

The Goal : Health for All The Commitment : All for Health*

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ABSTRACT

Primary Health Care was the means by which Health for All by the Year 2000 AD was to be achieved. And Health for All was possible only if All were mobilised for Health. This meant not just governments and medical establishments, but people themselves. Primary health care is essentially health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford. And in working for such positive health, the role of health experts or doctors is the same as that of a gardener faced with insects, moulds and weeds. Their work is never done. Primary health care is a health conscious people's movement. Its implementation depends on knowledge of proper disposal of services and a persistent demand from an active and quality conscious consumer-the public. Strong political will, community participation and intersectoral coordination are its basic principles. However, the National Health Policy of India, 1983, was hardly debated in both houses when tabled. Both NHP 1983 and 2002 failed to confer the status of a Right to health, while most other nations are planning newer strategies to put Right to Health and Medical Services into practical use. Community participation in health is an aphorism that awaits genuine realisation in many countries of the world, notably of the third world. India, unfortunately, is no exception. Progressive Five Year Plans in India have reduced percentage spending over health as a part of GDP, which is an alarming state of affairs. Public awareness and activism alone can remedy this alarming condition. The people should not forget that health is not only a commodity that a benevolent government/ institution/ individual bestows on them. It has to be earned and maintained by the individual himself. Health problems cannot be solved in isolation. They will ultimately be part of our struggle for an egalitarian society, because better health care is a sign of a more evolved one.

Key terms : Primary Health care, National Health Policy, Health, Right to Health, Health for All by 2000 AD, Alma Ata Conference

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Introduction

*DROP ME DOWN IN AFRICA, or Asia or Latin America. You
give me US dollars 20 a head of the population I'm going to serve.
And I'll show you we can produce a miracle.**

'We can do it!' He said further, in the context of health development, 'and with the resources we have, if we can only mobilise the minimum of international solidarity' (Walgate, 1988).

The optimism of the man could not but have percolated to the office that he held. And to its policy-making. But inspite of such honest proclamations and the realisation that there is an organic relationship between health and human advancement, most community health care delivery systems contain an overload of pessimistic and demoralised staff members. This is specially true of developing countries. It is a huge infrastructure, but a sleeping one. And one that moves only on external motivation. And incentives.

How should we, then, view WHO slogans like 'Health for All — All for Health'?** It is catchy as such slogans go. It takes the ball out of the medical man's court and almost challenges the people to accept it in theirs. 'Beginning with people, not doctors', as the retired WHO Chief said, 'turning the whole thing upside down... It is a question of whether you have the political guts to trust people, to allow ordinary people to decide the way the money is being spent in health care' (*ibid*).

There's the rub. And a big one at that. It involves fighting not only established dogma but the bureaucratic infrastructure of the medical establishment with its paraphernalia of medical institutions, the drug industry, and the enormous socioeconomic clout that both wield.

Health for All by 2000 A.D.

In 1977 the 30th World Health Assembly resolved that the main social target in coming decades for Governments, as for the WHO, should be 'the attainment by all citizens of the world by the year 2000 A.D. of a level of health that will permit them to lead a socially and economically productive

* Dr Halfdan Mahler, erstwhile WHO Director General for 15 years (Walgate, 1988). Make it \$ 80 according to today's standards(- eds.).

** The WHO usually issues a message for the year on World Health Day, April, 7, every year. This was the message given by Dr U. Ko Ko for World Health Day, 1988, New Delhi Regional Office for South East Asia, p. WHO/1988/2. But it is a slogan worth analysing today to find out how far we have reached in this direction and where do we go from here.

life' (WHO, 1979). This goal got coined into a slogan *Health for All by the Year 2000 A.D.* Health for all meant that every individual should have access to *Primary Health Care* — a very important concept which we shall discuss later — and through it to all levels of a comprehensive health system. An year later, in 1978, the famous Alma Ata World Conference identified *Primary Health Care* as the key to the achievement of *Health for all by 2000 A.D.* In May 1979, the World Health Assembly endorsed the Declaration of Alma Ata and invited Member States to formulate national policies, strategies and plans to attain this target. One of its important guidelines was that each Member State should have a National Health Policy (NHP).

Now, the WHO definition of health is not how health is commonly understood. Health as the absence of disease is a negative definition. The WHO, in the *Preamble* to its Constitution, defined it positively way back in 1948 and threw a challenge to community workers to construct suitable models of health care:

*Health is a state of **complete** physical, mental and social **well-being**, and not merely an absence of disease or infirmity. (Emphasis added.)*

This definition encouraged researchers to work out positive parameters of health, which they did. For example, the parameters of *physical* health were (Crew, 1965):

A good complexion, a clean skin, bright eyes, lustrous hair with a body well clothed with firm flesh, not too fat, a sweet breath a good appetite, sound sleep, regular activity of bowels and bladder and smooth, easy, co-ordinated movements. All the organs of the body are of unexceptional size and function normally; all the special senses are intact; the resting pulse rate, blood pressure and exercise tolerance are all within the range of "normality" for the individual's age and sex. In the young and growing individual there is a steady gain in weight and in the mature this weight remains more or less constant at a point about 5 lbs. more or less than the individual's weight at the age of 25.*

Mental health meant (Laycock, 1962) :

- i) *Freedom from internal conflicts. No internal wars, no self-condemnation or self-pity.*
- ii) *One well-adjusted with others. Who accepts criticism and is not easily upset. Who understands the emotional needs of*

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- WHO definition of health (1948).

*By sweet, the author means pleasant or odourless, not sweet like that of a diabetic - eds.

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others and tries to be considerate and is courteous in his dealings with them.

iii) One with good self-control. Not overcome by emotion; not dominated by fear, anger, love, jealousy, guilt or worries. Who faces problems and tries to solve them intelligently.

Social health took account of the social and economic conditions and wellbeing of

the individual in the context of his social network, his family, his community and his nation. This definition of social health was modified in 1978 to include the ability to lead a socially and economically productive life (WHO, 1978). Many factors of social wellbeing are yet to be identified (Ahmed and Coelho, 1979), to rectify which lacuna the 29th World Health Assembly took note of the importance of *social health* (World Health Assembly, 1975). A useful definition which resulted was that by Donald *et al* (1978), 'social health is the quantity and quality of an individual's ties and the extent of his involvement with the community.'

As should be immediately obvious, the WHO definition of health mentioned earlier is idealistic rather than realistic. Ideal health will always remain a mirage. Health in this context is to be considered a potentiality — to be promoted, to be supported, for the maximum good of the maximum number. In working for positive health, the role of health experts or doctors is the same as that of a gardener faced with insects, moulds and weeds. Their work is never done (Dubos, 1969).

Primary Health Care

Primary health care therefore became the major thrust of the WHO. It was also professed to be the Primary objective of the Indian health sector during the Sixth Five Year Plan (1980-85) and subsequent plans. The National Health Policy 2002 also accords primacy to preventive and first line curative initiatives at the Primary Health level (Govt. of India, 2002). The approach during the Ninth Five Year Plan (1999-2002) was to improve access to and enhance the quality of Primary Health Care in urban and rural areas by providing an optimally functioning primary health care system as a part of Basic Minimum Services (Govt. of India, 1999). 'On Primary Health Care', is the answer the WHO Chief gave when asked how he would spend the 20 dollars a head that he asked for (Walgate, 1988). Essentially speaking, Primary Health Care involves activities that prevent the occurrence of disease itself. This is in keeping with the philosophy of positive health, not just control or cure of sickness. Most of modern medicine has directed efforts and expertise

at the secondary level, that is, after the disease has set in, to prevent distress and disability, and/or to rehabilitate. Primary health care seeks to obviate this need itself. If one can act before the disease sets in, if it is prevented, what need for medicine-diagnosis-treatment?

Even if it can never totally do so, it ensures a lesser need for such services. As should be obvious there is a major problem here. Although unobjectionable in theory, it creates practical difficulties. Apparently it seeks to undermine the clout of modern medicine and its appendages. This is hardly a situation that could arouse enthusiastic participation from either the medical establishment or the average professional medical man, though quite a few right thinking may accept it, even work for it. Secondly, it lays great faith in the people's ability to mobilise activities for their own health care, of course with guidance from community health workers and active participation of a health conscious government. Obviously we are still far from either, in India as in many other third world countries.

For this the major need is mobilisation of community and people's support to work for their own health. The emphasis is on disease prevention by immunisation, proper diet, hygienic living conditions and sewage disposal, greater health awareness and health education by educational institutions, more involvement of mass media, the governing bodies, and social and environmental activists, amongst health professionals as well as others.

Primary health care is essentially health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community (WHO/ UNICEF, 1978).

Primary Health Care is therefore a health conscious people's movement. Its implementation depends on knowledge of proper disposal of services and a persistent demand from an active and quality conscious consumer — the public.

Sad story

Strong political will, community participation and intersectoral coordination are the basic principles on which primary health care is based. A direct result of this in India was that since the Alma Ata Declaration of 1978 occurred during the

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Fifth Five Year Plan (1974-79), a clamour was raised within medical circles and outside for the Union Government to declare a National Health Policy (NHP). The Indian Medical Association (IMA) at its central meeting had already strongly voiced this an year before the Alma Ata Conference, initiating a countrywide movement through debates, seminars etc. Leaders of all political parties took part in a national debate held at IMA headquarters, New Delhi, demanding an early declaration

of a National Health Policy (Dutta, 1988). Close on the heels of this came the Alma Ata Declaration urging every country to have a declared NHP. The Indian Government then set working and announced its first NHP in 1982 which was formally approved by the Parliament in December 1983.

Now comes the sad part of this story. Strangely, when the bill was tabled there was hardly any discussion in both the houses. This showed lack of interest and/or poor awareness of something that should have been immediately perceived as of vital importance to the nation. One knows how non-enthusiasm amongst legislators guarantees non-functioning of the best of policies. The draft policy was hardly debated even on the floor of the state legislatures. The premier all India body of medical practitioners, the Indian Medical Association, was never consulted at the formulation stage and therefore could put forward criticisms only at the final stage, which, in an already callous atmosphere, proved of little avail.

National Health Policies (NHP, 1983; NHP, 2002)

The NHP, 1983, was a half-hearted attempt to synthesise recommendations of three important earlier committees, the Bhore Committee of 1946 (Government of India, 1946), the Mudaliar Committee of 1962 (Government of India, 1962), and the Shrivastav Committee of 1975 (Government of India, 1975, 1976). The Bhore Committee, 1946, set up before India's independence, concentrated on preventive medicine and tried to link health with social justice. It gave some surprisingly pragmatic directions. The Mudaliar Committee (1962) concentrated on medical education and development of training infrastructure for

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- WHO

static medical units. The Shrivastav Committee (1975) urged the training of a cadre of health assistants to serve as links between qualified medical practitioners and multipurpose workers (e.g. school teachers, post masters, *gram-sevaks*, etc.). While the NHP 1983 reiterated the pious resolution of taking health services to the doorstep of the people and ensuring fuller cooperation of the community, it failed to even declare health care as a fundamental right of the people. The WHO in its *Preamble* (1948) states, 'The enjoyment of the highest attainable standard of health is one of the fundamental Rights of every human being without distinction of race, religion, political belief, economic or social condition'. The General Assembly of the UN in its *Universal Declaration of Human Rights* the same year listed the *Right to better living conditions* and the *Right to Health and Medical Service* as vital Articles. But the NHP 1983 of India failed to say so categorically. This, when the *Directive Principles of State Policy of the Constitution of India (Part IV)* state, 'The State shall regard the raising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties'.

Russia was the first country to give its citizens a constitutional right to all health services. The French Constitution of 1946 'guarantees to all... protection of health'. In 1965-66, the Social Legislation in the United States declared health a human right. The 89th US Congress changed the concept of health maintenance from an individual to a social responsibility by enacting *Medicare* and *Medicaid*, and Comprehensive Health Planning from 'the womb to the tomb'. Most nations are continuously planning newer strategies to put the Right to Health and Medical Service into practical use. But both the NHP of India 1983 and 2002, failed to even confer the status of a 'Right' to Health. Both have some worthwhile proposals, no doubt, but the major social thrust and vision to convert their commitment into a Right is still lacking. This is due to poor awareness amongst the planners and bureaucratic circles, lesser demand from a community unaware of its fundamental rights and a medical establishment which seeks to wallow in its short-sighted establishment propagation strategies. While goals of medicine

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worldwide have changed from curative to preventive, preventive to social, and social to community medicine, India has still to reap the benefits of this philosophy to any significant degree. Community participation in health is an aphorism that still awaits genuine realisation in many countries of the world, notably of the third

world. India unfortunately is no exception. This, in spite of the fact that through the framework of the Ninth Five Year Plan (1997-2002), new initiatives were supposed to be taken to achieve the following (Park, 2003; p638) :

- a. *Horizontal Integration of vertical programmes;*
- b. *Develop disease surveillance and response mechanism with focus on rapid recognition report and response at district level;*
- c. *Develop and implement integrated non-communicable disease control programme;*
- d. *Health impact assessment as a part of environmental impact assessment in developmental projects.*
- e. *Implement appropriate management systems for emergency, disaster, accident;*
- f. *Screening for common nutritional deficiencies especially in vulnerable groups and initiate appropriate remedial measures;*
- g. *Reduction in the population growth rate has been recognized as one of the priority objectives. It will be achieved by meeting all felt-needs for contraceptives and by reducing the infant and maternal morbidity and mortality so that there is reduction in the desired level of fertility; and*
- h. *Implementation of reproductive and child health programme by effective maternal and child health care, increased access to contraceptive care; safe management of unwanted pregnancies; nutritional services to vulnerable groups; prevention and treatment of RTI/STD; reproductive health services for adolescents; prevention and treatment of gynaecological problems; and screening and treatment of cancers, especially that of uterine cervix and breast;*

And the pious proclamations of the National Health Policy 2002 of Goals to be achieved by 2015 (Govt. of India, 2002). See Table 1:

Table 1 National Health Policy - 2002 Goals to be achieved by 2015	
- Eradicate Polio and Yaws	2005
- Eliminate Leprosy	2005
- Eliminate Kala Azar	2010
- Eliminate Lymphatic Filariasis	2015
- Achieve Zero level growth of HIV/AIDS	2007
- Reduce mortality by 50% on account of TB Malaria and other vector and water borne diseases	2010
- Establish an integrated system of surveillance National Health Accounts and Health Statistics	2005
- Increase health expenditure by Government as a % of GDP from the existing 0.9% to 2.0%	2010*
- Increase share of central grants to constitute at least 25% of total health spending	2010
- Increase state sector health spending from 5.5% to 7% of the Budget	2005
- Further increase to 8% of the Budget	2010

Adapted from Park (2003, p635).

In the concept of positive health, man must cease to be the target of disease or preventive measures. He becomes a *collaborator*, an active person who accepts responsibility for his own health. Hence greater involvement of families and communities in health matters is a must. Here health care *for* the people changes to health care *by* the people. As the eminent medical historian Henry Sigerist said way back in 1941 (Sigerist, 1941):

The people’s health ought to be the concern of the people themselves. They must struggle for it and plan for it. The war against disease and for health cannot be fought by physicians alone. It is a people’s war in which the entire population must be mobilised permanently.

In the past, people were neglected as a health resource. They were merely looked upon as sources of pathology or victims of pathology and consequently as targets for preventive and therapeutic services. This negative view of people’s

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* The government does realize that health spending as % of GDP must increase to 2% but it depends on the people to voice this need strongly enough for power wielders to be motivated to act. - eds.

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role in health has slowly but surely changed. Now people work towards keeping their own health, they struggle and plan for it and take proper responsibility of looking after it.

'Forgetting' Health

Perhaps in India health planning has only followed what happened to health care as a concept decades ago at the international level. Although health is one of man's most precious possessions, we must know that health was "forgotten" when the *Covenant* of the League of Nations was drafted after the First World War. Only at the last moment, was 'World Health' brought in. Health was again "forgotten" when the *Charter* of the United Nations was drafted at the end of the Second World War. The matter of health had to be introduced *ad hoc* at the United Nations Conference at San Francisco in 1945 (Evang, 1967). Thus even in the scale of values of a body like the UN it cannot be said that health occupied a prominent place. No wonder then that it is easily side-lined due to pressure almost everywhere. Health is often taken for granted and not fully appreciated till it is lost. The modern thought that health is not merely a precious possession, but also a resource in which the whole community has a stake and which it is desirable to maintain and promote, has still to percolate to the individual and collective consciousness of the Indian people and its governance.

Probably our History has a role to play here. One of the two indigenous systems of medicine, *Ayurveda*, was highly advanced during the Vedic period and Emperor Ashoka's time. But it underwent an eclipse with the Moghul invaders who brought in the *Unani-Tibb* system with them. The British halted the progress of both. They established an infrastructure for their own people (and the 'natives' who served them) by bringing in the 'Allopathic' system. The rest of the country was left to its own fate — the system of indigenous or home-made medicine that never underwent any upgrading. Some benevolent *Zamindars* set up charitable dispensaries/hospitals, as did some missionary organisations. But they served only certain sections of the population. Establishment of Medical Colleges and Hospitals paved the way for modern medicine in India for which the British deserve due credit. But it served to further stunt the growth of the indigenous systems. They were looked down upon. Prejudice and lack of patronage encouraged quacks and charlatans to monopolise and

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further discredit these systems, a state from which they have never really been able to look up.

The training centres for medical and paramedical personnel set up by the British were on the lines of their own country. They became incurably elitist and created a firm though artificial barrier between the common man and the products of such institutions.

The medical centres became preserves of donors and founder-philanthropists. They sincerely attempted to run these institutions along British lines after the British left, but could not in any way involve the community as a whole in the planning, propagation and working of these institutions.

To offset the static and elitist nature of this colonial reality has been the major thrust of community medicine all over the Third World. Hence the slogans "Primary Health Care" and 'Health for All'. The Chinese came up with their concept of 'barefoot doctors' which has had its own significant role to play. India experimented with *Multi-Purpose Health Workers* (MPW), recommended by the Kartar Singh Committee of 1973; (Government of India, 1973), a sort of barefoot doctor-cum-immunising technician cum -health educationist-cum- family planning advisor. The scheme envisaged that by the Sixth Five Year Plan (1980-85) there would be 2 MPWs, one male and one female, at each sub-centre to serve a population of 5000. Though the scheme is claimed to be implemented vigorously by the Ministry of Health and Family Welfare even today, it has still to be popularised and mounted on a war footing because of obvious difficulties that such schemes enter into with policy planners — both amongst the august medical bodies and the government. The former is more concerned with upholding medical standards and understandably scoffs at such schemes. The government which could have promoted this and similar schemes hardly gives health planning the pride of place that it deserves. Even a cursory look at the Health Budget will show that in progressive Five Year Plans its percentage has been decreasing (from 3.33% for the First Five Year Plan, 1951-56, to 1.9% and 1.7% for Sixth and Seventh Plans 1980-85 and 1985-90, respectively; and a measly 0.95% for the VIII Plan (1992-97).^{*} Since community medicine lacks both the glamour and the clout that the curative medical establishment has in ample, it is only natural that primary health care, health planning and implementation remain more a dream goal than a reality in India.

^{*} Figures for IX Plan (1997-2002) and X Plan (2002-2007) not available, but may be expected to reduce further. Percentages calculated from Table 3 given by Park, 2003, p639. .

Better health care is the sign of a more evolved society. Health problems cannot be solved in isolation. They will ultimately be part of our struggle for an egalitarian society.

In sum, as things stand, there cannot be Health for All in this country unless the people unite and raise the slogan All for Health. If the goal is Health for All, the commitment has to be All for Health. They will have to become more aware of their health rights and obligations and will have to stress this need through various social-welfare, consumer and political bodies. And

we need a government having the political will to put these aspirations into practice. That this is no mean expectation should be obvious considering the apathy, callousness, and cover-up that resulted after the Bhopal tragedy. Moreover the people should not forget that health is not only a commodity that a benevolent government/institution/ individual can bestow on them. It has to be earned and maintained by the individual himself. And for this it is essential both to motivate individuals to accept responsibility for their own health as also to sufficiently deprofessionalise medicine so that such motivated laymen can play a greater role in their health care, without jeopardising the legitimate importance of the health care professional in the field. How these could be brought about should engage the attention of at least some of those who have the welfare of this nation's population at heart.

Medicine and Commitment

Medicine began as an art and gradually evolved into a science over the centuries. It was conceived in sympathy and was born out of necessity. It is based on intuitive and observational propositions. It is the cumulative experience of the medical man and his branch. It has drawn richly from traditional cultures of which it was a part, later on from biological and natural science, and more recently from social and behavioural sciences. Its principle value is health and its only worthwhile goal can be 'Health for All'. Any account of medicine at a given period must be viewed in relation to the civilisation and human advancement at that time. It is intimately related to their philosophy and religion, economic conditions, form of government, education, value accorded to scientific attitude, and the aspirations and awareness of the people.

Better health care is the sign of a more evolved society. Moreover, health problems cannot be solved in isolation. They will ultimately be part of our struggle for a more egalitarian society. Neither can it be done by passing the buck. The government can conveniently pass on the blame to the people's ignorance and the medical man's noncooperation. The people can equally conveniently blame the government's ineptitude and the medical man's dereliction of duty. And the medical man can equally well blame the government's callousness and the people's lethargy.

The time for such games-playing is past. Only a popular realisation and an active movement of All for Health can ensure the benefits of medicine and Health for All.

This is a commitment in honour.

As is said, "*Politics is too important a matter to be left to politicians*", we may similarly say, "*Health is too important a matter to be left to doctors, and governments, alone.*" *

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* Adapted from, "*War is too serious to be left to the generals*", Charles - Maurice de Talleyrand (Attr.)

Questions that the Sixth Monograph Raises

- Q1. How can we bring about greater health awareness amongst people ?
- Q2. How can people take charge of their own health ?
- Q3. How far has primary health care as a concept succeeded all over the world? In the developing countries? And in India?
- Q4. Why is there a lack of political will in India about health problems? How can it be remedied?
- Q5. Do people really care what governments do with regard to health? Do governments really care what people need with regard to health? Do medical people really care what governments , and people, do with regard to health?
- Q6. What specific thrust areas need to be targeted in the current X Five Year Plan (2002-2007), and subsequent plans, to increase health spending and bring about proper utilization of health-funds by the Center and States?
- Q7. How far have we reached in the direction of Health for all by the Year 2000 (It is already 2004, remember)? And where do we go from here?
- Q8. Will we ever have governments, people and medical establishments actively cooperating to bring about better health care for the citizens of this country?
- Q9. What should doctors and medical institutions do?
- Q10. What should governments do ?
- Q11. What needs to be done to make health and education a hard-core political issue from the soft one it is today?
- Q12. How can we ensure a Right to Health for the Indian citizens too?
- Q13. How can we ensure that education, health and employment become the focus of attention in developing societies like India?
- Q14. What specific efforts need to be put in to increase health spending from 0.9 % to 2% of GDP?
- Q15. Are policies like *medicare* and *medicaid* viable in India?)