5.1. **HEALTH IS A FUNDAMENTAL RIGHT**

*Darshini Mahadevia*, (August 2000), emphasized that, Health is a fundamental human right, and emphasized at the Alma-Ata conference on health, which focused on equitable and cost-effective primary health care, health has become an important national concern in most countries. Especially, in the developing countries, where health status of large sections of population is still low and population growth rates are high, health sector is very important. Since 1960s, human development movement and from the beginning of the 1990s, human development reports of the United Nations Development programme (UNDP) have emphasized improvement in the health status of the population as one of the important goals of development.

5.2. **FAMILY PLANNING AND CONTRACEPTIVE INJECTION**

*Vineeta Bal, Lakshmi Murthy and Vani Subramanian*, (December 2000), observes that Some fifteen years ago when village women made their way to a family planning camp in the Patancheru primary health centre in Andhra Pradesh to get a contraceptive injection, little did they know that they were creating history. The blatant flouting of requirements of informed consent, the hazardous nature of the drug and the unsuitability of this hormonal long-acting contraceptive for the ill-equipped health delivery system were the grounds on which Stree Shakthi Sanghatana, Saheli, Chingari and several individuals field a write petition in the Supreme Court on India in 1986 asking for a stay on the phase IV clinical trials of the injectable contraceptive-Norethisterone Enanthate (Net En).

5.3. **PRIVATE HEALTH CARE AS AN INDUSTRY**

*Rama V Baru, Imrana Qadeer and Ritu Priya*, (July 2000), noted that, during the mid-1980s the government formally recognized private health care as an industry, helping corporate hospitals to then mobilize loans from public
financial institutions. During the same period import duties on medical equipment were slashed and land was leased at extremely low rates to many of these large private hospitals. These concessions and subsidies largely benefited the tertiary, multi-specialist hospitals in the private sector.

5.4. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)/INFECTIONS

T Jacob John, (July 2001), elaborates that Acquired Immune Deficiency Syndrome (AIDS) Control Retroviral Drug, from the time of the direction of the Human Immunodeficiency Virus (HIV) in India in 1986 has been spreading relentlessly. In fact there is evidence to show that it had been present in India as far back as in 1984. The infection has now spread to almost all regions of India, including rural communities in many states. In regions with Human Immunodeficiency Virus (HIV), the prevalence has increased in persons with sexual behaviour that puts them at risk for infection. In addition, infection is being increasingly detected in the general population, for example in monogamously married women whose husbands may have other sex partners. Such spread within the general population has resulted in continuing risk of transmission via blood transfusions and also the risk of mother-to-child transmission resulting in pediatric Acquired Immune Deficiency Syndrome (AIDS). The preventive measures adopted by the National Acquired Immune Deficiency Syndrome (AIDS) Control Organizations (NACO), including awareness creation, blood safety and popularization of condoms may have retarded the speed of spread to some extent, but the prevalence has been increasing with time, according to the National Acquired Immune Deficiency Syndrome (AIDS) Control Organizations (NACO) sentinel surveillance data. The latest estimate of the burden of Human Immunodeficiency Virus (HIV) infections in India is in the range of 3.5 to 3.9 million infected persons. According to National Acquired Immune Deficiency Syndrome (AIDS) Control Organizations (NACO), the
overall prevalence is less than 0.4 per cent in our population of one billion. If we apply effective measures of prevention now, we may still have an opportunity to avert a larger tragedy, especially for the hundreds of thousands of families who continue to remain vulnerable.

5.5. ROLE OF VITAMIN IN LIFE

Meena Gupta, (October 1999), has documented the role of vitamin A in preventing blindness. However, there is growing evidence of its role in providing protection against other infections, especially measles, diarrhea and pneumonia, and in controlling mortality during pregnancy and infancy. Improved vitamin A status reduces the duration, severity and complications associated with measles and diarrhea.

5.6. PRIMARY HEALTH CARE

Sucha Singh Gill and Ranjit Singh Ghuman (December 2000), notices that, The right to basic education and primary health care have been recognized as human rights in the United Nations (UN) charter of Human Rights prepared in 1948. India being signatory to the United Nations (UN) Covenant on human rights, it is the duty of the government to provide primary health care to every citizen of the country. Preventive health care is mostly ignored in rural areas where it is often considered unusual to visit a health personnel/centre when a person is marinating normal health.

5.7. MEDICINAL PLANTS

S K Datta said that (September 2001), India’s diverse agro-climatic zones, variation in regional topography, wide variation in flora and fauna has contributed to the richness of its biological diversity. Depending on the availability of principal medicinal plants, the country has been divided into eight phyto-geographic regions. The principal medicinal and aromatic plants
found in different regions and the respective tribal population who are the custodians of the treasure.

5.8. PATENT LAWS

P K Vasudeva feels that (October 2000), Biotechnology is a fast emerging technology of the millennium and it is difficult to keep pace with the developments taking place in the field. However, the patent laws do not refer to biotechnology. The European Patent Convention refers to microbiological inventions. Most of the biotechnological inventions fall within the following broad categories: (i) Preparation of chemical substances utilizing organisms. The substances may be new or known but can be prepared by the use of micro-organisms. (ii) The process techniques employed for the production of genetically engineered organisms, probes, vectors, and so on, which fall in the areas of genetic engineering, hybridoma technology and cell fusion tissue culture, gene therapy, and fermentation technology, (iii) Basic studies dealing with various bio-chemical and physiological process in leaving cells to understand the signals for expression (iv) Studies on the role and structure of molecules such as chromosomes. Deoxyribo Nucleic Acid (DNA), Deoxyribo Nucleic Acid (RNA) cytoplasm, specific hormones and their inter and intra-relationships. However, it is not easy to get patents in biotechnology as the distinction between invention and discovery is very thin.

5.9. HEALTH CARE

Yamini Mishra says that (October 2001), Unsafe abortion is one of the most neglected problems of health care in developing countries. Despite evidence from all over the world showing that the legal proscription of abortions but has adverse impact on the health of mothers, roughly one-third of the world’s women live in countries with strict abortion legislation where
women are not allowed to opt for abortion under any circumstances, or only in extreme and/or emergent cases of rape, incest, or where the woman’s life or health is in serious danger.

According to Krishna Soman (June 2002), Rural health care delivery in West Bengal is at the crossroads. The state that has been ruled since the last two decades by a coalition of left-wing parties that advocate working class-based politics is today faced with the onslaught of liberalization and markets. The World Bank is the largest investor in health sector, operating in the state for more than a decade. Interestingly, while the bank has shown interest in shaping the health of the health sector with a major proposal of privatization, the planning wing of the state government has put up an agenda of alternative approach to reforms within the ‘limited power of the state’. The approach to reforms is likely to be on its ‘own terms’, ‘a new active way by upholding the interests of the common people’ and ‘without any pressure of conditionalities of the external loan’.

Gita sen, Aditi Iyer and Asha George, observes that, A Comparison Survey of National Sample Survey (NSS) surveys, 1986-87 and 1995-96, (April 2002), Assessing the magnitude, direction, and impact of changes in the health sector in India during the 1990s are complex. Not only has there been a multiplicity of changes at the micro and macro levels affecting aspects ranging from health financing to health-related behaviour, but the data are fragmentary and disparate in their reliability and scope.

Ramamani Sundar and Abhilasha Sharma finds that, A Survey of Urban Poor in Delhi and Chennai, (November 2002), Improving the health of individuals, particularly those belonging to socially and economically disadvantage groups, is key objective of the Indian government, and a major consequence of a constitution that repeatedly directs the state this end. Moreover, the Indian government has, at a various point in times, embraced
the objective of promoting the health of the poor and the disadvantaged in its policy statements and actions, one being its signing of the Alma Ata declaration of 1978, emphasizing ‘Health for All’ (Lok Sabha Secretariat 1985). National Health Policy Statement of 1983, the government stated that “The highest priority would require being devoted to efforts at launching special programmes for the improvements of maternal and child health, with a special focuses on the less privileged sections of society”.

According to Dr. Preetha Reddy, Corporatization of healthcare services in India has ushered a new era where world-class facilities and global services are now available in numerous cities and towns. The first stage of healthcare in free India continued from Independence to well into the mid-eighties. It was period characterized by immense gaps—an infrastructure gap, a manpower gap and more importantly a yawning quality gap. Quality healthcare at that point of time synonymous with its trip to overseas. And if you could not afford to do so, your chances of recovery were weighed down by serious handicaps.

Kewal Handa said that (2011), The Indian healthcare scene is a picture of contrast and paradoxes. On one end of the spectrum. Indian doctors and nurses in the top 50 cities are among the most sought after in the world, while at the other end, much of rural India relies on semi-trained, ill-equipped village paramedics posing as doctors. India is home to Serum Institute, which produces half of all child immunization vaccines in the world. While more than 40 per cent of children in India do not receive the routine immunisations provided free by the government.

S Srinivasan says that (June 2011), there are a few articles of faith regarding healthcare which are gaining increasing currency: good quality health care should be accessible, affordable, and available to all in need and
the poorest person should get the same quality of healthcare as the richest person. Obviously in India this would be seen as daydream. But in even the so-called developed economies, expect the United States (US), free quality healthcare is reality with nobody having to pay at the point of service and nobody denied.

Zakir Husain (January 2011), says that, The Alma-Ata Declaration in 1978 called on all governments to “formulate national policies, strategies and plans of action to launch and sustain primary health care as a part of a comprehensive national health system”. In India, however, health has traditionally received low priority in the central and state budgets. Expenditure on health sector comprised, for instance, less than 1 per cent of the Gross Domestic Product (GDP) in 1999- one of the lowest in the world. Further, there was a considerable urban bias characterizing health policy and investment strategies – about 75 per cent of the resources and infrastructure were concentrated in urban India. The resultant increase in the incidence of both communicable and non-communicable diseases, coupled with poor health facilities in rural areas resulted in high infant, child and maternal mortality rates.

According to Abhay Shukla, Kerry Scott and Dhanjay Kakde (July 2011), contribution to the ongoing conversation about the merits, shortcomings and potential of India’s National Rural Health Mission (NHRM) it specifically focuses on Community-Based Monitoring (CBM) within National Rural Health Mission (NHRM). Community-Based Monitoring (CBM) is a form of public oversight where the rural communities that Non Recurring Maintenance (NRM) is intended to serve actively and regularly monitor the state of their local public health system as an input to improving the health services received by them.
Anant Phadke (May 2011), says that in October 2010, the planning commission of India with the approval of the prime minister, appointed a high level expert group to develop a framework for universal health coverage to be implemented over 2010-20. Given the abysmal health and healthcare scenario this move by the United Progressive Alliance government seems to be among the more enlightened once aimed at facing the next parliamentary elections. Elections cannot be won by mere deceit, money and muscle power as people have began voting for improved services and concessions. (Unfortunately it is also true that elections can be won by populist measures like the arogyashri health scheme as seen from Andhra Pradesh experience). Indian employers and the government are increasingly realizing that official expenditure on health care is handled wastefully and that there is almost explosive dissatisfaction amongst people about the healthcare situation.

According to Upendra Bhojani, N S Prashanthi and Narayanan Devedasan, (April 2011), considering the number of academic institutions in the country, India’s contribution to health research remains poor. In 2007, the number of original research papers from India indexed in a widely used health-related bibliographic database constituted only 1.64 per cent of global health research outputs. Dandona and colleagues highlight the poor quality of health research and misplaced priorities; more research output on basic and clinical research, compared to public health research.

Imrana Qadeer (January 2002) writes that, the much-awaited National Health Policy (NHP) has finally been circulated as a draft, for public debate. On the face of it the document includes all that which is indicative of a progressive public health policy. For example, it talks of integration of vertical programmes, strengthening the infrastructure, promotion of public health as a discipline, filling the gap of availability of doctors by introducing short-term training for basic services, decentralization of health care delivery through
pachayati raj and autonomous monitoring institutions, setting up a national disease surveillance system as well as a national accounting system, strengthening ethical practices, and regulation of private practice. It also talks of increase in investments, particularly from the centre. This would go up to 25 per cent from the present 20 per cent of the total health expenditure. It would be also inducing greater investment by the states as well, whose expenditure has gone down from 7 per cent to 5 per cent of their budgets.

A K Shiva Kumar (April 2005) noticed that, improving health may have finally made it to the agenda of policy reforms. The budget announcements for 2005-06 ought to be therefore viewed against this backdrop of renewed interest in health. The National Common Minimum Programme announced by the United Progressive Alliance (UPA) government underscores the urgent need to increase the levels of public spending on health from 0.9 per cent of Gross Domestic Product (GDP) to 2-3 per cent over the next five years. It calls extending health insurance coverage for the poor, stepping up investments to control communicable diseases and providing leadership for the control and prevention of Acquired Immune Deficiency Syndrome (AIDS). In response, the prime minister has announced the setting up of a National Rural Health Mission (NHRM). The ministry of health and family welfare has been actively engaged in outlining a vision and strategy for such a mission. The National Advisory Council, following intense discussions on ensuring a healthy future has put out a set of recommendations for considerations by government of India. The planning commission, as part of the Mid-Term Appraisal of the Tenth Five Year Plan, has undertaken a comprehensive and meaningful review of the health sector, noting in the process, several shortcomings and identifying critical areas for further investments.
Ajeet Mathur (May 2004), says that, Information Technology (IT) is poised to revolutionize healthcare trade through new thresholds in human connectivity. What difference does Information Technology (IT) make to worldwide production and trade in healthcare commodities and services? Will Information Technology (IT’s) role in design of healthcare trade raise revenues and improve healthcare in developing countries? Do commercial interests claim priority over people’s health? This assesses the expanding role with respect to these questions in (a) design and development of healthcare products and services, (b) delivery systems, and, (c) healthcare administration. Information Technology (IT) facilitates trade in healthcare services and e-commerce, and more importantly, it facilitates worldwide convergence in several aspects of healthcare management and organization. The pervasive nature of Information Technology (IT) and its uneven diffusion also introduce some vulnerability. The wide range of national and regional needs and circumstances concerning rights to health, rights to trade and rights to development. National policies and international regimes need to strike a harmonious balance between the rights.

5.10. BIOTECHNOLOGY

Ian Scoones study reveals that, (July 2002), Biotechnology is seen by many as a potential important boost to a flagging economy, especially in the post dot.com boom period. Ministers’ speeches are littered with the slogans: ‘from information Technology (IT) to Bio Technology (BT)’, newspaper columns are full of speculation about how India will join the biotech race, and commentators offer grandiose claims about how biotech will contribute to economic growth. International agencies too increasingly are India’s large educated middle class population, the presence of elite science institutions and a track record in the Information Technology (IT) sector as the essential precursors to entry into the global knowledge economy.
According to Vijay Kumar, Yadavenu and Deepak Kumar (January 2011), the recent biotechnological breakthroughs which are considered the fountainhead of innovations are the mapping of the human genome to successful construction of the first self-replicating, synthetic bacterial cell. It is considered that the synthetic cell is the proof of the principle that genomes can be designed in the computer, chemically made in the laboratory and transplanted into a recipient cell to produce a new self-replicating cell controlled only by the synthetic genome. Chemical messages presented in right order and put in right chemical context can produce life. These latest developments have tried to resolve the age-old debate about reduction of life to the sum total of its parts. This vindicates the view that the gestalt is outcome of actions and motives of the distend individuals.

5.11. PHARMACEUTICAL INDUSTRY

Pradeep Agrawal and P Saibaba, notes that, (September 2001), pharmaceutical enjoys a special place as a major research-oriented and knowledge-based industry. Numerous drug formulations for various ailments are invented, patented, produced and marketed throughout the world every year. In this study a brief analysis was presented on how the Indian pharmaceuticals industry might be affected by the new patent laws that will come into force from January 1, 2005 as part of the Trade Related Intellectual Property Rights (TRIPS) agreement, negotiated under the World Trade Organizations (WTO) regime.

Raj Vaidya and Pooja Borkar, observes (August 2007), that the Classical definition, “Pharmacy is the art, science and practice of preparing, preserving, compounding and dispensing of drugs.” This definition could satisfy the expectations of the professionals and the requirements of the society in the past. Pharmacy as a subject and as a profession has gone through many stages of metamorphosis. The old classical definition of
pharmacy is no longer acceptable to the members of the profession. In the 1990s the American Pharmaceutical Association (A Ph A) defined pharmacy as a “Patient oriented health service that applies a scientific body of knowledge to improve and promote health through assurance of safety and efficacy in drug related therapy.” This American Pharmaceutical Association (A Ph A) definition gives much significance to the contemporary concepts of practice of pharmacy in the hospital, community and clinical pharmacy practice.

**Anant Phadke** (February 2002), said that, the draft note for the cabinet committee on Economics Affairs, titled ‘Pharmaceutical Policy 2001’, follows the old pattern of exclusively focusing on economic issues related to the drug industry. It primarily deals with pricing of drugs and profitability. This time the additional concern is the increased focus on making the Indian drug industry on par with the international standards. Despite the repeated demand from consumers and health groups that the health ministry be actively involved in the preparation of the pharmaceutical policy, this draft policy has been prepared only by the ministry of chemicals and fertilizers, totally excluding issues of rationally of drug production.

According to **Sunitha Natti** (February 2012), Three out of every 10 global citizens suffering from Hepatitis B, cholera, rabies and tuberculosis use vaccines produced in India. Indian pharmaceutical companies account for nearly 80 per cent of all United Nations (UN) vaccine purchases. Over 70 per cent of patients from 87 developing countries receive medicines procured from India by the United Nations International Children Emergency Funds (UNICEF), international Dispensary Association, the Global Fund and Clinton Foundation.
5.12. HEALTH CARE PRODUCT SERVICE

K.K. Rajesh says that (2011), Illness has become more prevalent than ever before and yet there is a major increase in consumption of offerings in the area of preventive health care. A McKinsey and Company report indicates that total consumer spending on healthcare products and services in the country grew at a Compound Annual Growth Rate (CAGR) of 14 per cent from 2000 to 2005. Spending on healthcare, which was 7 per cent of average household income in 2005, is expected to grow to 13 per cent by 2025. The same report estimates that the size of the pharmaceuticals industry could treble between 2005 and 2015 to $20 billion, making India rank among the top 10 pharmaceutical markets in the world.

5.13. PUBLIC HEALTH

Stanley Chazhoor (June 2007), World Health Organization (WHO), in a Conference in 1988 at Alma Ata, declared, “The Conference strongly reaffirms the health, which is a state complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the actions of many other social and economic sectors in addition to the health sector”. The Declaration urged upon all nations to make full use of all available resources as well as mobilize the human potential of all communities to implement the policy of Health for All. It considered the factors such as Self-reliance, Social awareness, Creation of self-help groups, Self-care and the Role of government and non-government organizations to guide and help the individuals and their families in solving their health problems.
C U Theresia and K S Mohindra, (July 2011), writes Kerala and Sri Lanka have captivated the global public health community since the late 1970s. Despite relatively modest economies since independence, their health achievements have been dramatic—some of the basic population health indicators are similar to the world’s wealthiest nations and certainly superior to their South Asian counterparts. Furthermore, women in Kerala and Sri Lanka are recognized for their relatively high status compared to the rest of South Asia.

Meeta and Rajivlochan, (October 2010), narrates, it is matter of contemporary fact that health facilities in India have collapsed. Public health facilities are close to non-existent and private health services far too few, far too exploitative and focused mainly on the urban areas. This makes for a significant contribution to agrarian distress that is currently visiting the countryside. In fact, a closer look at health-related information with respect to the problems of farmers suggests that health issues might even be more important than farm-related ones.

Subrata Mukherjee and Jean-Prederic Levesque (November 2010), writes, there is a large number of studies, especially in the context of developing countries which have examined inequalities in age-adjusted mortality rates, child mortality rates, incidence of chronic illness, and self-reported health status. Depending on the specific focus of each of these studies, they have examined the distribution of healthcare, variable across different socio-economic and demographic sections of the population. In addition, utilization of healthcare services is often considered an important process indicator of healthcare services. The unequal distribution of healthcare across a population may not always be due to differences in morbidity or the need for healthcare; rather it may often be the outcome of unequal access to healthcare by various segments of the population.
**Harini Narayanan** (February 2011), says that the union budget 2010-11 announced in early 2010, made it clear that nationally run health programmes were not going to be important for the government this year. The overall increase in health budget was only rupees 2,766 crores for all programmes including the national health mission. The only area related to health in which significant expansions where proposed (through clear budgetary allocations where not declared) was that a health insurance. This was in spite of the fact that a broad spectrum of internal and independent five-year reviews of the National Rural Health Mission (NRHM) had indicated that it had brought significant benefits to many areas of primary healthcare provision in rural areas around the country, and that fund utilization levels were impressive and occasionally even exceeded budgetary allocations. This is not an election year; the government’s primary concern at this time is the health market rather than public-health services.

**Narhar Shankar Deodhar** (January 2008) feels that, it is high time that health experts realize that the public in the developed countries, developing countries and the least developed courtiers differ widely and significantly in several attributes and characteristics. True practitioners of health public in different countries and regions of the world, therefore, had their own definitions of science and technology of public health, epidemiology, etc. the term ‘new public health’ was one of the common expressions. The basic problem was the attempt by international organizations and consultants to formulate “universal formula” for highly divergent disparities, the reality of the people of the world. For want of understanding the implications, the primary healthcare approach of the World Health Organization failed in its objectives. There is no introspections and “public health” is being new clothing in Un Millennium Development Goals.
Benny George (February 2011), writes that, Global geopolitical ambitions notwithstanding, it is a well acknowledged fact that the public health services in India are appallingly poor. The World Health Statistics 2010, released recently by the World Health Organization (WHO), bears testimony to that. According to this report, India is home to 23 per cent of the tuberculosis patients, 86 per cent of diphtheria patients, 54 per cent leprosy patients, 29 per cent of pertussis patients, 42 per cent of polio victims and 55 per cent of malaria patients in the world. India also has the highest percentage of underweight children below the age of five years (43.5 per cent). This is far in excess of the percentage of the world population (17 per cent) that India supports. Let us take a look at the water supply and sanitation facilities in India. Virmani contends that historically the greatest advances in longevity and mortality reduction have come not from having well-maintained public health facilities such as modern drainage and sewerage systems, drinking water systems that produce and deliver disease-free water and sanitation facilities.

The patients’ Charter for Tuberculosis Care outlines (March 2012) the rights and responsibilities of people with Tuberculosis (TB). It empowers people with the disease and their communities through knowledge of the disease. Initiated and developed by patients from around the world, the charter makes the relationship with health care providers a mutually beneficial one.

According to Ramesh Bhat and Somen Saha, (August 2004), The National Common Minimum Programme (CMP) of United Progressive Alliance (UPA) government contains four important guidelines for the health sector: (a) increasing allocation to 2-3 percent of Gross Domestic Product (GDP); (b) major expenditure on primary health care and communicable diseases with political backing for Human Immunodeficiency Virus/
Acquired Immune Deficiency Syndrome (HIV/AIDS) control; (c) health insurance for the poor; and (d) regulation of drug prices for ‘life-saving’ drugs and revival of public sector production units. The Common Minimum programme (CMP) argues for Building a stronger health system. The first budget for the United Progressive Alliance (UPA) government has presented broad guidelines on the government’s plan to address these issues. However, translating these policies into actions remains major challenge. Priorities and policies without giving the consideration to ground level realities are mere rhetoric.

5.14. HEALTH AND DEMOGRAPHY

Vijay Kumar Yadavendu, comments that, (December 2003), the survival of any human society is inextricably linked with the health of its population. Since ancient times, human beings and societies have tried to discover rules and protocols that would enhance chances of sustained good health. In sociological terms, the word ‘public’ implies the outcomes of interactions between individual human beings. The term ‘public health reflects this concern for ensuring health of human collective. Nijhuis and Van der Maesen suggest, “Most theoretical debates about the pros and cons of public health approaches are confined to the methodological scientific level. Philosophical foundations such as underlying ontological notions are rarely part of public health discussions, but these are always implicit and lie behind the arguments and reasoning of different viewpoints or traditions”.

According to Andrew Mitchell, Ajay Mahal and Thomas Bossert, (January 2011), among the many challenges India faces in improving the health of its population is lowering the financial burden of seeking health services. Out-of-pocket spending on health is the dominant form of healthcare financing in India and reaches inordinately high levels. Households with members requiring hospital care face financial catastrophe: the cost of
hospitalization in India has been estimated to reach almost 60 per cent of individuals’ total annual expenditures—with around 40 per cent of individuals nationwide borrowing money or selling assets to pay for expenses—and results in almost one-quarter of those hospitalized falling below the poverty line. In 2004, only the richest 20 per cent of urban households spent less than 10 per cent of income on health and around 40 per cent of low-income residents—urban or rural—who do not seek care cite financial hardship as the primary driver for that decision.

K. Gangadaran (June 2007), narrated that, Kerala registered a significant improvement in key health care indicators. The health situation in the state reflects a paradox. It is a paradox of high morbidity and low mortality, which resulted in the crucial social problem of ageing. Health is fundamental human right emphasized the Alma-Ata declaration in 1978. Since the Alma-Ata conference on health which focused the equitable and cost effective primary healthcare, health has become an important concern in most countries especially in the developing countries, their health status of large section of population is very low. Since 1960s’ the social development movement and from the beginning of the 1960’s the human development reports of the united nations of the development programme have emphasized the improvement in the health status of the population as one of the important goals of development.

According to Siddharth Agarwal, Aravinda Satyavasa, S.Kaushik, and Rajeev Kumar (2007), one of the dominant concerns of the present age is the improving the living conditions of the rapidly increasing population living in cities. For the first time in human history beginning 2007, more than half of the population will live in cities. Estimates by the United Nations suggest that the world urban population has been increasing at a rate of 1.8 per cent annually and will soon outpace the overall world population growth of 1 per cent.
5.15. HEALTH AND INSURANCE

Ajay Mahal said that, (February 2002), The passage of the Insurance Regulatory and Development Authority (IRDA) Bill in December 1999 in the Indian Parliament marked a definitive point in the move towards the privatization of the Insurance sector in India. Upto then, the provision of various types of formal insurance was under the exclusive control of the public sector. The bill allows for the entry of private sector entities in the Indian insurance sector, including health insurance, and envisages the creation of a regulatory authority that would oversee the operation of various players in the insurance market.

5.16. PHARMACEUTICAL MARKET

Subodh Priolkar, (2012), The Global pharmaceutical market was around US$ 860 billion in 2010. The biggest player in the market, the United States (US), contributed almost half the value (45 per cent) with Europe following the next (24 per cent) and Japan (11 per cent). China contributed around 2 per cent and India’s contribution was a meager 2 per cent.