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Research Papers

SCENARIO OF RURAL HEALTH CARE SYSTEM IN INDIA.

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ABSTRACT

Universal access to safe drinking water, health and education is a must for any society to progress which can also be considered as the basic requirement of the people. Public health is considered a public good where everybody benefits from it but no body individually is ready to pay. Good health for any individual calls for at least adequate nutrition and adequate physical exercise. But the pathetically poor state of health of the vast majority of India's population is the direct outcome of the skewed concept of development adopted starting with the New Economic Policy of 1991(NEP-1991).

Important issues in health is need for public health capacity-building, and a separate public health cadre, Quantity and quality of public health human resources required, Types of courses and strategies of education, Numbers and types of institutions required, and Nature of curriculum, skills and capacities required. Poor people are driven by desperation to private hospitals and more often than not end up in serious debt due to very heavy expenses on tests, drugs and surgeries. The question of public health should not be simply viewed from the number of doctors or hospital beds available per capita, because the basic-needs spectrum of food –shelter-clothing –health education is seriously asymmetric and it gets worse with government policy being increasingly driven by corporate designs.

1. INTRODUCTION

In the current model of development, priority is being given to industrial growth at the cost of growth in other sectors. However, the UN Cocoyoc Declaration states that the purpose of development "should not be to develop things but to development". It goes on to list health along food, shelter, clothing and education as basic needs, and states that the fulfilment of these needs must be part of process of growth. Good health for any individual calls for at least adequate nutrition and adequate physical exercise. But the pathetically poor state of health of the vast majority of India's population is the direct outcome of the skewed concept of development adopted starting with the New Economic Policy of 1991(NEP-1991).The question of public health should not be simply viewed from the number of doctors or hospitals beds available per capita, because the basic needs spectrum of food-shelter-clothing-health education is seriously asymmetric, and it gets worse with government policy being increasingly driven by corporate designs.

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2. SYSTEM OF MEDICINE

The larger part of the medical system is based upon education that is provided in medical colleges that grant the MBBS degree. Naming this is a "health care system" may not be accurate because it largely concerns management and treatment of sickness and disease rather than health, and merely attempts to restore the patient to a state of absence of disease, not to vibrant good health. With advances in medical science preventing many debilitating diseases, and providing treatment for a range of other diseases, greater longevity has been observation in almost all societies across the world. The habitats of poor people are in or near places where industrial or municipal wastes (mostly untreated) are discharged or dumped, or near places from where industrial input materials are mined or otherwise drawn. The urban scenario is bad especially in metres where the exhaust emissions of exploding vehicle populations are responsible for asthma and respiratory diseases especially among children. All these are direct causes of ill-health that no public health care system, howsoever efficient, can eliminate without first tackling the fundamental causes. To its credit, Government of India has taken a realistic view of medical needs and recognised other systems of medicine, namely, ayurveda, homeopathy, siddha and unani, which are more affordable for poor people. However, the scale at which these facilities are available to people is grossly insufficient.

3. CONCEPT OF HEALTH CARE

Since health is influenced by a number of factors such as adequate food, housing, basic sanitation, healthy lifestyles, protection against environmental hazards and communicable diseases, the frontiers of health extend beyond the narrow limits of medical care. It is thus clear that "health care" implies more than 'medical care". It embraced a multitude of "services provided to individuals or communities by agents of the health services or professions, for the purpose of promoting, maintaining, monitoring, or restoring health". The term "medical care" is not synonymous with "health care". It refers chiefly to those personal ser-6ces that are provided directly by physicians or rendered as the result of physician's instructions. It ranges from domicilliary care to resident hospital care. Medical care is subset of health care system. Health care is a public right, and it is the responsibility of governments to provide this care to all people in equal measure. These principles have been recognized by nearly all governments of the world and enshrined in their respective constitutions, -in India, health care is completely or largely a governmental function.

4. LEVELS OF HEALTH CARE

It is customary to describe health care service at 3 levels, viz. Primary secondary and tertiary care levels. These levels represent different types of cases involving varying degrees of complexity,

4. 1. Primary care level

It is the first level of contact of individuals, the family and community national health system,where "primary health care", "essential" health care is provided. As a level of care, it is close the people, where most of their health problems can be dealt with and resolved. It is at this level that health care will be most effective within the context of the area's need and limitations. In the Indian context, primary health care is provided by the complex of primary health centres and their subcentres through the agency of multipurpose health workers, village health guides and trained dais. Besides providing primary health care, the village health teams" bridge the cultural and communication gap between the rural people and organised health sector. Since India opted for health for All" by 2000 AD, the primary health care system has been reorganized and strengthened to make the primary health care delivery system more effective.

4. 2. Secondary care level

The next higher level of care is the secondary (intermediate) health care level At this level more complex problems are dealt with. In India, this kind of care is generally provided in district hospitals and community health centres which also serve as. The first referral unit.

4. 3. The tertiary level

The tertiary level is a more specialized level than secondary care level and requires specific facilities and attention of highly specialized health workers. This care is provided by the regional or central level institutions, e.g., medical College Hospitals. All India Institutes, Regional Hospitals,

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Specialized Hospitals and other Apex Institutions.

5. HEALTH NEEDS AND DEMANDS

The purpose of health planning is to meet the health needs and demands of the possible. Health needs have been defined as "deficiencies in health that call for preventive, curative, control or eradication measures". The need for medical care, safe water supply, adequate nutrition, immunization, family planning are all community health needs. It may be mentioned that the health needs as seen by experts. Some needs may not be perceived at all; others vaguely perceived, and still others awaken only on conduct with new ways of life. People's needs are conditioned by their aspirations. In a democratic society, people's needs may be presented as demands.

6. HELATH SYSTEM IN INDIA

Health services are designed to meet the health needs of the community through the use of available knowledge and resources. It is not possible to define a fixed role for health services when the socioeconomic pattern of one country differs: much from another. The health services are delivered y the "health system", which constitutes the management sector and involves organizational matters. Two major themes have emerged in recent years in the delivery of health services:

1 First, that health services should be organized to meet the needs of entire populations and not merely selected groups. Health services should cover the full range of preventive, curative and rehabilitation services. Health services are now seen as part of the basic social services of a country;

2 Secondly, it is now fully realized that the best way to provide health care to the vast majority of undeserved rural people and urban poor is to develop effective "primary health care" services supported by an appropriate, referral system.

The social policy throughout the world was to build up health systems based on primary health care towards the policy objective of Health for by 2000 AD. Community participation is now recognized a major component in the approach to the whole system of health care-treatment promotion and prevent on The street is on the provision of these services to the people-representing a shift from medical care to health care and from urban population to rural population.

India is a Union of 28 States and 7 Union territories. Under the Constitution of India, the States are largely independent in matters relating to the delivery of health care to the people. Each State, therefore, has developed its own system of health care delivery, independent of the Central Government. The Central responsibility consists mainly of policy making, planning, guiding, assisting, evaluating, and coordinating the work of the State Health Ministries, so that health services cover every part of the country, and no State lags behind for want of these services. The health system in India has 3 main links, i.e., Central, State and Local or peripheral.

6.1. AT THE CENTRAL LEVEL

The official "organs" of the health system at the national level consist of:

1.The Ministry of Health and Family Welfare;
2.The Directorate General of Health Services; and
3.The Central Council of Health and Family Welfare.

6.1.1. UNION MINISTRY OF HEALTH AND FAMILY WELFARE

The Union Ministry of Health and Family Welfare is headed by a Cabinet Minister, a Minister of State and a Deputy Health Minister. These are political appointments. Currently, the Union Health Ministry has the following departments:

1.Department of Health and
2.Department of Family Welfare.

The functions of the Union Health Ministry are set out in the seventh schedule of Article 246 of the Constitution of India under

1.The Union list and
2The Concurrent list.

6.1.2. DIRECTORATE GENERAL OF HEALTH SERVICE

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The Director General of Health Services is the principal adviser to the Union Government in both medical and public health matters. The Directorate comprises of three main units, e.g., medical care and hospitals, public health and general administration. The general functions are surveys, planning, coordination, programming and appraisal of all health matters in the country. The specific functions are

1 International health relations and quarantine
2 Control of drug standards
3 Medical store depots
4 Post graduate training
5 Medical education.

6.1.3. CENTRAL COUNCIL OF HEALTH

The Central Council of Health was set up by a Presidential Order on 9 August, 1952 under Article 263 of the Constitution of India for promoting. The functions of the'"Central Council of Health are:

1.To consider and recommend broad outlines of policy in regard to matters concerning health in all its aspects such as the provision of remedial and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research.
2.To make proposals for legislation in fields of activity relating to medical and public health matters and to lay down the pattern of development for the country as a whole.
3.To make recommendations to the Central Government regarding distribution of available grants-in-aid for health purposes to the States and to review periodically the work accomplished in different areas through the utilisation of these grants-in- aid.

6.2. AT THE STATE LEVEL

Historically, the first milestone in State health administration was the year 1919, when the States (then known as provinces) obtained autonomy, under the Montague-Chelmsford reforms, from the Central Government, in matters of public health. By 1921-22, all the States had created some form of public health organization. The Government of India Act, 1935 gave further autonomy to the States. The health subjects were divided into three groups: federal, concurrent and state. The "state" list which became the responsibility of the State included provision of medical care, preventive health services and pilgrimages within the State. The position has largely remained the same, even after the new Constitution of India came into force in 1950. The State is the ultimate authority responsible for all the health services operating within its jurisdiction.

6.3. AT THE DISTRICT LEVEL

The principal unit of administration in India is the district under a Collector. There are 593 (year 2001) districts in India. There is no "average" district. That is the districts vary widely in area and population. Within each district again, there are 6 types of administrative areas

1.Sub - divisions
2.Tehsils (Talukas)
3.Community Development Blocks
4.Municipalities and Corporations
5.Villages
6.Panchayats

The Town area committees are like panchayats. They provide sanitary services. The Municipal Boards are headed by a Chairman/President, elected usually by the members. The term of a Municipal Board ranges between 3-5 years. The functions of a municipal board are: construction and maintenance of roads, sanitation and drainage, street lighting, water supply, maintenance of hospitals and dispensaries, education, registration of births and deaths, etc. Corporations are headed by Mayors. The councillors are elected from different wards of the city. The executive agency includes the Commissioner, the Secretary, the Engineer and the Health Officer. The activities are similar to those of the municipalities, but on a much wider scale.

7. Public health

Health has been declared a fundamental human right. This implies that the State has a

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responsibility for the health of its people. National governments all over the world are striving to expand and improve their health care services. The current criticism against health care services is that they are
1.predominantly urban oriented
2.mostly curative in nature, and
3.accessible mainly to a small part of the population,

The present concern in both developed and developing countries is not only to reach the whole population with adequate health care services, but also to secure an acceptable level of Health for all by the year 2000 AD., through the application of primary health care programmes. Public health is the responsibility of the Ministry of Health and Family Welfare, and at the local level, of Health Officers in urban or rural areas, whose official focus is on preventive health (hygiene and immunization) and medical treatment. No attention at all is given to levels of nutrition or availability of food and water that are vital to raise immunity levels and good health. The standard of medical attention and treatment available in government hospitals is pathetic and there is great dissatisfaction across the country among patients in this regard. Now government hospitals are being leased out to the private sector with no real benefit to poor patients. Poor people are driven by desperation to private hospitals and more often than not end up in serious debt due to very heavy expenses on tests, drugs and surgeries. A study done for the WHO in six Indian States found that 16 per cent of households it looked at were pushed below the poverty line by heavy medical costs Availability of medical insurance to the middle class gives them financial relief in case of sickness, but it does not and cannot bring improved health.

8. PRIVATE HEALTH

The private sector is a broad group that includes for profit and not-for profit providers, NGOs, missionary hospitals, private pharmacies and blood banks and unqualified informal providers some of whom are registered and some are not. For the purposes of this study it is useful to divide private sector providers into three major groups, each of which is discussed in more detail below;

Rural Medical Providers (RMPs);
Not-for-profit sector including NGOs and religious-based facilities;
Corporate or for-profit sector.

The private sector has grown rapidly to fill this gap. Private spending now accounts for over 80 percent of health care spending one of the highest ratios in the world. Some surveys estimate that more than 90 percent of beds are in the private sector. The sector is dominated by unqualified, formal providers practicing in “quackery”, representing a challenge to public sector regulatory and planning capacity. Although the NGO sector operates in an efficient and self-regulated manner it comprises a tiny fraction of health care services in India – less than 1 percent in most states. The formal for-profit sector covers a broad range of facilities from small clinics and nursing homes to large corporate chains of tertiary facilities. The best private hospitals offer world class facilities that are able to attract an international clientele. Unfortunately the whole sector does not meet such standards. The private sector has grown in an unregulated manner and often offers overlapping facilities in which public doctors practice in their own time both legally and illegally. Problems that continue to plague the sector include, variable quality, unnecessary procedures, un qualified practitioners.

At independence less than 8% of all medical institutions in the country were maintained by wholly private agencies.14 By the early 1990s this figure had reached close to 60% and there are indications that it increased even further during the last decade. In large part, the private sector has emerged in response to the current health care situation outlined above. The decade to 1996 witnessed a steep decline in the market share of public health services. The proportion of patients seeking ambulatory care in the public sector fell from 32% to 26% in rural areas and from 30% to 17% in urban areas. Similarly, by 1996, the private sector accounted for 54% of rural hospitalization and 70% of hospitalization in urban areas.15 There is strong evidence that such official statistics grossly underestimate the size of the private sector which, through facility surveys in various states, has recently been estimated as high as 93 percent of all hospitals and 64 percent of all beds nationwide.16 This remarkable growth in private sector health services has occurred largely by accident as the private sector has stepped in to meet needs that the public sector could not address.

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9. HEALTH PROGRAMMES IN INDIA

It may be noted that as many as nearly 30 different major health programmes have been introduced ever since independence in India. These programmes are sometimes generic in nature and applicable to the entire population; at times they aim at controlling specific mass diseases; sometimes they target women and children. And a few programmes are meant exclusively for children, the details of which are given in table –

HEALTH PROGRAMMES IN INDIA
Table – 1

YEAR	PROGRAMMES	NATURE
1952	National Family Planning Programme	General
1953	National Malaria Control Programme	Disease specific
1955	National Filaria Control Programme	Disease specific
1955	National Leprosy Control Programme	Disease specific
1958	National Malaria Eradication Programme	Disease specific
1958	Primary Health Centres Progrtamme	General
1962	National Goitre Control Programme	Disease specific
1962	National Small Pox Eradication Programme	Disease specific
1962	National Tuberculosis Programme	Disease specific
1962	School Health Programme	Nutrition
1963	Applied Nutrition Programme	Nutrition
1963	Mid-day meals Programme	Nutrition
1964	Maternal and Child Health Programme	General
1970	Iron and Folic Acid Supplementary Programme	Nutrition
1970	Special Nutrition Programme	Nutrition
1971	Anemia Control Programme	Nutrition
1971	Vitamin A Prophylaxis Programme	Nutrition
1974	Minimum Needs Programme	General
1975	ICDS Programme	General
1975	Integrated Health Scheme	General
1976	National Programme for Prevention of Blindness	Disease specific
1978	Expanded Programme of Immunization	Immunization
1980	National Diarrhea Control Programme	Disease specific
1983	National Leprosy Eradication Programme	Disease specific
1985	Universal Immunization Programme	Immunization
1990	ARI Control Programme	Disease Specific
1992	CSSM Programme	General
1995	Pulse Polio Eradication Programme	Immunization
1996	Reproductive and Child Health Programme	General

Source: National Family Health Survey, 2000-2001,
Institute for Population Science, Mumbai.

10. HEALTH PLANNING IN INDIA

Health planning in India is an integral part of national socio-economic planning. The guidelines for national health planning were provided by a number of committees dating back to the Bhore committee in 1946. These committees were appointed by the Government in India from time to time to review the existing health situation and recommend measures for further action. A brief review of the recommendations of these committees, which are important landmarks in the history of public health in India, is given below. The Alma Ata Declaration on primary health care and the National

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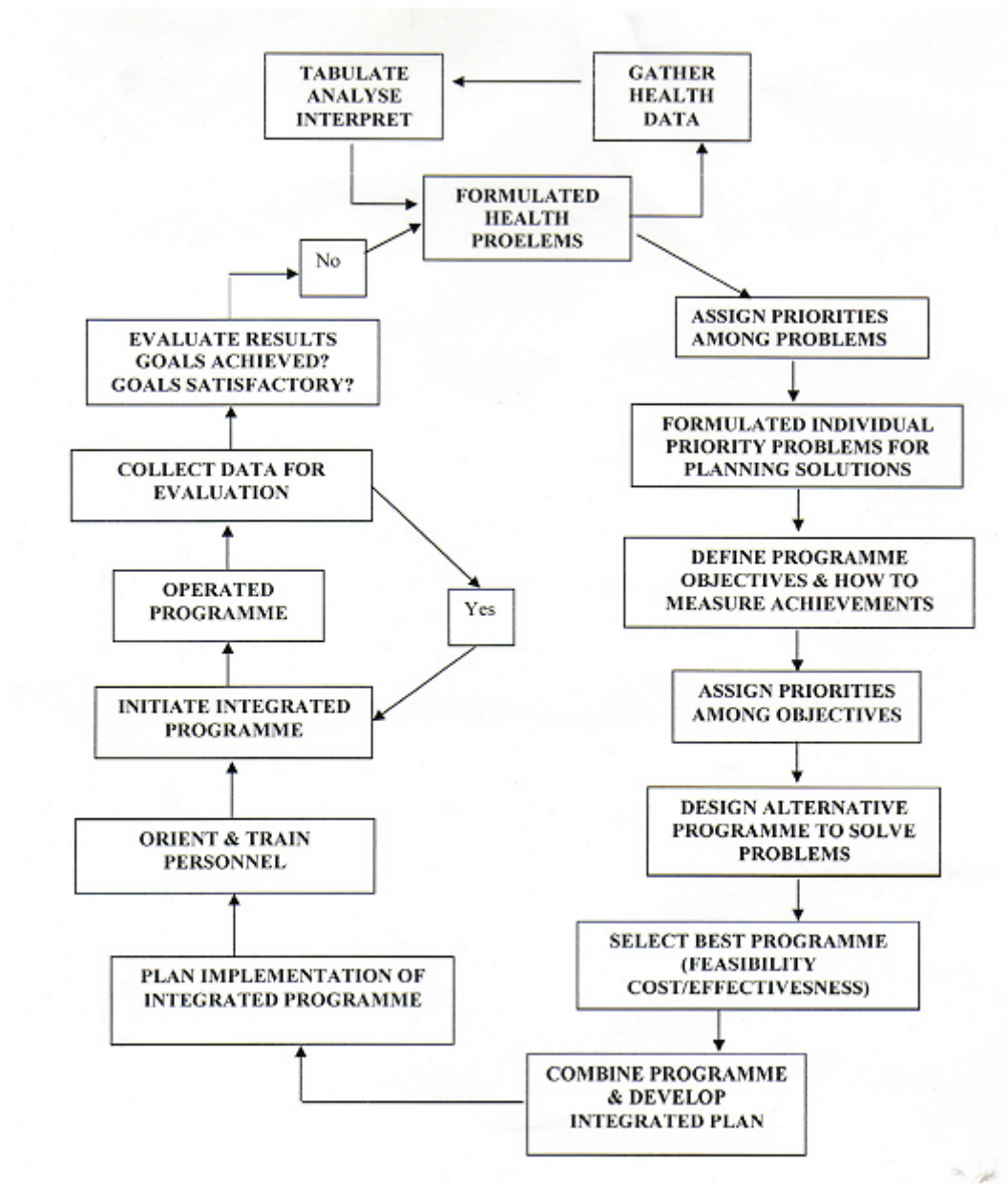
Health Policy of the Government gave a new care the central function and main focus of its national health planning in India, making primary health care the central function and main focus of its national health system. The goal of national health planning in India was to attain Health for all by the year 2000.

10.1. PLANNING CYCLE

Planning is the broad foundation on which much of the management is based. Planning may be defined as a process of analysing a system, or defining a problem, assessing the extent to which the problem exists as a need, formulating goals and objectives to alleviate or ameliorate those identified needs, examining and choosing from among alternative intervention strategies, initiating the necessary action for its implementation and monitoring the system to ensure proper implementation of the plan and evaluating the results of intervention in the light of stated objectives. Planning thus involves a succession of steps.

FIGURE -1



SOURCE: Preventive and Social Medicine (2002)

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10.2. BHORE COMMITTEE, 1996

The government of India in 1943 appointed the Health Survey and Development Committee with Sir Joseph Bhore as Chairman, to survey the then existing position regarding the health conditions and health organization in the country, and to make recommendations for the future development. The committee observed: 'if the nation's health is to be built, the health programme should be developed on a foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of patients.' Some if the important recommendations of the Bhore committee were;

(1) Integration of preventive and curative services at all administrative levels;

(2)The committee visualised the development of primary health centres in 2 stages:

1.As a short- term measures, it was proposed that each primary health Centres in the rural areas should cater to a population of 40,000 with a secondary health Centre to serve as a supervisory, coordinating and referral institution. For each PHC , two medical officers , 4 public health nurses, one nurse , 4 midwives, 4 trained dais, 2 sanitary inspector, 2 health assistance, one pharmacist, and 15 other class iv employees were recommended.

2.A long-term programmes (also called the three million plan) of setting up primary health units with 75-bedded hospitals for each 10,000 to 20,000 population an for nard secondary units with 650-bedded hospitals, again, regionalized around district hospital with 2500 beds, and

(3). Major changes in medical education which includes 3 months training in preventive and social medicine to prepare "social physicians"

Although the Bhore Committee's recommendations did not form part of a comprehensive plan for national socioeconomics development, the committee's Report continuous to be a major national document, and has provided guidelines national health planning in India.

10.3. MUDALIAR COMMITTEE, 1962

In 1956, the Government of India appointed another committee knows as "Health Survey and Planning committee", popularly known as the mudaliar committee (after them name of its chairman, Dr. A.L.Mudaliar) to survey the progress made in field of health since submission of the Bhore committee's Report and to make recommendation for future development and expansion of health service. The mudaliar committee found the quality of services provided by the primary health centres inadequate, and advised strengthening of the existing primary health centres before new centres were established. It also advised strengthening of sub divisional and district hospitals so that they may effectively function as referral centres.

The main recommendations of the Mudaliar Committee were:

1.Consolidation of advances made in the first two five year plans;

2.Strengthening of the district hospital with specialist services to serve as central base of regional services;

3.Regional organizations in each state between the headquarters organization and the district in charge of a Regional Deputy or Assistant Directors – each to supervise 2 or 3 district medical and health officers;

4.Each primary health centre not to serve more than 40,000 population;

5.To improve the quality of health care provided by the primary health centres.

10.4. CHADAH COMMITTEE, 1963

In 1963, a committee was appointed by the Government of India, under the chairmanship of Dr. M.S.chadah, the then Director General of health service to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme. The committee recommended that the "vigilance" operation in respect of the National Malaria Eradication Programme should be the responsibility of the general health services, i.e. primary health centres at the block level. The committee also recommended that the vigilance operations through monthly home visits should be implemented through basic health workers. One basic health worker per 10,000 populations was recommended. These workers were envisaged as "multipurpose" workers to look after additional duties of collection of vital statistics and family planning, in addition to malaria vigilance. The Family Planning Health Assistants were to supervise 3 or 4 of these basic health workers. At the district level, the general health services

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were to take the responsibility for the maintenance phase

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10.5. MUKERJI COMMITTEE, 1966

As the states were finding it difficult to take over the whole burden of the maintenance phase of malaria and other mass programmes like family planning, smallpox, leprosy, trachoma, etc, due to paucity of funds, the matter came up for in Bangalore in 1966. The Council recommended that these and related questions may be examined by a committee. Of Health Secretaries, under the Chairmanship of the Union Health Secretary, Shri Mukerji. The Committee worked out the details of the BASIC HEALTH SERVICE which should be provided at the block level, and some consequential strengthening required at higher levels of administration.

10.6. JUNGALWALLA COMMITTEE, 1967

The Central Council of Health at its meeting held in Srinagar in 1964, taking note of the importance and urgency of integration of health services, and elimination of private practice by government doctors, appointed a Committee known as the "Committee on Integration of Health Services" under the chairmanship of Dr. N. Jungalwalla, Director, National Institute of Health Administration and Education, New Delhi to examine the various problems including those of service conditions and submit a report to a central Government in the light of these considerations. The report was submitted in 1967.

The committee recommended integration from the highest to the lowest level in the services, organization and personnel. The main steps recommended towards integration were:

1.Unified cadre
2.Common seniority
3. Recognition of extra qualifications
4.Equal pay for equal work
5.Special pay for specialised work
6.No private practise, and good service conditions.

10.7. SINGH COMMITTEE, 1973

The Government of India constituted a committee in 1972 known as "The Committee on Multipurpose Workers under Health and Family Planning" under the chairmanship of kartar Singh, Additional secretary Ministry of Health and Family Planning, Government of India. The committee submitted its reports in September 1973. Its main recommendations were:

1.That the present Auxiliary Nurse Midwives to be replaced by the newly designated "Female Health Workers", and the present-day Basic Health Workers, Malaria Surveveilance workers, vaccinators, Health Education Assistants (Trachoma) and the Family Planning Health Assistants to be replaced by "Male Health Workers"
2.The programme for having multipurpose workers to be first introduced in areas were malaria is n maintenance phase and smallpox has been controlled, and later to other areas as malaria passes into maintenance phase or smallpox controlled.
3.For proper coverage, there should be one primary health centre for a population of 50,000;
4.Each primary health centre should be divided into 16 sub-centres each having population of about 3,000 to 3,500 depending upon topography and means of communications;
5.Each sub centre to staff by a team of one male and one female health worker.

10.8. SHRIVASTAV COMMITTEE, 1975

The Government of India in the Ministry of Health and family planning had in November 1974 setup a 'Group on Medical Education and Man Power' Popularly known as the shrivastav committee:

The group submitted its report in April 1975. It recommended immediate action for :

1.Creation of bands of para-professional health workers from within the community itself to provide simple, promotive, preventive and curative health services needed by the community;
2.Establishment of 2 cadres of health workers, namely – multipurpose health workers and health assistants between the community level workers and doctors at the PHC;
3.Development of a 'Referral Services Complex' by establishing proper linkages between the PHC and

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higher level referral and service centres, viz taluk\tehsil, district, regional and medical college hospitals, and
4.Establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of the University Grants Commission.

10.9. RURAL HEALTH SCHEME, 1977

The most important recommendation of the Shriastav Committee was that primary health care should be provided within the community itself through specially trained workers so that the health of the people is placed in the hands of the people themselves. The basic recommendations of the Committee were accepted by the Government in 1977, which led to the launching of the Rural Health Scheme. The programme of training of community health workers was initiated during 1977-78. Steps were also initiated (a) for involvement of medical colleges in the total health care of selected PHCs with the objective of reorienting medical education to the needs of rural people; and (b) reorientation training of multipurpose workers engaged in the control of various communicable disease programmes into unipurpose workers. This "Plan of Action" was adopted by the Joint Meeting of the Central Council of Health and Family Planning Council held in New Delhi in April 1976.

11. FIVE YEAR PLANS

The five year plans were conceived to re-build rural India, to lay the foundations of industrial progress and to secure the balanced development of all parts of the country. Recognising "health" as important contributory factor in the utilization of manpower and the uplifting of the economic condition of the country, the Planning Commission gave considerable importance to health programmes in the five year plans. The broad objectives of the health programmes during the five year plans have been:
(1) Control or eradication of major communicable diseases;
(2) Strengthening of the basic health services through the establishment of primary health centres and sub centres;
(3) Population control; and
(4) Development of health manpower resources.

11.1. TENTH FIVE YEAR PLAN (2002-2007)

Today India has a vast network of governmental, voluntary and private health infrastructure manned by large number of medical and paramedical persons. During the Tenth Plan, efforts will be further intensified to improve the health status of the population by optimizing coverage and quality of care by identifying and rectifying the critical gaps in infrastructure; manpower, equipment, essential diagnostic reagents and drugs. The approach during the Tenth Plan will be to improve access to, and enhance the quality of primary health care in urban and rural areas by providing an optimally functioning primary health care system as a part of Basic Minimum Services and to improve the efficiency of existing health care infrastructure at primary, secondary and tertiary care settings through appropriate institutional strengthening, and improvement of referral linkages.
The monitorable targets for the Tenth Five Year Plan and beyond are as follows:
•Reduction of poverty ratio by 5 per cent points by 2007, and by 15 per cent points by 2012;
•All children in school by 2003; all children to complete 5 years of schooling by 2007;
•Reduction in gender gaps in literacy and wage rates by at least 50 per cent by 2007;
•Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2 per cent;
•Increase in literacy rate to 75 per cent within the plan period;
•Reduction of infant mortality rate to 45 per 1000 live births by 2007 and to 28 by 2012;
•Reduction of maternal mortality ratio to 2 per 1000 live births by 2007 and to 1 by 2012; and
· All villages to have sustained access to potable drinking water within the Plan period.
These targets reflect the concern that economic growth alone may not lead to the attainment of long-term sustainability and of adequate improvement in social justice. Earlier plans have had many of these issues as objectives, but \in no case specific targets were set. As a result, these were viewed in terms of being desirable but not essential. However, in the 10th plan, these targets are considered to be as central to the planning frame work as the growth objective. Technological improvements and increased access to health care have resulted in a steep fall in mortality, but the disease burden due to communicable diseases

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and non- communicable diseases, environmental pollution and nutritional problems continue to be high. In spite of the fact that norms for creation of infrastructure and manpower are similar throughout the country, there remains substantial variation between states and districts within the states, in availability and utilization of health care services and health indices of the population. During Tenth Plan there is continued commitment to provide essential primary care, emergency life saving services, services under national disease control programme free of cost to individuals, based on their needs, and not on their ability to pay. Government has set targets in the Tenth Five Year Plan to control certain diseases like HIV/AIDS, tuberculosis, leprosy, malaria, and blindness etc.

THE ACHIEVEMENTS DURING THE PAST 55 YEARS OF PLANNED DEVELOPMENT
TABLE - 2.

S.No		1st Plan 1951-56	10th Plan 2002 - 2007
1.	Primary Health Centres	725	23236 (Sep 2005)
2.	Subcentres	NA	146,026
3.	Community health centres	--	3,346
4.	Total beds (2002)	125,000	914,543
5.	Medical colleges	42	242
6.	Annual admissions in medical colleges	3,500	26,449
7.	Dental colleges	7	205
8.	Allopathic doctors	65,000	767,500
9.	Nurses	18,000	865,135
10.	ANMs	12,780	506,925
11.	Health visitors	578	50,393
12.	Health Workers (F) (in position)	--	133,194
13.	Health Workers (M) (in position)	--	61,907
14.	Block Extension	--	2,645
15.	Health Assistant (M) (in position)	--	20,181
16.	Health Assistant(F)/LHV	--	17,371
17.	Village Health Guides	--	3.23 Lakh

SOURCE: Bulletion

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INVESTMENTS IN HEALTH AND FAMILY WELFARE PROGRAMMES DURING DIFFERENT PLAN PERIODS. (IN RS. CRORES)
TABLE- 3

Period	Total plan Investment	Health	Family Welfare	Water supply& sanitation
I Plan (1951-56)	1960.00	65.20	0.1	NA
II Plan (1956-61)	4672.00	140.80	2.20	NA
III Plan (1961-66)	8576.00	225.00	24.90	10.70
Annual Plans (1966-69)	6625.40	140.20	70.50	102.70
IV Plan (1969-74).	15,778.80	335.50	284.40	458.90
V Plan (1974-79)	39,322.00	682.00	497.40	971.00
1979-80 Outlay	11,650.00	268.20	116.20	429.50
VI Plan (1980-85)	97,500.00	18211.05	1010.00	3922.02
VII Plan (1985-90)	180,000.00	3,392.89	3,256.26	6,522.47
Annual Plan (1990-91)	61,518.10	960.90	784.90	1876.80

12. NATIONAL HEALTH POLICY-2002

The Ministry of Health and family Welfare, Govt. Of India, evolved a National Health Policy in 1983 keeping in view the national commitment to attain the goal of Health for All by the year 2000. Since then there has been significant changes in the determinant factors relating to the health sector, necessitating revision for the policy, and a new national Health Policy-2002 was evolved.

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to decentralized public health system by establishing new infrastructure in the existing institutions. Over-riding importance would be given to ensure a more equitable access to health services across the social and geographical expanse of the country. Primary will be given to preventive and first line curative initiatives at the primary; health level. The policy to disease burden such as tuberculosis, malaria, blindness and HIV/AIDS. Emphasis will be laid on rational use of drugs within the allopathic system. To translate the above objectives into reality, the Health Policy has laid down specific goals to he achieved by year 2005, 2007, 2010 and 2015.

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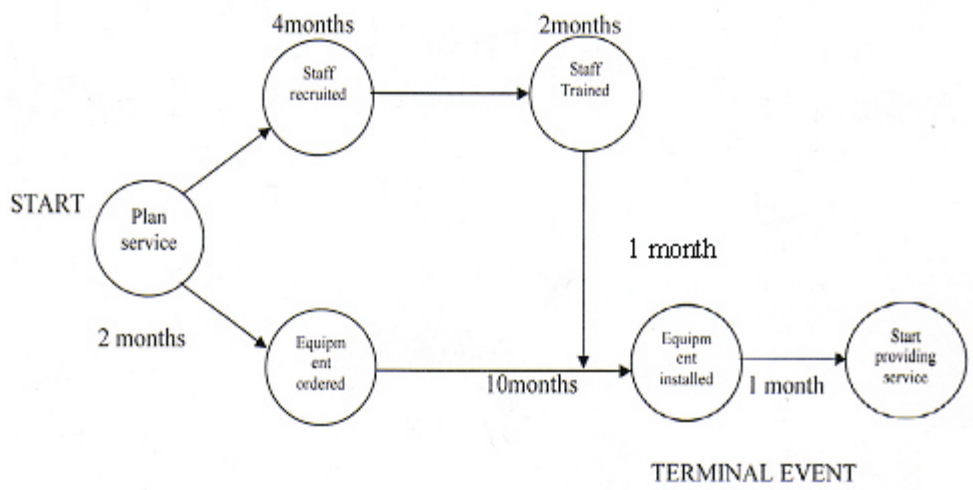
NETWORK ANALYSIS
Figure- 2



SOURCE: National Health Policy 2002

TABLE-4

NATIONAL HEALTH POLICY	**2002**
GOALS TO BE ACHIEVED BY	**2015**
Eradicate Polio and Yaws	2005
Eliminate leprosy	2005
Eliminate kala-azar	2010
Eliminate lymphatic Filariasis	2015
Achieve zero level growth of HIV/AIDS	2007
Reduce mortality by 50% on account of TB, Malaria and other vector and water borne diseases	2010
Reduce prevalence of blindness to 0.5%	2010
Reduce IMR to 30/100 and MMR to 100/Lakh	2010
Increase utilization of public health facilities from Current level of <20% to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
Increase health expenditure by Government as a % Of GDP from the existing 0.9% to 2.0%	2010
Increase share of central grants to constitute at least 25% of total health spending	2010
Increase state sector health spending from 5.5% to 7% of the budget.	2005
Further increase to 8% of the budget	2010

SOURCE: National Health Policy

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However, longevity has usually not been accompanied by the good health associated with robustness and fitness, and often only results in adding years to life - years of regular visits to doctors and hospitals with expensive medication and drug-dependence, and lowered levels of restricted physical activity. In any case, this is affordable only to the wealthy or people with medical insurance. This has been criticized as "adding years to life without adding life to years".

13. HEALTH PROBLEMS IN INDIA

Before discussing the health care system, it is worthwhile to consider what are the major health problems in India. These are briefly reviewed here.

13.1 POPULATION PROBLEM

India's population was 1027 million in 2001. It is alarming to note that India's population is more than that of USA, USSR and Japan put together and that India adds to itself every year 18 million people, equivalent to the population of Australia, at the rate of 50,000 babies per day. Population explosion absorbs the national income and lowers the standard of living. It leads to food shortage since it often exceeds increase in food production. In a study by the FAO, one-third of the 72 developing countries were found to lag behind in food production in comparison to the growth of population. 5 Uncontrolled fertility directly threatens the health 'of mothers and infants and may undermine the health of other family members as well, Infants born within 18 months of the birth of a previous child are 2 and 3 times more likely to die than those born after longer interval, as shown by studies in Kenya and Egypt respectively; Babies born in Indonesia to mothers aged less than 18 years are 30% more likely to die than thos'e born to mothers aged 20-24 years; According to surveys in 25 developing countries in 980's, 35% births occur within 24 months of previous births, though many women wish to avoid these. If these births could be delayed till women want them, then overall child mortality would decrease by 20% in all these countries taken together and by 30% in some countries of South America.

In addition to the above, rapid population growth has serious pollutional consequences as well. It has been labeled as the prime cause of pollution and environmental degradation in the world today. At a rate of increase of 2.1 % every year, population doubles in just 30 years. But there is no associated doubling of resources. Increased demand for fuel and living space further accelerates the rate of deforestation. More deforestation, mining and construction work lead to higher dust pollution and floods. Production of more goods needed by more people means higher industrialisation and industrial Pollution. More transportation need for more people means higher vehicular pollution. Burning of more fuel for transport, cooking and electricity needed by more people means higher carbon dioxide production. The net result is high environmental pollution as a result of high population growth. Coupled with this is the increasing amount of non-bio degradable wastes which pollute the environment.

13.2. MALNUTRITION

The major problems are protein-energy malnutrition, low birth weight, anemia, and exophthalmia and iodine deficiency disorders. The national health goals provided for reduction of LBW to 10% by 2000 AD and for reduction in incidence of goiter by that time to near zero (Table 25.10).

13.3 LACK OF ENVIRONMENTAL SANITATION

This includes the twin problems of unhygienic methods of excreta disposal and non-availability of safe drinking water. These together are responsible for the high incidence of diarrheal diseases, polio and infective hepatitis, etc. The national goal aimed at providing safe water and safe excreta disposal facilities for 100% population by 2000 AD.

13.4. HIGH PREVALENCE OF COMMUNICABLE DISEASES

These include malaria, filaria, leprosy, diarrheal diseases, UIP target diseases (including tuberculosis) and viral hepatitis, enteric fever, kala azar, STD, etc. They account for a very high rate of morbidity and mortality. To take just one example, as many as 40% persons in the population are infected with tubercle bacilli (i.e. are tuberculin positive) and 1.5% have radiological evidence of pulmonary tuberculosis. Of the latter, about one-fourth are sputum positive. The number of pulmonary tuberculosis patients in India is estimated to be 9-10 million, of whom 2.5 million are open cases. Nearly 4 million people are now believed to be HIV positive.

13.5. Lack of Medical Care Facilities

This is evident from the fact that about 75 % medical facilities are concentrated in urban areas where only about 25 % population resides, resulting in gross unavailability of health care support in the rural areas.

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14. CAUSES FOR FAILURE IN PUBLIC HEALTH SYSTEM

Demonstrably, the public health care system in India has failed and it is possible to pinpoint the main causes

1.Development is seen by national leaders as ensuring 2rowth of the economy (GDP growth rate) rather thanas development of people's health and well-being.

2.The concept of health itself is not well understood at governmental and public levels. Health issues are not included adequately in primary or secondary education or even meaningfully in medical education.

3.The connection between nutrition, social welfare and basic needs on the one hand and health, on the other hand has not been made at governmental levels because of being handled by different ministries and due to "health-illiteracy" of the individuals handling those matters.

4.Health statistics are merely figures that do not translate into action because there is limited understanding of the real issues behind health - "health-illiteracy",

5.Degradation of the environment due to industrial and other pollution has a serious adverse affect on public health, especially on the poorer sections of society who are in the majority.

6.The medical system is being increasingly privatized and profit-oriented in preference to providing health cover to those who need it. This is the emergence of the so-called health industry.

7.The "engine" that drives the health industry is the profit-oriented pharmaceutical MNCs.

8.Advertisement (especially targeting children) of so-called health foods and other products like soft drinks, confectionery and junk foods cause malnourishment even in the upper socio-economic stratum, and erode sensible traditional diets.

9.Governments have failed to comprehensively provide primary health cover (very effective and cheap to deliver), but has instead favoured hi-tech, multi-speciality hospitals that treat complicated diseases at great expense that the poor cannot afford. This is connected with the fact that primary health cover does not contribute to GDP growth nearly as much as swanky, 5-star hospitals do.

Unless there is a paradigm shift in the understanding of health and its implications, and the political will to provide health services to the majority of the population as a part of development along with the other basic needs, there cannot be any substantial improvement in the current pathetic status of public health care.

15. NEED FOR A PUBLIC HEALTH MOVEMENT

We would like to conclude by making a plea to strengthen the public health movement in India, to supplement the People's Health Movement the evolved in 2000 AD. The rationale is as follows:

1.Public health capacity building, including establishment of a stand-alone public health cadre is long overdue in the country in order to strengthen public health systems and make them responsive to complex public health challenges.

2.Today's complexity also requires that the focus of attention is not just on PHFI and its emerging institutions and initiatives however high profile they may be in the media, but on all the ongoing and evolving initiatives in education, strategies for public health and community health in India - subjecting them to the same questions and scrutiny, reviewing their relevance, contribution, lessons learnt through their experience, and their potential contribution or continued irrelevance to the new challenges. The questions we are asking of PHFI are also questions that we should be asking ourselves in the context of the pre-PHFI developments in HRD in India in both the mainstream and the alternative sector. Have any of our initiatives made a significant difference.

3.In the current market place that prevails in policy and system development and with the dialectics of medial tourism vs the National Rural Health Mission, this debate needs to move from radical spaces to critical engagement. This engagement could be through a public health watch and a public health movement that tackles the continuing lacunae of human resources for Health for All in the country.

4.A few years before the national and Global People's Health Assemblies and the adoption of the Indian and Global People's Charter for Health, CHC identified a 12-point agenda for action to strengthen health human resource development in the country to counter the disturbing and distorting trends evident in the 1990s. These included:

5.Banning medical college expansion

6.Strengthening MCI - making it more professional and socially oriented.

7. Setting up a National Human Power Development Commission with a strong multi-disciplinary focus

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to evolve need based and evidence based change
8. Strengthening existing medical education efforts, including medical education cells and social and community orientation
9.Examination reforms towards rational and ethical systems
10.Promoting creative autonomy for experimentationtowards primary health care, community health and general practice
11.Strengthening continuing education of health and allied professions involving IGNOU approaches and expertise
12.Strengthening public health capacity-building and development of public health cadre
13.Research in health human power development including implications of privatization, brain-drain and new economic policies
14.egulation of privatization and commercialization of medical education and health
15.Promoting training of health worker training.

Since 2000 AD, the People's Health Movement in India (Jan Swasthya Abhiyan) has developed as this emerging countervailing movement in which we al! are actively involved. What is also needed urgently is an alternative public health network that brings together all those united in their concerns for public health capacity-building — both civil society networks like JSA, MFC or professional associations like the Indian Association of Preventive and Social Medicine (IAPSM), Indian Public Health Association (IPHA), INCLEN and other alternative training groups. An active engagement with initiatives such as NRHM, PHFI, SEAPHEIN as well as with social movements is part of the challenges and opportunities ahead.

16. CONCLUSION

A fundamental and necessary function of health care system is to provide a sound referral sister. It must be a two-way exchange of information and retiming patients to those who referred them for follow-up care. It will ensure continuity of care and inspire confidence of the consumer in the system. For a large majority of developing countries (including India) this aspect of the health system remains very weak. Efficient government health care institutions as a result of better government spending also makes the health sector more competitive and thereby reduce the private cost of health care. Evidence shows that Indian states where government health spending is good and efficient drastically reduced the reliance of households on impoverishing out-of pocket spending.

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