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Health care systems in transition III. India, Part I. The Indian experience

Imrana Qadeer

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Introduction

Indian society is distinguished by marked cultural pluralism and a relatively young population that in 1999 has grown to one billion. Its regional and economic diversity and complex social structure and extremes of poverty and wealth make planning a challenging task. Developing economic self-reliance, tackling poverty and building a strong welfare state were major commitments of the newly independent India. After 1949, a conscious effort was made to invest in education and health services. Constitutionally, health services were the responsibility of the provincial states. The role of central government was to define policies, provide a national strategic framework, financial resources and specified services such as services for people crossing international borders and medical education. In the 26 States and two Union Territories, districts were the operative units wherein the population of about 1.3–1.5 million was served by a network of Primary Health Centres (PHCs) and sub-centres organized as a pyramid with the district hospital at the apex.

Health sector planning had two major thrusts: the first, to build an infrastructure to provide basic medical care, maternal and child health (MCH) services, health information, education and referral services; and the second, to develop specific national health programmes to control communicable diseases, provide family planning services (FPSs) and control severe forms of nutritional deficiencies. To carry out these tasks, a support system had been developed which included education and training, research, health information and monitoring, drug and equipment production, etc.

Unfortunately, India's grand plans for health sector development began to be distorted when the overall planning process shifted emphasis in the 1980s and a growth-centred economic approach began to take root in India as in other world economies. This economic philosophy, which was premised on a 'trickle down' view of the benefits of economic growth, resulted in the growth of urban centres which overshadowed the development of the vast rural hinterlands and which themselves were left to the mercy of feudal interests. Thus, though annual growth rate rose from 2.8 per cent in 1961–1966 to 5.7 per cent in 1980–1985,[1] significant regional disparities have become more visible. To tackle the disparities within the health sector, under cover of the National Emergency in 1976, extreme coercion and force was used in an attempt to control population numbers in order to deal with the developmental crisis.

The failure of India's vertical programmes, such as the National Malaria Eradication (NMEP) and Family Welfare Programmes (FWP), generated pressures for modification of these vertical programmes. By the late 1970s these programmes were integrated into the general district health services, yet they retained their predominance in terms of policy planning and funding. Consequently, they subsumed the resources of the general health services and undermined programmes such as tuberculosis control and MCH services.[2] Despite signing the WHO Alma Ata declaration in 1978, distortions in resource distribution between rural and urban services, preferences for hi-tech and specialized medical care over primary care, and a shift of priorities back in favour of the social élite, in terms of both problem identification and infrastructure growth, have remained unchanged.[3]

The impact of this early development varied. During the 1980s the comprehensive PHCs advocated by WHO were modified into selective PHCs, as proposed by critiques of the Alma Ata declaration.[4] By the end of the 1980s, a substantial health service infrastructure had been developed. The number of PHCs had increased to such an extent that their coverage could be reduced from 100 000 to 30 000 people, and the sub-centres now covered a population of 5000 instead of the earlier 10 000. Each Community Health Centre, the level below the District Hospital, covered a population of 100 000. The medical schools and specialized hospitals were mainly located in the urban areas along with their municipal services. Substantial numbers of professional and paramedical personnel had been trained (Table 1). In addition to this, institutions of traditional systems

Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi 110067, India.

Imrana Qadeer, Professor

Table 1 Health service institutions and personnel in India

	1980	1985	1990	1995
Hospitals and dispensaries	6596	7369	11245	15097
		21874		28225
Primary health centres	5499	7250	20536	21802
Sub-centres	4932	83008	130390	132285
Beds	460886	518598	–	870161
Medical colleges	106	106	128	160
Doctors	255138	306966	365000*	474270
Nurses	146201	197735	311235	512595
Auxiliary nurse–midwife	71434	98543	150431	229304
Sanitary inspectors and health assistants	25192	28050	22967*†	34649†
Pharmacists	155621	157666	–	175000

* Figures for 1991.
† Health assistants only.
Sources: GOI (1996), *Rural health statistics of India*, Bulletin, Ministry of Health; GOI (1996–1997), *Economic survey of India*; GOI (1997), *Ninth Five Year Plan*.

of medicine such as Ayurvedic and Unani dispensaries and a few hospitals were also established as a part of the government health care infrastructure. Thus, a rather extensive infrastructure was developed even though problems such as regional inequities, poor outreach and functional inadequacies remained. This infrastructure, with a potential to provide genuine PHC, was, however, largely usurped by the family planning programme with its strong political and administrative backing.

The pressures for change

Since the 1980s, pressures for change have come from different quarters. As far as the public sector health services were concerned, the increasing democratic aspirations of sections of the population created pressures for improved coverage and better facilities. Interestingly, the emerging middle class, which had succeeded in acquiring a reasonably adequate standard of living, lobbied for 'hi-tech hospitals' which conformed to their concepts of 'international standards' of health care. The lower middle class and the poor, who had little experience of the benefit of effective public health services, reinforced this medicalized image of publicly funded health services. Private sector practitioners, who had enjoyed the privilege of State protection since independence in India's mixed economy of service provision, aspired to influence policy and create more advantages for themselves. The subsidies they were offered, along with free medical education and the privilege of occupying important positions in public institutions and medical colleges in most States, led to the rapid growth of an influential private sector.[5] It used the public sector as a springboard to acquire status and power and then pressurized the public authorities to loosen control over medical care. The private sector grew from polyclinics to nursing homes, private hospitals and, finally, to the development of corporate hospitals. As a result, the private sector has developed its own niche in the provision of individual curative medical care, but not public health. Whereas 50 per cent or more of the out-patient and indoor patient care is provided by the private doctors, 67 per cent of the poorest 40 per cent needing hospitalization in rural areas, prefer to go to public hospitals. Private sector also benefited from government subsidies to medical education and import subsidies on equipment and drugs.[6]

The national and international population control lobby demanded that the use of infrastructural resources that it had provided should be devoted exclusively to programmes that were directly or indirectly linked to population control.[7,8] It was this pressure that led to a significant shift in investment patterns. Investment in family planning rose from 15 per cent of overall spending on health during the sixth Five Year Plan to 24 per cent and then 35 per cent in the seventh and eighth Five Years Plans, respectively, whereas investments in other health programmes fell drastically (Table 2). This reduced existing selective PHC services – such as maternal and child health care, nutritional services, communicable disease control and family planning services – to a technocentric reproductive and child health (RCH) strategy. Organized medical professionals opposed the incorporation of other health care practitioners, thereby reinforced the pressure for attaining international standards in the provision of all medical technology. Along with the drug and equipment industry, the professionals' demand for increased use of hi-tech medical care further shifted the focus away from PHC.

Last but not the least were the growing global political and economic pressures on an ill-planned economy where the political leadership, instead of critically assessing the situation, took the softer options of shifting from international aid, which was no longer adequate, to an increased dependence on loans. By the mid-1980s, international donors were in a position to demand from the Indian government returns of accumulated interest as part of their conditions for providing further loans. The official documents indicative of policies from the mid-1980s onwards, such as country statements from India for the UN conferences on *Population and development* in Cairo in 1994 and *Women and development* in Beijing in 1996, started reflecting policy documents for India prepared by the World Bank. The draft Indian national population policy of 1994 reflected these same priorities and it was apparent that India was beginning to lose its hold on its own planning processes.

By the mid-1990s India needed to take a hard look at its planning processes and introduce appropriate corrective measures (reforms). In terms of available support for this process, Indian politicians accepted most that was offered without much discretion. As a result the country opened itself to the entire gamut of Structure Adjustment Policies (SAP) of the International Monetary Fund and the World Bank. These were a set of uniform strategies applied to countries irrespective of their contexts and needs, to protect the interests of international capital.[9]

Table 2 Intrasectoral financial allocations for health sector (millions of rupees)

Sub-sectors	1951–56 Plan I	1956–61 Plan II	1961–66 Plan III	1966–69 Annual	1969–74 Plan IV	1974–79 Plan V	1980–85 PlanVI	1985–90 Plan VII	1992–97 Plan VIII
Control of communicable diseases	231.0 (16.5)	640.0 (28.4)	690.0 (27.7)	231.0 (10.2)	1270.0 (11.1)	2681.7 (11.5)	5240.0 (27.0)	10126.7 (7.7)	10450.0 (4.2)
Total health	903.0 (64.5)	1460.0 (64.9)	1500.0 (60.2)	939.0 (41.6)	4335.0 (37.5)	7962.0 (34.1)	18211.0 (27.0)	33928.9 (25.8)	75759.5 (30.5)
Family planning	7.0 (0.5)	30.0 (1.3)	270.0 (10.8)	829.0 (36.7)	3150.0 (27.3)	5160.0 (22.1)	10100.0 (15.0)	32562.0 (24.7)	65000.0 (26.0)
Water supply and sanitation	490.0 (35.0)	760.0 (35.8)	720.0 (28.9)	490.0 (21.7)	4070.0 (35.2)	10220.0 (43.8)	39220.0 (58.0)	55970.0 (50.5)	107430.3 (43.0)
Grand total of health + family welfare + water supply and sanitation	1400.0	2250.0	2490.0	2258.0	11555.0	23342.0	57530.0	131716.5	248189.8

Figures in parentheses are percentages of grand total, except for communicable diseases, which is per cent of total health.
Source: respective Five Year Plans of the Government of India, Planning Commission.

Health sector reforms

SAP led to the introduction of health sector reforms in India. Instead of learning from past experiences and contradictions within the Indian health care system and enhancing an efficient and integrated approach to improving its working, the entire exercise was dominated by the unquestioning acceptance of the prescribed reforms. The impatient middle class, hoping to acquire international living standards, and the private sector both played a crucial role in justifying the reforms. The main aspects of the IMF–World Bank-inspired reforms were: cuts in health sector investments, opening up of medical care to the private sector, introduction of user fees and private investments in public hospitals, and purely technocentric public health interventions.

In the 1990s when SAP was formally accepted and cutbacks in the welfare sector were introduced, PHC suffered a further set back. The proposed health sector reforms had a direct impact on PHC because:

(1) intersectoral strategies for PHC were already being undermined by a weakening food security system, massive unemployment and loss of subsistence for many Indians;
(2) infectious disease control programmes were disrupted by a reduction in investment (Table 2);
(3) medical care was handed over to the private sector without any mechanisms to ensure the quality and standards of treatment, as well as access to services.

FWP of the early 1980s, which had moved towards a recognition of its links with infant, maternal, and childhood mortality and communicable diseases, was forced back into an isolated reproductive health strategy that focused on effective, if potentially unsafe, technocentric approaches to fertility reduction.

Instead of focusing on poverty-related infectious diseases through comprehensive strategies, attention was shifted to new priorities identified by 'experts'. Thus, non-communicable disease control through educational and curative strategies was added in the name of epidemiological transition, despite the fact that the growth of such diseases was due more to hazardous working conditions[10] and growing social pressures of survival.[11] The control strategy over-emphasized individual 'life styles', which cannot be changed by the majority of the population, who have no option but to survive under the given conditions. Secondly, by emphasizing curative services for this set of diseases the drug and equipment industry was promoted.

Vertical and technology-intensive approaches to communicable diseases have replaced epidemiological and health systems research. The result is that cost-effectiveness of individual patient care rather than maximizing population coverage has become the driving force of health care planning. Ultimately, this may serve the purpose of selling technologies but there is evidence that it may not add to public health.[12] The present approach therefore is not truly 'cost effective' as larger health gains could be made with other strategies. Programmes for the control of tuberculosis and AIDS are examples of the negative effects of strategies that neglect general health services. The lack of adequate general health services not only makes control of these diseases more difficult but, at least in the case of AIDS, contributes to its spread.[13]

Reliance on a purely bio-medical approach ignores the social and economic conditions in which people live and seek help, and which are potentially the main causes of the problems sought to be alleviated. A purely bio-medical strategy may not recognize such underlying social and economic conditions. For example, a study of the Revised National Tuberculosis Control Programme (RNTCP) by the Department of International Development demonstrated that only 50 per cent of individuals diagnosed with tuberculosis were given treatment.[14] Those not receiving treatment included those who lacked economic support, were unable to balance work with the demands of Direct Observation Treatment, found behaviour of members of the clinical team undesirable or were migrants.[14] Even more disturbing was the observation that some of the providers were

pre-selecting individual cases to make management easier for themselves. Thus, those who were recent migrants, homeless, without ration cards and therefore difficult to follow up were excluded. In other words, those who needed help most were in fact the most vulnerable under the RNTCP. An assessment during 1993–94 shows that not only were those who were diagnosed under RNTCP poorly covered, but that coverage in four urban pilot projects only ranged between 5 and 30 per cent of the expected, compared with the WHO recommendation of 70 per cent coverage.[15]

Transition under health sector reforms

The impact of the reforms during the 1990s has been crucial in changing the structure as well as the content of the health care system. The consequence of these reforms fall into three main categories: (1) cuts in public sector investment; (2) donor driven priorities; (3) privatization of medical care.

Cuts in public sector investment

The first massive cuts in health sector expenditure were part of the 1992–1993 budget. The cuts were of such an extent that the ensuing epidemics and the government's failure to control them forced the government to reduce cuts in future years; but they were not reversed, which led to stagnation in the growth of the promised infrastructure (Table 3). Not only was the secondary and tertiary care unit deprived of resources, but inevitably, PHC also suffered. It did not receive the required support in terms of referral services, nor adequate material and staff. The disjunction between rural and urban service provision sharpened and FWP dominated basic services. As the cutbacks involved the social sector as a whole, there was an additional loss of inter-sectoral support (Table 4). The dwindling subsidies to the public distribution system, especially food rations, education and transport, resulted in population living at subsistence levels or below the poverty line becoming even more vulnerable. Some studies demonstrated that in rural areas ill health has become a major cause of indebtedness.[16]

Since independence, India had incrementally developed a system for monitoring its health services through the office of the Drug Controller of India, the epidemiological monitoring units for malaria, cholera and plague, and through monitoring of national programmes and national institutes. In addition, the Indian Council of Medical Research was attempting to set standards for medical research. It supported epidemiological and health care research that required large-scale funding, technical expertise and long-term field monitoring.

The work of these institutions was also curtailed by the cutbacks, as is evident from their failure to either restrain the illegal human experiments in the name of research on quinacrine as a contraceptive or control the supply of the drug directly to practitioners without the approval or permission of the Government.[17] The Plague epidemic of 1994 provided yet further evidence that closing down monitoring units was detrimental to public health practice.[18]

The national institutions suffered a loss of autonomy due to the cutbacks, as they now had to depend on external funding, providing leverage to those who provided loans and aid. They could now dictate planning priorities, the structure of the institutions themselves and the nature of the research performed. An example of this loss of autonomy was the recommendations made by a WHO–Government of India review committee, which stated that 'the National Tuberculosis Institute Bangalore is a research organisation; therefore, programme management and standard setting functions are inappropriate for it'.[19] This was a strange recommendation as the National Tuberculosis Institute was responsible for

Table 3 Plan outlay for communicable disease control during the 1990s (millions of rupees)

Control programmes	1990–91	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99
Malaria	735.0 (27.79)	830.0 (28.23)	770.0 (26.18)	900.0 (19.15)	900.0 (15.95)	1190.0 (18.46)	1140.1 (9.01)	183.00 (12.60)	290.07 (16.30)
Tuberculosis	139.3 (5.26)	160.0 (5.44)	290.0 (9.86)	350.0 (7.45)	460.0 (8.14)	500.0 (7.76)	520.7 (4.11)	80.00 (5.51)	125.00 (7.03)
Leprosy	232.0 (8.78)	240.0 (8.16)	350.0 (11.90)	350.0 (7.45)	940.0 (16.64)	800.0 (12.41)	740.0 (5.80)	79.00 (5.40)	79.00 (4.44)
Kala azar	–	–	–	–	200.0 (3.50)	200.0 (3.10)	35.0 (0.27)	10.00 (0.70)	10.00 (0.60)
AIDS	–	–	639.9 (21.75)	662.4 (14.09)	720.0 (12.74)	798.0 (12.38)	1406.0 (11.11)	124.10 (8.50)	110.60 (6.20)
STD	–	–	4.5 (0.15)	5.0 (0.11)	2.5 (0.04)	1.8 (0.03)	4.0 (0.03)	4.0 (0.03)	4.0 (0.02)
Total health	2645.3 (28.16)	2940.0 (28.19)	2941.5 (22.73)	4700.0 (27.01)	5650.0 (28.32)	6445.7 (28.96)	12654.7 (44.70)	14512.4 (43.90)	17776.8 (41.40)

Figures in brackets are percentages of total health, except for the last row in which they represent the percentages of the total sector (including health, family welfare, water, and sanitation). Sources: GOI, *Expenditure budgets*, Vol. 2, 1994–95 to 1998–99; Ministry of Finance, GOI (1999), *Ninth Five Year Plan*, Planning Commission.

Table 4 Central government expenditure, planned and non-planned, on social services by year (millions of rupees)

	1990–91	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99
Rural development	26780	28300	32110	46800	58030	66090	50810	53210	58900
Education, art, culture and youth	16860	17550	18780	23780	27990	36800	39880	51340	65350
Social welfare and nutrition	5200	6280	8030	8800	9870	18000	50810	53210	58900
Basic services	–	–	–	–	–	–	24660	28730	37600

Source: *Economic survey of India 1998–99*, pp. 142–143.

originating the National Treatment Programme and, since its inception in 1964, had been instrumental in providing the rationale for policy, planning, management, standard setting and operational research in the programme.

Donor-driven priorities

Globalization of the Indian economy and ensuing health sector reform as part of this process essentially meant that the national priorities became dominated by the interest of international capital. According to the 1999 Annual Report of the Reserve Bank of India, India owes international agencies such as the World Bank and International Monetary Fund a debt of US$98 billion. Privatization became the driving force of reforms, not just of medical care but also of public health services such as water supply, sanitation, and sewerage treatment facilities. The transition from a genuine search for reforms to the resetting of priorities in health services by the donors has been damaging.

The Indian experience had clearly shown that the answer to the problems of its Family Welfare Programme lay in working towards the welfare of families through an integrated approach to their well being.[20] As SAP focused on growth-oriented developmental strategy at the cost of welfare, family welfare was also reduced to a technocentric reproductive and child health strategy. This strategy focuses on women of reproductive age at the cost of all other age groups, some of whom will carry their problems into their reproductive phase. The expansion of RCH was at the expense of all other components of PHC, which, if implemented, would reduce mortality and ill health among younger age groups, and thereby contribute to a decline in fertility. The absence of an integrated approach to family welfare was particularly damaging for India, where almost 50 per cent of the population live at or below subsistence levels. Differences in mortality rates for the different classes speak for themselves (Table 5). Despite the fact that infectious diseases remain the main cause of mortality, investments increased only for selected programmes for tuberculosis, leprosy and AIDS control at the cost of programmes such as National Malaria Control and Diarrhoeal Diseases Control Programmes (Table 3). The tuberculosis, leprosy and HIV programmes were themselves transformed into vertical programmes but with doubtful impact at a population level.

There has also been a trend to initiate new national programmes to control non-communicable diseases. Thus, cancer, diabetes and heart diseases have occupied central places on the agenda for health service provision. The argument behind this shift is that the onslaught of the epidemiological transition creates a double burden of disease. National statistics based on lay reporting shows that 36 per cent rural deaths are due to infectious diseases, another 10 per cent are due to nutritional deficiencies, whereas for about 20 per cent the cause of death is reported as non-communicable disease. However, even for the last category, the probability that the underlying aetiology is really an infectious agent is estimated to be about 50 per cent, suggesting that infections, along with under-nutrition, still cause 56 per cent of all deaths.[21]

The market for information, education and communication (IEC) technology is also being promoted in the name of educating the people, although adult literacy levels remain at an average of 52 per cent in the country and the female population, with a 39 per cent literacy rate, carries the brunt of illiteracy.[22] The drive to promote the use of the technologically advanced interventions is underwritten by distorting concepts such as PHC and health systems research. In its district planning projects the World Bank has completely transformed both these concepts. PHC has become 'primary level care', as secondary and tertiary care is left to the private and non-governmental organization (NGO) sectors. Similarly, in the name of operational research, technological and administrative changes have been introduced at the district level without setting up alternative strategies, without any rational epidemiological basis for a given technological intervention and without assessing baseline information required to evaluate future changes.[23]

Table 5 Infant mortality rates by total annual income of the house holds in India 1984

Annual income of the households in rupees	Infant mortality rate		
	rural	urban	combined
5000 and below	128.6	85.4	124.2
5001–10000	108.1	71.5	100.7
10001 and above	91.8	51.5	79.7

Source: GOI (1984), *Mortality differentials in India*: Vital Statistics Division, Office of the Registrar-General of India, New Delhi, p. 6.

Privatization of medical care

The existence in India of a private sector is not new. A public–private mix has existed for a long time with the latter making full use of the former. What is new today is the opening up of the public sector hospitals to private investment and the introduction of user fees. However, both these measures have failed either to augment services for the poor or to introduce greater efficiency. In fact, by increasing the cost of medical care they have made it more difficult for those who most need help to access public sector services.[24] As public sector hospitals are preferred to private sector hospitals for the treatment of serious illnesses,[25] the middle classes are elbowing out the poor as the pressure on hospital increases.

The increased involvement of the private sector in the provision of medical care in the absence of any kind of public regulation, regular service evaluation, quality control or even self-regulation may lead to further destabilization of basic services. As curative interventions were the key preventive instruments for a large number of national disease control programmes, this retreat of the public sector from medical care will affect the working of the national programmes. Under no compulsion to use standardized therapeutic strategies, in a hurry to cure so as to retain its clientele and not bound to provide full information about its patients, the private sector pays little heed to the demands of the national programmes. In the case of the National Malaria Control Programme, the irrational use of drugs for resistant parasites, the use of different drug regimes by private practitioners and treatment often without even attempting to make a diagnosis have become major hurdles in malaria control. Similarly, in the case of tuberculosis control, it has been reported that 'eighty different regimes were prescribed by 102 doctors (private practitioners) generally more expensive than the most expensive standard regimes'.[26]

Yet another change is the expanding influence of the free market. Earlier, when the Indian Medical Council found a drug or a technology ineffective or harmful it recommended that it not be incorporated into the national strategy. This also resulted in the particular drug not being marketed. Now, despite such recommendations, under the guise of the individual doctor's freedom to practice, the free market sells harmful drugs such as norethisterone enantate (NET-EN) without adequate warning to the public. The production and prices of drugs have also been seriously affected. The list of drugs under price control has been reduced from 378 to 73 and the prices of drugs have rocketed.[27] Private insurance for the handful of salaried employees is yet another transition towards strengthening the free market in health.[28]

Privatization has also indirectly affected the health sector. Market forces, by altering the patterns of production, have pushed an almost self-sufficient food economy into a cash crop-producing one, which undermines food security systems and is likely to add to ill health.[29]

The reforms are essentially premised on the false hope that countries like India, with their burden of poverty and illiteracy and malnutrition, can afford to cut back on social sector investments and rely on the free market and the private sector in health to provide answers to its public health problems. The rationale that adequate resources for health care can be generated through privatization, the introduction of user-fees, cuts in subsidies, and the expansion of private insurance systems has either proved to be wrong or so limited in its application that it leaves major aspects of the problem untouched.[30] The contradiction between the two perceived roles of the state as 'partner'[31] and as 'controller'[32] of the private sector remains unresolved. If the State is weakened and is forced to roll back its influence, it cannot provide the regulatory functions necessary for the market to operate in the public interest.

Without addressing these issues, the focus of the SAPs has been on altering the structure of the economy itself. Health sector reforms have become instruments to promote markets rather than a means to improve the health sector and, ultimately, health. Liberalizing the structure of taxation promotes spending by those who are well off. Thus, by making taxation more flexible, making health care into a commodity, and shifting the burden of health services onto the poor – through the introduction of user fees and privatization of medical care – relief is provided only to those who have the means to join the consumer markets. The health sector reforms have replaced the principle of payments based on earning with fixed rates of payments for different service packages. The poor who fall ill more will pay more, relative to the rich, who may pay a smaller proportion of their incomes for the treatment of same illness. The rich are also less likely to fall ill, as they are already better provided with basic facilities such as food, housing, clean drinking water and sanitation. It is apparent that the transition brought about by the reforms has not been successful in bringing relief to the majority of India's people.

Future possibilities

Demographic and health indices in India slowly but steadily improved until 1991 (Table 6) but the mortality differentials between classes (Table 5) indicate that India cannot afford to focus on the welfare of its middle class and élite alone. Its democratic constitution demands a better deal for its less privileged.

A popular answer to the dilemma is decentralization. However, decentralization is no panacea for the ills of the health care system, which also requires appropriate public health measures, state support and efficient personnel. For decentralization to succeed in the Indian context, it has to be a process of devolution of power and not just delegation of responsibilities by the centre to the periphery. The former involves sharing of decision-making power and control over resources, not just administrative decentralization or shifting

Table 6 Some selected demographic indices in India

		Life expectency				
	TFR	male	female	CBR	CDR	IMR
1951	6.0	37.2	36.2	40.8	25.1	148
1961	5.7	44.2	42.7	39.3	18.9	138
1971	5.0	50.9	50.2	37.1	17.0	120
1981	4.5	55.4	55.7	37.2	19.0	110
1991	3.8	58.1	58.6	29.5	9.8	80
1996	3.5	59.0	59.7	27.4	8.9	72

CBR, crude birth rate; CDR, crude death rate; IMR, infant mortality rate. Source: GOI, *Ninth Five Year Plan*, 1997–2002 (Draft), Planning Commission, New Delhi.

the responsibility of resource mobilization, which often has a negative impact on the periphery – especially on the poor within these regions.[33] Devolution will simultaneously require strengthening of grassroots democratic institutions, such as the Panchayati Raj Institutions of local self-governance.[34]

The NGOs too can only play a limited role, as their strength lies in their specificity and innovative approaches. This specificity of action, small population coverage and dissimilar programmes limit the effectiveness of NGOs for public health work that requires extensive coverage, co-ordination and an inter-sectoral approach towards health services. The majority of externally funded NGOs are often involved in the implementation of RCH- and AIDS-related programmes. They are often projected as the representatives of civil society. The fact is that RCH and AIDS are not central public health issues, nor are NGOs the sole voice of civil society.

Adequate investment in the health sector to raise it above the present 1.2 per cent of GNP[35] is a necessity if the present health care system is to be rejuvenated and reformed. It is worth while remembering that even though external funding constitutes a fraction of the total investments in health,[36] it is being allowed to distort national priorities. The health sector brings in soft loans and has been used in the past as a means to obtain hard currency for the country.

The sectoral reforms will have to be based on the accumulated experience of the past and on adequate health services research. Similar exercises have been performed to attain these aims in the past[37] and this knowledge base needs to be consolidated and reused. There is an urgent need to define the responsibility of the State towards all people and to translate this commitment into practice. Once the limits of State responsibility are defined in epidemiological, economic and political terms, the role of the private sector can be defined. Steps towards its rationalization, standardization of quality of care and evaluation may then lead to a desirable public–private mix where the private sector also has some responsibilities and not just the privileges and profits. International support is important, but it must be in line with the needs of the public sector health services and not at their expense. Ignoring these issues means avoiding some unpalatable health indicators. For the first time in independent India, the crude death rate has remained almost unchanged over the last decade.[38] The infant mortality rate in urban areas, which was 50 per cent in 1990, increased to 52 per cent in 1994.[39] These trends call for more sensitive and appropriate reforms than those put in place in the 1990s.

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