Chapter-3

Public Health Policies and Programs in India: State and Private Agencies

3.1 Introduction

The National Health Policy was first formulated in 1983 and updated in 2002. It served quite satisfactorily in guiding the approach for the health sector as stated in the Five-Year Plans. But the context and the situation has changed totally over the years. As per the report of NHP 2017 the health priorities in the country are changing. The reports have also stated that there is a rapid decline in maternal and child mortality throughout the years but there is still a huge burden in regard to non-communicable diseases and some other infectious diseases. Another important change that has been noticed in recent years is the growing expenditure costs in health care services which could be considered as an important reason of poverty in the nation. Further, it is also explicitly mentioned by different health activists and academicians that the rising economic growth enables enhanced fiscal capacity. Thus, there was an urgent need of a new health policy which could deal with all these new changes in the health sector.

The primary objective for the formulation of National Health Policy 2017 is to strengthen the role of government in shaping the new healthcare system. This new healthcare system tries to cover all the dimensions such as organization of healthcare service, prevention of diseases, encouraging the idea of medical pluralism, encouraging better financial protection strategies, promoting good health through cross sectoral actions, human resource development, technological accessibility etc. The primary goal of the policy is to provide universal access to quality health care services to all the people without having any financial difficulties. The policy also envisages the attainment of highest possible level of health and wellbeing of all the people. The policy emphasized the importance of Sustainable Development Goal (SDGs).

In regard to the Policy principles it is stated that professional standards, integrity and ethics should be maintained in the entire healthcare system of the country which is further supported by transparency and responsibility. It explicitly talks about equity of healthcare system and vehemently opposes practices of any discrimination on the basis of gender, poverty, caste etc. The policy further envisages for the accessibility of quality health care facilities to the entire nation and the prevention of exclusion on the basis of social and economic difference.

3.2 Public Health Pre and Post Independence

Perhaps the first written document on Public Health in India was the report of the Royal Commission on the sanitary state of the British army in India in 1863. Health has never been the country's priority after independence. It is only from last few years that there has been steady growth in the public expenditure on health in India and estimated around 0.8

or 0.9 percent of GDP. It is indeed interesting to mention that the share of public expenditure to health expenditure in India is only 15 percent whereas the averages of Saharian and African countries have of 40 % and high European countries have 75 percent. Modern healthcare system in India was first introduced in army troops by the Britishers and then it gradually popularized among the general masses. It is well evident that the development of modern healthcare system in India by Britishers was not in fact a choice rather, a response to mitigate the crisis and emergency of that time. But it is very unfair to deny that the advent of modern medicine including the institution of public health, hospitals, health centers, health research laboratories are in fact the benefit of colonial rule in India. It is also interesting to note that the public health system as introduced by colonial government was very limited and bias. An important development in health sector in India has been noticed in 1880s when the responsibilities of local health and sanitation were transferred to the partly elected local government bodies. This is also the fact that the new changes in public healthcare system made certain praiseworthy impacts such as the significant decline of the vibrant disease of that time cholera; panchayats were established with the responsibilities of local sanitations and health, provision of drinking water etc. A famous scholar Hugh Tinker in his work mentioned about the inadequacy of resources, personnel and infrastructure in public health system under British raj in India. He further explains that the healthcare system under colonial raj was highly biased and self limiting. It was only the Indian Elite sections and British service holders who were benefitted by this healthcare system (**Tinker**)

The great Indian freedom fighter and a genuine scholar Dadabhai Naoroji in his work Indian Political Economy states that the colonial rule was very much responsible for making India a poor nation. He further extended his argument that it was the unbearable taxation system of colonial raj which ultimately led to the occurrence of great Indian famine where millions of people died due to starvation. Sashi Tharur, the great Indian academician, politician, diplomat of recent time has also mentioned the same idea in his book and his many interviews. Gopal Krishna Ghokhle, a legend of India also raised his voice against the poor healthcare system in India under the colonial rule. Thus, a group of scholars believed that the medical backwardness in India is the consequence of British rule in India. On the other hand, it is noteworthy to mention that in the late colonial period in India there were many instances of the presence of different charitable institutions and voluntary organizations followed by civil society activists and some nationalist organizations who were sincerely associated with local health and sanitation issues, as a consequence the colonial government started neglecting its responsibility towards the public health system of the nation.

After independence a notable problem in Indian public health was the increasing growth of malaria patients in the nation. It was perhaps the most important reason for growing mortality and morbidity rate in India at that time. Bulks of population were affected by the disease. So at the very of the Independence, Nehru government had to cope up with the gigantic problem of malaria in the nation. So, National Malaria Eradication Programme was started by the government to mitigate the problem. But it was very

difficult for the newly set up government to ensure proper funding to the programme as a consequence the programme was highly dependent on outside funding. It was estimated that U.S. government contributed more than 50% to the programme. It was estimated that by 1958 around 8704 malaria control squads were in operation in the entire nation and by early 60s it almost disappeared from the nation. During that time also there have been wider healthcare service variations among Indian states, the state of Kerala and Mysore had very well developed rural public health system facilities as compared to other states. Many historians and academicians have argued that it was the lack of proper political commitment and public awareness which further deteriorated the Indian public health at larger extent. It is a fascinating fact that since independence the state of Kerala has been performing a commendable task in regard to public health. It is said by an observer that if Primary Health Centre were closed for some times then there was a massive demonstration in front of the Collector's office. Apart from Kerala the state of Tamilnadu has also made a remarkable achievement in the sphere of public health in recent times. The initiation of Mid DayMeal Scheme in 1982 which guaranteed one time meal in a day in every government aided schools had made an everlasting impact in reducing the mal-nutrition and under nutrition as well as in the regular attendance of students in the class. (Amrith, Feb 2009)

The first detailed plan of National Health Service scheme in India was prepared by Bhore Committee in the year 1946. This scheme provides the universal coverage of free healthcare services to the entire population. After thoroughly analyzing the public health conditions of the nation the Bhore Committee had proposed certain recommendations in the formulations of Nation Health Service. Some of the important recommendations are as follows; Firstly, it stressed about the notion of adequate provision of medical care to all the individuals in order to promote the positive health environment. Secondly, the policy should have the special provisions to the mothers, children and physically disabled people. Thirdly, there should be a provision for widest possible basis of cooperation between the health personnel and the general people. Fourthly, the policy should have the provision to provide free and fair medical care both preventive and curative to all. Finally, it also suggests for the creation and the maintenance of healthy environment in every home and work place. The Bhore committee had also recognized the vast disparities of health between urban and rural India and suggested a wider healthcare provisions for the rural masses of India. Bhore Committee further recommended for the urgent minimum requirement in the Indian health sector such as; per 100,000 populations for 567 hospital beds. Per 100,000 populations for 62.3 doctors, Per 100,000 population for 150.8 nurses. What exactly existed during that time was Per 100,000 population for 24 beds, per 100,000 population for 15.87 doctors and per 100,000 population for 2.32 nurses and in the England during those days had the following situations; Per 100,000 population for 714 beds, per 100,000 for 100 doctors and per 100,000 for 333 nurses. Thus, it is revealed from the above data that the healthcare systems of India during those days were highly inadequate and poor. Moreover, the vision set out by the Bhore Committee in the very onset of the India's Independence was far from being achieved in real sense. (Duggal 2001) . Following the Bhore Committee, several other committees have been set up by

the government of India to improve the general healthcare system of the country. Some important among them are as follows;

3.2.1 The Bhore Committee, 1943-46

In 1943, the Bhore Committee, also known as the Health Survey and Development Committee was formed with Sir Joseph Bhore as the Chairman.

Recommendations of the Committee

- Integration of preventive and curative services of all administrative levels
- Development of Public Health Centres in 2 stages – ***Short term measure & long term measure***

Table-3.1

Short Term Measures

- One Public Health Centre (PHC) for 40,000 population

No. of Doctors	No. of Nurses	No. of Public Health Nurses	No. of midwives	Trained Dais	Sanitary Inspectors	Health Assistants	No. of Pharmacists	Class IV Employees
2	1	4	4	4	2	2	1	15

Long Term Measures (The 3 Million Plan)

- Bedded Hospitals for each 10,000 to 20,000 population and secondary units with 650
- Bedded Hospitals, regionalised around District hospitals with 2500 beds

Major change was brought in which include 3 month-long training in preventive and social medicine to prepare social physicians.

3.2.2 Mudaliar Committee, 1962

Headed by Dr. A.L. Mudaliar, this committee known as the Health Survey and Planning Committee was appointed to appraise the performance in health sector since the submission of the report of Bhore Committee.

This committee reported that the conditions of the PHCs were not satisfactory and that priority be given to strengthen the established PHCs before starting new ones. Importance was laid on strengthening the sub divisional and district hospitals. The Committee stressed that a PHC should cater to only 40,000 populations and that the curative, preventive and promotive services should be provided at the PHC. Further, the committee suggested that Indian Medical Service be replaced by All India Health Services.

3.2.3 Chadha Committee, 1963

This committee under the chairmanship of Dr. M.S. Chadha, was appointed to advice about the necessary arrangements for the maintenance phase of National Malaria Eradication Programme. It was suggested by the committee that the basic health workers should carry out the vigilance activity in the National Malaria Eradication Programme (NMEP) in the ratio of 1: 10,000. The same basic health workers were to work simultaneously in malaria work, duties of family planning and data collection under the supervision of family planning health assistants.

3.2.4 Mukherjee Committee, 1965

The Mukherjee Committee under the chairmanship of the then Secretary of Health, Shri Mukherjee was appointed to review the performance particularly in the area of family planning. The committee recommended separate staff specifically for family planning programmes. For other purposes, the basic health workers were to be utilised. The committee further went on to recommend the separation of the malaria and family planning activities so that the family planning activities would receive complete attention from its workers.

3.2.5 Mukherjee Committee, 1966

Paucity of funds made the effective functioning and undertaking of multiple activities of leprosy, family planning, small pox, National Malaria Eradication programme problematic. Headed by the then Union secretary, Shri Mukherjee, the Mukherjee Committee (1966) was specially set up to look into these problems. The committee recommended the Basic Health Services to be provided at the Block level.

3.2.6 Jungawalla Committee, 1967

In 1964, the Jungawalla Committee, known as the 'Committee on Integration of Health Services' was appointed under the chairmanship of Dr N. Jungawalla, the then Director of National Institute of Health Administration and Education.

3.2.7 Kartar Singh Committee, 1973

This committee known as the "Committee on Multipurpose Workers under Health and Family Planning" was constituted under the chairmanship of the then Additional Secretary of Health, Shri Kartar Singh.

3.2.8 Shrisvastav Committee, 1975

In 1974, this committee known as "Group on Medical Education and Support Manpower" was constituted to determine steps needed to 'reorient medical education in accordance with national needs and priorities and to develop a curriculum for health assistants who were to function as a link between medical officers and MPWs.' The recommendations were as follows:-

1. creation of bonds of paraprofessional and semi-professional health workers from within the community itself
2. establishment of 3 cadres of health workers namely multipurpose health workers

3.2.9 Bajaj Committee, 1986

Under the chairmanship of Dr. J.S. Bajaj, the then professor of AIIMS, an "Expert Committee for Health Manpower Planning, Production and Management" was constituted in 1985.

3.3 Health Programmes in India

3.3.1 Preventive and Promotive Healthcare

- **Mission Indradhanush**

- Launched by the Ministry of Health and Family Welfare, Government of India on 25th December, 2014
- To accelerate the process of immunization by covering 5% and more children every year.

3.3.2 Programmes for Communicable Diseases

I. Integrated Disease Surveillance Programme (IDSP)

- Launched in November 2004 with assistance from World Bank
- The main aim was to detect and respond to disease outbreak quickly
- World Bank funded the Central Surveillance Unit (CSU) at NCDC and identified states – Uttarkhand, Rajasthan, Punjab, Maharashtra, Gujarat, Tamil Nadu, Karnataka, Andhra Pradesh, West Bengal
- Remaining 26 States/ Union Territories were to be funded from domestic budget.
- To continue in the 12th Plan with domestic budget

II. Revised National Tuberculosis Control Programme (RNTCP)

- Launched in 1997
- Covered entire nation with RNTCP-II by March 2006
- Initial Objectives : to achieve and maintain a TB treatment success rate of at least 85% among new sputum positive patients (NSP); to achieve and maintain detection of at least 70% of the estimated new sputum positive people in the community
- Main objectives of RNTCP-II : to consolidate the gains achieved in RNTCP-I; to initiate services to address TB/HIV/MDR-TP; to extend RNTCP to private sector

III. National Leprosy Eradication Programme (NLEP)

- 1955 – National Leprosy Control Programme launched
- 1983 – National Leprosy Eradication Programme launched
- 1983 – Introduction of Multidrug Therapy (MDT) in phases
- 2005 – Elimination of Leprosy at National Level
- 2012 – Special action Plan for 209 High Endemic Districts in 16 States

Objectives:

- Early detection through active surveillance by the trained health workers
- Regular treatment of cases by providing Multi-Drug Therapy (MDT) at fixed in or centres a nearby village of moderate to low endemic areas/ district
- Intensified health education and public awareness campaigns to remove social stigma attached to the disease

IV. National Vector Borne Disease Control Programme

- Launched in 2003-04 by merging National Anti Malaria Control Programme, National Filaria Control Programme and Kala Azar Control Programme. Japanese Enciphilitis and Dengue also included.
- Directorate of NAMP – the nodal agency for prevention and control of vector borne diseases.

This Health programme was started with the following objectives: -

- Early diagnosis and prompt action
- Surveillance for outbreak of disease
- Community participation and social mobilization for vector control
- Capacity development

The various programmes started under the **NVBDCP** are:

1. **National Anti Malaria Programme** with the main objective to bring down malaria transmission to a level at which it would cease to be a major public health problem
2. **Kala Azar Control Programme**

V. National AIDS Control Programme II

- Launched in December, 1999
- Objectives- to minimise the spread of HIV infection in the country; to increase India's capacity to respond to HIV/AIDS on a long term basis

VI. Pulse Polio Programme (PPI)

- Launched in 1995 as a result of WHO's Global Polio Eradication Initiative.
- Covers all children below 5 years to be given 2 doses of Oral Polio Vaccine (OVP) in December and January every year until the eradication of polio.
- Objectives- to achieve 100% coverage under OVP
- To reach the children of inaccessible areas through improved social mobilization; to chalk out mop-up operations in areas where poliovirus has almost disappeared; to sustain high level of morale among the public.

3.3.3 Programmes for Non-Communicable Diseases

I. National Tobacco Control Programme (NTCP)

- Launched in 2007-98 by the Ministry of Health and Family Welfare, Govt. of India in 42 Districts of 21 States/ Union Territories.
- Objectives- to spread awareness about the harmful effects of tobacco; to make them aware of the Tobacco Control Laws and facilitate its effective implementation; to control tobacco consumption thereby minimizing the deaths caused by its use

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

- Started in 2010 across 21 States to control and prevent the rising burden of Non-Communicable Diseases through health promotion, early diagnosis, management and referral of cases, also by fortifying the infrastructure and vitalizing capacity building.

III. National Programme for Control Treatment of Occupational Diseases

- One of the major constituents of both NHP 1983 and 2002, however very little attention has been given to alleviate the problems of occupational diseases.

IV. National Programme for Prevention and Control of Deafness (NPPCD)

- Implemented by Ministry of Health And Family Welfare with technical support of Directorate General of Health Services.
- At the State level, it is implemented by the Department of Health and Family Welfare with technical guidance of the State Nodal Officer (an ENT surgeon at Directorate level)
- Purpose: to identify early, diagnose and treat ear problems responsible for hearing loss and deafness.
- Objectives

i. to prevent avoidable hearing loss on account of disease or injury
ii. to medically rehabilitate persons of all age groups suffering with deafness
iii. to strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme, for persons with deafness
iv. to develop institutional capacity for ear care services by providing support for equipment, material and training personnel.

- Long term objective:

a) to prevent and control major causes of hearing impairment and deafness so as
b) to reduce the total disease burden by 25% of the existing burden by the end of 12^{th} Five Year Plan

V. National Mental Health Programme

- Came into force from 7th July, 2018 for providing mental healthcare for the ones with mental illness and also to protect and promote their rights.

VI. National Programme for Control of Blindness

- Launched in 1976

- 100% centrally sponsored scheme
- Goals – to reduce the prevalence of blindness (1.49% in 1986 -89) to less than 0.3% ; to establish an infrastructure and efficiency levels in the programme to be able to cater new cases of blindness each year to prevent future backlog
- Objectives – to reduce the backlog of blindness

3.3.4 National Nutritional Programmes

I. Integrated Child Development Services (ICDS)

II. National Iodine Deficiencies and Disorder Control Programme

III. Mid-Day Meal Programme

3.4 National Health Policy (NHP) 1983

After independence also public health has given a very low importance in India. It will take almost 35 years to initiate a formal national health policy in India which was actually started from the year 1983 in the name of National Health Policy of India. The National Health Policy of 1983 has provided several positive changes in the health sector of India some of the noteworthy initiatives are as follows;

- The policy states about the time bound programme for setting up the dispersed network of comprehensive health care services in the country which should be designed on the basis of ground reality.
- There should be an intermediation with health volunteer having knowledge, skills and technologies in health sector.
- Establishment of proper decentralized healthcare systems which ensure the well work out referral system in each level of hierarchy.
- The policy should encourage the spread of specialty and super specialty healthcare services and encourages the role of private sector to provide such facilities.

As per the report of National Health Policy 2002, the following achievements have been made throughout the years since 1951 to 2000 in the health sector of India.

Table-3.2

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6
Crude Birth Rate	40.8	33.9	26.1
Crude Death Rate	25	12.5	8.7
IMR	146	110	70

Epidemiological Shifts			
Malaria(cases in million)	75	2.7	2.2
Leprosy cases per 10000 population	38.1	57.3	3.74
Small pox (no of cases)	44,887	Eradicated	
Guinea worm (no of cases)		37992	Eradicated
Polio		29709	265
Infrastructure			
SC/PHC/CSC	725	57,363	1,63,181
Dispensaries& Hospitals (all)	9209	23,555	43,322
Beds (Pvt & Public)	117,198	569,495	8,70,161
Doctors (allopathy)	61,800	268700	503900
Nursing Personnel	18054	1,43,887	7,37000

Source: Annexure 14 National Health Policy 2002.

It is well evident from the above figures, that the public health system both in terms of facilities and infrastructure has been developed with good margin over the years. But it was not sufficient to cope up the growing health needs of the population. Disease like HIV/AIDS emerged in the very first half of 1980s which was absolutely new and virulent. Diseases such as cholera, some forms of hepatitis etc were continuously present in the society. It is also evident that the latter half of the 1980s witnessed different new life threatening diseases like cardiovascular disease, Cancer, Diabetes in the Indian society. Another important area of concern in the sphere of public health in India was the continuous persistence of nutrient deficiencies among women and children both in macro and micro level. It is undoubtedly true that the provisions made in the National Health Policy of 1983 ensures an immense and wider range of healthcare facilities to the entire people of India in general and the poor and under privileged in particular, but in practice it was far from its outlined goals as a result which it was overridden by a new health policy named National Health Policy of 2002.

3.4.1 National Health Policy (NHP) 2002

It has been repeatedly argued that public health sector in India received very low budget at the time of budget allocation. It was given a very low priority since the very inception of country's independence. It has been neglected throughout the years. As per the Constitution of India, health is the matter of state concerned and not the business of centre. As per the report of NHP 2002 the current annual per capita expenditure in health in the country is Rs 200. So, in this situation it was very much obvious to have a poor quality and low standard of health sector in the country. To avoid all these discrepancies

and to provide quality healthcare facilities for the people, this new NHP was formulated. Some of the important provisions of NHP 2002 are as follows;

- The main focus of the NHP 2002 was to ensure equity in regard to public health facilities provided and enjoyed in different states of India. As it is perceived that there is a wider health disparities among the different states of India the details of which are as follows;

Table-3.3

Health Disparities among Indian States

Sector	Population BPL (%)	IMR/ Per 1000 live Births (1999 -SRS)	<5Mortality Per 1000 (NFHS II)	Weight for Age % of children under 3 years	MMR/ lakh (Annual Reports 2000)	Leprosy cases per 1000 population	Malaria +ve Cases in year 2000 (in thousand)
India	**26.1**	**70**	**94.9**	**47**	**408**	**3.7**	**2200**
Rural	27.09	75	103.7	49.6	----	----	----
Urban	23.62	44	63.1	38.4	----	----	----
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharashtra	25.02	48	58.1	50	135	3.1	138
Tamilnadu	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

(Source: http://mohfw.nic.in/np2002htm & National Health Policy 2002)

- The policy vehemently opposed the practices that the access and benefits of healthcare facilities on the basis of socio-economic status. The details of which are as follows;

Table-3.4

Disparities in Health Status among Socio-Economic Groups

Indicator	Infant Mortality/ 1000	Under 5 mortality/ 1000	%Children Underweight
India	70	94.9	47
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

(Source: http://mohfw.nic.in/np2002htm & National Health Policy 2002)

- The policy advocated that the National Health Policy should be formulated in such a manner that it provides the maximum flexibility to permit the state administration to craft their own plans and programmes as per the needs of the people.

- The policy has mentioned about the role of private sector in regard to public health facilities, it has further mentioned about the establishment of comprehensive information system based on regulatory mechanism to ensure an adequate standard of diagnostic centers, medical institutions and proper conduct of clinical practices etc.
- The policy also mentioned about the existing poor healthcare system in terms of poor infrastructure, inefficient health activists and ignorance of the people. So the policy recommended for the immediate improvement in infrastructure, frequent training of health activists and the organization of health awareness campaign.
- Another important characteristic of this policy is the participation of local self governments like village panchayat and municipalities in the health sector of nation. The Policy introduced a full decentralization process in the Health sector in India.
- The policy also recommended for healthy environment and sufficient resources to pursue the effective research on healthcare development in the nation.
- The policy also encouraged the practices of Traditional Indian healthcare system such as Ayurveda, Yoga, Unani, Sidha and Homeopathy.
- NHP 2002 addressed the problem of an acute shortage of Doctors, Nurses and beds in different hospitals in all over the country.
- It also encouraged the active participation of different volunteer organizations, NGOs and Civil Society activists in the public health sector.

Apart from these, there are several other provisions of this health policy. Moreover, the primary aim of this policy is to provide the standard quality good healthcare facilities to the entire population of the country. The policy strongly emphasized in the decentralized healthcare system by establishing new infrastructures or by upgrading the existing institutions. Some of the important achievements of NHP 2002 are as follows;

Table-3.5

SL No	Programme	Year
1	Eradicate Polio and Yaws	2005
2	Eliminate Leprosy	2005
3	Eliminate Kala Azar	2010
4	Eliminate Lymphatic Filariasis	2015
5	Achieve Zero level growth of HIV/AIDS	2007
6	Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
7	Reduce Prevalence of Blindness to 0.5%	2010
8	Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
9	Increase Utilization of public health facilities from current level of <20to>75%	2010
10	Establish an Integrated system of surveillance, National Health Accounts and Health Statistics.	2005
11	Increase health expenditure by Government as a% of GDP from the existing 0.9% to 2.0%	2010
12	Increase share of Central grants to constitute at least 25% of total health spending	2010
13	Increase State Sector Health spending from 5.5% to 7% of the budget. Further increase to 8%	2005 2010

Source: Annexure -14 National Health Policy 2002

3.4.2 <u>National Rural Health Mission (NRHM)</u>: It was launched by the former Prime Minister of India Dr. Manmohan Singh on 12th of April 2005. The primary aim of the mission was to provide accessible, affordable and quality healthcare facilities to all rural population of India particularly the most vulnerable sections or groups. Further, the Empowered Action Group states, North Eastern States, Jammu & Kashmir and Himachal Pradesh have given a special focus under the NRHM scheme. The mission sought to establish a community owned, decentralized and fully functional healthcare delivery system with inter-sectoral convergence at all levels. It also ensured a wider range of determinants of health like sanitation, nutrition, water, education, social and gender equality etc. The mission illustrated the five main approaches to improve the public health delivery system in India. These approaches are stated below:

Table-3.6

Communitize	Hospital Management Committee/ PRIs at all levels untied grants to community/ PRIs bodies Funds, functions and functionaries to local community organizations and

	decentralized planning such as village health and sanitation committee etc.
Improved Management through Capacity involves	block and district health office with managerial skills NGOs in capacity building and Continuous skill development support etc.
Flexible financing	untied grants to institutions, NGO sector for public health goal, NGOs as implementers, Risk Pooling- money follow patient and more resources for more reforms etc.
Innovation in Human Resource Management	increased number of nurses, 24x7 emergencies in PHCs and CHCs, multi skilling etc
Monitor progress against standards	Setting IPHS standards Facility Surveys Independent Monitoring Committees at Block, District and State levels.

(Source: NRHM framework for implementation 2005-2012)

As it is mentioned above that one of an astonishing provision of National Rural Health Mission is its support for the establishment of decentralized healthcare facilities in India. Thus, on the basis of NRHM provision there are three tier healthcare systems in India viz. Sub centers at the village level, Primary Health Centre at the block level and Community Health Centre at the district level. The mission further explicitly mentioned about the necessities of Accredited Social Health Activists (ASHA) and Aganwadi Workers (AWW) to provide every possible facilities to the rural population. It is also stated in the provision that the recruitment of the health activists under ASHA and AWW should be made in the proper coordination between ANMs and the local panchayat of the concerned region. The mission also envisaged that every village with 1000 population must have one female Accredited Social Health Activist (ASHA) supported by Aganwadi Workers (AWW) as well as Village Health (VH) and Sub Centre (SC). Every gram panchayat i.e. Sub Health Centre Level comprising 5-6 villages must be filled with skilled educated RMPs, 2 ANMs, 1 male MPW. For every Primary Health Centre Level which comprised 30-40 villages should be filled with 3 staff nurses, 1 LHV for 4-5 SHCs, Ambulance/hired vehicle, Fixed Day MCH/ Immunization clinics, AYUSH Doctor, 24x7 emergencies etc. Every Block Level Hospital which comprised 100 villages and 100,000 populations should be vested with Ambulance, telephone, Obstetric/ Surgical Medical emergencies 24x7 and Round the Clock services etc. (Ministry of Health and Family Welfare Framework for Implementation 2005-2012).

Table-3.7

Programmes of NRHM with specific time frame

SL No	Programmes	Time frame	Outcome Report
1	For every 1000 population there is a fully trained ASHA (All Accredited Social Health Activist) activists.	50% by 2007 100% by 2008	Progress Report submitted quarterly
2	Committee of Village Health and Sanitation in villages	30% by 2007 100% by 2008	Progress Report submitted quarterly
3	Establishment of ANMs and sub centers to provide service guaranteed by IPHS in 1,75000 places	30% by 2007 60% by 2009 100% by 2010	Annual assessment report
4	Establishment of 30000 PHCs with 3 staff nurses to provide service guaranteed by IPHS	30% by 2007 60% by 2009 100% by 2010	Annual assessment report
5	Establishment of 65000 CHCs with 7 specialists and 9 staff nurses to provide service guaranteed by IPHS	30% by 2007 50% by 2009 100% by 2012	Annual assessment report
	Establishment of 1800 taluka/ Sub Divisional Hospitals to provide quality health services	30% by 2007 50% by 2009 100% by 2012	Annual assessment report
6	Establishment of 600 District Hospitals to provide quality health services	30% by 2007 50% by 2009 100% by 2012	Annual assessment report
7	Establishment of Rogi Kalyan Samity and Hospital Development Committees in all CHCs/ sub divisional hospitals and District Hospitals	30% by 2007 50% by 2009 100% by 2012	Annual assessment report
8	Preparation of District Health action Plan 2005-2012 by each district of the country	50% by 2007 100% by 2008	Appraisal process
9	Provision for untied grants provided to each Village Health and Sanitation Committee, PHC, Sub Centres and CHC for the	50% by 2007 100% by 2008	Quarterly Progress Report

	promotion of local health action		
10	Provision of annual maintenance grants provided to every sub centers, PHC, CHCs	50% by 2007 100% by 2008	Quarterly Progress Report
11	Establishment of State and District Health Society functions with fully requisite management skills	50% by 2007 100% by 2008	Independent Assessment
12	Provision for the System of Community Monitoring	50% by 2007 100% by 2008	Independent Assessment
13	Provision to ensure sufficient availability of drugs and medicines at sub centers/ PHC/ CHCs	50% by 2007 100% by 2008	External Assessment
14	Provision that every SHCs/ PHCs/CHCs/ Sub divisional Hospitals should develop the intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programme, TB, HIV/AIDS etc	30% by 2007 50% by 2008 70% by 2009 100% by 2012	Annually report system
15	Provision of convergence of health determinants like drinking water, sanitation, women empowerment , child development, school education, family literacy in District Health Plan	30% by 2007 60% by 2008 100% by 2009	Independent assessment
16	Provision for the publication of Annual State and District Specific Public Health Report	50% by 2007 100% by 2008	Independent assessment
17	Provision of institution wise assessment of performance as per service guarantees by the policy	30% by 2008 60% by 2009 100% by 2010	Independent assessment
18	Provision of Mobile Medical Units provided to each district of the country	30% by 2007 60% by 2008 100% by 2009	Quarterly progress report submitted

(Source: NRHM framework for implementation 2005-2012)

It is no doubt that the scheme envisaged by government in the name of NRHM to meet the rural public health need was very astonishing and appreciable but in practical sense it is far from its stipulated goals. There is a wide gap in policy formulation and policy implementation in regard to NRHM scheme encapsulated with wider regional health disparities in India. Further, there is also a wide gap between the reports submitted to the government and the real conditions of public health under NRHM system in India. An eminent scholar Zakir Hossain in his paper entitled ‘Health of the National Rural Health

Mission' has explicitly mentioned about the several loopholes faced by NRHM in different states such as insufficient infrastructure which involves the lack of electricity supply to Sub Centers in some States, shortage of beds for patients in many Primary Health Centers, poor condition of sanitary provision in PHCs and CHCs etc. Huge Shortage of Equipments and Medicine in all three units in several states, scarcity of manpower in all three units in many states are also considered as the loopholes of the scheme. Moreover, the NRHM envisages that every village of India must have an ASHA workers (Accredited Social Health Activist) selected by the village panchayat who are entitled to act as the interface between the community and the public health system. As per the norms for recruiting the workers of ASHA, it is stated that they have been selected on the basis of recommendation of ANMs, anganwadi workers and the panchayat head but in many instances it has been found that ASHA workers are recruited not on the basis of the criteria mentioned above but in a personal relation such as people of influential families, relatives of local leaders or the persons backed by the politicians etc. Further, in some cases the wives of community health workers were appointed. It is also worth mentioning to state that there is no scheduled training of the health activists and there is a huge scarcity of kits in all three units of health sectors in several states. Moreover, there is very irregular and infrequent training of health activists, the quality of training is also varying from state to state. Hence, it is revealed from the above explanation that NRHM scheme has not been fully successful in attaining its stipulated goals but it is still striving towards achieving its true goals by overcoming the existing loopholes.

3.4.3 NUHM: National Urban Health Mission was launched by the government to provide quality healthcare services to the population of urban areas specially the urban poor or vulnerable section of societies. This mission was viewed as a sub mission under the National Health Mission (NHM) and approved by the union cabinet on 1st 2013 for providing the quality healthcare facilities to the urban population. It had been launched in all cities and towns of India with the population of more than 50000. If we analyze the urban health scenario in India then we could see that there is a huge health disparity among the urban population of India. Some are getting high tech super specialty care whereas some are lack the basic primary healthcare facilities especially the poor or slum dwellers. On the basis of the 2001 census, around 28.6 crore people live in urban areas which has increased to 37.7 in 2011. The growth of urban population has adversely led to the increased number of urban poor in the countries. According to census 2001, more than 4.26 crore people lived in slums in different towns and cities which are expected to reach around 7.66 crore in 2011. Thus, the growing trend of urbanization entails a greater threat to the government of India. It is very evident that there is an inadequacy of urban public health delivery system; the urban poor don't have an access to proper healthcare facilities, suffer from social exclusion and lack of information. Ineffective outreach and weak referral system ultimately pave the way for the creation of such a policy which can solve the existing health related difficulties of the urban poor population in the country and National Urban Health Mission (NUHM) is such a mission, which was launched by the government to meet all these health needs of the urban poor in India.

As per the data prescribed by the Ministry of Health Family Welfare (GOI) in May 2013 regarding the health conditions of the urban poor in Indian states, around 46% children are under-weight , 46.8% urban poor women are illiterate, 71.4 % urban poor are anaemic, only 18.5% of urban poor have access to piped water supply. There was an increasing number of vector borne diseases among urban poor, no provision for safe drinking water, poor condition of sanitation and hygiene, high growth of water borne diseases, diarrhea, dysentery, high density of population with poor environmental condition, growth in lung diseases, TB, Cardiovascular diseases etc. As per the report on the causes of deaths in India (2001-2003) based on SRG, RGI India, the following deaths have been noticed in urban area.

Table-3.8

Causes of Death	Male	Female
Tuberculosis	5.9	4.5
Respiratory Infections	3.0	4.5
Cardiovascular Diseases	30.3	26.3
COPD, Asthma and other respiratory disease	8.1	6.7
Malignant and other neoplasm	7.5	8.5
Senility	3.4	7.4
Diarrheal Disease	3.9	6.1
Unintentional Injuries: other	4.1	4.7
Symptoms sing and ill-defined conditions	4.0	4.6
Digestive diseases	5.0	2.5

Source: Report on causes of death in India (2001-2003) based on SRG, RGI

Table-3.9

Further the report also prescribed the age-wise causes of death in Urban India. The details of which are as follows:

Causes of Death	0-4 years	5-14 years	15-24 years	25-69 years	70+ years
Digestive diseases	-------	3.5%	-------	5.8%	-------
Respiratory infections	19.5%	8.3%	-------	-------	-------
Malaria	1.2%	5.9%	3.5%	-------	-------
Fever of unknown origin	1.2%	-------	-------	-------	-------
Nutritional deficiencies	3.1%	-------	-------	-------	-------
Cardiovascular Diseases	-------	-------	7.6%	32.8%	34.7%
Malignant and other neoplasm	-------	3.8%	5.3%	11.3%	5.6%
COPD, Asthma and other respiratory diseases	-------	-------	-------	7.7%	10.6%
Tuberculosis	-------	-------	8.1%	7.7%	2.9%
Senility	-------	-------	-------	-------	14.3%

Diarrheal diseases	13.2%	17.4%	-------	-------	5%
Unintentional Injuries: other	3.1%	14.7%	11.2%	3.6%	4.5%
Symptoms signs and ill defined conditions	3.6%	5.9%	8.4%	4.3%	3.8%
Congenital anomalies	5.2%	-------	-------	-------	-------
Maternal condition	-------	-------	3.7%	-------	-------
Genito- Urinary Diseases	-------	-------	-------	3.3%	2.8%
Diabetes Mellitus	-------	-------	-------	2.8%	3.4%
Other infectious and parasitic diseases	8.8%	12.4%	4.3%	-------	-------

Source: Report on causes of death in India (2001-2003) based on SRG, RGI

Thus, it is revealed from the above facts that the reliable and quality healthcare facilities were very much essential in the urban areas which actually could address all these health malaise in the region. So, the government of India has launched National Urban Health Mission (NUHM) to alleviate the health difficulties faced by the urban population in general and urban poor and vulnerable section of people in particular.

Aims, Objectives and Strategies

The primary aim of National Urban Health Mission (NUHM) is to provide equitable and quality healthcare services to all urban population in general and poor and more vulnerable section of people in particular. It is also stated that, strengthening the preventive and promotive measures to improve the health of people and prevention of any kind of diseases is the soul objective of the mission. To achieve the goal as stated above, the following strategies have been formulated by the mission. These are;

1. Development of appropriate public health delivery system across various towns and cities with improved infrastructures.

2. Strengthening the existing public health system in the region.

3. Encouraging the role of private sector in health regime both for profit and non profit private agencies.

4. Improving accessibility and building community capacity by involving the institutions like Mahila Arogya Samity (MAS) and the workers of Accredited Social Health Activists (ASHA).

5. Encouraging the active involvement of Urban Local Bodies for facilitating healthcare facilities in the region.

Further, the mission has used the institutional structures as already created by NRHM at all levels for its proper functioning. At the centre level, there is Mission Steering Group (MSG) under the Union Health minister; the Empowered Programme Committee (EPC) under the Secretary (H&FW) and the National Programme Coordination Committee (NPCC) under the mission director responsible for overall guidance and formulation of

decisions. National Programme Management Unit (NPMU) a national body has been created to facilitate and monitor the implementation of NUHM. At the state level, the State Project Management Unit (PMU) and National Rural Health Mission (NRHM) have been further strengthened to enhance the programme management capacity. In regard to Cities and towns, the state government will either constitute a City Urban Health Mission/City Urban Health Society or it supports the existing District Health Mission/ Society under NRHM. The entire activities of NUHM is coordinated by the City Level Urban Health Committee supervised by the Municipal Commissioner / District Magistrate/ Deputy Commissioner/ Sub Divisional Magistrate as on the basis of whether the city falls under district or sub division. It is also noteworthy to mention that for the 7 mega cities of the country such as Delhi, Mumbai, Kolkata, Chennai, Bengaluru, Hyderabad and Ahmadabad NUHM will be implemented through the respective ULBs. Three tier healthcare facilities have been introduced under the mission which comprise of Urban Health Posts (UHP)/ Urban Family Welfare Committee (UFWC) and Dispensary as well as Maternity Homes/ Tertiary and Super specialty hospitals in cities and urban areas. The mission also encouraged the participation of private agencies and volunteer organization for providing healthcare services to the general masses. Further, MSG that is Mission Steering Group and EPC i.e. Empowered Programme Committee are vested with the power of modification of the schemes and policies. MSG is also empowered with the power of the approval of financial matter in regard to NUHM policies and schemes. It is also stated in the mission that Empowered Programme Committee has the power to change the financial norms prepared by the Mission Steering Committee. (India 2013)

As per the statement of Ministry of Health and Family Welfare, Government of India regarding the goal of achievement by the National Urban Health Mission (NUHM) in India, it viewed that inspite of all arrangements made by the government to alleviate the health difficulties of urban poor population, there are still a major gaps and constraints on the part of urban poor to avail the facilities provided by the government. Such constraints are as follows:

- Healthcare facilities on the basis of inequitable spatial differences are the major constraints on the part of urban poor population.
- Distance of Health service centers from the poor areas is another problem of the poor general masses.
- Very poor lab facilities and shortage of essential medicines, drugs and equipments in the health centers are also viewed as the major constraint or gap.
- Shortage of healthcare staffs and limited number of efficient health professional is also considered a major constraint of the mission.
- Poor avaibility of the doctors as because they are more career oriented rather than serving the poor people.
- In many cases the patients were first treated by the under qualified medical practitioners.
- Low health infrastructure.
- Poor Community linkage and outreach.
- No proper measure to identify the poor population.

Apart from these entire shortcomings, the NUHM is playing a crucial role for providing the basic healthcare facilities to the urban poor population and constantly trying to alleviate the health related difficulties of the general masses in urban India by focusing more on deprived and vulnerable section of society. Moreover, it is also well evident that there is wider healthcare service delivery variations state wise in India. So, in the case of NUHM also some states are performing quite well, some are in a moderate form and some are in a very low performance.

3.4.4 The Draft National Health Policy 2015: Another important landmark in the process of healthcare development in India is the introduction of Draft National Health Policy (DNHP) in India. It was initiated by the government to provide highest possible level of good health and wellbeing to all its citizens by way of ensuring the preventive and promotive health care orientation in all developmental policies. This policy advocated for the harmony of purpose between the public and private healthcare service delivery system to achieve the goal of "universal healthcare". The policy seeks to deliver a comprehensive set of preventive, promotive, curative and rehabilative services through the sub centers and PHCs. This policy extensively laid emphasis on the holistic approach and cross sectoral convergence in addressing social determinants of health and it can be achieved through planned and adequately financed institutional mechanisms.

The primary goal of the policy was to attain the highest possible level of good health and wellbeing to all the citizens by way of preventive and promotive healthcare orientation in all developmental policies, and universal access to quality healthcare services to all without having any financial hardships.

Principles of the Policy:

The main concern of the policy was to establish an equitable healthcare service to all the citizens irrespective of caste, class, creed, religion, gender etc. The policy also extensively focused in reducing the healthcare service disparities across the various regions of the nation. So, in totality it tries to establish an equal healthcare service for all in India. This policy also advocated for the proper designing of healthcare system and services to cater to the entire population of the nation. Another important principle of this policy was to provide effective, safe, quality healthcare services with dignity and confidentiality by way of enhancing the practice of patient-centric approach in healthcare sector. The policy perceived that it is essentially important for the participation of private agencies both for profit and not for profit organizations including voluntary organizations and NGOs in health services to meet the desired end. Further, it also considered the provision of medical pluralism by ensuring the research activities in regard to the validity and sustainability of the practices of different local healthcare traditions for the development of integrative practice. This policy also promoted the decentralized way of decision making to ensure greater participation and responsiveness as well as transparency in decision making, total elimination of corruption in healthcare system and financial and performance accountability. Other important principles as stated in the policy are professionalism, integrity and ethics of the health activists, development of the

system of learning and adaptability, emphasis should be given to affordability in healthcare service expenditure.

Objectives:

- The first and foremost objective of this policy is to improve the health status of population through organized policy action in all health sectors as well as to enhance preventive, promotive, curative and rehabilitative healthcare services to its citizens.
- To ensure in the reduction of out of pocket expenditure in health service costs.
- Complete assurance of universal availability of comprehensive and free primary healthcare services including the maternal, child and adolescent health.
- To enhance the financial protection for all the section of population by enabling the universal access to free and essential drugs, emergency ambulance services, free medical and surgical care facilities to the common people.
- Ensuring the affordability of secondary and tertiary care services through the combination of government and private agencies in the health sector.
- Encouragement of private healthcare industry and medical technology to improve the healthcare facilities to the population.

This policy also encompasses a large section of socio- economic determinants of health sector. The framers of this policy realized that the public health is largely affected by the social and economic environment such as food and nutrition, education, income, awareness, sanitation housing, employment, industrial and occupational safety, social protection etc. So, health is not an isolated entity rather it is the condition created by the social and economic environment of a particular system or society. It is further argued that the growing degradation of public health in India is due to the growing degradation of socio-economic conditions of the general masses of India. Thus, it is felt that without improving the social and economic conditions of the common people it is impossible to improve public health in India. With this vision, the policy formulated certain important steps for the development of social and economic environment of the general masses which are as follows;

- Swacha Bharat Abhiyan: The policy genuinely supports the Swacha Bharat Abhiyan which was already in practice and argued that the success of this Abhiyan could be measured through the reduction in water and vector borne diseases.
- Balanced and Healthy Diets: The establishment and activities of aganwadi centers in almost all the villages of India including the ICDS(Integrated Child Development Scheme) for the promotion of balanced and healthy diets is also an important initiative in this line. The success of which could be measured through the reduction of malnutrition and improved food safety.
- Nasha Mukti Abhiyan: Another important initiation in this regard was the introduction of Nasha Mukti Abhiyan by the government and the success would be measured in terms of considerable decreases in use of tobacco and alcohol.

- Yatri Suraksha: The policy also involves the yatri suraksha scheme which enables the proper application and implementation of traffic rules and ensures the preventive measures for road and rail safety to all.
- Nirbhaya Nari: Strict implementation of legal actions regarding the matters of gender violence and sexual violence is also an important characteristic of this health scheme.
- Finally the policy also talks about employment security, preventive measures at the work place including exercise and movement, understanding of occupational disease epidemiology etc.

Thus, it is revealed that the Draft National Health Policy 2015 has made several positive changes in Indian public health care system. It is further argued that the changes made by this policy were infact a dire need of the present situation. The implementation of some of the policy such as Swach Bharat Aviyan and Public Private Partnership in health has made a great impact in the life of the common people. Indian people have fully supported the implementation and application of these two policies. Apart from these, several other implementation of this policy were noteworthy and necessary for the improvement of public health care system in India like the introduction of medical pluralism by giving special preference to Indian Indigenous Medicine and introduction of NEET for medical entrance examination to ensure quality and corruption free medical education in India.

Another important landmark in the process of public healthcare development in India could be termed as the initiation of National Family Health Survey (NFHS) in India. National Family Health Survey (NFHS) is a detailed analysis of every health related problems and activities of Indian citizens. It provides detailed information regarding the fertility, mortality, family planning, nutrition and other basic heath related activities. The primary objective of the Survey is to find out the exact data on health related activities of Indian citizens such as fertility, mortality, family planning, nutrition, education etc. The National Family Health survey have been carried out in four different times in India initiated by the Ministry of Health and Family welfare, coordinated by the International Institute of Population Sciences (IIPS), Bombay. The Survey was conducted in the following different period.

Table-3.10

NFHS	YEAR
1st NFHS	1992-93
2nd NFHS	1998-99
3rd NFHS	2005-06
4th NFHS	2014-15

3.4.5 1st National Family Health Survey: This survey was carried out in three different phases in India started from April 1992 to September 1993. The survey covered around 500,492 residents. On the basis of the survey, it is stated that 57 % of all females aged 6 and above are illiterate and only 9% have a high school education. There are wide variations in regard to female literacy and the level of fertility among the Indian states. The level of fertility is very low in the south Indian states of Kerala, Andhra Pradesh, Karnataka and Tamil Nadu. It is average in West Indian states of Goa, Gujarat and Maharashtra. On the other hand it is high in the states of Uttar Pradesh, Bihar, Haryana and Arunachal Pradesh. Female literacy also varies widely across the states such as it is estimated as 80% in Kerala and 30% in Rajasthan. Further, it is revealed from the survey that the state of Orissa has the highest infant mortality rate of 112 per 1000 live births followed by the states of Uttar Pradesh as 100%, Bihar and Assam 89% and Madhya Pradesh 85% consecutively. Whereas, the infant mortality rate is very low in the states of Kerala as 24% and Goa as 32%. The report also stated that every year in India around 100,000 women die due to the causes related to pregnancy and childbirth. It is also revealed from the survey report that both the antenatal care and delivery services are inadequate in many states of India. The states of Kerala, Tamilnadu and Goa have estimated the highest level of antenatal care received by mothers as 97%, 94% and 95% consecutively but the states like Rajasthan and Bihar have only 31% and 37% of antenatal care services. It is further noticed that 30% of young children age between 12 to 23 months have not been vaccinated of the diseases like tuberculosis, diphtheria, pertussis, tetanus, polio and measles. Apart from these, the report also states that there is an acute under nutrition in the country. It is estimated that around 53% of the children below age four are underweight. (Planning), 1992-93)

3.4.6 2nd National Family Health Survey: The second NFHS was carried out in the year 1998-99 to find out the exact information on fertility, family planning, nutrition and health care of Indian population. This survey was also coordinated by the International Institute for Population Science. This survey covers almost 90% of the population for data collection from all the 26 states of India. NFHS-2 also expanded its visions in regard to Public health in India and included the various new topics in its questionnaires such as reproductive health, women's autonomy, domestic violence, women's nutrition, anemia and salt iodization etc. This survey provides detailed information about the socio-economic condition of the population in general and public health condition of Indian citizens in particular. As per the survey report, the mortality rate is very high of 80-90 % in per 1000 live births in Meghalaya, UP, MP, Orissa and Rajasthan to lower mortality rate of 16% in per 1000 live births in Kerala. Fertility rate is continuously declining in India. The report also states that the percentage of girls attending school also varies from one to another state in India such as 90% in Kerala and Himachal Pradesh, 51% in Bihar and 56% in Rajasthan. The report also mentioned that the states of Kerala, Goa and Tamilnadu have achieved an enormous success in regard to the promotion of maternal and child health which was the most important component of the Family Welfare Programme of India. But on the other hand, states like Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and north eastern states are relatively performing below the national

average. As per the report of NFHS-2, 47% of children below the age of three years are underweight, 46% of children are stunted and 16% are wasted. It is further stated that undernutrition is much higher in rural areas than in urban areas. The report of the NFHS-2 states that 72% of children ages between 12-23 months have been vaccinated against tuberculosis, 63% have received three doses of polio vaccine, 55% have received three doses of the DPT vaccine and 51% have vaccinated against measles. It is also stated that 30% children under the age of three had fever, 19% had symptoms of ARI (Acute Respiratory Infection) and 19% had diarrhea. It has also stated that on the basis of the body mass index 36% of women in India are undernourished, the proportion of which as state-wise are as follows Orissa 48%, West Bengal 44% Arunachal Pradesh 11%, Sikkim 11% and Delhi 12%.Obesity is the major problem among the different groups of women in India. It is estimated that overall 52% of women in India have some degree of anemia. The report also states that 17-33% of married women received a home visit from the health activists in all states. It is also reported that 65% of Indian households go to the private hospitals/ Clinics or doctors for treatment and 34% of population normally go for public medical sector in India.

3.4.7 3rd National Family Health Survey: The third National Family Health Survey was also conducted by the Ministry of Health and Family Welfare, GOI coordinated by the International Institute of Population Sciences (IIPS) in the year 2005-2006. The primary objective of the survey is to find out the exact data or information in regard to population, health and nutrition, morbidity and mortality, family welfare etc from every state of India and Union territories. The NFHS-3 also provides information on several new and emerging issues of the time such as family life education, safe injection, perinatal mortality, high risk sexual behavior, tuberculosis, adolescent reproductive health and malaria etc. It is believed that NFHS-3 is the first nationwide community based survey in India to provide an estimate of HIV prevalence in the general population of India. It also provides estimates of HIV prevalence among women aged 15-49 and men aged 15-54.

3.4.8 4th National Family Health Survey: In accordance with the series of NFHS, the 4th National Family Health Survey was conducted in the year 2015-2016 to collect the up-to-date information on population, health and nutrition, morbidity and mortality, family welfare etc from every states of India and Union territories. It was conducted by the Ministry of Health and Family Welfare (MoHFW), Government of India and also coordinated by the International Institute of Population Sciences (IIPS), Mumbai. The survey was funded by the United States Agency for International Development (USAID), the Bill and Melinda Gates Foundation (BMGF), UNICEF, UNFPA, the MacArthur Foundation and the Ministry of Health and Family Welfare (MoHFW), Government of India. The primary goal of the NFHS-4 is to provide essential and up-to-date data on health and family welfare to the Ministry of Health and Family Welfare (MoHFW) and other national agencies for the formulation of different policies and programmes regarding health and family welfare in the country. It has also been entrusted with the responsibility of providing the information on important emerging issues on health and family welfare. Another important objective of the survey is to measure the trends in

family welfare and health indicators over the years in India and Indian States. It has also given the responsibility to provide information on fertility, infant and child mortality, perinatal mortality, adolescent reproductive health, high risk sexual behaviour, tuberculosis and malaria at the national and state levels. As per the report of the NFHS-4, there is a continuous decrease in the infancy and early childhood deaths in the nation. It is further further reported that the infant mortality rates range from a low of 10 deaths in Andaman and Nicobar Island to a high of 51 deaths per 1000 live births in Madhya Pradesh. The report also states that there is a huge reduction in maternal deaths due to the proper care of women during pregnancy. It is further stated that almost all the mothers have received proper health healthcare facilities by the healthcare service providers in the every states of India. It is also reported that in the states of Goa, West Bengal, Sikkim and Pondicherry more than $4/5^{th}$ of the children are fully immunized. Anemia has also declined but over nutrition continues to be a great threat for the adults. It is reported that atleast 3 in 10 women are overweight or obese in the states of Goa, Pundicherry, Tamilnadu and Andaman and Nicobar Island. (G. Ministry of Health and Family Welfare 2016)

It is a well evident fact that there is a wide gap between the theory and practice in public healthcare system in India. It is revealed from the above discussion that the healthcare services in India have achieved a greater position throughout the years. But if we see the reality of the healthcare system in rural India then the whole picture of what we have studied in the report will be changed totally. The condition of rural public health in India is getting from bad to worse day by day. It is also evident that the condition of public health in India is in a great crisis. On the basis of the recent analyses of some eminent academicians, there is high absenteeism, low quality of clinical care, low satisfaction level and rampant corruption in the field of public health system in India. (Jeffrey Hammer 2007). As per the report submitted to the Prime Minister of India by the Voluntary Health Association of India known as Independent Commission on Health in India (ICHI) in 1997 states that the public health services are in a advanced stage of decay in India. On the basis of the Delhi based newspaper report namely *Pioneer* on April 2005, it was stated that there has been a zero percent growth in the setting up of primary health centers in India and the target was 193. It was further stated that the target of setting up of countrywide Community Health Centre was 103 but only 11 CHCs were set up during April 2004 and January 2005. An eminent academician Monica Das Gupta has mentioned that the health policies in India have largely focused on medical services and clinical services but the implementation of basic public health regulation has been neglected in India. So, she states that public health in India is 'focusing on clinical services while neglecting services that reduce exposure to disease is like mopping up the floor continuously while leaving the tap running'. It is further stated that the NRHM has failed to achieve its outlined objectives, there is no scientific evidence to justify their proposals as seeking towards optimization of the use of resources. There was no systematic approach for human resource development, cadre structure in both centre and state level and any organization for conducting health system research at various levels. (Banerji, Politics of Rural Health in India 2005). It is further argued that the market domination in

the healthcare system is both systemic and systematic. Corporate hospitals have occupied the supreme position in regard to the country's healthcare system. There is wide network between big multi-specialty hospitals with small nursing homes, medical practitioners, private clinics, diagnostic centres and even the medical pharmacies. In this alarming situation, the insurance based healthcare system of Draft National Health Policy further accelerated the situation towards more market oriented healthcare system in the country. Hence, it was rigorously condemned by the academicians, social activists and civil society members by stating it as pro-business formulation of the DNHP. (Mohan Rao, April 25, 2015)

3.5 State and Private Agencies in Health Sector in India:

It was generally believed that there was a dire need of economic reforms in the country. The growth of Indian economy was comparatively low at 3.5 percent from 1950 to 1980. Series of policies and programmes, plethora of procedures, political upheavals, and bureaucratic controls with other factors finally led India into a great economic crisis in 1991.The economic crisis of India was infact an impact of the long mismanagement of the economy such as high fiscal deficit, high balance of payment deficit, double digit inflammation, low forex reserves etc. To resolve the crisis, an attempt was made by the government in the name of Structural Adjustment Programme (SAP). As per the report of Human Development 2004 of UNDP, India ranked 127th position out of 177 countries with an HDI of 0.595. It had been observed that India's position was lower than many newly industrialized countries (NICs) such as Indonesia and Malaysia and also lower than China and Sri lanka. Thus, finally India adopted the economic policy and introduced the policy of Liberalization, Privatization and Globalization (LPG). There was a huge impact of LPG in the lives of the common people. Each and every domain of private and public affairs has been affected by the new economic policy. As a consequence, public health in India has also been largely affected by the new economic system and the Public Private Partnership (PPP) in Health was the outcome of such new development. World Health Organization in the year 1997 states that Health Sector Reform (HSR) is a sustainable process of fundamental changes in the policy and institutional arrangements of the health sector and supervised and directed by the concerned government. The main purpose of the reform is to develop the functioning and performance of the health sector which directly affect the health status of the people. The World Development Report 1993 states that there are different kinds of Reform Strategies, some of which are as follows;

- Alternative Financing: It includes user fees, health insurance, community financing and private sector investment.
- Institutional Management: It involves autonomy of hospitals, monitoring and management by local government agencies.
- Public Sector Reforms: It includes civil service reforms, capacity building and productivity improvement.
- Collaboration with the Private Sector: It involves public/private partnership, joint ventures etc.

Among all these stated reforms, the collaboration with the private sector in health sphere has emerged as a dominant public health reform (PHR) in various countries of the world due to the limited resources in the public sector of the government. It is generally believed that both Public Sector and Private Sectors are loaded with their respective strength and weaknesses, neither the public sector nor the private sector individually can operate in the best interest of the health system. So, there is an acute need for the collaboration of both private and public sector to improve the status of public health. It is further conceived that both public and private sectors are benefitted by the collaboration in the health sector. (Ref). There is a wider belief that bureaucracies are very inefficient in and unresponsive in public health sector, so inclusion of private sector infact will promote efficiency and ensure good qualities of health services in public sector. (WHO 2001).

Analyzing the health sector in India, the World Bank (2001) and National Commission on Macroeconomics in Health (2003, 2005) strongly advocated for the need of collaboration of Public Private Partnership in Health Sector by making both private and public sector more accountable. Thus, the tenth five year plan (2002-2007) explicitly emphasized the essentiality of private sector participation in the health sector of India. Further, during the reign of the UPA government the Rural Development Minister Jairam Ramesh once remarked that the "country's healthcare system had collapsed". Prime Minister including all other important ministers such as P.M. Manmohan Singh, Health Minister Gulam Nabi Azad, Standing Committee deputy chairman Montek Singh Ahluwalia and President Pranab Mukherjee were in favour of providing Universal Health Coverage – Healthcare for all which in fact is possible only through the collaboration of public and private health sector.

In India, this Public Private Partnership generally means a partnership or collaboration between government and private agencies where the government pays the private companies to provide a service for certain period of time. There are several definitions of PPP some of which are given below:

- WHO 1999 defines "Public Private Partnership means to bring together a set of actors for the common goal of improving the health of the population based on the mutually agreed roles and principles".
- Axelsson, Bustreo and Harding 2003 define "Public Private Partnership is a variety of co-operative arrangements between the government and private sector in delivering public goods or services provides a vehicle for coordinating with nongovernmental actor to undertake integrated comprehensive efforts to meet community needs.....to take advantage of the expertise of each partner, so that resources, risks and rewards can be allocated in a way that best meets clearly defined public needs."
- Blagescu and Young 2005 define "a partnership means that both parties have agreed to work together in implementing a program and that each party has a clear role and say in how that implementation happens".
- World Economic Forum 2005 defines "a form of agreement (that) entails reciprocal obligations and mutual accountability, voluntary or contractual relationship, the sharing of investment and reputational risks and joint responsibility for design and execution".

On the basis of above definitions, it is revealed that there are basically three important fundamental themes in any Public Private Partnership. Firstly, there should exist a relative sense of equality between the partners. Secondly, there should be mutual commitment to agreed objectives and thirdly, there should be mutual benefit of the stakeholders involved in the partnership. Thus, it is a collaborative effort and reciprocal relationship between two or more partners in which the terms and conditions, partnership structure, performance and delivery, accountability etc are clearly specified and mentioned. The primary objective of any health sectors is to provide equity, efficiency, quality and accessibility of health. To achieve this end the government has initiated several programmes and policies, and PPP is such an important initiation of government to meet the general public health discrepancy in the country.

There are various opinions regarding the merits and demerits of Public Private Partnership. World bank 2004 states that not for profit organizations are working vehemently for the poor and disadvantaged people. It has also been noticed that their sustenance highly depends on philanthropic donations and external funding. But these not for profit organizations are playing an outstanding role to cater to the public health needs of the general masses. However, the collaboration between not for profit organization and the government in different states in health sector made a remarkable success. According to Bennet (1994) there are five main problems in collaboration with private for profit provision of health services. Firstly, there is a use of illegitimate and unethical means to maximize profit. Secondly, private for profit parties are less concerned towards public health goals. Thirdly, there is a lack of interest in sharing clinical information. Fourthly, they will create brain drain among public sector health staffs and finally, there is a lack of regulatory control over their practices. But the scholars like Craig and Mitchell (2000) advocated that the strength of private sector is its innovativeness, efficiency and competition. Management skills and standards are quite high in private for profit sector.

Table-3.11

Pros and Cons in collaboration with Private Sector

Sub Sector	Pros	Cons
Informal	Accessible Client- Oriented	Poor Quality care Difficult to mainstream Low cost, Poorly educated.
Not for Profit	High Quality Targeted to the poor	Small coverage Lack of resources Low cost, cannot be scaled up, and involves the ad hoc interventions.
	High Quality	High Cost

For Profit	(in select Ad hoc interventions disciplines) Huge outreach Variable Quality/ Coverage innovative Efficient.	Clustered in cities.

(Source: World Bank 2004)

Inspite of all differences, the public and private sectors are constantly interacting with each other in different occasions. Moreover, the government often needs the support of private sectors for more resources and to expand coverage as well as to provide diversity of services. On the other hand, private sectors often approached the government in regard to policy formulation, tax exemption fee settings etc. (Y 2000)

The Ministry of Health and Family Welfare (MOHFW), Government of India conceived that the growing discontentment in public health in India could only be demolished with the help of private sector. It is only by the means of partnership with private sector the growing menace in public health system of India could be transformed. Further the ministry also presupposes that the partnership will improve the delivery mechanism and facilitates in the increase of mobilization of resources for healthcare development. Moreover, the partnership improves the quality of healthcare services; it also accelerates and enhances self regulation and accountability in the system, reduced cost of care, adoption of best practices and focused in the services to the poor. ADBI (2000) states that there are several pre-conditions which are responsible for the success of a partnership such as:

- Mutual Understanding of Partners regarding the benefits.
- A clear understanding of partners regarding their responsibilities and obligations.
- Strong support system.
- Political stability both government and legal.
- Regulatory framework which is followed and enforced.
- Building an appropriate system for organizational efficiency and management for both partners.
- Building up the system of strong management information.
- Transparency in act and activities of partners.
- There should be a system of clarity on incentives and penalties.

It has also been noticed in many countries that the legal and political consideration often creates an obstacles for partnership with private sector. Another important obstacle for partnership are the difference between public sector and private sector in relation to work culture, notion of efficiency, quality of care, type of patients seeking services and resource commitment. On the basis of the research literature, there are various kinds or models of public/ private partnerships in health sector which are as follows:

- Contracting (contracting-in and contracting-out)
- Social Marketing
- Joint Venture
- Subsidies and Tax Incentives
- Vouchers or Service Purchase Coupons
- Hospital Autonomy
- Operate and Transfer
- Philanthropic contributions
- Health Cooperatives
- Grants-in- aid
- Capacity building
- Leasing and Social Health Insurance etc.

All these partnership models are equally important and useful in different circumstances but contracting model has been widely prevalent form.

Contracting Model: It is an important instrument for engaging the private sector in health sector reforms. Under this system, the private provider receives certain amount or grants from the government for providing or delivering certain services. There is a specified written agreement between government and private sector in regard to their relationship. Bennett and Mills (1998) mentioned several stages in contracting process such as:

- Decision to contract and the services to contract.
- Tendering and selection of the contractor
- Contract Design
- Implementation
- Monitoring the performance
- Evaluating the implication of contracts on the public health system

Other important issues regarding the objectives and scope of the services are costing of the services, supervision, special privileges for the poor, relative capacity of partners in managing contract etc.

Comprehensive lengths of case studies have been conducted by the authors for Indo-Dutch Programme for Alternatives in Development (IDPAD). It covers the entire health services in different States of India. The study involves clinical care services and non clinical support services, stationary establishments and mobile services. The study also includes diagnostic services, maternal and child health services, community health financing activities, health promotion activities, general curative care, ICT based health service provision etc. This study compiled the 16 case studies conducted in the 9 different states of India in order to analyse the different models of Public Private Partnership (PPPs). It extensively reviewed the cases, contract documents, memorandum of understanding etc. it also analysed the feedback from different stakeholders such as public and private partner officials and patients. The partnership initiative covers from

super speciality tertiary-care hospital like Appollo Hospital, Raichur, SMS Hospital to primary care like 'karura trust' in Karnataka for slum communities and 'Aparna Swasthya Kendra' in Delhi. Further, the study also examined the Community Health Insurance Schemes of two states such as Arogya Raksha Scheme in Andhra Pradesh and Yeshasvini scheme in Karnataka. The study explicitly analysed the mobile health services in Tamilnadu, Uttaranchal and West Bengal. On the basis of the report prepared by IDPAD, it is revealed that except some of the states like Kerala, Karnataka and Tamilnadu, the public health condition of most of the other Indian states are not upto the mark. The report also states that the collaboration with private sectors in healthcare services are also quite successful in southern states of India like Kerala, Andhra Pradesh, Karnataka etc but it is also a story of mess in the states like Bihar, Jharkhand, Assam and Sikkim etc.

3.6 Conclusion

Hence, it is revealed from the entire discussion that the public health condition in India is a total mess. There are huge healthcare service disparities among the different states of India. It is also well evident that there are different types of healthcare services enjoyed by the different strata of people in India. Some sections of society who are wealthier have access to the best healthcare services in India, some other sections of society who are middle class have access to different kinds of healthcare services and the ones who are poor have a different kind of healthcare facilities in India. The situation is further pathetic in the rural areas of the nation. There is a huge gap in theory and practice of public health conditions in India. The reports of different health commissions and committees state that the conditions of public health are improving very rapidly throughout the years in India, but when we go to the field, particularly in the rural areas, and then only we are able to realize the real picture of public health condition in India.