

EVOLUTION OF HEALTH POLICY IN INDIA

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Date: 18th April 2001

PREFACE

Health and health care development has not been a priority of the Indian state. This is reflected in two significant facts. One, the low level of investment and allocation of resources to the health sector over the years – about one percent of GDP with clear declining trends over the last decade. And second the uncontrolled very rapid development of an unregulated private health sector, especially in the last two decades.

Yes, we have a health policy document but it took 35 years after Independence for the government to make a health policy statement in 1982-83. And it is no coincidence that such a policy statement came only after the 1978 Alma Ata Declaration of the World Health Assembly – Health For All by 2000 AD. But this does not mean that there was no health policy all these years. There was a distinct policy and strategy for the health sector, albeit an unwritten one. This was reflected through the Five Year Plans. This, despite the fact that health is a state subject.

At the state government level there is no evidence of any policy initiatives in the health sector. The Central government through the Council of Health and Family Welfare and various Committee recommendations has shaped health policy and planning in India. It has directed this through the Five Year Plans through which it executes its decisions. The entire approach has been program based. The Centre designs national programs and the states have to just accept them. The Centre assures this through the fiscal control it has in distribution of resources. So, essentially what is a state subject the Centre takes major decisions. However it is important to note that this Central control is largely over preventive and promotive programs like the Disease Control programs and Family Planning, which together account for between two-thirds and three-fourths of state budgets. Curative care, that is hospital and dispensaries, has not been an area of Central influence and in this domain investments have come mostly from the state's own resources.

Post-SAP one sees a declining role of the Centre in the health sector. The opening up of the economy has allowed state governments to directly negotiate with agencies like World Bank and this has meant taking some initiative on the policy front even if it is driven by the lending agency. In this context a number of state governments have set up think tanks and/or policy groups to facilitate policy making and planning for the health sector.

In this document we will historically trace the evolution of health policy making in India in the context of the development of the health sector. We will also review the current scenario and suggest future directions for policy initiatives.

1. Historical Context of India's Health Policy

Introduction

Structured health policy making and health planning in India is not a post-independence phenomena. In fact, the most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946. This was the 'Health Survey and Development Committee Report' popularly referred to as the Bhore Committee. This Committee prepared a detailed plan of a National Health Service for the country, which would provide a universal coverage to the entire population free of charges through a comprehensive state run salaried health service. Such a well-studied and minutely documented plan has not as yet been prepared in Independent India.

The Bhore Committee proposals required implementation of structural changes in the then health care system, and had they been implemented they would have radically altered health care access and health status of the Indian masses, especially the 80% population residing in rural areas. It is only an embarrassment for the Indian nation that more than half a century later there is no evidence of development of health care services to a level that the Bhore Committee regarded as a minimum decent standard. And neither has the health status of the masses altered very significantly – both in terms of the technology and means available as well as in comparison with developed countries today. The gap then and now has not changed much.

Health services in India today are as inadequate and underdeveloped as they were during the time of the Bhore Committee. The analysis of the health situation by the Bhore Committee in the early forties would hold good if a similar enquiry is undertaken today, over half a century later. Instead of the National Health Service that the Bhore Committee had envisaged, which would be available to one and all irrespective of their ability to pay, further commodification of health care services took place strengthening the operation of market forces in this sector. The enclave pattern of development of the health sector continues even today - the poor, the villagers, women and other underprivileged sections of society, in other words the majority, still do not have access to affordable basic health care of any credible quality.

Universal coverage of the population through some health plan is historically well entrenched today, whether this be through health insurance or state run health services. There is no developed country, whether capitalist or socialist, which has not insured through either of the above means or a combination a minimum standard of health care for its population. In socialist countries the state provides health care,

among other 'social services', as a basic right of the citizen. In capitalist countries social security has evolved under the concept of a welfare state and health care is one of the prominent elements. However, such assured universal coverage of health care has not emerged in any satisfactory manner in underdeveloped countries, including India. "The underdevelopment of health and health services (in these countries) is brought about by the same determinants that cause underdevelopment in general - the pattern of control over resources of these countries in which the majority of population has no control over their resources." (Navarro, 1981,) But given a political commitment some form of a National Health Service can be evolved in these countries.

The Colonial Period

Modern medicine and health care were introduced in India during the colonial period. This was also a period that saw the gradual destruction of pre-capitalist modes of production in India. Under pre-capitalist mode of production institutionalized forms of health care delivery, as we understand today, did not exist. Practitioners who were not formally trained professionals but inheritors of a caste-based occupational system provided health care within ones homes. This does not mean that there was no attempt of evolving a formal system. Charaka and Sushruta Samhitas, among other texts, is evidence of putting together a system of medicine. Universities like Takshashila, Nalanda and Kashi did provide formal training in Indian medicine (Jaggi, 1979: XIII, 1-3). But the little evidence that exists shows that such structured medicine existed mostly in towns around the courts of the rulers; and in the countryside healers operated as practitioners of what we term today as 'folk medicine'.

However, the institutions that functioned as hospitals were more in the nature of *punyasthanas*, *dharmaśalas*, *viharas* and *maths*. They were the Indian equivalent of Western alm-houses, monasteries and infirmaries which were provided with stocks of medicine and lodged the destitute, the cripple and the diseased who received every kind of help free and freely (Fa-hein as quoted in Jaggi, 1979:XIV.3). Similarly, during the Mughal Sultanate the rulers established such hospitals in large numbers in the cities of their kingdom where all the facilities were provided to the patients free of charge (Jaggi, 1979: XIV.4). These activities were financed not only by the kings but also through charities of the rich traders and wealthy persons in the kingdom (ibid, 3-4).

Hence, in the pre-colonial period, which coincides with the pre-capitalist period, structured health care delivery had clearly established three characteristics. **Firstly, it was considered a social responsibility and thus state and philanthropic intervention was highly significant. Secondly, the services that were provided by these facilities were provided free to all who availed them or had access to them. Caste,**

class and occupation did however limit access. And thirdly, most of these facilities were located in towns thus projecting a clear urban bias.

It is generally believed that the Ayurvedic system of medicine, the dominant formal Indian System of medicine, became stagnant after 10th Century A.D. Unani-Tibb, which was based on Greek medical theory, received greater state patronage, atleast until the advent of Europeans on Indian soil (Jaggi, 1980: XV. 7-8).

The first Europeans to set up a medical establishment in India were the Portuguese. In 1510 the Royal Portuguese Hospital was established in Goa. This was transferred to the Jesuits in 1591 and it became one of the best-run hospitals in the world. Ofcourse, its access was limited to European Christians only, though later Jesuits set up a separate unit to cater to Indian Christians (Jaggi, 1979 : XIV. 71-73).

The English East India Company set up its first hospital in 1664 at Fort St. George in Madras because they could not see the "English men drop away like dogs" (especially the soldiers) because of disease (Crawford, 1914: II.401). This was followed by hospitals in Bombay and Calcutta for the same reasons.

As the needs of the British population, especially the armed forces, increased due to larger territories coming under their administration and an increased number of English troops, a more organized medical establishment was necessitated. Thus on 1st January 1764 the Indian Medical Service (IMS) was founded, initially as the Bengal Medical Service (Jaggi, 1979: XIV.27).

The IMS catered mostly to the needs of the armed forces. However, by early 19th century hospitals for the general population were established in chief mofussil towns, besides the Presidency headquarters (Crawford, 1914 : II.430). The expansion of medical facilities followed the devolution of the imperial government especially after 1880 with the setting up of Municipalities and District Boards. However, these medical facilities had a distinct racial and urban bias. Separate provisions were made on employment and racial grounds, though in some places non-official Europeans were allowed access to hospitals designed for civil servants. In General Hospitals, wards for Europeans and Eurasians were separated from those for the rest of the population (Jeffery, 1988:87). These facilities, atleast till the Montagu-Chelmsford Reforms of 1919, were located in urban areas in the military and civilian enclaves of the English.

Another aspect, which received early attention, atleast in the cantonments, were public health measures. The continued high mortality of British soldiers despite good access to medical services led to the appointment of a Royal Commission to enquire into sanitary conditions of the army in 1859. "Fevers, intermittent, remittent, and typhoid, cholera, dysentery, smallpox, spleen disease, diarrhoea, rheumatism, such is the account of station after station. Epidemics, the result of imperfect civilization and removable causes prevail in India at the present day, as epidemics used to prevail in Europe in the Middle Ages. The work of civilization and sanitary improvement has yet to be initiated in this great country. The prevailing causes are everywhere the same – filth, stagnant water, damp, foul ditches, want of drainage, bad drinking water, utter neglect of ventilation and of all sanitary measures, overcrowding of houses, and foul air." (Indian Medical Gazette, 1871: VI.214)

The Royal Commission submitted its report in 1864, recommending setting up of Sanitary Commissioners in each Presidency. Preventive health care consequently began to get some importance atleast in the cantonments. Within 30 years of creation of such Commissioners the death rate in the army declined from 69 per 1000 in 1857 to about 16 (Jaggi, 1979: XIV.105). But in the general population mortality due to diseases emanating from insanitary conditions continued to be extremely high. For instance, just four diseases – cholera, smallpox, fevers and bowel complaints - in 1886 claimed over 368,000 lives in Madras Presidency alone, in contrast to 368,000 deaths in 50 years ending 1886 from four countries – England, France, Germany and Austria - on the battle-fields! (Ibid: 103).

The rural areas had to wait till the Government of India Act of 1919 whereby health was transferred to the provincial governments and the latter began to take some interest in rural health care. In fact, rural health care expansion in a limited way began in India first from 1920 onwards when the Rockefeller Foundation entered India and started preventive health programmes in the Madras Presidency in collaboration with the government, and gradually extended its support for such activities in Mysore, Travancore, United Provinces and Delhi. The focus of their activities was on developing health unit organizations in rural and semi-rural areas, in addition to support for malaria research and medical education (Bradfield, 1938: 274-275).

This intervention of the Rockefeller Foundation is historically very important for development of health care services and health policy in India, especially for rural areas. It may be considered a watershed that paved the path for the ideology that rural areas need only preventive health care and not hospitals and medical care clinics, i.e., they need

"Public Health" and not medical care. The result of this was that medical care activities of the State were developed mainly in the urban areas and rural areas were deprived the devolution of medical care within their reach. This is an important historical fact to note because these same differential treatments for urban and rural areas have continued even after Independence. With regard to public health the same biases were seen. Only European areas enjoyed the benefits of civic concern. This racial distinction and the much more pronounced role taken by the States in Indian towns, provide the main points of difference between the Indian and the British experience. Despite having a more centralized, active and interventionist government than in Britain and one that attempted to draw on British experience, India gained few benefits (Jeffery, 1988: 98).

The same was true in the case of medical education in India. Europeans and certain western oriented Indian communities like Christians in Bengal and Parsis in Bombay largely monopolized it, atleast until 1920 (Ibid, 84).

The Imperial government in India adopted measures that were totally inadequate to deal with the problems at hand because of the racial and urban bias - the European minority and later "Indian Gentlemen" received undue concern, while the Indian majority received little more than crumbs from the white table (Ramasubban, 1982 : as quoted in ibid, 19).

During the colonial period hospitals and dispensaries were mostly state owned or state financed. The private sector played a minor role as far as this aspect of health care delivery was concerned. However, the private health sector existed in a large measure as individual practitioners. The earliest data available on medical practitioners is from the 1881 census which records 108,751 male medical practitioners (female occupation data was not recorded). Of these 12,620 were classified as physicians and surgeons (qualified doctors of modern medicine) and 60,678 as unqualified practitioners (which included Indian System Practitioners) (Census-1881, 1883: III.72). In addition there were 582 qualified medical practitioners serving in army hospitals (Ibid, 71). However, the census data does not reveal the proportion of private practitioners. The earliest data available for private practitioners is for the year 1938 when an estimated 40,000 doctors were reported to be active. Of these only 9,225 or 23% were in public service and the rest in private practice or private institutions (Bradfield, 1938: 2-4).

The Bhore Committee Report corroborates this when for 1941-42 it reports 47,524 registered medical practitioners in India (17,654 graduates and 29,870 licentiates) (Bhore 1946: I.35). Of these only

13,000 or 27% worked in government and other agencies (including private institutions) and the remaining were in private professional practice (*Ibid*: I.13-14). Besides, there were practitioners of non-allopathic systems, both of the formally trained variety and the informal inheritors of medical practice. One estimate reveals that there was one vaid/hakim per 4285 population in 1868 i.e. about 47,000 known indigenous practitioners (*Indian Medical Gazette*, 1868: III.87).

This clearly shows that the private health sector was fairly large and well established. It also indicates the early commodification of health care delivery, which is inevitable under capitalism. Given the racial and urban bias of the State health services this large group of private practitioners must have catered to a large chunk of Indians who didn't have access to the State services but who were able to muster resources to utilize the services of the private practitioners.

The above historical overview is necessary to understand the development of health care services in India in the post-independence period because one can see a remarkable continuity in the pattern of development of health care services from the colonial period into free India.

On the Eve of Independence

Below a brief review of the Bhore Committee report is presented to demonstrate that the opportunity for radical transformation of the health care system in India was available on the eve of Independence.

Eighteenth October 1943 marks a watershed in health policy making and health planning in India. It was a great historical moment. In the midst of World War II and in succession to the Quit-India movement the Government of India (Central Government of British India Provinces) announced the appointment of the Health Survey and Development Committee under the chairmanship of Sir Joseph Bhore. Its secretary was Dr. KCKE Raja and one of the joint secretaries Dr. K.T. Jungalwala. Some of the well-known members included Dr. J.B. Grant, Dr. B.C. Roy, Pandit P.N. Sapru and Dr. A.L. Mudaliar. The terms of reference of this committee, popularly referred to as the Bhore Committee, were simple: (a) broad survey of the present position in regard to health conditions and health organization in British India, and (b) recommendations for future development (Bhore, 1946, I.1).

The letter of appointment of the Committee further stated, "A survey of the whole field of public health and medical relief has not hitherto been attempted. The immediate necessity for initiating such a survey has arisen from the fact that the time has come to make plans for post-war development in the health field (*A Post-war Reconstruction Committee*,

that later grew into the Planning and Development Department was set up in 1943 to make 5 year Plans for India's development). The Government of India considers that such plans should be based on a comprehensive review of the health problem... One of the difficulties with which the committee will be confronted is that of finance. Financial considerations clearly cannot be ignored. Plans based on assumption that unlimited funds will be available for recurring expenditure will have little practical value. On the other hand it would be equally unwise to assume that expenditure on health administration will in the future be limited to the sums that were expended in the pre-war years. It is desirable, therefore, to plan boldly, avoiding on the one hand extravagant programmes which are obviously incapable of fulfillment and on the other hand halting and inadequate schemes which could have no effect on general health standards and which, would bring little return for the expenditure involved" (Ibid, I. 1-2).

Prior to this in 1938 the Indian National Congress established a National Planning Committee (NPC) under Jawaharlal Nehru. One of its sub-committees was on National Health under the chairmanship of Col.S.S. Sokhey. Its report, published in 1948, was sketchy compared to the Bhore Committee Report - it was not as well studied and it lacked in detailed analysis of the existing health situation as well as of the future plans. In fact, it borrowed its analysis of the health situation from the Bhore Committee and also concurred with most of its recommendations (NPC, 1948: 36).

On the basis of an interim report of the National Health sub-committee presented to the NPC in August 1940, the NPC resolved that:

- (a) India should adopt a form of health organization, in which both curative and preventive functions are suitably integrated, and administered through one agency.
- (b) Such an integrated system of health organization can be worked only under state control. It is, therefore recommended that the preservation and maintenance of the health of the people should be the responsibility of the state.
- (c) There should be ultimately one qualified medical man or woman for every 1000 population, and one (hospital) bed for every 600 of population. Within the next ten years the objective aimed at should be one medical man or woman for every 3000 of population, and a bed for every 1500 of population. This should include adequate provision for maternity cases.
- (d) The medical and health organization should be so devised and worked as to emphasize the social implications of this service. With this object in view the organization should be made a free

public service, manned by whole-time workers trained in the scientific method.

(e) Adequate steps be taken to make India self-sufficient as regards the production and supply of drugs, biological products, scientific and surgical apparatus, instruments and equipment and other medical supplies... No individual or firm, Indian or foreign, should be allowed to hold patent rights for the preparation of any substances useful in human or veterinary medicine (NPC, 1948: 224-226). *(It is interesting to note that on the issue of patents Mr. Ambalal Sarabhai, a member of the NPC, with obvious vested interests, dissented and urged that pharmaceutical patents should be treated on the same basis as copy-right in books or industrial patents (ibid, 226)).*

The Bhore Committee endorsed this resolve of the NPC through its recommendations. In formulating its plan for a National Health Service the Bhore Committee set itself the following objectives:

1. The services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;
2. These services should be placed as close to the people as possible, in order to ensure their maximum use by the community, which they are meant to serve;
3. The health organization should provide for the widest possible basis of cooperation between the health personnel and the people;
4. In order to promote the development of the health programme on sound lines the support of the medical and auxiliary professions, such as those of dentists, pharmacists and nurses, is essential; provisions should, therefore, be made for enabling the representatives of these professions to influence the health policy of the country;
5. In view of the complexity of modern medical practice, from the standpoint of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute "group" practice, should be made available;
6. Special provision will be required for certain sections of the population, e.g. mothers, children , the mentally deficient etc.,
7. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it and
8. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement recreation, are essential (Bhore, 1946: II.17).

The Bhore Committee further recognized the vast rural-urban disparities in the existing health services and hence based its plan with specifically the rural population in mind. Its plan was for the district as a unit. "Two requirements of the district health scheme are that the peripheral units of the (health) organization should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration" (Bhore, 1946: II.22).

The district health scheme, also called the three million plan, which represented an average districts population, was to be organized in a 3-tier system "in an ascending scale of efficiency from the point of view of staffing and equipment. At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health service at its headquarters and of supervising the work of these primary units. The headquarters of the district will be provided with an organization which will include, within its scope, all the facilities that are necessary for modern medical practice as well as the supervisory staff who will be responsible for the health administration of the district in its various specialized types of service" (Ibid, II.22).

This health organization would provide integrated health services - curative, preventive and promotive - to the entire population. "The health organization is expected to produce a reasonably satisfactory service for rural and urban communities alike. It is based mainly on a system of hospitals of varying size and of differing technical efficiency. The institutions will play the dual role of providing medical relief and of taking an active part in the preventive campaign" (Ibid. II.30).

What would be the structure of this national health plan? Stated in terms of a ratio to a standard unit of population the minimum requirement recommended by the Bhore Committee was:

- 567 hospital beds per 100,000 population
- 62.3 doctors per 100,000 population
- 150.8 nurses per 100,000 population (Bhore, 1946: III.3-4)

What existed at that time (1942) in India was:

- 24 beds per 100,000 population
- 15.87 doctors per 100,000 population
- 2.32 nurses per 100,000 population (Bhore, 1946: I.13)

In contrast what existed in the UK in 1942 was:

- 714 beds per 100,000 population

- 100 doctors per 100,000 population
- 333 nurses per 100,000 population (Ibid)

We may conclude from the above that the health care facilities that existed in India at the time of the Bhore Committee were embarrassingly inadequate. In fact, most of these were in urban areas and largely in enclaves of the British Civil administration and Cantonments (Jeffery, 1988: 98). What the Bhore Committee recommended was not excessive when we look at the ratio of facilities already existing in the UK even prior to the setting up of its National Health Service.

The Bhore Plan

The organizational structure of the National Health Scheme as envisaged by the Bhore Committee is given below in some detail (Bhore, 1946: II.17-34, III.3-4).

Primary Unit: Every 10,000 to 20,000 population (depending on density from one area to another) should have a 75 bedded hospital served by six medical officers including medical, surgical and obstetrical and gynecological specialists. Six public health nurses, 2 sanitary inspectors, 2 health assistants and 6 midwives to provide domiciliary treatment should support this medical staff. At the hospital there should be a complement of 20 nurses, 3 hospital social workers, 8 ward attendants, 3 compounders and other non-medical workers.

Two medical officers along with the public health nurses should engage in providing preventive health services and curative treatment at homes of patients. The sanitary inspectors and health assistants should aid the medical team in preventive and promotive work. Preferably at least 3 of the 6 doctors should be women.

Of the 75 beds, 25 should cater to medical problems, 10 for surgical, 10 for obstetrical and gynaecological, 20 for infectious diseases, 6 for malaria and 4 for tuberculosis. This primary unit should have adequate ambulatory support to link it to the secondary unit when the need arises for secondary level care.

Each province should have the autonomy to organize its primary units in the way it deemed most suitable for its population but there was to be no compromise on quality and accessibility. Hence, a highly dense province like Bengal may have a primary unit for every 20,000 population but a province like Sind (now in Pakistan) or Central Provinces (now Madhya Pradesh) which have a highly dispersed population may have a primary unit for every 10,000 or even less population unit. The deciding factor should be easy access for that unit of population.

Secondary Unit: About 30 primary units or less should be under a secondary unit. The secondary unit should be a 650 bed hospital having all the major specialties with a staff of 140 doctors, 180 nurses and 178 other staff including 15 hospital social workers, 50 ward attendants and 25 compounders.

The secondary unit besides being a first level referral hospital would supervise both the preventive and curative work of the primary units. The 650 beds of the secondary unit hospital should be distributed as follows :

Medical:	150
Surgical:	200
Ob. & GY.:	100
Infectious diseases:	20
Malaria:	10
Tuberculosis:	120
Pediatrics:	<u>50</u>
	<u>650</u>

District Hospital: Every district centre should have a 2500 beds hospital providing largely tertiary care with 269 doctors, 625 nurses, 50 hospital social workers and 723 other workers. The hospital should have 300 medical beds, 350 surgical beds, 300 Ob. & Gy. beds, 540 tuberculosis beds, 250 pediatric beds, 300 leprosy beds, 40 infectious diseases beds, 20 malaria beds and 400 beds for mental diseases. This distribution was based on the epidemiological profile the Committee had constructed based on their enquiry. A large number of these district hospitals would have medical colleges attached to them. However, each of the 3 levels should have functions related to medical education, and training including internship and refresher courses.

In addition to this basic infrastructure the Committee recommended a wide range of other health programs, keeping in mind the special problems that India faced due to its economic and political conditions, which would provide support and strength to this health organization.

Certain diseases were singled out for special inputs that would be needed to control and/or eradicate them. They were singled out because they constituted a major problem then. And most of them 54 years later still constitute a major problem in the country. These diseases were malaria, tuberculosis, small pox, cholera, plague, leprosy, venereal diseases, hookworm disease, filariasis, guinea-worm disease, cancer, mental diseases and mental deficiency and diseases of the eye and blindness.

For all these diseases the Committee found that facilities are grossly inadequate and need urgent attention - proper sanitation and other public health measures are the key to eradicate or control such diseases (Bhore, 1946: I.88-132). After a thorough review of the prevalence of these diseases a detailed plan to deal with them had been outlined. This plan was to be executed as a part and parcel of the general health services (Bhore, 1946, II.147-212).

The Committee also made special recommendation in the area of environmental hygiene, public health engineering, housing, health education, health services for mothers and children, health services for school children, industrial health service, the population problem, medical education and research and vital statistics.

All this shows that the Bhore Committee plan was not only well studied and argued but also comprehensive and suited to the Indian situation. The Committee categorically states, "we are satisfied that our requirements can only be met satisfactorily by the development and maintenance of a state Health Service" (Ibid, II.13). It recommended that all services provided by the health organization should be free to the population without distinction and it should be financed through tax revenues (Ibid, II.14). It further recommended that the health service should be a salaried service with whole-time doctors who should be prohibited from private practice (Ibid, II.15).

The Bhore Committee ends its report on a clear note of urgency for implementation of the plan in its full form. "The existing state of public health in the country is so unsatisfactory that any attempt to improve the present position must necessarily involve administrative measures of such magnitude as may well seem to be out of all proportion to what has been conceived and accomplished in the past. This seems to us inevitable, especially because health administration has so far received from governments but a fraction of the attention that it deserves in comparison with other branches of governmental activity. We believe that we have only been fulfilling the duty imposed on us by the Government of India in putting forward this health programme, which can in no way be considered as extravagant either in relation to the standards of health administration already reached in many other countries or in relation to the minimum requirements of any scheme which is intended to demonstrate an appreciable improvement in the health of the community. For reasons already set out, we also believe that the execution of the scheme should not be beyond the financial capacity of governments.

"We desire to stress the organic unity of the component parts of the programme we have put forward. Large-scale provision for the training

of health personnel forms an essential part of the scheme, because the organization of a trained army of fighters is the first requisite for the successful prosecution of the campaign against diseases. Side by side with such training of personnel, we have provided for the establishment of a health organization which will bring remedial and preventive services within the reach of the people, particularly of that vast sections of the community which lies scattered over the rural areas and which has, in the past, been largely neglected from the point of view of health protection on modern lines. Considerations based on inadequacy of funds and insufficiency of trained workers have naturally necessitated the suggestion that the new organization should first be established over a limited area in each district and later extended as and when funds and trained personnel become increasingly available. Even with such limitations the proposed health service is intended to fulfill, from the beginning and in an increasing measure as it expands, certain requirements, which are now generally accepted as essential characteristics of modern health administration. These are that curative and preventive work should dovetail into each other and that, in the provision of such a combined service to the people, institutional and domiciliary treatment facilities should be so integrated as to provide the maximum benefit to the community. There should also be provision in the health organization for such consultant and laboratory services as are necessary to facilitate correct diagnosis and treatment. Our proposals incorporate these requirements of a satisfactory health service.

"We have drawn attention to these aspects of the health programme because we feel that it is highly desirable that the plan should be accepted and executed in its entirety. We would strongly deprecate any attempt, on the plea of lack of funds, to isolate specific parts of the scheme and to give effect to them without taking into consideration the interrelationships of the component parts of the programme. Our conception of the process of the development of the national health services is that it will be a cooperative effort in which the Centre, acting with imagination and sympathy, will assist and guide a coordinated advance in the provinces. We therefore look forward to a pooling of resources and personnel, as far as circumstances permit, in the joint task that lies before the governments" (Ibid. II.516-517).

This above review provides not only a brief summary of the Bhore committee report but it also lends a contrast to the present level of development of health care services. If the concern of our health policy is universal access to health care with equity, then the above discussion is very relevant even today.

2. The Evolution of Health Plans and Policies

With the end of colonial rule in India the population of the country expected a radical transformation of the exploitative social structure that the British rule had nurtured and consolidated. But these expectations were belied, as the new rulers were mere indigenous substitutes for the colonial masters.

The new rulers mouthed a lot of radical jargon and even put it in writing in the form of the First Five Year Plan document and other more specific documents for various sub-sectors of the economy.

The first Five Year Plan describes the central task of planning thus : "The problem is not one of merely re-channeling economic activity within the existing socioeconomic framework; that framework has itself to be remoulded so as to enable it to accommodate progressively those fundamental urges which express themselves in the demands for the right to work, the right to adequate income, the right to education and to a measure of insurance against old age, sickness and other disabilities. The Directive Principles of State Policy enunciated in Articles 36 to 51 of the constitution make it clear that for the attainment of these ends, ownership and control of the material resources of the country should be so distributed as best to subserve the common good, and that the operation of the economic system should not result in the concentration of wealth and economic power in the hands of a few. It is in this larger perspective that the task of planning has to be envisaged" (FYPI, 1952, 8).

The Second Industrial Policy Resolution of 1956 also endorsed these Directive Principles, in contrast to the 1948 Resolution, and recommended a policy framework that would help achieve the general policy of parliament to adopt "the socialist pattern of society as the objective of social and economic policy" (as quoted in FYP II, 1956, 44). The Second Plan reiterated that, "the pattern of development and the structure of socioeconomic relations should be so planned that they result in not only an appreciable increase in national incomes and employment but also in greater equality in incomes and wealth. This means that the basic criterion for determining the lines of advance must not be private profit but social gain. The benefits of economic development must accrue more and more to the relatively less privileged classes of society and there should be a progressive reduction of the concentration of incomes, wealth and economic power" (ibid, 22).

However, our postcolonial history is a witness to the rapid dilution of these progressive principles, objectives and resolutions. The States'

plans and policies have in no way made a significant impact on redistribution of resources for the common good. On the contrary the policies and plans have helped in strengthening of inequalities and underdevelopment continues unshattered.

The postcolonial period health care sector has seen private medical practice develop as the core of the health sector in India initially strengthening the enclave sector, and then gradually spreading into the periphery as opportunities for expropriation of surplus by providing health care increased due to the expansion of the socioeconomic infrastructure. It must be noted that this pattern of development of the health sector was in keeping with the general economic policy of capitalism. Thus the health policy of India cannot be seen as divorced from the economic and industrial policy of the country.

In India until 1982-83 there was no formal health policy statement. The policy was part and parcel of the planning process (and various committees appointed from time to time), which provided most of the inputs for the formulation of health programme designs.

Planning in India

In the early years after independence the Indian state was engrossed in helping and supporting the process of accumulation of capital in the private sector through large scale investments in capital goods industry, infrastructure and financial services. The social sectors like health and education were low priority areas. Industrial growth was the keyword. Table 1 and 2 give an overview of plan expenditure in India by major sectors of the economy and of the health sector. It is evident from these tables that Economic Services have right through from plan one to plan nine been allocated over four-fifths of the resources and the social sectors like health, education, water supply and housing have received only residual resources.

At this point it's worth asking the question as to who benefits from this vast expenditure on economic services?

The expenditure on agriculture is for the vast infrastructure for agricultural development. It includes agricultural research and education, crop husbandry, soil and water conservation programs, dairy development, fisheries, forestry, food marketing, storage and warehousing, cooperatives, and agriculture finance and refinance institutions. This infrastructure is directed towards raising agricultural production - food grains, oilseeds, sugarcane, jute, cotton, milk, eggs, fish etc. This expenditure has helped increase food grain production fourfold (from 50 million tons in 1951 to 203 million tones in 1999), oilseed production also fourfold (from 6.2 million tonnes to 25.2 million

tonnes for the same period) cotton by over four times, (3 million bales of 170 kgs each to 12.2 million bales) and sugarcane five times (from 57 million tonnes to 296 million tonnes) (Economic Survey 1999-2000). Over nearly fifty years this is by no means a fantastic growth considering the increase in expenditure of 416-fold for agriculture and rural development between the first and ninth five year plans.

Rural Development Programs (earlier called community development projects) have seen a quantum jump, especially since the introduction of the minimum needs program with the fourth five year plan to give a boost to rural infrastructure and provide some placebos to the small and marginal peasantry. However, these efforts at programming have not contributed in any significant manner to reducing rural poverty or in enhancing rural purchasing power.

Like crop production, irrigation too increased nearly fourfold between the first and ninth five year plans from 23 million hectares in 1951 to 84 million hectares in 1999. But who has benefited from all this? It is mainly the rich and the middle peasantry who has gained from programs under agriculture and irrigation under the various five-year plans. A large proportion of the small peasantry has been marginalized or wiped out over the years increasing the ranks of the rural proletariat. (see D. Bandopadhyay "Land Reforms in India: An analysis", Economic and Political Weekly, June 21-28, 1986).

The sectors that have received over 55% of plan resources are industry, power, and transport and communication. These constitute the basic economic infrastructure of an industrial economy. Why has the state deemed it necessary to invest such large resources to these sectors of the economy neglecting the social sectors (education, housing, health, social welfare etc.) where the state's role is more crucial, especially in an underdeveloped country like India? Infact, it is clearly evident that over the years investment in the health sector has declined sharply in terms of the share it gets in the plan kitty.

Though the second five-year plan talked of socialism, the State's increased participation in these basic economic sectors was very important for capitalism to flourish. The Indian bourgeoisie did not have the resources to establish basic and capital goods industry and infrastructure. The State was urged to provide this support. Not only this but on the eve of the fourth five year plan the banking sector was nationalized and it grew by leaps under State patronage. This provided the private sector with vast finance capital to expand their hegemony.

The public sector industry, which is mainly in basic and capital goods sector, has been incurring net losses, with the exception of the petroleum

industry (which over the years has accounted for about 70% of the profits of the public enterprises). Most of the produce manufactured by these public enterprises is consumed by the private manufacturing sector to make finished goods and hence the public sector's losses must be viewed in this context, that is, the public sector is basically subsidizing the private sector. To illustrate this with a simple example we can take the use of energy, which is produced almost wholly by the public sector. Between 1951 and 1985 on an average three-fifths of the energy utilization has been by the industrial sector and only about 12% by the households. Today while the share of the industrial economy is lower at 40% it is power-driven agriculture which has raised its share from 4% in 1951 to 30% in 1998 and the household share being 20% in the same year.

When we consider the fact that even after 50 years of planning three-fourths of the population still lives at the subsistence level or below it, and industrial development has reached a level that has generated employment in the organized sector for only about 10% of the work-force, it becomes clear that the bulk of planning has not benefited the vast majority in any significant way.

By contrast the contribution of the five-year plans to the social sectors is abysmally poor; less than one fifth of the plan resources have been invested in this sector. Health, water supply and education are the three main sub-sectors under social services.

Health care facilities are far below any acceptable human standard. Even the targets set out by the Bhore Committee on the eve of India's independence are nowhere close to being achieved. We have not even reached half the level in provision of health care that most developed countries had reached between the two world wars. Curative health care services in the country are mostly provided by the private sector (to the extent of two-thirds) and preventive and promotive services are almost entirely provided by the State sector.

The case of education is perhaps worse. Even after 53 years of independence and a constitutional guarantee for universal basic education (upto 14 years) only 65% of the population is literate and school enrolment of children beyond the primary level, and especially of girls, is very poor even in comparison to many other third world countries.

Planning should have given an equal emphasis to social services, especially health, water supply and sanitation, education and housing which are important equalizing factors in modern society. These four sub-sectors should have received atleast half of the resources of the

plans over the years. Only that could have assured achievement of the goals set forth in the Directive Principles.

From the above discussion it is evident that the Five year plans to which large resources were committed has not helped uplift the masses from their general misery, including the provision of health care.

Health Policy and Plans

It was not until 1983 that India adopted a formal or official National Health Policy. Prior to that health activities of the state were formulated through the Five year Plans and recommendations of various Committees. For the Five Year Plans the health sector constituted schemes that had targets to be fulfilled. Each plan period had a number of schemes and every subsequent plan added more and dropped a few.

In the fifties and sixties the entire focus of the health sector in India was to manage epidemics. Mass campaigns were started to eradicate the various diseases. These separate countrywide campaigns with a technocentric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. Cadres of workers were trained in each of the vertical programmes. The National Malaria Eradication Programme (NMEP) alone required the training of 150,000 workers spread over in 400 units in the prevention and curative aspects of malaria control (Banerji, 1985).

The policy of going in for mass campaigns was in continuation of the policy of colonialists who subscribed to the percepts of modern medicine that health could be looked after if the germs which were causing it were removed. But the basic cause of the various diseases is social, i.e. inadequate nutrition, clothing, and housing, and the lack of a proper environment. These were ignored. National programs were launched to eradicate the diseases. The NMEP was started in 1953 with aid from the Technical Cooperation Mission of the U.S.A. and technical advice of the W.H.O. Malaria at that period was considered an international threat. DDT spraying operations was one of the most important activities of the programme. The tuberculosis programme involved vaccination with BCG, T.B. clinics, and domiciliary services and after care. The emphasis however was on prevention through BCG. These programmes depended on international agencies like UNICEF, WHO and the Rockefeller Foundation for supplies of necessary chemicals and vaccines. The policy with regard to communicable diseases was dictated by the imperialist powers as in the other sectors of the economy. Along with financial aid came political and ideological influence. Experts of various international agencies decided the entire policy framework, programme design, and financial commitments etc..

During the **first two Five Year Plans** the basic structural framework of the public health care delivery system remained unchanged. Urban areas continued to get over three-fourth of the medical care resources whereas rural areas received "special attention" under the Community Development Program (CDP). History stands in evidence to what this special attention meant. The CDP was failing even before the Second Five Year Plan began. The governments own evaluation reports confessed this failure.

Within CDP the social sectors received very scant attention. Infact CDP meant, for all practical purposes, agricultural development. This proved to be so in the subsequent plan periods when CDP got converted into various agricultural programs like Intensive Agricultural Districts (or Area) Program (Green Revolution!) in the early sixties; when that failed then the Small Farmers Development Agency and the Marginal Farmers and Agricultural Laborers Program in the late sixties, and still later the Integrated Rural Development Program. Seeing the success of the Employment Guarantee Scheme of Maharashtra the emphasis shifted to rural employment programs like National Rural Employment Program, Jawahar Rozgar Yojana and Employment Assurance Scheme. Besides this women's empowerment became a major development issue in the nineties and schemes like Development of Women and children in rural areas, micro-credit programs etc..were floated and presently all such schemes have been integrated into the Swaranjayanti Gram Swarozgar Yojana. These changing nomenclatures do not necessarily reflect structural changes but merely repackaging of the same continuum since the CDP days. We have seen earlier that all the investment in agriculture to date has had a very small impact on food production and even today over four-fifths of the population dependent on agriculture lives on the threshold of survival. Similarly the impact of the rural development programs has been limited. Yes, they have helped stall absolute poverty and have helped as fire-fighting mechanisms but they have not produced sustained results. They have not impacted on poverty in structural terms. The numbers of poor keep rising each year while economists and planning commission experts keep fighting on proportions over and under the poverty line! For the politicians rural development investment is critical to their survival and they use it as appeasement to seek favour from the electorate.

The health sector organization under CDP was to have a primary health unit (a very much diluted form from what was suggested by the Bhore Committee) per development Block (in the fifties this was about 70,000 population spread over 100 villages) supported by a Secondary health unit (hospital with mobile dispensary) for every three such primary health units. The aim of this health organization was "the improvement of environmental hygiene, including provision and protection of water

supply; proper disposal of human and animal wastes; control of epidemic diseases such as malaria, cholera, small pox, TB etc.; provision of medical aid along with appropriate preventive measures, and education of the population in hygienic living and in improved nutrition" (FYPI, 227).

It is clear from the above statement of objectives of the health organization under CDP that medical care had no priority within the structure of such an organization. In contrast, in the urban areas (which developed independent of CDP) hospitals and dispensaries which provided mainly curative services (medical care) proliferated. Thus at the start of the third Five year Plan there was only one Primary Health Unit per 140,000 rural population (14 times, less than what the Bhore Committee recommended) in addition to one hospital per 320,000 rural population. In sharp contrast urban areas had one hospital per 36,000 urban population and one hospital bed per 440 urban residents (rural areas had 1 hospital bed per 7000 rural population.)

To evaluate the progress made in the first 2 plans and to make recommendation for the future path of development of health services the **Mudaliar Committee** was set up in 1959. The report of the committee recorded that the disease control programmes had some substantial achievements in controlling certain virulent epidemic diseases. Malaria was considered to be under control. Deaths due to malaria, cholera, smallpox etc. were halved or sharply reduced and the overall morbidity and mortality rates had declined. The death rate had fallen to 21.6% for the period 1956-61. The expectation of life at birth had risen to 42 years. However, the tuberculosis program lagged behind. The report also stated that for a million and half estimated open cases of tuberculosis there were not more than 30,000 beds available.

The Mudaliar Committee further admitted that basic health facilities had not reached atleast half the nation. The PHC programme was not given the importance it should have been given right from the start. There were only 2800 PHCs existing by the end of 1961. Instead of the "irreducible minimum in staff" recommended by the Bhore Committee, most of the PHC's were understaffed, large numbers of them were being run by ANM's or public health nurses in charge (Mudaliar, 1961). The fact was that the doctors were going into private practice after training at public expense. The emphasis given to individual communicable diseases programme was given top priority in the first two plans. But primary health centers through which the gains of the former could be maintained were given only tepid support (Batliwala, 1978).

The rural areas in the process had very little or no access to them. The condition of the secondary and district hospitals was the same as that of

the PHC's. The report showed that the majority of the beds and various facilities were located in the urban areas. The Committee recommended that in the immediate future instead of expansion of PHC's consolidation should take place and then a phased upgrading and equipping of the district hospitals with mobile clinics for the treatment of non-PHC population. But the urban health infrastructure continued to increase to meet the growing demands for medical care and this was where the state governments own funds were getting committed. The Centre through the Planning Commission was investing in preventive and promotive programs whereas the state governments focused their attention on curative care – some sort of a division of labor had taken place which even continues to the present.

The Mudaliar Committee with regard to medical human-power suggested measures to improve the service condition of doctors and other personnel in order to attract them to rural areas. The committee makes a mention that except for the substantial increase in the number of doctors, number of other categories of health personnel was still woefully short of the requirement. Inspite of this the committee insisted that medical education should get a large share of public health resources. This was in clear contradiction to the committee's findings that doctors were not willing to go to rural areas. The decade scrutinised by the Mudaliar Committee had crystallized the trends and failings in the health system, yet the Committee held on to the belief that improvement in the technical excellence of medical care and substantial addition to medical humanpower would ultimately succeed in changing the country's health status. This is precisely what happened in the next two plan periods - allocations for training of doctors, especially specialists, increased. This was reflected in a large increase in medical college seats with outturn doubling in just one plan period. The outturn of nurses and other auxiliary personnel continued to stagnate.

The **third Five Year Plan** launched in 1961 discussed the problems affecting the provision of PHCs, and directed attention to the shortage of health personnel, delays in the construction of PHCs, buildings and staff quarters and inadequate training facilities for the different categories of staff required in the rural areas. (FYP III, 657) The Third Five Year Plan highlighted inadequacy of health care institutions, doctors and other personnel in rural areas as being the major shortcomings at the end of the second Five Year Plan (Ibid, 652). The doctor syndrome loomed large in the minds of planners, and increase in supply of humanpower in health meant more doctors and not other health personnel. While the 3rd plan did give serious consideration to the need for more auxiliary personnel no mention was made of any specific steps to reach this goal. Only lip service was paid to the need for increasing auxiliary personnel but in the actual training and establishment of institutions for these

people, inadequate funding became the constant obstacle. On the other hand, the proposed outlays for new Medical Colleges, establishment of preventive and social medicine and psychiatric departments, completion of the All India Institute of Medical Sciences and schemes for upgrading departments in Medical Colleges for post graduate training and research continued to be high (Batliwala, 1978).

In this way we see that the allocation patterns continued to belie the stated objectives and goals of the overall policy in the plans. The urban health structure continued to grow and its sophisticated services and specialties continued to multiply. The 3rd plan gave a serious consideration for suggesting a realistic solution to the problem of insufficient doctors for rural areas "that a new short term course for the training of medical assistants should be instituted and after these assistants had worked for 5 years at a PHC they could complete their education to become full fledged doctors and continue in public service" (FYP III, 662). The Medical council and the doctors lobby opposed this and hence it was not taken up seriously.

Ignoring the Mudaliar Committee's recommendation of consolidation of PHC's this plan period witnessed a rapid increase in their numbers but their condition was the same as the Committee had found at the end of the second plan period. In case of the disease programme due to their vertical nature we find a huge army of workers. The delivery of services continued to be done by special uni-purpose health workers. Therefore we find that in the same geographical area there was overlapping and duplication of work. In 1963 the **Chadha Committee** had recommended the integration of health and family planning services and its delivery through one male and one female multipurpose worker per 10,000 population.

India was the first country in the world to adopt a policy of reducing population growth through a government sponsored family planning programme in 1951. In the first two plans the FP programme was mainly run through voluntary organizations, under the aegis of FPAI. Faced with a rising birth rate and a falling death rate the 3rd plan stated that "the objective of stabilizing the growth of population over a reasonable period must therefore be at the very center of planned development". It was during this period that the camp approach was tried out and government agencies began to actively participate in pushing population control. This was also the time when family planning became an independent department in the Ministry of health.

The heavy emphasis on population control was due to the influence of various developed countries, but especially the USA. In 1966 a U.N. advisory mission visiting India strongly recommended, "The directorate

(health and family planning) should be relieved from other responsibilities such as maternal and child health and nutrition. It is undoubtedly important for family planning to be integrated with MCH in the field particularly in view of the loop programme, but until the family planning campaign has picked up momentum and made real progress in the states the director general concerned should be responsible for family planning only" (U.N. Advisory Mission 1961). This recommendation is reinforced by the fear that the programme may be otherwise used in some states to expand the much needed and neglected MCH services (Banerjee, 1973). This was a fundamental change in India's health policy. This policy change, though it had its own inner compulsions, was more so due to the influence of foreign agencies. To endorse this strategy The Special Committee to Review the Staffing Pattern and Financial Provision under Family Planning was appointed (**Mukherjee Committee**). This committee indicated that the camp approach had failed to give the family planning program a mass character and hence the coming in of IUCD (loop) was a great opportunity. This committee also recommended introduction of target fixation, payments for motivation and incentives to acceptors. It suggested reorganization of the FP program into a vertical program like malaria and recommended addition of one more Health visitor per PHC who would specifically supervise the ANMs for the targets of this program. Also the Committee recommended retaining of private practitioners for a fee of Rs. 100 pm for 6 hours work per week plus payment of Rs. 10 per sterilization and Rs. 2 per IUCD insertion. (Mukherjee Committee, 1966)

The **4th Plan** which began in 1969 with a 3 year plan holiday continued on the same line as the 3rd plan. It quoted extensively from the FYP II about the socialist pattern of society (FYP IV, 1969, 1-4) but its policy decisions and plans did not reflect socialism. Infact the 4th plan is probably the most poorly written plan document. It does not even make a passing comment on the social, political and economic upheaval during the plan Holiday period (1966-1969). These 3 years of turmoil indeed brought about significant policy changes on the economic front and this, the 4th plan ignored completely. It lamented on the poor progress made in the PHC programme and recognized again the need to strengthen it. It pleaded for the establishment of effective machinery for speedy construction of buildings and improvement of the performance of PHCs by providing them with staff, equipment and other facilities. (ibid, 390) For the first time PHCs were given a separate allocation. It was reiterated that the PHC's base would be strengthened along with, sub-divisional and district hospitals, which would be referral centers for the PHCs. The importance of PHCs was stressed to consolidate the maintenance phase of the communicable diseases programme. This acknowledgement was due to the fact that the entire epidemiological trend was reversed in 1966 with the spurt in incidence of malaria which

rose from 100,000 cases annually between 1963-65, to 149,102 cases (GOI, 1982). This was admitted by the planning commission. FP continued to get even a more greater emphasis with 42% of health sector (Health + FP) plan allocation going to it (FYP IV, 1969, 66). It especially highlighted the fact that population growth was the central problem and used phrases like "crippling handicap", "very serious challenge" and an anti-population growth policy as an "essential condition of success" (Ibid, 31-32) to focus the government's attention to accord fertility reduction "as a program of the highest priority" (ibid, 391). It was also during this period that water supply and sanitation was separated and allocations were made separately under the sector of Housing and Regional development. (ibid, 398-414).

It was in the **5th Plan** that the government ruefully acknowledged that despite advances in terms of infant mortality rate going down, life expectancy going up, the number of medical institutions, functionaries, beds, health facilities etc, were still inadequate in the rural areas. This shows that the government acknowledged that the urban health structure had expanded at the cost of the rural sectors. (FYP V, 1974, 234) This awareness is clearly reflected in the objectives of 5th Five Year Plan which were as follows : (Ibid, 234).

- 1) Increasing the accessibility of health services to rural areas through the **Minimum Needs Programme (MNP)** and correcting the regional imbalances.
- 2) Referral services to be developed further by removing deficiencies in district and sub-division hospitals.
- 3) Intensification of the control and eradication of communicable diseases.
- 4) Affecting quality improvement in the education and training of health personnel.
- 5) Development of referral services by providing specialists attention to common diseases in rural areas.

The methods by which these goals were to be achieved were through the MNP, the MPW training scheme, and priority treatment to backward and tribal areas.

Major innovations took place with regard to the health policy and method of delivery of health care services. The reformulation of health programmes was to consolidate past gains in various fields of health such as communicable diseases, medical education and provision of infrastructure in rural areas. This was envisaged through the MNP which would "receive the highest priority and will be the first charge on the development outlays under the health sector (Ibid, 234). It was an integrated packaged approach to the rural areas. The plan further

envisioned that the delivery of health care services would be through a new category of health personnel to be specially trained as multi-purpose health assistants. However, the infrastructure target still remained one PHC per CDP Block (as in the FYPI but the average Block's population was now 125000)!

The **Kartar Singh Committee** in 1973 recommended the conversion of uni-purpose workers, including ANMs, into multi-purpose male and female workers. It recommended that each pair of such worker should serve a population of 10,000 to 12,000. Hence the multi-purpose worker scheme was launched with the objective to retrain the existing cadre of vertical programme workers and the various vertical programmes were to be fully integrated into the primary health care package for rural areas. (Kartar Singh Committee, 1974)

Another major innovation in the health strategy was launched in 1977 by creating a cadre of village based health auxiliaries called the **Community Health workers**. These were part time workers selected by the village, trained for 3 months in simple promotive and curative skills both in allopathy and indigenous systems of medicine. They were to be supervised by MPWs, and the programme was started in 777 selected PHCs where MPWs were already in place.

This scheme was adopted on the recommendations of the **Shrivastava Committee** (Shrivastava, 1975) which was essentially a committee to look into medical education and support manpower. The committee proposed to rectify the dearth of trained manpower in rural areas. The committee pointed out that "the over-emphasis on provision of health services through professional staff under state control has been counter productive. On the one hand it is devaluing and destroying the old traditions of part-time semi-professional workers, which the community used to train and throw up and proposed that with certain modifications can continue to provide the foundation for the development of a national programme of health services in our country. On the other hand the new professional services provided under state control are inadequate in quantity and unsatisfactory in quality" (Ibid.). This very direct statement from the committee which was set up to review medical education and its related components assumes significance because it showed that the investment on health care has not been going to the people. The main recommendations of the committee was to have part-time health personnel selected by the community from within the community. They would act as a link between the MPW at the sub-centers and the community. With regard to medical education the committee cried for a halt to opening of new medical colleges. (Ibid.) The committee emphasized that there was no point in thinking that doctors would go to rural areas because there were a number of socio-economic dimensions

to this issue. Thus their option for rural areas was the CHW scheme. This attitude was clearly supportive of the historical paradigm that rural and urban areas had different health care needs – that urban populations need curative care and rural populations preventive. This also is discriminatory since inherent in this paradigm is deprivation for the rural masses. Earlier, in 1967 the **Jain Committee** report on Medical Care Services had made an attempt to devolve medical care by recommending strengthening of such care at the PHC and block/taluka level as well as further strengthening district hospital facilities. The Jain Committee also suggested integration of medical and health services at the district level with both responsibilities being vested in the Civil Surgeon/Chief Medical Officer. But recommendations of this Committee, which is the only committee since Independence to look at medical care and also for the first time talked about strengthening curative services in rural areas, were not considered seriously.

In the middle of the 5th Plan a State of National Emergency was proclaimed and during this period (1975-77) population control activities were stepped up with compulsion, force and violence now characterizing the FP program. In the midst of all this the **National Population Policy** was announced whose core aim was a “direct assault on the problem of population rise as a national commitment”, (Karan Singh, 1976) this clearly contradicting the statement India made at the Bucharest Population summit that “development is the best contraceptive”, ironically by the same health minister! One of the recommendations included was legislation by state governments for compulsory sterilization. With the end of the Emergency and a new government in power this policy was sent to the freezer.

Family Planning, which started with an insignificant outlay in the 1st plan, was now taking the single largest share in the health sector outlay. (FYP V, 247-256). Inspite of the realization on the part of planners and policy makers that most of the investment which were being made in the health sector were going to urban areas, health human power, medical facilities, water supply and sanitation etc. continued to grow in urban areas where only 20% of the population were residing (Ibid, 234), and within the urban areas a disproportionately larger chunk was being appropriated by the privileged classes as is evident from social consumption patterns.

In the 5th Plan water supply and sanitation got a greater emphasis. It was one of the important objectives in the MNP to provide adequate drinking water to all villages suffering from chronic scarcity of water. The outlay during this plan period for water supply was Rs. 10,220 millions, almost an equal amount to that allocated to the health sector (Ibid, 264).

The provision of safe water supply and basic sanitation is either absent or grossly inadequate for the vast majority of the population of India in both rural and urban areas. The major cause of the various diseases which affect the Indian population such as diarrhoea, amoebic dysentery, cholera, typhoid, jaundice are water borne. These diseases are also carried and spread due to lack of basic sanitation. To alleviate this problem in 1960 the National Water Supply and Sanitation Committee (**Simon Committee**) was formed to review the progress made under the national programmes in the first 2 plans. The report came out with the finding that the states themselves lacked data and information regarding the magnitude and nature of the problem. It stressed the need for an immediate survey and investigation to obtain correct data on the existing conditions both in urban and rural areas on which future planning and implementation could be based. It strongly recommended that the end of the 3rd plan must provide minimum drinking water to all villages in the country (Simon, 1960). This did not happen even till the end of the 5th Five Year Plan.

The drought of 1979-80 (and the subsequent droughts experienced in many districts of different states) which was accentuated by an acute scarcity of drinking water due to the drying-up of wells, tanks and other sources added urgency to the problem. Subsequent plans gave water supply an even higher priority with allocations outstripping health and family planning taken together.

The **Sixth Plan** was to a great extent influenced by the Alma Ata declaration of **Health For All by 2000 AD** (WHO, 1978) and the **ICSSR - ICMR report** (1980). The plan conceded that "there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed of mostly by the well to do classes. It is also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services" (Draft FYP VI, Vol. III, 1978, 250).

The plan emphasized the development of a community based health system. The strategies advocated were : (Ibid, 251-252)

- a) provision of health services to the rural areas on a priority basis.
- b) the training of a large cadre of first level health workers selected from the community and supervised by MPWs and medical officers of the PHCs.
- c) No further linear expansion of curative facilities in urban areas; this would be permitted only in exceptional cases dictated by real felt need or priority.

The plan emphasized that horizontal and vertical linkages had to be established among all the interrelated programmes, like water supply, environmental sanitation, hygiene, nutrition, education, family planning and MCH. The objective of achieving a net reproduction rate of 1 by 1995 was reiterated. (FYP VI, 1980, 368)

This plan and the seventh plan too, like the earlier ones make a lot of radical statements and have recommend progressive measures. But the story is the same - progressive thinking and inadequate action. Whatever new schemes are introduced the core of the existing framework and ideology remains untouched. The underprivileged get worse off and the already privileged get better off. The status quo of the political economy is maintained. However, the Sixth and the Seventh plans are different from the earlier ones in one respect. They no longer talk of targets. The keywords are efficiency and quality and the means to realize them is privatisation. Privatisation is the global characteristic of the eighties and the nineties and it has made inroads everywhere and especially in the socialist countries.

The Sixth and Seventh Five Year Plans state clearly : "..... the success of the plan depends crucially on the efficiency, quality and texture of implementation. a greater emphasis in the direction of competitive ability, reduced cost and greater mobility and flexibility in the development of investible resources in the private sector (by adapting) flexible policies to revive investor interest in the capital markets" (FYP VI, 1980, xxi and 86)

"Our emphasis must be on greater efficiency, reduction of cost and improvement of quality. This calls for absorption of new technology, greater attention to economies of scale and greater competition" (FYP VII, 1985, vol. i, vi). The National Health Policy of 1983 was announced during the Sixth plan period. It was in no way an original document. It accepted in principle the ICMR-ICSSR Report's (1981) recommendations as is evidenced from the large number of paragraphs that are common to both documents. But beyond stating the policy there was no subsequent effort at trying to change the health situation for the better.

The **National Health Policy (NHP)** in light of the Directive Principles of the constitution of India recommends "universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford" (MoHFW, 1983, 3-4). Providing universal health care as a goal is a welcome step because this is the first time after the Bhore Committee that the government is talking of universal comprehensive health care.

A policy document is essentially the expression of ideas of those governing to establish what they perceive is the will of the people. These may not necessarily coincide for various reasons and influences that impinge upon both the rulers and the ruled. Implementing a policy, especially if it seeks to significantly change the status quo, necessarily requires a political will. Whether the political will is expressed through action depends on both the levels of conscientisation of the electorate and the social concerns of those occupying political office.

A health policy is thus the expression of what the health care system should be so that it can meet the health care needs of the people. The health policy of Independent India, adopted by the First Health Ministers' Conference in 1948 were the recommendations of the Bhore Committee. However, with the advent of planning the levels of health care, as recommended by the Bhore Committee, were diluted by subsequent committees and the Planning Commission. In fact, until 1983 there was no formal health policy, the latter being reflected in the discussions of the National Development Council and the Central Council of Health and Family Welfare, and the Five Year Plan documents and/or occasional committee reports as discussed above. As a consequence of the global debate on alternative strategies during the seventies, the signing of the Alma Ata Declaration on primary health care and the recommendations of the ICMR-ICSSR Joint Panel, the government decided that the above fora may have served the needs in the past but a new approach was now required,

"It is felt that an integrated, comprehensive approach towards the future development of medical education, research and health services requires to be established to serve the actual health needs and priorities of the country. It is in this context that the need has been felt to evolve a National Health policy," (MoHFW, 1983, p 1)

The salient features of the 1983 health policy were:

- (a) It was critical of the curative-oriented western model of health care,
- (b) It emphasised a preventive, promotive and rehabilitative primary health care approach,
- (c) It recommended a decentralised system of health care, the key features of which were low cost, deprofessionalisation (use of volunteers and paramedics), and community participation,
- (d) It called for an expansion of the private curative sector which would help reduce the government's burden,
- (e) It recommended the establishment of a nationwide network of epidemiological stations that would facilitate the integration of various health interventions, and
- (f) It set up targets for achievement that were primarily demographic in nature.

There are three questions that must now be answered. Firstly, have the tasks enlisted in the 1983 NHP been fulfilled as desired? Secondly, were these tasks and the actions that ensued adequate enough to meet the basic goal of the 1983 NHP of providing "**universal, comprehensive primary health care services, relevant to actual needs and priorities of the community**" (MoHFW,1983, p 3-4)? And thirdly, did the 1983 NHP sufficiently reflect the ground realities in health care provision?

During the decade following the 1983 NHP rural health care received special attention and a massive program of expansion of primary health care facilities was undertaken in the 6th and 7th Five Year Plans to achieve the target of one PHC per 30,000 population and one subcentre per 5000 population. This target has more or less been achieved, though few states still lag behind. However, various studies looking into rural primary health care have observed that, though the infrastructure is in place in most areas, they are grossly underutilised because of poor facilities, inadequate supplies, insufficient effective person-hours, poor managerial skills of doctors, faulty planning of the mix of health programs and lack of proper monitoring and evaluatory mechanisms. Further, the system being based on the health team concept failed to work because of the mismatch of training and the work allocated to health workers, inadequate transport facilities, non-availability of appropriate accommodation for the health team and an unbalanced distribution of work-time for various activities. In fact, many studies have observed that family planning, and more recently immunisation, get a disproportionately large share of the health workers' effective work-time. (NSS,1987, IIM(A),1985, NCAER,1991, NIRD,1989, Ghosh,1991, ICMR,1989, Gupta&Gupta,1986, Duggal&Amin,1989, Jesani et.al,1992, NTI,1988, ICMR,1990)

Among the other tasks listed by the 1983 health policy, decentralisation and deprofessionalisation have taken place in a limited context but there has been no community participation. This is because the model of primary health care being implemented in the rural areas has not been acceptable to the people as evidenced by their health care seeking behaviour. The rural population continues to use private care and whenever they use public facilities for primary care it is the urban hospital they prefer (NSS-1987, Duggal & Amin,1989, Kannan et.al.,1991, NCAER,1991, NCAER,1992, George et.al.,1992). Let alone provision of primary medical care, the rural health care system has not been able to provide for even the epidemiological base that the NHP of 1983 had recommended. Hence, the various national health programs continue in their earlier disparate forms, as was observed in the NHP (MoHFW,1983, p 6).

As regards the demographic and other targets set in the NHP, only crude death rate and life expectancy have been on schedule. The others, especially fertility and immunisation related targets are much below expectation (despite special initiatives and resources for these programs over the last two decades), and those related to national disease programs are also much below the expected level of achievement. In fact, we are seeing a resurgence of communicable diseases.

With regard to the private health sector the NHP clearly favours privatization of curative care. It talks of a cost that "people can afford", thereby implying that health care services will not be free. Further statements in the NHP about the private health sector leave no room for doubt that the NHP is pushing privatisation. NHP adopts the stance that curative orientation must be replaced by the preventive and promotive approach so that the entire population can benefit (*Ibid.*, 3). The NHP suggests that curative services should be left to the private sector because the state suffers from a "constraint of resources" (*Ibid.*, 5). It recommends, "with a view to reducing governmental expenditure and fully utilizing untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage the establishment of practice by private medical professionals, increased investment by non-governmental agencies in establishing curative centers and by offering organized logistical, financial and technical support to voluntary agencies active in the health field ... and in the establishment of centers equipped to provide specialty and super specialty services ... efforts should be made to encourage private investments in such fields so that the majority of such centers, within the governmental set-up, can provide adequate care and treatment to those entitled to free care, the affluent sectors being looked after by the paying clinics". (*Ibid*, 7-8)

The development of health care services post-NHP provide a clear evidence that privatisation and private sector expansion in the health sector has occurred rapidly, that in the name of primary health care the state has still kept the periphery without adequate curative services (while the states' support to curative services in urban areas continues to remain strong) and that the state health sectors' priority program still continues to be population control (as recommended in NHP (*Ibid.*, 4)).

The expansion of the private health sector in the last two decades has been phenomenal thanks to state subsidies in the form of medical education, soft loans to set up medical practice etc... The private health sector's mainstay is curative care and this is growing over the years (especially during the eighties and nineties) at a rapid pace largely due to a lack of interest of the state sector in non-hospital medical care services, especially in rural areas (Jesani&Ananthram,1993). Various studies

show that the private health sector accounts for over 70% of all primary care treatment sought, and over 40% of all hospital care (NSS-1987, Duggal&Amin,1989, Kannan et.al.,1991, NCAER,1991, George et.al.,1992). This is not a very healthy sign for a country where over three-fourths of the population lives at or below subsistence levels.

The above analysis clearly indicates that the 1983 NHP did not reflect the ground realities adequately. The tasks enunciated in the policy were not sufficient to meet the demands of the masses, especially those residing in rural areas. "Universal, comprehensive, primary health care services", the 1983 NHP goal, is far from being achieved. The present paradigm of health care development has in fact raised inequities, and in the current scenario of structural adjustment the present strategy is only making things worse. The current policy of selective health care, and a selected target population has got even more focused since the 1993 World Development Report: Investing in Health. In this report the World Bank has not only argued in favour of selective primary health care but has also introduced the concept of DALYs (Disability Adjusted Life Year's) and recommends that investments should be made in directions where the resources can maximise gains in DALYs. That is, committing increasing resources in favour of health priorities where gains in terms of efficiency override the severity of the health care problems, questions of equity and social justice. So powerful has been the World Bank's influence, that the WHO too has taken an about turn on its Alma Ata Declaration. WHO in its "Health For All in the 21st Century" agenda too is talking about selective health care, by supporting selected disease control programs and pushing under the carpet commitments to equity and social justice. India's health policy too has been moving increasingly in the direction of selective health care - from a commitment of comprehensive health care on the eve of Independence, and its reiteration in the 1983 health policy, to a narrowing down of concern only for family planning, immunisation and control of selected diseases. Hence, one has to view with seriousness the continuance of the current paradigm and make policy changes which would make primary health care as per the needs of the population a reality and accessible to all without any social, geographical and financial inequities. Table 3 gives a good idea of how the health infrastructure in India has evolved over the years.

The **7th Five Year Plan** accepted the above NHP advice. It recommended that "development of specialties and super-specialties need to be pursued with proper attention to regional distribution" (FYP VII, 1985, II, 273) and such "development of specialised and training in super specialties would be encouraged in the public and the private sectors". (Ibid., II, 277). This plan also talks of improvement and further support for urban health services, biotechnology and medical electronics and non-communicable diseases (Ibid, II. 273-276). Enhanced support for population control

activities also continues (Ibid., II. 279-287). The special attention that AIDS, cancer, and coronary heart diseases are receiving and the current boom of the diagnostic industry and corporate hospitals is a clear indication of where the health sector priorities lie.

On the eve of the **Eighth Five Year Plan** the country went through a massive economic crisis. The Plan got pushed forward by two years. But despite this no new thinking went into this plan. Infact, keeping with the selective health care approach the eighth plan adopted a new slogan – instead of Health for All by 2000 AD it chose to emphasize Health for the Underprivileged (FYP VIII, 322). Simultaneously it continued the support to privatization, “In accordance with the new policy of the government to encourage private initiatives, private hospitals and clinics will be supported subject to maintenance of minimum standards and suitable returns for the tax incentives.” (ibid, 324)

The **9th Five Year Plan** by contrast provides a good review of all programs and has made an effort to strategise on achievements hitherto and learn from them in order to move forward. There are a number of innovative ideas in the ninth plan. It is refreshing to see that reference is once again being made to the Bhore Committee report and to contextualise today's scenario in the recommendations the Bhore Committee had made. (FYP IX, 446) In its analysis of health infrastructure and human resources the Ninth Plan says that consolidation of PHCs and SCs and assuring that the requirements for its proper functioning are made available is an important goal under the Basic Minimum Services program. Thus, given that it is difficult to find physicians to work in PHCs and CHCs the Plan suggests creating part-time positions which can be offered to local qualified private practitioners and/or offer the PHC and CHC premises for after office hours practice against a rent. Also it suggests putting in place mechanisms to strengthen referral services. (ibid, 454)

Another unique suggestion is evolving state specific strategies because states have different scenarios and are at different levels of development and have different health care needs. (Ibid, 458). The Ninth Plan also shows concern for urban health care, especially the absence of primary health care and complete reliance on secondary and tertiary services even for minor ailments. This needs to be changed through provision of primary health care services, especially in slums, and providing referral linkages at higher levels. (Ibid, 460).

During the Eighth Plan resources were provided to set up the Education Commission for Health Sciences, and afew states have even set up the University for Health Sciences as per the recommendations of the **Bajaj committee** report of 1987. This initiative was to bring all health sciences

together, provide for continuing medical education and improve medical and health education through such an integration. The Ninth Plan has made provisions to speed up this process. (ibid, 468)

During the 8th Plan period a committee to review public health was set up. It was called the **Expert Committee on Public Health Systems**. This committee made a thorough appraisal of public health programs and found that we were facing a resurgence of most communicable diseases and there was need to drastically improve disease surveillance in the country. The Ninth Plan proposes to set up at district level a strong detection come response system for rapid containment of any outbreaks that may occur.(Ibid, 477). Infact, the recommendations of this committee have formed the basis of the Ninth Plan health sector strategy to revitalize the public health system in the country to respond to its health care needs in these changed times. (Ibid, 499) Also the Plan has proposed horizontal integration of all vertical programs at district level to increase their effectiveness as also to facilitate allocative efficiencies.

What is also interesting is that the 9th Plan also reviews the 1983 National Health Policy in the context of its objectives and goals and concludes that a reappraisal and reformulation of the NHP is necessary so that a reliable and relevant policy framework is available for not only improving health care but also measuring and monitoring the health care delivery systems and health status of the population in the next two decades (Ibid, 503). In this context the 9th Plan is critical of the poor quality of data mangement and recommends drastic changes to develop district level databases so that more relevant planning is possible.(Ibid, 472). Taking lead from the 9th Plan the Ministry of health and Family Welfare is presently working on a new Health Policy document. A draft version which came out in June 1999 was found wanting and is being reworked presently.

The Ninth Plan also reviews population policy and the family planning program. In this review too it goes back to the Bhore Committee report and says that the core of this program is maternal and child health services.. Assuring antenatal care, safe delivery and immunization are critical to reducing infant and maternal mortality and this in turn has bearing on contraception use and fertility rates. (Ibid, 519). This is old logic which the family planning program has used, only earlier their emphasis was on sterilization. In the early sixties the setting up of subcentres and employing ANMs was precisely for the MCH program but at the field level this was hijacked by the family planning program. This story continues through the seventies and eighties. MCH became Safe Motherhood, and expanded Program of Immunization and the latter using a mission approach under Sam Pitroda became Universal Program

of Immunisation. In the 7th Plan this got combined again to become Child Survival and Safe Motherhood, but the essential emphasis remained on family planning. But since the 8th Plan and into the 9th Plan CSSM acquired a genuine seriousness and presently it is transformed into the RCH program on the basis of the ICPD-Cairo agenda and receives multi-agency external funding support to provide need based, demand driven, high quality integrated reproductive and child health care. (*ibid*, 519 and 557). In the midst of all this the **National Population Policy** was announced with a lot of fanfare in the middle of 2000. It is definitely an improvement from its predecessors but the underlying element remains population control and not population welfare. The major concern is with counting numbers and hence its goals are all demographic. But I said earlier that there is improvement from the past because the demographic goals are placed in a larger social context and if that spirit is maintained in practice then we would definitely move forward.

There is exactly a year to go for the completion of the 9th Plan and a review of all its innovative suggestions shows that we have once again failed at the ground level. We have been unable to translate these ideas into practice. And despite all these efforts one can see the public health system weakening further. The answer is found in the 9th Plan itself. It laments that all these years we have failed to allocate even two percent of plan resources to the health sector (*ibid*, 503). The same reason has killed the initiative shown in the 9th Plan process at the start itself by continuing the story of inadequate resource allocations for the health sector.

Another issue of concern is the **influence of international agencies** in policymaking and program design both within and outside the plans. Right from the First plan onwards one can see the presence of international aid agencies who with a small quantum of money are able to inject large doses of ideology. It cannot be a coincidence that almost every health program the Indian government has taken up since the first plan has been anticipated by some international donor agency. Whether it was the CDP in the fifties, IUCD and malaria in the sixties or RCH and AIDS in the nineties, most health programs have been shaped through external collaboration. Historically, though there is a qualitative and quantitative difference. Upto the eighties the influence came through advice and ideology and hence its penetration was limited but now there is a lot of money also coming in, mostly as soft loans, and if we continue without making a paradigm shift and making structural changes, we will be transferring a burden to the next generation which it may be unable to carry!

In conclusion we would like to indicate that the neglect of the public health sector is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter, as can be seen in Table 1, get only a residual attention by the state. Thus the solution for satisfying the health needs of the people does not lie in the health policies and plans but it is a question of structural changes in the political economy that can facilitate implementation of progressive health policies.

Table 1 : PLAN EXPENDITURE BY MAJOR SECTORS (Rupees Million) (Figures in brackets are percentage to total)

	Plan One 1951-56	Plan Two 1956-61	Plan Three 1961-66	Annual Plans 1966-69	Plan Four 1969-74	Plan Five 1974-79	Annual Plans 1979-80	Plan Six 1980-85	Plan Seven 1985-90	Annual Plans 1990-92	Plan Eight 1992-97	Plan Nine Outlay 1997-2002
ECONOMIC SERVICES (A)	14940	38170	70847	56495	127936	325923	102090	915072	1807460@	1015948@	3895410@	6574690
	(76.0)	(81.7)	(82.6)	(85.3)	(81.1)	(82.7)	(83.8)	(83.7)	(82.6)	(82.5)	(80.2)	(76.5)
1. Agriculture & rural dev.	2900	5490	10889	11071	23204	48649	19965	152006	315094	176010	702003	1207970
	(14.8)	(11.7)	(12.7)	(16.7)	(14.7)	(12.3)	(16.4)	(13.9)	(14.4)	(14.3)		
2. Irrigation & flood control	4340	4300	6647	4710	13541	38765	12879	09299	165899	82060	313989	554200
	(22.2)	(9.2)	(7.8)	(7.1)	(8.6)	(9.8)	(10.6)	(10.0)	(7.6)	(6.7)		
3. Power	1490	4520	12523	12125	29317	73995	22405	307513	616893	368347	1289045	2223750
	(7.6)	(9.7)	(14.6)	(18.3)	(18.6)	(18.8)	(18.4)	(28.1)	(28.2)	(29.9)		
4. Village & small ind'ry	480	1870	2408	1261	2426	5925	2557	19451	32493	18191	72657	}
	(2.19)	(4.0)	(2.8)	(1.9)	(1.5)	(1.5)	(2.1)	(1.8)	(1.5)	(1.5)		} 651480
5. Industry & Minerals	550	9380	17263	15104	28644	89886	23835	150024	259711	111197	406231	}
	(2.8)	(20.1)	(20.1)	(22.8)	(18.2)	(22.8)	(19.6)	(13.7)	(11.9)	(9.0)		
6. Transport & Commu'n	5180	12610	21117	12224	30804	68703	20449	176779	379736	239503	1015479	1666530
	(26.4)	(22.0)	(24.6)	(18.5)	(19.5)	(17.4)	(16.8)	(16.7)	(17.4)	(19.4)		
SOCIAL SERVICES(B)	4720	8550	14918	9759	29852	68339	19675	177845	379836	215257	959161	2017310
	(24.0)*	(18.3)*	(17.4)	(14.7)	(18.9)	(17.3)	(16.2)	(16.3)	(17.4)	(17.5)	(19.8)	(23.5)
1. Education }				5887	3068	7743				49155	215987	
				(6.9)	(4.6)	(4.9)				(4.0)		
	1490	2730				17103						
	(7.6)	(5.9)				(4.4)						
2. Scientific Research}				716	471	1308				16204	71095	184580
				(0.8)	(0.7)	(0.8)				(1.3)		
3. Health	652	1408	2259	1402	3355	7608	2231	20252	36886	19656	81376	193741
	(3.3)	(3.0)	(2.6)	(2.1)	(2.1)	(1.9)	(1.8)	(1.8)	(1.7)	(1.6)		
4. Family Planning	1	50	249	704	2780	4918	1185	13870	31208	18055	59728	151202
	(0)	(0.1)	(0.3)	(1.1)	(1.8)	(1.3)	(1.0)	(1.3)	(1.4)	(1.5)		
5. Water & Sanitation}				1057	1027	4589	10916	3876 }		**	**	**
				(1.2)	(1.0)	(2.9)	(2.8)	(3.2) }				
	330	850					103753					
	(1.7)	(1.8)					(9.5)					
6. Housing & Urban Dev}				1276	733	2702	11500	3688 }	48362	30323	138043	
				(1.5)	(1.1)	(1.7)	(2.9)	(3.0) }	(2.2)	(2.5)		
7. Other welfare	1920	2690	3474	2354	7375	16294	5151 }	156285**	81864**	392934**		
	(9.8)	(5.8)	(4.1)	(3.5)	(4.7)	(4.1)	(4.2) }	(7.2)	(6.6)			
GRAND	19660*	46720*	85765	66254	157788	394262	121765	1092917	2187296	1231205	4854572	8592000
TOTAL(A + B)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)

* Includes rehabilitation; ** Water and Sanitation included in Other welfare; @ includes general and general economic services

Sources : 1. Basic Statistics Relating to the Indian Economy : 1950 to 1981, CSO, GOI, 1983, Pg. 148-149. 2. Economic Survey 1986-87, Min of Finance, GOI, 1987, Pg S-31 and S-32 (for Vth to VIth Plan). 3. Indian Planning Experience: A statistical profile, Planning Commission, GOI, New Delhi, 2000 Pg 33-36 (Pan VII, VIII and IX)

Table 2: Pattern of Investment on Health and Family Welfare (Rs. Crores)

Period	Total Plan Investment	Health	%	Family Welfare	%
First Plan (Actuals) (1951-56)	1,960.00	65.20	3.33	0.10	0.01
Second Plan (Actuals) (1956-61)	4,672.00	140.80	3.01	5.00	0.11
Third Plan (Actuals) (1961-66)	8,576.50	225.90	2.63	24.90	0.29
Annual Plans (Actuals) (1966-69)	6,625.40	140.20	2.12	70.40	1.06
Fourth Plan (Actuals) (1969-74)	15,778.80	335.50	2.13	278.00	1.76
Fifth Plan (Actuals) (1974-79)	39,426.20	760.80	1.93	491.80	1.25
Annual Plan (1979-80)	11,650.00	268.20	2.30	116.20	1.00
Sixth Plan (Actuals) (1980-85)	1,09,291.70	2025.20	1.85	1387.00	1.27
Seventh Plan (Actuals) (1985-90)	2,18,729.60	3,688.60	1.69	3,120.80	1.43
Annual Plans (1990-91, 1991-92)	1,23,120.50	1,965.60	1.60	1,805.50	1.47
Eighth Plan (Actuals) (1992-97)	4,85,457.20	8,137.60	1.68	5,972.80	1.23
Ninth Plan (Outlay) (1997-2002)	8,59,200.00	*19,374.11	2.25	15,120.20	1.76

Note i) *: Includes Outlay of Rs. 266.35 crores for the Department of ISM&H.

Source : **Indian Planning Experience - A Statistical Profile**, Planning Commission, GOI, New Delhi, 2000
Ninth Five Year Plan, Planning Commission, GOI, New Delhi, 1998

Table 3: HEALTH INFRASTRUCTURE DEVELOPMENT IN INDIA 1951-1998 UPDATE

			1951	1961	1971	1981	1991	1995	1996	1997	1998
1	Hospitals	Total	2694	3054	3862	6805	11174	15097			17000
		% Rural	39	34	32	27		31			
		% Private				43	57	68			
2	Hospital & dispensary beds	Total	117000	229634	348655	504538	664135	870161			950000
		% Rural	23	22	21	17		20			
		% Private				28	32	36			
3	Dispensaries		6600	9406	12180	16745	27431	28225			
		% Rural	79	80	78	69		43			
		% Private				13	60	61			
4	PHCs		725	2695	5131	5568	22243	21693	21917	22446	24000
5	Sub-centres				27929	51192	131098	131900	134931	136379	
6	Doctors	Allopaths	60840	83070	153000	266140	395600	459670	475780	503950	522634
		All Systems	156000	184606	450000	665340	920000			1100000	1155000
7	Nurses		16550	35584	80620	150399	311235	562966	565700		
8	Medical colleges	Allopathy	30	60	98	111	128		165	165	
9	Out turn	Grads	1600	3400	10400	12170	12086				
		P. Grads		397	1396	3833	3139				
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	79.4	91.3	104.9	120.7
11	Health outcomes	IMR/000	134	146	138	110	80	74/69	72	71	72
		CBR/000	41.7	41.2	37.2	33.9	29.5	29	25	24	
		CDR/000	22.8	19	15	12.5	9.8	10	9	9	
		Life Expectancy years	32.08	41.22	45.55	54.4	59.4	62	62.4	63.5	
	Births attended by trained practitioners	Per 1000 live births				18.5	21.9		28.5		
12	Health Expenditure Rs. Billion	Public	0.22	1.08	3.35	12.86	50.78	82.17	101.65	113.13	126.27
		Private@	1.05	3.04	8.15	43.82	173.60	233.47		590.93	
		CSO estimate of pvt.		2.05	6.18	29.70	82.61				

@ Data from - 1951:NSS 1st Round 1949-50; 1961: SC Seals All India District Surveys,1958; 1971: NSS 28th Round 1973-74; 1981: NSS 42nd Round 1987; 1991 and 1995: NCAER – 1990; 1995: NSS 52nd Round 1995-96; 1997: CEHAT 1996-97

Source : 1. Health Statistics / Information of India, CBHI, GOI, various years

2. Census of India Economic Tables, 1961, 1971, 1981, GOI

3. OPPI Bulletins and Annual reports of Min. of Chemicals and Fertilisers for data on Pharmaceutical Production

4. Budget Papers of Central and State Governments, various years

5. National Accounts Statistics, CSO, GOI, various years

3. Towards Structural Changes and a New Health Policy

Universal coverage and equity for primary health care are accepted and oft repeated goals. It is often mentioned to be a fundamental human right. Universal coverage and equity are closely related.

"Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential... Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible" (Whitehead,1990, p 9).

This is possible only when health care programs can assure universal coverage. The experience of all countries having near-universal health care systems is that with increased coverage of health care services inequities decline rapidly.

To assure equity and universal coverage the present health care system needs modifications. The health sector in India is a mix of public and private health care services. To compound this duality there are multiple systems - allopathy, ayurveda, homoeopathy, unani, siddha etc... Studies have shown that the multiplicity of systems is confined to training alone because in actual practice an overwhelming number of practitioners of all systems practice modern medicine (NSS-1987, Duggal&Amin,1989, Kannan et.al.,1991, NCAER,1991, NCAER,1992, George et.al.,1992, FRCH,1993, Nandraj&Duggal,1996). Thus in practical terms multiple systems do not operate widely, as an overwhelming number of practitioners prescribe or treat with modern medicines.

As mentioned earlier, the private health sector is concerned primarily with curative services. Medical care for common illnesses is provided through general practitioners, who constitute 80% of the private health sector. These practitioners, qualified in various systems of medicine, practice modern medicine - a whopping 96% of them according to the 1987 National Sample Survey on Morbidity and Utilisation of Health Services. Thus, private medical practitioners operate under conditions of complete absence of any control, monitoring and regulation by either the government or professional bodies. In fact, there are a large, unknown number of unqualified practitioners, especially in areas where qualified doctors are difficult to find. The general practitioners together handle over three-fourths of all outpatient cases in both rural and urban areas. The role of the private sector in hospital care is comparatively limited but expanding at a fast rate. The private sector, though owning 68% of the hospitals accounts for only 36% of the hospital beds and 54% of all hospital cases (NSS-1997). However, with the availability of a new generation of health care technologies and the consequent entry of the

corporate sector in a large way, the private hospital sector is all set for an unprecedented growth (Jesani, 1993).

In contrast, the public health sector presents a vastly different picture. In urban areas the public health sector has hospitals and dispensaries which provide both outpatient and inpatient care. These hospitals are generally overcrowded; firstly, because their number is inadequate and they are insufficiently staffed, and secondly, populations from peripheral rural areas also utilise urban hospitals for both outpatient and inpatient care because rural areas lack these services. In the 1983 NHP it was recommended that hospitals should become only referral centres but no effort is in evidence for evolving such a system. In the rural areas the state has set up a network of primary health centres through which various national health programs are integrated. We have discussed in a preceding section the observations of various studies on the performance and utilisation of PHCs. The weakest component of PHC services is curative care and this is the main reason why PHCs are so grossly underutilised - less than 8% of all illness care (NSS-1987, NCAER, 1991, Jesani, 1992) - and have so little credibility. The PHCs and subcentres in public opinion are basically family planning centres. The effort at setting up rural hospitals to fill this demand gap for curative care is woefully slow, and is further made more difficult with the non-availability of medical personnel. Observations show that where rural hospitals are well staffed and equipped they are as crowded as the district hospitals. Thus, in comparative terms the public sector serves the urban areas better than it does the rural areas but in absolute terms even the urban population is underserved as far as public health services are concerned.

Whereas the public health sector is inadequately equipped to meet the health care demands of the people, the private sector meets them without consideration of quality, rationality and social concern. Public opinion, expressed through the various utilisation studies referred to above, indicates that distance, hours of availability, waiting time, personal attention and supply of medicines are important factors that favour the use of private health care providers. Where these factors are favourable for public health facilities the utilisation of the latter improves substantially. Thus these factors have to be kept in mind while planning health care provision.

Apart from the above noted scenario of health care services in the country a further rationale for change in the health policy is provided by global experience in evolving universal health care systems. There is a general tendency to move towards more organised national health systems and an increased share of public finance for health care (Roemer, 1985, OECD, 1990). Almost all developed capitalist (exception USA) and socialist countries have universal health care systems where

the share of the fiscal burden by the public sector is between 60% and 100% (*ibid.*). This trend is the consequence of the pursuit for equity and universal coverage. Countries that have not set up universal systems for health care continue to experience high inequities. In spite of being economically most developed, the USA is an outstanding example where still over 30 million persons don't have access to a reasonable level of health care (President Clinton in his campaigns had promised to wipe out this lack of health care through Federal intervention). The fate of most Asian and African countries is miserable - low public sector investment, large private sector, and wide-ranging inequities in access to basic health care. In the case of most Latin American countries a significantly large proportion of population is covered for primary health care, though coverage is still not universal. A large country like India cannot wait for economic development as a precondition for health care development. Intervention in social sectors like health, education and housing can be independent of economic development as demonstrated by most socialist countries. These in turn create social conditions for a more rapid economic development.

Such a justification was even argued out by the Bhore Committee in 1946:

"We feel that a nation's health is perhaps the most potent single factor in determining the character and extent of its development and progress. Expenditure of money and effort on improving the nation's health is a gilt-edged investment which will yield not deferred dividends to be collected years later, but immediate and steady returns in substantially increased productive capacity.... In regarding national health as the foundation on which our plan of reconstruction must be based if it is to yield optimum results, we feel we are merely repeating an axiomatic proposition. We need no further justification for attempting to evolve a comprehensive plan which must inevitably cover a very wide field and necessarily entail large expenditures if it is to take into account all the more important factors which go into the building of a healthy, virile and dynamic people.... The idea that the State should assume full responsibility for all measures, curative and preventive, which are necessary for safeguarding the health of the nation, is developing as a logical sequence. The modern trend is towards the provision of as complete a health service as possible by the State and the inclusion, within its scope, of the largest possible proportion of the community. The need for assuring the distribution of medical benefits to all, irrespective of their ability to pay, has also received recognition." (Bhore, 1946)

Keeping this view in mind and given the existing health care development it is even more important that structural changes in the health sector are

made. If 'health for all' is the political commitment then the health policy should be talking about changes that can help achieve this goal and establish equity and universal coverage for health care.

As pointed out earlier, for all practical purposes the health sector may be divided into the private sector and public sector, each with its specific features. In distribution of services and facilities we encounter two set of dichotomies in the health sector, the curative (private sector) - preventive (public sector) dichotomy, and in case of public services the rural (preventive) - urban (curative) dichotomy. That is , curative services are largely found in the private domain and preventive services in the public domain. Where the public health services are concerned there is also a clear rural-urban divide with the curative care in public domain being concentrated in urban areas and preventive services in rural areas.

It is extremely important to remove these dichotomies for universal coverage and equity considerations. Therefore the first step is to recognise the health sector as a single sector of a public - private mix with a social goal, and the second step is to consider health care as comprehensive without any social and geographical discrimination. Hence there is a need for organising the existing health care system under a universal umbrella for the delivery of primary care as per the rational needs of the people.

Further it is important in this context to define the minimum which should be included under primary care. Primary care services should include at least the following:

- General practitioner/family physician services for personal health care.
- First level referral hospital care and basic speciality (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic) services, including dental and ophthalmic services.
- Immunisation services against vaccine preventable diseases.
- Maternity services for safe pregnancy (or safe abortion), delivery and postnatal care.
- Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.
- Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- Ambulance services.
- Contraceptive services.
- Health education.

The above listed components of primary care are the minimum that must be assured, if a universal health care system has to be effective and acceptable. The key to equity is the existence of a minimum decent level of provision, a floor that has to be firmly established. However, if this floor has to be stable certain ceilings will have to be maintained toughly, especially on urban health care budgets and hospital use (Abel-Smith, 1977). This is important because human needs and demands can be excessive and irrational. Those wanting services beyond the established floor levels will have to seek it outside the system and/or at their own cost.

Therefore it is essential to specify adequate minimum standards of health care facilities which should be made available to all people irrespective of their social, geographical and financial position. There has been some amount of debate on standards of personnel requirements [doctor: population ratio, doctor: nurse ratio] and of facility levels [bed: population ratio, PHC: population ratio] but no global standards have as yet been formulated though some ratios are popularly used, like one bed per 500 population, one doctor per 1000 persons, 3 nurses per doctor, health expenditure to the tune of 5% of GNP etc.. Another way of viewing standards is to look at the levels of countries that already have universal systems in place. In such countries one finds that on an average per 1000 population there are 2 doctors, 5 nurses and as many as 10 hospital beds (OECD, 1990, WHO, 1961) The moot point here is that these ratios have remained more or less constant over the last 30 years indicating that some sort of an optimum level has been reached. In India with regard to hospital care the Bureau of Indian Standards (BIS) has worked out minimum requirements for personnel, equipment, space, amenities etc.. For doctors they have recommended a ratio of one per 3.3 beds and for nurses one per 2.7 beds for three shifts. (BIS 1989, and 1992). Again way back in 1946 the Bhore Committee had recommended reasonable levels (which at that time were about half that of the levels in developed countries) to be achieved for a national health service which are as follows:

- one doctor per 1600 persons
- one nurse per 600 persons
- one health visitor per 5000 persons
- one midwife per 100 births
- one pharmacist per 3 doctors
- one dentist per 4000 persons
- one hospital bed per 175 persons
- one PHC per 10 to 20 thousand population depending on population density and geographical area covered
- 15% of total government expenditure to be committed to health care, which at that time was less than 2% of GNP

The above requirements were worked out, after a thorough study of the health situation in the country, by the Committee members. They traveled right across the country's length and breadth to gather information and record observations. It is a pity that this exercise is lost to history because of inadequate efforts on part of the planners and policy makers to implement fully the recommendations of the Bhore Committee.

The first response from the government and policy makers to the question of using the above norms in India is that they are excessive for a poor country and we do not have the resources to create such a level of health care provision. Such a reaction is invariably not a studied one and needs to be corrected. Let us construct a selected epidemiological profile of the country based on whatever proximate data is available through official statistics and research studies. We have obtained the following profile after reviewing available information:

- Daily morbidity = 2% to 3% of population, that is about 20-30 million patients to be handled everyday (7 - 10 billion per year)
- Hospitalisation Rate 20 per 1000 population per year with 12 days average stay per case, that is a requirement of 228 million bed-days (that is 20 million hospitalisations as per NSS -1987 survey, an underestimate because smaller studies give estimates of 50/1000/year or 50 million hospitalisations)
- Prevalence of Tuberculosis 11.4 per 1000 population or a caseload of over 11 million patients
- Prevalence of Leprosy 4.5 per 1000 population or a caseload of over 4 million patients
- Incidence of Malaria 2.6 per 1000 population yearly or 2.6 million new cases each year
- Diarrhoeal diseases (under 5) = 7.5% (2-week incidence) or 1.8 episodes/child/year or about 250 million cases annually
- ARI (under 5) = 18.4% (2-week incidence) or 3.5 episodes per child per year or nearly 500 million cases per year
- Cancers = 1.5 per 1000 population per year (incidence) or 1.5 million new cases every year
- Blindness =1.4% of population or 14 million blind persons
- Pregnancies = 21.4% of childbearing age-group women at any point of time or over 40 million pregnant women
- Deliveries/Births 25 per 1000 population per year or about 68,500 births every day

(estimated from CBHI, WHO,1988, ICMR,1990<a>, NICD,1988, Gupta et.al.,1992, NSS,1987)

The above is a very select profile which reflects what is expected out of a health care delivery system. Let us take handling of daily morbidity alone, that is, outpatient care. There are 30 million cases to be tackled every day. Assuming that all will seek care (this usually happens when health care is universally available, in fact the latter increases perception of morbidity) and that each GP can handle about 60 patients in a days work, we would need over 500,000 GPs equitably distributed across the country. This is only an average; the actual requirement will depend on spatial factors (density and distance). This means one GP per about 2500 population, this ratio being three times less favourable than what prevails presently in the developed capitalist and the socialist countries. Today we already have over 1,300,000 doctors of all systems (520,000 allopathic) and if we can integrate all the systems through a CME program and redistribute doctors as per standard requirements we can provide GP services in the ratio of one GP per 700-1000 population.

The transformation of the existing system into an organised system to meet the requirements of universality and equity will require certain hard decisions by policy-makers and planners. The most important lesson to learn from the existing model is how not to provide curative services. Curative care is provided mostly by the private sector, uncontrolled and unregulated. The system operates more on the principles of irrationality than medical science. The pharmaceutical industry is in a large measure responsible for this irrationality in medical care. Twenty thousand drug companies and over 60,000 formulations characterise the over Rs. 160 billion drug industry in India. (In addition to this there is a fairly large and expanding ayurvedic and homoeopathy drug industry estimated to be atleast one-third of mainstream pharmaceuticals) The WHO recommends about 300 drugs as essential for provision of any decent level of health care. If good health care at a reasonable cost has to be provided then a mechanism of assuring rationality must be built into the system. Family medical practice supported by an organized referral system, which is adequately regulated, is the best and the most economic means for providing good health care and this can be done only if the entire health care system is organized under regulated and controlled system.

To make such a system work a number of policy initiatives and decisions need to be taken. We will not discuss the question of feasibility here because it is a political matter. We will only say this that provision of basic health care will have to be made statutory if the goal is health for all with equity. Thus, the first task on the part of the government would be the proclamation of an organised health care service under which every citizen would be enrolled irrespective of his/her social, geographical or financial status. The structure, the terms and conditions, administrative measures etc., will have to be spelt out by an Act of

Parliament. The Act must take cognisance of existing ground realities and assure that the implementation process addresses these ground realities. For instance, the elimination of rural-urban disparities in health care provision must be the primary task to begin with if such a policy has to be successful.

Another priority policy initiative needed for implementing a universal health care system would be related to tackling the medical profession. A small, established section of the medical profession would oppose any organised system of health care because it would threaten their position in the health care market. In sharp contrast, the younger professionals (the majority) would welcome such a step because it would not only give them an assured market/clientele but it also would provide for relative equality within the profession. This is precisely what happened when Britain introduced the NHS system or Canada implemented its health sector reforms. Thus one of the prime foci of such a policy should be regulating provider behaviour. This would include issues of licensing, registration, CME, compulsory public service, especially in rural areas, strict controls over outmigration of doctors, integration of various systems of medicine, standards of medical practice and hospital care etc...

Hitherto the health sector has operated without any restrictions and regulations. This has to be changed to assure better distribution of health manpower. Thus licensing in setting up medical practice will have to be resorted to. Strong restrictions and disincentives in overserved areas and incentives in underserved areas will be necessary to ensure equitable access to all. This would mean setting up of norms for access and availability, for instance, minimum and maximum number of doctors in a given radial distance or population in dense and sparse areas. Further to enhance the number of doctors under the public health sector compulsory public health service must be legislated. No medical graduate must be given a registration until he/she has served a minimum of 5 years in public health services, of which at least 3 years should be in rural areas. Similarly, until the 3 years of rural service is completed post-graduate course registration too should not be allowed. This is the minimum return that must accrue to society for its contribution to the social production of doctors. Further, doctors trained in the country, especially those at the cost of the public exchequer, should not be allowed to migrate abroad. In specialties where training is not available within the country only government service doctors should be allowed to go abroad for obtaining those skills and must return and develop that specialty with public sector support.

Another major policy issue that needs addressing is medical education. In practice the multiple-system doesn't work because people

overwhelmingly demand modern medicine, and non-allopathic doctors too practice modern medicine. Hence there is a need to bring drastic changes in medical education. Whether MCI or the other Councils like it or not, the only solution is to have a single cadre of basic doctors. Those who want to study alternative systems can do it as a basic specialisation. This restructuring is a must to prevent the gross medical cross-practice and malpractice, which at times is dangerous. Thus there is an urgent need to restructure medical education to produce a cadre of basic doctors who would provide compulsory service in the public health sector for a specified period. The integration of existing doctors of different systems of medicine can be done through a crash CME program so that their knowledge and skills are rationalised and updated. Further, doctors should not get permanent registration but periodic with renewal being linked to completion of relevant CME programs as is done in many countries.

Another area of policy action would be setting up standard norms for medical practice and hospital care. The Bureau of Indian Standards has begun this process but more concerted efforts are needed to finalise norms and assure their implementation. This is very important for any universal health care system because the entire monitoring and auditing of the system will depend on having such norms. Social audit and information management can only be facilitated if standards of practice and care are well established.

Issues related to pharmaceutical production and pricing should be a major concern of a national health policy. Unfortunately as of now the health ministry's role is limited to monitoring drug quality standards. The health ministry is presently in no position to assure the production of essential drugs or even drugs required for the various national programs. The Hathi Committee Report in 1975 had indirectly suggested this when it stated that production and distribution of drugs must be a social responsibility of the State. But his report was never taken seriously. The health ministry must make efforts at vesting control of the pharmaceutical industry in order to assure the production of rational and essential drugs. For a universal health care system to function unimpaired, essential drugs must be available in the required quantities whenever and wherever needed. This will be possible only if the health ministry has complete control of the pharmaceutical industry under its wings.

And the most important area for policy initiative would be the efforts needed to generate resources through various alternative modes of financing. The thumb-rule for a policy on health financing should be that no direct payments are made by patients to providers because a direct payment system increases both costs and inequalities, as well as leaves

ample room for irrational medical practice. The health ministry has to pressurise the government to commit a much larger quantum of funds to the health sector. This need not be only through the existing mechanism of financing (tax revenues) but also through other public and private sources. Employers and employees of the organised sector will be a major source to generate payroll taxes (ESIS, CGHS and other such health schemes should be merged with general health services). The agricultural sector is the largest sector in terms of employment and population and at least one-fourth to one-third of this population has the means to contribute to a health scheme. Some mechanism, either linked to land revenue or land ownership, will have to be evolved to facilitate receiving their contributions. Similarly self-employed persons like professionals, traders, shopkeepers, etc. who can afford to contribute can pay out in a similar manner to the payment of profession tax in some states. Further, resources could be generated through other innovative methods - health cess collected by local governments as part of the municipal/house taxes, proportion of sales turnover and/or excise duties of health degrading products like alcohol, cigarettes, paan-masalas, guthkas etc.. should be earmarked for the health sector, voluntary collection through collection boxes at hospitals or health centres or through community collections by panchayats , municipalities etc... All these methods are used in different countries to enhance health sector finances. Many more methods appropriate to the local situation can be evolved for raising resources. The effort should be directed at assuring that at least 50% of the families are covered under some statutory contribution scheme.

The issues raised above to bring about policy reform are by no means exhaustive. There are many other substantive issues in the health sector which need policy intervention for change. Any health policy must necessarily look at such issues if they are serious about making structural changes in the health sector.

Finally, we would like to place the above discussion in a global perspective. Way back in the 19th century public health expert Henri Sigerist had said "*Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade - it becomes a public function of the State*" and since then most of Europe and many other countries have made this a reality. And today when such demands are raised in third world countries, India being one of them, it is said that this is no longer possible - the welfare state must wither away and make way for global capital! Europe is also facing pressures to retract the socialist measures which working class struggles had gained since 19th century. So we are in a hostile era of global capital which wants to make profit out of anything it can lay its hands on. But we are also in an era

when social and economic rights, apart from the political rights, are increasingly on the international agenda and an important cause for advocacy.

Thus health and health care is now being viewed within the rights perspective and this is reflected in Article 12 "**The right to the highest attainable standard of health**" of the International Covenant on Economic, Social and Cultural Rights. This requires *availability, accessibility, affordability, and quality* with regard to both health care and underlying preconditions of health.

"*Availability* refers to the existence of health facilities, goods and services to meet the basic health needs of the people, including, *inter alia*, hospitals and clinics, trained medical personnel, essential drugs and so forth. *Accessibility* means that health facilities, services and goods must be within physical reach for all parts of the population (*without any discrimination or conditionality*). *Affordability* requires that health facilities, services and goods be affordable for all. (*That is there should be no constraints in the form of payments for seeking health care*.) *Quality* means that health facilities, services and goods must be scientifically and culturally appropriate. This requires, *inter alia*, skilled medical personnel, scientifically approved drugs and hospital equipment, clean water and adequate sanitation, sufficient information on environmental hazards and health risks. Cultural appropriateness signifies that health policies must be at once respectful of the people's culture and aimed at improving people's health status." (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000; *italicised text in parentheses added by author*).

It is in this perspective that the present paper is located and hopes to set the agenda for priorities in health and health care. The Central government in India is presently in the process of formulating a new health policy and we hope that issues raised here contribute to that process. Similarly some state governments have shown keenness recently to formulate health policies or atleast debate and discuss these, though not with the same enthusiasm of formulating Population Policies. Also the Planning Commission is supporting state governments to formulate Human Development Reports and in the next one year we should be seeing almost all states coming out with such reports in which discussion on health and related issues will be one of the core themes and we should be able to see innovative state specific strategies emerge as envisaged by the 9th Five Year Plan.

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2. Homoeopathic Enquiry Committee, 1949, MoHFW, GOI, New Delhi: Suggested establishment of Central Council of Homoeopathic Medicine and standardisation of homoeopathic education and equipment
3. Dasgupta Committee – Environmental Hygiene Committee 1949, MoHFW, GOI, New Delhi: Looked into housing, water supply, general sanitation, conservancy and drainage systems, waste disposal, vector control etc..
4. Pandit Committee – Committee on Indigenous Systems, 1951, MoHFW, GOI, New Delhi: This was to follow up on the Chopra Committee and it advised against integration of modern and indigenous medicine for teaching or otherwise and it was instrumental in setting up the Jamnagar based Central Research Institute in Indigenous Systems of Medicine.
5. The Pharmaceutical Enquiry Committee, 1954, Min of Commerce and Industry< GOI, New Delhi: This looked into business practices of the pharmaceutical industry and recommended that drug production must be done from basic chemical stage so that foreign dependence is reduced and suggested the need for an essential drug list.
6. Model Public Health Act Committee, 1955, MoHFW, GOI, New Delhi: Bringing together all health legislation and rationalising them
7. Committee on Social and Moral Hygiene, 1956, Central Social Welfare Board, GOI, Ne Delhi: Looked into the problem of immoral traffic in women and children and suggested progressive sex education, a national plan to deal with venereal diseases and strengthening of the family planning program.
8. Committee to study the formulation of uniform standards in respect of education and regulation of practice of vaidyas, hakims and homoeopaths, 1956, MoHFW, GOI, New Delhi: Standardised degree courses at 5 ½ years, including internship and compilation of pharmacopaeia and dictionary.
9. Dave Committee – Committee to study and report on standards for education and regulation of practice of indigenous systems of medicine, 1956, MoHFW, GOI, New Delhi: Defined admission criteria and registration of practitioners both institutionally qualified and traditional.
10. Udupa Committee – Committee to assess and evaluate present status of Ayurvedic medicine, 1960, MoHFW, GOI, New Delhi: Emphasised on shudh ayurveda, need for standardization of pharmaceutical products, and suggested investigation into secret remedies and to make ayurveda system open and modern.
11. Manickavaley Committee – Committee to study and report on pattern of statistical units for Health Departments, 1960, MoHFW, GOI, New Delhi: Setting up of reporting and registration agencies for vital and health statistics at all levels
12. Renuka Roy Committee – School Health Committee, 1960, MoHFW, GOI, New Delhi: Promotion of preventive care through schools, provision for school meals, health education as part of school curricular, and integration of school health through the primary health care network.
13. Ayyar Committee – Hospital Equipment Standardisation Committee, 1964, DGHS, GOI, New Delhi: Worked out standards for hospital furniture, medical equipment and staff pattern for different levels of hospitals.
14. Shah Committee – Committee to study the legalisation of abortion, 1966, MoHFW, GOI, New Delhi: Estimated abortions @ 13 per 1000 population, found the provision under IPC very restrictive and recommended liberalization of abortion

15. Jungalwalla Committee – Committee on Integration of Health Services, 1967, DGHS, GOI, New Delhi: Integration of all different programs of the Health department and consolidation of a single cadre of doctors
 16. Medical Education Committee, 1969, MoHFW, GOI, New Delhi: standardization of medical admissions criteria, discontinuation of licentiate course, continuation of reservations, and making PSM an integral part of medical education.
 17. Small Family Norm Committee, 1978, MoHFW, GOI, New Delhi: This committee made recommendations to restrict benefits if a couple had more than three children, like maternity benefits, bonus to women employees, compensation for IUD and sterilization to continue, special health and welfare benefits for those accepting sterilization, liberalization of abortion, income tax benefits for those with small families etc..
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