People's Partnership for Health Towards a Healthy Public in India

Community Health Needs

THE AIM OF THE HEALTH SYSTEM IS TO HELP EVERY MEMBER OF THE COMMUNITY to be and to remain as healthy as possible given the resources available. It has become increasingly clear that this can not be done through a paternalistic approach of delivering health to the people; the people must be partners in achieving health, the governments' role being that of facilitator and catalyst. Active participation by the people should be an essential element of all (public sector) health systems and in this paper it is assumed that this component will be taken as a first step. All other aspects discussed can only achieve optimal efficiency along side an active partnership with the community.

To achieve this aim of a healthy population, the community has to adopt a healthy life style, live in a life sustaining environment (especially quantitatively and qualitatively adequate water and effective sanitation), have access to preventive care and establish a system for the early detection and prompt response to potential and actual disease outbreaks. In addition, and not instead, the community requires access to curative care at an appropriate level. Though curative care is needed as there will always be breakdowns in health including injuries and disease, it is most important that the system plan to have a major focus on health promotion, preventive measures and water and sanitation. Health decision makers must resist the temptation to be swayed by the glamour of high-technology tertiary curative initiatives to neglecting health related measures in favour of disease linked interventions.

Curative care does not lead to the health of the community; it merely helps to manage the breakdowns in health. To maintain health the system has to be geared to provide preventive and promotive health and subsequently any deviations from health can be tackled by the curative system at the individual level and by public health measures at the community level. In all interventions the role of the people themselves must remain at the fore. Effective health care, whether delivered in the community or in the most advanced tertiary care institution ultimately depends upon the active participation of the recipients of the care. Unless the people are actively involved, they and the community can not be healthy.

Another look is suggested to re-align India's health priorities. Today only 0.9% of the GDP is allocated to health, a proportion far less than many less developed and poorer countries than India. To make the situation even more stark, it must be remembered that of even this grossly inadequate allocation, a large proportion is spent on urban tertiary care and only a minor share is allocated to health care for the rural areas. Of this latter proportion the majority is dedicated to curative care leaving preventive and promotive interventions at the tail end of the budget allocation.

The increasing role of the private corporate sector has further accentuated the disparity; the disparity between rich and poor, urban versus the rural, tertiary care versus primary care and the disparity between curative versus preventive / promotive interventions. The opening of many large deluxe hospitals has resulted in the affluent having many additional options for health care but the poor in slums and the rural community seem to have been forgotten. It is worth noting that many if not most of these deluxe institutions have been directly or indirectly heavily subsidised from the public exchequer.

Improving the health status of the community is desirable not only because healths itself is an objective worth striving for, but also for very sound economic and social

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reasons. A healthy population is not only a happy and contented population with a good quality of life, but it is a more productive population. Keeping people healthy also is cost effective because sickness is very expensive not only in terms of direct costs but also because of loss of productivity. Therefore not only the individual and family but the State also incurs expenditure in managing illness. Preventing disease and promoting health pays many dividends.

Various evaluations of the state of health in India have confirmed that even though there have been very significant improvements in many health parameters, the state of health of large segments of the population are very far from satisfactory. India can be proud of the fact that the expectation of life at birth has doubled since India became Independent. Other parameters that have shown marked improvement include the infant mortality rate, child mortality rate, maternal mortality etc. However these same parameters show that the benefits of improvement in health status are not uniformly available in all parts of the country, particularly to the poor. In health and in health care the divide between urban and rural, between rich and poor is very real and marked.

In the 57 years since Independence the laudable and far-sighted recommendations of the Sir Joseph Bhore committee have largely been forgotten and health care in India has become dangerously skewed towards tertiary level curative medicine. Even the Alma Ata Declaration that India was a signatory to, did not serve as a catalyst to bring about a mid-course correction in emphasis.

While some communicable diseases have been eradicated, most notably small pox and Guinea Worm, others are still far too common and play an important role in the morbidity and mortality experience in the country. While the usual communicable diseases still contribute a great deal of morbidity and even mortality, especially for women and children, the position has actually got more severe with the onslaught of new and re-emerging diseases. NACO estimates that India already has 5.1 million HIV infected persons. The position of Malaria and other vector borne diseases such as dengue, filarial and Kala Azar are also alarming. India even today remains one of the most important holdouts in the battle to eradicate polio and has more Leprosy and Tuberculosis cases than any other country in the world.

At the same time the augmented longevity of Indians has allowed increasing numbers of people to reach an age where non communicable diseases become an important cause of morbidity and even mortality. The demographic transition has resulted there being a larger cohort of older people and therefore more diseases associated with that age group. In absolute numbers there is an increase in the numbers of people with non-communicable diseases. The demographic change has acted in consonance with the ill-effects on health brought about by a changing life-style and pattern of nutrition. Obesity and a largely sedentary life is showing its affects; cigarette smoking, alcohol and drug use have become more acceptable and all these factors taken together have resulted in a manifold increase in the life-style associated diseases.

The prevailing view appears to be that 'health' is a part of the largesse that can be doled out by the government. Unfortunately this opinion is not limited to health care decision makers but has now come to be accepted even by the community. The government has tried with out success to provide 'health' to the people for many decades. An urgent need is for the health care decision makers to come to terms with the fact that 'health' is not a commodity that can be doled out to a passive community. People are not currently treated as important partners in the general plan for improving health in the country. To be healthy the community has to take an active or even pro-active role and the governments' major role should be as a partner in health care that plays a catalytic role and in addition helps by providing infra-structure and human resources.

Ill-health is increasingly realised to be a manifestation of the interaction of a multiplicity of factors - biological, nutritional, socio-cultural, environmental. The multiplicity and complexity of causal factors explains why ill-health as not amenable to simple technical fixes that the doctor can administer within his ward or hospital. Medicines, injections, and even vaccines can not ensure health; to have a healthy population requires an active role by the people themselves with attention to a multitude of correctional interventions.

Even in the case of bacterial or communicable disease, the presence of the bacteria is only one of the factors that are required before disease manifests. Without the specific disease causing organism a communicable disease does not occur; but the presence of the concerned organism does not necessarily result in disease. Tuberculosis is an obvious example. The mere presence of the tuberculosis bacteria in the body is not automatically followed by the disease tuberculosis. Tubercular disease results when a multitude of factors come into play and thus permit the disease to gain a foothold in the body.

The prevention of the disease tuberculosis therefore offers several options. Obviously there can be no disease if the bacillus does not enter the body, but this difficult to attain at the community level. It is also possible to prevent the disease by increasing the body's resistance to the organism either specifically (by immunisation) or in general (by a healthy life-style).

We do not have specific vaccines for many diseases. HIV is one such example as there is no vaccine available as yet. But the disease can be totally prevented by adopting a life-style that does not expose one to risk of infection.

Malaria that affects so many millions of persons all over the world is another example. We do not have a specific vaccine against malaria yet but it can be controlled by preventing the breeding of the mosquitoes that act as the vector for transmitting the plasmodium from an infected person to a susceptible person by doing away with breeding places, or by introducing larvivorous fish such as the Guppy or Gambusia. Adult mosquitoes can be killed by residual insecticide spraying on their resting places or even by space sprays. The disease can also be prevented by not allowing mosquitoes to bite susceptible people by using bed-nets or insect repellents. There are many options available to prevent malaria but in almost

all of them the active cooperation by the community itself can make the difference between a successful effort and an expensive exercise in futility. Even a widespread and efficient curative facility for the treatment of those suffering from malaria, will have little impact on the prevalence of Malaria in the community!

These examples are there not only for communicable disease. With the demographic change now manifesting India is starting to have a serious problem of non-communicable diseases such as coronary artery disease. The solution is not to focus exclusively or even largely on developing intervention facilities for angioplasty and bye-pass surgery, but to make a serious effort to initiate life-style changes at an early age. Exercise and physical fitness must be encouraged, obesity treated as a disease and a diet conducive to sensible lipid levels adopted. Together with avoiding smoking these interventions will do more to reduce the burden of coronary artery heart disease for the people than the setting up expensive tertiary care facilities for cardiac care and bye-pass surgery!

A Columbia University project estimated the consequences of Cardiovascular disease in developing countries. India was one of the five countries studied (A Race against Time - KS Reddy editor). They reported that in 2000 India was loosing 9,221,165 person years of life due to cardio-vascular diseases. This figure was estimated to rise to 17,937,070 by 2030! The economic consequences of loosing over nine million person years of life can be imagined. Another way of looking at the same data is by expressing the burden of disease in terms of DALYs or disability adjusted life years lost due to cardiovascular disease. The Global Burden of Disease study estimated that India lost 28.6 million DALYs due to CVD in 1990. Initiating preventive promotive interventions to reduce the burden of disease due to CVD is likely to pay much greater dividends than establishing only treatment facilities to cater to the consequence of heart disease.

What we need to address community health needs is a greater emphasis on areas such as preventive and promotive health, nutrition, water and sanitation, a system of prompt detection of and response to disease outbreaks and factors predisposing to ill health. At he same time a healthy life-style including curbs on tobacco and drug use, judicious exercise will have to be promoted. These are all factors that fall under the rubric of Public Health measures.

It is not contended that tertiary care hospitals are unnecessary but that preventive and promotive health care interventions properly implemented can not only improve health but prevent conditions that would need heroic interventions to save life. Preventing heart attacks is better than doing coronary bye-pass surgery. Because there will always be instances when prevention efforts do not succeed, tertiary care institutions will be needed to provide care for those persons who have developed severe disease. However it is the balance between curative care and preventive care that has to be determined. It is manifestly wrong to ignore the prevention of ill-health and focus ones energy almost entirely on institutions with expensive technology to deal with the long term consequences of preventable morbidity. Hospitals are needed, however the system can not ignore the fact that all too often hospitals cater to the consequences arising from our failure to keep people healthy.

The treatment of ill-health can not only begin in the health care facility and neither is the treatment completed within the boundary walls of the hospital. Unfortunately too many practitioners of curative care are both physically, and more important mentally, confined to the hospital walls. Disease starts in the community and its management and treatments also comes to fruition in the community. Hospitals are monuments to disease and not temples of health; every sick individual is a reminder of the failure of the system to provide health care to the people

It is not suggested for a moment that the sick do not need hospitals and health care facilities. However until more effective measures are taken to actively promote health and prevent ill-health, we will continue to cater to our failures. Nor is it being suggested that curative care is unnecessary. Curative care is essential, but in too many cases it is essential only because we have failed to prevent sickness.

Comprehensive health care is a spectrum of activities that ranges from providing usable and understandable information on promoting health all the way to the most technologically advanced intervention at centres of excellence. Establishing a facility to do cardiac surgery and heart transplants is necessary and good, but is it not more important to set in place a system that will prevent persons from deteriorating to the extant that they need heroic interventions? Both types of investments are needed but a balance must be struck and it is manifestly both morally wrong and cost-inefficient to build curative infra-structure without putting in an even greater effort to prevent disease or to stop its progression as soon as possible.

There have recently been some statements from the highest level of decision makers promising an increased allocation for health. That is good and a step in the right direction. Care must be taken however to ensure that the increased budget is not spent in the same proportion as the existing outlays and thus further accentuate the gap between tertiary curative infrastructure and Public Health services for urban slums and rural community's. It is essential that urgent action is taken to correct the gross discrepancy between the allocations for curative versus that for preventive/promotive care.

There are powerful lobbies that suggest that the governments' role is limited to primary care and public health and that all curative care, certainly tertiary level care, should be left to the private sector. Perhaps the advocates of such an arrangement forget that some 37% of our population live at or below the poverty line. Private sector health care would be completely out of their reach. This tenet also completely ignores the right to health care ensured by our constitution.

In a country like India it will be unthinkable to invest in primary care for the poor and disadvantaged without making tertiary care available to those that need such interventions. Morally a focus on primary care facilities for the rural and slum areas can only be justified if a system is developed

alongside to provide higher levels of care to those that need it. Of course the other side of the coin is that without an efficient and functioning primary care set-up, India will not be able to afford the cost of tertiary care. Tertiary care must be available to those whose condition needs specialised care, rich or poor. In such cases tertiary level care can be provided to the poor either at heavily subsidised public sector supported institutions or at private sector hospitals through a mechanism of State support or health insurance. But a health system that does not provide tertiary level care to those poor and needy persons who need it and yet caters to the affluent is wrong and should be unthinkable. The provision by design of one level of care for the poor and another for the rich urban dweller is something that can not be condoned in any country.

The gap is not so much between the urban and rural but between the affluent privileged persons and the poor. The urban poor, the slum dwellers, are perhaps most discriminated against group in India; practically no health infra-structure is available for the slum dweller, especially the millions living in 'unrecognised' slums. These people build our cities, clean them and provide the domestic service that ensures our comfort. Yet they have virtually no access to the civic services most urban people take as a matter of right. This is an issue demanding urgent action.

Focusing on providing preventive and promotive care does not require a massive addition to the budget, but it does require funds. When a model Primary Health Centre was evaluated, Anand et al (Natl. Medical J India, 1995) reported the division of costs of running a properly functioning Primary Health Centre with a well balanced emphasis on preventive and promotive care. They have reported that curative care cost 32%, communicable disease control cost 17%, child care 17%, maternal care 11% and family welfare 10% of the total cost.

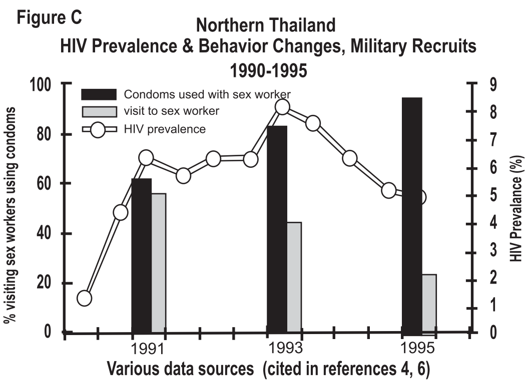
Preventive and promotive Care: Need, Efficacy and Cost

There is ample evidence that many if not most health problems of concern to the community are more amenable to management that includes community level interventions. Even that most intractable of public health problems HIV/AIDS, responds to action by the people rather than due to technical interventions. There are just a few countries that have rolled back or even arrested the progression of HIV/AIDS in the community. Thailand, Cambodia and Uganda are examples of programmes that have showed results. The example of Uganda is particularly relevant to India.

It is important to note the analysis of two of the well-known success stories in HIV. Both Thailand and Uganda have demonstrated a reduction in HIV prevalence in the general population. The 100% condom programme in Thailand was more than condom promotion; education was an integral component. The Thai data showed a remarkable fall in HIV prevalence in young army recruits. However this fall in prevalence was accompanied not only by an increase in condom use but, most importantly by a reduction in visits to sex workers.

Fig 1

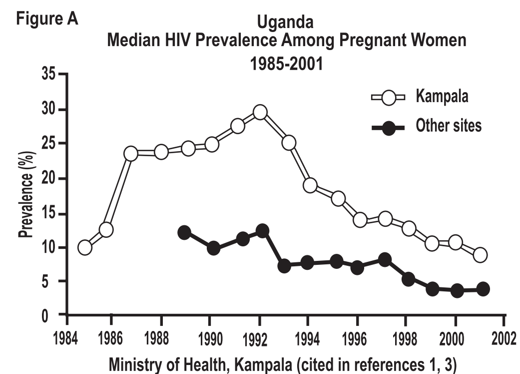
Northern Thailand



Condom use cannot take all the credit for the change in HIV prevalence in army recruits, though behaviour change played a major role in the reduction. The figure below is a composite representation of the interventions in northern Thailand. While it is clear the HIV prevalence fell after 1993 and that condom use increased, the concomitant reduction in the visits to sex workers clearly points to a change in behaviour in the community. Condom use probably played a role, but reduced access to sex workers was obviously a major factor.

Fig 2

Uganda



The data from Uganda is even more striking. There is a marked and consistent fall in HIV prevalence in pregnant women starting from a peak in 1992. Similarly detailed analysis of the data from Uganda has showed that the major fall in HIV prevalence occurred before condoms became available to the programme and before they were advocated nationally for protection against HIV infection. The change appeared to have come about largely because of behaviour change. Rates of partner exchange came down significantly and

more young persons were abstinent for longer. A matter of great interest is the fact that condom use became a part of the national programme only in 1996, long after the prevalence had started to fall. Uganda's success is attributed to an initiative by the President who decided to control the rapidly increasing prevalence of HIV/AIDS by starting a people's movement to reduce casual sex.

Incidentally a sharp contrast is provided by a bordering country - Botswana - that started at the same level but followed advice to focus on condom use. The HIV prevalence in Botswana has continued to rise until it is one of the highest levels in world, and the budget has remained comparable!

Both these examples have clearly demonstrated the great role of promotive interventions. The lives saved and the benefits to the economy of the country are immense. Of course in the example of HIV/AIDS the benefits are even starker because there is no cure for HIV/AIDS. In a rough estimate made In 1999 the cost and possible consequences of HIV/AIDS in India was estimated The following paragraph is taken from chapter 2 of the book edited by Peter Godwin.

"Estimates about the average cost of one bed day vary naturally from hospital to hospital. In the Government sector, one bed day at the All India Institute of Medical Sciences costs Re600 per day[1] . Recently the medicine costs of one hospital bed per day was calculated to be Re 250 in a government tertiary care hospital in Bombay[2]. This comes to Rupees 160 million annually. In a district hospital on the other hand the cost of one bed for one day comes to only Re200[3]. The costs in the private sector similarly vary greatly but they are in general many times more expensive than a similar bed / facility in the government sector Even if we take a figure at the lower end of the range, the 57 million bed days would cost Rupees 11400 million"

It is worth noting that these estimates of the cost of care were made using an estimated 1.75 million infected and did not include the cost of anti-retrovirals. Today India estimates that we have 5.1 million persons living with the virus, the cost of hospital beds has gone up and India is committed to the provision of anti-retroviral drugs.

In a paper published in Health Policy (47 (1999) 195-205) we estimated that the cost of HIV to the nation would range from 6.73 to 59.19 billion Rupees annually. It is noteworthy that the upper estimate was made on an assumption of 4.5 million infections in India. Today NACO estimates 5.1 million infections and the cost of treatment has increased manifold with the availability of anti-retroviral drugs. The sound economic rationale for a focus on preventive and promotive interventions rather than on exclusively building more and more care facilities needs no elaboration.

HIV/AIDS is of course a special case as there is currently no vaccine and no cure. But it highlights the importance of preventive and promotive care. The HIV epidemic can be controlled, Uganda has shown us how. The key is making the community partners in the venture and behaviour change through preventive and promotive interventions.

To take another example, diarrhoea, acute respiratory infections (ARI) and meningitis are three of the most common causes of morbidity and mortality in early childhood. Two-thirds of all early childhood deaths are attributable to these three conditions. The health care system manages these conditions in the community by treatment at the primary, secondary and tertiary care institutions both in the public and the private sectors. A recent study by Anand et al from the AIIMS estimated the cost of treating these conditions. It will be seen from the **Table 1** given below that considerable expenditure is involved, especially if one keeps the frequency of these episodes in mind.

Table 1

Cost of inpatient treatment of diarrhoea, acute respiratory infection (ARI) and meningitis in various settings

Disease	Level of care	Private sector Rs (Mean; 95% CI)	Public sector Rs (mean; 95% CI)
Diarrohea	Secondary	5672 (4436-6908)	1315 (1115-1514)
	Tertiary	3155 (2503-3807)	8580 (5918-11252)
Acute respiratory infections	Secondary	8261 (5886-10636)	2229 (1961-2497)
	Tertiary	4506 (3489-5522)	7598 (6143-9053)
Meningitis	Secondary	7428 (3976-10881)	1842 (460-3203)
	Tertiary	6991 (3916-10067)	17844 (15407-20281)

These data include the identification and measurement of direct medical costs, valuation of hospital costs, out-of-pocket expenditure, productivity losses (Anand et al.)

It also must be realised that it is not the State alone that incurs this expenditure; in India it is now estimated that on an average the patient bears 83% of the cost of health care.

The sad thing is that all three conditions can largely be prevented by action at the community level by a functional Public Health system coupled with active community action for health. Those cases of diarrhoea and ARI that do occur can be treated effectively at the early stages in the community setting itself.

Tobacco provides another example. It has been estimated that the cost of tobacco related disease in India in 1999 (Rath and Chowdhury, quoted in "Tobacco Control in India p135) was estimated to be Rs. 277.611 billion **(Table 2)**. The cost in 2002-2003 the cost was estimated to have risen to Rs. 308.33 billion, an increment of 11% in two years. The direct costs of caring for patients with Coronary Artery Disease and Chronic Obstructive Lung Disease gives an idea of what these conditions mean to the community.

1. Choubey PC. Add. Professor of Hospital Administration, All India Institute of Medical Sciences, New Delhi. 1997. Personal Communication.
2. Salunke, SR., 1997Director Health Services, Maharashtra. Personal communication.
3. Choubey PC. Add. Professor of Hospital Administration, All India Institute of Medical Sciences, New Delhi. 1997. Personal Communication

Table 2

Estimates of the cost of three major tobacco-related diseases for the year 2001-2002

Total cost	Rs 25,478
Cancers	
Direct cost	Rs 49,980
(+) 1%	Rs 4998
Indirect cost	Rs 300,020
(+) 9.2	Rs 27,602
Total cost	Rs 382,600
Total cost of CAD: 4.61 million x Rs 30,310 = Rs 139.7 billion	
Total cost of COLD: 40.65 million x Rs 25478 = Rs 103.57 billion	
Total cost of cancers: 0.17 million x Rs 382600 = Rs 65.04 billion	
Total cost of the three = Rs 308.33 billion	
Major tobacco-related diseases in 2001-2002 = Rs 308.33 billion	

CAD: Coronary artery disease; COLD: Chronic obstructive lung disease
Source: Reddy and Gupta 2004

Even if we do not consider the opportunity costs due to loss of manpower and reduced work efficiency, in terms of direct payments patients with CAD and COLD involves a direct loss of Rs. 8520.30 and Rs. 2257.60 to patients and their care-givers and when the losses borne by the State/Employers are considered a total of Rs. 14,909 and Rs. 11,952 is involved per patient of CAD and COLD respectively. The extant of the morbidity related to cancers, heart disease and lung disease is phenomenal and to a very significant extant preventable by a combination of taxation and vigorous behaviour change communication.

A study was carried out by Pandav of the cost benefits of the salt iodisation programme proposed for Sikkim. Iodine deficiency disease is common in Sikkim as it is in other parts of India. Iodised salt has been shown to be effective in preventing this condition. The benefits of iodised salt programme in Sikkim alone showed a total resource saving of Rs.24,406,000 with an investment of Rs.17,669,000. It is clear that preventive/promotive interventions make sense in many ways and pay real economic dividends even if we disregard the priceless benefits of eliminating the parents anguish over a cretin in the family!.

One must not make the mistake of assuming that preventive and promotive interventions do not require any funds or technical expertise. The delivery of effective health promotion requires manpower, resources and technical expertise. When Thailand was rolling back HIV infection it was spending the equivalent of US$ 45 million a year on air time alone to propagate the concept of HIV prevention (. To some extant some staff is already in place, but because of the low priority given to health promotion, even this limited resource is misused or not utilised for Behaviour Change Communication. Technical expertise is required to plan and implement cost efficient and effective interventions, only the technology required is not establishing more advanced curative facilities without investing in mechanisms to effectively deliver preventive and promotive health care. Even health communication to be effective needs to be structured correctly and that too requires skills and experience.

Focusing on providing preventive and promotive care does not require a massive addition to the total health budget, though the health budget itself does require a major increment. What is urgently needed is that the priority change from a largely curative focus to a balanced programme of providing preventive, promotive public health care rather than an over-riding allocation to urban curative care.

Even when a model Primary Health Centre was evaluated, Anand et al (Natl. Medical J India) reported the division of costs of running a properly functioning Primary Health Centre with a well balanced emphasis on preventive and promotive care. They have reported that curative care cost 32%, communicable disease control cost 17%, child care 17%, maternal care 11% and family welfare 10%. In other words at the peripheral level curative care needs only about a third of the non-salary budget, preventive, promotive interventions demand at least 2/3 of the available resources.

Health in the Community

Having discussed earlier in the document that preventive measures are effective and that though Prevention costs money the returns far exceed the investment, we will now consider possible ways to improve the health of the community. Of course this discussion will remain in the context of the basic premise that effective improvement in health and health care in the community is contingent upon involving the community itself as partners in the health system. To reiterate what has been said earlier in the document, improving the health of the community, especially of the poor in both rural and urban settings demands resources in the form of skills, a suitable structure and finances.

- First and foremost the system must be built around the concept of the centrality of the community's involvement in its own health care.
- A health promoting life style in essential for health as life-style diseases are becoming increasingly important.
- Factors such as water and sanitation play a very important role
- Disease outbreaks, and risk factors for disease must be detected as soon as possible and corrective action initiated without delay
- Easily accessible essential basic care must be available to all with referral facilities for complicated conditions

Mechanisms for Health in the Community

To meet the health needs of the community interventions are required at a minimum of five levels.

- Peoples participation in health care is the basic prerequisite.
- A system of education and behaviour change communication has to be put in place with an objective of promoting a healthy life style

- An effective mechanism for dealing with disease outbreaks has to be incorporated into the public sector health system
- Suitably trained staff with an expertise in Public Health measures must be become an essential part of the public sector health care team.
- Basic curative care and access to secondary and tertiary level care as needed

Peoples Participation or Community involvement.

To be effective and self sustaining the community itself must be involved in health care. This can take many forms, through the Panchayati Raj Institutions, the involvement of community based and non-government organisations and the involvement of people at all levels of health intervention. This must be the first change brought about in the functioning of the public sector health system. Only when the people are involved as equal partners in health care can the health system even begin to meet the health needs of the community. Doctors can prescribe but the medicine will be effective only when it is taken. Unless the people are involved in their own health care, not as passive recipients of a dole from the "authorities" but as active players the fullest benefits are not likely to reach the community on a sustainable basis. The active role of the community is more important now than ever before. The so-called "lifestyle diseases" both communicable and non-communicable are now contributing a major share of the morbidity and mortality experience of the community. These diseases, whether HIV, cardi-vascular disease, diabetes or even accidents are not amenable to prevention by conventional 'medical' interventions such as medicines or vaccines. The key to their prevention is behaviour change and this can only be achieved by the people themselves, the health system increasingly needs to assume a catalytic and technical resource role.

Education and Behaviour Change Communication

More and more the diseases that affect people are the group collectively described as 'Life Style Diseases'. Most other diseases that plague the community though not strictly speaking in the above category can also be prevented or modified by behaviour change. It is essential therefore that the public sector health team include expertise in health education and behaviour change communication.

Besides mass media efforts, the role of both the doctor and all other members of the Public Health team in one to one and small group communication can not be overestimated. As was clearly demonstrated by IEC based project in 68 districts of Bihar, Madhya Pradesh, Utter Pradesh and Rajasthan simple health messages communicated by health workers to village key persons (link persons) are effectively communicated to the community with clearly demonstrated health benefits to the community. Such measures require improved management rather than extensive infusion of funds. Some dedicated staff for communication in the form of the district Media Officer and the block extension educators are already in place as a part of the health team; they need direction and supervision to do their own jobs rather than being utilised as odd bodies.

A especial case must be made to use the school setting for inculcating the habits of healthful living right from the school age. It is these members of our society that are going to the citizens of the future and there is increasing evidence to suggest that school age children are powerful communicators who can change the way the family behaves and thinks.

Similarly college going students need information on healthy living, not only because if the need to protect themselves from many life threatening conditions but also to act as change agents and information repositories in their future lives. The sudden freedom from parental and school supervision when a student joins college, coupled with peer pressure leads many youth to experiment with tobacco, alcohol and other drugs and with sex. In the current environment of the spread of HIV and hepatitis virus in the community such 'innocent' experimentation may lead to serious or even fatal illnesses. Some Universities such as Delhi University have a system of compulsory subsidiary subjects that have to be taken by some groups. Though compulsory the marks do not count for the final result. A Health subsidiary subject is badly needed not only so that students are empowered to protect themselves for diseases such as HIV/AIDS but also to give them the facts to enable them to influence others with preventive and promotive information.

In addition to a health subsidiary, a 'University Talks AIDS' type activity can be expanded to provide preventive and promotive messages.

Early Detection and Prompt Response: Disease Surveillance

Disease outbreaks are still a feature of the health scenario in India. The major epidemics that were a feature in British India are now fortunately a thing of the past but smaller scale outbreaks are still a fact that has to be addressed by the health system. The peoples felt needs can not be said to have been met unless a system is put into place to detect actual and potential outbreaks very early and by responding promptly minimize suffering in the community.

Outbreaks of communicable disease are still not uncommon, too frequently the health system learns about them from the media or the political system. It is rare to hear of an impending outbreak detected and tackled, even more uncommon to learn of the health system taking proactive steps to abort disease epidemics.

Every disease outbreak that occurs in the community and is not tackled fast not only increases the avoidable morbidity and mortality, but also produces dissatisfaction with the health system. This in turn makes the community less likely to accept preventive and health promotive messages from the health system.

There is an urgent need to have a system in place to detect

the first signs of an impending or potential outbreak and then initiate steps to control the problem. This process needs two pre-requisites, a system in place and the expertise available to the community. Unfortunately the skills of Public Health are not a part of the public sector health infrastructure

A system that follows the usual 'medical' practise of diagnosis first and then an appropriate response is not a model that meets community needs where the first priority is control rather than diagnosis. This may seem contradictory but one must remember that John Snow controlled the epidemic of Cholera in London long before the causative organism had been identified and the more recent example where successful control measures were put in place for SARS much before the organism had been identified.

It is not implied that a proper diagnosis is unnecessary but merely that response can not and should not be delayed until the exact organism is identified and typed. Much can be done to ameliorate the morbidity and mortality in the community on the basis of general public health disease control measures once an outbreak is identified.

Early detection can best be achieved by the peripheral health staff and the community (including PRI) itself acting in consonance to bring actual and potential health problems to the attention of the health system. The current all too frequent scenario where the health system at the headquarters learns about a disease outbreak from the media or political system and then informs the peripheral health staff is obviously unsatisfactory. Information from the community should alert the local health functionaries and initiate a response mechanism without waiting for instruction from above.

The etiological diagnosis is important, but response can not wait for it to be established because so much can be done to minimise morbidity and mortality even before the exact aetiology is established. To establish the diagnosis a laboratory back-up is required.

It would seem logical to involve existing health institutions in the process rather than to establish a completely fresh chain of public health laboratories. India has over two hundred medical colleges and about 600 districts. It would seem logical to give the responsibility for microbiology support and tertiary referral for 3 districts to each Medical College. After all every such teaching institution has a complete microbiology department with laboratories, staff and specialist expertise. The clinical departments of these institutions can also provide expert advise for clinical management of persons affected by the outbreak. This process would minimise expenditure, make experts available to the community and provide valuable training opportunities for the students and junior doctors. Medical colleges should be persuaded to accept their corporate responsibility to the community they serve.

Once a system is put into place for the early detection and reporting of disease outbreaks it can be expanded to also become aware of risk factors that predispose to disease outbreaks (increased mosquito breeding may well presage an outbreak of malaria, indeed an increase of potential breeding sites after an unusual monsoon may foretell of increased mosquito breeding). In such situations timely action can prevent an outbreak. An extension of this concept would be awareness about risk factors for Non Communicable Diseases (NCD).

Skilled Manpower -Public Health Expertise

If the public sector health care system is to be efficient and responsive to the needs of the community, especially in view of the resource constraints that are an integral and continuing part of the health care scenario in India, several steps need to be taken. Micro-level planning is essential so that the activities and priorities of the health system match the actual and felt needs of the community that the system serves. The health interventions must be tailored to meet the particular health needs of the community concerned and can not be addressed by an Nation-wide or even State-wide plan. The people and the public sector health providers must together evolve a plan to meet the needs of the community.

For appropriate planning, information is needed, for information to be generated from data, and data to be collected meaningfully from the system and community, skills are needed - the skills of Public Health. Lacking these skills it is no wonder that all attempts to initiate micro-level planning have met with resistance and failure. Micro-planning has been recommended repeatedly both by the Central Council for Health and Family Welfare and by the Planning Commission.

If the health system does not address the felt health needs of the community, and if top down dictated health interventions are all that the community experiences, it is no wonder that the community looks at the government health structure as an expensive and redundant imposition by the government. The people feel that the health infra-structure serves the governments needs and does not cater to the needs of the community.

India can not afford the luxury of developing a health care programme by trial and error. We neither have the resources nor the time to delay making the benefits of existing knowledge in health available to all our people. Of course advances in knowledge and technology are needed and will take place, but we must never forget that we already have the technical knowledge to tackle most of the health problems plaguing our citizens in the community. Can we justify the delaying the application of available science with the excuse that 'better' science lays ahead. Staff skilled in modern Public Health will be in a position to bring the advantages of current scientific knowledge to finding solutions and selecting the best option for health interventions in the community. In most cases the effective options will include a partnership with the community.

It is a peculiarity of the public sector health care system in India that in the field of health care in and for the community, there is no emphasis on the skills and knowledge of modern discipline of Public Health. The Medical Council of India (MCI) has mandated that a major portion of the undergraduate medical curriculum be devoted to Public Health by any name. Preventive and Social Medicine, Community Medicine, Public Health are all different names for essentially the same discipline and every medical student in India has to study

this subject. Many medical colleges also train post-graduate students in this subject and award the MD degree. Some Institutions also confer a doctorate in the subject. Yet the decision makers in all but two States in India have decided that the skills of Public Health and related disciplines are not essential in those responsible for looking after the health of a district or even that of a State or the Nation. They feel any medical degree, any specialisation is adequate qualification for planning and implementing health care plans in the community. A neurosurgeon or anatomist is supposed to be able to implement Public Health programmes by virtue of the wisdom that goes with seniority! This decision seems to defy logic and appears contrary to the basic objectives of health care. Not only the highest planning and health decision making bodies in the country have emphasised the importance of the discipline of Public Health (by any name) but even the premier health body in the UN system, the World Health Organisation has stressed the importance of the discipline of Public Health for the health of the community.

World Health Organisation and Public Health

The WHO has given the development of Public Health a very high priority in its agenda. An idea of its stand on the need for better Public Health for the country , with all its implications of preventive and promotive health care, better disease surveillance and prompt response to disease outbreaks and the great importance of water, sanitation and sound affordable nutrition can be gauged from the fact that they organised in the end of 1999 an important international meeting with high level expert participants from many parts of the world to deliberate on Public Health in the 21st Century. The focus of this meeting was to a very large extent on India.

Calcutta Meeting

This meeting held in Kolkata (then Calcutta) resulted in what came to be called the Calcutta Declaration. The Declaration was presented at the final plenary chaired by Mr Jyoti Basu and endorsed not only by the Public Health community in India but by the international bodies and experts attending the meeting. The Declaration was again endorsed by the Indian Public Health Association in Agra and more recently during a follow-up meeting organised by WHO.

The first clause of the Declaration reads as follow:

1. Promote public health as a discipline and as an essential requirement for health development in the region. In addition to addressing the challenges posed by ill-health and promoting positive health, public health should also address issues related to poverty, equity, ethics, quality, social justice, environment, community development and globalisation.

The entire text of the Calcutta Declaration is given as appendix 1 at the end of the Document together with the recommendations of the follow-up meeting. However the role of the discipline of Public Health is emphasised as a pre-requisite for implementing a community centric health focus with an emphasis on preventive and promotive measures.

The WHO has also proposed a model for Comprehensive Community and Home-based Health Care (SEARO Regional Publication No 40) which puts the community at the centre of the care paradigm and stresses the multi-facetted integrated care is needed to meet community needs for health care.

Public Health – Expertise to Meet Community Needs.

Except in the case of two states in India (Tamilnadu and Gujarat) formal qualification in Public Health or its allied disciplines is not a requirement for any of the 'health' related positions. The District Medical Officer of Health can be a person trained in any discipline appointed only on the basis of seniority with no regard for job requirements as long as he or she has a basis MBBS degree. He or she can be an eye specialist by training and be expected to guide the provision of preventive and promotive health services, to tackle communicable disease outbreaks or to carry out an epidemiologic investigation. This mismatch between training and job responsibilities is unfortunately the norm. After all the Union Ministry of Health and Family Welfare appointed a professor of Anatomy from the Maulana Azad Medical College in Delhi to be the final technical authority in the Directorate, Union Ministry of Health and Family Welfare for determining the health related aspects for women and children!

Public Health is well defined discipline with its own expertise and skills; a person from another branch of medicine, no matter how qualified in his or her own field can not take the position of a specialist in Public Health just as a specialist in Public Health can not take the place of another specialist. The body of knowledge and skills are not related to the seniority or influence of the person but to the training and experience.

The fact that there is a special body of knowledge and skills that deals with the provision of health care to the community is not seriously questioned. The Medical Council of India has given the subject, by whatever name, a position of great prominence in medical education. All the over 215 medical colleges in India teach the subject - this is mandated by the MCI. In almost every one of those Medical Colleges the subject is taught badly and as an abstract discipline. The students in turn neither care nor are interested as they have imbibed the prevailing attitude that the subject is of no real value to their ultimate objectives. Unfortunately as things stand at present they are correct.

The MCI has also made provisions for postgraduate degrees in the subject. At this point of time those students who opt for a MD in a Public Health related subject are generally those who have not succeeded in making it into a more prestigious subject. This is not surprising. Unlike other specialties, those qualified in Public Health are not uniquely qualified for any particular positions except perhaps to join faculties in medical schools to produce more misfits like themselves. There is no strong cadre of Public Health Specialists

even though a very large part of the health care provider workforce in the country is engaged in delivering health care to the community rather than exclusively to individual patients.

Our founding fathers who wrote the Constitution of India were a farsighted and wise group. There are many aspects of the provisions made in the Indian Constitution that have been acclaimed as establishing a high standard for other fledgling nations to emulate, or for that matter set an example for several important nations that had been free for a long time. Amongst the provisions is the fact that the Constitution establishes Public Health as a fundamental right and therefore enjoins upon the Government the responsibility to put into place health care systems that provides every citizen the right of access to health care. This does not mean that the State has to ensure that everyone is healthy, and obviously it can not do that, but merely that the best achievable health care provision is provided with equitable access being guaranteed.

This provision is spelt out in the Directive Principles of State Policy which states:-

"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."

-The Constitution of India; Part IV

India has provided the infrastructure for providing health care, an extensive network of Primary Health Centres and Subcentres is in place; the vast majority, but by no means all, has staff in place. Unfortunately the government health care facilities do not meet the health expectations of the community and their functioning as nodes for preventive and promotive health care is largely reactive rather than proactive. The community identifies these facilities as the "governments Family Planning Centre" rather than their own health care facility. The efficiency of the peripheral health care facility's functioning is reflected in the less than satisfactory state of various indicators of health prevailing in the community.

Maternal mortality is still unacceptably high is much of the country, the infant mortality rate is even now very high in large parts of the nation. Immunization rates are unacceptable in many states and even with all the effort being put into it by many agencies, even polio immunization goals are not met. Outbreaks of communicable disease are not a thing of the past.

CEA Wilson in 1920 defined Public Health and this was accepted with minor adaptations by the WHO in 1982 as:-

"The science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of social machinery to ensure for every individual a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity."

Subsequently the organization of health care, both preventive and curative came to be included in the mandate of the specialist in Public Health. In modern usage the term has come to be used synonymously with various allied disciplines such a Preventive and Social Medicine, Community Medicine, Community Health, Public Health Administration etc and during discussions it is understood to include related skills such as epidemiology, behaviour change communication etc. It is in this larger context, incidentally very like the concept of 'comprehensive health care' as proposed in the Bhore Committee report, that the term is used in this paper.

Unfortunately the term Public Health is used to mean several different things. As defined above it refers to those special skills and the body of knowledge that deals with the organization and delivery of efficient health care to the community. Unfortunately the term is also used to talk about the 'state of health of the public'. Another usage is synonymous with "Public Sector Health Care" or health care activities delivered by the state and includes both curative and preventive aspects. This unfortunate ambiguity in language prevents clarity of thought and action.

Public Health the discipline has much to offer the community. Evidence based planning and proactive interventions to prevent or abort disease outbreaks are only some of the benefits. Currently reactive rather than proactive decisions are taken about health interventions in the community and even these decisions are to frequently being taken hurriedly in several ways in response to pressure from 'above'.

- Very often the mandate comes down from above as if India is a homogenous entity and local priorities are identical across the country.
- Another way to take decisions is based on 'it has always been done this way'.
- All too frequently interventions are based on a guess and the pressure to do something. The intervention is justified with the implicit understanding that if the intervention does not work something else can be tried.

If the intervention does not produce results most often no body will know - the community does not expect results and the system does not have the information or skills to determine if an effect was produced. What matters is that the crisis has passed, the system met the need to 'do something' and in any case the system is not accountable for inefficiency in results or cost.

How long can we justify denying the people the fundamental rights guaranteed by the Constitution? By denying the people the benefits of modern Public Health, we are denying large segments of the population of the best options for health care.

Having outlined some of the reasons for the sorry state of health in India, and also having argued that improved Public Health services are absolutely essential if the benefits of modern health care are to reach the community at large, this section briefly outlines a vision for the structure and organisation of health care in India in the context of optimising public sector health care in the country with the ultimate ben-

efits to the community.

As described earlier, Public Health in India has entered a vicious cycle where the lack of professional avenues to use Public Health expertise has removed the incentive for the development of expertise in Public Health and has almost eliminated research and development in that field. New entrants into Public Health are almost always those persons who have failed to enter more highly regarded disciplines and have entered the discipline as a last resort. Poor material at point of entry means that the average product at the end of the training is still very limited in intellectual capacity, expertise and especially initiative. This further lowers the already low status of the discipline and in turn additionally reduces the ability of the discipline to attract talent.

Other than teaching positions in medical colleges, specialists in Public Health (and its allied disciplines such as SPM, Community Medicine etc.) have almost no avenues for employment that demands their specialisation as a mandated specification. In a country of well over a billion population, the number of Public Health jobs (other than teaching positions) is still in two digits! Why should anyone good enter a discipline that gives very few avenues for employment and carry's the additional stigma of low status in the eyes of their professional peers, health decision-makers and even the public. The remuneration their specialisation earns is only a fraction of that taken home by their clinical colleagues. Those that opt for Public Health face the fact that their colleagues look at them as professional failures and deserving of pity rather than respect.

Naturally the specialty has not made an impact on decision makers and decision makers see no reason to give the specialty a priority.

A lot needs to be done. Better human material needs to be drawn into the discipline, the discipline itself needs to establish that Public Health specialists offer what no others can, and peer acceptance needs to be enhanced.

It is unlikely that mere pious platitudes by health decision makers are likely to materially influence the situation as it exists today. Improving the quality of teaching and training, and even increasing the number of seats available in teaching institutions will ultimately make little difference to the overall picture; we will just get more of the same, students interested not in the practice of Public Health but desperate students who could not get admission in more coveted disciplines and who are therefore willing to settle for the postponement of the need to earn a living for another three years and the magic letters 'MD' after their names to impress the unsuspecting public.

The proposed Institutes of Public Health can not be considered as solutions to the problem, they are only one step. The limiting factor at this time is the lack of recognition of the discipline. Unless there are dedicated job opportunities for specialists in Public Health, good material will not be drawn into the discipline and the Institutes of Public Health will not affect the health situation in the country.

If the objective is to bring the advantages of the skills and knowledge of the modern science of Public Health to the community and the health care delivery system then persons trained in Public Health must be available at all levels from the CHC to the Directorate of Health. This will improve the quality of health care to the public and by creating job opportunities will draw talent into the discipline.

One can not expect a trained cardiac surgeon to fill the position where neurosurgery is to be performed. It does not matter that he too is a super-specialist and a surgeon. Why should the health decision makers not demand that every person who deals with Public Health have the expertise and qualification in a related discipline?

This suggestion does not depend on a significant enhancement of money spent on salary and related staff costs. What are needed are the political will and the decision by Government. What is proposed is that the benefits of the knowledge and skills of modern Public Health be made available at all levels from the District to the Ministry of Health. This does not entail the creation of many new posts, what is needed is merely the division of existing positions into either the clinical stream or the Public Health stream. All those members of the health team, including doctors and nurses, whose primary job description requires the treatment of individual patients should fall into the clinical stream. All those health care providers, including doctors and nurses whose primary job description entails the provision of health care to the community, preventive and promotive interventions and first contact physicians can constitute the Public Health cadre. Public Health, just as clinical medicine, needs a team effort to function. The Public Health team needs to draw upon expertise from medicine, social sciences, communication, engineering and environmental sciences to provide the broad canvas that is required to sketch the scope of interventions required to provide a health promoting ambiance for the community.

The difference can be illustrated by spelling out the implication at the district level. The clinical stream at the district would be headed by a appropriately qualified person in a suitably named position equivalent to what used to be called the 'Civil Surgeon' of the district. The Civil Surgeon was generally also the chief of the district hospital. In the proposed arrangement, the Public Health stream at the district would be headed by the 'Chief Medical Officer of Health', while the curative care wing would be looked after by the Civil Surgeon. The other health department staff including doctors would be divided between the two depending upon their role. Perhaps one additional position would be required. The Civil Surgeon and CMOH should be of the same seniority.

The most under-utilised part of the health infrastructure at present is the Community Health Centre. The CHC is supposed to be first level of referral for a network of PHCs in its hinterland. They are staffed by 4 specialists (clinical) and one general duty medical officer. This latter post could be designated for the Public Health stream and provide leadership for public health related activities in the PHCs.

The principle of differentiation and parity should extend all the way up to the top. It would be necessary to have two Director Generals of Health, one for Clinical Services and the other for Public Health. Incidentally this was the practice

earlier when one position was designated the Inspector General of Civil Hospitals and the other as the Director of Public Health. It also has precedent in that the Ministry of Health has two Secretaries - one for Health and the other for Family Welfare so there should be no grave administrative reason why there can not be two directors of Health Services. Unless the Public Health stream has an equivalent career path it will remain a second choice, lower in status and esteem than the clinical group.

The principle of parity must extend to a realistic assessment of remuneration and take home pay between the two streams, with an eye to the desirability of attracting talent to positions not normally open to medical practice for fees.

The proposed scheme can only work if Public Health qualifications are mandated for all Public Health jobs. This will need an interim arrangement and relaxation until sufficient trained staff is available. Perhaps an example of what may work will involve the following decisions:

- A decision at the policy level to re-organise the public sector health care system in the country into two parallel and equal streams - clinical care and Public Health care
- The two streams to be equal in terms of real remuneration and seniority, with two positions of equal seniority at the level of Director General of Health Services and lower down two positions of equal rank at the district level
- Essential academic qualifications should be defined for each stream with Public Health and related disciplines being mandated for all positions in the Public Health stream.
- An interim relaxation for persons opting for the Public Health stream, perhaps all persons being required to get certification by the end of the second year, and only persons with diploma (DPH/MPH) / MD (PSM) / Dr.PH or PhD being eligible for posts after 5 years.

Producing the trained staff required.

If the scheme is implemented, provisions will have to be made to strengthen facilities for producing enough trained persons to meet the need for Public Health manpower. I feel this can be done fairly easily without too large an investment in training facilities or establishing many new Schools of Public Health. What is needed is a reorganisation of the postgraduate training present in many medical schools. At present the MD degree in PSM is a 3 year course. With a little readjustment, the intake can be increase manifold for the first year. The first year should be devoted to a conventional DPH/MPH type programme. At the end of the first year, those who qualify should be awarded a DPH or MPH. The best few in each class, not exceeding the usual intake for MD, can be offered the opportunity to go on for another two years where they would learn academic Public Health including advanced epidemiology, research methodology and do their research and write a thesis.

A short term measure to tide over the immediate requirement of trained persons would be to use one or more of the Open University's to run distant learning courses offering certification in aspects of Public Health for in-service candidates. These certificates would permit officers to continue to serve while they work towards more advanced academic qualifications.

A similar arrangement would be required to strengthen the training of other team members for Public Health. In the long term the number of schools of Public Health would have to be increased from the current one so as to establish a training facility in each region of the country. There is already one at Kolkata and others would be needed for the south, west, central and north zones.

Public Health - a team effort.

Like modern curative care, Public Health too is a team effort. There is an urgent need to draw social scientists, nurses, specialists in communication into the discipline and the Public Health service. Public Health training facilities must open their doors to related disciplines and not confine their instruction only to doctors. Such a mix of knowledge and experience can only enrich the discipline and benefit the community.

Other Systems of Medicine

Various systems of medicine other than allopathic are present in the community and play an important role in providing health care to the community. Setting a system in place that does not take this large army of qualified and unqualified health care providers into partnership is wasteful of a valuable resource. While it is neither practical or even legal to train them in certain aspects of allopathic health care, much good can be achieved by using this valuable resource for preventive and promotive health care.

A simple measure such as hand washing after using the toilet, before cooking or handling food and before eating has been demonstrated to have a significant effect on preventing diarrhoeal disease. Measures such as these can be as or more effectively propagated by practitioners of Indian Systems of Medicine as by the allopathic team. Most health promotive measures are likely to strike a sympathetic chord with our fellow providers of health care.

Curative Care

Curative care is also required alongside preventive and promotive health interventions. The issue is not one or the other but the appropriate balance between the two wings. While basis or primary health care is needed at the periphery and bye and large is provided for in the rural areas, there is a marked unfilled need to cater to the requirements of urban slum populations. This must be considered a priority health requirement.

Another shortcoming of the existing health system is the almost complete absence of a working referral system. An effective system of both upward and downward referral will do much not only to improve the care available to peripheral populations but also increase community satisfaction with

the health system.

In summary to make sure that health care reaches out to every citizen of India, the system has to be re-organised. It must be ensured that every person, whether living in the poorest unrecognised slum or the most distanced small village gets the benefits of health care. The following steps are unavoidable if the intention is to improve the health status of all our people.

- People must be treated as active partners in their own health care
- The messages of health sustaining lifestyles must be incorporated into the formal educational curricula and also imparted to the public at large
- The focus must change to emphasize preventive and promotive health care ie Public Health
- Potable water and sanitation requirements must be addressed
- Positions dealing with health care to the community must be occupied exclusively by persons trained in Public Health while those doctors and staff engaged largely in providing curative care to individual patients should form the curative wing of the health service. This differentiation must extend from the PHC up to the Directorate of Health Services
- An appropriate level of curative care must be provided to all those who need it. The financing mechanisms can be worked out

The Constitution of India has given every citizen the right to expect good health care. This is being denied, not because of cost but because of the reluctance to accept that Public Health can make health care more efficient. How long can we avoid accepting what is self-evident.

Appendix 1

The Calcutta Declaration

We, the participants in this Regional Conference on public health in South-East Asia in 21st Century, appreciate the substantial achievements made in improving the health status of the people in the countries of the South-East Asia Region in the past decades. However, we enter the 21st century with an unfinished agenda of existing health concerns and new and complex challenges that demand innovative solutions. We uphold the centrality of meeting the health needs of the community and our responsibility to preserve, protect and promote the health of the people.

We commit ourselves to the goals of poverty alleviation, equity and social justice, gender equality and universal primary education, which are all essential elements in the pursuit of health for all. We recognise that expertise in public health and capacity building, as well as experience are essential for sustaining partnerships in designing, developing and providing health for the community. We emphasise the importance of public health as a multidisciplinary endeavour to meet the health needs of people.

Having noted the progress in public health practice, education and training, and research in the countries of South-East Asia Region, and having reviewed the lessons from public health-related policies and programmes, we endorse the following strategies and directions for enhancing health development in South-East Asia Region in the 21st century:

1. Promote public health as a discipline and as an essential requirement for health development in the region. In addition to addressing the challenges posed by ill-health and promoting positive health, public health should also address issues related to poverty, equity, ethics, quality, social justice, environment, community development and globalisation
2. Recognise the leadership role of public health in formulating and implementing evidence-based healthy public policies; creating supportive environments; enhancing social responsibility by involving communities; and increasing allocation of human and financial resources
3. Strengthen public health by creating career structures at national, state, provincial and district levels, and by establishing policies to mandate competent background and relevant expertise for persons responsible for the health of populations, and
4. Strengthen and reform public health education and training, and research, as supported by the networking of institutions and the use of information technology, for improving human resource development

We urge all Member Countries as well as WHO to continue to provide leadership and technical cooperation in building partnerships between governments and UN and bilateral development agencies; academia; NGOs; the private sector; the media, and other organs of civil society, and to jointly advocate and actively follow-up on all aspects of this Calcutta Declaration on public health

Subsequently The WHO organized a follow up informal consultation in December 2003 in Delhi entitled 'Future Directions in Public Health-Calcutta and Beyond'.

References

Anand et al. National Medical Journal of India.

Government of India. Report on tobacco control in India. New Delhi: Ministry of Health & Family Welfare, Centres for Disease Control and Prevention and World Health Organization; 2004.

University of Sydney, Earth Institute, Columbia University and IC Health. A race against time. New Delhi: Secretariat of IC Health; 2004.