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HEALTH OF THE PEOPLE: AS PERCEIVED BY POLICIES IN INDIA

The people's health has always been a concern of democratic governments and especially in India. The various Government Committees it has formed over the years to look at challenges in the health sector and to give recommendations for overcoming shortcomings and the programmes and policies adopted through its Five-Year Plans give us a picture of the efforts taken by India in the development of health of its citizens. Instead of all these efforts and consistent improvements achieved, the health status in India is still much below the international standards. As per the WHO (1948) definition, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." India however, is still lagging behind in accepting this definition in the full since there is a lot of discrepancies involved in the development of its health sector. Health is also a tied to the level of social and economic development in the country. India has States with high health status such as Kerala which is comparable with highly developed countries such as United Kingdom. It also has States such as Utter Pradesh and Bihar which lag behind even the less developed countries such as Bangladesh in health status. While India has got well-developed health facilities in its metropolitan centres, its small towns and rural areas sometimes do not even have basic health infrastructure. A high income class receives all the modern facilities of medical science, while a considerable number of Indians of destitute Indians live Below the Poverty Line (BPL) due to medical expenses. There is All of these realities cannot be blamed on government policies in the health sector alone but rather relate to the overall development policies of the concerned state governments through the years.

Under the Indian Constitution, only civil and political rights are

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justiciable; social and economic rights like health, education, and livelihood are under the Directive Principles of State Policy and are not justiciable. Under the Directive Principles of State Policy[1], Articles 38[2], 39 and 47 dealt with the duty of the State to provide better health to its citizens. The Indian Constitution makes a forceful appeal to the States to pave attention to the health of the people through Directive Principles of State Policy but also clearly mentions that no court can enforce them. The Constitution has made healthcare services largely the responsibility of the State Governments but left enough maneuverability for the Centre since large numbers of items are listed also in the concurrent list[3]. Even though, the States have a major role in developing the health status of people, policies in States subjects such as health and education are closely bound to Central policies and the States have to follow the Centre in the overall direction of the policy.

The following section on the state's Five-Year Plans and the various government committees, plans and policies in the health sector will provide a background to help understand the health sector in India.

Health Sector Policies in India

India witnessed the emergence of various committees constituted by the Central Government to outline the shortages of health sector and to suggest recommendations for the development of the health sector in the country. The Bhore Committee[4] was constituted in 1943 before Independence and so its main objective was to make a survey on the existing health conditions and make recommendations for future development. The Report highlighted the ground realities such as that life expectancy was as low as 27 years (1927-30 period) and infant mortality rate was 162 per thousand live births (1937), maternal mortality rate was 20 per 1000 live births. Nearly half of the numbers of deaths were among children under 10 years of age. Further, food consumption was insufficient and ill-balanced. The curative side of public health was as dismal with only one doctor for 63,000 people, one nurse for 43,000, one midwife for 60,000 and 0.24 beds per 1000 persons.

The first two Five-Year Plans (1951-1961) made their allocations to implement the Bhore Committee recommendations especially related to building up a primary base for health services in the country. In order to prevent diseases relating to nutrition deficiency, school feeding programmes were recommended. Malaria and tuberculosis received prime importance in the control of diseases programmes[5]. The Central Government constituted the Mudaliar Committee[6] in June 1959 to review the First and Second Five-Year Plan health projects. By the end of the Second Plan[7], the number of primary health units increased to 2,800 as

against 725 units during the First Plan period. Also, there was 4,500 maternity and child welfare centres across the country during this period.

The malaria eradication programme reached its maturity in India after 1960 and the Chadha Committee of 1962 was constituted to evaluate the malaria eradication programme. This Committee recommended that basic health workers would function as multipurpose workers, in addition to malaria work, to carry out the duties of family planning and collating vital statistics.

Family Planning Programmes following a clinical approach in their initial phase. When the 1962 census showed a continuous rise in population growth, the Central Government decided to adopt a demographic goal to reach a crude birth rate of 25 by the year 1972. Low-intensity family planning programmes offered since 1952 were later converted into a high-intensity approach. In 1965, the Mukherjee Committee[8] was formed to review the performance of Family Planning Programmes and a separate Department for Family Planning was constituted at the centre during 1966.

The States however, found it difficult to undertake multiple activities such as family planning, malaria eradication programmes etc., effectively due to shortage of staff and funds. To review the staffing pattern of primary health centres and Central assistance of funds to States, Government of India constituted a Committee in 1966 under the Chairmanship of Secretary, Health (Shri Mukherjee)[9]. This Committee recommended a separate staff for family planning programmes and urged the Centre to provide 50% expenditure of the additional staff for a period of ten years. Subsequently, health sector staff became overloaded with programmes of disease prevention and family planning apart from meeting healthcare needs. The Kartar Singh Committee in 1973 was constituted to tackle this issue of integrating health and medical services at the periphery and supervisory level. The Hathi Committee[10] in 1975 addressed the issue of rising drug prices and dependence on multinational corporations for drug availability. The 1978 Drug Policy was based on its recommendations to ensure self-reliance in India in the pharmaceutical industry with public sector dominance.

The importance of primary healthcare to the rural population was again recognized during the 1974-79 period with the minimum needs programme (MNP). The Central Government also addressed the issue of medical education needing to adapt to be able to meet the changing requirements of rural areas and formed a Group on Medical Education and Support Manpower in 1974 under the Chairmanship of Dr. J. B. Shrivastav. In order to achieve universal commitment to Alma Ata Declaration[11], a Working Group on Health for All by 2000 A.D[12] was set up in 1981. Following this, India came out with its first National Policy on Health in 1983[13].

Decentralised primary health system, private medical practitioners and increased involvement by non-governmental organisations were considered ways to achieve universal healthcare by the year 2000. To achieve 'Health for All (HFA)', the Eighth Five-Year Plan[14] (1992-97) emphasized a community-based system covering about 30,000 people as the basic unit of the primary healthcare system. But in accordance with the new policy of Government, private initiatives were supported and the Drug Policy of 1986 also, advocated less government controls and a market-based pricing.

In 1995, the Central Government constituted an Expert Committee on Public Health System[15] to review the public health system in the country with a major emphasis on epidemic surveillance and health management information systems. A National Health Policy was formulated during the year 2002 that highlighted 14 goals to be achieved within the timeframe and welcomed private participation in all areas of health activities. Other major committees in this period include the Mashelkar Committee in Drug Regulatory Issues, 2003 and the National Commission on Macro Economics and Health, 2005.

The National Rural Health Mission (NRHM) (2005-12)[16] formulated during the Tenth Plan period was promoted as a tool to provide effective healthcare to rural population. Greater involvement of local governments and creation of more auxiliary health workers such as Accredited Social Health Activist (ASHA) to act as an interface between community and public health system especially to women and child health were important facets of the programme. Apart from the NRHM, the Eleventh Five-Year Plan (2007-12) stressed the need for strengthening health sector infrastructure through public-private partnerships (PPPs).

A wider view of the financial commitment of Central Government towards health sector can be is shown in Table 1 below. From the 1950s to 2007 Five-Year Plans period, the percentage of total health sector outlay in the total planned investment in the country was almost stagnant or even fell during some Plan years. Moreover, there was a decreasing trend in the central allocations under the head 'Health' as percentage of total planned investment. However, in the case of 'Family Welfare', its share increased, from a mere 0.005% of total planned outlay in the first Five-Year Plan to 1.83% in the Tenth Five-Year Plan. Moreover, the ratio of Family Welfare to Health has increased from a mere 0.15% in the First Plan to 87% in the Tenth Plan. This shows a bias of the Central Government towards vertical programmes.

Table No.1: Five-Year Plan Outlays showing the Pattern of Central Allocation in India (In Billion US$).

SL. No.		Total Planned Investment in the country	Health	Family Welfare	AYUSH	Total Health Sector
1.	1st Plan (1951-56)	411.76	13.70 (3.3)	0.02 (0.005)	-	13.72 (3.3)
2.	4th Plan (1969-74)	2103.84	44.73 (2.1)	37.07 (1.8)	-	81.80 (3.9)
3.	6th Plan (1980-85)	13834.39	256.35 (1.9)	175.57 (1.3)	-	431.92 (3.1)
4.	8th Plan (1992-97)	16760.62	289.35 (1.7)	250.97 (1.5)	4.17 (0.02)	544.49 (3.2)
5.	10th Plan (2002-07)	30537.68	638.28 (2.1)	558.13 (1.8)	15.95 (0.1)	1212.35 (4)

Figures in brackets indicates percentage to total Plan Outlay.
Source: Ministry of Health and Family Welfare, Gov. of India, *National Health Profile*, 2008.

The efficacy of these Central Government programmes for providing a better health status needs to be examined by looking into the actual health situation prevailing in the country. The following section will provide a brief analysis of prevailing health status and related variables.

Health Status

As seen from Table 2 of the National Family Health Survey (NFHS) results, there was considerable improvement in the health status for selected indicators such as total fertility rate (TFR), child delivery under medical facility, child mortality rates and vaccination coverage for children.

Though considerable improvements have taken place, India is still lagging behind its international commitment towards achieving the Millennium Development Goals (MDGs)[17]. India has committed to 12 of the 18 MDG-targets relevant to it and out of this, 4 targets are directly related to health viz., to reduce the under five mortality rate by two-thirds between 1990 and 2015, to reduce the maternal mortality ratio by three quarters between 1990 and 2015, to halt HIV/AIDS by 2015 and to halt malaria and other major diseases by 2015 and reverse their incidence. Moreover, globally, India's rank in the Human Development Index 2009 is quite low – 134 out of 182 countries.

Table No. 2: National Family Health Survey (NFHS) Findings.

	TFR	Delivery Under medical facility	Child Mortality Rates		Vaccination coverage	
			Infant Mortality Rates	Under-5 mortality Rates	Polio3 Vaccination	Meas les
NFHS I (92-93)	3.4	26	79	109	54	42
NFHS II (98-99)	2.9	34	68	95	63	51
NFHS III (05-06)	2.7	41	57	74	78	59

Source: Ministry of Health and Family Welfare, Gov. of India, "NFHS 3 Key Findings," 2007.

Table No.3: Health Indicators of Selected Countries.

	TFR 2009	% of Births with skilled attendants	Under-5 Mortality M/F Est. 2005-10	Infant Mortality Ratio	Maternal Mortality ratio	GNI Percapita PPP$ (2007)	Health Expenditures, Public (% of GDP)
India	2.7	47	77/86	53	450	2740	0.9
China	1.8	98	25/35	22	45	5420	1.9
Japan	1.3	100	5/4	3	6	34750	6.6
Indonesia	2.1	73	37/27	25	420	3570	1.3
Malaysia	2.5	100	12/10	9	62	13230	1.9
Vietnam	2	88	27/20	19	150	2530	2.1
Bangladesh	2.3	18	58/56	42	570	1330	1
Sri Lanka	2.3	99	21/18	15	58	4200	2
Asia	2.3	65	56/61	40	330	NA	NA

Source: UNFPA, *The State of World Population*, 2009.

The overall health status of India for the selected health indicators is much lower than many Southeast Asian countries and even than less developed countries in Asia. Total fertility rate was highest for India at 2.7 percent and only 47 percent of births taking place in India are attended by skilled assistants, while it was 98 and 99 percent for China and Sri Lanka respectively. Due to this, maternal mortality ratio in India was as huge as

450 per 100,000 live births, while it was only 58 for Sri Lanka. Also, Under-5 mortality rate and infant mortality rates were much higher at 77 and 53 deaths per 1,000 live births respectively, while, it was just 5 and 3 deaths respectively for Japan.

Besides all these statistics, the public health expenditures as percentage of GDP was also the lowest in India at only 0.9 percent of GDP. Above all, poverty aggravates conditions in India as the GNI per capita was only US$2,740 in 2007, while it was US$4,200 for Sri Lanka and US$34,750 for Japan.

Table No.4: Healthcare Expenditure of Selected Countries.

	Government Expenditure as % of total expenditure on health	Out-of pocket expenditure as % of total health expenditure	Others*
India	26.2	66.3462	7.4538
Bangladesh	33.3	64.9658	1.7342
Vietnam	39.3	54.7514	5.9486
China	44.7	50.876	4.424
Malaysia	44.4	40.6992	14.9008
Sri Lanka	47.5	45.5175	6.9825
Indonesia	54.5	30.121	15.379
Japan	81.3	15.1096	3.5904
South-East Asia	36.9	54.8339	8.2661

* Others include NGOs, charities, insurance companies, etc.
Source: WHO, *World Health statistics*, 2010.

Table 4 provides a detailed analysis of healthcare expenditure of several countries compared to that in India. The Government of India's expenditure on health as a percentage of total expenditure is only 26.2%, about 66% of health expenditure is borne by the patients themselves and a meager of 7% is borne by NGOs, insurance companies, and so on. The government expenditure is much lower even compared to the less developed countries, whereas, the Japan government spends 81.3% of total health expenditure. This low level of public health expenditure is a major concern in a country like India which has one of the lowest per capita GDPs in the world.

Table No.5: Health Indicators of Selected States in India.

	Child Mortality Rates		Mal Nutrition among children	Vaccination among children (12-23 months)	Prevalence of anaemia among women (15-49 years)	Maternal Care (percentage of deliveries assisted by health personnel*)	Per capita Net State Domestic Product (at current prices 2005-06) (US$) +
	Infant Mortality Rates	Under-5 mortality Rates	Weight for age (% below -2 SD)	All basic vaccinations #	Mild anaemia (10.0-11.9 g/dl)		
India	57	74.3	42.5	43.5	38.6	46.6	587.4
Central & Eastern States	65.2	87.1	48.8	42.2	43.8	35.7	376.0
Southern States	35.6	42.4	30.7	64.3	34.2	83.7	670.4
Bihar	61.7	84.8	55.9	32.8	50.5	29.3	177.8
Madhya Pradesh	69.5	94.2	60.0	40.3	40.8	32.7	349.8
Rajasthan	65.3	85.4	39.9	26.5	35.2	41	409.8
Uttar Pradesh	72.7	96.4	42.4	23.0	35.1	27.2	300.8
Kerala	15.3	16.3	22.9	75.3	25.8	99.4	733.0

* Doctor, nurse, midwife, lady health visitor, or other health personnel.
# BCG, measles, and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth).
+ 1US$ = 44.27 ROUPIES
Source: National Family Health Survey 2005-06.

Moreover, large scale discrepancies among health indicators arise within India and are clear from Table 5. Central and Eastern States averages for selected health indicators were much lower than the national averages, while, Southern States stood ahead of the national average. This is much clearer in child mortality rates, malnutrition rates and maternal care. The Under-5 mortality rates were as high as 96.4 per 1,000 live births in Bihar, while the national averages was 74.3 and 42.4 for Southern States, while, it was as low as 16.3 for Kerala. Malnutrition rates among children were as high as 60% for Madhya Pradesh, 56% for Bihar, while it was 23% in Kerala. About 51% of women are anaemic in Bihar with a national average of 39%, while Kerala had a low figure of 26% anaemic women. Maternal care as measured by percentage of deliveries attended by health personnel was as high as 99% in Kerala and 84% in the Southern States as a whole, while, it was only 36% for the Central and Eastern States and a low 27% in Uttar Pradesh. The differences can also be viewed in the per capita net state domestic product (SDP) for the entire country. The per capita net SDP for the year 2005-06 was US$ 733 for Kerala and US$ 670.4 for the Southern States as a whole, while it was only US$ 376 for Central and

Eastern States which was much below the national average of US$ 587.4.

Moreover, there exists a high rural-urban disparity in health indicators in India. This is evident from the MDG India Report 2009[18], where a 22 point rural-urban gap was found for infant mortality rates (IMR), i.e, 58 per 1000 live births for rural and 36 for urban. In 2007, there were 10 States which had more than a 20 point difference between rural and urban incidence of infant mortality deaths The rural-urban gap in delivery attended by skilled persons in 2005-06 was as high as 36 percentage points, or in other words, about 75.2% of deliveries in urban areas were attended by skilled personnel, while only 39.1% women got this facility for rural areas.

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More than 60 years after Independence, even as India's health status has considerably improved, various conditions of ill-health that obtained at the time of Independence still prevail in the country. Though the rural population consists of 74% of India's total, they had had only 19 beds per 100,000 population as on 1993, while the urban population, had 218 beds per 100,000 population for the same year. Though there has been considerable progress achieved in rural infrastructure over the years, India's rural areas lacked 20,486 sub-centres, 4,477 primary health centres, and 2,337 community health centres as of March 2008[19].

One of the reasons for the poor state of affairs in India is the undermining or the diluting of the role of primary health centres (PHCs) in the country, which were meant to be the veins of healthcare system. PHCs were meant to provide a network of healthcare especially to the rural population by which they are connected to the mainstream health system prevailing in the country. According to the Bhore Committee long-term programme (three million Plan)[20], a primary health unit with 75 beds for each 10,000 to 20,0000 population had to be setup by the Government in order to provide preventive and curative health with maximum results. However, the Indian Public Health Standards (IPHS)[21] has adopted a norm of primary health centres covering 20,000 to 30,000 people with only 6 beds. Even with this minimal standard, there is a shortfall of 713 PHCs in Bihar, 515 in Madhya Pradesh, 700 in Uttar Pradesh and 4,504 nationally as of March 2009. Since the Third Five-Year Plan, the Centre had lost its vision on 'healthcare delivery' as achieved in the early post-Independence period by converting PHCs into programme implementation centres of centrally-sponsored schemes such as family planning programmes and controlling communicable diseases. A stable and sustainable primary health system to integrate rural India with provisions of 'healthcare services' according to local needs, was undermined. The Centre was reluctant to look at regional needs. Implementation of programmes was mostly funded by international agencies. It took some 36 years after

Independence to finally frame a National Policy on health in 1983, and that too under compulsion from India's commitment to the Alma Ata declaration. By that time, the policy environment in the country had begun to change – the Central Government was getting ready to liberalize different sectors and slowly withdrawing from its social sector commitments in the name of funding limitations. The new liberal policy has tended to decrease the public expenditure on health. While this was matched with growing support and providing subsidies to the private sector to initiate private-public partnerships, private participation was mostly urban and profit-oriented. Costs of outpatient as well as inpatient care increased considerably and medical expenses became one of the major reasons leading to indebtedness. Moreover, there exist no regulatory bodies to control the pricing mechanism in the private hospital field. The number of essential drugs[22] under price control has reduced from 347 in 1979 to merely 25 in 2002. Drug prices became market determined. This is the case for a country were more than 37 percent of population living below poverty line and 66 percent of expenditure are borne from their own pockets. Health insurance cannot be considered as a remedy due to its ever increasing costs.

As committees have highlighted, the reluctance of doctors to work in rural areas and shifting of doctors to private sector because of monetary benefits further aggravated the problem in rural areas. Creation of community workforces such as the Accredited Social Health Activist (ASHA) through NRHM cannot be treated as a permanent solution for rural healthcare. As D. Banerjee[23] had written, "NRHM is a simplistic approach to a complex problem. Government has refused to learn from the experiences from the past the devastating impact on the painstakingly built rural health services of the imposition of the ill-conceived, ill-formulated, techno-centric vertical programmes."

There exist no shortcuts to achieving a sustainable and better healthcare status in India, but to increase government initiatives in strengthening rural health centres with the prime objective of 'delivery of healthcare' rather than just programme implementation centres. Only then can a real democratic state as defined by Abraham Lincoln – 'government of the people, by the people and for the people' – be achieved in India. India will not rise if it its public health system will not rise with its economy.

Notes :

[1] M. Desai and D. Chand, "Fundamental Right to Health and Public Health Care," in M.Desai and K.B.Mahabal (eds.), *Health Care Case Law in India: A Reader* (New Delhi: CEHAT and ICHRL, 2007), pp. 17-35.

[2] Article 38 of the Indian Constitution urges the State to secure a social order for the promotion of welfare of people. Article 39 contains certain principles to be followed by the State for securing health and strength of the workers, men and women and more specifically to protect the freedom and dignity of childhood and youth. Article 47 reads, "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health."

[3] According to the Constitution, all activities engaged in by the governments are categorized as falling in the Central List, States List and Concurrent List. Activities that fall under the Concurrent List are mostly subject to over-lapping jurisdiction between the Central Government of India and the State Governments.

[4] Ministry of Health and Family Welfare, Government of India, *Report of the Health Survey and Development Committee Survey*, 1946.

[5] Planning Commission, Government of India, "Chapter 32: Health," *First Five Year Plan Document*, pp. 1-12.

[6] Ministry of Health and Family Welfare, Government of India, *Report of the Health Survey and Planning Committee*, 1961.

[7] Planning Commission, Government of India, "Chapter 32: Health," *Third Five Year Plan Document*, pp.6-7.

[8] Ministry of Health and Family Welfare, Government of India, *Report of the Committee Appointed to Review Staffing Pattern and Financial Provision under Family Planning Programme*,1966.

[9] Ministry of Health and Family Welfare, Government of India, *Mukherjee Committee Report: Part II*, 1968.

[10] A. SenGupta, Reji K Joseph, S Modi & N Syam (2008), "Economic Constraints to Access to Essential Medicines in India," Society for Economic and Social Studies & Centre for Trade and Development, New Delhi, pp. 19-21.

[11] The Alma Ata Declaration was adopted at the International Conference on Primary Health Care, Alma Ata (in the former USSR) in September 1978 expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.

[12] Ministry of Health and Family Welfare, Government of India, *Report of the Working Group in 'Health for All by 2000 A.D*, 1981.

[13] Ministry of Health and Family Welfare, Government of India, *National Health Policy*, 1983.

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[17] Central Statistical Organisation, Ministry of Statistics and Programme Implementation, Government of India, "Millennium Development Goals - India Country Report 2009: Mid-term statistical Appraisal," 2009.
[18] Central Statistical Organisation, Ministry of Statistics and Programme Implementation, Government of India, "Millennium Development Goals- India Country Report 2009: Mid-term statistical Appraisal," 2009, pp. 52-53.
[19] Ministry of Health and Family Welfare, Government of India, "Bulletin on rural health statistics in India for the year 2008," p. 9.
[20] Manager of Publications, Delhi, Government of India Press, *Report of the Health Survey and Development Committee*, Volume II, Recommendations, 1946, p. 23.
[21] Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, "Indian Public Health Standards (IPHS) For Sub-Centres: Guidelines," March 2006.
[22] A. SenGupta, Reji K Joseph, S Modi & N Syam (2008), "Economic Constraints to Access to Essential Medicines in India," Society for Economic and Social Studies & Centre for Trade and Development, New Delhi, pp. 16.
[23] D.Banerji (2005)," Politics of rural health in India," International Journal of Health Service, Vol.35, No.4, pp. 783-796.