CHAPTER - II

CHAPTER - II
REVIEW OF LITERATURE

SECTION 'A'

This Chapter deals with a brief review of the developments in the medical and health in India. It covers the provision of health care services, establishment of hospitals and dispensaries. It lays emphasis on the provision of sanitation, clean-water supply, school health services, essential drugs and personnel problems. This will help to know the existing machinery for health-care. This will focus on the gap between the medical and health-care. Also, this will indicate the areas yet to be considered by future studies.

The Health Survey and Development (Bore Committee 1943-46) Committee[1] came to know that the curative and preventive services were inadequate. The Committee opined that there were insufficient hospitals and dispensaries providing medical relief to the rural people. Also the Committee stressed that the quality of the services provided to the rural people was very poor. The Committee recommended that:

(a) No individual should lose the opportunity to avail medical relief because of his inability to pay for it;

(b) All laboratory and institutional facilities should be provided to the consultants for the proper diagnosis and treatment;

(c) Health programme should start from the very beginning, stressing on preventive work;

(d) Medical relief and preventive health care should be provided to the vast rural people as much as possible. Health services should be placed as close to the people in order to get maximum benefit to the communities to be served.

(e) Health consciousness should be greased with the help of health education and providing opportunities to the people to participate in the local health programmes.

(f) The medical services should start from the place where they are required.

The Environmental Hygiene Committee (B.C.Das Gupta Committee - 1948-50)[2] found that the houses in the rural area are built without the facilities of latrines and water supply. The Committee strongly recommended that the programme must be planned for water supply in the rural area over a period of time. The State Governments should extend the Rural Malaria Control by spraying of DDT regularly in all the malaria endemic areas. Every State Government should pass a comprehensive Public Health Act. The Central Government should shoulder the responsibility to make available the personnel required for the improvement of environmental hygiene.

The Homeopathic Enquiry Committee (J.N.Mukerjee Committee : 1948-49)[3] recommended the establishment of a

Central Council of Homeopathic Medicine. The practitioners of Homeopathic Medical System should register under this Council and the Central and State Governments should take strong action to penalise against the users of bogus and illegal degrees, diploma, titles, etc. The State should exercise control over concerned homeopathic pharmaceutical laboratories and manufacturers. The Committee stressed the paramount necessity of proper scientific training to all the persons who desire to practice homeopathy as a profession.

Model Public Health Act Committee (Das Gupta Committee : 1953-55)[4] was appointed by the Government of India to draw up a model comprehensive Public Health Act, which the various States in India might enact with such modifications as may be necessary to suit the local conditions. The Committee in its report recommended a unified and integrated health organization at various levels to be operated through:

(a) Directorate of Health Services : This was to be under the Director of Health Services, assisted by the required number of Deputy Directors for individual programmes/activities;

(b) District Headquarters Organization : The medical Officer of Health shall be the Chief Administrative Officer in charge of health services in the district. He would be assisted by one or more Deputy Medical Officers of Health;

(c) Sub-Divisional Headquarters Organization : The Sub-Divisional Officer of Health shall be in charge of medical and health services in the sub-division and would be supported by necessary medical and para-medical personnel;

(d) Thana Health Centre Organization (in urban area): The Thana Health Centre Organization would be located in urban areas and would be under the charge of the Thana Medical Officer of Health, who will also supervise the Rural Health Centres. The organization will consist of staff of the hospitals and dispensaries, sanitary inspectors and health assistant supported by three or more field workers and lady health visitors, supported by midwives;

(e) Rural Health Centre: The Rural Health Centre would have, besides the Medical Officer, Health Visitors with ANM (Auxiliary Nurse Midwives) for midwifery and child welfare services and Health Assistants for vaccination, inoculation, disinfection and other sanitation works.

Dayashankar Trikamji Dave Committee (1955)[5] recommended to establish two separate councils, similar to the Indian Medical Council. These councils should have control over the maintenance of uniform teaching started in all institutions. One council meant for Ayurvedic and Unani systems of medicine and the other for Homoeopathic system. Separate Directors for

(a) Ayurvedic and Unani, and (b) Homoeopathic, systems of medicines should be created in the Government of India's Central Ministry of Health and also in the State as far as possible. All the teaching institutions should have indoor hospitals. Refresher courses in Ayurveda, Unani and Homoeopathy Systems should be organized in teaching institutions.

Udupa Committee (1958-59)[6] recommended to adopt uniform policy of teaching and practice of Ayurvedic in the rural areas of the country. Government should start at the State, district and tahsil level the Ayurvedic hospitals and dispensaries. Where it is not possible, the wards of Ayurvedic out-patient department should be set up in modern hospitals. Registration of the Ayurvedic practitioners should be enforced and completed in all States. They should be given privilege to issue the medical certificates of all types, as it has been given to the modern medical practitioners.

Health Survey and Planning Committee (Mudaliar Committee : 1959-61)[7] recommended that:

(a) The attempt to start mass campaigns against certain diseases like tuberculosis, small-pox, cholera, leprosy and filariasis, is commendable but the method of dealing with these diseases individually will not be conducive to the organization of unified efforts needed for the promotion of total health care. The health personnel engaged in such mass campaigns must be trained to tackle all health

problems in any area while the overall supervision for particular disease may require special attention through specialists; in rural areas, it is neither possible for desirable to have separate agencies to deal with separate diseases.

(b) Paramedical personnel recruited at present for individual diseases such as BCG, leprosy, malaria and filariasis, should be given further necessary training in other diseases in order to make them multi-purpose personnel and allocate them to urban and rural centres. Otherwise, there is likely to be immense loss of manpower.

(c) There should be an Auxiliary Nurse Midwife for every 5000 population and Auxiliary Health Worker for double that population.

(d) The problem of integration of medical and health services should not be postponed because of certain initial difficulties.

(e) The technical set up at State-level should be headed by a Director of Health Services with a number of Deputy Directors.

School Health Committee (1960)[8] recommended to provide all children with school health services for their personality development and for their well-being. These services should form the part of the general health services of the community. One additional school officer and four auxiliary

nurse midwives should be increased to carry this programme. The Committee also recommended to form councils and sub-committees from central to village level to achieve and look after the school health services.

National Water Supply and Sanitation Committee (Smt.Lourdhammal Simon Committee : 1960-62)[9] suggested that the rural water supply and sanitation should be given very high priority, as they have far-reaching effects in rehabilitating rural health and economy. Rural sanitation forms an integral part of the programme.

Contributory Health Services Scheme Assessment Committee (1961-62)[10] opined that the highest priority should be given to provide separate permanent building for all dispensaries. The dispensaries should be provided appropriate general practitioners and specialists. All the staff members should reside within the premises of dispensaries. The Committee is also of the view that the contributory health administration should periodically meet different categories of staff arranged for talks on personnel management, patients relationship, community health and corporate life.

Family Planning Programme[11]: India recognized the importance of controlling the population from the very beginning of its development plans. The Family Planning Programme upto 1961 was being implemented as a part of the health programme. However, the Census of 1961 revealed that the

Family Planning Programme, though being run for nearly a decade, had not made much headway and that hardly any appreciable reduction had been achieved during the previous decade in the growth rate of population.

In 1961, India invited UN Mission on Population Activities to visit the country and advise on the steps to be taken for greater acceptance of the small family norm by the population. The recommendations of the UN Mission were considered by the Committee appointed by the Government of India. Based on the recommendations of this Committee, it was decided to have Family Planning Programme as a vertical programme with a separate hierarchy at the central level, in the form of a separate Department of Family Planning to the most peripheral level with separate workers of family planning. Considering the direct relationship between infant mortality and acceptance of small family norms, it was also decided to integrate the Mother and Child Health (MCH) Programme with Family Planning.

Committee on Essential Drugs (K.N.Rao Committee 1966-1969)[12] suggested to avoid multiplicity of drug manufacturers. The Government should produce, through public sector, essential drugs that are consumed in large quantity. It also advised the Government to publish a Journal to educate the doctors and medical practitioners and to organize one Committee for screening the literature and publishing materials relating to drugs.

The Study Group of Hospitals (Ajit Prasad Jain Committee, 1966)[13] recommended to raise the bed strength at the Primary Health Centre (PHC) from six to ten. Atleast one of the sub-centres in the block should be raised to the status of a PHC to reduce the burden of the PHC. There should be one lady doctor for Family Planning work, in addition to the lady medical officer in the PHC. The laboratory technician at the PHC should be utilized to undertake the blood and urine tests of the patients attending the PHC. The Committee also recommended that one of the allopathic dispensaries, existing, should be upgraded in any block or which do not have any PHC. Accommodation facilities should be provided to the doctors. The Committee felt that it is the need of time for setting up of the out-patient department and emergency services, special hospitals to the status of the PHC.

The Committee on Multi-purpose Workers under Health and Family Planning Programmes (Kartar Singh Committee 1973)[14] recommended that, "multi-purpose workers for the delivery of health, family planning and nutritional services are both feasible and desirable". The programme of having multi-purpose workers should be introduced in the first phase in areas where malaria is in the maintenance phase and small-pox has been controlled. The programme can be extended to other areas as malaria passes into the maintenance phase or where small-pox is controlled. This will be the second phase.

The workers engaged in the cholera control, filaria and leprosy programmes may continue as such for the time being. Similarly, BCG vaccinators may also continue as such. However, all these workers will be made multi-purpose workers in the third phase of the programme.

The Committee also recommended integration at different levels. The doctors at the PHC should be able not only to render health care to the population, but also to check the work of the health workers at the sub-centres and their supervisors. All the dispensaries in the jurisdiction of a PHC should be linked with it. Also the doctors of the PHC should divide the population on a geographical basis for their field visits. While one doctor is on a field visit, another should be available at the PHC.

Better co-ordination between the PHC and taluka/ tehsil level hospital and administration and between the latter and the district level agencies concerned with health is essential. The links between these agencies and medical colleges are also to be established/improved. Similar is the case for a revamping of the health administration machinery.

The Committee observed that with the diverse, diffuse and at times, conflicting array of medical facilities available in the country, it is not surprising that there is a constant cry of neglect and of inadequacies, particularly for the under-privileged sections of the society, which

constitute the vast majority of the population. Even though the country has the poor doctor:population proportion, as compared to the developed societies, it is an incontrovertible fact that the proper harnessing of the available resources and a re-organization of the entire system can go a long way in solving the health problems of the society.

All these recommendations of the Committee are implemented in Maharashtra. Initially, the medical officers of the PHC have divided the population on the geographical basis, but the visits to the sub-centres and the villages are paid on the papers instead. Merely one or two visits in a year are paid to the sub-centres that are on the way. Work execution of the Auxiliary Nurse Midwives is done in the PHC itself.

The Government of Andhra Pradesh[15] has brought out a comprehensive report on the public health, which has thrown sufficient light on the issues like control of communicable diseases, health services, food and nutrition, environmental hygiene and personnel management. Telangana region has been dealt with separately. The Report is of descriptive nature. It did not point out the operational problems and adequacy of the services available in both urban and rural areas.

Rao[16] opined that the health of the Indian people depends on three main factors, viz. standard of life, standard of the education and the organization of the public health

services. He felt that the aims of the organizations of public health services should satisfy the needs of the people. All the health workers, whether Governmental, voluntary or private, should work for a common objective, namely, the health and the well-being of the nation. The Department of Public Health and Medicine should form a single unitary agency and function with the co-operation of the entire medical profession and voluntary agencies to advance these objectives.

Jawaharlal Nehru,[17] in his speeches, exhorted the delegates and participants to work for the maintenance of high health standards. He also recommended to utilise the Ayurvedic and Unani system and had a strong plea to extend the medical and health services to every individual of the country free of cost.

Prodipto Roy and Joseph Kivlin[18] have exposed the problems and prospects of the Family Planning on the countryside.

The three major Seminars conducted by the Indian Institute of Public Administration, New Delhi, during May 1971 to August 1971[19] mainly dealt with the Family Planning in the country - the policy involved administration of the various Family Planning Programmes. Since its main focus on Family Planning, the health objective did not receive any attention, except to make a mention in few places for the purpose of reference and not to highlight its policy or its attendant problems.

An evaluation study conducted by the Government of Andhra Pradesh in 1973 on the working of Primary Health Centres[20] has pointed out various inadequacies in achieving the objectives of the Primary Health Centres and made a number of recommendations on the powers and functions of the medical officers, the role of Development Officers and importance of training. Also, it recommended the necessity of providing conveyance to the field staff.

The Srivastava Committee (1974)[21] suggested the following measures:

> A nation-wide network of effective and efficient services suitable for our conditions, limitations and potentialities should be evolved. Steps should be taken to create bands of para-professional or semi-professional health workers to form the community itself for providing simple, protective, preventive and creative services required by the community.
>
> The primary health centre should be provided with one additional doctor and a nurse to look after maternal and child health services.
>
> The possibility of utilizing the services of senior doctors at the medical colleges, regional, district or taluka hospitals for brief periods at the primary halth centres should be explored.

The primary health centre, tahsil, district, regional and medical college hospitals should develop living and direct link with the community around them as well as with one another within a total referral services complex.

The Government of India should constitute an Act of Parliament, a Medical and Health Education Commission for coordinating and maintaining standards in medical and health education on the pattern of University Grants Commission.

Blakie[22] commented on the effectiveness of the Indian Family Planning Programme and the health care of the poor and the inadequate attention paid to the health standards of the countryside.

The Indian Council of Social Science Research, in a Survey in Research in Public Administration (1973),[23] makes it clear that only macro studies have been undertaken in the sphere of health. It expresses the need to make study on micro level.

Thapar[24] advocated the need for immunization of the children upto 6 years against various diseases and provide anti-natal care facilities to all pregnant women. He recommended to develop indigenous medicines to integrate services of Ayurvedic doctors.

Talgeri and Ashok Mitra,[25] both have stressed on the control of population.

Athreya[26] is of the opinion that the demand of hospitals is increasing but because of inadequate finance, the demand remains quite. This must be overcome with availing the funds required to fulfill the demand of hospitals.

Goel[27] has done a great work by writing four books on the significance of health and how such aspects could not receive proper attention of the Central and State Governments. He deeply stressed on the want of sound administrative system that is important in achieving the goals or objectives of health policy. He recommended that the proper training and periodical orientation courses should be sponsored for those who are responsible for health care.

Sethi[28] identified various problems of health and advised to decentralize the health care facilities.

Murlimanohar and Rameshwaram[29] pointed out why the doctors are not ready to work in the rural areas. They advocated to appoint the village health workers on the lines of Chinese barefoot doctors.

Vasant Prabhakar Pethe,[30] in his book 'Population Policy and Compulsion on Family Planning' devoted to the population growth and family planning and various problems relating to both the aspects.

Nirmal Murthy[31] focused on the Family Planning Programme carried out by various large organized sectors. The acceptance rate of family planning in these organized programmes were higher than those in the National Programmes. This study is related with the issue of the family planning.

Merchant[32] pointed out that no proper guidance is given to the patients about the dosage, side effects or adverse reaction of the drugs while distributing it to them. To overcome this, Mr.Merchant has recommended the appointment of Pharmacy degree- or diploma-holders.

Gopalan[33] has touched the very important aspects of health such as nutrition and expressed the need for arrestig under-nutrition.

Shrinivasan[34] stressed that health-care is one of the most important of all human endeavours to improve the quality of life of the people and commented on the inadequacy of the health-care services.

Maya Reddy[35] cleared that the shortage of drugs at Primary Health Centres is not the end-result of proper utilization of scarce resources.

Jawaharlal Nehru,[36] knowing the exact importance of health in nation-building, says that if the funds can be available for big wars there is no reason why they should not be provided for the fight against ill-health.

Satyanarayan Rao[37] commented on the absence of uniform policy on health, defective administrative structure, the problem of coordination and accountability, non-associationship of specialists in the policy formulation and recommended to organize integrally the large teaching hospitals in the State.

Again Satyanarayan Rao has experienced that the Central and State Governments have not paid attention as much required on the problems of health and have failed to evolve comprehensive health scheme as majority of the people do not receive proper benefit through the medical care programmes. He pointed out many deficiencies in the organization and working of the Osmania General Hospital.

Venkatadri[38] pointed out that the municipal authorities have been giving greater attention to the preventive side rather than curative side. He felt that the efficiency of the public health administration should be assessed in terms of public satisfaction.

Harichandran[39] stated that the attainment of the health for all by 2000 A.D. will remain a daydream unless due attention is given. The problems of under-nutrition and malnutrition afflict a considerable section of the society. Mortality and morbidity have a link with malnutrition. The worst victims of this problem are children in the age groups of 0 to 6 years, pregnant women and nursing mothers. He suggested to improve the nutrition power of the poor people.

For this, the Integrated Child Development Proramme (ICDP) and other programmes like literacy, rural sanitation and water supply should be formulated.

Y.P.Rudrappa[40] says that the primary health care connote different things to different people and different countries. But as declared, primary health care should atleast include -

(a) Health education regarding prevailing health problems, methods of controlling and preventing them;

(b) Adequate food supply and proper nutrition;

(c) Adequate supply of safe water and basic sanitation;

(d) Maternal and child health services, including family planning;

(e) Immunization against major infectious diseases, prevention and control of locally endemic diseases;

(f) Appropriate treatment of proper diseases, injuries and provision of essential drugs.

This is to enable the citizens of the country to reach the level of health that will permit them to lead a socially, economically productive life. This has to be achieved as a part of overall development and in the spirit of the social justice.

Y.P.Rudrappa[41] correctly has pointed out that the primary health care cannot be achieved by health sector

alone. To succeed the strategy, it must involve other economic development sectors related to health, viz. education, agriculture, water supply and sanitation, communication, etc. Not only the doctors or other health professionals, but all health professionals of all categories and of systems of medicines, whether allopathy or any other can tackle this task. Allopathy, Homoeopathy, Ayurveda, etc., shall have to be involved. He has suggested correctly the involvement of all systems of medicine and all components of health teams to achieve the national health goals, a National Master Plan, which indicates what has to be done? who has to do it? during what time? and with what resources? He has also expressed the want of provision for evaluation of the plan.

ICSSR Committee[42] recommended that: (1) the Government of India should, in consultation with all concerned, formulate a Comprehensive National Policy on Health, dealing with all its dimensions. Implementation of this policy will be collaborative and cooperative responsibility of individuals, families, local committees, health personnel and State and Central Governments, and (2) the basic objectives of the policy should be:

(a) to integrate the development of the health system with overall plans;

(b) to provide an environment and an access to adequate food by each individual;

(c) to extend the edges of literacy;

(d) to replace the existing model of health care services by an alternative new model which will be :

- combining the best elements in the tradition and the culture of the people with modern science and technology;
- integrating promotive, preventive and curative functions;
- democratic, decentralized and participatory;
- oriented to the people, i.e. providing adequate health care to every individual and taking special care of the vulnerable groups;
- economical, and
- family rooted in the community and aiming at involving the people in the provision of the services they need and increasing their capacity to solve their own problems;

(e) to train the personnel, to produce drugs and to organize research needed for this alternative health care system;

and finally, (3) a detailed, time-bound programme should be prepared, the necessary administrative machinery created and finance provided on the priority basis, so that this new policy will be fully implemented and the goal of health for all by 2000 A.D. will be achieved.

Lal Bbahadur Singh[43] points out the effect of unemployment on the educated youth. He says that educated unemployed youths suffered from greater number of general

health problems of a psychological nature as compared to the employed youths.

P.Pande, A.K.Mohanty and R.C.Pradhan[44] have studied the Integrated Child Development Scheme (ICDS). They have focused light on adult education, immunization, health education, nutrition and community involvement for the development of the child.

The Working Group on Health (1980),[45] revising Minimum Need Programme, recommended the new pattern for establishment of District Hospitals, Sub-divisional Health Centres, Community Health Centres, PHC's and Sub-Centres. The group also advised to appoint health volunteers for every village or for each 1000 population. For water supply, coordination committee should be formed and simultaneous efforts must be made to arrange environmental sanitation alongwith water supply. The Working Group is of the opinion that special training should be given to the existing health workers for manpower development. Special incentives should be given to the medical personnel for working in rural areas, which should include rural posting allowance, non-practising allowance, an educational allowance for their children, rent-free residential quarters or HRA, etc. Unemployed doctors should be employed in rural areas with offer of certain incentives like loan at low rate of interest, subsidy in purchase of certain instruments, honararium and to make available the place for the construction of residence and clinic. The Group also

opined that the eradication of poverty, inequality and ignorance must be eradicated for the progress of good health care services. The Group further advised to provide maternal facilities for infant and child health care.

Pandav and Kochupillai[46] thought that the difficulty of obtaining iodized salt was responsible for the continuing goitre problem. But as pointed out in the article, only this is not the case, several things need to be done to make the control programme successful.

H.Mahadevappa[47] aptly knowing the importance of health education said, "It is vital that strenuous efforts must be made to achieve health education among the population, using all devices like TV, radio, etc. In addition to this, multi-purpose health workers should be included in goitre control programme as one of the main objectives in the health education. The planning of the goitre control programme should be done by the State Ministry of Health".

He also suggested to delegate authority to district health officer for local implementation of the goitre control programme. Coordination with all the Departments concerned should be ensured and accountability should be enforced. Every year, efficiency of the control programme should be evaluated and reported to the State health authorities. He also cleared that the implementation of the national health programme is the work not only of the health officials but also

of the officials from other Departments with responsibility in that area including those education and transport and the general public should participate as well.

Paul, S.,[48] giving evidence of doctors in-charge of Primary Health-care Centres (in the goitre endemic States), who were using themselves uniodizedsalt and did not list goitre as a major health problem, has stressed on the health education, which he wishes, must be started with public health personnel including the doctors. He also added that the public non-government organizations, etc., could be given much wider role in the preventive and people-oriented programmes.

Bhatlavande, P.V.[49] studied the effectiveness of working of trained traditional birth attendants (Dais). Government has organized training for these birth attendants with the aim of reducing the risk for the mother and the baby. This programme has been operational for many years. It was, therefore, Dr.Bhatlavande felt, necessary to assess exactly what was being done by the traditional birth attendants in caring for rural women during pregnancy and during and after labour. He has recommended -

(a) To have a fresh look at the Dai Training Programme;

(b) To identify untrained birth attendants and give them proper training;

(c) Coordination among the Dais and CHVs to enhance the health-care delivery system;

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(d) Re-orientation training for trained Dais once in six months.

Indira Gandhi,[50] aptly knowing the problems of rural people and the importance of health in the economic development of the nation, while addressing the World Health Assembly in May 1981, observed,

> "In India, we should like health to go to homes instead of large numbers gravitating towards centralized hospitals. Services must begin where people are and where problems arise".

On the problems pointed out and recommendations made by various Committees, experts and researchers, the Government of India has passed the following Acts:

1. Indian Medical Council Act (Amendment), 1947;
2. Pharmacy Council Act, 1948;
3. Dental Act, 1948.

(A) Laws relating to Drugs, Food-adulteration and Cosmtics :-

1. Drugs and Magic Remedies (Objectionable Advertisement) Act, 1954 and 1963;
2. Prevention of Fooc Adulteration Act, 1954, 1964, (Amendment) 1971;
3. Drugs Act, 1955;
4. Opium Laws, 1957;
5. Poisons Act, 1958;
6. Drugs (Amendment) Act, 1960, 1962:
7. Medicinal and Toilet Preparations (Amendment) Act, 1961;

8. Drugs and Cosmetics (Amendment) Act, 1964; 1972 (Amendment).

(B) Medical Education :-

1. Dentists (Amendment) Act, 1955, 1972;
2. Indian Medical Council Act (Amendment), 1956, 1958, 1964;
3. Indian Nursing Council (Amendment) Act, 1951;
4. Pharmacy (Amendment) Act, 1959;
5. Indian Medicine Central Council Act, 1970;
6. All India Institute of Medical Sciences Act, 1956;
7. Post-Graduate Institute of Medical Educational Research, Chandigarh Act, 1956;
8. Homeopathy Central Council Act, 1975.

(C) Maternity :-

1. Maternity Benefit Act, 1961 (Amendment) 1972;
2. Medical Termination of Pregnancy Act, 1971;

(D) Miscellaneous :-

1. Registration of Births and Deaths Act, 1969;
2. St.John Ambulance Association Act, 1956;
3. Indian Red-Cross Society (Amendment) Act, 1956;
4. Countess of Dufferin Fund Act, 1957;
5. Child Marriage Restraint (Amendment) Act, 1978;
6. Hindu Marriages Act, 1955.

The problems in the sphere of health-care have been widely studied by various authors, Committees and research scholars. Mostly they have succeeded in identifying various

problems and shortcomings in the implementation of the health policies and administrative structure, procedure and practices.

From the literature, it is clear that the Family Planning has been studied in depth. Rest of the aspects like health-care in the countryside, hospitals, maternity and child health services, drugs, leprosy and indigenous systems of medicine have been studied in a most general way. Some of them have commented on the policies of health, suitability of administrative structures, powers and functions assigned to different functionaries. Some others have stressed on the shortage of medical staff, drugs and medicines. Yet some others have focused light on the unavailability of suitable official accommodation for the health units and proper housing facilities to the field staff. Some have stated that the health-care units have become centres of ill-health because of unbearable and unhygienic, unsanitary conditions and inadequate supply of safe drinking water and absence of proper lighting arrangements.

All the studies so far conducted reflect that the objectives of establishing health-care units are not being realized and what little is being done should be called as a total wastage of public money. All these are macro studies, which have focused attention on allopathy. The indigenous systems of medicine and their relationship with allopathy have not been considered. Also the role of voluntary organizations

and scope for their work in the field of medicine have not been stressed.

SECTION 'B'

NATIONAL HEALTH POLICY

Policy is a window through which one can see in the future activities that are to be undertaken for the achievement of pre-determined objectives. Without a Plan, no one can tackle the problem efficiently and effectively. Each country forms its own policy relating to the problems that are to be tackled. The policy involves the aims, objectives, targets and the activities that would be undertaken to achieve these aims and objectives. It visualizes the determined results, the measures to achieve them and the methods to be adopted. In all, the policy refers to that administrative body which determines the choice of an action.

Before Independence, health was a major problem because of unawareness of the Government in improving the health standard of the people. Realizing this situation, framers of the Constitution of India have made a specific mention that "the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health are among its primary duties". But unfortunately, till 1983, National Health Policy was not

formulated. Health-care activities were carried on as a part of the National Five-Year-Plan Programmes.

Since the attainment of Independence, the country has made significant progress in improving the health status of its people. Plague and small-pox have been completely eradicated. Cholera has been successfully contained and considerable headway has been made in the control of malaria, leprosy, tuberculosis, blindness, filariasis and several other diseases. The planning process has also contributed to the development of a nation-wide primary health care infrastructure in the place of largely hospital-based services.

India also is a signatory of Alma Ata Declaration of 1978, which aims at the attainment of "Health for All" by the year 2000 A.D. The determined objectives are to be secured through the primary health care approach. The National Health Policy is a blueprint for such concerted action by the government, the private voluntary agencies and the people for the attainment of the ideal of 'Health for All'.

2.1 FIVE-YEAR-PLANS AND NATIONAL HEALTH POLICY:

On publication of Bore Committee Report, the country became Independent. The Constitution was adopted and the country embarked on a planned economic development. Realizing that the health is an important contributory factor in the utilization of manpower and in the upliftment of the

economic conditions of the country, considerable amount of weight has been given to the health programmes in the Five-Year Plans, respectively. Its objectives varied from Plan to Plan depending on the magnitude of the problems.

The details of the objectives listed in the Five-Year Plans are as follows:

2.1.1 The First Five-Year Plan (1951-56):

At the preparation of the First Five-Year Plan, the health standard of the people was very low. Many people were victims of communicable diseases. The mortality rate was very high. In such conditions, the First Five-Year-Plan was aimed at improving the health standards of the people.

The First Five-Year Plan, relating to the health had the following objectives:

(a) Provision of water supply and sanitation;

(b) Control of malaria;

(c) Preventive health-care of the rural population;

(d) Health services for mothers and children;

(e) Education and training and health education;

(f) Self-sufficiency in drugs and equipments;

(g) Family Planning and population control.

2.1.2 The Second Five-Year Plan (1956-61):

The Second Five-Year Plan aimed at extending the existing health services within the reach of all the people. The main objectives were:

(a) Provision of adequate institutional facilities;

(b) Development of technical manpower through proper training programmes;

(c) Control of communicable diseases, such as malaria, tuberculosis, leprosy, small-pox, cholera, as the first step in the improvement of public health;

(d) Improvement of environmental sanitation in the urban and rural areas; and

(e) Family Planning.

2.1.3 The Third Five-Year Plan (1961-66):

The Third Five-Year Plan was formulated with the broad objective of expanding health services. The Third Plan laid greater emphasis on preventive public health services and control of communicable diseases. The major objectives in regard to health were listed as follows:

(a) Control of communicable diseases;

(b) Improvement of environmental hygiene, specially rural and urban water supply;

(c) Availing improved training facilities to the medical and health personnel;

(d) Provision of adequate institutional facilities;

(e) Maternal and child health services and family welfare; and

(f) Health education and nutrition.

2.1.4 The Annual Plans (1966-67, 1967-68, 1968-69):

Due to uncertain economic situation in the country,

the Fourth Five-Year Plan, which was to commence from April, 1965, was postponed till 1969. However, the interval period was covered by Annual Plans, with total plan investment outlay (all heads of development) of Rs.6,626.40 crores, out of which, expenditure on health was Rs.325.8 crores (4.92% of total outlay). (Appendix 1A-1989).

2.1.5 The Fourth Five-Year Plan(1969-74):

During the Fourth Five-Year Plan, due priority was given to the control of malaria, tuberculosis, leprosy, trachoma, eradication of small-pox, strengthening of primary health centres and family planning.

The broad objectives of the Fourth Five-Year Plan were:

(a) Strengthening of PHCs and sub-divisional and district hospitals;

(b) The integration and implementation of programmes relating to control of communicable diseases such as tuberculosis, malaria, leprosy and small-pox;

(c) Training of health functionaries; and

(d) Achievement of self-sufficiency in production of drugs and equipments.

2.1.6 The Fifth Five-Year Plan (1974-79):

Considering the provisions of health facilities as a major component of the Minimum Needs Programme. The Fifth Five-Year Plan stressed on the improvement of health

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services in the rural areas.

The major objectives of the Fifth Five-Year Plan were:

(a) Expanding the network of medical facilities and health services in the country;

(b) Increasing accessibility of health services and medical facilities in the rural areas;

(c) Correction of disparities in health services between rural and urban areas;

(d) Intensification of national programmes for eradication of communicable diseases, especially malaria and small-pox;

(e) Laying greater stress on provision of adequate supply of potable water and the disposal of waste;

(f) Improving the quality of health services by using the trained medical and para-medical personnel at the PHC level; and

(g) Providing necessary rural orientation to the medical and para-medical personnel.

2.1.7 The Sixth Five-Year Plan (1980-85):

Following were the major objectives of the Sixth Five-Year Plan:

(a) Better health care services must be provided for the rural poor;

(b) A community based programme of health-care and medical

services should be launched on a priority basis.

The Sixth Plan gave due consideration for the eradication of poverty, meeting the basic human needs and population control as integral components of the human resource development programme. The Minimum Needs Programme was allowed to continue as a main instrument for the development of rural health-care delivery system. In the State sector, rural health infrastructure was to be further strengthened in order to achieve "Health for All by 2000 A.D.".

2.1.8 The Seventh Five-Year Plan (1985-90):

Family welfare, water supply and sanitation were stressed more in the Seventh Five-Year Plan. The total outlay for the Seventh Five-Year Plan was estimated at Rs.1,80,000.8 crores, out of which, Rs.3,392.9 crores (1.9%) were allocated for health, Rs.3,256.3 crores (1.8%) were allocated for family welfare and Rs.6,522.5 crores (3.6%) were for water supply and sanitation. Following were the major objectives of the Seventh Five-Year Plan:

(a) Special attention should be given to preventive and promotive aspects of health-care;

(b) The Minimum Needs Programme would try to ensure effective coordination existing between health and health-related services and activities like nutrition, safe drinking water supply and sanitation, housing and education;

(c) Eradication of communicable diseases;

(d) Containment of newly emerging health problems like cancer, coronary heart diseases, diabetes;

(e) To expand training facilities for doctors and paramedical personnel;

(f) Standardization and integration of Indian Medical system of medicine.

2.2 NATIONAL HEALTH POLICY:

A critical evaluation of various programmes launched through the Five-Year Plans in the sphere of health reveals that a fairly good amount of progress has been achieved in the promotion of health status of the people. The mortality rate per 1000 population has been reduced from 27.4 to 14.8 and life expectancy at birth has increased from 32.7 to over 52 years. Plague and small-pox have been completely eradicated and considerable headway has been made in the control of malaria, leprosy, tuberculosis, blindness and several other diseases.

But the achievement compared to the magnitude of the problem stands insignificant, as a number of objectives are yet to be achieved. The most important objectives like water supply and sanitation, self-sufficiency in the production of drugs and equipments, preventive health care of the rural people, development of adequate technical manpower, health education and nutrition, provision of adequate institutional

facilities for organizing health services, integrated approach to the global problems of filaria, tuberculosis, leprosy, training facilities to various functionaries, correction of differences in health services and medical services between urban and rural areas, provision of better health care services and community based health care programmes, medical and school-health services have yet to make a headway.

The root cause of all these shortcomings is non-adoption of a comprehensive National Health Policy. Partial approach adopted in every successive Five-Year Plan has contributed for partial results, that have served the needs in the past. It was felt that an integrated comprehensive approach towards the future development of medical education, research and health services was required to be established to serve the actual health needs and priorities of the country. It was in this context that the National Health Policy was evolved by the Government in the year 1983.

The aims and objectives of the National Health Policy are broad-based and laudable. The National Health Policy has declared to fulfill the promises made by the Government to achieve the target of clean water supply and sanitation arrangement in adequate quantities by the year 1990 and health for all by 2000 A.D.

The National Health Policy aims at taking the services to the door-step of the people and ensuring fuller participation of the community in the health development process. It has been recognized that if the quality of the lives of the people is to be improved, their health status must be raised. In this perspective, health development is to be viewed as an integral part of overall human resource development. Consequently, a coordinated approach is sought to be established among all the health-related programmes, e.g. protected water-supply, environmental sanitation and hygiene, nutrition, housing and education. To be successful, an attack on the problems associated with diseases must be accompanied by a direct and formal attack on poverty, ignorance and superstition.

The National Health Policy points to the need of restructuring the health services - the preventive, promotive and rehabilitative aspects of health care and brings out the need for establishing comprehensive services to reach the population in the remotest areas. The programmes are being implemented through the fullest involvement of the communities. It views health and human development of overall socio-economic development. For the realization of various objectives, the policy indicates specified goals to be achieved by 1985, 1990 and the year 2000 (Annexure-I).

Following are some of the major steps taken in

this direction:

(1) To shift the emphasis from the curative, to the preventive and promotive aspects of health care as well as to take services to the door-steps of the people, the following changes have been brought about:

(a) Establishment of one sub-centre for every 5000 rural population (3000 in tribal and hilly areas) with one male and one female worker. 28,367 sub-centres were opened during the period 1984-85 to 1987-88. More than 1,02,674 sub-centres, now-a-days, are working in the country.

(b) It has been decided to have one Primary Health Centre for every 30,000 rural population (for every 20,000 population in hilly and tribal areas).

(2) To secure community involvement, a programme is being evolved to train one health guide for every 1000 rural population or for every village. About 3.50 lakh village health guides had been trained till 1.4.1985.

(3) The Leprosy Control Programme has been converted into 100% Centrally-funded programme. The Leprosy Control Programme was taken up as a Leprosy Eradication Programme and National Leprosy Eradication Commission was set up for providing policy guidelines. A National Leprosy Eradication Board was also established for the effective implementation of the recommendations made by the Commission.

Intensive case detection and treatment, application of multi-drug sytem, extensive health education and rehabilitation of cured patients are the main features of the new strategy. Of the estimated 4 million population in the country suffering from leprosy, about 3.28 million have already been detected and 2.97 million have been brought under treatment. The activities in this sphere include establishment of various Leprosy Control Units, Survey, Education and Treatment Centres, Temporary Hospitalization Wards, Reconstructive Surgery Units, etc. The ultimate objective is to eradicate the scourge of leprosy by the year 2000.

(4) To tackle the problem of malaria, the National Malaria Eradication Programme is being implemented vigorously all over the country. Surveillance and spraying of insecticides alongwith health education on sanitation, personal protection measures, etc., are being undertaken under this programme. As a result of all this, the incidence of malaria has been showing a steady decline.

(5) A new strategy has been adopted for tackling tuberculosis by detecting as many cases as possible and bringing them under effective treatment. During 1986-87, 14.39 lakhs cases were detected and in the half year of 1987-88, 9.48 lakhs new cases have been detected. Till 1988, 371 fully equipped district tuberculosis centres are functioning in the country.

(6) A National Programme for the control of blindness has been launched to reduce the incidence of blindness from the present levl of 1.13% to 0.3% by the year 2000.

(7) Diagnostic and treatment facilities for cancer are being augmented especially at the Regional Centres for Cancer Research at Ahmedabad, Bangalore, Calcutta, Cuttack, Delhi, Gauhati, Gwalior, Madras and Trivandrum.

(8) There is a proposal to ensure that all salt used for human consumption is iodized by the year 1990.

(9) A Medical Education Review Committee was set up to review the content, quality and relevance of teaching and training in medical institutions. The Committee has already submitted its Report and efforts are under way to evolve a National Medical and Health Education Policy.

(10) In achieving the objectives of Health Policy, efforts have been initiated to generate the required medical and health manpower at various levels.

(11) The Health Policy envisages active support and involvement of voluntary organizations in providing of Health and Family Welfare Services.

(12) While recognizing the importance of the Indian System of Medicine and Homeopathy, the policy lays emphasis on the development of these systems and their involvement in Primary Health Care. Various schemes have been

undertaken to improve the quality of education, promotion of research programmes and production of herbal and other medicines. In order to facilitate the availability of genuine and effective Ayurvedic and Unani medicines, Government has established the Indian Medicine Pharmaceutical Corporation Limited. It has gone into commercial production.

(13) In order to enforce the Prevention of Food Adulteration laws more effectively, State Governments have been advised to establish separate Department for prevention of food adulteration and strengthen laboratories and food inspection units.

(14) To ensure the availability of reliable and effective drugs to the people, the Drugs and Cosmetics Act has been amended.

(15) The Policy stresses the need of medical research relevant to the needs of the society.

As pointed out by Mr.G.Rameshwaram in his book, the National Health Policy has a number of shortcomings. Firstly, no attention has been paid to the existing health conditions of the slum dwellers of the country, whose number is increasing abnormally in all major metropolitan cities.

Secondly, clean drinking water and clean surroundings are of vital importance for the maintenance of personal hygiene and ensure freedom from diseases. These two important ingredients of health have also not been given any attention, either in allocation of the required finance or personnel.

Thirdly, population explosion is one of the major factors for the declining health standards. The control measures have been in vogue right from the launching of First Five-Year Plan. This vital aspect has been ignored by the Policy-makers.

Fourthly, a well-defined personnel policy, touching all aspects from recruitment to retirement, did not find any mention.

Fifthly, the objective of educating ruralites on the problems of health and first-aid services through community health guides could not be realized for want of supply of medicines and meeting the expenditure on the honorarium to be paid to the guides. The scheme's failure has neither been taken notice of nor any alternative is made for it in the National Health Policy.

Sixthly, the important question of regional imbalance in terms of health and health services did not find any place in the policy.

Finally, the effectiveness and utility of the existing hospitals and the policy of establishment of new hospitals in rural areas have not been considered in the National Health Policy.

If the objective of "Health for All by the year 2000 A.D." is to be achieved, every aspect that contributes directly to the maintenance of health and living standards

must be identified and given due priority.

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