enhanced through various measures including partnership with the government.

Good governance, transparency, and accountability in the delivery of health services will be ensured through involvement of PRI, community, and civil society groups. Health as a right for citizens is the goal that the Plan will strive towards:

- Reducing Maternal Mortality Ratio (MMR) to 1 per 1000 live births.
- Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births.
- Reducing Total Fertility Rate (TFR) to 2.1.
- Providing clean drinking water for all by 2009 and ensuring no slip-backs.
- Reducing malnutrition among children of age group 0–3 to half its present level.
- Reducing anaemia among women and girls by 50%.
- Raising the sex ratio for age group 0–6 to 935 by 2011–12 and 950 by 2016–17.
4.5.4 HEALTH SYSTEMS IN INDIA

India is a union of 28 States and 7 Union Territories. Under the Constitution of India the States are largely independent in the matters relating to the delivery of healthcare to the people. Each state, therefore, has developed its own system of Healthcare Delivery, independent of central government. The central responsibility consists mainly of policy making, planning, guiding, assisting, evaluating and coordinating work of the State Health Ministers, so that health services cover every part of the country and no state lags behind for want of these services. The Health System in India has three main lines namely—(A) Central (B) State (C) Local /Peripheral or District.

Since health is a state subject, there is no uniform “model” of a district health organization in India. Each state develops its own pattern to suit its policy and convenience.

Under the “Multi Purpose Workers Scheme”, it has been suggested to the states to have an integrated set up at the district level by having a Chief Medical Officer (CMO) of the district with 3 Deputy CMO’s (drawn from the cadre of existing of Civil Surgeons, District Health Officers and District Family Welfare Officers) with each of the deputy CMO being in charge of one third of the district for all health, Family Welfare and MCH programmes. It has been suggested that the district pattern should be based on the number of PHCs (Park, 2009: P-812).

The Working Group on Health for All by 2000 A.D. appointed by the Planning Commission, recommended that the ‘District Hospitals’ should be converted into ‘District Health Centers’, each center monitoring all preventive, promotive and curative services of 1 million population. It has been recommended that the district set up should be reorganized on the basis of the number of primary health centre (PHC) it comprises.

4.6 INTERNATIONAL HEALTH

“Nothing on the earth is more international than diseases” said Paul Russell. Health and diseases has no political and geographical boundaries. Disease in any part of the world is a constant threat to other parts.

In the 14th century a procedure known as “quarantine” was introduced in Europe to protect against the importation of Plague. Ships, Crews, Travelers and Cargoes suspected of harbouring infection were detained for a 40 day period. This was the origin of international
health work. Gradually opposition of quarantine came from several quarters because 40 days detention obstructed and raised serious inconvenience to international trade and travel. It became necessary for international agreement and cooperation on quarantine matter to control communicable diseases. International conference was held and organization set up for the discussion, agreement and cooperation on matter of international health.

A brief account of these endeavours and of early health organizations which preceded the WHO is given below.

1. First International Sanitary Conference (1851)
2. Pan American Sanitary Bureau (PASB-1902)
3. Office International D' Hygiene Publique (1907)
4. The Health Organization of the League of Nations (1923)
5. The United Nations Relief and Rehabilitation Administration (UNRRA-1943)
7. The United Nations Development Programme (UNDP-1966)
8. The United Nations Fund for Population Activities (UNFPA-1974)
9. The World Health Organization (WHO)

The WHO is a specialized and non-political agency of the United Nations Organization (UNO), with Headquarter at Geneva. Its constitution came into forces on 7th April 1948, which is celebrated every year as “World Health Day”.

Objective of WHO

The objective of WHO is the “attainment by all peoples of the highest level of health” which is set out in the preamble of the constitution. By the year 1996 WHO had 190 member states and two associate members.