International Journal of Research (IJR)
e-ISSN: 2348-6848, p- ISSN: 2348-795X Volume 2, Issue 4, April 2015
Available at http://internationaljournalofresearch.org

Health Service in India – A Challenge to Inclusive Growth

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Abstract

Health is a composite state of mental, physical and social well being. The health care service of the country is highly influenced by our socio-economic condition. The unequal distribution of health care service contradicts our national development. We need to realize the equitable health service in India. Before independence good health service is not available in India. The independent India has made a remarkable development in health service, expansion of health infrastructure, improvement in nutritional status, provision of basic sanitation, man power development and population control. It served as a mechanism for the development of health service in India. The inclusion of universal immunisation programme reflecting our national family and health care development. Infant mortality rate, sex ratio, maternal mortality rate, life expectancy indicates the level of development in our health service. The primary development has been made through the Five Year Plans. The improvement in health status has become an important indicator of inclusive growth.

Key words:

Immunization; Inclusive growth; Mortality rate; Sex ratio; Population growth; Family planning; Health care service.

INTRODUCTION:

India is a developing country with its 1.21 billion of population. It is the biggest democracy and second highest populous country in the world. Here larger section of people is living in below poverty line. The health and hygiene are not up to the score. Our health service remains in miserable condition. Annually 1 lakh mothers die during the child birth. Almost 22 lakh infants and children die from illness. Around 5 million people suffer from AIDS. Health care is a very big alarm for our country. The health sector is now facing major challenges to provide qualitative customer oriented better health service. With healthy population our growth cannot be inclusive. Apart from money and machine, man is also an important element of inclusive growth.

Materials and Methods

The study based on secondary data. Data were collected from the census report 1951s to 2011 and National Health Survey Reports. Data were also analysed through the consecutive census reports.

Historical perspective of health service in India

The development of primary health care service started from the Vedic period. The history finds evidence of primary health service in Indus Valley Civilisation (3000 B.C). The people were using underground drains, developed sanitary system, public bath etc. Ayurveda and Siddha medicines came into existence in Vedic period. The Manu Sahmita also gave a detail description about health, hygiene rituals, mental and spiritual aspects of life. 'Health' or 'Arogya' was cited with high priority in day to day life of people. Their concept of health includes physical, mental and spiritual well-being. "Sarve Vabantu Niramaye" means "let all be free from all diseases" represents their

International Journal of Research

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healthy and good wishes. Due to negligence and ill support of people Ayurveda became loses its popularity.

In the Post – Vedic period (600B.C – 600 A.D) the University of Nalanda and Taxsila provides medical education for better health service. Around 1850 A.D. the Muslim rule came into existence. At that time Arabic system of medicine (Unani) was introduced. The changing political scenario slowly changes the system of health service in India.

In 1757 the British rule establish in Indian soil. During 18th century the British government established medical college for their benefits. Especially for the British armed forces and privileged civil servants. They introduced their own system of health care service. Our indigenous medicine was completely neglected by them. In 1764 the East India Company established medical troops in Bengal. In 1785 medical department was set up in Bengal, Madras and Bombay presidencies. The department was completely controlled under central government until 1919. The Montgomery-Chelmsford Reforms of 1919 led the foundation of decentralisation of health administration. Then the Government of India Act 1935 further gave autonomy to the provincial government. The health activities are divided in federal, federal-cum provincial and provincial government. In 1946 a Health Survey and Development Committee was established. That was named as Bhore Committee. The committee was appointed to review the existing health service system in India.

Health service in India after independence

India gained its independence in 1947. Before that the colonial rulers were not concerned about the development of Indians. They were introducing all developmental facilities for their betterment. Our health and sanitary work was not maintained properly. The people were suffering from number of hazardous diseases. At that time the recommendations of Bhore Committee was get its utmost importance. The emergency of health care service was reflected through the Community Development Programme. It was launched in Oct. 1952. It aims at all round rural development. The Community Development Programme proposed to establish one Primary Health Centre (PHC) for each Community Development Block (CDB). The PHC were covered medical care, maternal health, child health, school health, prevention of communicable diseases, malnutrition and sanitation etc. All PHC had three sub-centres. They are looking after by the trained midwifes. The midwife was properly trained about the maternal and child health care service. The situation continued with a miserable condition of health sector. After review by number of expert committees the government took step forward through the Five-Year Plans.

Development of health service through the Five Year Plans

Better health is the primary indicator of national progress. The social, economical and infrastructural development can be possible through the healthy society. It increases the human capability towards productive work. The good health also ensures a complete adjustment with his environment. So the development of health service should our primary focus.

The First Five Year Plan (1951 – 56) initiated a balanced development. It ensures steady improvement in the living standard of people. In 1950 the death rate was 16.5 and infant mortality rate 1000 per 127. The low mortality rate and high death rate shows the clear picture of our health service. Around 2lakh maternal death occurs in this period. Epidemic disease contributes 5.1% of the total mortality rate. The lack of hygienic environment, proper housing, poor nutrition, and safe water supply, improper removal of human waist, low economic status and low health education causes the high death rate. So in the first plan our government introduced number of programmes to control the communicable dieses. The National Family Planning Programme (FPP) was

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introduced in 1952 to stabilize the population growth. The main aim of Family Planning Programme was better health and welfare of the family. The first plan also priorities on health education and training, self-sufficiency in drugs and equipments, better health service for mother and children, provision of safe drinking water supply and sanitation, preventive health care of rural population through health units and population control etc. This pattern of health service development has been suggested by the health survey and development committees.

The main aim of Second Five Year was to expand the existing health service and improve the national health. The plan focused to develop technical manpower through training programmes. It proposed to establish institutional facilities for the both rural and urban people. The provision of cheaper accommodation with all medical care was made on this plan. Separate accommodations for the acute communicable disease are provided. During the Second plan special arrangement was made to increase the number of nurses, mid-wives, pharmacists, sanitary inspector and other technicians. In 1954 Mudalier Committee was set up to evaluate the progress made by the first five year. It reported that the basic health facilities had not reached to half of the geographical area. But the death rate had fallen to 21.6% in the period of 1956 – 61. The life expectancy had risen to 42 years. The committee also suggested improving the service condition of doctors and other administrators. That will attract them towards rural areas.

In the Third Five Year Plan (1961-66) primarily the health and family planning programmes were expanded. It ensures to provide minimum physical condition with greater efficiency and productivity. The preventive public health services are gained importance in this plan. The plan also emphasize on family planning programme. The broad aim of the plan was to the health service deficiencies. In this plan B.C.G. campaign was accelerated. The control and treatment of trachoma provision has been made in the Third Plan. The research programme on development of human genetics, physiology of production, effective local contraceptives, sterilisation cases are gave importance in the plan also. The plan highlighted insufficient health care institutions and doctors. In 1963 the Chadha Committee was set up. It recommended the integration of health and family planning services. It also suggests making the delivery through one male and one female. In this plan period Mukharjee Committee was also set up to review the staffing pattern and financial provisions under family planning programme.

The first three plans were focused on control and eradicate communicable diseases and birth control. But the Fourth Plan emphasized on strengthens primary health centre especially rural areas. Sub-divisional and district hospitals were strengthen in Fourth plan. Total non-plan expenditure of the RS. 120 crores. In the beginning of the Fourth plan 502 clinics had been set up in Assam, Haryana, MP and Nagaland. In 1971, Medical Termination of Pregnancy (MTP) Act was passed. It ensures women to have safe abortion services. The Fourth plan highlighted the population growth was central problem. It used the phrase like "Crippling Handicap" for population growth.

The Fifth Five Year Plan emphasized on immunisation programme. The Expanded Programme of Immunisation (EPI) was introduced in 1978. The main aim of this programme was to reduce mortality rate. The 20 – Point Economic Programme was announced in 1975. It provides financial investment on the health sector. The objective of the Fifth Five Year Plan was to increasing accessibility of health service in rural areas through the Minimum Needs Programme (MNP), checking regional disparities, improving qualitative health training etc. Water supply and sanitation got a greater emphasize in the fifth plan. In 1977 the recommendations of Shrivastav Committee, Community Health Worker Scheme was

adopted. They are not permanent work. They were selected by the village and supervised by the MPWs. During the fifth plan a state of National Emergency was declared (1975 – 77). With this situation population control activities becomes compulsory. So the National Population Policy was adopted in this period.

The Sixth plan was highly influenced by the Alma Ata, declaration of "Health for All by 2000 A.D." (WHO, 1978) and the report ICSSR – ICMR (1980). The plan gave importance towards the development of community based health service. Apart from that the broad objective of the plan was to stabilize the population growth by reducing Net Reproduction Rate (NRR). During the Sixth Plan the National Health Policy (NHP) of 1983 was launched. Its policies are based on ICMR – ICSSR recommendations. The aim of the NHP was to providing 'universal, comprehensive primary health care service, relevant to actual needs and priorities of the community'.

The Seventh Plan accepted and implemented the policies of NHP. It suggested for specialist and super-specialist for better health service. The special attention of the Seventh Plan was control of population growth, AIDS, Cancer and Coronary heart diseases. During this plan several scheme were introduced.

- All India Hospital Post- Partum Programme (AIHPPP)
- Child Survival & Safe Motherhood Programme (CSM)
- Universal Immunization Programme (UIP)
- Urban Family Welfare Centres for Slum Dwellers.

The economic crisis was a major hindrance of the Eight Plan. So the plan support to privatisation. The slogan of the Eight Plan was not "Health for All" but "Health for the Underprivileged". The introduction of Panchayati Raj and Nagar Palika Act (1992) helps a lot in providing better health service to the underprivileged people. It provides special assistance to poor performing districts. To review the public health system an expert committee was set up in the Eight Plan. A National Policy on Education in Health Sciences was also formulated.

The Ninth Plan further emphasized on improvement of health status, infrastructural development, manpower development and population control of the country. The plan focused on

- Integration of all health developmental programmes.
- Improvements of the drugs supplies.
- Development of the Non-Communicable Diseases Control Programme.
- Increase the involvement of voluntary organisations, private organisations and Self-help-groups in the health care system.
- Activate PRIs in planning and implementing the health programmes at the local level.
- Creating awareness to avoid the barriers of utilizing existing health care services.
- Ensure medical service including eye and ENT case.

During the Ninth Plan a Technical Appraisal Committee was constituted for the proper maintains of technical equipments.

The Tenth Five Year Plan was emphasized on human development and family welfare programmes. The state like Bihar, Rajasthan, Odisha, Madhya Pradesh, Chhattisgarh, Jharkhand, U.P. and Uttaranchal gained more attention for effective family welfare programmes. So the Indian government formed "Empowered Action Group" (EAG, 2001.) under the Ministry of Health and Family Welfare Department. All the recommendations of the

Seventh, Eighth and Ninth plan were effectively implemented in the Tenth Plan. The National Vector-Borne Diseases Control Programme was implemented in this period. It also focused on quality assurance, sufficient stock of drugs, evaluation of the operational research, improve preventive and cancer prevention, impure access to mental care in primary and secondary level, alleviation of macro environmental pollution, reforming the health sector etc. The Tenth Plan also targets to achieve these goals.

- Reducing the population growth to 16.2%
- Reducing Maternal Mortality Ratio (MMR) to 2percent 1000 by 2007 and 1 by 2012.
- Reducing IMR to 45 per 1000 by 2007 and to 28 by 2012.

The Eleventh Five Year Plan adopted the policy of faster, broad-based and inclusive growth. Its main thrust was to achieve good health for the people, especially the depressed, poor and underprivileged. It aims to provide clean drinking water, public health, sanitation, access to food etc. The primary focus was given to reduce the disparities in health care service across the country. The marginalised, women, tribal were given special attention. The vision of this plan was to –

- Reducing Total Fertility Rate (TFR) to 2.1%.
- Reducing anaemia among women by 50%.
- Raising Sex Ratio to 950 by 2016 -17.
- Reducing MMR.
- Reducing IMR.
- Restructuring the Public Health Management to integrate AYUSH in the national health care system.
- Promoting scientific validation of AYUSH therapy.
- Expansion of international co-operation etc.

Infant mortality rate, maternal mortality rate, sex ratio and life expectancy are the basic socio-economic indicators. It shows the level of growth and determines the form of development.

Table: 1 CBR: Crude Birth Rate, CDR: Crude Death Rate, TFR: Total Fertility Rate.

Year	CBR	CDR	TFR
1981	37.2	19.0	4.5
1991	29.5	9.8	3.8
2001	25.4	8.4	3.1
2011	21.8	7.1	2.5

Source: SRS Estimate Bulletin, Vol.48, 2012

Table: 2 Maternal Mortality Rate

Year	MMR
1997 – 1998	398
1991 – 2001	327
2001 - 2003	301
2004 – 2006	254
2007 - 2009	212 (16.3%)

Source: National Family Health Survey

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Table: 3 Sex Ratio – (Female per 1000 Male 1951-2011 in India)

Census Year	Sex Ratio
1901	972
1921	955
1941	945
1961	941
1981	934
2001	933
2011	940

Source: India: 2004-11 (SRS-2012), Register General of India

Fig. 1 Source: Census of India & Technical Group on Population Projection, National Commission on Population

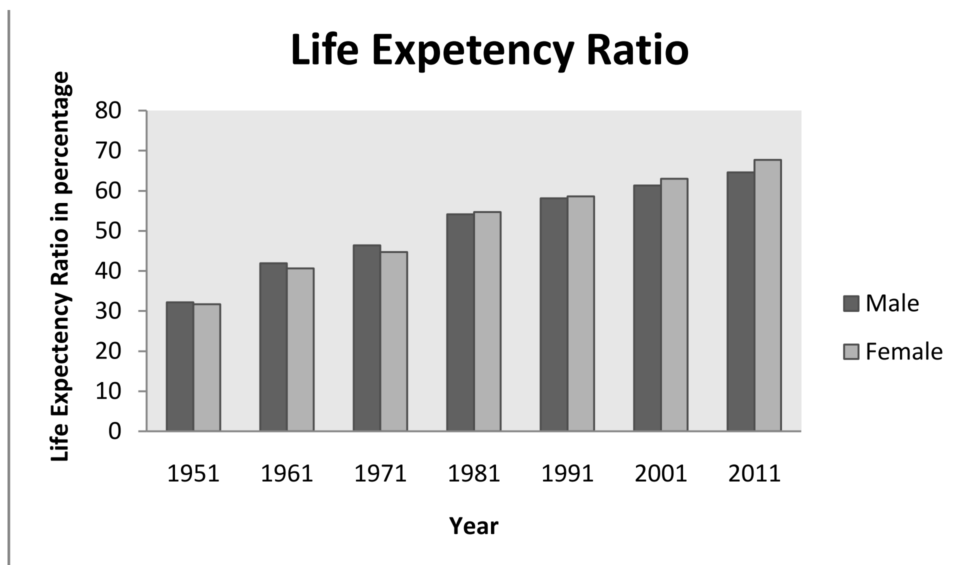
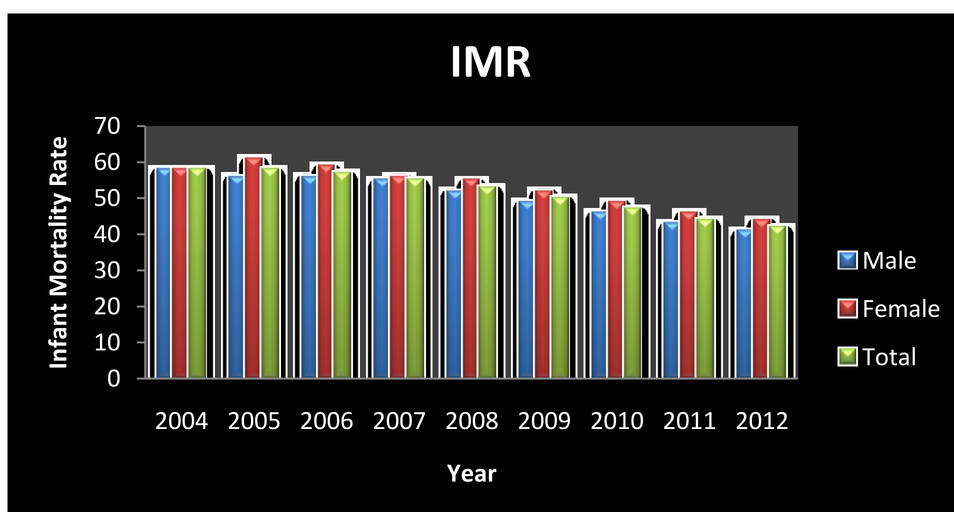


Fig. 2 Source: SRS Bulletin, Volume 48, No. 2 September, 2013; SRS-2012



Data on CBR, CDR and TFR is featured in table 1. It shows the controlling rate over population growth. The birth rate and death rate steadily decreases which reflects in fertility rate. The table 2. shows that the MMR also decreased in a positive ratio. But the sex ratio has not improved too abreast with change of IMR. It clears the picture of gender discrimination of the country. The figure 1. Shows status of expectations of life which is in a balancing ratio. But the IMR has reduced at a faster pace with compared to sex ratio and MMR.

Conclusion

Health is a very important aspect of socio-biological condition of our life. It is also a fundamental human right. The safe motherhood and child survival is an absolute feature of health and hygiene. So the government health policies have to focus in that sphere where they failed to acquire effective result. It will accomplish for the better future. Though there are various initiatives and innovations still we are lagging behind the health care service. There is a need of revitalisation in health care system. The health awareness programme, campaigning through dramas, mass media, electronic media and NGOs participation will encourage our primary health service. The information regarding family planning, better nutrition, health care programmes should be communicated among rural, urban and tribal slums. The infrasture development is also an important step towards its development. The inclusive health policy should make our system universal. It also leads to inclusive development of our country.

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