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SOME EXPERIENCES OF HEALTH FOR ALL IN INDIA

Dr. S. Gnanaprakesh MA., M.Phil., PhD., PGDCA., Assistant Professor in Economics, PG & Research Department of Economics, Urumu Dhanalakshmi College, Tiruchirappali – 620019. Tamil Nadu.

Dr. J. Jayalakshimi MA., M.Phil., PhD., Assistant Professor in Economics, PG & Research Department of Economics, VHNSN College, Virudhunagar, Tamil Nadu.

INTRODUCTION

Despite these differences the World Health Assembly in 1977 declared that all citizens of the world should attain a level of health that will permit them to lead a socially and economically productive life. This culminated in the international objective of HEALTH FOR ALL by the year 2000 as the social goal of all governments. Health for all means that health is to be brought within the reach of every one in a given community. It implies the removal of obstacles to health–that is to say, the elimination of malnutrition, ignorance, disease, contaminated water supply, unhygienic housing etc. It depends on continued progress in medicine and public health.

Halfdan Mahler, Director General (1973-1983) of the WHO, defined Health For All in 1981, as follows:

Health For All means that health is to be brought within reach of everyone in a given country. And by "health" is meant a personal state of well being, not just the availability of health services – a state of health that enables a person to lead a socially and economically productive life. Health For All implies the removal of the obstacles to health – that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing – quite as much as it does the solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines.

- Health For All means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it.
- Health For All demands, ultimately, literacy for all. Until this becomes reality it demands at least the beginning of an understanding of what health means for every individual.
- Health For All depends on continued progress in medical care and public health. The health services must be accessible to all through primary health care, in which basic medical help is available in every village, backed up by referral services to more specialised care. Immunisation must similarly achieve universal coverage.
- Health For All is thus a holistic concept calling for efforts in agriculture, industry, education, housing, and communications, just as much as in medicine and public health. Medical care alone cannot bring health to in hovels. Health for such people requires a whole new way of life and fresh opportunities to provide themselves with a higher standard of living.

The adoption of Health For All by government, implies a commitment to promote the advancement of all citizens on a broad front of development and a resolution to encourage the individual citizen to achieve a higher quality of life.

The rate of progress will depend on the political will. The World Health Assembly believes that, given a high degree of determination, Health For All could be attained by the year 2000. That target date is a challenge to all WHO's Member States. The basis of the Health For All strategy is primary health care.

Two decades later, WHO Director General Lee Jong-wook (2003–2006) reaffirmed the concept in the World Health Report 2003:

Health for all became the slogan for a movement. It was not just an ideal but an organizing principle: everybody needs and is entitled to the highest possible standard of health. The principles remain indispensable for a coherent vision of global health. Turning that vision into reality calls for clarity both on the possibilities and on the obstacles that have slowed and in some cases reversed progress towards meeting the health needs of all people. We have a real opportunity now to make progress that will mean longer, healthier lives for millions of people, turn despair into realistic hope, and lay the foundations for improved health for generations to come.

OVERALL HEALTH SITUATION IN INDIA

Let us now turn our attention to the overall health situation in India. We will look at some basic statistics impacting health, review health care delivery systems and critique the achievements as well as the unfulfilled targets of health care delivery.

Population Profile: The work on the next census (2001) has already started. Even without it, it can be said that India is heading towards a population explosion. It is one of the most populous nations in the world–second only to China. Nature has only finite resources and the consequences of an ever expanding population to mankind as a whole are grave. Let us look at some of these demographics or should we say "Demographics".

LARGE POPULATION

High fertility both in terms of birth rate and family size. Declining mortality Illiteracy rate of about 40% Dependency ratio of 0.9, that is, every economically productive member has to support almost one dependent. This table summarizes the most recent demographic information available:

India: Demographic profile

Total Population (eatimated1996)	952	Million
Population rural% (1995)	73.2	–
Adult literacy rate % (1995)	52	–
Density of population per sq.km (1995)	283	–
Sex ratio female per 1000 male (1991)	929	–
Average family size (1988)	34.8	–
Age at marriage, female (1991)	19	Years
Annual per capita GNP (at current prices 1994–95)	INR 8984	–

When we compare some of the available statistics to that prevalent in the west the following is the observation.

SELECTED HEALTH AND SOCIOECONOMIC INDICATORS

	Other developing Countries	Developed Countries
Life expectancy at birth (years) 1996	66	77
IMR (per 1000 live births)	55	6
Maternal mortality per 100,000 live births 1990	350	13
Doctor population ratio per 10,000 (1993)	8.4	25.2
Nurse population ratio per 10,000	9.6	74.2
GNP per capita (US $)(1994)	1133	24414
Adult Literacy rate	73	99

A LOOK AT MORTALITY STATISTICS

POSITIVE ACHIEVEMENTS

During the last few decades, there has been a notable improvement in the health status of the population. The death rate has steadily declined. The life expectancy at birth has gone up considerably since 1951, recording an estimated 62 years during 1995. Many of the infectious diseases have shown a decline, e.g. plague and malaria.

SOME DRAWBACKS

There is still a lot that needs to be done. India's health standards are still low compared to those in developed countries. The infant mortality rate (IMR) India is still high (about 74) as compared to a low of about 6 in developed countries. It does not compare even favorably to some countries in the African continent. Even among underdeveloped countries the IMR is considerably higher. The life expectancy rate in India is at least 10–15 years behind the western life expectancy.

A LOOK AT SOME MORBIDITY PROFILES

Although some diseases have been brought under control many diseases like tuberculosis, filariasis, leprosy, malaria, diarrhea diseases continues to be a major health problem. Small pox has been eradicated. But measles and polio are still widely prevalent. Bacterial meningococccal meningitis has been on the increase. We still have not controlled viral hepatitis infections. AIDS may become one of the most deadly diseases in the near future. Diarrheal diseases still are a major cause of morbidity and mortality in children. Malnutrition occurs very commonly in children, especially in the rural areas.

About 30 per cent of babies are born with a birth weight of less than 2.5. kg. Vitamin A deficiency is a major cause of preventable blindness. India is home to almost half the cases of tuberculosis in the world. Not so encouraging is the widespread occurrence of leprosy. People continue to be afflicted by malaria. Many deaths occur due to Paramoecium falciparum infections. Kala–azar has made a resurgence. An estimated 20,000 cases occur annually. Lastly sexually transmitted diseases are widely prevalent.

In addition to the above the so called slow epidemics of diseases such as diabetes, cancer, heart diseases also affect people in third world countries. Smoking is decreasing in many developed countries due to health fears, but it is on the rise in developing countries. It is estimated that in certain developed countries as high as 60% of the men smoke. Heart attacks occur at a younger age in South Asia as compared to the rest of the world. With the adoption of western lifestyle, diabetes is increasingly seen in India.

WHAT HAS BEEN DONE SO FAR TO TACKLE THESE HEALTH PROBLEMS?

1. ESTABLISHMENT OF PRIMARY HEALTH CARE CENTERS:

The establishment of primary health care centers started earnestly after independence in 1952. Over the years, a network of primary health centers and sub–centers have been established. The primary health centers are the major health care providers in the rural areas. At the village level, a band of voluntary health workers (e.g. village health guides and trained dais) has been created. They are selected by the local community and trained to deliver primary health care. Secondary health care is provided by the district hospitals and newly created community health care.

Tertiary health care is provided by the teaching hospitals and institutions and other apex hospitals. Both in the rural and urban areas, the public and private sectors exist side by side. A large number of voluntary organizations are also involved in providing health care to the people.

2. ESTABLISHING A HEALTH CARE WORK FORCE

Major requirement in developing an adequate health infrastructure is health manpower which must be adequate both as regards quality and quantity. Many medical colleges (allopathic) and nursing schools were started soon after independence. There are about 400,000 allopathic doctors. In addition the alternative forms of medicine also contribute to the workforce e.g. Ayurvedic system, Homeopaths, Unani system, they number approximately 6 lakhs and are actually more than the existing allopaths. When all doctors are included the ratio of doctor: patient population is roughly 1:2100.

3. HEALTH CARE AND INSURANCE

As compared to the West, health care insurance does not exist in a big way. As part of the public sector health services, there are a number of schemes such as Central Govt. Health scheme (CGHS) and the Employees State Insurance Scheme (ESIS) under which comprehensive health care services are provided to the families of employees. The beneficiaries covered by these schemes work out to a little less than 6 per cent of the Indian population. Some private sectors provide insurance to their employees. With the government opening up the insurance sector to international competitors the insurance scenario will undergo a dramatic change in the coming years.

PRIMARY HEALTH CARE

Another important declaration was the Alma Ata (erstwhile USSR) joint conference of WHO–UNICEF. It was declared that "The existing gross inequality in the health status of people particularly between developed and developing as well as within countries is politically, socially and economically unacceptable". The Alma–Ata conference called for acceptance of the WHO goal of Health for all by 2000 A.D. and proclaimed "Primary health care as a way to achieving health for all".

This slogan was adopted and incorporated into delivery of health services by many countries including India. India is a signatory to the Alma–Ata Declaration of 1978. The National Health Policy, approved by the parliament in 1983 clearly indicates India's commitment to the goal of health for all by the year 2000 AD.

THE DECLARATION OF ALMA ATA STATED THAT PRIMARY HEALTH CARE INCLUDES AT LEAST:

- Education about prevailing health problems and methods of preventing and controlling them.
- Promotion of food supply and proper nutrition.
- An adequate supply of safe water and basic sanitation.
- Immunization against infectious diseases.
- Prevention and control of endemic diseases.
- Appropriate treatment of common diseases and injuries.
- Provision of essential drugs.

There are some statistical measures used to give an idea of the health status of a community or nation as a whole.

These are:

CRUDE DEATH RATE

It is defined as the number of deaths per 1000 population per year in a given community.

EXPECTATION OF LIFE

Life expectancy at birth "The average number of years that will be lived by those born alive into a population if the current age–specific mortality rates persist". Life expectancy is a good indicator of socio–economic development in general.

INFANT MORTALITY RATE

Infant mortality rate is the ratio of deaths under 1 year of age in a given year to the total number of live births in the same year, usually expressed as a rate per 1000 live births. It is one of the most universally accepted indicators of health status not only of infants, but also of whole populations.

ACHIEVING HEALTH FOR ALL

In 1977, the World Health Assembly decided that the main social target of governments and of WHO should be the attainment by all the people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. In other worlds, as a minimum, all people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live. The third evaluation of

progress in implementing the Global Strategy for Health for All by the year 2000 (carried out in 1997) has shown significant improvements worldwide both in health status and in access to health care. Increasing numbers of Member States are carrying out monitoring and evaluation of their health-for-all strategies at specified intervals; for the first evaluation in 1985, 147 out of 166 Member States reported, at least with respect to the global indicators. In 1997, 158 out of 191 Member States did so, although some indicators were more widely covered than others - e.g. 90% of countries reported on immunization, but only 30% on access to local health services.

Overall there has been strong political commitment to achieving the health-for-all goals, and most countries have endorsed at the highest level the necessary policies and strategies. Existing health services are being reoriented to a health system based on primary health care, taking into account the role of the individual, the family, the community and local nongovernmental organizations, as well as health personnel. Substantial attention has been given to the health of women and their role in development.

Globally there have been significant increases in the following elements of primary health care since the first evaluation in 1985: immunization against the eight EPI target diseases; trained attendance at childbirth; local health services; and water supply and excreta-disposal facilities. Gaps between the developing and developed countries have been significantly reduced, although improvements in the least developed countries have been less satisfactory.

Coverage levels for the various elements of primary health care have improved in the developing countries. In these countries, 65% of pregnant women have access to antenatal care services and 53% to skilled attendance at delivery. In rural areas, 75% of the population have access to a safe water supply, and about 34% to adequate sanitation.

The rapid increase in coverage of immunization programmes from 5% in the 1970s to over 80% in 1996, has had a big impact on the health status of children. These improvements, however, are less significant in the LDCs than in other developing countries.

It is estimated that by 1997, 106 countries representing 64% of the global population had an average life expectancy at birth above 60 years; an infant mortality rate below 50 per 1000 live births, and an under-5 mortality below 70 per 1000 live births. In 1975, 69 countries representing 30% of the global population met these targets.

There was inevitably concern about resources for health in view of the growing costs of health services. Countries use various methods to finance their health systems, but few countries, even the most prosperous, are satisfied with the distribution of financial resources between promotive and curative services. There are also many problems associated with the provision of human resources for health - problems relating to education and training and to distribution.

CONCLUSION

As health systems become more complex and costly, and as the application of new and existing technologies becomes more refined, making the right decisions about the allocation of often scarce resources has become more difficult. Reproducibility and comparability of results are essential to the success of health laboratories. The concept of quality assurance - comprising external quality assessment and internal quality control - has been promoted by WHO and accepted worldwide. The Organization has also emphasized the provision and improvement of the quality of radiological services for diagnosis and therapy, areas that have seen spectacular progress.

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