Chapter IV
Implementation of Right to Health: Role of Government

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4.1 Introduction

A policy is typically described as a deliberate plan of action to guide decisions and achieve rational outcome(s)[1]. It is a guide to action to change what would otherwise occur, a decision about amounts and allocations of resources: the overall amount is a statement of commitment to certain areas of concern[2].

In a welfare state like ours it is the duty of the Government not only to make legislations but to take effective steps so as to put into action the basic human right of health. These actions are the obligations of the government and should be more focused on the following aspects:

- Providing adequate health care, including health facilities, and those goods and services that are necessary for the treatment of illness and rehabilitation. Hence it also includes timely and appropriate health care together with essential elements such as hospitals; clinics and other health-related facilities; and essential medicines.
- Providing basic amenities which determines the health of the population that include safe and potable water; adequate sanitation; an adequate supply of safe food; adequate nutrition; adequate housing; health occupational and environmental conditions and education and information abort health, including sexual and reproductive health.
- Ensuring people's e participation in decision making that includes the design and implementation of policies that affect their health, at community, national and international levels.
- Providing adequate facilities concerning to maternal, child and reproductive health.

[1] en.wiktionary.org/wiki/policy
[2] jech.bmj.com/cgi/content/full/55/9/622

- Effective steps to be taken for the Prevention, treatment and control of diseases; and
- Ensuring all these obligations on the basis of non-discrimination in access to health care.

4.2 Reports of various Committees formed for public health

After Independence, India adopted the welfare state approach, which was dominant worldwide at that time. As with most post-colonial nations, India too attempted to restructure its patterns of investment. During that time, India's leaders envisaged a national health system in which the State would play a leading role in determining priorities and financing, and provide services to the population. Hence the government has from time to time set up number of committees to ensure public health. The recommendations given by the committees made to improve the public health system in India. The following are the major committees formed and established to look into the public health matter.

4.2.1 Bhore Committee[3]

The emphasis of the first health report, i.e. the Health Planning and Development Committee's Report, 1946 (popularly known as the Committee Report) on the role of the State was explicit. The committee submitted its report in the post war period. The committee recommended on several aspects for the improvement in the public health sphere. It was a plan equivalent to Britain's National Health Service. The Report was based on a countrywide survey in British India. It is the first organized set of health care data for India. The poor health status was attributed to the prevalence. It considered that the health programme in India should be developed on a foundation of preventive health work and proceed in the closest association with the administration of medical

[3] See Bhore Committee 1946, Report of the Health Survey and Development Committee, Vol 1, Survey Vol II, Recommendations, Vol III, GOI, Manager of Publication, New Delhi.

relief. The Committee strongly recommended that health services system should be based on the needs of the people, the majority of whom were deprived and poor. It felt the need for developing a strong basic health services structure at the primary level with referral linkages. It was decided that medical benefits would have to be supplied free to all at the point of delivery and those who could afford to pay should channel contributions through the mechanism of taxation. Though the report stated that '...it will be for the governments of the future to decide ultimately whether medical service should remain free to all classes of the people or whether an insurance scheme would be more in accordance with the economic, social and political requirements of the country at the time'. They recommended that State Governments should spend a minimum of 15% of their revenues on health activities.

One of the noteworthy recommendations of the Committee was to enact Public Health Act that aimed for the codification of all health laws, incorporate new provisions and make amendments under the legislations to meet the needs of the society, formulation of health care plans and the most important was to legalise the self-regulatory medical councils.

4.2.2 Sokhey Committee[4]

The National Planning Committee (NPC) set up by the Indian National Congress in 1938 under the chairmanship of Colonel S. Sokhey stated that the maintenance of the health of the people was the responsibility of the State, and the integration of preventive and curative functions in a single state agency was emphasized. The Sokhey Committee Report was not as detailed as the Bhore Committee Report but endorsed the recommendations of the Bhore Committee Report. It stressed on the need of better public health facilities.

[4] Sokhey Committee Report, 1948, Naitonal Health: Report of the Sub-Committee of the National Planning Committee.

4.2.3 Mudaliar Committee

The concern of the Health Survey and Planning Committee (Mudaliar Committee 1962) was limited to the development of the health services infrastructure and the health cadre at the primary level. It felt the growth of infrastructure needed radical transformation and further investment.

The committee also brought a detailed report on the status of health care in India. It also had a major task to follow up the recommendations of the Bhore Committee and make recommendations for further progress. It strongly recommended to implement a comprehensive Public Health Act and in furtherance to it drafted a Model Public Health Act. The recommendations of this committee were taken into consideration by the government in formulation of various public health policies[5].

4.2.4 Ajit Prasad Jain Committee

It undertook an in depth study on the conditions of hospitals in the public sector but failed to focus on the private hospitals. It laid down certain standards to improve the conditions only at the public sector.

Meanwhile the Chaddha Committee Report (1963), the Kartar Singh Committee Report on Multipurpose Workers (1974) and the Srivastava Committee Report on Medical Education and Support Manpower (1975) remained focused on giving recommendations on how the health cadres at the primary level should be distributed.

4.2.5 ICMR/ICSSR Committee[6]

The ICMR/ICSSR Report (1980) was in fact a move towards articulating a national health policy that was thought of as an important step to realize

[5] Mudaliar Committee Report 1961, Report of the Health Survey and Planning Committee, Vol I and II, Ministry of Health, Government of India, New Delhi.

[6] Indian Council of Social Science Research (ICSSR) and Indian Council of Medical Research (ICMR). Health for All: An alternative strategy. Report of a Study Group. New Delhi:Icssr; 1980

the Alma Ata Declaration. It was realized that one had to redefine and rearticulate and get back into track an integrated and comprehensive health system that policy-makers had wavered from. It reiterated the need to integrate the development of the health system with the overall plans of socioeconomic and political change. It recommended that the Government formulate a comprehensive national health policy dealing with all dimensions-environmental, nutritional, educational, socioeconomic, preventive and curative. The National Health Policy, 1983 attempted to incorporate all these. Provision of universal, comprehensive primary health services was its goal. A large number of private and voluntary organizations who were active across the country in the health field were to support the Government in its efforts to integrate health services. Evolving a decentralized system of health care and nationwide chain of epidemiological stations were some of the main recommendations.

4.2.6 Varadappan Committee[7]

The main concern of the committee was the nursing profession. It pointed out a major lacunae and that was the ineffectiveness of Nursing Council to stop unqualified non-registered nurses in private nursing homes from practicing or to deregister nurses who violate its code of guidelines.

4.3 Brief Overview of five years plan

A very brief overview of first five year plan (1951-56) to tenth five year plan (2002-2007)[8] in the public health sector is given herewith to know the gradual progress in the sphere of providing public health care. The objectives of the First (1951-56) and Second Five-Year (1956-61) Plans

[7] Varadappan Committee 1989, Report of the High Power Committee on Nursing and Nursing Profession, Ministry of Health and Family Welfare, New Delhi

[8] Planning commission of India, Government of India

were to develop the basic infrastructure and manpower visualized by the Bhore Committee[9]. Though health was seen as fundamental to national progress, less than 5% of the total revenue was invested in health. The following priorities formed the basis of the First Five-Year Plan: provision of water supply and sanitation; control of malaria; preventive health care of the rural population through health units and mobile units; health services for mothers and children; education, training and health education; self-sufficiency in drugs and equipment; family planning and population control. Starting from the first plan, vertical programmes started, which became the centre of focus. The Malaria Control Programme, which was made one of the principal programmes, apart from other programmes for the control of TB, filariasis, leprosy and venereal diseases, was launched. Health personnel were to take part in vertical programmes. However, the first plan itself failed to create an integrated system by introducing verticality. Another major shift came in the Third Plan (1961-66) when family planning received priority for the first time. Increase in the population became a major worry and was seen as a hurdle to the development process. Although the broad objective was to bring about progressive improvement in the health of the people by ensuring a certain minimum level of physical well being and to create conditions favourable for greater efficiency, there was a shift in focus from preventive health services to family planning. During the Fourth Plan (1969-74), efforts were made to provide an effective base for health services in rural areas by strengthening the PHCs. The vertical campaigns against communicable diseases were further intensified. During the Fifth Plan (1974-79), policy-makers suddenly realized that health had to be addressed alongside other development programmes. The Minimum Needs Programme (MNP) promised to address all this but became an instrument through which only health infrastructure in the

[9] See 4.2.1

rural areas was to be expanded and further strengthened. It called for integration of peripheral staff of vertical programmes but the population control programme got further impetus during the Emergency (1975-77) and most of the basic health workers got sucked into the family planning programme. The Sixth Plan (1980-84) was influenced by two policy documents: the Alma Ata Declaration and the ICMR/ICSSR report on 'Health for All by 2000'.The Seventh Plan (1985-90) restated that the rural health programme and the three-tier health services system need to be strengthened and that the government had to make up for the deficiencies in personnel, equipment and facilities. The Eighth Plan (1992-97) distinctly encouraged private initiatives, private hospitals, clinics and suitable returns from tax incentives. With the beginning of structural adjustment programmes and cuts in social sectors, excessive importance was given to vertical programmes such as those for the control of AIDS, tuberculosis, polio and malaria funded by multilateral agencies with specified objectives and conditions attached. Both the Ninth (1997-2002) and the Tenth Five-Year Plans (2002-2007) start with a dismal picture of the health services infrastructure and go on to say that it is important to invest more on building good primary-level care and referral services. Both the plans highlight the importance of the role of decentralization but do not state how this will be achieved.

4.4 Eleventh five year plan (2007-2012)

The eleventh five year plan in its health and family welfare plan recognizes health of a nation to be an essential component of development, vital to the nation's economic growth and internal stability. It further lays down that assuring a minimal level of health care to the population is a critical constitution of the development process. It vision for health lays down that it will provide an opportunity to restructure policies to achieve a New Vision based on faster, broad-based, and inclusive growth. One objective of the Eleventh Five Year Plan is to

achieve good health for people, especially the poor and the underprivileged. In order to do this, a comprehensive approach is needed that encompasses individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene, and feeding practices. The Plan will facilitate convergence and development of public health systems and services that are responsive to health needs and aspirations of people. Importance will be given to reducing disparities in health across regions and communities by ensuring access to affordable health care.

It is further reiterated in the eleventh plan that special attention will be given to the health of marginalized groups like adolescent girls, women of all ages, children below the age of three, older persons, disabled, and primitive tribal groups. It will view gender as the cross-cutting theme across all schemes.

In order to achieve these objectives, aggregate spending on health by the Centre and the States will be increased significantly to strengthen the capacity of the public health system to do a better job. The Plan will also ensure a large share of allocation for health programmes in critical areas such as HIV/AIDS. The contribution of the private sector in providing primary, secondary, and tertiary services will be enhanced through various measures including partnership with the government. Good governance, transparency, and accountability in the delivery of health services will be ensured through involvement of PRIs, community, and civil society groups. Health as a right for all citizens is the goal that the Plan will strive towards.

The following are the Time-Bound Goals for the Eleventh Five Year Plan

- Reducing Maternal Mortality Ratio (MMR) to 1 per 1000 live births.
- Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births.

• Reducing Total Fertility Rate (TFR) to 2.1.

• Providing clean drinking water for all by 2009 and ensuring no slip-backs.

• Reducing malnutrition among children of age group 0–3 to half its present level.

• Reducing anemia among women and girls by 50%.

• Raising the sex ratio for age group 0–6 to 935 by 2011–12 and 950 by 2016–17.

In order to find effective solutions the plan will aim for inclusive growth by introducing National Urban Health Mission (NUHM) which along with National Rural Health Mission, will form Sarva Swasthya Abhiyan.

The eleventh five year plan approach towards drinking water, sanitation and clean living conditions would deal with the problems of rural water supply, urban supply, rural sanitation and urban sanitation. The following strategies have been formed in order to achieve 100% coverage of clean water and sanitation in rural areas, rural sanitation programme will be linked with NRHM.

- Convergence of health care, hygiene, sanitation, and drinking water at the village level
- Participation of stakeholders at all levels, from planning, design and location to implementation and management of the projects
- Instituting water quality monitoring and surveillance systems by involving PRIs, community, NGOs, and other CSOs
- Increased attention to IEC campaign

Efforts will be made to launch a *Sarva Swasthya Abhiayan* in the country that will cover the primary health care, safe drinking water, and

sanitation in urban areas. Thrust areas to be pursued during the Eleventh Five Year Plan are summarized below:

- Improving Health Equity
  - NRHM
  - NUHM
- Adopting a system-centric approach rather than a disease-centric approach
  - Strengthening Health System through upgradation of infrastructure and PPP
  - Converging all programmes and not allowing vertical structures below district level under different programmes
- Increasing Survival
  - Reducing Maternal mortality and improving Child Sex ratio through Gender Responsive Health care
  - Reducing Infant and Child mortality through HBNC and IMNCI
- Taking full advantage of local enterprise for solving local health problems
  - Integrating AYUSH in Health System
  - Increasing the role of RMPs
  - Training the TBAs to make them SBAs
  - Propagating low cost and indigenous technology
- Preventing indebtedness due to expenditure on health/protecting the poor from health expenditures
  - Creating mechanisms for Health Insurance
  - Health Insurance for the unorganized sector
- Decentralizing Governance
  - Increasing the role of PRIs, NGOs, and civil society
  - Creating and empowering health committees at various levels
- Establishing e-Health
  - Adapting IT for governance
  - Establishing e-enabled HMIS

– Increasing role of telemedicine

• Improving access to and utilization of essential and quality health care

– Implementing flexible norms for health care facilities (based on population, distance, and terrain)

– Reducing travel time to two hours for EmOC

– Implementing IPHS for health care institutions at all levels

– Accrediting private health care facilities and providers

– Redeveloping hospitals/institutions

– Mirroring of centres of excellence like AIIMS

• Increasing focus on Health Human Resources

– Improving Medical, Paramedical, Nursing, and Dental education, and availability

– Reorienting AYUSH education and utilization

– Reintroducing licentiate course in medicine

– Making India a hub for health care and related tourism

• Focusing on excluded/neglected areas

– Taking care of the Older persons

– Reducing Disability and integrating disabled

– Providing humane Mental Health services

– Providing Oral health services

• Enhancing efforts at disease reduction

– Reversing trend of major diseases

– Launching new initiatives (Rabies, Fluorosis, Leptospirosis)

• Providing focus to Health System and Bio- Medical research

– Focusing on conditions specific to our country

– Making research accountable

– Translating research into application for improving health

– Understanding social determinants of health behaviour, risk taking behaviour, and health care seeking behaviour.

- Budget for health and family welfare in the eleventh plan:

To achieve the desired outcomes in the health sector, a substantially enhanced outlay for the Department of Health and Family Welfare has been earmarked during the Eleventh Five Year Plan (2007– 2012). The total projected GBS for the Eleventh Plan is Rs 120374.00 crore (at 2006–07 prices) and Rs 136147.00 crore (at current prices). This enhanced outlay is about four times the initial outlay for the Tenth Plan (Rs 36378.00 crore). A large proportion of this amount, i.e., Rs 89478.00 crore (65.72 %) is for NRHM, the flagship of the GoI. Another Rs 625 crore is to be contributed by the Department of AYUSH to make a total of Rs 90103 crore for NRHM during the Eleventh Five Year Plan. For the other ongoing schemes, a total of Rs 23995.05 crore has been earmarked. For the new initiatives it is Rs 20846.95 crore. Rs 1827.00 crore has also been earmarked for OSC.

4.5 AYUSH (AYURVEDA, YOGA AND NATUROPATHY, UNANI, SIDDHA AND HOMEOPATHY)

The eleventh plan recognizes that there is a resurgence of interest in holistic systems of health care, especially, in the prevention and management of chronic lifestyle related non-communicable diseases and systemic diseases. Health sector trends suggest that no single system of health care has the capacity to solve all of society's health needs. India can be a world leader in the era of integrative medicine because it has strong foundations in Western biomedical sciences and an immensely rich and mature indigenous medical heritage of its own.

The vision for AYUSH provides to mainstream AYUSH by designing strategic interventions for wider utilization of AYUSH both domestically and globally, the thrust areas in the Eleventh Five Year Plan are: strengthening professional education, strategic research programmes,

promotion of best clinical practices, technology upgradation in industry, setting internationally acceptable pharmacopoeial standards, conserving medicinal flora, fauna, metals, and minerals, utilizing human resources of AYUSH in the national health programmes, with the ultimate aim of enhancing the outreach of AYUSH health care in an accessible, acceptable, affordable, and qualitative manner.

4.6 National Rural Health Mission 2005- 2012

The preamble to NRHM runs as "Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

The National Rural Health Mission seeks to provide effective healthcare to rural population throughout the country with special focus on 18

states, which have weak public health indicators and/or weak infrastructure. These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

The goals as mentioned in the Mission Statement are as follows:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, Child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

The Mission statement formulates strategies to fulfill the goal and the same has been divided broadly into two parts i.e. Core strategies and supplementary strategies. The plan of action has been articulately laid down in different components as follows:

- Role and responsibilities of accredited social health activists (ASHA) who shall be a female and every village to have at least one such social health activists.
- The sub centers to be strengthened by adequate provision of essential drugs.

- Mission aims at Strengthening PHC for quality preventive, promotive, curative, and supervisory and Outreach services by adequate drugs, equipments and 24 hour staff personnel.
- It also focuses on strengthening the Community health Centres for first referral care.
- District Health Plan would be an amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition.
- Health Plans would form the core unit of action proposed in areas like water supply, sanitation, hygiene and nutrition.
- Adequate sanitation and hygiene is also to be provided for better health care.
- Disease control programmes to be strengthened and new initiatives to be launched for control of non-communicable diseases.
- Regulation of public private partnership for public health goals are made clear.
- New health financing mechanisms shall be formed assigning the work to a task group to examine the same.
- Reorientation of health/medical education to support rural health issues has been give emphasis to.

Apart from these the mission statement also provides for institutional mechanisms; technical support; it emphasis the role of State Governments, panchayati raj institutions and NGOs under NHRM and funding arrangements.

4.7 National Urban Health Mission (NUHM)

The Centre will launch a National Urban Health Mission at a cost of Rs. 8,000 crore in about three months. The summary of National Urban health Mission[10] is as under:

[10] MOHFW, Draft Urban Health Mission, Urban Health Division, Govt. of India, 2008

4.7.1 Problem statement

NUHM recognizes both growth of urban areas and the growth of urban poor, especially those living in the slums. As a result there is pressure on the existing infrastructure which is deficient. It recognizes the inaccessibility of the health care facilities in the urban areas due to the following reasons; overcrowding of patients, ineffective in outreach and referral system and lack of standard and norms for urban health care delivery system, social exclusion, lack of information and assistance to access the modern health care facilities and lack of economic resources.

The urban poor suffer from poor health status, as per NFHS-III the under five mortality rate among urban poor at 72.7 is higher than the urban average of 51.9. More that 50% children are underweight, and almost 60% of the children miss total immunization before completing 1 year. Poor environmental condition coupled with high population density makes them vulnerable to diarrhoeal diseases, malaria, lung diseases such as asthma, tuberculosis etc.

4.7.2 Coverage

In phase I, the mission aims to cover 430 cities with more than one lakh population across the country. It proposes to cover district head quarters with less than one lakh population during phase II. On a priority basis the mission would cover a list of 100 cities during the first year. Same norms will be applied to all the cities, irrespective of the population. It intends to cover the urban poor population living in listed and unlisted slums, all the other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, any other temporary migrants. The Government of India will allocate

approximately Rs. 8600 crores from the Central Government for a period of 4 years (2008-2012) to the NUHM.

4.7.3 Goal of NUHM

It aims to address the health concerns by facilitating equitable access available health facilities by rationalizing and strengthening the capacity of the existing health care delivery system. It proposes to address gaps with the support of non governmental organizations. It aims to evolve a model out of diverse facilities available. It hopes to synergize the mission with the existing progammes such as JNNURM, SJSRY and ICDS which have similar objectives to NUHM.

4.7.4 Key strategies

- strengthening existing primary public health systems
- Public private partnership
- Communitised risk pooling / insurance mechanism with IT enablement
- Monthly health and nutrition day
- Capacity building of key stakeholders
- Special provision to include the most vulnerable
- monitoring of quality of services
- Community participation in planning and management
- Identification of target group, through distribution of Family/Individual
- Health Suraksha Cards

4.7.5 Model

Three-tier system of health care

I. Community Level

Community Outreach Services

Mahila Arogya Samitees (MAS)

Urban Social Health Activist (USHA)

II. Urban Health center level

Strengthening existing public health facility

Empanelled private providers

III. Secondary/Tertiary level

Public or private empanelled providers

It aims to provide community level care with the support of USHA and MAS. In urban poor settlements, promote position of one USHA for 1000-2500 population covering about 200 to 500 households and ensure community participation through community-based institutions, through one MAS for 20-100 households and Rogi Kalyan Samitees. These mechanisms will make sure community participates in planning and management.

Community risk pooling and health insurance will be organized through MAS. MAS members would be encouraged to save money on monthly basis for meeting health emergencies. MAS would decide the lending norm and rate of interest, and NUHM would provide a seed money of Rs.2500 @ Rs.25 per head. It would also provide incentives based on targets achieved. It envisages earning income from interest on small loans and interest on saving. The premium for health insurance would be paid from the fund.

The mission would promote an urban health insurance model for hospitalization. Premium would be subsided through the mission. The insurance would be implemented through risk pooling with the partnership of center, state, Urban Local Bodies (ULB) and communities. Under this scheme a Smart Card/Individual or Family Health Suraksha card will be given to a family for five for a premium of Rs.600. Additional

cost is expected to be contributed by state or Urban Local Bodies or Beneficiaries. The insurance project aims to cover both the urban below poverty line groups as well as the above poverty line groups.

The collected pooled premiums will be paid to IRDA approved Insurance Company/TPA; but the subsidy for slum populations will be provided by the Mission. The benefit package includes coverage for hospitalization. Surgery and ambulatory surgery expenses. Pre existing condition/diseases including maternal and childhood illnesses would also be covered, with minimum exclusions.

Services will be accessed from the accredited empanelled providers from both public and private sectors. There will be a mobilser or an administrator, maybe part of the insurer who will be responsible for implementation. IRDA approved insurance company will be assigned the job. The premiums will be self financed for APL populations while the BPL populations will be provided subsidy from the center.

NUHM will follow similar system to NRHM and use health missions at city and state level for operationalization. It proposes to strengthen the role of urban local bodies. For the purpose of promoting transparency and accountability it propose to incorporate elements such as health service delivery charter, health service guarantee and concurrent audit; audit at the level of funds released and utilized. It proposes the convergence of both the communicable and non communicable disease progammes at the city level through integrated planning. The existing IDSP structure would be leveraged for improved surveillance. It proposes to promote decentralized governance by vesting the powers to the urban heath centers for converge of all the programmes at the urban health center level.

It recognizes the need for additional human and financial resource and it purposes to ensure that it would be taken care. Over 800 crores has been allocated and function as 100% centrally sponsored programme during the first year and it expects the state and the local bodies would contribute and own the programmes initiated by the mission.

4.8 National Health Policy 1983

The Constitution of India has certain goals based on the principle of equality, freedom, justice and dignity of the individual. The Directive Principles of State Policy under Part IV aims at the elimination of poverty, ignorance and ill-health and directs the State to 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, securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities to develop in a healthy manner.

Right from the time our country has achieved independence, it has made various plans and policies for upholding the constitutional obligation. In all the successive Five Years Plans, health care has been in the forefront.

With a view to have an integrated comprehensive approach towards the future development of medical education, research and health services that serves the actual health needs and priorities of the country The National Health Policy for the first time was evolved in the year 1983. The National Health Policy 1982 was initiated in the context of high population growth having an adverse effect on health of people. It was three decades from the attainment of independence and the policy makers were well aware that the health situation of the country was not satisfactory. It was accepted in the policy statement of 1983 that the demographic and health picture of the country constituted a cause for

serious and urgent concern. Further the policy statement made population growth as one of the factors adversely effecting on the health of the people of the country.

The need for evolving a health policy in 1983 was stimulated as India was committed for attaining the goal of "Health for All by the Year 2000" given by the World health Organization. Hence for the attainment of this goal this policy statement was made considering a large variety of inputs into health. The policy emphasized upon some the following key areas:

- Medical and health Education
- Need for providing primary health care with special emphasis on the preventive, promotive and rehabilitative aspects
- Re-orientation of the existing health personnel
- Practitioners of indigenous and other systems of medicine and their role in health care

The scope of the National health policy, 1983 was limited and it could be very well analyzed that many core areas in the field of health care were left out.

4.9 National Health Policy 2002

The Government of India came up with a more comprehensive policy called the National Health Policy in the year 2002. The National Health Policy (2002) includes all that is wanted from a progressive document and yet it glosses over the objective of NHP 1983 to protect and provide primary health care to all.

Government initiatives in the pubic health sector recorded some noteworthy successes over time with the help of National Health Policy and programmes undertaken at various levels to ensure health of citizens. The policy of 2002 showed the achievements that were undertaken through the years 1951-2000 in a tabular form as follows:

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	110	70 (99 SRS)
Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no of cases)	>44,887	Eradicated	
Guinea worm (no. of cases)		>39,792	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363	1,63,181 (99-RHS)
Dispensaries &Hospitals(all)	9209	23,555	43,322 (95-96-CBHI)
Beds (Put & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors(Allopath)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

The above table specifically shows that there has been a positive difference from the year 1951 to 2000. From the above statistics the Government can be believed to be successful in providing the health care services and treatment through out the country. But the reality is along with the development of health care in India, the population also increased to a very large extent and that was a challenge before the Government to provide adequate health facilities at each corner of the

country. The policy statement accepted the fact that despite the impressive public health gains as revealed in the above mentioned statistics, the fact that the morbidity and mortality levels in the country were unacceptably high. These unsatisfactory health indices were accepted as an indication of the limited success of the public health system in meeting the preventive and curative requirements of the general population.

The Constitution of India based on the principles of equality ensured equal treatment to all irrespective of any discrimination. The same is very difficult to be achieved when we talk about health care services. Despite the conscious efforts in the development process the following statistics, which formed a part of the National Policy 2002 shows that the attainment of health indices has been very uneven across the rural – urban divide?

Differentials in Health Status among States

Sector	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mort-ality per 1000 (NFHS II)	Weight For Age- % of Children Under 3 years (<-2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 population	Malaria +ve Cases in year 2000 (in thousands)
India	26.1	70	94.9	47	408	3.7	2200
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharashtra	25.02	48	58.1	50	135	3.1	138
TN	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

This clearly shows that the states where literacy level is high are better performing states as compared to those where literacy level is low.

At the same time the differences in health status among socio-economic groups was also identified by the policy makers as follows:

Differentials in Health status Among Socio-Economic Groups

Indicator	Infant Mortality/1000	Under 5 Mortality/1000	% Children Underweight
India	**70**	**94.9**	**47**
Social Inequity			
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

This shows that people belonging to SC, ST and other disadvantaged groups are at a more vulnerable position as compared to others.

The policy statement of 2002 had a focus on the current scenario. It was mentioned by the policy makers that the state of public health infrastructure was far from satisfactory, further more it was accepted that for the outdoor medical facilities, funding was insufficient; the presence of medical and para-medical personnel was much less than that required by prescribed norms; the availability of consumables was negligible; the equipments in many public hospitals were obsolescent and unusable; and, the buildings were in a dilapidated state. In the indoor treatment facilities, again, the equipments were obsolescent; the availability of essential drugs was minimal; the capacity of the facilities was grossly inadequate, which leaded to over-crowding, and consequentially to a steep deterioration in the quality of the services. It was also acknowledged that the medical education system was not much satisfactory and the quality of education was highly uneven and in several instances even sub-standard. The need for the specialists in public health and family medicine was desired. Information, education and communication were the fore front areas whereby the health

facilities can be better improved. It was accepted that health research facilities in the country had been very limited. The role of private sector was emphasized that contributed significantly to secondary level care and tertiary care. Though private sector was perceived to be financially exploitative but people always preferred to incline towards it. Some other areas where there was a dire need of improvement as suggested in the policy statement were women's health, medical ethics, enforcement of quality standards for food and drugs, regulation of standards in para medical disciplines, environmental and occupational health, providing medical facilities to users from overseas, the impact of globalization on the health sector, inter-sectoral contribution to health, population growth and health standards, alternative systems of medicine etc.

With all the above aspect in the minds of the policy makers the National Policy on Health, 2002 was executed with the following objectives:

- To achieve an acceptable standard of good health amongst the general population of the country
- The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions.
- Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country.
- Emphasis will be given to increasing the aggregate public health investment through a substantially increased contribution by the Central Government
- It is expected that this initiative will strengthen the capacity of the public health administration at the State level to render effective service delivery.

- The contribution of the private sector in providing health services would be much enhanced, particularly for the population group which can afford to pay for services.
- Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation.
- Emphasis will be laid on rational use of drugs within the allopathic system.
- Increased access to tried and tested systems of traditional medicine will be ensured

Within these broad objectives, NHP-2002 endeavors to achieve the time-bound goals mentioned in the following table

Goals to be achieved by 2000-2015

Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kala Azar	2010
Eliminate Lymphatic Filariasis	2015
Achieve Zero level growth of HIV/AIDS	2007
Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
Reduce Prevalence of Blindness to 0.5%	2010
Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
Increase utilization of public health facilities from current Level of <20 to >75%	2010
Establish an integrated system of surveillance, National Health Accounts and Health Statistics.	2005
Increase health expenditure by Government as a % of GDP from the existing 0.9 % to 2.0%	2010
Increase share of Central grants to Constitute at least 25% of total health spending	2010
Increase State Sector Health spending from 5.5% to 7% of the budget	2005
Further increase to 8%	2010

The fourth point of the National health policy 2002 prescribes its policy towards various aspects like

- Financial resources
- Equity
- Delivery of national public health programmes
- The state of public health infrastructure
- Extending public health services
- Role of local self-government institutions

- Norms for health care personnel
- Education of health care professionals
- Need for specialists in 'public health' and 'family medicine'
- Nursing personnel
- Use of generic drugs and vaccines
- Urban health
- Mental health
- Information, education and communication
- Health research
- Role of the private sector
- The role of civil society
- National disease surveillance network
- Health statistics
- Women's health
- Medical ethics
- Enforcement of quality standards for food and drugs
- Regulation of standards in paramedical disciplines
- Environmental and occupational health
- Providing medical facilities to users from overseas
- Impact of globalization on the health sector

Some of the key points of summation as laid down by the policy are as follows:

- NHP 2002 does not claim to be a road map for meeting all the health needs of the populace of the country because the health needs of the country are enormous and the resources limited. So the policy has to make choices between priorities and operational options.

- NHP – 2002 focuses on the need for enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities.
- Under the umbrella of the macro-policy prescriptions laid down in this document, governments and private sector programme planners will have to design separate schemes, tailor-made to the health needs of women, children, geriatrics, tribals and other socio-economically under-served sections.
- An adequately robust disaster management plan has to be in place to effectively cope with situations arising from natural and man-made calamities.
- The need to ensure 'equity' in the health sector is well recognized in NHP 2002, and so a marked emphasis has been provided in the policy for expanding and improving the primary health facilities.
- The policy attempts to provide guidance for prioritizing expenditure facilitating rational resource allocation.
- The Policy highlights the expected roles of different participating groups in the health sector. Apart from the role that the central Government has to guarantee in assisting public health programmes, the need for the delivery of public health services by the State administration, NGOs and other institutions of civil society has been emphasized.
- The policy agree to the fact that the health levels significantly depends on population stabilization but at the same time complementary efforts are much needed in other areas of social sectors like improved drinking water supply, basic sanitation, minimum nutrition etc.

- It emphasizes the role of more empathetic and committed service providers in private and public sectors for the significant improvement in the quality of health services.

The National Health Policy is concluded with the words that in the area of public health, an improved standard of governance is a prerequisite for the success of any health policy.

4.10 National Population Policy

The immediate objective of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

4.11 National Policy on Indian Systems of Medicine & Homoeopathy 2002

In many places, the Indian Systems of Medicine & Homoeopathy continue to be widely used due to their accessibility, and sometimes, because they offer the only kind of medicine within the physical and financial reach of the patient. The Indian medicine system is also embedded in the beliefs of a wide section of the public and continues to be an integral and important part of their lives and for some, it is also a way of life. Complementary and Alternative Medicine or Traditional Medicine is rapidly growing worldwide. In India also, there is resurgence of interest in Indian Systems of Medicine. People are becoming concerned

about the adverse effects of chemical based drugs and the escalating costs of conventional health care. Longer life expectancy and life style related problems have brought with them an increased risk of developing chronic, debilitating diseases such as heart disease, cancer, diabetes and mental disorders. Although new treatments and technologies for dealing with them are plentiful nonetheless more and more patients are now looking for simpler, gentle therapies for improving the quality of life and avoiding iatrogenic problems.

India possesses an unmatched heritage represented by its ancient systems of medicine which are a treasure house of knowledge for both preventive and curative healthcare. The positive features of the Indian Systems of Medicine, namely, their diversity and flexibility; accessibility; affordability; a broad acceptance by a section of the general public; comparatively low cost; a low level of technological input and growing economic value have great potentials to make them providers of health care that the larger sections of our people need a huge infrastructure already exists comprising thousands of hospitals and dispensaries, registered practitioners and twice the number of Indian Systems of Medicine & Homoeopathy colleges as available for allopathy. Many Post-Graduate institutions offer doctoral courses. Four researches councils and several apex scientific institutions and universities have also contributed to clinical research, ethno-botanical surveys, pharmacological and pharmacognostical studies on plants and drug standardization of simple and compound ISM formulations. Clinical research studies covering the use of ISM drugs for a range of diseases and public health problems conducted over the last thirty years have led to many useful conclusions about the use of single and compound ISM drugs to treat numerous intractable problems. Although Govt. set up an independent Department in 1995 to give focus to these issues, ISM has not been able to play a significant role in health care delivery services for

want of their legitimate involvement in public health programmes. Hence a policy is drawn to gain the significance of Indian systems of medicine and homeopathy.

4.12 National AIDS Prevention and Control Policy

A well organized Blood Transfusion Service (BTS) is a vital component of any health care delivery system. An integrated strategy for Blood Safety is required for elimination of transfusion transmitted infections and for provision of safe and adequate blood transfusion services to the people. The main component of an integrated strategy include collection of blood only from voluntary, non-remunerated blood donors, screening for all transfusion transmitted infections and reduction of unnecessary transfusion.

The Blood Transfusion Service in the country is highly decentralized and lacks many vital resources like manpower, adequate infrastructure and financial base. The main issue, which plagues blood banking system in the country, is fragmented management. The standards vary from State to State, cities to cities and centre to centre in the same city. In spite of hospital based system, many large hospitals and nursing homes do not have their own blood banks and this has led to proliferation of stand-alone private blood banks.

The blood component production/availability and utilization is extremely limited. There is shortage of trained health-care professionals in the field of transfusion medicine.

For quality, safety and efficacy of blood and blood products, well-equipped blood centres with adequate infrastructure and trained manpower is an essential requirement. For effective clinical use of blood,

it is necessary to train clinical staff. To attain maximum safety, the requirements of good manufacturing practices and implementation of quality system moving towards total quality management, have posed a challenge to the organization and management of blood transfusion service.

Thus, a need for modification and change in the blood transfusion service has necessitated formulation of a National Blood Policy and development of a National Blood Programme which will also ensure implementation of the directives of Supreme Court of India - 1996.

4.13 Pharmaceutical Policy 2002

The basic objectives of Government's Policy relating to the drugs and pharmaceutical sector were enumerated in the Drug Policy of 1986. These basic objectives still remain largely valid. However, the drug and pharmaceutical industry in the country today faces new challenges on account of liberalization of the Indian economy, the globalization of the world economy and on account of new obligations undertaken by India under the WTO Agreements. These challenges require a change in emphasis in the current pharmaceutical policy and the need for new initiatives beyond those enumerated in the Drug Policy 1986, as modified in 1994, so that policy inputs are directed more towards promoting accelerated growth of the pharmaceutical industry and towards making it more internationally competitive. The need for radically improving the policy framework for knowledge-based industry has also been acknowledged by the Government. The Prime Minister's Advisory Council on Trade and Industry has made important recommendations regarding knowledge-based industry. The pharmaceutical industry has been identified as one of the most important knowledge based industries in which India has a comparative advantage.

4.14 Draft National Policy for Persons with Disabilities

Our society is witnessing rapid socio-economic changes in its traditional structure. The increased pace of industrialization and urbanization is leading to erosion of joint family structures which had provided a place of security and a modicum of care to all members of family. The Persons with Disabilities face dual challenge of marginalization on account of normal socio-economic changes as well as on account of their physical and mental condition. They often start life with little access to opportunities and continue in the same state through out their lives. Hence, there is a need for a policy framework, which protects their rights and provides them equal opportunity to participate fully in the society and enhance their dignity and self-respect.

4.15 National Water Policy 2002

Water is a prime natural resource, a basic human need and a precious national asset. Planning, development and management of water resources need to be governed by national perspectives.

4.16 Conclusion

The overview of the plans and policy reports not only throws light on the gap between the rhetoric and reality but also the framework within which the policies have been formulated.

The health reports and plans mostly concentrated on building the health services infrastructure and even this lacked a sense of integration. Most of the policy reports miss out on the importance of a strong referral system. Instead, there has been more emphasis on building the primary level care and even that has lacked proper implementation. The multisectoral approach that is much needed and the intersectoral linkages that are essential for a vibrant health system have not been well thought out, and there has been no plan drawn out for it later. The outline of plan documents and their implementation have been

incremental rather than being holistic. It is important to question whether it is only the low investment in health that is the main reason for the present status of the health system or is it also to do with the framework, design and approach within which the policies have been planned.

At the same time it can also be concluded that it is not only the obligation of the State to take steps in promoting the health care to the people but certain groups like the health professional associations such as medical associations; those providing health care like medical professionals; those involved in service delivery like medical representatives; health authorities both governmental and non-governmental; health promotion groups like NGOs providing health-related education, working in sexual and reproductive health, HIV/AIDS and mental health; community health care groups, advocates for patients' rights and anti-smoking organizations. Trade unions, consumer protection agencies and religious groups may also contribute towards providing health issues.

All these groups should mainly focus health in concurrence with human rights, humanitarian assistance, sustainable development, domestic violence, education and the environment in which they live. The health care services provided by all of the above groups should mainly focus on the poor, vulnerable or otherwise disadvantaged group like women, children, adolescents, aged persons, refugees, asylum seekers, minority groups suffering from discrimination, indigenous peoples, persons with disabilities, victims of communal violence and victims of natural calamities.