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TOWARDS A RATIONAL HEALTH FUTURE

I am very grateful to Prof. H.D. Tandon for inviting me to address the convocation of an august body like the National Academy of Medical Sciences. I deem it a great honour particularly since in the past your convocations have been addressed by some of the most illustrious sons of our country.

I have no expertise in the disciplines whose promotion is the primary concern of your Academy. However, anyone who works in the Planning Commission develops some understanding and awareness of pressing national problems, even though he may not have any particular expertise in those areas. The development of an effective national health care system is no doubt of great importance for social and economic development of India. Thus as part of my work in the Planning Commission, I do get opportunities to look at the planning of health care services. I, therefore, thought that the best use of the opportunity you have provided me would be to share with you some reflections on the planning of health care system in our country.

In the history of health planning in India, the Report of the Health Survey and Development Committee (the Bhore Committee) which appeared in1946 was truly a great landmark. This Committee set out a bold vision for the development of a nation wide health care system and also outlined a comprehensive action programme to realize this vision. Because of its broad sweep and the comprehensive nature of its recommendations, this report has had a powerful impact on the evolution of health policy in independent India.

The main principles underlying the Committee's proposals for future health development were as follows :

a) The large amount of preventable suffering and mortality in India is mainly the combined result of inadequacy of provision in respect of environmental sanitation, nutrition, health education and medical services. Thus a broad based multi-sectoral strategy is needed to tackle the problem of low level of health in India and health planning is to be seen as an integral part of the overall planning for social and economic development.

b) The expansion of medical services is an important element of a strategy to improve the health status that no individual should fail to secure adequate medical care because of inability to pay for it.

c) The health programme must, from the beginning, lay special emphasis on preventive work.

d) Health services should be placed as close as possible to the people in order to ensure the maximum benefit to the communities to be served. There is, therefore, an urgent need to provide as much medical relief and preventive health care as possible to the vast rural population of the country.

e) It is essential to secure the active cooperation of the people in the development of the health programme. Health consciousness should be stimulated by providing education on a wide basis as well as by providing opportunities for the individual participation in local health programmes.

Based on these principles, the Committee elaborated both medium-term (ten-year) and long-term (forty-year) perspectives for the development of health care system. The Committee proposed a comprehensive three-tier system of primary health care for a typical administrative district with a population of about three million. For the successful implementation of this programme, the Committee envisaged a massive expansion in the number of trained personnel at all levels. In addition, the Committee made several suggestions for the improvement of environmental sanitation and nutrition standards.

The Bhore Committee's emphasis on integrated primary health care, social and preventive aspects of medicine and health care, people's participation and strong inter-sectoral cooperation for the realization of health goals is now an accepted part of the national strategy for the planning of health care system. Beginning with the First Five Year Plan, considerable progress has been made in developing primary health care facilities which seek to provide an integrated package of services dealing with medical care, maternal and child health, family planning, control of communicable diseases, environmental sanitation and health education. The three-tier system of rural health care, consisting of subcentres, primary health centres and community health centres is by now nearly fully operational. By the end of the Sixth Five Year Plan, the country had 83026 sub-centres, 11101 primary health centres including subsidiary health centres and 649 community health centres.

Until the early seventies, various national programmes in the field of health, family welfare and nutrition were functioning almost independently of each other. There was little or no coordination between the field workers of these programmes. This was sought to be corrected in 1974 when, on the recommendations of the Kartar Singh Committee, the Government decided to convert the uni-purpose health workers engaged in delivery of services for a single, specialized health condition into multi-purpose workers (one male and one female worker serving a population of about 5000 in plains and 3000 in hilly and tribal areas) for provision of an integrated package of simple health care services at the grass-root level. Although the training programme for multipurpose functionaries has not progressed satisfacatory,1.60 lakhs of such workers had been trained by the end of the Sixth Five Year Plan.

A further major step forward in the development of a participatory, decentralized and people-oriented primary health care system was taken in 1977 when, on the recommendations of the Shrivastava Committee, the scheme of community health volunteers was launched with one health volunteer being selected by the people themselves for a population of 1000. The scheme was intended to secure close cooperation between the community and the organized health services at the grass root level. As on 1st April 1985, 3.5 lakh health volunteers/guides were in position.

There has been a large expansion in training facilities for health personnel of all categories. The country now produces 12000 doctors per annum as against 3000 at a time of independence. The number of medical colleges has gone up from 25 in 1948 to 110 in 1985. To give social orientation to the medical education, upgraded departments of preventive and social medicine were established soon after independence in all medical colleges. They seek to provide a social dimension to the practice of various clinical disciplines and to relate the elaborate field of community health to the social, cultural and economic setting of the country. We have a wide network of apex level institutions which are doing creditable work in their respective fields of research, education and training. The country has now a carefully worked out programme of medical and health research centering on control of communicable diseases, fertility control, promotion of maternal and child health, control of nutritional and major metabolic disorders and the development of alternative strategies for health care delivery. Thrust areas have been identified in each broad field.

Recognizing the great importance of elementary education, adult education, safe drinking water, housing and nutrition in the promotion of health, these items were included in the Minimum Needs Programme launched during the Fifth Plan. This programme is now an integral part of our Five Year Plans.

As a result of all these developments, there has been a significant improvement in the health status of the nation. There has been a steady fall both in the general death rate as well as in the infant mortality rate. The life expectancy at birth has almost doubled in the last forty years. Even, then, the overall pace of progress cannot be considered very satisfactory. As was pointed out in the *Statement on National Health Policy* issued in 1982, in spite of significant progress, "*the demographic and health picture of the country still constitutes a cause for serious and urgent concern*". In this context, the policy statement drew the country's particular attention to the following aspects :

i) The high rate of population growth continued to have an adverse effect on the health of our people and the quality of their lives.
ii) The mortality rates for women and children were still distressingly high.
iii) Efforts at raising the nutritional levels of our population were still to bear fruit and the extent and severity of malnutrition continued to be exceptionally high.
iv) Communicable and non-communicable diseases were still to be brought under effective control and eradicated.

More or less similar conclusions were reached by the ICSSR-ICMR sponsored study entitled "*Health for All-An Alternative Strategy*" published in 1981. Although nearly five years have passed since the publication of the *Statement on National Health Policy*, the list of areas identified therein as being a cause for serious and urgent concern still remains valid. The country's population is still growing at an annual rate of about 2 per cent. The infant mortality rate which is a sensitive indicator of the state of the nation's health is still at an unacceptably high level of 105 deaths per 1000 live births. Although plague and small pox have been eradicated, incidence of cholera and malaria curbed, the over-all situation regarding control of major communicable diseases is far form satisfactory.

Experience of countries like China, Sri Lanka and of States like Kerala shows that access of health care and medical services is an important influence on the death rate. In this context, one has to recognize that despite a significant quantitative expansion of health services since independence, the overall pace of expansion has been inadequate when judged against objective needs. Thus while the Bhore Committee had recommended that the hospital-bed ratio be raised to 1.03 over a ten year period, this ratio was as low as 0.65 even in 1985. Judging by past rends, the country has no chance of achieving the Bhore Committee's targets for 1971 in terms of doctor-population ratio (one doctor for 1000 population), nurse-population ratio (one nurse for a population of 300) and other para-medics-population ratio even by the turn of the century. This of course is not a recent development. As early as 1961, *The Health Survey and Planning Committee* (presided over by Sir Lakshmanaswamy Mudaliar) had come to the conclusion that it was not feasible for the State to provide free medical service on the scale visualized by the Bhore Committee in the near future. The Bhore Committee had obviously taken too optimistic a view of the financial and administrative constraints to the rapid expansion of health services. Taking a more realistic view, the Mudaliar Committee came to the conclusion that it should be considered fairly satisfactory if the ratio of one bed per 1000 population was achieved during the fourth or fifth plan periods. Unfortunately, this target is far from being achieved even in 1987.

The inadequate quantitative expansion of medical services has been accompanied by persistence of large regional disparities in the availability of health services and sharp inequalities in the access to these services. In particular, the needs of rural areas and the under-privileged sections in urban areas have yet to receive adequate attention. Despite sustained emphasis on primary health care, the system remains highly biased in favour of urban areas, and provision of secondary and tertiary care. In allocating scarce resources, the needs of super-specialties located in large urban conglomerates often receive greater attention than the provision of elementary basic health services at the grass root level. The qualitative aspects of services rendered by the primary health centres are far from the vision visualized by the Bhore Committee. There have been visible gaps in the education and training of health personnel. In particular, there has been a persistent lag in the training of para-medical and auxiliary workers so that the primary health care system continues to suffer from inadequacy of supporting facilities, resources and personnel. Training and education still tend to be too theoretical and didactic with inadequate emphasis on attitude building and development of practical skills. Social reorientation of medical education seeking to introduce a community bias in training with due emphasis on preventive and promotive services is still a distant dream. We are training doctors who are not motivated enough for providing services in rural areas. The departments of preventive and social medicine have failed to attract enough of talented persons since clinical disciplines enjoy much greater prestige. The Bhore Committee's ideal of the doctor of the future being a social physician protecting the people and guiding them to a healthier life is far

from being a reality. Medical and health research shows promising results but there is still a significant communication gap between the researchers, planners, policy makers and users of technology in the health services. The fruits of researches conducted in the country have often not percolated to the grass-roots of the health delivery system. Research in hospital management and administration and in public health engineering have not received as much attention as they deserve.

Factors contributing to the present unsatisfactory state have been aptly brought out in the *Statement on National Health Policy, 1982*. To quote this document :

"The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and the establishment of curative centres based on the western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based, disease and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, especially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive public health and rehabilitative aspects of health care. The existing approach, instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policies in regard to the education and training of medical and health personnel, at various levels, have resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve individuals and families in establishing a self-reliant community."

Together with inadequate growth of health services and the grave structural and functional weaknesses of the health delivery system, there have been several other environmental factors which have limited the scope for improvement in the nation's health status. Planning for better health cannot take place in isolation but has to be viewed as an integral part of an overall design to provide income and food security, and improved access to such basic amenities as education and safe drinking water. Although food production in India since 1950 has on the whole risen at a rate faster than population, per capita availability of food grains has not shown a significant increase. This coupled with the prevailing inequalities in income and wealth, creates a situation whereby all citizens are not assured of minimum essential supply of food and nutrition. It is, therefore, not surprising that until the mid-seventies, the proportion of people below the poverty line did not show any strong downward trend. Both the Bhore Committee and the Mudaliar Committee had pointed out the harmful consequences of malnutrition on the health and wellbeing of people. Although some intervention strategies such as the expansion of public distribution system, provision of mid-day school meals and supplementary nutrition programmes meant for pre-school children and pregnant and lactating women have been evolved, their impact on the nutrition status is still limited. Similarly, though both the Bhore Committee and the Mudaliar Committee had stressed the importance of ensuring the supply of safe drinking water, the progress has been rather slow. Also, arrangements for sanitation and disposal of human wastes still remain highly inadequate. Moreover, with a literacy rate of nearly 36 per cent and a much lower literacy rate for women, growth of health consciousness through proper education has yet to make much headway. High infant mortality, illiteracy among women and inadequate access to health care facilities still constitute a formidable barrier to the voluntary acceptance of the small family norm. It is not surprising that although India was the first developing country to officially launch a programme of family planning, there has been as yet no perceptible decline in the rate of population growth in the last thirty years. And if our population continues to grow at more than 2 per cent per annum, the goal of providing decent health care facilities for all the citizens may allude us for a long time to come.

Since the adoption of the statement on National Health Policy, Government have taken several measures to expand and streamline the country's infrastructure of health services. The Seventh Five Year Plan envisages a significant expansion in the facilities for primary health care. Thus by the end of the Seventh Plan, the goal of having one sub-centre for a population of 5000 in plains and 3000 in tribal and hilly areas is likely to be achieved. The goal of having one primary health centre for a population of 30,000 in plains and 20,000 in hills is also likely to be achieved. Considerable progress is likely to be made in achieving the target of establishing one community health centre for a population of one lakh by 2000 A.D. A good deal of attention is being given to reorientation of medical education. Planning, production and management of health manpower is receiving added attention. An expert committee under Dr. J.S. Bajaj which has recently looked into this matter has emphasized the urgent need to enunciate a national policy on education in health sciences, with clear perspectives and well formulated strategies for the future growth and development of health manpower in the country.

Intersectoral cooperation for promotion of health is also being increasingly emphasized. The comfortable food situation has created new opportunities to expand the network of public distribution system and for paying greater attention to the nutritional status of the more vulnerable sections of our people. Since the Sixth Five Year Plan, there has been a very substantial expansion in the anti-poverty programmes which seek to enhance the income and productivity of the poorer sections of the population. The new education policy firmly commits the Government to the universalization of elementary education. By the end of the Seventh Plan, all problem villages are likely to be provided facilities for safe drinking water. The ICDS programme which is now operating in about 1500 blocks is making an important contribution to improving the health and nutritional status of pre-school children. Altogether, the overall environment is now more conducive to the promotion of health than ever before. There is a growing realization that planning of social services should take place as part of the overall strategy of human resource development.

All this augurs well for a more forward looking action programme for the future growth of our health care system. However, as the ICSSR-ICMR study pointed out, the objectives and targets of the health sector cannot be achieved by a linear expansion of the existing system and even by tinkering with it through minor reforms. The time has, therefore, come for a major fresh look at our strategies and programmes for health care. We must work out a new design of the national health care system which is both effective and equitable and which the country can also afford at the present stage of its development. Modern health care systems based on western models are proving to be a very expensive proposition even in highly developed countries. Thus given the poverty of our country, a blind copy of these models cannot help to universalize access to basic health care facilities.

It goes without saying that any major new initiative on the health front will require both additional outlays and thorough overhaul of the many of the existing approaches to the education and training of medical and health personnel and the organization of the infrastructure of health services. There should be an intensive debate on these issues so that we can evolve a new perspective on health which is fully integrated into a well thought out design for the development of the country's human resources.

Experience elsewhere suggest that although the development of an effective health system is not very cheap, it is not beyond reach given the requisite political will and a firm commitment to the goal of social equity. According to available estimates, China spent about 3.3 per cent of GDP in the early eighties on healthcare and through a carefully designed strategy was able to achieve highly impressive gains in the health status of its people. Thus the death rate fell from 25 per 1000 in 1949 to 6.6 per 1000 population in 1982. The infant mortality rate declined from 200 per 1000 live births in 1949 to 35 per 1000 live births in 1982. The average life expectancy rose from 35 years in 1949 to 69 years in 1982. In our country, the experience of Kerala indicates that despite a relatively low level of income, it is possible to reduce mortality rates substantially by integrating health policies and programmes with a broad based strategy of socio economic development.

The ICSSR-ICMR study referred to earlier has estimated that for financing an effective health care system India would need to spend 6 per cent of its GNP on health care by 2000. The country is already committed to spending 6% of its national income on education. These are highly desirable objectives. However, their realization would involve a massive step up in national expenditure on health and education. The implications of such a large step up need to be clearly understood. There should be an enlightened national debate on the financing of an expanded programme of social services like education and health.

It is likely that in the present state of the country's development, the bulk of expenditure on education and health will have to be in the public sector. Thus if the requisite resources are to be devoted to health and education programmes without hurting the pace of economic expansion, there will have to be a significant improvement in the state of public finances. In particular, the country will have to be prepared to pay as taxes a much higher proportion of national income. After all, increased outlays on health and education can hardly be financed by recourse to borrowings. In addition, there has to be much closer scrutiny of non-plan expenditure particularly on subsidies. The country cannot simply agree to spend more on health and education and at the same time go on giving more and more subsidies for the use of electricity, water and fertilizers. Simultaneously, the internal resource generating capacity of public enterprises must be improved. Above all, there should be a careful identification of national priorities and scarce national savings should be used to the maximum extent possible for meeting the basic human needs of our people rather than in copying life styles of affluent post industrial societies. There must be a firm commitment to the objective of social equity in the deployment of national resources.

There are also important issues in the management of health services. Because our country is so poor, utmost emphasis has to be laid on developing a health care system which is cost effective. A decentralized, people oriented health care system with strong emphasis on preventive and promotive aspects of health care and people's participation can make an important contribution to the realization of this objective. Thus, while ensuring strong Central commitment, guidance and financial support for the expanded national health care system, its management and operation should be decentralized to the maximum extent possible. Moreover, to secure optimum results, the management of the health services should be integrated into a comprehensive strategy of human resources development – a strategy which takes into account local needs, resource endowments and social and cultural characteristics of a region. It is only by adopting location specific strategies that we can secure adequate participation of the people in the management of health and human resource development.

In the financing of an expanded programme of human resource development, there should be equitable participation on the part of Centre, States and local authorities. The objective should be that by the year 2000 all the development blocks in our country should enjoy a nationally approved minimum package of services and facilities included in the national minimum needs programme. As I stated above, the health policy and perspective should fit into this larger design. I, therefore, sincerely hope that in months to come there will be an intensive discussion of the issues involved in elaborating the health perspective for the nation so that by the time we come to formulate the Eighth Five Year Plan, this perspective shall form an integral part of the national plan for social and economic development, striving, to achieve, among other things, the cherished national goal of health for all by the year 2000 A.D.