

HEALTH PLANNING IN INDIA

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Introduction

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 and 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 of the Central government. 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, MCH and Family Planning, which together account for between half and two-thirds 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.

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.

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).

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.

While planning contributed substantially in the development of the economic infrastructure, 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 techno-centric 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. Thus 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. In spite 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 manpower 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 manpower 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 PHCs 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 envisaged 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). In spite 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, were the tasks enlisted in the 1983 NHP 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. Annexe 1 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 a few 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 management 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 began working on a new Health Policy document. A draft version which came out in June 1999 was found wanting and was revised and released for public debate in September 2001.

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.

The 9th Plan period is coming to a close 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.

On the eve of the 10th Plan, the **draft National Health Policy 2001** has been announced and for the first time feedback invited from the public. "Universal, comprehensive, primary health care services", the NHP 1983 goal, is not even mentioned in the NHP 2001 but the latter bravely acknowledges that the public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continues to be unacceptably high, and resource allocations generally insufficient - *"It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services."*(para 2.4.1 NHP 2001).

The draft NHP 2001 needs to be lauded for its concern for regulating the private health sector through statutory licensing and monitoring of minimum standards by creating a regulatory mechanism. This has been an important struggle of health researchers and activists to build accountability within the private health sector and it is hoped the new policy addresses this issue rigorously. Also the express concern for improving health statistics, including national accounts, is welcome. A mechanism of assuring statutory reporting not only by the public system but also the private sector is an urgent requirement so that health information systems provide complete and meaningful data.

The main **objective** of NHP 2001 is to achieve an acceptable standard of good health amongst the general population of the country (para 3.1). The goals given in Box IV of the policy document are laudable but how their achievement in the specified time frame will happen has not been supported adequately in the policy document. For instance, goal number 10 " Increase utilization of public health facilities from current level of <20 to >75%" is indeed remarkable. What it means is reversal of existing utilization patterns which favour the private sector. While we support this goal to the hilt we are worried that many prescriptions of the policy favour strengthening of the private health sector and hence is contrary to this goal. In sum the draft NHP 2001 is a mere collection of unconnected

statements, is a dilution of the role of public health services envisaged in the earlier policy and is unabashedly promoting the private health sector. We hope that the feedback solicited by the Ministry of Health on this policy is taken seriously and adequate political backing for genuine reforms within the health sector which strengthen the public health system takes place.

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 and planning. 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, 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 alone but it is also a question of structural changes in the political economy that can facilitate implementation of progressive health policies.

Annexe 1: HEALTH INFRASTRUCTURE DEVELOPMENT IN INDIA 1951-2000

			1951	1961	1971	1981	1991	1995	1996	1997	1998	2000
1	Hospitals	Total	2694	3054	3862	6805	11174	15097	15170	15188		17000
		% Rural	39	34	32	27		31	34	34		
		%Private				43	57	68	68	68		
2	Hospital & dispensary beds	Total	117000	229634	348655	504538	806409	849431	892738	896767		950000
		% Rural	23	22	21	17		20	23	23		
		%Private				28	32	36	37	37		
3	Dispensaries	Total	6600	9406	12180	16745	27431	28225	25653	25670		
		% Rural	79	80	78	69		43	41	40		
		% Private				13	60	61	57	56		
4	PHCs	Total	725	2695	5131	5568	22243	21693	21917	22446	23179	24000
5	Sub-centres	Total			27929	51192	131098	131900	134931	136379	137006	140000
6	Doctors	Allopaths	60840	83070	153000	266140	395600	459670	475780	492634	503947	530000
		All Systems	156000	184606	450000	665340	920000			1080173	113347	1211124
7	Nurses	Total	16550	35584	80620	150399	311235	562966	565700	607376		
8	Medical colleges	Allopathy	30	60	98	111	128		165	165	165	
9	Out turn	Grads	1600	3400	10400	12170	13934	*	*	*	*	
		P. Grads		397	1396	3833	3139			3656		
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	79.4	91.3	104.9	120.7	165.0
11	Health outcomes	IMR/000	134	146	138	110	80	74/69	72	71	72	70
		CBR/000	41.7	41.2	37.2	33.9	29.5	29	27	27	27	26
		CDR/000	22.8	19	15	12.5	9.8	10	9	8.9	9	8.7
	Life Expectancy	years	32.08	41.22	45.55	54.4	59.4	62	62.4	63.5	64	65
	Births attended by trained practitioners	Percent				18.5	21.9		28.5		42.3	
12	Health Expenditure	Public	0.22	1.08	3.35	12.86	50.78	82.17	101.65	113.13	126.27	178.00
	Rs. Billion	Private@	1.05	3.04	8.15	43.82	173.60	233.47	329.00	399.84	459.00	833.00
		CSO estimate pvt.		2.05	6.18	29.70	82.61	279.00	329.00	373.00		

@ 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

*Data available is grossly under-reported, hence not included

Notes: The data on hospitals, dispensaries and beds are underestimates, especially for the private sector because of under-reporting. Rounded figures for year 2000 are rough estimates.

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. Finance Accounts of Central and State Governments, various years

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

6. Statistical Abstract of India, GOI, various years

7. Sample Registration System - Statistical Reports, various years

8. NFHS - 2, India Report, IIPS, 2000

References:

- Banerjee, D, 1973: Population Planning in India – National and Foreign Priorities, CSMCH, JNU, New Delhi
- Batliwala, Srilatha, 1978: The Historical Development of Health Services in India, FRCH, Bombay
- Bhore, Joseph, 1946 : Report of the Health Survey and Development Committee, Volume I to IV, Govt. of India, Delhi
- Chadha Committee, 1963: Special Committee for NMEP Maintenance Phase, MoHFW, GOI, New Delhi
- Duggal, Ravi and S Amin, 1989 : Cost of Health Care, Foundation for Research in Community Health, Bombay
- Expert Committee on Public Health Systems, 1993, MoHFW, GOI, New Delhi
- FYP I – IX, various years: Five Year Plans – First to Ninth, Planning Commission, GOI, New Delhi
- George, Alex et.al., 1992 : Household Health Expenditure in Madhya Pradesh, FRCH, Bombay
- Ghosh, Basu, 1991 : Time Utilisation and Productivity of Health Manpower, IIM, Bangalore
- Gupta, JP and YP Gupta, 1986 : Study of Systematic Analysis and Functioning of Health Teams at District and Block Levels, NIHFW, New Delhi
- ICMR, 1989 : Utilisation of Health and FP services in Bihar, Gujarat and Kerala, Indian Council of Medical Research, New Delhi
- ICMR, 1990 : Evaluation of Quality of Family Welfare Services at Primary Health Centre Level, ICMR, New Delhi
- IIM(A), 1985 : Study of Facility Utilisation and Program Management in Family Welfare in UP, MP, Bihar (3 Vols.), Public System Group, Indian Institute of Management, Ahmedabad
- Jain Committee, 1967: Report of the Study Group on Medical Care Services, MoHFW, New Delhi
- Jesani, Amar and S Ananthram, 1993 : Private Sector and Privatisation in Health Care Services, FRCH, Bombay
- Jesani, Amar et.al., 1992 : Study of Auxiliary Midwives in Maharashtra, FRCH, Bombay
- Kannan KP et.al., 1991 : Health and Development in Rural Kerala, Kerala Shashtra Sahitya Parishad, Trivandrum
- Karan Singh, 1976: National Population Policy, NIHA Bull, IX,2, 155-160
- Kartar Singh Committee, 1973: Committee on Multipurpose Worker under Health and Family Planning, MoHFW, New Delhi
- MoHFW, 1983 : National Health Policy, Govt. of India, Ministry of Health & Family Welfare, New Delhi
- MoHFW, 2001: Draft National Health Policy, Ministry of Health and Family Welfare, New Delhi
- Mudaliar Committee, 1961: Health Survey and Planning Committee, MoHFW, New Delhi
- Mukherjee Committee, 1966: Committee to Review Staffing Pattern and Financial Provision under Family Planning Programme, MoHFW, New Delhi
- Navarro, Vicente : 'Introduction' in V. Navarro (ed) Imperialism, Health and Medicine, Baywood, New York, 1981
- NCAER, 1991 : Household Survey of Medical Care, National Council for Applied Economic Research, New Delhi
- NCAER, 1992 : Rural Household Health Care Needs and Availability, NCAER, New Delhi
- NIRD, 1989 : Health Care Delivery system in Rural Areas - A Study of MPW Scheme, National Institute of Rural Development, Hyderabad
- NPC : National Health sub-committee (Sokhey Committee) ed. K.T. Shah, National Planning Committee, Vora & Co., Bombay, 1948.
- NSS-1987 : Morbidity and Utilisation of Medical Services, 42nd Round, Report No. 384, National Sample Survey Organisation, New Delhi
- NSS-1996 : Report No. 441, 52nd Round, NSSO, New Delhi

NTI, 1988 : Report of the Baseline Survey Danida Health Care Project 2 Vols., NTI, Bangalore
Shrivastava Committee, 1975: Report of the Group on Medical Education and Support
Manpower, MoHFW, New Delhi
Simon Committee, 1960: National Water Supply and Sanitation Committee, GOI, New
Delhi
