Chapter 2

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Chapter 2

REVIEW OF LITERATURE

In both the Classical and Neoclassical literature the concept of public health was never sharply focused. Any reference to social health was clubbed with the overall concepts of welfare and wellbeing. It was tangentially suggested that the health of the working class and their overall welfare and wellbeing would determine the level of productivity in every area of economic and social life. One of the greatest classical economists Malthus brought about a close relationship between the wage rate and the standard of living, and consequently suggesting the level of health status among the working masses. But even in this context Malthus left the entire process of adjustment in the long run to events relying mostly on the operation of the “Invisible hand”, thereby suggested that in the matter of Public Health it is the laissez-faire policy which would have a dominant role to play, meaning thereby, that the Government would have no responsibility for an active role.

Since Classicists and Neoclassicists aired their views in the context of social health, lots of water has flower down the Ganges. Economists, sociologists, political activists, bureaucrats, and administrators are inclined to take a view that the governmental role in the formulation, structuring and implementation of policy will have a very great significance in the determination of social and public health of a population at a global level. Several agencies operating at the national and international levels, the governmental and semi governmental organisations as also nongovernmental
organisations (NGOs) are playing a very significant and vital role in enhancing the public health at national and global levels. Even the United Nations Organisation (UNO) has appointed several committees and commissions from time to time to look into the problems of areas, which are health challenged. A permanent wing of the UNO has been operational in the form of the World Health Organisation (WHO), since its establishment in 1948. At the global level the determinants of public health to a large extent are governed by the policies of various governments and NGOs. In the present chapter it may appear appropriate to make brief references to the literature available at the world level, and then subsequently addresses the issues relevant in the Indian context, and particularly in the context of rural Andhra Pradesh.

At the global level the health scenario is quite different as between the developed rich-north countries and the developing and underdeveloped poor-south countries. Precisely in the same way in the Indian context the health scenario is distinctly different between the urban and rural parts of India. In case of Andhra Pradesh too, the rural and urban determinants of the health status are bound to be different and with this in focus the present study seeks to address only the problems of rural Andhra Pradesh. The present chapter therefore is accordingly divided into three sections. Section I briefly highlights the literature available at the global level. In Section II the attention is shifted to the Indian context, while in Section III the rural areas of Andhra Pradesh are brought under sharp focus.
2.1 PUBLIC HEALTH AT GLOBAL LEVEL

The global level literature in regard to the determination of social health, can probably involve several areas and documents encompassing periods before the Second World War. However it is not proposed to go into these historical details at all. For the purpose of present study, the literature review is confined only to significant reports which appeared at the international horizon, which dominated the thinking process and the policy formulations subsequently in various countries and also in several international organisations instituted at the auspicious of United Nations Organisation. Even in this context, only a tangential reference is made to various bodies and the reports without going into details. Since the basic issues considered in this study relate to Social Determinants of Health in the Rural Andhra Pradesh (India), a cursory reference to various committees and commissions during the Post World War era are justified.

References must be made to the World Health Organisation (WHO) Constitution (1948)\(^4\), where a strong affirmation is witnessed in regard to the social dimensions of health. However, this was relegated to background view of the subsequent public health era, which was entirely dominated by technology-based programmes for the attainment of requisite levels of public health. The Alma Ata (now Almaty) Conference (1978)\(^5\), under the leadership of Halfdan Mahler, emphasised the role of Intersectoral action on the Social Determinants of Health (SDH). The Intersectoral action was the central theme in


the model of comprehensive primary health care proposed to drive the “Health for All” programme. Subsequently however a scaled-back version of Primary Health Care (PHC) gained influence. The selective primary health care focused on a small number of cost effective interventions, and has gone down in the literature as the GOBI7 (Growth monitoring, Oral rehydration, Breastfeeding and Immunisation) strategy. The United Nations Children’s Fund (UNICEF) in its child survival resolution has promoted this strategy.

2.2 TECHNOLOGY AND DISEASE SPECIFIC CAMPAIGNS

Prior to the Alma Ata Conference (1978), a very brief reference to the issues considered during nineteen fifties, nineteen sixties and early nineteen seventies may be made only for the sake of chronological continuity. Throughout the 1950’s in line with the WHO Constitution, an emphasis on technology and disease specific campaigns have been witnessed. It may be mentioned that the post Second World War era registered Cold War politics and de-colonisation strategies resulting in political freedom to colonies of the erstwhile British Empire. The imprints of Second World War hazards were also noticed in the policy formulations. Apart from politics of the bipolar world divided as it was between the Union of Soviet Socialist Republics (USSR) and the United States of America (USA), and the ideological overtones, the problems of health in the poor south countries of Asia, Africa and Latin America in regard to the maintenance of social health came to be generally differentiated with those in the rich north countries of Western Europe and United States of America. The model for promoting health in terms of the
WHO Constitution appeared difficult in consideration of these basic differences in the north-south countries and the ideological overtones which were prevalent during 1950’s.

As a point of significance, most of the public health programmes had a vertical character and narrowly focused on technology-driven campaigns targeting specific diseases such as, malaria, smallpox, TB and yaws. Such programmes attempt to meet specific identified targets and by and large ignore the social context of health and wellbeing. Such programmes met with spectacular success and particularly in the context of the eradication of smallpox. But the failures were also equally evident in terms of the WHO-UNICEF campaign for the global eradication of malaria.

2.3 COMMUNITY – BASED APPROACHES

By the mid nineteen sixties, it was clearly realised that dominant technology-driven, medical and public health models met with only partial success if at all in the context of a majority of disadvantaged and poor population in the developing and the under developing countries. A vigorous search for alternatives appeared and the emphasis shifted from narrowly focused technology-specific-campaigns targeting specific diseases to campaigns relating to urban based curative care with the social, economic, political and administrative dimensions of health, occupying the center-stage. During the mid and late nineteen sixties, and the early nineteen seventies several government and semi government organisations came together to evolve “Community Based Health

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6 Litsios S. Malaria control, the cold war, and the postwar reorganization of international assistance. Geneva: WHO.
Programmes (CBHP)” 7. Such joint ventures generally emphasise the grass root participation and the empowerment of the community in health decision making, and their efforts were made operational in a wider context involving, economic, social, and political dimensions.

In this context, health education, disease prevention occupies a central role, while reliance came to be placed on locally recruited community health workers, with limited training. China’s rural health workers, referred to as bear-foot doctors8, were the most famous examples. The community-based initiatives mostly in poor countries of Asia and Africa, also surfaced during this period. Such initiatives took into account the social and environmental determinants of health and also the significance of political, economic and administrative environments. These initiatives met with different degrees of success in the context of different countries. But this approach came to be recognised and emphasised by leading scholars, international public health planers and development experts and broadly adoption of this approach to health and the priorities associated with it came to be largely recommended. To mention only one expert in this context, reference may be made to the work published by Kenneth Newell, Director – Division of Strengthening Health Services, WHO in 19759. In the year 1975 itself the WHO and

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UNICEF came out with a joint report\textsuperscript{10} examining alternative approaches in meeting the basic needs in the developing countries. This report emphasised the shortcoming of the vertical disease programmes, which relied on the technological aspects while ignoring the community aspects. The report further emphasised the social factors, such as poverty, inadequate housing, and lack of education as the basic causes of ill-health in the developing countries.

As pointed out earlier Halfdan Mahler, a Danish Physician and a public health activist, occupied a prestigious position as the Director General of the WHO in 1973. Mahler was a contentious leader with deep moral convictions for whom social justice was a holy word\textsuperscript{11}. Mahler was particularly disturbed by the health inequities between the developed and the developing countries and was an architect of the strategy “Health for All by the year 2000”, which he proposed to the World Health Assembly 1976. According to him this strategy implied “the removal of the obstacles to health that is to say, the elimination of mal-nutrition, ignorance, contaminated drinking water and unhygienic housing quite as much as it does the solution of purely medical problems\textsuperscript{12}. Halfdan Mahler was a visionary and his views transformed the subsequent thinking and practices with a view to attaining satisfactory levels of public health, through policy interventions of the government. This new theme occupied the centre stage at the international conference on primary health care, jointly sponsored by the WHO and the


\textsuperscript{11} Cited in Cueto, The origins of primary health care.

\textsuperscript{12} Mahler H. 1981. The meaning of "health for all by the year 2000". World Health Forum 2 (1): 5-22.
UNICEF at Alma Ata, Kazakhstan, in September 1978. About 2000 delegates from 134 countries and 67 international organisations participated in this conference. The deliberations at Alma-Ata, set a land mark in modern public health and came out with a declaration substantiating Mahler’s goal of “Health for all by the year 2000” with Primary Health Care (PHC) as the means. The adoption of “Health for All (HFA)” with public health strategy, PHC heralded the emergence of “Social Determinants” as a major public health concerned. This declaration and the subsequent adoption of the strategy forcefully underlined the fact that public health strategy cannot be provided only through health services. But the issues are required to be addressed by underlying “Social, Economic and Political causes of poor health.

The basic concern of the present work, thus appears to be universally accepted by the highest decision makers in this regard and the stakeholders namely, the government (134 countries), international organisations (67), delegates (3000), participating at the Alma Ata, WHO – UNICEF sponsored Conference in 1978 reiterating the policy perspective formulated at this epoch making convention. For the first time it was emphatically stated that public health was not exclusively the domain of health services, but also was related to the social, economic, political and administrative spheres. Both the developed and developing countries striving to attain reasonable standards of public health\textsuperscript{13} need to give proper attention and appropriate significance to these areas as well.

As a matter of fact the several elements associated with public health care (PHC)

approach came to be manifested, in the Chinese “barefoot doctors” model and the community based experience which guided the health concerns in the previous decades. It was widely recognised that the “PHC was the first level of contact of the individuals, the family and community with the national health system”\textsuperscript{5}. The PHC was soon recognised and accepted as part of “overall social and economic development of the community”. The PHC strategy came to be associated with three basic issues. The first one related to appropriate technology “emphasising shift of health resources from urban hospitals to meeting the requirements of rural and disadvantaged segments of the population. The second involves a “critique of medical elitism” which implies reduce reliance on highly specialised nurses and doctors and greater mobilisation of community members to take responsibilities in health promoting activities. The third core component of the PHC involved a link between health and social development. As a result “Health work was perceived not as an isolated and short lived intervention but as part of improved living conditions”\textsuperscript{8}.

Under Halfdan Mahler acting as Director General of WHO, the organisational profile of the WHO came to be restructured with a significant emphasis on “Health for All (HFA) through Public Health Care (PHC)”. Accordingly, Health for All incorporated intersectoral action to address Social and Environmental determinants. During the nineteen eighties the context of Intersectoral Action for health (IAH) gained increased prominence and a special unit was created within the WHO to address this theme. In this endeavour, the WHO and the Rockefeller Foundation in 1986 co-sponsored a major
consultation at Bellagio\textsuperscript{14}. Further technical discussions on IAH were held at the 39\textsuperscript{th} World Health Assembly, which included working groups on health inequalities, agriculture, food and nutrition, education, culture, information and lifestyles. Emphasis was also placed on the issues relating to environment, water and sanitation, habitat and industry\textsuperscript{15}.

### 2.4 SOCIAL DETERMINANTS OF HEALTH

Further in mid nineteen eighties and onwards, the Social Determinants of Health were given prominence in any discussion and policy formulation for the health improvement movement. The Canadian Public Health Association, Canada’s Health and Welfare department and the WHO were the co-sponsors of the first international conference on Health Promotion held in Ottawa in November 1986. This conference draws heavily from the report of the Canadian government in 1974, which goes down as Lalonde Report (1974)\textsuperscript{16}. This report can easily be considered as one of the most significant public health initiatives taken by the Canadian government. In terms of this report, the health promotion drive has been considered to be an integral part of the government’s strategies and policy for the enhancement of public health\textsuperscript{17}. More


fundamentally this report identifies four areas for special emphasis for promoting the health status in the context of Canada. These are as under:

(i) Genetic and Biological factors,

(ii) Behavioural and Attitudinal factors – the so-called life styles,

(iii) Environmental factors, which include economic, social, cultural and physical factors, and;

(iv) The organisation of health care systems.

This report has very clearly made a distinction between the Health Promotion\textsuperscript{18} and Health Education as strong pillars of any Public Health advancement drive. Since both are strategies aimed at improving public health, on many occasions, there appears to be confusion between these two significant terms; but it has to be appreciated that although the concepts of these terms are complementary, they are not necessarily synonymous. It needs to be appreciated that health promotion involves the empowerment of the community in improving public health by improving the social, physical and economic environments through preventive health services. By bringing about improvements in the social, physical and economic environments, the health education strategy also attempts at empowering individuals or a group of individuals through increased knowledge and understanding but does not involve the political advocacy that may be necessary in health promotion. However it is important not to politicise issues in health promotion\textsuperscript{19}.


Undoubtedly, a new Public Health initiative was heralded by the Lalonde Report for the Canadian Government (1974), which incorporated health promotion as an integral part of the Government strategy to improve public health. Lalonde identified four main influences as mentioned above on people’s health. These constituted an integral part of the policy formulation as incorporated in the Lalonde report (1974) and led to the identification of four fields in which the health could be promoted. The Lalonde report emphasises that the ill health does not happen by chance or through bad luck, but occurs because of a total lack of appreciation of the impact of these four factors and consequently, no significance accorded to them in the policy formulation at the governmental level. Although the reference in point was Canada, the universal application of the factors raised came to be widely acknowledged.

At a global level, the key components of health promotion were defined in a charter agreed at the First International Conference on Health Promotion held in Ottawa in 1986. The Ottawa Charter stated that: Health is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well being, an individual or group must be able to identify and to realise aspirations to satisfy needs and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capabilities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well being. The Ottawa Charter (1986) also indicates that: “health promotion should focus on equity in health and reducing
differences in health by ensuring equal opportunities and resources to enable all people to achieve their fullest health potential”. The five proposed areas for health promotion action in the Ottawa charter were as follows:

(i) Building healthy public policy;
(ii) Creating supportive environments;
(iii) Strengthening community action;
(iv) Developing personal skills; and
(v) Reorientation of the health services.

The Ottawa Charter on Health Promotion is one of the key documents which is guiding the precepts and practices of health promotion drives, at individual and country level as also at the global level. It is significant therefore to reiterate eight key determinants of health (prerequisites of health), which have been incorporated in the Ottawa Charter (1986). These are “peace, shelter, education, food, income, a stable eco-system sustainable resources, social justice, and equity.

It was understood that this broad range of fundamental enabling factors could not be addressed by the health sectors alone, but would require coordinated action among different governments as well as among non-governmental and voluntary organizations, the private sector and the media. And further, subsequent to Ottawa Charter a series of international health conferences promoted and developed the message put forward in the Charter and pleaded for a sustained movement in its regard.
2.5 ALMA ATA: “GOOD HEALTH AT LOW COST”

In the following years, it was generally not possible to adopt the message of the Ottawa Charter and translate it into practice, particularly in the context of poor countries and marginalised communities. The Rockefeller Foundation in April 1985 sponsored a conference and a theme, which was evolved during its deliberations, which emphasised “Good Health at Low Cost” (GHLC). The deliberations at this conference aimed at evolving strategies to foster sustainable health improvement in the developing world. An examination with respect to three countries namely, China, Costa Rica and Sri Lanka along with one Indian state (Kerala) was closely conducted and the inference drawn indicated that universally good health despite low Gross Domestic Product (GDP) was obtained in terms of Life Expectancy and Child Mortality, in comparison to relatively high-income countries.

The good health at low cost (GHLC) came to be frequently sited and frequent references are made even today in the context of poor developing or under developed countries where cost related strategies for the attainment of good health continue to be significant. In all these strategies, intersectoral policies were structured in which determinants to health were identified as key tools for improving population health in general and meeting the needs of vulnerable section of population in particular.

Details of the policy formats promoting GHLC in respect of countries namely, China, Costa Rica and Sri Lanka are available in general documents but most of the

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strategies highlight the following five shared social and political factors according to Rosenfield P\textsuperscript{21}:

(i) Historical commitment to health as a social goal;
(ii) Social welfare orientation to development;
(iii) Community participation in decision-making processes relative to health;
(iv) Universal coverage of health service for all social groups (equity); and
(v) Intersectoral linkages for health.

It almost confirms that substantial health gains were possible even in countries with low levels of GDP or in communities which were economically challenged\textsuperscript{22}. Thus the strategy of GHLC is very encouraging for the under developed and the developing world in the promotion of good health. Most of these countries did not have a historical tradition towards conservation of good health nor was good health accepted as a social goal. The democratic values in all these countries were of very recent origin and the concept of good health was generally clubbed along with that of social welfare. Therefore the five factors listed above were obtained in much diluted forms, if at all, and in quite a few cases, they were simply non-existent. The most significant factor absent was the Intersectoral linkages for health. As a result in several of the developing and under developed countries a formal commitment to Intersectoral Action for Health (IAH) became an integral part of their official health policy frameworks during the 1980’s. Despite this a mere commitment was not translated in the national implementation of the


IAH. The social and environmental health determinants in practice appear to be the weakest components of the strategies associated with “health for all”. Several countries tried to implement the IAH without reinforcing the five contributing factors in an integrated fashion, but the emphasis was given to these factors in isolation. The isolated factors were hand picked and chosen without any rationale and as a result the unified force which the five social and the political factors could give to the IAH was often missing. It was also observed that the IAH objectives were also not very seriously accepted and as a result, the desired effects were not realised.

2.6 WHO’S CSDH

The background paper prepared for the Commission on Social Determinants of Health (CSDH) in March 2005 has quoted the work of later analysts as identifying reasons for the failure of IAH and reasons why the IAH failed to takeoff in many countries. One of the main reasons mentioned concerned that of evidence and measurement. The decision makers were not supplied with adequate and authoritative quantitative evidence on the specific health impacts attributable to activities in non-health sectors such as housing, transport, education, food policy or industrial policy. Apart from a lack of appropriate benchmark studies and the quantitative evidence for policy formulation, the IAH also found several government structures and budgeting processes poorly adapted to Intersectoral approaches. According to one review following five difficulties were identified:

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(i) Vertical boundaries between sections in government;
(ii) Integrated programmes often seen as threatening to sector-specific budgets, to the direct access of sectors to donors, and to sectors’ functional autonomy;
(iii) Weak position of health and environment sectors within any governments;
(iv) Few economic incentives to support intersectorality and integrated initiatives; and
(v) Government priorities often defined by political expediency, rather than rational analysis\(^{25}\).

In several countries the political implications of the adoption of IAH and the implications of the full-fledged version of PHC were not readily acceptable mostly because of alarming global costs and administrative bottlenecks. At the same time it was desirable to structure the public health policies in a selective fashion with a view to attaining limited goals. At the same time it was realised that the IAH would form the long-term objectives. During the 1980’s the concept of PHC was confined to selective attainment of health and as a result, the focus was placed on limited areas to promote health status. For instance maternal health and child health were conceived to be the areas of where simple policy interventions might substantially reduce the illness and the premature deaths. GOBI could be sited as an excellent example of the strategy of selective intervention. Even, if adoption of GOBI meant, a partial withdrawal from the Alma Ata Charter. It revolutionised the child survival and the child survival revolution promoted by UNICEF in the 1980’s\(^{26}\). In this context through out the 1980’s the PHC


emerged in a selective form as an alternative to the Alma Ata vision in the early 1980’s. This actually meant that the PHC was widely replaced by the SPHC. This was probably because of the logical reflection of a broader shift in political power relations and economic doctrines occurring at global level. In consideration of the vastness of this topic it would appear reasonable to merely mention it without getting into a PHC vs SPHC debate. This debate should be considered from a wider perspective and the issues related to public health can be appreciated by a commitment to Intersectoral Action for Health (IAH) only. During the 1980’s a clear shift in emphasis came to be witnessed. The economic and political model, which emerged during this period, came to be recognised as an approach for “neoliberalism”. The emphasis emerged, because of policies of liberalisation or freeing of markets. The basic tenets of the neoliberal vision has been the conviction that the markets freed from the government interference are the best and the most efficient allocators of resources in the production and distribution and are the most effective tools for promoting and ensuring the continuous of common good, including public health. Rightly or wrongly, it was believed that state sponsored resources, and delivery mechanisms generally were wasteful, cumbersome and averse to innovation. It was further believed that the concept of a welfare state in accordance with the perception of neoliberalists would interfere with normal functioning of the market and would lead to an inevitable waste of resources and thereby, generate unsatisfactory results. As a result, the policy makers were called upon to reduce and greatly minimise the role of the state in the key areas not excluding public health, and thereby prevent inefficiencies. It


was largely advocated that the issues determining the public health status be left to market forces. All this, need not imply a reversal to the classical doctrine of laissez faire and laissez passer, which would indicate, minimisation of or total elimination of government intervention in regard to the promotion of economic advance which in turn would offer a better quality life making possible a higher public health status for the population.

2.7 CONTEXT OF THE NEOLIBERALISM

The emphasis in the 1980’s was on faster rate of economic growth, which would have to play a key role in determining the public health status since it was believed that the faster rate of economic growth was possible, though the allocation of resources driven by market mechanism. The economies of the USSR and East European countries deliberately moved away from state-managed economic development to market friendly economic advance. It is precisely in this context that the doctrines of perestroika and glasnost appeared on the horizon. Such policies created a market-driven favourable climate for enhanced investment to achieve accelerated economic development which would ensure a satisfactory public health status. The neoliberal view was backed by appropriate policies in the United States of America (under the leadership of Ronald Reagan); in the United Kingdom (under the leadership of Margaret Thatcher); and even in Germany (under the leadership of Helmut Kohl). These powerful economists spread the message of neoliberalism through the bilateral programmes. Being the donor countries such programmes gained reasonable success in the poor developing and underdeveloped countries. International agencies like the International Bank for
Reconstruction and Development (the World Bank) and the International Monetary Fund (IMF) also backed such bilateral programmes. The international financial institutions operating a global level also supported such programmes through direct intervention in the economics of poor countries by rescheduling the dates and continuing aid commitments28.

The neoliberal doctrine operated through the health sector reforms undertaken by many low and middle-income countries during the 1980’s29. These programmes also made it possible to achieve broader economic and structural adjustments for facilitating the debt-restructuring process. The World Trade Organisation (WTO), which was formed in 1995 also greatly, supported these arrangements. In conformity to neoliberalism, the doctrines of public health policies, precepts and practices came to be influenced. Whether it was Canada, Sweden or United Kingdom, the policy formats kept in mind globalisation, liberalisation and in the process got active support from the international agencies operating specially, in the field of health like the WHO. However the leadership in this matter witnessed a shift from the WHO to the World Bank. This was largely because of resources commended by the World Bank and the lending in the population and health sector by the Bank had exceeded the total budget of the WHO. The World Bank’s Health policy model, gained momentum and also a wider acceptability as suggested by the World Development Report30 “Investing Health” (1993).


2.8 THE SOCIAL DETERMINANTS OF HEALTH (SDH) APPROACHES

The mid 1980’s and the whole of 1990’s witnessed several debates and on many occasions the authority of Canadian Lalonde report was invoked. But more importantly a specific vocabulary in this context came to be evolved, “Social Determinants of Health” and widely used. Tarlov (1996)\textsuperscript{31} was probably the first to employ this term in a systematic and scientific fashion. Tarlov identified 4-categories of health determination, namely,

(a) Genetic and biological factors;
(b) Medical care;
(c) Individual health care related behaviour; and
(d) Social characteristics;

within which the living takes place. Tarlov (1996) significantly emphasised, the social characteristics which predominate the health determinants. Without going into details a series of important publications, which generalised the use of the term may be indicated. The list of experts who contributed to the concept, Social Determinants of Health, through the publication of the second edition brought out by WHO in 2003\textsuperscript{32} entitled, “Social Determinants of Health: The solid facts” is as follows:

(i) Professor Mel Bartley, University College London, United Kingdom;
(ii) Dr David Blane, Imperial College London, United Kingdom;
(iii) Professor Danny Dorling, School of Geography, University of Leeds, United Kingdom;


(iv) Dr Jane Ferrie, University College London, United Kingdom;

(v) Professor Martin Jarvis, Cancer Research UK, Health Behaviour Unit, University College London, United Kingdom;

(vi) Professor Sir Michael Marmot, Department of Epidemiology and Public Health and International Centre for Health and Society, University College London, United Kingdom;

(vii) Professor Mark McCarthy, University College London, United Kingdom;

(viii) Dr Mary Shaw, Department of Social Medicine, Bristol University, United Kingdom;

(ix) Professor Aubrey Sheiham, International Centre for Health and Society, University College London, United Kingdom;

(x) Professor Stephen Stansfeld, Barts and The London, Queen Mary’s School of Medicine and Dentistry, London, United Kingdom;

(xi) Professor Mike Wadsworth, Medical Research Council, National Survey of Health and Development, University College London, United Kingdom; and

(xii) Professor Richard Wilkinson, University of Nottingham, United Kingdom.

It is understandable that the SDH should find favour with the thinkers, activists and the policy makers in the developed countries. It is equally gratifying that on the lines of SDH a Multi-pronged Programme for disadvantaged families: Mexico’s oportunidades got evolved and successfully implemented in Mexico. This was essentially an anti-poverty programme which involved cash transfers for inducing poor parents in rural areas to send their children to school, improve the use of preventive and other medical services and adopt better nutrition. The responses to SDH in Mexico emerged on the launching

of this Multi-pronged Programme\textsuperscript{34} and they continued to trickle down even today\textsuperscript{35}. The SDH approach accepted a centre-stage amongst several thinkers who influenced the policy formats during the 1990’s. Dahlgren & Whitehead in 1991 emphasised the Intersectoral and Multi-dimensional approach to the SDH and diagrammatically presented the SDH scenario as follows:

![Figure 2.1: Layers of Influence on Health](image)

**Figure 2.1: Layers of Influence on Health**


\textsuperscript{34} Gertler P, Boyce S. 2001. An Experiment in Incentive-Based Welfare: The Impact of PROGRESA on Health in Mexico.

The European Health Policy Conference of 1995 brought out this diagrammatic representation of SDH under a sharp focus and particularly appreciated the broad format which structured the SDH. For instance as has been indicated in the diagram the parameters governing SDH are as follows:

(i) Age, sex and hereditary factors;
(ii) Individual lifestyle factors;
(iii) Social and community networks;
(iv) Specific Socio-economic factors such as, agriculture and food production, education, work environment, living and working conditions, unemployment, water and sanitation, healthcare services, and housing; and
(v) General Socio-economic, cultural and environmental conditions.

In addition to these specific parameters influencing the SDH, Dahlgren & Whitehead also emphasised general socio-economic, cultural and environmental conditions as significant factors influencing and governing SDH. Thus it will be seen that at every conceivable health conference, a comprehensive Intersectoral and Intrasectoral approach to the SDH formulation came to be emphasised with the subsequent policy formulation emerging there from. The 21st century witnessed continued action in furtherance to SDH policy formats and constitute a leading edge in several economies of the world. As a matter of fact the global development agenda is increasingly shaped by the Millennium Development Goals (MDG’s)36. These goals were adopted by 189 countries participating in the Millennium summit (September 2000) organized under the

auspicious of United Nations. Since the MDG has almost a universal acceptability in the present century, it may be in order to bring out the MDG’s at some length. In the first place, 8 MDG’s are linked to quantitative targets and indicators. They are listed below:

(i) Poverty and Hunger reduction;
(ii) Education;
(iii) Women’s empowerment;
(iv) Child Health;
(v) Maternal Health;
(vi) Control of Epidemic diseases;
(vii) Environmental Protection; and
(viii) Development of fair global trading system.

This would clearly indicate that the MDG framework is refocusing its attention on the need for coordinated Multisectoral action. It will be seen that 3 out of the 8 MDG’s have a direct focus on health, while several of the other MDG’s have important health components. This would indicate that the overall health target in the 21st century has a higher priority in the development agenda than any time before. The new prominence to overall health status has been further highlighted during the exercises by the WHO Commission on Macro Economics and Health coupled by the ongoing efforts of communication and civil society groups, which have been incessantly pressing the demand for health as a Human Right. The requirement of a higher level of public health status has come to be recognised, as a development issue, and it gets inextricably mixed with an increasing awareness about health inequalities with the same country as also those as between different countries.
2.9 GROWING MOMENTUM FOR ACTION ON SDH

The 21st century witnessed a much wider support to the MDG and thinking and practice at the global level and changed the direction of international health and development. This movement was quite distinct from the scenarios in 1990’s where the confrontations on the issues of globalisation created a cleavage amongst nations. This has led to the recognition of the complexity and ambiguity of global political and economic processes, which resulted in a more pragmatic and cooperative situations. A more equitable distribution of cost and benefits was thought of and an atmosphere of harmonise thinking prevailed with the commencement of 21st century.

The WHO came to be assigned a new role in promoting action on health and equity. A new WHO Director General, Lee Jong-wook, came out in an article in December 2003. “A crucial part of justice in human relations is promotion of equitable access to health-enabling conditions….The Alma Ata goal of Health for All was right. So were the basic principles of primary health care: equitable access, community participation, and intersectoral approaches to health improvement. These principles must be adapted to today’s context.”

Immediately thereafter Lee addressed, 57th World Health Assembly, and made it clear the intention of the WHO for setting up of a global commission on Health Determinants to advance a pro-equity agenda. Lee went on further to say “the aim is to


bring together the knowledge of experts, especially those with practical experience of tackling these problems. This can provide guidance for all other programmes.\textsuperscript{39}

Soon thereafter the issues were taken up to the next level, by forming the Commission on Social Determinants of Health (CSDH). It was an apt time for the formation of such a commission because of the momentum for the action on Social Determinants of Health (SDH) was rising from all quarters. The issues relating to development were largely addressed and as a result the conditions automatically surfaced in which the advances in health policy to attain SDH were found to be with the reach of all concerned. Mapping of entry points for policy formulation and subsequent action on SDH with respect to disadvantaged groups of individuals or countries where health care interventions appeared necessary got structured with focus on the following four interrelated issues.

(i) Decreasing \textit{social stratification} itself, by reducing "inequalities in power, prestige, income and wealth linked to different socioeconomic positions";  

(ii) Decreasing the \textit{specific exposure} to health-damaging factors suffered by people in disadvantaged positions;  

(iii) Lessening the \textit{vulnerability} of disadvantaged people to the health-damaging conditions they face; and  

(iv) Intervening through \textit{healthcare} to reduce the unequal consequences of ill-health and prevent.

\textsuperscript{39} Lee Jong-wook, speech to the 57th World Health Assembly, 17 May 2004.
Associated with the issues of entry points Graham and Kelly bring out the relationship between people’s socioeconomic circumstances and their health and emphasised two kinds of responses\textsuperscript{40}. The first set of responses focus attention on the disadvantaged groups with poorest health and the most socially excluded in areas; which are very difficult to reach. Against this background the most significant policy intervention would have to be improvements in the accessibility to medical and health care facilities by restructuring connectivity levels. The second set of issues broadly hint at the existence of a broader social gradient in health meaning thereby that the groups in the poorest circumstances or at the poorest health. In such situations the policy interventions on the lines of preventive care might devaluate the desired results.

The targeted interventions for achieving the intermediary determinants of social health would have to be thought of\textsuperscript{41}. In spite of all that has been said and done such approaches have attracted criticism which at best can be described as a negative way of looking at things, particularly when the critiques argue that the unintended effect of targeted interventions may be to legitimate poverty making it more tolerable for individuals on one hand and less costly for the society on the other\textsuperscript{42}. All these would strongly emphasise that the various policy entry points must be selected with due consideration to the desirability and feasibility aspects. Such policies must be aligned also at various levels, keeping in mind the appropriate social and political policy formats


\textsuperscript{41} Macintyre S, Petticrew M. 2000. Good intentions and received wisdom are not enough. Journal of epidemiology and Community Health 54 :802-803.

\textsuperscript{42} Petticrew M, Macintyre S. 2001. What do we know about effectiveness and cost - effectiveness of measures to reduce inequalities in health?
prevalent at relevant time. It needs to be emphasised also that the policy entry points for different countries as also within the specified disadvantaged groups within the same country would have to be quite different in consideration of differing socioeconomic and political administration environments. The point which is being made out is that an identical health entry point policy will not be appropriate in every context.

As a matter of fact the concept of Good Health at Low Cost (GHLC) which has already been referred to as a development during the mid 1980’s. In this context, a classification of countries on the following three criteria\(^\text{43}\) was made with a view to suggesting policy interventions.

(i) The extent to which health is a priority in the governmental/societal agenda, reflected in the level of national resources allocated to health;

(ii) The degree to which responsibility for financing and organizing the provision of health services to individuals is assumed as (1) a collective social responsibility or (2) primarily the responsibility of the individuals concerned; and

(iii) The extent to which society (through political authorities) assumes responsibility for an equitable distribution of health resources.

The WHO health equity team in the early 21\(^\text{st}\) century, in 2003 to be precise argued for a more historically and politically aligned understanding of health systems\(^\text{44}\).


The cost factor had to surface in practically all the policy formulations. But more importantly, the Commission on Social Determinants of Health\(^{45}\) (CSDH) had to grapple with several strategic questions. Against this backdrop the eight key strategic questions would have to be answered for the promotion of health:

(i) How will the CSDH position itself on the "Mahler-Grant problem"? (i.e., choosing or compromising between a far-reaching structural critique based on a social justice vision and promoting a number of tightly focused interventions that may produce short-term results). This issue fundamentally concerns how Commissioners understand their political role, and the place they assign to moral values in an undertaking that aims to leverage policy action and bring concrete, measurable results rapidly.

(ii) What evaluation structure will the CSDH put in place to identify appropriate policy entry points for different countries/jurisdictions?

(iii) To interest political leaders, a SDH policy agenda will have to offer opportunities for some "quick wins". This principle applies to country-level political processes and at the global level to the Commission itself. What might "quick wins" look like, for countries tackling social determinants and for the CSDH?

(iv) How will the Commission develop its relationship with the major international financial institutions, in particular the World Bank?

(v) How can the CSDH most effectively position itself within the global and national processes connected to the Millennium Development Goals (MDGs)?

(vi) Is it scientifically credible, strategically desirable and/or ethically acceptable for the CSDH to argue that health policies tackling social determinants are a wise

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\(^{45}\) *Action on the Social Determinants of Health: Learning from previous experiences* (March 2005) - *A background paper prepared for the Commission on Social Determinants of Health. Geneva: WHO*
investment that will "pay off" in terms of enhanced economic performance and/or cost savings to health systems down the line?

(vii) Can the CSDH operate strategically to get "buy-in" from the business community, without losing credibility with other key constituencies, including civil society organizations? How will potential conflicts among these interests be mediated within the Commission as its work proceeds?

(viii) Drawing together all these and other issues is the question of "story". This is not a mere footnote to the scientific and political problems the Commission must confront, but is at the heart of the CSDH's effort to catalyse change. What story do the members of the CSDH collectively want to tell about social conditions and human well-being? What narrative will capture the imaginations, feelings, intellect and will of political decision-makers and the broader public and inspire them to action?

In consideration of the main strategic questions raised above a potential resistance to the messages set down by the CSDH was to be expected. One need not go into the details of this aspect but one should appreciate that the SDH interventions would represent opportunities to improve the health status of populations and particularly, of the disadvantaged segments and vulnerable groups and that to at relatively low cost. As a result the National Governments had to be very keen to implement the SDH but, it would have the capacities in terms of resources, to come out with the desired interventions. In several Governments, an improvement in health status by attending to SDH was considered to be everybody’s business. And even on occasions it lead to a diminished role of the Ministry of Health (MoH). The MoH officials were unwittingly drawn into the political arena and were called upon to deliver immediate results in consideration of the election cycles. It was not realised that there are no shortcut solutions to the attainment of
superior health status through the instrumentality of SDH. The causal link between SDH interventions and the outcome in terms of superior health status are quite obvious but an attempt to forge such links to achieve payoffs in terms of votes was certainly not desirable. It was argued by several social activists, McGinnis being quite prominent amongst them that “It takes more than just evidence that social change would improve health to convince the general public [or a fortiori policymakers] that such redistributive investments should be undertaken. These choices are very much about ideology and social values”\textsuperscript{46}.

The CSDH was clear that the opposition to its recommendations did not originate from the Governmental sectors alone but even the corporate world displayed its displeasure because the implementations might lead to a negative impact on corporate profits. With reference to these reforms, particularly in Latin America, it was argued that the excluded health policies are those that have a negative impact on corporate profits such as safety programs in factories and agriculture, accident reduction in vehicle transportation, tobacco reduction, the promotion of generic drugs, and the promotion of essential drug lists\textsuperscript{47}. In line with this viewpoint it appears reasonable to assume that resistance to several strategies proposed under the banner of SDH would have to be considered as a fact of life. The list of active opponents from the corporate world is long and consideration of this viewpoint will be merely repetitive in nature. It would be worthwhile to consider the responses within the international organisations particularly in


the context of the developing communities. It is fairly well-known that the World Bank and IMF enjoy enormous power and influence over the health and social policy in the developing countries\textsuperscript{48,49}. This aspect has already been commented upon earlier. It may however be pointed out that these Global Monetary Agencies along with International Financial Institutions (IFIs) may on occasion tender advise to countries which in many cases run counter to the approaches which the CSDH may promote. In this view of the matter one of the main strategic issues that emerge would relate to the task of CSDH to develop harmonious relationships with the major financial institutions such as the World Bank, the IMF and other IFIs.

Apart from this the successes of CSDH would depend upon its capacity to structure a series of alliances and partnerships at various levels such as global institutes, national Governments and policy makers, the corporate world and several civil society organisations like the NGOs. One must emphasise also that the success of the CSDH would very largely depend on its ability to be simultaneously operative at several levels, and at the same time harmonise the activities at all these levels for the attainment of superior health status through the functioning of Social Determinants of Health. To be truly effective the CSDH must align its policy recommendations with the MDGs and capitalise on the momentum of global and national commitment to the goals. The document embodying the final report of the UN Millennium Project that was published in January 2005 more significantly highlights the “interwovenness of the broad range of


economic, health and environmental issues in international development under the MDGs\(^50\).

As a matter of fact several thinkers in the field of SDH had started the analysis of the political/structural aspects of resistance to the SDH approaches\(^51,52\). Nevertheless it must be appreciated that the CSDH has been embarking on a mission. With a view to maximising its chances of success the strategic questions sum up the selective historical perspective, which has been elaborated above. This historical overview along with the above eight key strategic questions would be crucial in policies. These policies would get evolved at the national level and would have to be supported also at the international level. Such efforts will have to be actively supported by the medical personnel and the health officials. In addition the players operating in social and economic fields, political and administrative areas would have to play a significant role in the successful implementation of the message given by the CSDH.

### 2.10 PUBLIC HEALTH ADMINISTRATION IN INDIA

While reviewing literature in the Indian context, it is not proposed to go into details and offer a historical review of public health policy. The reference may be made to the *Oxford Text Book of Public Health*\(^53,49\) for a very brief historical prospective. It

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has been recognised and considered that traditional medicine in India managed illness at the individual level and not at the public level. However it was recognised that the spread of disease was due to contact among people or and due to hereditary transmission. Kautilya around 300 BC during the early Maurya dynasty in India, implored the king to ensure the health and prosperity of his subjects through various measures and regulations. Quarantine and Prohibition were major measures historically employed to protect the transmission of diseases.

Several public health educational and research institutes (Calcutta based) were established by the British in India in early 1920’s to carry out public health training and research in India. The Calcutta School of Tropical Medicine and Hygiene and the All-India Institute of Hygiene and Public Health are instances in point. The Haffkine Institute in Bombay, the King Institute of Preventive Medicine in Madras, the Central Vaccine Research Institute in Kasauli, the National Institute of Communicable Diseases in Delhi (previously known as the Malaria Institute of India), the Indian Research Fund Association (later re-designated as Indian Council of Medical Research), and the National Institute of Nutrition in Hyderabad were the other exemplary research and teaching institutions established in India. Several conferences at the national and international level were also organised during the Colonial era. Notable examples would be the International Health conferences organised by the League of Nations Health Organisation in the early 1930’s in New Delhi. These conferences focused attention merely on sharing

experiences on public health development in the countries under colonial rule, especially in Asia and Africa. The Inter-Governmental Conference in 1937 at Bandung and the Netherlands East India (Indonesia) on public health and rural health development in Asia under the auspicious of the League of Nations Health Organisation could be quoted as other noteworthy examples. The Indian government participated in these conferences and noted along with the other participating governments, the pitiable conditions of communicable diseases, nutritional deficiencies disorders in rural areas, and identified areas for public intervention. However the experiences of these conferences, as also the discussions and deliberations therein were never translated into reality and there was hardly any follow-up action. The only notable exception appears to be the setting up of Bhore Committee\textsuperscript{57} in 1945 to review the health situation and recommend improvements in the Indian Health System\textsuperscript{58}. Even after the Independence and despite the commencement of planning era, the healthcare facilities were almost non-existent.

2.11 PUBLIC HEALTH MANAGEMENT IN RURAL SETTINGS

A number of rural health centers and demonstration centers were scattered in India but they could hardly make any dent. In the pathetic situation prevalent in regard to public health care the scene between 1950 and 1970 was not exactly very encouraging. This was despite the fact that in October 1957 under auspicious of the WHO, the Inter-

\textsuperscript{57} Govt. of India (1946): Report of the Health Survey and Development Committee, Government of India Press, Shimla.

\textsuperscript{58} The Govt. of India have been appointed various committees from time to time to render advice about different health problems in India viz, Bhore Committee (1946), Chopra Committee, Mudaliar Committee (1962), Chadah Committee (1963), Mukherjee Committee (1965), Mukherjee Committee (1966), Jungalwalla Committee (1967), Kartar Singh Committee (1973), Shrivastav Committee (1975), Bajaj Committee (1986).
Nation Conference on the Rural Health was organised. Beyond mere recognition, that in rural health, countries were the basic health units where comprehensive health care could be provided to the rural population and that such units should be strengthened, hardly any improvements were instituted. As a matter of fact this conference had reviewed and analysed a wide range of subjects like, the functioning of rural health services, the training and use of multipurpose village workers, the enhancement of prevention and control of epidemic and endemic diseases, the utilisation of local resources and promoting Intersectoral Action and the participation of local people including formation of village health committees. The Shrivastav Committee\(^{59}\) in 1975 recommended for providing primary healthcare within the community itself through specially trained workers so that health of the people is placed in the hands of the people themselves. The Govt. of India has launched the Rural Health Scheme in 1977 by accepting the basic recommendations of the Shrivastav Committee.

It would not be out of place to mention that way back in 1947 itself, a dedicated team of disciples of Gandhiji, Dr. T. S. Soundram and Dr. Ramachandran founded Gandhigram\(^{60}\) which aimed at synthesising Rabindranath Tagore’s Vishva Bharati and Sevagram of Mahatma Gandhi, and was the home of many rural development programmes. In 1956, a year before the above mentioned Inter-Nation Conference on the Rural Health under the auspicious of WHO in New Delhi, the Gandhigram Rural Institute


came to be established with faith and the deep devotion to Gandhiji’s revolutionary concept of the “Nai Talim” system of education. Among basic objectives of this Gandhigram Rural Institute, which later on was converted into full-fledged Rural University, was to function as a center for extension work leading to integrated rural development campus. Public health concepts were developed, strengthened and transmitted to the rural masses for the evolution of appropriate rural public health schemes leading to an improvement in rural health and hygiene. This aspect certainly is in line with the present dissertation and as it would appear since then the Gandhigram Institute of Rural Health and Family Welfare has been instituted to spread Gandhiji’s message in his revolutionary concept of “Nai Talim” system of education.

There could be several such agencies scattered all over the country conveying and translating the message of Public health in India in the rural settings. But it is not proposed to undertake a review of their activities in the context of the present study. It is proposed to shift our focus therefore to the governmental agencies particularly the policies of the governments at the center and the states in India. This is not to belittle the contributions of Non-Governmental Organisations (NGOs) actively involved in promoting rural health, directly or indirectly.

2.12 HEALTH POLICIES IN INDEPENDENT INDIA

In the context of India the achievement of political independence in 1947, and more importantly attainment of the status of a Republic on January 26, 1950 appear to be

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significant political land marks which would have considerable significance on the welfare conceptions of the government. In terms of the Indian constitution, Public Health appears both in the Central List as also in the State List of subjects. As a result of this concurrent nature of the public health policy, issues relating to these aspects were considered both at the Central as also in the State Ministries. The budgetary allocations continue to be met at both the Central and the State levels. The policy formulation structured at the Central level got percolated to the level of States both in the form of directives and recommendations. Over the years there may not have been direct conflicts between the centre and the state policies but the prioritisation at these two levels during different time spans appear to be considerably different. Without going into the details of these differences, which were only of the degree and not of the kind, it would appear reasonable to dwell over issues considered in what came to be turned as National Health Policy (NHP). Such policy was concerned with issues relevant and pertinent to those time periods relating to the five year plans at the Centre as also for various State Governments. It is not proposed to dwell over the emphasis given to the health issues as reflected in the budgetary allocations in so far as they determine the plan and non-plan expenditure on various heads of the health aspects.

2.13 NATIONAL HEALTH POLICY OF INDIA 1983

For purposes of the present review of literature concerning the public health in India, a meaningful beginning could be made from an examination of the National Health

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Policy document of 1983 and then proceed to consider several policy pronouncements in this connection issued from time to time. It appears reasonable then to bring out the National Health Policy (NHP) of 1983. This policy statement borrowed from Homepage of the Ministry of Health and Family Welfare, Government of India has revealed the following noteworthy initiatives under the NHP (1983):

(i) A phased, time-bound programme for setting up a well dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves;

(ii) Intermediation through ‘Health volunteers’ having appropriate knowledge, simple skills and requisite technologies;

(iii) Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level; and

(iv) An integrated net-work of evenly spread speciality and super-speciality services; encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government’s facilities is limited to those entitled to free use.

It may be worthwhile to bring out in a tabular form the achievements through the years 1951 to 2000 associated with the public health sector. This table indicates for the three years 1951, 1981 and 2000, the performance with respect to several parameters and should be indicative of the performance of the health sector for the 30 years between 1951 and 1981, i.e., before the launch of the NHP (1983) between nineteen eighties and two thousand could be discovered from the data available for the year 2000.
Table No. 2.1
Achievements through the years 1951 – 2000 in India
(Demographic/epidemiological/ health infrastructural Indicators)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>1951</th>
<th>1981</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic Changes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>36.7</td>
<td>54.0</td>
<td>64.6</td>
</tr>
<tr>
<td>Crude Birth Rate</td>
<td>40.8</td>
<td>33.9</td>
<td>26.1</td>
</tr>
<tr>
<td>Crude Death Rate</td>
<td>25.0</td>
<td>12.5</td>
<td>8.7</td>
</tr>
<tr>
<td>IMR</td>
<td>146.0</td>
<td>110.0</td>
<td>70.0</td>
</tr>
<tr>
<td>Demographic Changes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria Cases (in thousands)</td>
<td>75000</td>
<td>2700</td>
<td>2200</td>
</tr>
<tr>
<td>Leprosy cases per 10000</td>
<td>38.1</td>
<td>57.3</td>
<td>3.74</td>
</tr>
<tr>
<td>Small pox (No. of cases)</td>
<td>&gt; 44,887</td>
<td>Eradicated</td>
<td>---</td>
</tr>
<tr>
<td>Guinea worm (No. of cases)</td>
<td>---</td>
<td>&gt; 39,792</td>
<td>Eradicated</td>
</tr>
<tr>
<td>Polio (No. of cases)</td>
<td>---</td>
<td>29,709</td>
<td>265</td>
</tr>
<tr>
<td>Epidemiological Shifts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHC/CHC/Sub centres</td>
<td>725</td>
<td>57,363</td>
<td>1,63,181</td>
</tr>
<tr>
<td>Dispensaries &amp; Hospitals (all)</td>
<td>9,209</td>
<td>23,555</td>
<td>43,322</td>
</tr>
<tr>
<td>Beds (Pvt &amp; Pblic)</td>
<td>1,17,198</td>
<td>5,69,495</td>
<td>8,70,161</td>
</tr>
<tr>
<td>Doctors (Allopathic)</td>
<td>61,800</td>
<td>2,68,700</td>
<td>5,03,900</td>
</tr>
<tr>
<td>Nursing Personnel</td>
<td>18,054</td>
<td>1,43,887</td>
<td>7,37,000</td>
</tr>
</tbody>
</table>

Source: National Health Policy 2002 (India) document.

It has to be appreciated that the significant achievements brought out in the table are the outcome of not only the public health initiatives but the substantial contributions in this regard must be acknowledged from the developmental sector which would cover rural development, agriculture, food production, sanitation, drinking water supply, education, employment, housing conditions, income, health resources, preventive care,
connectivity, demographic scenario, standard of living & environment, and local economy. Inspite of a reasonably satisfactory picture which come to fore as indicated by the various parameters between 1951 and 1981 and between 1981 and 2000, it appears necessary to emphasise that the public health scenario still left a lot to be achieved. For instance the incidence of malaria staged resurgence. A new and extremely virulent communicable disease – HIV/AIDS also emerged on the scene. The common water-borne infections – Gastroenteritis, Cholera, and some forms of Hepatitis – continue to remain at a high level of morbidity in the population.

The scenario after the announcement of NHP (1983) has also witnessed an increase in mortality through lifestyle diseases like diabetes, cancer and cardiovascular ailments. The persistent nature of the incidence of the macro and micro level nutrient deficiencies, especially among women and children was yet another area of grave concern in the public health policy. Even so, the NHP (1983) document was reasonably optimistic about the health needs of the people, particularly the poor and the under privileged categories, and hoped to provide Health for All by the 2000 AD, through the universal provision of comprehensive primary health care services.

2.14 NATIONAL HEALTH POLICY OF INDIA 2002

It would not be wrong to generalise, that in retrospect the financial resources required and the public health administration capacity available fell far too short of the requirement to offer Health for All by the year 2000 AD. It was therefore natural that
the National Health Policy (NHP) 2002\textsuperscript{64} had to be structured keeping in mind the realistic availability of financial resources and the likely support in public health administrative capacity. Recommendations of the NHP (2002) therefore attempted to maximise the broad based availability of health services coupled with the financial allotment for attaining public health goals. On the whole the NHP (2002) attempts to setout a new policy framework for the accelerated achievement of public health goals in the changing socio – economic conditions prevailing in the country. Without going into the details of NHP (2002) it would be appropriate to merely indicate several areas of emphasis and then pass on to the National Rural Health Mission (NRHM) Document of 2005 – 2012 which is more significant and relevant in the context of the present study relating to Social Determinants of Health in Rural Andhra Pradesh. The issues raised and deliberated upon by the NHP (2002) may be very briefly highlighted as under:

(i) **Financial Resources:**

Over years the investment in public health has been on the lower side and has even been declining as mentioned in the NHP (2002) document. It will be seen that the public health investment as a percentage of GDP declined, from 1.3 per cent in 1990 to 0.9 per cent in 1999. The aggregate expenditure in the public health sector is a meager 5.2 per cent of the GDP. And even out of this only about 17 per cent expenditure is under the public health spending head. The balance 83 per cent is out-of-pocket expenditure. Further the central budgetary allocation for health during this period has been only 1.3 per cent and has been stagnating at that level. The budgetary allocation in the states

averages out at about 7 per cent and has registered a decline to 5.5 per cent. More realistically speaking the current annual per capita public health expenditure in the country works out to no more than a mere Rs. 200/-. The quality of public health as a result is far below the desirable standard. Further the public health services in terms of the Constitution of India have been the responsibility of State Governments. Insufficient State resources are marginally supplemented by the Centre and as a result the public health sector has always been experiencing an acute shortage of funds. The NHP (2002) has been quite appreciative of the budgetary constraints in which the public health policy in India has got to be formulated, and appropriate schemes to implement the policy are required to be structured. The NHP (2002) approach can be considered to be more practical and keeps in mind the ground realities in the Indian scenario, in relation to availability of resources.

(ii) **Equity Considerations:**

Ever since commencement of the planning era, centralised planning was accepted as a key parameter for accelerating the development process in the country and at the same time to bring about an equitable regional distribution of allocated resources. And as a matter of fact a conscious deliberate effort was made in attaining equitability in regard to regional distribution of resources. However the ground reality as will be evident from the following table will indicate very wide disparity of health status in the population, below poverty line (BPL) among different states. The table relates to the urban and rural divide in regard to the health status of the BPL population and then proceeds to identify the better performing and those which are low performing. These issues of disparity are quite clear from this table.
Table No. 2.2
Differentials in Health Status among the Indian states.

<table>
<thead>
<tr>
<th>SECTOR</th>
<th>Population BPL (%)</th>
<th>IMR per 1000 Live Births (SRS-1999)</th>
<th>Mortality per 1000 population (NFHS – 2)</th>
<th>Weight for Age-% of children under 3 years</th>
<th>MMR per Lakh (Annual Report 2000)</th>
<th>Leprosy cases per 10000</th>
<th>Malaria +ve cases in year 2000 (in thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDIA</td>
<td>26.10</td>
<td>70</td>
<td>94.9</td>
<td>47.0</td>
<td>408</td>
<td>3.70</td>
<td>2200.0</td>
</tr>
<tr>
<td>RURAL</td>
<td>27.09</td>
<td>75</td>
<td>103.7</td>
<td>49.6</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>URBAN</td>
<td>23.62</td>
<td>44</td>
<td>63.1</td>
<td>38.4</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Kerala</td>
<td>12.72</td>
<td>14</td>
<td>18.8</td>
<td>27.0</td>
<td>87</td>
<td>0.90</td>
<td>5.1</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>25.02</td>
<td>48</td>
<td>58.1</td>
<td>50.0</td>
<td>135</td>
<td>3.10</td>
<td>138.0</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>21.12</td>
<td>52</td>
<td>63.3</td>
<td>37.0</td>
<td>79</td>
<td>4.10</td>
<td>56.0</td>
</tr>
<tr>
<td>Orissa</td>
<td>47.15</td>
<td>97</td>
<td>104.4</td>
<td>54.0</td>
<td>498</td>
<td>7.05</td>
<td>483.0</td>
</tr>
<tr>
<td>Bihar</td>
<td>42.60</td>
<td>63</td>
<td>105.1</td>
<td>54.0</td>
<td>707</td>
<td>11.83</td>
<td>132.0</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>15.28</td>
<td>81</td>
<td>114.9</td>
<td>51.0</td>
<td>607</td>
<td>0.80</td>
<td>53.0</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>31.15</td>
<td>84</td>
<td>122.5</td>
<td>52.0</td>
<td>707</td>
<td>4.30</td>
<td>99.0</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>37.43</td>
<td>90</td>
<td>137.6</td>
<td>55.0</td>
<td>498</td>
<td>3.83</td>
<td>528.0</td>
</tr>
</tbody>
</table>

Source: National Health Policy 2002 (India) document.

(iii) Delivery Mechanism of the Public Health:

In a country like India with almost continental dimensions and diversified socio-economic and techno-political settings, it is impossible to structure a uniform Programme for implementing the public health policy of the government. The Programme therefore would have to be consistent with the ground realities in each state. A great extent of flexibility in the matter of structuring and implementation of programmes has been recognised and emphasised by the NHP (2002) Document.
(iv) The state of Public Health Infrastructure:

The NHP (2002) Document proceeds with an objective assessment of the quality and efficiency of the existing machinery in the field. It is believed that without considering this vital aspect regarding the infrastructure of public health it would be futile to frame a new policy and expect results from its implementation.

(v) Extension of Public Health Services:

The NHP (2002) document recognises the fact that there is a general shortage of the medical personnel in the country. This shortage is more predominant in the rural and less developed areas. Several incentives and inducements offered by the government to attract Private Medical Practitioners to rural areas have not produced the desired results. The quality of paramedical staff in adequate numbers is also not available in the rural areas. The training of personnel also left considerable gaps and hence the NHP (2002) Document has very rightly addressed its concerns to these and related issues.

(vi) Local Self – Government Institutions:

In some of the states of the country the programmes and funds for the health sector at different levels have been made available through the Panchayati Raj Institutions\(^\text{65}\) (PRIs). The NHP (2002) assigns a special role to these local self governing institutions and it is noticed as of today that this experiment has produced encouraging results. As a matter of fact, an organisational structure has already been created in terms of PRIs. Using this organisational structure for need based allocation of resources

\(^{65}\) The Panchayati Raj is a 3 – tier structure of local self – government in India, linking the village to the district. The Panchayati Raj institutions are accepted as agencies of public welfare to strengthen democracy at is root, and to ensure more effective and better participation of the people in the government. Govt. of India (1964) Panchayati Raj, Ministry of Community Development, Government of India, New Delhi.
towards the promotion of health amongst the challenged sections of society, and for closer supervision through the elected representatives appeared to be the key factors. This mode can be effectively used not only in the rural areas but also in urban settings particularly in the context of the disadvantaged in the slum areas. States which have so far not used this mode of delivery have been encouraged by the NHP to do so for promotion of healthcare.

(vii) **Healthcare Personnel:**

It is common knowledge that in India, doctors, nurses and paramedical personnel are in short supply and therefore the NHP has recommended the ad-hoc deployment of the medical personnel to address this deficiency.

(viii) **Education for Healthcare Professionals:**

The academic institutions in the areas of medicine and dental colleges are not only in short supply in the country but are not evenly spread. Medical professionals have a tendency to concentrate in urban areas, totally neglecting the rural settings. Apart from this the quality of education in the medical/academic institutions is not uniform and therefore the quality of professionals like doctors and nurses is also not uniformly matched. The NHP (2002) policy in recognition of such a disparity has recommended a policy initiative to rectify this aspect.

(ix) **Role of Specialists in Public Health:**

In any underdeveloped and developing country, the availability of specialists in various branches of medicine is acutely felt. In India, specialised expertise is available to a very small extent. Multi-speciality equipment which would enable specialists to render expert services is not available to the required level in the public health services. In
consideration of this aspect the NHP (2002) has examined the possible means of ensuring adequate availability of personnel and equipment in the public health to discharge the public health responsibilities in the country.

(x) **Nursing Personnel:**

Apart from the inadequate availability of specialised equipment and the expert doctors in the super speciality areas in public health sector, the supply of professionally trained nurses and paramedical personnel have also been found to be inadequate and the NHP (2002) has especially addressed these aspects.

(xi) **Generic drugs and Vaccines:**

The NHP (2002) acknowledges that generic drugs, medicines and vaccines in India are available at relatively low cost, but also emphasises the apprehension that as a result of globalisation there could be a price rise in this area. The NHP (2002) recommended measures to ensure future health security of the country at affordable cost.

(xii) **Urban Health:**

The NHP (2002) Document expresses its grave concern about the existing status of urban health in the country and acknowledges the non-existence of uniform organisational structures for promoting urban health. Considering the fact that the present urban population is about 30 per cent of the total and projecting it to 33 per cent by 2010, the NHP (2002) Document rightly observes that the bulk increase is because of migratory character of the population in the country. Most of this population would be in urban slums. This could lead to the crumbling of what ever meager organisational structure for urban health that exists and the slum dwellers may be forced to avail expensive and non-affordable private healthcare. This aspect has been also addressed by the NHP (2002)
policy which has expressed the need for providing the under-privileged population a minimum standard of broad based health facilities.

(xiii) Mental Health:

The Mental Health disorders are like an ice-berg where only a tip surfaces above the water, while a very large mask is beneath the water, which lies unnoticed. The facilities in this context available in the country are very inadequate. The NHP (2002) has undertaken to address these deficiencies in the Public Health sector.

(xiv) Information, Education and Communication:

The NHP (2002) Document laments over the inadequacy in regard to information, education and communication (IEC) in the primary healthcare areas. The IEC initiatives are adopted both for spreading the curative guidelines and also to bring about behavioural changes to prevent lifestyle diseases such as HIV/AIDS etc. The present IEC strategy is very much fragmented and relies heavily on the mass media, and therefore can not reach about 35 per cent of the illiterate population. The NHP (2002) proposes to rectify this aspect by targeting school and college students for imparting information regarding to basic principles of Preventive Healthcare. The policy also hopes to target this group to improve the general level of awareness in regard to health promoting behaviour.

(xv) Health Research:

Although Health Research in the private sector assume some significance during the last decade, it is worthwhile noting that both public and private expenditure on health research does not workout to more than 1.5 per cent of total annual (1998-99) health expenditure of Rs. 80, 000 crores. With such rock bottom expenditure on research, it is impossible to expect any dramatic breakthrough within the country by way of new drugs
and vaccines. Against this backdrop the NHP (2002) Document is compelled to address these inadequacies and spell out a minimum quantum of expenditure during the coming decade for promoting research activities in the Health Sector.

(xvi) **Role of Private Sector:**

With the new economic policy regime in the country, emphasising liberalisation, privatisation and globalisation in the year 1991, the government policy has become more and more market friendly and significantly higher roles have came to be assigned to the private sector in every walk of life. In the health sector too, the private sector in accordance with the overall policy change in the county would be allotted an important role. The NHP (2002) Document is quite aware of this role for the public sector in the overall public health scenario in the country.

(xvii) **The role of Civil Society:**

Apart from the Government involvement in the attainment of adequate levels of health in the country, the Civil Society is also called upon to play a significant role. In this context the Non–Governmental Organisations (NGOs) will have a crucial role in implementation of public health programmes. And the NHP (2002) will suggest policy instruments for utilising the NGOs and the other Civil Society institutions.

Apart from these significant aspects, the NHP (2002) has also considered National Disease Surveillance Networks, Adequacy of the Health Statistics for the formulation of appropriate health promoting schemes and has specially attended to the problems of the Health of Women and Children. The issues relating Medical Ethics have also been ponder over and some thought has also been given to the enforcement of quality standards for food and drugs. The issues relating to the standard of Paramedical Services
have also been attended and further, the health risks arising out of environmental pollution and occupational health hazards have also been recognised. Provisions for providing Medical Services for users from Overseas have also been suggested as an integral part of the NHP (2002). The impact of Globalisation on the health sector has also occupied the attention of the NHP (2002). The recognition to intersectoral contribution to health has been noted and health standards have been examined. Lastly the National Umbrella for the National Health framework, the Alternative Systems of Medicine have also been incorporated Ayurveda, Unani, Sidda, and Homeopathy, and all these would have a substantial role to play. The main objective of the NHP (2002) has been to achieve an acceptable standard of health amongst the general population.

The goals to be achieved between 2000 and 2015 have been indicated in the Table No. 2.3. It may be pointed out that the policy presentation of NHP (2002) has been indicated specially in relation to the issues raised by the NHP document. While summing up the NHP indicates that the issues raised in the policy prescriptions made and the objectives outlined put together would define a vision for the future. The health needs of the country are enormous but the financial resources available and the managerial support that can be offered would make the realisation of the vision a most optimistic exercise. One of the most significant contributions of NHP (2002) appears to be *Equity in the Health Sector*, that has to be treated as an independent goal to be achieved to the

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66 The latest WHO’s sponsored Commission on Social Determinants of Health (CSDH) in its Final Report 2008 has the title “Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health”. This probably confirms the National Health Policy 2002 India, emphasis on Equity considerations and a brief study of this document would confirm the emphasis being given at the international level to the distribution of health services to the disadvantaged categories of global population signifying the role of Equity considerations in forming Health Policy at the global level.
greatest possible extent. Further the NHP (2002) highlights the expected roles of different participating groups in the Health Sector. It appears befitting that the present comments on the NHP (2002) be summed up in the words of NHP policy document itself.

**Table No. 2.3**
Goals to be achieved by 2000-2015

<table>
<thead>
<tr>
<th>S. No.</th>
<th>GOAL</th>
<th>By the YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Eradicate Polio and Yaws</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 30/1000 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, National Health Accounts and Health Statistics.</td>
<td>2005</td>
</tr>
<tr>
<td>11</td>
<td>Increase health expenditure by Government as a % of GDP from the 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 health spending</td>
<td>2010</td>
</tr>
<tr>
<td>13</td>
<td>Increase State Sector Health spending from 5.5% to 7% of the budget. Further increase to 8%.</td>
<td>2005</td>
</tr>
</tbody>
</table>

*Source: National Health Policy 2002 (India) document.*

It has been emphasised that the National Health Policy is a culmination of several processes. These are not just medicine and health oriented but, they take into account also
the social and economic development which brings about an enhancement in the quality of life. It has been also recognised and appreciated in the context of policy formulation for achieving superior health standards that a disaggregation of issues as between the urban and rural health of the population has to be made for achieving the health goals of the respective population segments. The challenged segments of the population in the rural areas have characteristics which are distinctly different from those obtained in the challenged categories of population in the urban areas. Considering this fact, as a landmark segregating the two sets of challenged populations in the urban and rural settings, the Government of India has issued a Mission Document 2005-2012 specifying the objectives and purpose of the National Rural Health Mission (NRHM) in India. The primary goal of the NRHM 2005-2012 as the document specifies has been “to improve the availability of and access to quality healthcare by people, especially those residing in rural areas, the poor, women and children”.

2.15 NATIONAL RURAL HEALTH MISSION 2005 – 2012

The comprehensive NRHM document comes out with an overview of the state of Public Health and proceeds to offer a vision statement of the NRHM. The goals of the NRHM have been spelt out and the strategies for achieving the goals have been structured. The strategies are subdivided into core strategies and supplementary strategies. The plan of action has also been incorporated in the NRHM Mission Document. It is interesting to point out that this plan of action has been exhaustively drawn and has been divided into several components. For instance the Component –A

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relates to the “Accredited Social Health Activists”, while the Component – B indicates how precisely the Strengthening of Sub-Centres have brought about. The Component – C emphasise the Strengthening of Primary Health Centres (PHCs), while Component – D is related to the role, the Community Health Centres (CHCs) play for the First Referral Care and the way the CHCs could be strengthened for the effective discharge of their assigned task. The Component – E is about the District Health Plan, while the Component – F is about the Convergence of Sanitation and Hygiene under the NRHM. The Component – G is involved in the process of strengthening the Disease Control Programmes. The Component – H is related to a very significant aspect of the NRHM which spells out the Public Private Partnership (PPP) Public Health Goals, including regulation of Private Sector. For achieving all these activities the required New Health Finance Mechanisms have been dealt with the Component – I. It is quite natural that the Reorientation of the Health/Medical Education to support the Rural Health issues will have to be considered on a priority basis. This aspect has been exhaustively spelt out in the Component – J.

The Plan of Action has disaggregated into various components in the above paragraph cannot be very effective without an adequate understanding of the institutional mechanisms and for this purpose the technical support would have to be adequately made available. To this end Programme Management Support Centre has been thought of and an institution namely the Health Trust of India has been specially created. For the achievement of specific objectives setout in the NRHM, the role which the State Governments would have to play would become very significant and crucial. This has been also elaborately spelt out.
The eight North Eastern Indian States that include Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura have been brought under sharp focus, considering the fact that these geographical areas have problems quite distinct from the rest of the country. For the other parts of the country, NRHM has assigned a special role to the Panchayati Raj Institutions (PRIs) which are already playing a crucial role in the administrative setup in the Rural India, and have also been playing a key role in extending the democratic way of life amongst the rural settings in India. The PRIs have also been roped in for the promotion of NRHM activity. Apart from this the role of NGOs has also been specified. The Mission has also sought to revitalise local health traditions and bring them under the main stream as also the AYUSH infrastructure to strengthen the Public Health system at all levels. Such a comprehensive document as the NRHM has been cannot ignore the funding arrangements required to put through the various aspects of the NRHM. The entire activities of the NRHM have been punctuated against the time dimension: particularly the timings for the major components involved in the NRHM. The NRHM document is also very clear about the outcome that is expected both at the national level and also at the community level.

The Monitoring and Evaluation procedures associated with the NRHM have also been clearly specified. As one goes through the Mission Document, one is convinced about the comprehensiveness of the Mission and the purpose of its existence and hopes that the issues handled do not stay only at the paper level but get translated into reality. Only the time will tell whether this happens or not.
2.16 RURAL HEALTH STATUS IN INDIA

Quite apart from these policy statements which have been extremely dealt with in the context of the Public Health scenario at the all India level, an effort now is made to concentrate on some of the specific studies conducted by researchers and published in several national and international journals.

In the context of a study conducted by Baqui and Abdullah H (2008), reported in Bulletin of the World Health Organisation, on the Impact of the integrated nutritional and health programmes on neonatal mortality in rural northern India merits a special mention. This study relates to the health of the new born babies and the health programmes to reduce the neonatal mortality rates. In this context nutrition and health programmes in pursuit of Public Health policy have been given particular attention.

The study concludes that “the limited programme coverage did not enable an effect on neonatal mortality to be observed at the population level. A reduction in neonatal mortality rates in those receiving post natal home visits shows potential for the programme to have an effect on neonatal deaths”.

A special community – based study has been reported in the Indian Journal of Public Health conducted by Biswas (2008) titled, “An epidemiological study of Low

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An interesting study specially related to the incidence of summer associated symptoms, host susceptibility and their effect on quality of life among women between 18 to 40 years of age in an urban slum of Delhi was conducted by Pragya Sinha (2008) and reported in the Indian Journal of Public Health. The conclusion of the study appeared to be quite obvious as observed by the researcher “Continued high incidence of summer associated symptoms with adverse effect on their physical than random occurrence. This aspect requires for further studies”.

To highlight the impact of maternal and childcare programmes being implemented by the Ministry of Health and Family Welfare (MoHFW) in rural and urban areas across India an attempt has been made by Singhal D C (1992) in a study based on the NSSO data of 42nd round, titled “Maternal and Childcare in India” which was reported in the Social Change. The results of the study revealed that a very low percentage of children in the rural areas could avail of immunisation facilities throughout the country. In terms of rural-urban differential, this study has observed that the urban

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population has benefited more than their rural counterparts and rich households both in rural and urban areas have been able to derive better utilisation of immunisation facilities than the economically weaker sections. It was observed that around 70 per cent of the total childbirths in rural areas took place at home and on the other hand, adult education programmes has shown positive impact of the vaccination programmes both in the rural and urban area.

In a survey conducted by Rupert Samuel et. al. (1992) in Karnataka (South India) during 1989-1990 to measure the utilisation of primary healthcare services\textsuperscript{72}, it was found that 32.2 per cent got treatment only from the private sources, 41.3 per cent from the government sources and 26.0 per cent from either the private or the government services. During the course of the study it was observed that the low level economic status group had higher prevalence of sickness, which happens to be a noteworthy finding according to the objectives of the present study.

In another interesting study carried out by Kumar Narendra et. al. (1989) to understand the utilisation of health services at grass root level by aged in a tribal area of Madhya Pradesh\textsuperscript{73}, it was found that the utilisation of health services at PHC level in tribal dominated areas was more by non-tribals. Further it was also noted that majority of the aged patients were found coming on foot from within a radius of two kilometers. In


\textsuperscript{73} Kumar Narendra, Singh Ratanjeet and Tiwari Balakrishna (1989): Utilisation of health services at gross root level by aged in a tribal area, Aged in India (Socio-Demographic Dimensions), New Delhi: Ashish Publishing House.
this context, a study conducted by Kothari et. al. (1982), reported to Indian Pediatrics, on health services utilisation in rural India\textsuperscript{74} needs special mention. This study relates to the distance to health centres, non-availability of drugs, lack of faith and unsatisfactory behavior of healthcare staff. The author observed that the unsatisfactory behaviour of the staff at the health centres, the long distances involved, the non-availability of drugs and lack of faith in doctor’s treatment are some of the major factors responsible for the poor utilisation of hospital services.

The Department of Preventive and Social Medicine of the Government Medical College, Nagpur, Maharashtra, India had carried out a special community-based study as a part of rural filed practices, titled “Perceived morbidity, utilisation of health services and factors affecting it in a rural area”\textsuperscript{75}. The study was conducted jointly by Pathak Mrinalini Ketkar and Majundar (1981). The authors mainly focused on accessibility in terms of distance, infrastructural facilities, cost of medicine and availability of medicine.

It was found that more the severity of illness, the high degree of health services utilisation. It was also observed that there was a significant correlation between accessibility and utilisation of health services. According to the findings of this research, the study concludes that “education of a person is an important determination of values, beliefs, attitudes and goals. Since these factors influence behaviour, education influences the use of health services through a similar mechanism. Better education leads to a better

\textsuperscript{74} Kothari et. al. (1982): Health services utilisation in rural area, Indian Pediatrics, Vol. 19 (4): 303-314.

understanding of one’s environment, disease and processes related to it. Similarly occupation of population affects the health services utilisation in many ways”.

A very interesting study conducted by Johnson et. al. (1988) on the rural health practices in Kanyakumari district of Tamil Nadu, India was reported in the Indian Journal of Public Health. It aims to find out the choice for indigenous medicine and found that females showed a significantly higher acceptance of indigenous medicine than males and irrespective of age, religion or economic condition, people have preferred Indian Medicine. There was 100 per cent choice for indigenous medicine in treatment of cases like worms, jaundice and post-polio paralysis, whooping cough, numerous bites etc.

From the next section the focus on the review of literature would shift from the Indian scenario to the situation obtained in the state of Andhra Pradesh in general and in rural Andhra Pradesh in particular.

2.17 HEALTH STATUS IN THE RURAL ANDHRA PRADESH

While scanning through the available literature relating to rural health status in the state of Andhra Pradesh several studies came up for consideration. However all these studies were in the form of research papers and articles in reputed journals and had a limited focus and as such they were not concerned comprehensively about the overall health status in rural AP. Nevertheless only some of them may be mentioned as a

representative sample of the category of this type of literature since an exhaustive categorisation does not appear to be consistent with the basic theme of the thesis.

Nagdeve and Bharati (2003) of the International Institute for Population Sciences, Mumbai, India, have offered a detailed analysis regarding urban–rural differentials in maternal and child health in Andhra Pradesh. This study came to the conclusion that Andhra Pradesh was one of the most successful among Indian States in providing MCH services, even though urban-rural differentials continue to exist. The Indian Government must take the necessary steps to improve MCH programs, including the provision of information and education campaigns, and sending dedicated health personnel to remote and inaccessible rural areas in order to reduce child mortality. During the course of investigation the NFHS data collected from 4276 ever-married women in the age group 13-49 years in 1992 (NFHS-I) and 4032 ever-married women in the age group 15-49 years in 1998 (NFHS-II) were analysed. The analysis revealed a positive net change in maternal and child health input, its utilisation and its output in the years 1992-1998.

Yasoda Devi and Geervani (2004) have presented a memorable work entitled, Determinants of Nutritional Status of Rural Preschool Children in Andhra Pradesh, India. This study was conducted on a longitudinal basis in four villages in the Medak district of Andhra Pradesh. One-hundred and ninety-seven children up to four years old

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were selected from low-income households for the study. Pre-tested, structured interviews were conducted to collect information on child-related, maternal, paternal, and socio-economic factors from the households. The results of this study indicate a strong influence of socio-economic status and parental care on the control of infectious diseases and food intake, which are the two major causes for malnutrition among children in developing countries.

A very interesting study conducted by Nirupam Bajpai, Ravindra H. Dholakia and Jeffrey D. Sachs (2008) on Scaling up primary health services in Rural India: Public Health investment requirements and health sector reform, relating to case studies of Andhra Pradesh and Karnataka forms working paper No. 33, of Center on Globalization and Sustainable Development, The Earth Institute at Columbia University, published in January 2008 in its Working Paper Series. In this paper an attempt has been made to address two key questions: (i) In terms of state-wide scaling up of rural services (in Andhra Pradesh, and Karnataka) in the area of primary health, what it will cost financially and in terms of human resources to scale-up these services in all the rural areas of these two states? (ii) What policy, institutional and governance reforms may be necessary so as to ensure proper service delivery? It has been emphasised that merely setting up more health clinics, for instance, is not sufficient; higher public investments in

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these areas needs to be accompanied by systemic reforms that will help overhaul the present service delivery system, including issues of control and oversight, for example.

Rama V. Baru (1993) has brought out the Inter – Regional Variations in Health Services in Andhra Pradesh under a sharp focus in his article. According to this researcher economic development and availability of investible surplus, commercial activity and infrastructural facilities appear to be the major features determining the speed of health services in the private as well as the public and voluntary sectors. It has been further stated that a comparative study of advanced and backward districts in Andhra Pradesh has to be conducted which happens to be the focus of the present work.

Health Care Services in the Tribal Areas of Andhra Pradesh have been studied and analysed as a Public Policy Perspective by K. Sujata Rao (1998). The emphasis in this study is on disaggregating the health strategies in laying down a public policy prospective for the urban centres, the rural areas and the tribal population. According to the author tribal development strategies need to be more human-centred with health at its focus. The conventional, bureaucratised approach of looking at health issues for tribals in a sectoral, compartmentalised manner can have little impact on achieving health goals. Strategies to reduce morbidities and mortality among tribals would need to contain

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specific directions for establishing interconnectivity between income, food security, female literacy and good health right down to the PHC level.

The maternal nutritional status and practices & perinatal and neonatal mortality in rural Andhra Pradesh have been studied and analysed by Mahtab S. Bamji, P. V. V. S. Murthy, Livia Williams and M. Vishnu Vardhana Rao (2008). It is note-worthy that charitable trusts like, the Dangoria Charitable Trust, Hyderabad, in collaboration with Monash University, Australia & Division of Community Studies, National Institute of Nutrition (ICMR), Hyderabad, India, have also been active in the area of studying, analysing and prescribing a policy format for the attainment of enhanced Public Health status in the rural Andhra Pradesh. As will be seen the background and objectives of the study have been stated in its preamble in the following terms: despite a vast network of primary health centres and sub-centres, health care outreach in rural parts of India is poor. The Dangoria Charitable Trust (DCT), Hyderabad, has developed a model of health care outreach through trained Village Health and Nutrition Entrepreneur and Mobilisers (HNEMs) in five villages of Medak district in Andhra Pradesh, not serviced by the Integrated Child Development Scheme (ICDS) of the Government of India. Impact of such a link worker on perinatal/neonatal mortality has been positive. The study has attempted to examine the association of maternal nutrition and related factors with perinatal and neonatal mortality in these villages. In the course of the study it was observed that mortality during perinatal, neonatal period was 8.2 per cent of all births.

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Malnutrition was rampant. Over 90 per cent women had 3 or more antenatal check-ups, had taken tetanus injections and had complied with regular consumption of iron-folic acid tablets. Higher percentage of women in group I (mortality group) tended to have height less than 145 cm (high risk) and signs and symptoms of micronutrient deficiencies. However, differences between groups I and II were not statistically significant. Pre-term delivery, difficult labour (use of forceps), first parity, birth asphyxia (no cry at birth) and day of initiating breastfeeding showed significant association with mortality. The inferences emerging from the study clearly indicate that significant association between signs and symptoms of malnutrition with perinatal, neonatal deaths may have been masked by high prevalence of malnutrition in the mothers of both the groups and the small study sample size. However, maternal malnutrition may contribute indirectly through its effects on other pregnancy-related as well as delivery-related complications leading to adverse outcome of pregnancy. The HNEM experience of DCT suggests that a properly trained and supported village level worker can contribute to reduction in perinatal and neonatal mortality.

The International Institute for Population Sciences, Mumbai, India, has come out with a significant study specially in connection with the Factors Influencing the Health Resource Utilisation in Rural Andhra Pradesh. The study conducted by C. P. Prakasam and S. M. Thatte (1995) has undertaken at Guntur district of Andhra Pradesh. It aims to find out the health resource utilisation which has been catered through the Primary Health Centres (PHCs). The services of PHCs have been examined in terms of (i) Visit to PHCs,
(ii) Antenatal and Postnatal services, (iii) Immunisation, (iv) Family Planning Services, and for (v) Accidents and Causality services. Sixteen villages spread over the length and breadth of Guntur district has been selected to form a true representation of rural Andhra Pradesh. Among these villages 800 households consisting of 940 eligible women have been identified as respondents. The five major inferences from the study have been highlighted as follows:

- Nearly 54 per cent of rural women utilised services of PHCs for general healthcare.

- A majority of women availed services of PHCs for baby care and for improvement child health after delivery (Post-natal services). A small proportion of mothers (10 per cent) utilised PHCs for antenatal services.

- As high as 90 per cent of women have used Immunisation services available through the PHCs; the remaining women were not aware of it. Hence by introducing extension education programmes regarding Immunisation of the child, the universal Immunisation programme can be made a grand success.

- Nearly 77 per cent of the rural masses have not utilised the family planning services through PHCs, but have gone to the Private nursing homes.

- Utilisation of PHCs services for the accidents/causality services by the rural population in the study area was found to be very poor.

On the basis of these inferences significant policy implications have emerged. As stated in the report of the study it is evident that primary healthcare services through PHCs are not reaching the rural masses as expected by the various Health Committees. On the other hand, people are getting the same services through private nursing homes
and private hospitals to their satisfaction. Hence one can conclude that primary healthcare services should be delivered more through Non-Government Organisations (NGOs) so that we may achieve the “Health for All” goal within the specified time.

Yet another interesting study relating to Factors influencing differential utilisation of government hospitals across two contrasting regions, namely, Rayala Seema and Coastal Andhra had been conducted by Sivaraju (1987)\textsuperscript{84} and reported in the Journal, Hospital Administration. This study has brought under focus several variables including, distance, cost, and time involved in the process of utilisation and satisfaction level emerging out of it. According to the author it was observed that the respondents who are either partially or fully satisfied with government hospitals are relatively more in Coastal Andhra as compared to those in Rayala Seema. On the other hand, in Rayala Seema nearly one third of the respondents were not at all satisfied with the government hospitals which reveal their poor image in the minds of the public. It was also observed that the distance between the house and the hospitals is uniformly more in Rayala Seema as compared to Coastal Andhra where the utilisation was also found to be greater. Better economic conditions prevailed among the people and medical services were better utilised in Coastal Andhra as compared to the other region. Cleanliness and orderliness of the clinic, time spent by the doctor in examining the client, time spent by the client waiting to see the doctor, privacy provided at the clinic, facility to rest, and facility offered to the accompanying person etc., was relatively better in Coastal Andhra, because of the accessibility of good infrastructural health facilities, namely, optimum doctor –

population ratio, and higher socioeconomic conditions of the people as compared to their counterparts in Rayala Seema.

A very specific study reported in the Bulletin of the World Health Organisation\textsuperscript{85} conducted by Suraratdecha and Chutima (2008) relating to Cost and effectiveness analysis of Immunisation service. In this study Immunisation Service Delivery Support (ISOS) in Andhra Pradesh under the auspicious of health programmes (ISOS), Public Health has been brought under the focus. It is well known that the ISOS model was initiated in Andhra Pradesh for purposes of strengthening Immunisation services through supportive supervision. The objective of this approach are to: (i) identify areas of high performance and those that need improvement, (ii) assist staff in identifying and correcting wrong practices, (iii) improve staff skills, (iv) motivate staff, and (v) initiate corrective actions at appropriate levels through information sharing. During the study the performance of health centre and immunisation sessions was evaluated using 43 and 28 – point checklists, respectively, and demonstrated significant improvement during and following the two year implementation of ISOS. The average percentage change in health centre performance scores from baseline to the fourth round of evaluation was approximately 36 per cent, and immunisation session performance scores increased by an average of 9 per cent. The study noted that the incremental cost-effectiveness ratios were relatively sensitive to personnel and travel costs. Integration of ISOS into the Andhra Pradesh Immunisation System is projected to result in a 39 per cent potential cost saving per round of supervision visit.

The point which needs to be emphasised at this stage is that all these learned research papers and articles appearing in many renowned journals and conference documents do not have a comprehensive approach towards the health status but most of these works relate to a selected theme and as such have a limited focus regarding the health status.

2.18 COMPREHENSIVE SCHEMES FOR THE IMPROVEMENT OF RURAL HEALTH STATUS IN THE STATE OF ANDHRA PRADESH

The Press Information Bureau of Government of India has come out with a pronouncement from Lok Sabha Secretariat in New Delhi on March 05, 2008. The Andhra Pradesh Health Sector Reforms Programme (APHSRP) was jointly developed by the United Kingdom (UK)’s Department for International Developments (DFID) and the Government of Andhra Pradesh. The Programme will involve an expenditure of £ 40 million over three years. The exchange of letters for the programme to be phased out for a period of three years have already taken place and the agreed priorities of the APHSRP strategy and work plan for 2007 – 2008 has been put in place. The Programme will be implemented by the Department of Health, Medical and Family Affairs, Government of Andhra Pradesh. The main output on the implementation of the Programme will be on the following lines:

(i) Improved access to quality and responsive services, especially in remote and interior areas;

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(ii) Governance and management of health sector strengthened;

(iii) Institutional mechanisms for community participation and systems for accountability in functioning; and

(iv) Financial management systems strengthened and improved public expenditure on health.

This information was given by the Minister of State for Health & Family Welfare, Smt. Panabaaka Lakshmi in a written reply to a question in the Lok Sabha. Since this appears to be latest development significantly influencing the health status in the state of Andhra Pradesh with international collaboration and technical support it appeared to be in order to make a mention of it in the review of literature as far as the health status is concerned.

Obviously the health concerns in the state of AP are addressed not by the local government or government at the centre but the international agencies are offering their technical support and financial assistance in this context. In the present study an attempt will be made to develop this kind of comprehensiveness in the approaches to attain the health status.

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