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NATIONAL HEALTH POLICY

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NATIONAL HEALTH POLICY

INTRODUCTION

According to the World Health Organisation health is a "state of complete physical, mental and social well-being and not merely the absence of disease or deformity". One of the fundamental rights of every human being without distinction of race, religion, political belief, etc. is the enjoyment of the highest attainable standard of health.[1] Owing to a variety of factors like lack of health consciousness, low per capita income, lack of adequate education, non-availability of proper sanitary conditions and safe drinking water, unhealthy social taboos and the like, the health status of the average Indian leaves much to be desired. It has been the endeavour of successive Governments in India to improve the situation. This is especially so after Independence. The National Health Policy, which has recently been announced by the Government, is a logical culmination of the consistent efforts, aimed at securing a healthy life for all Indians, pursued by the Governments in the recent decades. While many are the achievements in the past, more needs to be done now and in the near future.

Since the attainment of Independence, the country has made significant progress in improving the health status of its people. Plague and smallpox 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. However, the planning process has also contributed to the development of a nationwide primary health care infrastructure, reversing the kind of largely hospital based services.

While addressing the World Health Assembly in May 1981, the late Prime Minister Smt. Indira Gandhi observed:

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

Also, India is a signatory to the Alma Ata Declaration of 1978 which is aimed at the attainment by all people of the world by the

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[1]Mudaliar Committee Report, 1961, p. 53.

year 2000 of a level of health that will permit them to lead socially and economically productive lives. The objective is sought to be secured through the primary health care approach.[2] The National Health Policy is a blue print for such concerted action by the Government, the private voluntary agencies and the people for the attainment of the ideal of health for all.

In this context it would be appropriate if we look back at the rapid strides the country has made in strengthening the health care system.

1. HEALTH CONDITIONS IN INDIA AT THE TIME OF INDEPENDENCE

The Health Survey & Development Committee (Bhore Committee), which was appointed by the Government of India in October 1943 to make a survey of the existing position in regard to health conditions and health organisation in what was then known as British India and to make recommendations for future developments, found that they had to confines themselves mainly to statistics of ill-health and death, in the absence of data on positive health.

The Bhore Committee which submitted their Report in 1946. found that the general death rate in "British India" was 22.4, the infant mortality rate was 162, and the expectation of life at birth was 26.91 for males and 26.56 for females. Nearly half the total number of deaths were among children under 10 years of age and in this age group one-half of the mortality took place within the first year of life.

Although vaccination had been in vogue for nearly eighty years, India continued to be a reservoir of smallpox.

Endemic diseases like leprosy, filariasis, guineaworm and hookworm, though not contributing to a large extent to the mortality figures, caused considerable morbidity.

The Bhore Committee found that the low state of public health, as reflected in the high mortality and morbidity (particularly among mothers and children), was preventible and was mainly due to the absence of environmental hygiene, adequate nutrition, adequate preventive and curative health services and intelligent co-operation from the people themselves. To these causes may be added illiteracy, unemployment, poverty, purdah system and early marriages.

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[2]L.S. Deb., 16-12-83, Col. 356.

There was a wide prevalence of insanitary conditions in urban and rural areas. The provision for protected water supply and drainage was totally inadequate. The food consumed by millions was both insufficient and ill-balanced.

The curative and preventive health services were totally inadquate. There were 1 doctor for 6,300, 1 nurse for 43,000, 1 health visitor for 400,000 and 1 midwife for 60,000 people.

Roughly one-fourth the number of doctors were in Government service, the rest being mostly settled in urban areas as private practitioners. Again there were only a total of 70 to 80 women medical officers in public service engaged purely in maternity and child welfare work. Very few of these were medical graduates.

Hospitals and dispensaries for providing medical relief to the people, particularly in the rural areas, were grossly insufficient and the quality of such services was very poor. There was only 0.24 bed per 1,000 population.

Some of the important recommendations made by the Committee in their Report were the following:

> "No individual should fail to secure adequate medical care because of inability to pay for it.
>
> "Health service should provide all consultant, laboratory and institutional facilities for proper diagnosis and treatment.
>
> "The health programme must, from the very beginning, lay special emphasis on preventive work.
>
> "As much medical relief and preventive health care as possible should be provided to the vast rural population of the country. Health services should be placed as close as possible to the people in order to ensure the maximum benefit to the communities to be served.
>
> "Health consciousness should be stimulated by providing health education on a wide basis as well as by providing opportunities for the individual participation in local health programmes.[3]

The short term measures suggested by the Committee included the raising of bed population ratio from 0.24 per 1000 to 1.03 at the end of 10 years, provision for travelling dispensaries to supple-

[3] Mudaliar Committee Report, pp. 15—20

ment the health services rendered by primary health centres, promotion of hygienic life, etc. The longer term aims included raising the bed-population ratio to 2 per 1000, establishment of more medical colleges, training centres for nurses, etc.[4]

2. DEVELOPMENT OF VERTICAL PROGRAMMES

The report of the Health Survey and Development Committee in 1946 and India gaining independence in 1947 led to intensive efforts by the new National Government for controlling of certain important communicable diseases. It was thought that as the development of the organisation recommended by the Bhore Committee will take a long time, it would be desirable to make special efforts for the control of smallpox, malaria, filaria, tuberculosis, and leprosy through special efforts directed specifically on these diseases.

Smallpox

The Bhore Committee brought out that the incidence of smallpox was highest in India and was responsible for about 70,000 deaths per year. The vaccination facilities were provided to a limited population and wherever such facilities were available the coverage was unsatisfactory.

The Government of India appointed an Expert Committee on Smallpox and Cholera. The Committee in its report in 1958 recommended launching of National Smallpox Eradication Programme and training and recruitment of 20,000 vaccinators for smallpox and cholera vaccination.

Malaria

It was estimated that nearly 75 million people suffered from malaria every year. Considering it as the major health problem, the National Malaria Control Programme was launched in 1953-54 in selected areas which gradually went on expanding to cover the whole country, with a vertical organisation with separate malaria officers, malaria inspectors, health inspectors and malaria workers.

Filaria

Experimental projects for the control of filaria was started in 1950 by the Indian Council of Medical Research and based on the report of the experimental project, the National Filaria Control

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[4] *Ibid.* pp. 19—20.

Programme was initiated in 1955. The National Filaria Control Programme established separate survey and control units for this purpose.

Tuberculosis

The BCG Vaccination Programme was started on a pilot basis in 1948. A National Tuberculosis Sample Survey in 1955 indicated the incidence of tuberculosis varying from 13 to 25 per thousand population in different parts of the country. Considering the high incidence of tuberculosis in the country, the National Tuberculosis Programme was launched in 1958 and a large number of BCG teams were established.

Leprosy

The Bhore Committee brought out that leprosy affected 2.5 per cent of the population in different parts of the country. The National Leprosy Control Programme was launched during the First Five-Year Plan (1951—56) by the establishment of survey and treatment teams in areas where incidence was more than 1 per cent. Each team covered a population of 80,000.

The Report of the Committee for the Control of Leprosy (1955) brought out that nearly 2.5 million people were suffering from leprosy and 205 million people live in endemic zones.

During the Third Five Year Plan, starting in 1961, the National Leprosy Control Programme was changed to the National Leprosy Eradication Programme.

Report of the Committee on Public Health Act, 1955

In pursuance of a resolution passed by the Central Council of Health, the Government of India appointed a Committee in 1953 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 local conditions. The Commitee submitted its report in 1955.

The Committee in its report recommended a unified and integrated health organisation at various levels to be operated through:

Directorate of Health Services under the Director of Health Services assisted by the required number of Deputy Directors for individual programmes/activities.

District Headquarters Organisation: The Under 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.

Sub-Divisional Headquarters Organisation

The Under Sub-divisional Medical 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.

Thana Health Centre Organisation (in urban areas)

The Thana Health Centre Organisation 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 Organisation will consist of staff for the hospitals and dispensaries, sanitary inspectors, one health assistant supported by three or more field workers and Lady Health Visitors, supported by midwives.

Rural Health Centre

The Rural Health Centre would have, besides the medical Officer, health visitors with ANM (Auxiliary Nurse Midwife) for midwifery and child welfare services and health assistants for vaccination, inoculation, disinfection and other sanitation works.

Health survey and Planning Committee (Mudaliar Committee 1959—61)

The Government of India, Ministry of Health, set up a Committee in June 1959 to undertake the review of the developments that had taken place since the publication of the Report of the Health Survey and Development Committee (Bhore Committee) in 1946 with a view to formulating further health programmes in the country in the third and subsequent Five-Year Plan periods. The terms of reference of this committee were:

(i) the assessment of developments in the field of medical relief and public health centres, submission of the Health Survey and Development Committee Report;

(ii) review of the second Five-Year Plan heatlh projects;

(iii) formulation of all the recommendations for the future plan of health development in the country.

The Committee known as the Health Survey and Planning Committee (Mudaliar Committee) submitted its report in October 1961.

The major recommendations of the committee in respect of future health organisation in the country were as follows:

"The attempt to start mass campaign against certain diseases like tuberculosis, smallpox, cholera, leprosy and filariasis is commendable but the method of dealing with these diseases individually will not be conducive to the organisation 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 nor desirable to have separate agencies to deal with separate diseases".

"Para medical 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".

"There should be one Auxilliary Nurse Midwife for every 5,000 population and an auxilliary health worker for double that population".

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

"The technical set up at state level should be headed by DHS with a number of Deputy Directors".

Family Planning Programme

India recognized the importance of controlling population from the very beginning of its development plans. The Family Planning Programme up to 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, has not made much headway and hardly any appreciable reduction has been achieved during the last decade in the growth rate.

In 1962, India invited a UN Mission on Population Activities to visit the country and advise the steps to be taken for greater acceptance of the small family norms by the population. The recommendations of the UN Mission were considered by a committee appointed

by the Government of India. Based on the recommendations of this committee it was decided to have the 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 multi-purpose workers under Health and Family Planning Programmes (1972-73)

The national programmes in the field of Health and Family Planning and Nutrition have been in operation in the country for many years. In general these programmes were being run almost independently of each other by the staff recruited under each programme. There was little or no coordination between the field workers or supervisory personnel of these programmes. They were separate and independent functionaries. This state of affairs came into existence because the various health programmes and later on family planning programme, were launched at different times and each was conceived to run vertically with its own staff. A question was raised in many quarters whether the same objectives could be achieved by coordinating these programmes and pooling the personnel. Accordingly the first meeting of the Executive Committee of Central Family Planning Council held on 20 September 1972 recommended:

> "Steps should be taken for the integration of medical, public health and family planning services at the peripheral level. A Committee should be set up to examine and make detailed recommendations on: (i) structure of integrated services at the peripheral and supervisory levels; (ii) feasibility of having multi-purpose/bipurpose workers in the field; (iii) training requirements for such workers; and (iv) utilization of mobile service units set up under family planning for integrated medical, public health and family planning services."

In pursuance of the above recommendations of the Executive Committee of the Central Family Planning Council, the Government of India appointed a Committee in October 1972. The Committee on Multi-purpose Workers under Health and Family Planning Programme (also known as Kartar Singh Committee) submitted its report in September 1973.

The Committee while reporting its findings after eliciting the views of health experts, health administrators and the community, stated that the existing staff of the primary health centres and sub-centres cannot adequately deal with the health and family planning requirements of the population involved. The population given to each worker is too large to be adequately covered and frequently visited. The community leaders were of the view that people are not happy with the services, that so many workers were coming to their homes and making enquiries for individual programmes without being in a position to tackle their health needs. On the basis of its findings the Committee recommended: "multi-purpose workers for the delivery of health and family planning and nutritional services are both feasible and desirable."

The Committee recommended that the programme of having multi-purpose workers should be introduced in the first phase in areas where malaria is in the maintenance phase and smallpox has been controlled. The programme can be extended to other areas as malaria passes into the maintenance phase or where smallpox is controlled. This will be the second phase. The workers engaged in 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 (Primary Health Centre) 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 field visit, another should be available at the PHC.

Better coordination between the PHCs, and Taluk/Tehsil level hospital and administration and between the latter and the district level agencies concerned with health is essential. The links between these and the 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. Even though the country has a poorer doctors-population ratio, as compared to the developed societies, it is an inescapable fact that a proper harnessing of the available resources and a reorganisation of the entire system can go a long way to solving the health problems of the country.

If proper bridges could be built between the medical college hospitals on one side and the primary health centres on the other, with taluq and district hospitals in between, a much closer liaison can be established between all the workers engaged in the health and family planning programmes. Graded facilities of specialist skills and investigative techniques can then be made available at different levels.

The existing practice of separating curative and preventive medicine also needs to be reviewed. The old departments of hygiene in medical colleges and their more recent prestigious replacements (Department of Preventive and Social Medicine) have to be evaluated. Whereas some divisions in the field of medicine like general medicine, surgery, obstetrics, opthalmology, etc., have to be there, it is questionable if divisions between preventive medicine, curative medicine and family planning need to be continued.

The time is ripe for a reappraisal of the whole organisation of medical services in the country. The existing divisions both on account of historical developments and of borrowed ideas from the West need to be reviewed and the entire system overhauled.

The recommendations of the Committee on Multi-purpose Workers on Health and Family Planning Programme were accepted by the Government of India and it was decided that the recommendations should be implemented from the beginning of the Fifth Five-Year Plan, 1974—79.

The problems faced in the implementation of multi-purpose workers scheme

The Multi-purpose Workers' Committee while recommending the introduction of the multi-purpose workers at the peripheral level and integration of services at all levels foresaw the difficulties and problems which were likely to be faced in the implementation of its recommendations. Certain new problems/difficulties also came to notice during the actual implementation of the recommendations. The various types of problems and difficulties faced can be divided into:

(i) administration (ii) training (iii) attitude

Adminsitrative problems

(i) Introduction of the Multi-purpose Workers Scheme required the integration of the cadres of the different vertical programme workers and their supervisors. At the time of their recruitment these workers had different basic qualifications and terms of service. It became administratively difficult to find out a solution for integrating various cadres and fixing *inter se* seniority among these workers and supervisors as each category of workers started making claims and counter claims regarding the seniority they should be given in the service.

Training

Workers and supervisors recruited under different programmes have different educational qualifications and different types of training. As such, working out a common training curriculum for these workers and supervisors poses a much greater problem.

As the scheme required reorientation training not only of the workers and their supervisors but also of the medical officers at the PHCs and district level and the training of trainers, the scheme threw up a large training load for which neither an adequate number of training institutions nor the required number of trainers were available.

Attitude problems

Under the vertical programme, officers at the State and district levels, particularly in respect of malaria, family planning, leprosy and tuberculosis programmes, had their own hierarchy and enjoyed appreciable administrative and financial powers. With the reorganisation and integration, the financial and administrative powers enjoyed by these officers were transferred to the Chief Medical Officer of the district. These officers saw in this change the crumbling of the hierarchy and loss of powers for which they were not prepared mentally, and opposed the scheme as impracticable and likely to affect the vertical programme implementation adversely.

The workers and supervisors under different programmes, though integrated, continued to draw their salaries and benefits from the budget of the individual programme and as such continued to have a more favourable attitude to the programme from the budget of which they drew their salaries.

The result of these operational problems have been that while it was envisaged that the whole scheme will be implemented in the country by 1982, there are still many States where the scheme has not been effectively implemented so far.[5]

4. FIVE YEAR PLANS AND THE HEALTH SECTOR

Soon after the publication of the Report of the Bhore Committee the country became independent. The new Constitution was adopted and the country embarked on a planned economic development. The First Five Year Plan of 1951—56 provided Rs. 65.2 crores for health development schemes. The main objectives of the First Five Year Health Plan were provision of water supply and sanitation, control of malaria, preventive health care, health care for mothers and children, education and training and health education.

"Health" (including water supply and sanitation) was allocated Rs. 217 crores out of the total plan outlay of Rs. 4672 crores in the 2nd Five Year Plan. In the Third Plan a sum of Rs. 361.00 crores, out of a total of Rs. 8576.5 crores was earmarked for Health. (Of this, the provision for water supply and sanitation in the urban and rural areas was of the order of Rs. 110.2 crores).[6] The corresponding Plan provisions during the Annual Plans 1966-1969, Fourth, Fifth and Sixth Five Year Plans were of the order of Rs. 313.3 crores, 1261.5 crores, 2360.1 crores, and 5753.1 crores respectively. (For details regarding Plan outlays please *see* Appendix 1 A).

During the first decade of plan activity, it may be justifiably claimed that, training facilities had been considerably expanded; facilities for treatment of the sick had improved; the groundwork for the fight against small pox, tuberculosis, leprosy and filariasis had been laid, the framework for planning and developing a national water supply and sanitation had been brought into existence and a movement for family planning on a mass scale had been set in motion. The infant and maternal mortality rate started declining.

In physical terms, the first 10 years of planned development saw the establishment of 2565 primary health centres, hospital beds had gone upto 18500, making a bed-patient ratio of 0.4 per thousand. In regard to mother and child health, more than 3500 centres were started in this period. Besides several colleges for nursing degree courses, centres for training health visitors, midwives, etc. were also

5. Saigal, M.D. : *Development of Health Services in India*, 1984.

6. Health statistics of India, 1983, p. 71.

started. Considerable progress was achieved in the fight against malaria, tuberculosis and leprosy.[7]

It may be mentioned in this connection that while the outlay on health, family welfare, water supply and sanitation represented 3.86 per cent of the total outlay in the First and 4.59 in the Second Plan, only 4.2 per cent of the total outlay was earmarked for health in the Third Plan.[8]

In the three Annual Plans of 1966—69 health sector (health and family welfare) received 3.2 per cent of the funds while the share of water supply and sanitation was 1.6 per cent. In the Fourth Plan, the health sector received 3.9 per cent of the outlay whereas the allocation for water supply and sanitation rose to 3.5 per cent. In the Fifth Plan the respective figures were 3.2 and 2.8. In the Sixth Plan provisions for these items are of the order of 2.9 per cent and 4 per cent respectively. In terms of actual size these come to Rs. 2831.1 crores and Rs. 3922 crores respectively.[9]

5. NATIONAL HEALTH POLICY

While the broad approaches contained in the successive Plan documents and discussions thereon might have generally served the needs of the situation 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 (NHP) was evolved by the Government.

The NHP aims at taking the Services nearest to the door-steps of the people and ensuring fuller participation of the community in the health development process. It has been recognised 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 resources development. Consequently, a coordinated approach is sought to be established among all the health-related programmes, for example, 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 frontal attack on poverty, ignorance and superstition.

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7. Mudaliar Committee Report, *op-cit.*, pp. 30—33.

8. Health Statistics of India, 1983, p. 71.

The National Health Policy points to the need of restructuring the health services on 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 as a vital component of over-all socio-economic development. For the realisation of the various objectives the policy indicates specified goals to be achieved by 1985, 1990, 1995 and the year 2000.

Some of the major steps taken towards this direction are the following:

(i) To shift the emphasis from the curative to the preventive and promotive aspetcs of health care as well as to take services and supplies nearest to the doorsteps of the people, the following changes have been brought about:

(a) It has been decided to establish one Sub-Centre for every 5000 rural population (3000 in Tribal and Hilly Areas) with one male and one female worker. 21135 new Sub-Centres have been opened during the four years, 1981-1984. The total number of Sub-Centres, as on 31-3-84 stood at 74307. A target of setting up 9071 more Sub-Centres during 1984-85 had been fixed by the Planning Commission.

(b) In place of the Primary Health Centre for every Community Development Block it has been decided to have one Primary Health Centre for every 30,000 rural population (for every 20000 in Hilly and Tribal areas). 1726 New Primary Health Centres have been established during the four years, 1981-84. As on 31-3-84, the country had a total of 7210 Primary Health Centres. The Planning Commission had fixed a target of setting up 197 more PHCs during the year 1984-85.

(ii) To further the Primary Health Care approach and secure community involvement, a centrally sponsored programme is being evolved to train Health Guides selected by the community for every village or every 1000 rural population 3.13 lakh village Health Guides had been trained till 1-4-84.

(iii) The Leprosy Control Programme has been converted into a 100 per cent Centrally funded programme and the

outlays in the current year make a five-fold increase over those in 1979-80. Following the late Prime Minister Smt. Indira Gandhi's call for eradication of leprosy on a time bound basis, the Leprosy Control Programme has now been taken up as a 'Leprosy Eradication Programme' and a National Leprosy Eradication Commission has been set up for providing policy guidelines. A National Leprosy Eradication Board has also been established for effectively implementing the recommendations of the Commission. Similar policy guidance and implementation Bodies will be set up in the States having high incidence of leprosy.

Intensive case detection and treatment, application of multi-drug regimen, extensive health education and rehabilitation of cured patients are the main features of the new strategy. Of the estimated 3.2 million population in the country suffering from leprosy, about 2.9 million have already been detected and 2.74 million brought under treatment. The activities in this sphere include establishment of various leprosy control units/ centres, survey, education and treatment centres, temporary hospitalisation wards, reconstructive surgery units, etc. The ultimate object is to eradicate the scourage of leprosy by the year 2000 A.D.

(iv) Malaria has been a major public health problem in the country. To combat this disease, the National Malaria Eradication Programme is being implemented vigorously all over the country. Surveillance and spray of insecticides, alongwith health education on sanitation, personal protection measures, etc. are being undertaken under this programme. Research activities are being continued regarding effect of insecticides on vector control and resistance of malaria parasites to common antimalarial medicines. As a result of all this the incidence of **malaria** has been showing a steady decline. The incidence of this disease showed a decline from 6.5 million cases in 1976 to 2.8 million cases (provisional) in 1982. Similarly the incidence of p. falciparum cases showed a decline from 7.5 lakhs in 1976 to 4.7 lakhs (provsional) in 1982.

The declining trend in the incidence of the disease continued in 1983 also. It has been decided by the Central Government to provide 100 per cent assistance to the States for the cost of malathion required for spray in the areas where the vector mosquitoes for malaria have been found to have developed resistance to B.H.C. and D.D.T.

(v) A new strategy has been adopted for tackling tuberculosis by detecting as many cases as possible and bringing them under effective treatment. 10.5 lakhs cases were detected and brought under treatment during 1982-83. During 1983-84 the target for detecting T.B. cases is fixed at 12.5 lakh cases and the progress in this regard is satisfactory. At present 354 fully equipped T.B. Centres are functioning in the country. Steps are also under way to ensure that at least 50 sputum examinations per month at each Primary Health Centre are carried out to provide easy case detection facility in the rural areas.

(vi) A national programme for the control of blindness has been launched to reduce the incidence of blindness from the present level of 1.3 per cent to 0.3 per cent by the year 2000 A.D. Cataract has been identified as the major cause for blindness. Sample surveys of the population have indicated 55 per cent of the 9 million blind in the country are suffering from cataract. Efforts have been stepped up to detect and control visual impairments. The National Programme for Control of Blindness envisages the development of various services at the peripheral and intermediate levels. Mobile units provide comprehensive eye care including surveys in villages and screening of school-going children, besides providing out-patient and surgical treatment. During the three years 1981-82 to 1983-84 the number of cataract operations performed in the country were 5.5 lakhs, 8.5 lakhs and 10.25 lakhs respectively. A target of 12.78 lakh operations has been fixed for 1984-85. Opthalmic care facilities have been strengthened in 540 Primary Health Centres, 250 District Hospitals and 30 medical colleges. All assistance and encouragement is being

provided to the non-governmental organisations engaged in the conduct of mobile eye camps. A scheme to prevent blindness caused by Vitamin 'A' deficiency among children through oral administration of massive dose of Vitamin 'A' is also in operation. This scheme is implemented in all States and Union territories.

(vii) 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. The Sixth Plan has allocated Rs. 11.50 crores for cancer control and treatment.

Efforts for dealing with diarrhoeal diseases and control of goitre have been intensified. No state in the country can be called goitre free. 12 iodization plants have been installed for the supply of iodized salt to the goitre endemic areas. There is a proposal to ensure that all salt used for human consumption is iodized by the year 1990.

(viii) *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.

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

(x) Community involvement and participation is the corner-stone of the National Health Policy. The Health Guide Scheme, under which a volunteer selected by the community becomes responsible to it for organising promotive and preventive measures, is the first step in this direction. It envisages the formation of Health Committees in every village to project the health needs of the community and be involved in the functioning of health services. A programme of training of Community leaders and preparing them for assuming higher responsibilities is already being implemented.

(xi) Voluntary organisations play an important role in providing *Health and Family Welfare* services supplementing the efforts of the Government. The Health Policy envisages active support and involvement of voluntary organisations. Financial assistance is provided by the Government to the voluntary organisations as in the following categories:

(i) To T.B., Leprosy, Cancer and other medical institutions on a non-recurring basis for purchase of essential equipment and for additions and alterations to the existing hospital buildings to enable them to expand and improve the existing facilities, and

(ii) Organisations which promote and undertake blood donations.

(xii) While recognising the importance of *Indian systems of medicine* and Homoeopathy, the Policy lays emphasis on the development of these systems and their involvement in Primary Health Care. Various schemes have been undertaken for improving 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 have established the Indian Medicine Pharmaceutical Corporation Limited. It has already gone into commercial production. Considerable progress has been made in the preparation of separate pharmocopeias for some of these systems.

(xiii) With a view to checking adulteration of food stuffs and making the enforcement of the Prevention of Food Adulteration laws more effective, State Governments have been advised to establish separate Departments for prevention of food adulteration and strengthen laboratories and food inspection units.

(xiv) To ensure availability of reliable and effective drugs to the people, the Drugs and Cosmetic Act has been amended providing for severe punishment to those engaged in the import, manufacture and sale of spurious and substandard drugs. The Government have also banned the import of certain drugs and prohibited the manufacture and sale of other therapeutically irrational combinations.

(xv) The Policy stresses the need of medical research relevant to the needs of the society.[10]

6. DISCUSSION OF THE NATIONAL HEALTH POLICY BY PARLIAMENT

The Rajya Sabha had discussed the National Health Policy on the 2nd, 3rd and 4th August 1983. Initiating the discussion, the Health Minister Shri B. Shankaranand, said that the objective of the policy was to achieve health for all by 2000 AD. He had also drawn attention to the specific targets, set by the Government to be achieved by the years 1985, 1990, 1995 and 2000. The following 20 members participated in the three-day discussion: Dr. M.M.S. Sidhu, Smt. Margaret Alva, Smt. Ila Bhattacharya, Shri T. Basheer, Shri Jagadambi Prasad Yadav, Km. Saroj Khaparde, Shri Vijoy Krishna Handique, Shri Dinesh Goswami, Dr. Malcolm S. Adiseshiah, Dr. Rudra Pratap Singh, Shri S. W. Dhabe, Shri P. N. Sukul, Shri Mirza Ershad Beg Ayub Beg, Shri B. Satyanarayan Reddy, Shri Chand Ram, Prof. B. Ramachandra Rao, Shri Hukum Dev Narayan Yadav, Prof. Sourendra Bhattacharjee, Shri Shiv Chandra Jha, and Dr. Bhai Mahavir. Replying to the debate Shri Shankaranand said that he was happy that all sections of the House had shown keen interest in the health policy. He added that the policy envisaged the targets, indicated the infra-structure required for achieving the targets, the manpower planning, etc. After the discussions the House rejected the two amendments proposed and adopted the motion that "the House approves the National Health Policy.

On 15 December, 1983, the Minister of Health and Family Welfare, Shri B. Shankaranand, moved a resolution in the Lok Sabha for the approval of National Health Policy contained in a statement laid on the Table of the House on 2 November, 1982.

Initiating the discussion on 16 December, 1983, Shri Shankaranand said that the National Health Policy evolved by the Government was aimed at taking the services nearest to the doorsteps of the people and ensuring fuller participation of the community in the health development process. Steps had already been initiated under

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[10] L.S. Deb., 16-12-83, cols. 356–362. Ministry of Health & Family Welfare, Annual Report, 1983–84, Introduction and Chapter 1, and R.S. USQ, No. 356, dt. 25-7-84.

[11] R. S. Deb. 2-8-83, 3-8-83, and 4-8-83.

Sixth Five Year Plan and the New 20-Point Programme of the Prime Minister for implementation of the policy.

The 17 Members who took part in the discussion which lasted two days were: Sarvashri Rupchand Pal, Neelalohithadasan Nadar, Jagannath Rao, Rajesh Kumar Singh, Krupasindhu Bhoi, Deen Bandhu Verma, J. S. Patil, Ram Pyare Panika, S.T.K. Jakkayan, Virdhi Chander Jain, Nathu Ram Mirdha, P. K. Kodiyan, Mool Chand Daga, Bishnu Prasad, Smt. Kishori Sinha, Smt. Jayanti Patnaik and Smt. Pramila Dandavate. Replying to the debate the Minister said that the Government was evolving a scheme of incentives to doctors to go to rural areas. The Resolution moved by the Minister seeking the approval of the National Health Policy was adopted by the House on 22-12-1983.[12]

7. OUTLOOK FOR THE SEVENTH PLAN

The Approach Paper to the Seventh Five Year Plan takes note of the goal of health for all by 2000 A.D. It is proposed that primary health care would continue as the main instrument of action to achieve this goal. Preventive and promotive aspects of health care will receive special attention. The Minimum Needs Programme would try to ensure that effective coordination exists between health and health related services and activities like nutrition, safe drinking water supply and sanitation, housing and education.

Eradication of communicable diseases, control and containment of newly emerging health problems like cancer, coronary heart diseases, hypertension, diabetes, accident, etc., training and education of doctors and paramedical personnel, medical research related to common health problems, standardisation and integration of Indian systems of medicine, etc. are the other areas, which have attracted special attention in the Plan Paper.

The Approach paper recognises the long term goal of reaching a net reproduction rate of 1 by 2000 A.D. Targets for family planning, particularly sterilisations, IUDs, and oral pills are being laid down in this regard. Mother and child health programmes are also given adequate importance.[13]

[12] L.S. Deb., 15-12-83, 16-12-83 and 22-12-83.

[13] Approach to the Seventh Five Year Plan, pp. 22—23.

APPENDIX I-A

Pattern of Investment on Health, Family Welfare and Water Supply and Sanitation (Plan outlays) in different Plan periods in Public Sector—Centre, States and U.Ts.

(Rs. in crores)

Period	Total Plan Investment/ outlay (all heads of development)	Health	Family Welfare	Sub-Total	Water Supply & Sanitation
1. First Plan (1951-56) actuals	1960·0 (100)	65·2 (3·3)	0·1 (—)	65·3 (3·3)	11·0 (0·56)
2. Second Plan (1956-61) actuals	4672·0 (100)	140·8 (3·0)	2·2 (0·1)	143·0 (3·1)	74·0 (1·58)
3. Third Plan (1961-66) actuals	8576·5 (100)	225·9 (2·6)	24·9 (0·3)	250·8 (2·9)	110·2 (1·3)
4. Annual Plan (1966-69) actuals	6625·4 (100)	140·2 (2·1)	70·4 (1·1)	210·6 (3·2)	102·7 (1·6)
5. Fourth Plan (1969-74) actuals	15778·8 (100)	335·5 (2·1)	278·0 (1·8)	613·5 (3·9)	548·0@ (3·5)
6. Fifth Plan (1974-79) actuals	39426·2 (100)	760·8 (1·9)	491·8 (1·3)	1252·6 (3·2)	1107·5 (2·8)
7. 1979-80 (actuals)	12601·0 (100)	275·4 (2·1)	118·5 (0·9)	393·9 (3·1)	395·3 (3·3)
8. Sixth Plan (1980-85) outlay	97500·0 (100)	1821·1 (1·9)	1010·0 (1·0)	2831·1 (2·9)	3922·0 (4·0)
9. 1980-81 (actuals)	14832·4 (100)	269·6 (1·8)	141·9 (1·1)	411·5 (2·9)	524·2 (3·5)
10. 1981-82 anticipated	18210·9 (100)	346·5 (1·9)	183·9 (1·0)	530·4 (2·9)	661·4 (3·6)
11. 1982-83 outlay	21081·7 (100)	388·8 (1·8)	245·0 (1·2)	633·8 (3·0)	692·6 (3·3)

Source : Health Statistics of India, 1983, p. 71.

@ Including LIC loans assistance which was not reflected in the State Plans.

APPENDIX I-B

Sixth Plan Outlays—Health Sector

(Rs. crores)

Sl. No.	Programme	1974-79			1980-85		
		States & U.Ts.	Centre	Total	States & U.Ts.	Centre	Total
1	2	3	4	5	6	7	8
1.	Minimum Needs Programmes for Rural Health						
	(a) Centrally Sponsored Schemes	—	—	—	102.62	168.50	271.12
	(b) Other schemes	120.30	—	120.30	305.84	—	305.84
	Total	120.30	—	120.30	408.46	168.50	576.96
2.	Control of Communicable Diseases	—	268.17	268.17	235.00*	289.00	524.00
3.	Hospitals and Dispensaries	—	—	—	—	45.00	—
4.	Medical Education & Research	225.53	67.66	293.19	576.59	62.00	720.09
5.	Traditional Systems of medicine and Homoeopathy	—	—	—	—	29.00	—
6.	Others	—	—	—	—	7.50	—
	Total	345.83	335.83	681.66	1220.05*	601.00	1821.05

*This includes Rs.195.30 crores towards 50% State share for Malaria Control Programme.

Source : Sixth Five Year Plan 1980–85, p. 382.

APPENDIX I-C

Sixth Plan– States/UT-wise distribution of outlay for Health Sector

(Rs. in Crores)

Sl No.	States/U.Ts.	Total	MNP including CHV and MPW Schemes	Remaining Programmes
(1)	(2)	(3)	(4)	(5)
	States			
1.	Andhra Pradesh	65.00	24.39	40.61
2.	Assam	32.00	12.00	20.00
3.	Bihar	82.40	36.27	46.13
4.	Gujarat	70.00	20.09	49.91
5.	Haryana	48.00	8.53	39.47
6.	Himachal Pradesh	16.18	5.00	11.18
7.	Jammu & Kashmir	48.00	9.03	38.97
8.	Karnataka	65.53	20.03	45.50
9.	Kerala	36.55	9.54	27.01
10.	Madhya Pradesh	94.00	36.07	57.93
11.	Maharashtra	89.46	30.00	59.46
12.	Manipur	9.70	5.27	4.43
13.	Meghalaya	7.10	4.43	2.67
14.	Nagaland	8.00	2.97	5.03
15.	Orissa	29.60	16.00	13.60
16.	Punjab	49.00	13.77	35.23
17.	Rajasthan	40.98	17.43	23.55
18.	Sikkim	4.35	1.39	2.96
19.	Tamil Nadu	67.80	21.82	45.98
20.	Tripura	8.56	3.36	5.20
21.	Uttar Pradesh	134.98	74.89	60.09
22.	West Bengal	34.00	25.88	58.12
	Total States	1091.19	398.16	693.03

(1)	(2)	(3)	(4)	(5)
	Union Territories			
23.	A & N Islands	1.85	0.44	1.41
24.	Arunachal Pradesh	8.05	4.00	4.05
25.	Chandigarh	6.10	0.85	5.25
26.	Dadra & Nagar Haveli	0.65	0.37	0.28
27.	Delhi	87.66	0.12	87.54
28.	Goa, Daman & Diu	14.00	0.55	13.45
29.	Lakshadweep	0.55	0.22	0.33
30.	Mizoram	7.00	3.26	3.74
31.	Pondicherry	3.00	0.49	2.51
	Total UTs	128.86*	10.30*	118.56*
	Total States & UTs.	1220.05	408.46	811.59

*Excluding outlay on Centrally Sponsored Schemes borne on the budget of the Health Ministry.

Source : Sixth Plan, 1980—1985, p. 383.

Per Capia (Public Su

Sl. No.	State/U.Ts.
1	2
	States
1.	Andhra Prades
2.	Assam includin Mizoram
3.	Bihar
4.	Gujarat
5.	Haryana
6.	Himachal Prad
7.	Jammu & Kashmir
8.	Karnataka
9.	Kerala
10.	Madhya Prade
11.	Maharashtra
12.	Manipur
13.	Meghalaya
14.	Nagaland
15.	Orissa
16.	Punjab
17.	Rajasthan
18.	Sikkim
19.	Tamil Nadu
20.	Tripura
21.	Uttar Pradesh
22.	West Bengal

APPENDIX I-D

Per Capia (Public Sector) Expenditure on Health (Medical and Public Health) and Family Welfare during the Years 1977-78 to 1979-80

Sl. No.	State/U.Ts.	1977-78 (Rs.)		1978-79 (Rs.)		1979-80 (Rs.)	
		Health	F. W.	Health	F. W.	Health	F. W.
1	2	3	4	5	6	7	8
	States						
1.	Andhra Pradesh	13.49	1.71	16.07	1.90	17.26	1.98
2.	Assam including Mizoram . .	12.24	0.93	14.28	1.01	14.08*	1.02*
3.	Bihar . .	6.94	0.93	8.86	1.26	9.61	1.06
4.	Gujarat . .	17.06	2.28	20.00	2.65	21.57	2.93
5.	Haryana . .	18.91	1.56	25.29	1.57	23.17	1.84
6.	Himachal Pradesh	30.41	2.98	51.40	2.94	61.93	3.17
7.	Jammu & Kashmir . .	38.57	1.12	53.20	1.61	66.82	1.65
8.	Karnataka .	12.64	2.08	14.50	2.28	15.43	2.25
9.	Kerala . .	19.26	1.77	21.20	1.86	25.20	2.23
10.	Madhya Pradesh	10.76	1.37	11.61	1.55	17.05	1.74
11.	Maharashtra .	16.88	1.13	21.41	1.55	25.34	2.06
12.	Manipur . .	22.98	1.51	35.73	2.67	73.86	3.65
13.	Meghalaya .	39.98	1.85	51.49	1.78	81.22	2.93
14.	Nagaland .	119.98	0.26	171.35	0.58	151.54	1.62
15.	Orissa . .	11.31	1.78	13.65	1.90	16.52	1.99
16.	Punjab . .	20.94	1.42	23.80	1.45	25.69	1.58
17.	Rajasthan .	19.69	1.24	23.21	1.39	19.74	1.58
18.	Sikkim . .	68.50	1.54	82.10	2.72	71.42	3.69
19.	Tamil Nadu .	14.73	1.52	16.72	1.78	16.83	1.63
20.	Tripura . .	21.21	0.76	25.86	0.90	30.32	1.00
21.	Uttar Pradesh .	8.11	1.33	9.92	1.40	11.73	1.43
22.	West Bengal .	16.54	0.75	17.73	1.01	20.12	1.42

1	2	3	4	5	6	7	8
	Union Territories						
23.	Arunachal Pradesh . .	56.15	0.17	79.53	0.28	91.49	0.66
24.	Goa, Daman & Diu . .	65.19	1.67	72.07	1.66	81.09	1.71
25.	Pondicherry .	65.77	2.12	70.76	2.23	129.70	2.54
26.	Mizoram . .					107.70	0.03
	Total . .	15.05	1.51	17.29	1.79	19.91	1.84

Notes : All India total includes Central Govt. & Expenditure in respect of U.Ts. of A.& N.Islands, Chandigarh, D. & N. Haveli, Delhi and Lakshadweep.

*Excluding Mizoram.

Source : Health Statistics of India, 1983, pp. 75-76.

	7	8				
	91.49	0.66				
	81.09	1.71				
	129.70	2.54				
	107.70	0.03				
	19.91	1.84				

respect of U.Ts. of akshadweep.

APPENDIX-I—E

Statement showing Physical Targets and Aehievements under Rural Healtn Programme

Sl. No.	Programme	Norm	Unit	Position obtaining as on 1-4-80	1980-85	
					Target (Additional)	Likely Position by 31-3-1985
1.	Community Health Volunteers	1 for every village of a population of 1000.	Lakh	1.40	2.20	3.60
2.	Sub-centres	1 : 5000 population in plains and 1: 3000 in tribal and hilly areas.	Nos.	50,000	10,000	90,000
3.	Primary Health Centres	1 : 30,000	Nos.	5,400 (in addition 1000 subsidiary health centres were also set up).	600 additional primary health centres + upgradation of 1000 dispensaries into subsidiary health centres.	6,000
4.	Upgraded Primary Health Centres to be converted to Community Health Centres.	1 : 1,00,000 or 1 per CD Block.	Nos.	340	174	514

SOURCE : Sixth Five Year Plan, 1980-85, p. 384.

APPENDIX II

Establishment of Primary Health Centres and Sub-centres in India since First Plan

	PHCs	
First Plan	725	
Second Plan	2,565	
Third Plan	4,631	
INTER-PLAN PERIOD 3 YEARS	PHCs	Sub-Centres
As on 31-3-1967	4,793	17,521
As on 31-3-1968	4,946	21,539
As on 31-3-1969	4,919	22,826
4TH FIVE YEAR PLAN		
As on 31-3-1970	5,015	23,527
As on 31-3-1971	5,112	28,489
As on 31-3-1972	5,183	28,167
As on 31-3-1973	5,248	31,034
As on 31-3-1974	5,283	33,509
5TH FIVE YEAR PLAN		
As on 31-3-1975	5,293	33,616
As on 31-3-1976	5,328	34,088
As on 31-3-1977	5,380	38,110
As on 31-3-1978	5,400	38,115
6TH FIVE YEAR PLAN		
As on 31-3-1979	5,423	40,124
As on 31-3-1980	5,484	49,049
As on 31-3-1981	5,568	51,192
As on 31-3-1982	5,739	59,511
As on 31-3-1983	5,955	65,643

SOURCE : Health Statistics of India, 1983, p. 149.

since First Plan

Sub-Centres

17,521
21,539
22,826
23,527
28,489
28,167
31,034
33,509
33,616
34,088
38,110
38,115
40,124
49,049
51,192
59,511
65,643

APPENDIX III

Number of PHC's and sub centres required and in position in Tribal Areas

Sl. No.	Name of the State/UTs.	Tribal Population (1971 Census) in lakhs	PHCs		Sub-Centres		
			Required 20,000 population	in position	Required 3,000 population	in position	Reference Period
1	2	3	4	5	6	7	8
1.	Andhra Pradesh	16·6	83	29	553	1919	30-9-82
2.	Assam . .	19.2	96	32	640	216	31-3-83
3.	Bihar . .	49·3	247	NA	1644	NA	
4.	Gujarat . .	37·3	186	65 (31-3-82)	1245	486	31-3-83
5.	Himachal Pradesh	1·4	7	9	47	48	31-3-83
6.	Karnataka .	2·3	12	55	77	788	31-3-83
7.	Kerala . .	2·7	13	5	90	43	31-3-83
8.	Madhya Pradesh	83·9	419	185	2796	2358	31-3-83
9.	Maharashtra .	29·5	147	121	985	720	31-3-83
10.	Manipur . .	3·3	17	NA	111	NA	
11.	Meghalaya .	8·1	41	26	271	101	30-9-82
12.	Nagaland . .	4·6	23	18	153	116	31-3-83
12.	Orissa . .	50·7	253	118	1691	1046	31-3-83
14.	Rajasthan .	31·3	156	23	1042	249	31-12-83
15.	Sikkim . .	0·5	3	2	17	11	31-3-83
16.	Tamil Nadu .	3·1	16	16	104	100	30-9-82
17.	Tripura** .	4·5	23	12	150	57	31-3-83
18.	Uttar Pradesh .	2·0	10	NA	66	1420	31-3-83
19.	West Bengal .	25·3	127	NA	844	NA	
20.	Arunachal Pradesh . .	3·7	18	45*	123	NA	
21.	Goa, Daman & Diu . . .	0·08	1	1	3	5	31-3-83

1	2	3	4	5	6	7	8
22.	Mizoram . .	3·3	17	18	111	290	31-3-83
23.	A & N Islands	0·2	1	1	6	..	30-9-82
24.	D & N Haveli	0·6	3	3	21	14	31-12-82
25.	Lakshadweep .	0·3	1	7	10	..	31-3-83
	TOTAL . .		1920	791	12800	9987	

*Health Units

**Dispensaries are treated as sub-centres.

SOURCE : Health Statistics of India, 1983, p. 157.

6	7	8
11	290	31-3-83
6	..	30-9-82
21	14	31-12-82
10	..	31-3-83
00	9987	

APPENDIX IV

Population per bed, Physician and Midwife/nurse for selected countries

Sl. No.	Name of the country	Population		Per			
		Year	Bed	Year	Physician	Year	Mid-wife/ Nurse
1	2	3	4	5	6	7	8
1.	Afghanistan .	1981	3700	1981	13467	1981	9111
2.	Argentina .	1969	180	1975	530	1973	93
3.	Australia . .	1980	150	1980	556	1980	146
4.	Bangladesh .	1981	4545	1981	8908	1981	15005
5.	Brazil . .	1976	245	1974	1650	1974	2280
6.	Burma . .	1981	1226	1981	4940	1981	1649
7.	Canada . .	1978-79	70	1979	548	1978	130
8.	Egypt . .	1981	500	1981	815	1981	771
9.	France . .	1977	82	1977	580	1977	151
10.	German (D.R.)	1978	94	1980	494	+	+
11.	Germany (F.R.)	1980	87	1980	442	1980	181
12.	India . .	1981	1265	1981	2545	1981	1857
13.	Indonesia . .	1979	1787	1979	11973	1979	1070
14.	Japan . .	1981	86	1981	761	1981	209
15.	Kenya . .	1978	601	1978	10136	1978	1039
16.	Libya . .	1981	201	1981	660	1981	319
17.	Malaysia (Peninsular) .	1981	370	1980	3267	1980	541
18.	Mexico . .	1974	860	1974	1250	1974	1400
19.	Nepal . .	1980	5477	1980	28768	1980	7448
20.	Pakistan . .	1981	1746	1981	3172	1981	4492
21.	Srilanka . .	1981	340	1981	7631	1981	1453
22.	Thailand . .	1980	658	1980	6870	1980	1104
23.	U.K. (England and Wales) .	1980	127	1979	711	1979	207
24.	U.S.S.R. . .	1978	82	1979	274	+	+
25.	U.S.A. . .	1980	171	1980	549	1980	196

+ Not available.

SOURCE : Health Statistics of India, 1983, p. 262.

APPENDIX V

Govt. Health Expenditure in different countries

Sl. No.	Name of Country	Percent of Govt. Health Expenditure to total Govt. Expediture		Per capita Expenditure on Health 1979 (in terms of 1975 dollars)
		1978	1979	
1.	Argentina	2.24	1.73	5
2.	Australia	10.36	10.14	187
3.	Brazil	7.83	8.50	21
4.	Burma	6.73	+	1
5.	Canada	7.62	7.56	126
6.	Egypt	3.55	+	8
7.	France	14.82	+	406
8.	Germany (FR)	19.33	18.99	437
9.	Ghana	7.26	5.96	+
10.	India	1.97	1.64	+
11.	Kenya	7.45	7.23	5
12.	Malaysia	6.39	6.41	15
13.	Mexico	3.97	3.90	10
14.	Nepal	5.33	5.15	1
15.	Pakistan	1.64	1.35	+
16.	Sri Lanka	+	+	5
17.	Thailand	4.38	4.33	3
18.	U.K.	12.73	12.78	219
19.	U.S.A.	10.15	10.48	183

SOURCE : W.H.O.
+ Not available

SOURCE : Health Statistics of India, 1983, p. 263.

NTI, 8/8/96 ①

Ref - DGHS Chronicle - quarterly newsletter of DGHS, Vol XXII, Oct-Dec 1986 & 64

The 20 pt. progr 1986.

Central Govt announced a new 20 pt. progr on 15 Aug, 1986 c emphasis on poverty removal in rural areas, raising productivity, reducing income inequalities, removing socio & ec. disparities & improving the quality of life. Progr. restructured in light of obj. achievements & experiences of 7th 5 Yr Plan. Pts rel. to H & Fw are

1. Health for All : we shall — a) improve the quality of PHC
   b) Fight leprosy, TB, malaria, goitre, blindness & other major dis's
   c) Provide immuniz. for all infants & children
   d) Improve sanit. facilities in rural areas, part for SC
   e) Pay special attention to progs for rehab. of handicapped.
2. Two child Norm. we shall
   a) bring abt acceptance of 2 child norm.
   b) promote responsible parenthood
   c) Reduce infant mortality.
   d) Expand maternity & child care facilities.

— x —

NTCP Out of abt (!) 431 Distt in the country 366 DTC staffed by trained Key personnel (med + PHW) + essential equip. have been est. so far. Additionally abt 300 TB clinics functioning mainly in cities + towns to cater to needs of local pop.

Target achieved from April - June 86 are

	Quarterly target (lakhs)	achievements during quarter (lakhs)
1. Detection of new TB cases	3.62	3.15
2. Sp ex. of PHC's	8.50	4.12

EPI Target & achievs 1985-86 (April 85 - Mar 86) fig in lakhs (2)

	Annual target 85-86	achiev 85-86	% T (+) or ↓ (-)	% achiev of annual target
BCG	140.44	128.81	+6.4	91.9%
DPT				95%
Polio				85.3%

Annual Target for 86-87

BCG (infants) - 153.0 L.

same for DPT / Polio

—x—

DGHS Chronicle Vol 22 July-Sept'86 - No 3

New Min of State for HFW & FW - on 12/5/86 Miss Saroj Khaparde

D/o Late - father Pandharam Khaparde - freedom fighter, associate of Gandhi & Nehru - a member of India's Provisional Parliament from 1950-52. Mother active party worker & volunteer.

Ms. SK - elected to Rajya Sabha in 1972-1974 & then continuously from 1976. Many Parliamentary committees worked/travelled

New DGHS Dr MD Saigal MBBS MS surgery - 11/6/86

EPI Integ of BCG vacc in EPI - Its performance / BCG vacc in target age grp (0-1yr) is poor in most States, Directives issued on 15 Jan 1986 to DHS's / State EPI Officers / STO's to immediately integrate BCG vacc in prog along with EPI so that all PHC staff may administer BCG vaccine along with other EPI vaccine right from time NLEP jointly evaluated by WHO & GOI in Feb'85

UIP launched 19 Nov 1985 as living memorial to Indira Gandhi aimed at providing protection to children against 6 vaccine preventable dis. - started in 30 dists & Calcutta urban agg of 50 med. colls in 628 blocks to cover 66 mill. pop - by end of the financial yr - expanded in phased manner to cover entire country by 1990.

Health Achievements 1985-86 – SS Dhanoa, Secy H+FW.

7th Plan – emphasis on preventive & promotive aspects + (3)
organising effective & efficient health services c̄ are comprehensive in nature, easily & widely available, accessible & affordable.
Accordingly broad objs are to control & eradicate communicable dis, provide preventive, curative & promotive health services to people c̄ improved PHC services in rural & tribal areas.

Rural Health Services –
At peripheral facilities of health delivery sys. enlarged. Longterm measures to ~~enlarge~~ expand network of PHC's, SC's formulated under MNP. By 31/12/85 there were
11,530 Subsidiary / Primary Hlth Centres
84,013 SC's.
1.8 L MPW's. of c̄ 0.94 L are ♀
3.85 L trained VHG's +
abt 5.16 L trained dais. – continuing prog.

Leprosy – Rifampicin & Clofazimine intro into progr. – MDR.
NTCP – 364 dts provided c̄ DTC's c̄ essential equip / trained staff. From April – Nov 1985 – DTC's detected 11.35 L new TB cases & 11.70 sp. ex. conducted for chronic chest symptomatics. 10 x ray units + 25 Odelca cameras being supplied to States UTs

—x—

DGHS Chronicle 86-87 SS Dhanoa – from intro to Annual Report 86-87 – Turn goals HFA 2000 + NRR of unity – prev. & promotive aspects augmented child survival & educ. component of FW prog.
UIP now in 92 dists – 90 more Dts will be taken up in 87-88 – sld further ↓ IMR
ORT, FWP – PHC's 12,314, 89815 SC's, 1.85 L MPWs of c̄ 1 L ♀, 3.9 L ~~VHG~~'s, 5.45 L trained dais

Additional 215 PHC's & 660 SC's established in rural areas.

Total no of PHC's in rural areas as on 1,542 + 10,489 SC's.

—x—

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EPI Present Pos & future Plan, Dr PC Roy, ADG (EPI) DGHS

EPI - intro 1978. Obj - ↓ morbidity, mortality, disability due to vaccine preventable diseases viz D, P, T, OPV, TB & typhoid by making free vaccine services easily available to all eligible children & expectant mothers. Measles included in 1985-87.

- most cost effective pub health measure.

- ↓ i — diet, better MCH & FW.

Aims to ↓ IMR from 110 to 87 : 1990 & below 60/1000 by 2000 AD as envisaged : NH. Policy. Also to ↓ perinatal mortality rate from 67 to 30-35/1000 births & preschool child mortality from 24 to 10 by 2000 AD, to ↓ neonatal neonatal mortality rate to ≤ 1/1000 LB & ↓ polio rate to < 0.33/1000 children (0-4yrs) by 1990 from present (1981) level of 1/1000.

& Achieving universal coverage of eligible children & pregnant mothers by end 1990

Implemented thru states/UTs thru GHS.

85-86 - 30 dts

86-87 - 62 new dts

to phased manner by 1990 :

↑ infrastr.

↑ personnel - to plan, monitor, eval

↑ prod of vaccines - self sufficiency : all except polio, needles - from UNICEF. ↑ indigenous prod being explored

WHO & many (plan) UNICEF - cold chain, vehicles

syringes, needles)

The prod

* earlier 5 point prog. later Sanjay Gandhi 5 pt. progr.

entered 26/10/97

Ref NTI Lib 29/5/96 THE NEW 20 POINT PROGRAMME, DAVP, Min of I & B, GOI ? 1982

(Directorate of Advertising & Visual Publicity)

20 Point Progr - initiated in 1975 'to lighten hardships of various groups' in addn to gen. dev. prog's. Incl.

1. – Abolition of bonded labour – legisl adopted in 1976
2. – Confisc. of smugglers property
3. – lower & middle income grps exempt from income tax
4. – national permit scheme for road transport enforced
5. – Providing irrigation to 5 mill hectares fulfilled
6. – National scheme for use of ground water taken up
7. – Super thermal power stations being established

Foll. changes in Govt, when Cong. came back to power.

New 20 Point Programme announced by PM Mrs Gandhi 14/1/82

FAMILY PLANNING

Point 13 – Promote FP on a voluntary basis as a people's movement.

Pop' doubled – 1947 – 34.2 cr, 1981 – 68.4 cr. Further ↑ will nullify gains of dev. effort. Birth rate of 37 for mid-census period 1971-81 ↓ to 21 (Sixth Plan goal), death rate to 9 & IMR – 50. % of couples practising FP stepped up from 22.5% to 36.5% by 84-85

HEALTH

Point No. 14 – Substantially augment numbers of primary health care facilities & control of leprosy, TB & blindness

Interestingly in the write up, leprosy & blindness are covered, but nothing specific abt TB mentioned!

Progress since beginning of planning – elimin' of plague & S. pox epidemics & Killed many', malaria incl greatly ↓. Incl of malaria & TB however still high. Preventable blindness d/o nutr def, dis, cataract Morbidity d/o nutr def, waterborne dis & envir. causes still high.

We have adopted goal of HFA by 2000 AD. To reduced oppr, thru preventive, promotive & curative measures & effective linkages & safe drinking water supply, sanit°, nutr°, educ°. ∴ adopted in 6th Pla. Rural Health infrastructure being strengthened & remodelled.

1 HHW Guide / 1000 pop°, - HE and FP, minor ailments Rx, referral to PHC
1 Subcentre / 5000 pop° - (3000 in hilly & diff. areas
1 PHC / 30,000 (20,000 in hilly, diff areas)
Referral service to CHC, dist / med. coll hosp.

By 1979-80 India had 1.4 L HG's, 50,000 SC's, 54000 PHC's, 1340 rural hosps / CHC's.

Sixth Plan Progr to add 4 L HG's, 174 CHC's, 40,000 SC's, 1,600 PHC's / Subsidiary Health Centre as part of Minimum Needs Progr for & provisions have been made in Central / State Plans.

National Leprosy Control Progr being implemented as a centrally sponsored Scheme, funded 100% by Centre. Objective to detect at least 90% of cases & arrest dis. in at least 40% cases. Since been decided to draw up & implement an intensive progr for eradic° of dis before end of century.

Progr for Prev of Blindness - to reduce blindness from 1.40% in base yr to 1% by end 84-85. Backlog of 60 L cases of cataract + 10 L cases added each yr. Capacity to deal in cataract to be augmented. Progr thrust - dev preventive care & services to prevent Blindness on acc of nutr deficiencies & dev curative facilities at PHC / Dist Hosp. Mobile clinics for eye care incl. operations to be provided. Voluntary contributions for eye camps.

" This agenda for the nation has been dovetailed with the overall plan of dev". It pinpoints areas of special thrust which will show immed. tangible results for various segments " — PM

" When the 20 Pt Progr first announced in 1975, I had cautioned you not to expect miracles. Then as now, there is only one magic to remove poverty — & that is hard work, helped by a clear-cut sense of purpose & discipline. On a steep road there is no place for pause. Our national motto is 'Satyameva Jayate' 'Truth alone Triumphs'. In our daily lives we shd adopt an additional motto " Shram eva Jayate". Dedication to truth & toil is the bedrock of respect, progress & prosperity. "

Other points : 20 PP

1. Irrigation, dryland agri
2. ↑ prod of pulses, oil seeds
3. ↑ IRDP + NREP.
4. agri. land ceilings, distr. surplus land, complete land records
5. enforce min. wages for agri labour.
6. Rehab. bonded labour.
7. ↑ progr for dev of SC/ST
8. Drinking water to all prob. villages
9. House sites + progs for constr. assistance
10. improve slum environ, house-p progr, arrest land price ↑
11. ↑ power gener, electrify all villages
12. ↑ afforestation, social + farm forestry, dev. biogas, alt. energy sources
13. FP 14. Health.
15. ↑ women, children welfare progs., esp in tribal hill & backward areas
16. ↑ universal elementary educ: 6-14 yr, esp girls + adult lit.
17. ↑ PDS & thru FPS. — industrial workers, students, backlists, consumer protect
18. Liberalise investment procedures, streamline industrial policies, ensure timely completion of projects. Handicrafts, handlooms, small & village industries for thrust to grow, update technology
19. Smugglers, hoarders, tax evaders, black money → combat!
20. ↑ work in, & public enterprises — ↑ efficiency, savings & int. resources.

Ministry of Prgr. Implementation monitors 20 Pgr.
assigned to
Dominant role of public sector - State instrumental in creating infrastructure vital for rapid gth. Heavy investment in ec + social overheads & improve gth of basic + heavy industries in public sector for long period industrialisation created necessary environ. for stimulating industrial gth of private sector.

Public sector enterprises have multiple goals -

a) achiev of natural self-reliance
b) import substitution
c) ↑ of regnl + social embalances.
d) Stability of prices

need to improve working, ↑ ability to generate resources, improve mang practices, ↑ efficiency, optimal utilis of capacity.