CHAPTER – I

PUBLIC HEALTH IN INDIA: INTRODUCTION AND EVOLUTION

Chapter I

I. Public health system in India: An Introduction and Evolution

This chapter gives an account of national health policies, health infrastructure, priorities and initiatives in health sector during the years after independence.

1.1 Introduction

Health is a positive state of well being in which harmonious development of physical and mental capacities of individual lead to enjoyment of rich and full life. Health is thus vital for concurrent and integrated development of the individual and community and for socio-economic development of the country. According to World Health Organization, Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity[1].

Public Health is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society (WHO). Public health is a social and political concept aimed at improving health, prolonging life and quality of life among whole populations through health promotion, disease prevention and other forms of health intervention.

Directive Principles of State Policy of Indian Constitution considers that the State shall regard raising of the level of nutrition and standard of living of its people and improvement of public health as among its primary duties under Article 47. In addition, under Article 42, the State shall make provision for securing just and humane conditions of work and for maternity relief. The health system in India is expected to perform with objectives based on these principles and evolve its spirit and structure to achieve these objectives.

1.2 Evolution of Public Health System in India

After independence, India embarked on a planned effort to raise standard of living of the people and impetus was given to health care, which was made integral part of socio-economic development. Over the past six decades, public health infrastructure and services has undergone remarkable changes and huge expansion in scale and nature based

[1]Health Promotion Glossary: Division of Health Promotion, Education and Communications (HPR) Health Education and Health Promotion Unit (HEP), World Health Organization, Geneva, 1998.

on recommendations by a number of expert committees[2]. Health being a State subject under the Constitution, State Governments has undertaken various initiatives to improve healthcare in their respective States. The Central Government has given the policy direction and thrust to healthcare through many national programs.

1.2.1 Expert Committee Reports

1. Bhore Committee

Just before independence Bhore committee[3] was constituted in 1943 to survey existing health conditions and organizations to make recommendations for future development. The committee emphasized the need for social orientation of medical practice, a high level of public participation and consequent development of environmental health. The two key recommendations are:

i) A blue print for Primary Health Centres (PHC), to serve a population of 10000 to 20000 and

ii) Formation of village health committees to obtain the active cooperation and support in development of health programs.

2. Mudaliar Committee

A committee under the chairmanship of Dr. Lakshmanaswami Mudaliar was set up in 1959 to assess the field of public health and medical relief. The important features of the recommendations are:

i. Strengthening of district hospitals

ii. Upgrading and strengthening of PHC

iii. Extension of functions of University Grants Commission to education in the field of medicine.

iv. Institution of National programs for malaria eradication, small pox, cholera, leprosy, tuberculosis and filariasis.

v. Levying of small fee for those availing hospital services, except those who are really poor.

3. Chadha Committee

A committee was constituted under the chairmanship of Dr M S Chadha in 1963 to go into the details of requirements related to planning and functioning of PHC and

---

[2] Kumar, Virendra – Government of India: Committees and Commissions in India Vol. 7: 1966.

[3] Health and Survey (Bhore) Committee Report: Government of India, Volume 1, Delhi Publications Division, 1946.

performance of National Malaria Eradication Program. The committee recommended strengthening of rural health services, vigilance through medical institutions and developing multipurpose domiciliary health services for all health programs.

4. Mukherjee Committee

The Central council of health, in 1965, appointed this committee to undertake a review of family planning and its strategy. The committee while recommending strengthening of administrative set up from PHC to State headquarters also recommended delinking of family planning from malaria eradication program, so that the former can receive undivided attention.

5. Jain Committee

A study group was constituted in 1966 under the chairmanship of Sri A P Jain to look into medical care services. The group studied the working of different hospitals in the country to improve the standards of medical care. The key recommendations were to provide specialist medical care at district hospitals, and improving the capacity and coverage of PHC to provide maternity facilities.

6. Kartar Singh Committee

This committee was constituted based on recommendation of central family planning council to study the issues of integrated services, training and mobile services. The main recommendations of the committee are:

i. MPHW for the delivery of health, family planning and nutrition services to the communities.
ii. At least one FHW/ANM to be made available for a population of 10000 to 12000.
iii. Each PHC should ultimately serve a population of 50000 and should have sub-centres spread over its area.
iv. Training for all workers engaged in the fields of health, family planning and nutrition.

7. Shrivatsava Committee

A committee was formed in 1974 to study medical education and manpower under Dr. J B Shrivatsava. The major courses of action recommended by the committee are:

i. Organization of basic health services (family planning, nutrition and health education) within the community itself and training the personnel for this purpose.
ii. Creation of national referral services by developing proper linkages between PHC and higher level referral and service centres.

iii. Creation of administrative and financial machinery to reorganize medical and health education in tune with the objective of national health services.

8. Analysis of Committee Reports

An analysis of recommendations of various expert committees reflects the changes and developments in public health delivery system in India. The basic framework suggested by Bhore committee for primary health care unit, continues till date as the focal point of public health delivery. The programs based approach of Mudaliar committee has been adopted to control major communicable diseases affecting the community.

Family planning is given impetus as a special activity after the recommendation of Mukherjee committee. Creation of multipurpose health workers and female health workers were the hallmark of recommendation of Kartar Singh Committee. Thus, in first few years of independence, development of public health delivery system was the product of recommendations of these committees constituted from time to time.

1.2.2 National and State Health Policies

1. Alma Ata Declaration

The Alma Ata declaration[4] in 1978 led to the launch of "Health for all by 2000" signed by 137 countries including India. The declaration advocated provision of first contact services and basic medical care within the framework of integrated health services. It was declared that PHC is essential for health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families through participation. The responsibility of the state to provide comprehensive primary health care as per this declaration led to the formulation of country's first National Health Policy in 1983.

2. National Health Policy, 1983

The strategy for health care development shifted from committee to policy based approach with the formulation of National Health Policy, 1983. The major goal of policy was to provide universal and comprehensive primary health services. The elements of this policy covered identification of problems requiring urgent attention and recommendations to ameliorate them, population stabilization, provision of primary health care, medical and health education, role of indigenous and other systems of medicine, medical industry, health insurance and legislation and medical Research.

---

[4] Primary Health: Indian Scenario: Section 11- Origin and evolution of primary health care in India, WHO India.

An important problem identified was the state of Maternal and Child Health Care (MCH). The NHP accorded highest priority to MCH services to focus on underserved sections of society. In order to achieve its goals, the policy identified key indicators and time bound targets to be achieved in respect of these indicators. Some key indicators identified were infant mortality rate, maternal mortality rate, life expectancy at birth, crude birth and death rate, effective couple protection, net protection rate, family size, pregnant mothers receiving antenatal care, deliveries by trained birth attendants and immunization status. Consequently, Reproductive and Child Health (RCH-phase I) program which incorporated child health, maternal health, family planning, treatment and control of reproductive tract infections and adolescent health was launched in 1997. Subsequently, RCH-phase II which aims at an outcome-oriented program based approach with emphasis on decentralization, monitoring and supervision based approach was launched in 2005.

Table 1.1	**Health Outcomes in India**		
Indicator	**1951**	**1981**	**2000**
Life Expectancy	36.7	54	64.6[5]
Crude Birth Rate	40.8	33.9	26.2
Crude Death Rate[6]	25	12.5	8.7
IMR	146	110	70

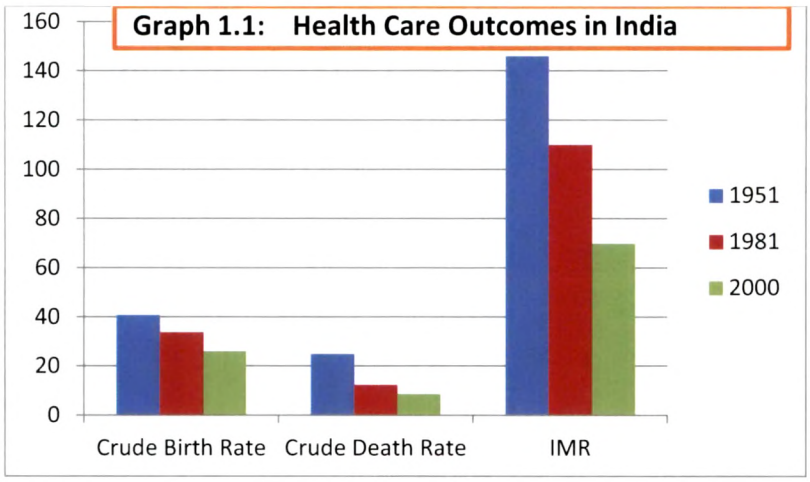
Source: Vital Statistics, Sample Registration System

To achieve these objectives, some noteworthy initiatives were undertaken in the policy:

1. A phased and time bound program for setting up a well dispersed network of comprehensive PHC services;
2. Intermediation through "Health Volunteers" having appropriate knowledge and skills;
3. Establishment of a well-worked out referral system to ensure that the patient load at the higher levels is not burdened by those who can be treated at the decentralized level and

[5]Birth Rate, Death Rate, IMR and TFR: India & States, National Commission on Population, Government of India.
[6]Sample Registration System Bulletins, Vital Statistics Division, Registrar General, Government of India

4. An integrated network of evenly spread specialty and super specialty services by encouraging private investment for patients who can pay so that Government facilities are limited to those entitled free use.



These initiatives in public health were successful in eradicating small pox and guinea worm diseases; vastly improved coverage of polio vaccination; and drastic reduction in Kala Azar, Leprosy and Filariasis. Significant fall was witnessed in total fertility rate and infant mortality rate too. IMR[7] reduced from 146 in 1951 to 110 in 1981 and then further to 70 in 2000 (Table 1.1)

On the other hand, the levels of morbidity and mortality were still high compared to many other developing countries. Incidence in Malaria witnessed resurgence; new communicable diseases like HIV/AIDS emerged as serious threats and there has been rapid increase in life-style diseases like diabetes, cancer and cardiovascular diseases[8].

3. National Population Policy, 2000

NPP, 2000 provided overreaching policy framework for family planning and child health goals. The immediate objective was to address the unmet needs of contraception, health care infrastructure, health personnel and, to provide integrated delivery of reproductive and child care services. It envisaged one-stop integrated and coordinated delivery at village level for basic RCH services through a partnership of Government with voluntary and NGO organizations. The medium-term objective was to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational

[7] Sample Registration System, Registrar General of India, Government of India.
[8] Health: Morbidity, Healthcare and Condition of the Aged - National Sample Survey 60th Round Report, Ministry of Statistics and Program Implementation.

strategies. The long-term objective was to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

To pursue these objectives, the following national socio-demographic goals were formulated to be achieved by 2010: Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20% for both boys and girls; Reduce infant mortality rate to below 30 per 1000 live births; Reduce maternal mortality ratio to below 100 per 100,000 live births; Achieve universal immunization of children against all vaccine preventable diseases; Promote delayed marriage for girls, not earlier than age 18 and preferably after 21 years of age; Achieve 80% institutional deliveries and 100% deliveries by trained persons; Achieve universal access to information/counseling, and services for fertility regulation and contraception; Achieve 100 per cent registration of births, deaths, marriage and pregnancy; Contain the spread of AIDS, and promote greater integration between the management of reproductive tract infections (RTI), sexually transmitted infections (STI) and the National AIDS Control Organisation; Prevent and control communicable diseases.; Integrate Indian Systems of Medicine (ISM) in the provision of RCH services, and in reaching out to households; Promote small family norm to achieve replacement levels of TFR; and bring about convergence in implementation of related social sector programs so that family welfare becomes a people centered program.

4. Millennium Development Goals

The Millennium Development Goals is eight international development goals that all 193 members of United Nations and many international organizations have agreed to achieve by the year 2015. They include eradicating extreme poverty, reducing child mortality rates, fighting disease epidemics such as AIDS, and developing a global partnership for development.

The MDG are a synthesis of the most important commitments made at the international conferences and summits in 1990s; to recognize explicitly the interdependence between growth, poverty reduction and sustainable development; to acknowledge that development rests on the foundations of democratic governance, rule of law, respect for human rights and peace and security; are based on time-bound and measurable targets accompanied by indicators for monitoring progress; and bring together the responsibilities of developing countries with those of developed countries.

The MDGs were developed out of the eight chapters of Millennium Declaration, signed in September 2000[9]. There are eight goals with 21 targets[10], and a series of measurable indicators for each target by 2015. Goal 1 is to eradicate extreme poverty and hunger with targets to halve the proportion of people living on less than $1 a day, achieve decent employment for women, men, and young people and halve the proportion of people who suffer from hunger. Goal 2 is to achieve universal primary education and ensure that all girls and boys complete a full course of primary schooling by 2015. Goal 3 is to promote gender equality and empower women with target to eliminate gender disparity in primary and secondary education by 2015.

Goal 4 is to reduce child mortality rates with targets to reduce it by two-third. Goal 5 is to improve maternal health with target to reduce maternal mortality rate by three quarters and achieve universal access to reproductive health by 2015; Goal 6 is to combat HIV/AIDS, malaria, and other diseases with target to halt and begin to reverse the spread of HIV/AIDS, achieve universal access to treatment for HIV/AIDS by 2010, halt and begin to reverse the incidence of malaria and other major diseases by 2015.

Goal 7 is to ensure environmental sustainability with target to integrate the principles of sustainable development into country policies and programs and reverse loss of environmental resources, reduce biodiversity loss by achieving a significant reduction in the rate of loss by 2010, halve the proportion of the population without sustainable access to safe drinking water and basic sanitation by 2015; to achieve a significant improvement in the lives of at least 100 million slum-dwellers by 2020; and Goal 8 is to develop a global partnership for development with target to develop an open, rule-based, predictable, non-discriminatory trading and financial system, provide essential drugs to developing countries in co-operation with the private sector pharmaceutical companies and make available the benefits of new technologies, especially information and communications. As a member of UNDP, India has adopted MDG wherein goals 3, 4 and 5 deals with public health issues of child health, maternal health and diseases in which the country has made huge commitment to achieve the universal targets[11].

---

[9] United Nations Millennium Declaration: Resolution 55/2 adopted by the general assembly - 55th session, 18/09/2000.

[10] Haines, Andy and Andrew Cassels. 2004. Can The Millennium Development Goals Be Attained? - BMJ: British Medical Journal, Vol. 329, No. 7462 (Aug. 14, 2004).

[11] Butler, John: Reaching the MDG in India, Oxfam India, Centre for Legislative Research and Advocacy, 2009

5. National Health Policy 2002

Health care scenario was evaluated as a precursor to new health policy. The public health investment which was already low declined from 1.3%to 0.9% between 1990 and 1999. Only 17% of the aggregate expenditure was public health spending and the balance was out-of-pocket expenditure. Hence, the issue of resource availability was a key concern in the formulation of new policy. Attainment of health indices has been very uneven with rural-urban divide, wide difference in attainment of goals between better-performing and low-performing states (Table 1.2) and between better-endowed and vulnerable sections of society (Table 1.3). Hence the new policy aimed to reduce the inequality and provide access to disadvantaged sections of society.

Table 1.2	**Health Indicators: Regional Inequity**				
Region/ State	BPL Population (%)	IMR Per 1000 (1999 SRS)	< 5 Mortality Per 1000 (NFHS II)	MMR per lakh (Annual Report 2000)	Underweight (% Children under 3 years)
India	26.1	70	94.9	408	47
Rural	27.09	75	103.7		49.6
Urban	23.62	44	63.1		38.4
Kerala	12.72	14	18.8	87	27
Maharashtra	25.02	48	58.1	135	50
Tamil Nadu	21.12	52	63.3	79	37
Orissa	47.15	97	104.4	498	54
Bihar	42.60	63	105.1	707	54
Uttar Pradesh	31.15	84	122.5	707	52
Rajasthan	15.28	81	114.9	607	51
Madhya Pradesh	37.43	90	137.6	498	55

Source: National Health Policy, 2002

A comparison of public health spending in select countries shows that the ratio is less in India compared to developing as well as developed countries[12] (Table 1.4). Vertical implementation structures have been created for major disease control programs which resulted in independent manpower had become expensive and difficult to sustain. For a

[12] Report of the National Commission on Macroeconomics and Health: National Commission of Macroeconomics and Health, Ministry of Health & Family Welfare, Government of India, New Delhi, September, 2005.

country of vast size and diversity, national health programs must be flexible enough to permit local modifications which must be implemented through State Governments' decentralized public health machinery. Hence there must be incentive to enhance the role of local self governments by devolving programs and funds at different levels of panchayat raj institutions. In addition, there were issues like education of health care personnel, need for specialists in public health, and availability of drugs and vaccines.

Table 1.3	**Health Indicators: Social Inequity**		
Category	**Infant Mortality Per 1000**	**< 5 Mortality Per 1000**	**% Children underweight**
All India	70	94.9	47
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

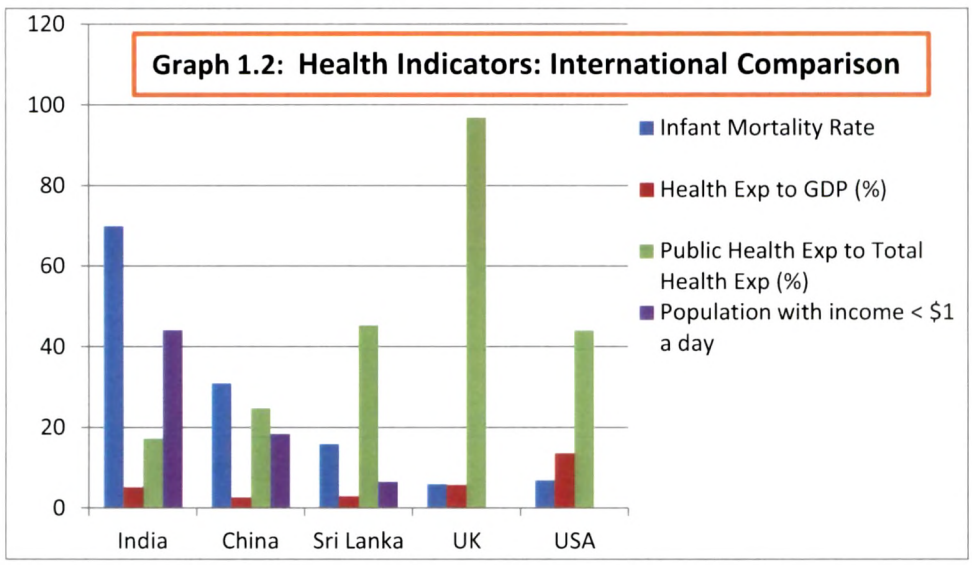
Source: National Health Policy, 2002

The NHP, 2002 was formulated from the recommendations of National Population Policy, 2000 with key objectives to address the problem of declining sex ratio, total fertility rate and speedy implementation of minimum needs program. A key area of recommendation was to focus on MCH, its administration, priorities, approach and goals for 2010. The goals envisaged under the policy are given in Table (1.5).

Table 1.4	**Health Indicators: International Comparison**			
Country	Population with income of <$1 a day	Infant Mortality rate (per 1000)	Health Exp to GDP (%)	Public Health Exp to Total Health Exp (%)
India	44.2	70	5.2	17.3
China	18.5	31	2.7	24.9
Sri Lanka	6.6	16	3	45.4
UK	-	6	5.8	96.9
USA	-	7	13.7	44.1

Source: Report of National Commission on Macroeconomics and Health

The policy approaches the issues from the perspective of outcomes, outputs and inputs. With an objective[13] to achieve acceptable standard of good health among the population of the country, some major initiatives were envisaged under the policy. The approach was to increase the access to decentralized public health system by involving panchayat raj institutions; Information, Education and Communication activities to disseminate public health related information to people; enhance the role of private sector particularly for the income group which can afford to pay for services; empowerment of women for overall improvement in community health and finally; establish new infrastructure in deficient areas and upgrade infrastructure in existing institutions.



Careful consideration was also given to issues of health care personnel which include improvement in infrastructure in medical and dental colleges, need-based and skill oriented syllabus with sizeable component for practical training, specialized education in public health and family medicine, and improve the availability and skill level of nurses. NHP 2002 envisages setting up of an organized urban primary health care structure with two tiers. Spending on health research was proposed to increase from 1% to 2% of health expenditure by 2010. Thus, the policy envisages providing increase in financial and material resources to achieve the desired outcomes through structural improvement: decentralization, integration and participation of all stakeholders in public health care delivery in the country.

[13] National Health Policy, 2002: Government of India New Delhi, Ministry of Health and Family Welfare, 2002.

Table 1.5	Goals under National Health Policy
Goal	**Time Limit**
Eradicate Polio	2005
Eliminate Leprosy	2005
Eliminate Kala Azar	2010
Eliminate Lymphatic Filariasis	2015
Achieve zero level growth in 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 per 1000 and MMR to 100 per 100000	2010
Increase utilization of public health facilities from current level of <20 to >75%	2010
Establish integrated system of surveillance, national health accounts and health statistics	2005
Increase health expenditure by Government as a % of GDP from 0.9% to 2%	2010
Increase share of Central grants to constitute at least 25% of total health spending	2010
Increase State health spending from 5.5% to 7% of the budget and; Further increase to 8%	2005 2010

Source: National Health Policy, 2002

Gujarat Population Policy, 2002

Gujarat has achieved huge strides in economic development with state domestic growth rate ranking among the top eight states of the country on a consistent basis. However, the State has recognised the prevalence of marked socio-economic disparities within the State, among districts, and between rural and urban areas. Sustained development of State depends primarily on human development for which conscious efforts have to be for significant improvement. To achieve this, in harmony with National Population Policy, 2000 and Gujarat Vision, 2010, Government of Gujarat released the State Population Policy 2002[14].

The goal of the policy was to improve the quality of life of the people. It aims at reducing gender discrimination, empowering women and ensuring extensive service support to achieve replacement level fertility by 2010. The objective of the policy was to

[14] Population Policy: Government of Gujarat, Health and Family Welfare Department, March 2002.

provide integrated reproductive health care services, including addressing the unmet need for contraception. The state aims to strengthen health care infrastructure and support systems to improve access to these services. The objective was to reduce TFR from the 3.0 to 2.1 by 2010; increase the contraceptive prevalence from 54.2% to 70%; reduce IMR from 63 to 16 per 1000 births; and reduce MMR from 389 in 1992-93 to less than 100 by 2010 (Table 1.6).

The key strategies to achieve these goals and objectives were: paradign shift from population control to reproductive and child health approach[15]; improve quality of services and make them client-oriented; promote gender equality, women empowerment and male paritcipation; decentralization, structural changes and financial reforms; promote inter-sectoral coordination and partnership between Government organizations, NGO, corporate sector, co-operatives and private sector; enforce accountability of public, private health and social service sector; resource mobilization, alternative financing and better financial utilization; and social mobilization through information, education and communiction.

Table 1.6	Targets under Gujarat Population Policy	
Health Indicators	**Current Status**	**2010**
Total Fertility Rate	3.0 (1998)	2.1
Couple Protection Rate (%)	54.2 (2001)	70
MMR, per lakh	389 (1992-93)	< 100
IMR, per 1000	63 (1999)	16
Under 5 mortality rate, per 1000	20.4 (1996)	< 10
Immunization (%)	48 (1998-99)	100
Delivery by trained attendants (%)	74.2 (1998-99)	100
Institutional Delivery (%)	46 (1998-99)	80

Source: Gujarat Population policy, 2002

. Thus the policy has recognized that infant mortality, maternal mortality and incidence of infectious diseases can be curtalied only by enhancing awareness among women; increased involvement of stakeholders; improved performance of health delivery system and establishing an effective monitoring system. In consonance with the NPP,

[15] Khanna, Renu: Women's Perspective on Population Policies; Feminist Critique of Population Policies: Population Policy of Gujarat – Medico Friend, July-Oct 2001.

Gujarat Population Policy also focuses on improving quality of life of people and improving women empowerment. The state has constituted Gujarat Population Commission (GPC) to oversee the implementation of the policy, review the progress and act as advisory body to the Government on population and development matters.