UNIT 7 MANAGEMENT OF HEALTH CARE PROGRAMMES BY INDIAN GOVERNMENT AND NGO'S*

Contents

Learning Objectives

After going through this Unit, you would be able to:

- Understand about health care delivery in India — its structure, organisation and functions;
- Discuss various health programmes and policies implemented by the Government of India, with focus on the post-independence era;
- Understand the role of NGOs in the health sector in Indian context; and
- Summarise India's key achievements and major challenges in Public Health.

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7.0 INTRODUCTION: HEALTH CARE SYSTEM IN INDIA

Health is clearly not the mere absence of disease. Good health condition ensures that the person is free from any disease and this gives him/ her ability to work and realise his/ her full potential. Good health confers on a person or groups' the freedom from illness and the ability to realise one's full potential. Health is best understood as the indispensable basis for defining a person's sense of well-being. In ensuring good health, a country's health care plays a major role. Health care covers not merely medical care; all aspects like preventive and curative and rehabilitative care are given due importance. It includes both public and private sector health care institutions; health promotion-prevention of disease- curative-rehabilitative elements is given representation in an ideal health care system.

Under the Indian Constitution, health is a state subject. Each state therefore has its own health care delivery system in which both public and private actors operate. While states are responsible for the functioning of their respective health care systems, certain responsibilities fall on the federal (central) government, namely policy making, planning, guiding, evaluating, assessing, assisting to the respective state governments and providing funding to implement the national health programmes. India's health care system is characterised by multiple systems of medicine which include not only Allopathy (western medicine) but also Ayurveda, Sidhha, Unani, Yoga and Sowa Rigpa type of medical systems. In India, apart from various national programmes targeting different diseases, we have both public (Government) owned hospitals and private hospitals and clinics.

Check Your Progress

1) Discuss India's health care system with special emphasis to its structure.

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7.1 HEALTH CARE: BASIC CONCEPTS

Health care is defined as a multitude of services rendered to individuals, families or communities by the agency of the health services or professions, for the purpose of promoting, maintaining, monitoring or restoring health (Park and Park, 2015).

7.1.1 Health Care and Public Health

Health care services are the set of institutions with adequate infrastructure; work force and funding that ensure the delivery of public health facilities/programmes in the country.

According to Monica Das Gupta (2006) public health services are conceptually different from medical services. They have a key goal in reducing a population's

exposure to diseases; for example, assuring food safety, vector control, waste management, health education etc., are important elements of health care along with the medical (curative) oriented facilities. Public health services produce "public goods" of incalculable benefit for facilitating economic growth and poverty reduction.

7.1.2 Main Characteristics of Health Care

The main characteristics of health care can be summarised as follows:

- **Appropriateness** (relevance) i.e. whether the service is needed at all in relation to essential human needs.
- **Comprehensiveness** i.e. whether there is an optimum mix of preventive, curative and promotional services.
- **Adequacy** i.e. if the service is proportionate to the requirements like doctor-patient ratio.
- **Availability** i.e. ratio between the population and the health facility
- **Accessibility** i.e. geographic, economic and cultural accessibility
- **Affordability** i.e. expenses involved in availing the health care services.

7.1.3 Levels of Health Care

Indian Health Care Services are usually organised at three levels as follows:

Primary Health Care: This is the first level of contact between the individual/ community and the health system, where "essential" health care is provided. A majority of prevailing health complaints, minor ailments, and common infections along with preventive services can be satisfactorily dealt with at this level. In India, Village Health Guides, ASHA Workers followed by the Sub-centres and the Primary Health Centres together constitute the primary level health care providers. Sub Centres and Primary Health Centres also provide reproductive health/ family planning services along with immunisation for children. Most of the vertical programmes use this level as the base of service provision.

In a PHC, a doctor along with ANM will be posted and they can handle a normal delivery; whereas the cases that require Caesarean section will be referred to CHC or secondary health care facility like district hospital where an Obstetrics and Gynaecology specialist is posted and other facilities like blood transfusion is available.

Secondary Health Care*:* At this level, more complex health problems are dealt with that are not effectively dealt at the primary level. It is essentially curative service oriented. It is provided by the district hospitals and the community health centres. They are also the first referral level in the health system. Facilities like X-Ray, CT/ MRI Scan, Blood bank etc., will be available and specialist doctors will be posted here. Various departments like, Obstetrics and Gynaecology, Ophthalmology, ENT, Oncology etc., will be functioning in these hospitals.

Tertiary Health Care*:* This level offers specialist and super specialist care. These institutions also do planning, developing managerial skills and teaching/ training the medical/ paramedical staff. Medical colleges and super speciality hospitals

are included in this category. They are generally referral hospitals where highly specialised treatments are available.

7.1.4 Components of a Just and Efficient Health Care System

Having a good network of health care is not adequate; but the system should be 'Just and Efficient' so that the services reach to the most marginalised and poor people of the society.

Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality. The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status.

Right to Health and Components

The right to health (Article 12) was defined in General Comment 14 of the Committee on Economic, Social and Cultural Rights – a committee of Independent Experts, responsible for overseeing adherence to the Covenant. The following are the components of Right to Health.

1) **Availability:** The health care services are available to all irrespective of the ability to pay, caste, class, religion, gender etc.

2) **Accessibility:** The health care services are physically and economically accessible to all. The accessibility to information is also part of accessibility.

3) **Acceptability:** Relates to respect for medical ethics, culturally appropriate, and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmes are people-centred and cater for the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent.

4) **Quality:** The services provided must be scientifically and internationally accepted. Safety, effectiveness, efficiency and timely nature of services are covered in this aspect.

According to Srinivasan (2006) the following four criteria are important to consider/evaluate a health care system as Just and Efficient.

a) Universal access, access to an adequate level and access without excessive burden.

b) Fair distribution of financial costs for access and a constant search for improvement to a more efficient system.

c) Training providers for competence, empathy, accountability, cost-effective use of resources etc.

d) Pay special attention to the vulnerable groups such as disabled, aged and children.

Frieden Thomas (2014) in his work lists six components that will ensure efficiency and success in public health care. They are:

a) Innovation to develop the evidence base for action.

b) A technical package of a limited number of high priorities, evidence–based interventions that together will have a major impact.

c) Effective performance management, especially through rigorous, real time monitoring and evaluation.

d) Partnerships and Coalitions.

e) Communication of accurate and timely information to the health community and civil society.

f) Political commitment to obtain resources and support for effective action.

Check Your Progress

2) List out important components of a Just and Efficient Health Care System.

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7.2 INDIA'S HEALTH CARE SYSTEM: AT A GLANCE

India's health care system can be classified into many categories based on various parameters.

Depending upon the function it addresses the Health Care system in India consists of four components. They are:

- Primary, secondary, tertiary institutions manned by medical and para-medical personnel;
- Medical colleges and para-professional training institutions to train the needed manpower and give the required academic input;
- Programme managers, managing on-going programmes at central, state and district levels; and
- Health management information system consisting of a two-way system of data collection, collation, analysis and response.

Depending upon the source of funds for operation and health resources (technology/work force) used, health care system is divided into five sectors as follows:

Public Health Sector — Include Primary health care (Sub-Centers and Primary Health Centres), Hospitals (Community Health Centres, Rural Hospitals, district Hospitals, medical colleges, specialist hospitals), health insurance schemes (ESI, Central Government Health Scheme) and other agencies health services (like defence hospitals, railway hospitals). Private Health Sector — This includes private hospitals, nursing homes, dispensaries, clinics etc.

Voluntary Health Agencies – which are not-for-profit organisations working in the field of health Depending Upon Type of Medical Systems we have

- Allopathy and AYUSH services are two broad categories. Indigenous System of Medicine consists of Ayurveda, Yoga, Unani, Siddha, Homeopathy, Sowa-Rigpa shortly termed as AYUSH. This has a separate ministry to provide fund, support Research and Development. Public hospitals, clinics and private hospitals/ clinics form part of this network.

- **Various National Health Programmes**

  National Health Programmes-they are vertical programmes, planned, developed, implemented and funded by the federal (central) government to combat particular diseases like malaria/leprosy etc. We will be studying more about these national programmes in detail in the following sections.

a) **Public Sector Health Care in India**

Primary Health Care in India forms the backbone of the health system, especially in rural areas. At village level, it consists of Village Health Guides, trained Dais and Anganwadi workers (From Integrated Child Development Scheme). This is supported and supervised/coordinated by the Sub-centres and the Primary Health Care Centres.

Accredited Social Health Activist (ASHA) is a woman who is selected from the village itself and she is trained to work as interface between the community and the public health system. ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

Village Health Guide*:* is a person who has an aptitude for social service and he or she is not a full-time government employee. He or she serves as a link between the community and the government health infrastructure. He or she is selected at the village level (1 for each 1000 rural population) and undergoes training in the nearest Primary Health Care Centre for three months. Primary responsibility of village health guide includes, helping the community with minor medical problems, ensure first aid, maternal-child health care, health education and sanitation.

Trained Birth attendants: Woman from village is selected and she undergoes a training of thirty working days at the Primary health care centre or maternal and child health centre. After the training she is provided with delivery kits, her main responsibility is to ensure safe delivery and promote small family norm.

Anganwadi Worker: Under the Integrated Child Development Scheme (ICDS) there is one Anganwadi worker employed for 1000 population. She is trained in various aspects of health, nutrition, primary education etc. and she plays a pivotal role in ensuring health access and health/ nutritional/ health supplements benefit to pregnant women, 0-6 year children, lactating mothers and adolescents.

Subcentre (SC): Government of India approves one SC for 5000 population in general and in hilly / tribal areas it is one per 3000 population. Two multi-purpose workers (shortly called as MPW — one male and one female) are employed here. They are responsible for all health service and health programme implementation in that area. Generally, the male MPW looks after programmes like malaria, Tuberculosis etc., whereas the female MPW will look after maternal and child health/ family planning services.

Primary Health Centre (PHC): One PHC is approved for 30000 population in rural/ plains whereas it is one PHC for every 20000 population in tribal/ hilly areas. The major functions of PHC includes health education, promotion of nutrition, sanitation, immunisation, MCH care, appropriate treatment of common diseases/ injuries, essential drug supply, implementing and supervising various national health programmes and referral services. PHC will have medical officers, staff nurse, nursing assistants, pharmacists and other supporting staff.

Angwanwadi Centers (Department of Women and Child Development): Nutritional needs of pregnant woman, nutritional needs of 0-6 year old children and adolescent girls' health requirements are met through anganwadi centers where food grains and medicines are distributed.

Secondary Level of Health Care consists of community health centres, rural hospitals, district hospitals and speciality hospitals.

Community Health Centres (CHC): One out of four PHC in a block is usually upgraded and recognised as a Community Health Centre (CHC). It should have 30 beds with specialists in surgery, medicine, gynaecology/ obstetrics and paediatrics. It also should have diagnostic facilities like X ray and laboratory facilities. One CHC usually covers a population of 80000-120000.

Health Insurance: No universal health insurance is mandatory in our country. However, two insurance-based programmes are well-implemented and managed in India. They are ESI and Central Government Health scheme. ESI was introduced in 1948 to provide medical care for people working in industries. Central Government Health Scheme was introduced in 1954 and it covers the employees of autonomous organisations, retired central government servants, retired judges, MPs of Parliament and their families. Ayushman India is a new scheme that was recently launched, and it aims to provide universal insurance coverage to the citizens of this country.

Other Agencies: This includes medical services provided by defence forces, through their hospitals/ medical colleges. Similarly, Indian railways also provide health care facilities for their employees and family members.

b) **Private Health Care in India**

This mainly consists of private hospitals, independent clinics, nursing homes etc. This sector is highly unorganised and is concentrated in urban areas. It provides mainly curative and immunisation services. Medical Council of India and Indian Medical Association regulate and control some aspects of the private health care sector.

c) **Ministry of AYUSH and its Health Care Institutions**

Ministry of AYUSH (which was initially the department of AYUSH), regulates, maintains and develop manpower, infrastructure, Research and Development, drugs etc., for AYUSH systems (Ayurveda, Yoga, Unani, Sidha, Homeopathy and Sowa-Rigpa). Both public sector institutions (primary level clinics, Ayurveda hospitals, Ayurveda/ homeopathy medical colleges) and private hospitals/clinics/colleges are under the control and supervision of Ministry of AYUSH.

d) **Voluntary Health Agencies**

Voluntary health institutions are not-for-profit organisations usually registered under the Societies Registration Act or the Trust Act. International level organisations like Red Cross Society, World Health Organisation etc., are also part of this network, which provides specialised training, skill development, R&D support to the federal (central) government. Indian Council for Child Welfare, Voluntary Health Association of India, The All India Blind Relief Society etc., are some other important organisations that render their services in the area of health.

Thematic Diagrammatic Representation of Indian Health Care Sector

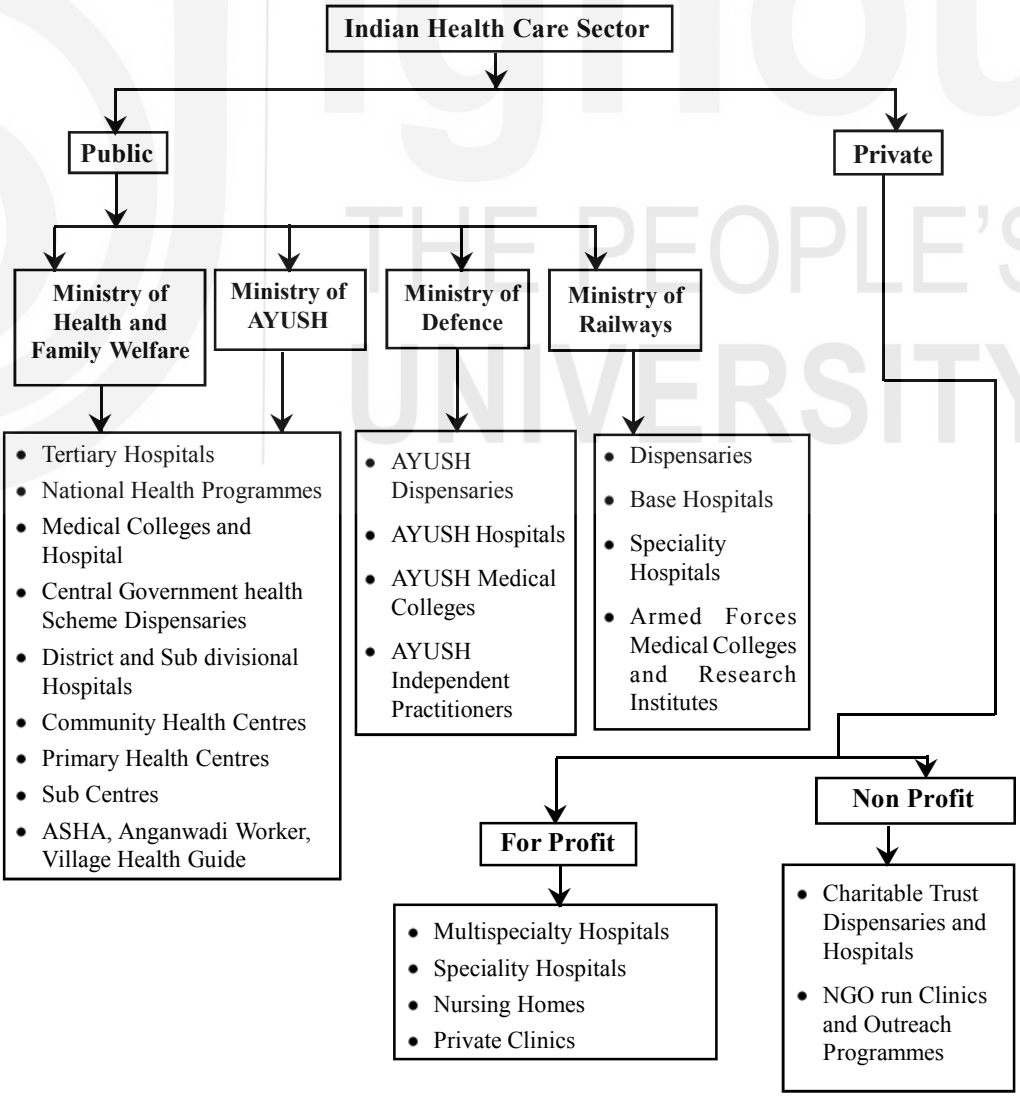

Fig. 7.1: The Indian Health Care Sector (Swedish Agency for Growth Policy Analysis (2014). India's Health Care System. Overview and Quality Improvements. Direct Response Report, pp.13).

7.3 NATIONAL HEALTH PROGRAMMES IN INDIA

The federal (central) government has undertaken several measures to improve the health of the people. Prominent among these measures are the National Health Programmes. Various international agencies like WHO, UNICEF, UNFPA etc., are also providing technical-material assistance in the implementation of these programmes. India, since independence has formulated and implemented couple of National Health Programmes and these programmes have helped the country to improve health status tremendously.

National Programmes has the following features in common:

- Targeting one disease — usually national health programme is shaped targeting one disease. For example, National Malaria Programme focused specifically malaria.
- Vertical in nature — i.e. each national programme has separate work force, fund allocation and research institutes etc., and the programme is usually not integrated with general health system. However, under the aegis of National Health Mission (NHM) almost all the national programmes are integrated with the general national health services.
- The impact of National health Programmes is constantly monitored through surveillance mechanism. This is to check the impact on the disease burden.
- They focus both preventive and curative aspects. Programme will have both curative and preventive elements integrated into the system.

In the following section, we will briefly discuss some of the important National health Programmes.

7.3.1 National Vector Borne Disease Control Programme (NVBDCP)

The NVBDCP is implemented in the States/ UTs for prevention and control of vector borne diseases namely malaria, filariasis, Kala-Azar, Japanese Encephalitis (JE), Chikungunya and Dengue. The Directorate of NVBDCP is the nodal agency to implement the programme. Now the programme is integrated with the National Health Mission (NHM). Under NVBDCP there are three strategies: a) Disease management including early case detection, complete treatment, strengthen the referral services and preparedness; b) integrated vector management; c) supportive interventions like behaviour change communication and capacity building.

National Malaria Control Programme was launched in 1953. In 1958, aim was to eradicate malaria. But in 1970s there was resurgence of malaria, and in 1999 the programme was renamed as National Anti Malaria Programme and in 2002 this national programme was integrated to NVBDCP.

National Filaria Control programme has been in operation since 1955. In India, in 1978 the operational component of this programme was merged with the Urban Malaria Scheme.

Kala-Azar which is now endemic to 31 districts of the country especially in West Bengal, Bihar and Uttar Pradesh received special attention, when a centrally sponsored scheme was launched in 1990-91. World Health Organisation is also supporting this programme by providing drugs free of cost.

Japanese Encephalitis (JE) is a disease with high mortality rate and those who survive do so with various degrees of neurological complications. JE vaccination is recommended for children between 1 to 15 years of ages.

Dengue in 1996 onwards often outbreaks of dengue are reported from across the states. Strategies used to combat this disease include identification and control of outbreak, demarcation of affected area, case management, vector control and Information Education Communication (IEC) activities.

Chikungunya is a debilitating nonfatal viral illness, remerging in the country after a gap of three decades. The diagnostic kits are developed and provided by the Institute of Virology, Pune. Vector control and IEC are the other strategies used.

All the above mentioned six diseases are vector borne and are integrated into NVBDCP, which stands presently implemented through the National health Services under National Health Mission (NHM).

7.3.2 National Leprosy Eradication Programme

The programme to combat leprosy was initially launched in 1955 and strategy was early detection of cases. By 1980 Central Government resolves to eradicate leprosy by the year 2000. In 1983, the programme was renamed as National Leprosy Eradication Programme and since 1993, the World Bank is supporting the programme. Decentralised, integrated leprosy services through general health care system, capacity building, use of IEC, medical rehabilitation are the components of the programme.

7.3.3 Revised National Tuberculosis Control Programme (RNTCP)

National Tuberculosis Programme (NTP) has been in operation since 1962. However, treatment success rates were unacceptably low, and death and default rates remained high. In 1993, the programme was renamed as the Revised National Tuberculosis Control programme and the strategy adopted DOTS (Directly Observed Treatment Short-Course) strategy. DOTS strategy ensured higher treatment completion rates. The organisation structure included state level offices, District Tuberculosis Centres, DOTS providers and microscopy centres.

7.3.4 National AIDS Control Programme

National AIDS Control programme was launched in India in the year 1987, immediately after the detection of the first case in 1986 in Chennai. National AIDS Control organisation (NACO) was set up as a separate organisation to plan, implement, and monitor and modify the components of the programme. At the state level, state AIDS control societies are established to implement the programme. The national strategy has the following components: a) establishment of surveillance centres to cover the whole country; b) identification of high risk

group and their screening; c) issuing specific guidelines for blood banks; d) IEC through mass media. Preventive, curative and rehabilitative services are provided. ICTC (Integrated Counselling and Testing Centres) and ART centres (Anti Retro Viral Therapy) are established integrated with general health services of the country.

7.3.5 Universal Immunization Programme

With the support of World Health Organisation (WHO) Indian Government launched expanded the programme on immunisation in 1974, against, six most common, preventable childhood diseases, viz. Diphtheria, whooping cough, tetanus, polio, tuberculosis and measles. Now UNICEF is also supporting the programme. Apart from this JE, rotavirus, Measles –Rubella, Chikenpox vaccinations is also available on optional-payment basis. Now, Universal Immunisation Programme is integrated with the general health system under the aegis of National health Mission and at Primary Health Centre level special emphasis is provided to achieve the universal coverage.

7.3.6 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

Cardiovascular diseases and other non–communicable diseases are surpassing the burden of communicable diseases in India. Considering this epidemiological risk, this programme was launched. The programme focuses on the health promotion, capacity building including human resource management and development, early diagnosis and management of these diseases with integration with the primary health care system. The programme is integrated with the general health services and is implemented through Primary Health Centres and Community Health Centres. Non-communicable disease clinics are established at Primary Health Centre and Community Health Centres. At district level, the work force is trained and deployed.

7.3.7 National Mental Health Programme

National Mental Health Programme was launched in 1982 with a view to ensure availability of mental health care services for all, especially for the risk groups and unprivileged section of the population. The aim of national mental health programme are: a) prevention and treatment of mental and neurological disorders and their associated disabilities; b) use of mental health technology to improve general services; c) application of mental health principles in total national development to improve the quality of life; d) streamlining / modernising mental hospitals; e) upgrading psychiatric department research and development.

7.3.8 Reproductive, Maternal, Neonatal, Child Health and Adolescents Programme (RMNCH+A)

This is the strategy based on a continuum of care approach and defines integrated packages of services for different stages of life. It aims to provide services from neo-natal stage to child, adolescent group to reproductive — maternal stages in a woman's life. Essential obstetric care, promoting anti-natal checkups, essential newborn care, family planning services and choices, HIV/AIDS, Sexually

transmitted Diseases (STD) support, immunisation, disease control among newborn and children, iron –calcium nutritional supply, supplementary nutrition to the lactating mothers, registration of all pregnancies, child birth and mortalities, adolescent health care etc., are the major components of this programme. Reproductive and Child Health Programme was launched in 1990s and had different phases before it is revamped and relaunched as RMNCH+A in 2013.

7.3.9 National Health Mission (NHM)

The Ministry of Health and Family Welfare is implementing various schemes and programmes to provide universal access to health care for its citizens. As a part of the plan to increase the efficiency of health care system, many programmes have been brought together under the overall umbrella of National Health Mission with National Rural Health Mission (NRHM) and National urban Health Mission (NUHM) as its two sub-mission. The NHM was approved in 2013. The main programmatic components include: a) health system strengthening in rural and urban areas; b) Reproductive-maternal-New Born-Child and Adolescent Health (RMNCH+A); c) control of communicable and non-communicable diseases.

7.4 ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN HEALTH SECTOR OF INDIA

Apart from the federal (central) and state governments, there are other stakeholders who are working in improving the health status of people. Non-Governmental Organisations play an important role in reaching out to the most underprivileged sections of the society. NGOs have long history of active involvement in the promotion of human well-being. In particular, NGOs provide important links between the community and government. They possess certain strengths and characteristics that enable them to function as effective and dynamic agents in this process. Their programmes ranging from research to community-based-projects cover the wide spectrum of human concerns and often pioneer in the fields of health and developments.

7.4.1 Understanding of NGOs

Non-Governmental organisations are called by various names across the world, such as third sector organisations, non-profit organisation, voluntary organisation, charitable organisation and community-based organisation. In India, they are often called as not-for-profit institutions and officially defined as an organisation that are – a) not-for-profit and ; b) by law or custom do not distribute any surplus they may generate to those who own or control them; c) are institutionally separate from the government; d) are self governing; e) are non-compulsory in nature.

Check Your Progress

3) NGOs play an important role in providing health care to the poor. Comment.

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NGOs generate funds from foreign funds, government grants, corporate social responsibility funds, NGOs own fund generating resources and other philanthropic/ individual charitable donations. Though the nature and focus of activities has changed over the time, NGOs have gained prominence in the wide spectrum of social life including health care. The World Health Organisation has acknowledged NGOs in terms of increasing recognition to complement government programmes and creating effective people's voice in respect of health service requirements and expectations.

7.4.2 Functions of NGOs in the Health System

The primary focus of NGOs in the health sector can be listed as follows:

- Establishing health care institutions;
- Fulfilling health and social needs of groups like women, elderly and vulnerable local communities;
- Dealing with specific health issues such as AIDS, alcoholism;
- Promoting Health Rights;
- Performing preventive health programmes; and
- Managing health finance/ funding and administration.

Some NGOs operate internationally and are concerned with global health issues. Some NGOs in India also play an important role in providing health care at the time of emergencies/ natural disasters.

7.4.3 The Health Activities of NGOs in India

NGO run hospitals are heterogeneous and vary in terms of ownership, financing and costs. In recent past, in about ten health–oriented projects of Ministry of Health and Family Welfare, NGOs have actively taken part as health service providers. All these NGO schemes are now under the provision of flexi pools of National Health Mission. Besides, some NGOs (especially the national counter parts of International NGOs) have their own health financing schemes.

In India, majority of these NGOs are covered under the Societies Registration Act or Indian Trusts Act. In addition, there are number of informal associations working at grassroots level without being registered in the legal level. The study by das and Kumar (PHFI, 2016) shows that one per hundred organisation primarily or subsidiarity is involved in health activities has a hospital. An overwhelming number of NGOs about 84% are found in outreach activities. The outreach activities are the main health activity in which generating awareness to targeted population is the major subcomponent of outreach for Indian NGOS.

Preventive care is the most common activity provided by the NGO sector in India. In most states, other than Kerala and Manipur maximum funds are directed towards preventive care. In Kerala maximum funds are spent for curative care with preventive care being the second highest. In Manipur, health system supportive services in terms of management and finance dominate other expenses.

Expenses for rehabilitative care are not significant except in few states like Karnataka.

According to Monica Das Gupta (PHFI, 2016) the health activities of NGOs in India can be broadly classified into nine groups as follows:

- Medical education
- Hospital services
- Rehabilitative clinics
- Outpatient clinics
- Ancillary services like lab and X Ray
- Nonclinical medical support like health system management
- Health insurance for targeted population
- Out-reach activities for preventive care
- Engagement in medical research

7.4.4 NGOs and Health Sector: Future

In a position paper by World Federation of Public Health Associations (2015) opined that the following are the areas in which NGOs can efficiently contribute to India's health care sector:

- At all stages, in the development of primary health care programmes NGOs can be more effective.
- NGOs can work for greater understanding and positive attitudes towards primary health care.
- NGOs can assist national policy formation in the areas of health care and integrate human development.
- NGOs can contribute to primary health care in many ways as follows by providing assistance to develop strengthen local capabilities; by further extending their capacity to work with poor, disadvantage and remote located population.

7.5 PROBLEMS, ACHIEVEMENTS AND PROSPECTS OF INDIAN HEALTH SYSTEM

Since independence, in the last seventy years India's health care system has developed at an impressive rate. We have large network of integrated primary-secondary-tertiary level services where both public and private providers co-exist. India's overall achievements regarding longevity and other key indicators are impressive but it is uneven across various states. For example, in Kerala Maternal Mortality Rate is 64 whereas national average is 165 and in states like Uttar Pradesh, it is still above 200 (NFHS IV data, 2015).

In the past seven decades, life expectancy has increased from 45 years to 68 years (2011 census). Infant mortality rate has come down from 230 during independence to below 40 in 2017. Crude birth rates have dropped to 26.1 and death rates to 8.7. India also successfully managed the population problem by effectively implementing the Family Planning Programme since 1950s. Reduction in IMR, under five mortality rates during the last seven decades is impressive.

Maternal Mortality Ratio reduced from 560 per 100,000 to 230 (Census 2011). This was achieved because of a cluster of services (anti-natal care, vaccinations, control of childhood diarrhoea and effective nutritional supply through anganwadi). India has also developed an impressive workforce and infrastructure in both public and private sector for health care. Further, diseases like smallpox stands eradicated, while other diseases like polio is near the elimination stage. Diseases like cholera, leprosy has reduced drastically. Disease burden of infectious diseases like tuberculosis, malaria etc., has marked reduction, whereas non-communicable diseases like cancer, hypertension, cardiovascular diseases, obesity etc., are rising. India is facing the epidemiological transition where the burden of communicable diseases is showing reduction whereas burden of non-communicable diseases is increasing. Recently, new diseases like Nipah, Zika etc., are also reported from India which is new public health threats for our country.

However, there are some limitations and challenges that the health care system of our country is facing. Some are listed below:

According to Monica Das Gupta (2016) it has long been accepted that the most effective approaches to improving population's health care are those that prevent rather than treat a disease. However, in India, public health policies and programmes have focused largely on the provision of curative care and personal prophylactic interventions such as immunisations; while other social determinants of health (like food, water, and sanitation) remains relatively neglected. This helps explain why India's health indicators are so much poorer than many other countries in East Asia.

The following are the reasons for the withering away of public health services in India (Das, 2016).

- Neglect of public health regulations and their implementation. Public Health Acts which constitute the legislative framework for public health provisions have not been updated and rationalised since the colonial era.
- Diversion of funds from public health services and general reduction of funds allotted to the public sector in health care.
- Organisational changes inimical to maintaining public health. The central government is the key actor in designing health policies and programmes because state budgets are highly constrained. However, the central government focuses on planning specific programmes. Therefore, the bulk of the funds allotted by the central government are tied to specific programme and the states are not free to reallocate the funds to the public health issues specific to the local priority.
- There is also inadequate inter-sectoral coordination. For example, health department has limited resources if the irrigation department generates malaria by leaving a canal half-finished and waterlogged.

The difference between rural and urban indicators of health status and the wide inter-state disparity in the health status needs further attention. The infrastructure and manpower developed is based completely on biomedicine (allopathy) and other AYUSH systems are not properly integrated to our health system. In fact, rural and tribal folk has more confidence and faith in AYUSH medical systems,

but this is not properly capitalised and the outlay for AYUSH streams was always negligible.

However, many encouraging trends are observed in the country's health system. There are many reasons to be hopeful that public health may receive more attention soon. Finance is available through large programmes; for example, National health Mission, Swach Bharat Mission etc., have huge fund allotments. Institutions are also being built at the local and national levels, which can play powerful roles in public health. For example, The Panchayathi Raj Act places emphasis on building local government and devolving health activities to them. Further recognising the importance of AYUSH a new ministry is established to promote the R& D and utilisation of these Indigenous Medical Systems.

Check Your Progress

4) Examine the challenges and prospects of Indian Health Care system.

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7.6 SUMMARY

Nearly 400 million people in India live on less than 1.25$ (PPP) per day and 44 per cent of all children are malnourished. Infant Mortality rate and Maternal Mortality Rate still unacceptably high despite earnest efforts by the government. There is a rise in infectious diseases as well as in non-infectious diseases. At the same time India's public spending on health is extremely low. In 2009, it amounted to just 1.1 per cent of GDP and National health Policy 2017 directs the State to gradually increase it up to 2.5 per cent of GDP by 2015. With a shrinking public health system, people have become dependent on private health care providers who currently handle 75 percent of outpatients. A country that aspires to be a developed one needs further strengthening of public health care and closer monitoring and regulation of private health care.

7.7 REFERENCES

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7.8 ANSWERS/HINTS TO CHECK YOUR PROGRESS

1) Under the Indian Constitution, health is a state subject. Each state therefore has its own health care delivery system in which both public and private actors operate. For details refer section 7.0.

2) According to Srinivasan (2006) four criteria are important to consider/ evaluate a health care system as *Just and Efficient.* (a) Universal access (b) Fair distribution of financial costs (c) Training (d) Special attention to the vulnerable groups. For details refer sub-section 7.1.4.

3) Non-Governmental Organisations play an important role in reaching out to the most underprivileged sections of the society. NGOs have long history of active involvement in the promotion of human well-being. For details refer section 7.4.

4) In India, public health policies and programmes have focused largely on the provision of curative care and personal prophylactic interventions such as immunisations; while other social determinants of health (like food, water, and sanitation) remains relatively neglected. For details refer section 7.5