

## **THE SHIFT IN INDIA'S HEALTH POLICY PARADIGM AND THEIR IMPLICATION ON HEALTHCARE NEEDS**

**NehaYadav**\*

---

### **Abstract**

This paper attempts to sketch the basics of a Health Service System that would be best suited to the overwhelming needs of the majority. The modest attempt has been to present a basic outline of the direction needs based on the understood shortcomings of the current services. In what follows, the paper will proceed from outlining the gross inequalities that would further guide the directions and changes needed for the change. The economic growth of the country has also witnessed rising inequalities. The health sector development has also been improved over time but, these gains have seen a highly unequal distribution across regions and social strata. The rich State decides the life of the poor, and the economic constraint only allows it offer family planning; such are the contentions against which this paper is written. The Health Services have not appreciated the inequalities in health status, participation and distribution of resources. This paper attempts to forge some basis on which should respond to the current needs of the people.

**Keywords: Primary health care, universal health coverage, health system, national health policy, out-of-pocket expenditure**

---

\* **Research Scholar, Centre for Social Medicine & Community Health, Jawaharlal Nehru University, New Delhi, India**

## 1. Introduction

During the final decades of the Cold War (the late 1960s and early 1970s) the United States (US) was involved in a crisis of its world dominance—it was in this political context that the concept of primary health care emerged. By then, the vertical programme initiated by World Health Organizations (WHO) and US agencies for malaria eradication since the late 1950s were criticized for their approach. New proposals for health services appeared, questioning about hospital-based health care system in developing countries and lack of preventive measures. Other studies outside public health domain challenged the assumption that health resulted from the transfer of technology or services. The British historian Thomas McKeown argued that the overall health was more related to the standard of living and nutrition than medical advances. Another inspiration for primary health care was the global popularity that the massive expansion of rural medical services in Communist China experienced, especially the ‘barefoot doctors.’ This visibility coincided with China's entrance into the United Nations system (including the WHO).

Primary health care favoured by a new political context that was characterized by the then recently decolonized African nations and the spread of anti-imperialist, and leftist movements in many less developed countries. US defeat in Vietnam War led Union of Soviet Socialist Republic (USSR) to attempt for a new leadership role, pushing the WHO towards Alma-Ata. New leaders and institutions personified the new institutional and political influences. Prominent among them was Halfdan T. Mahler, who was elected as WHO Director-General in 1973. In 1975 a joint WHO–UNICEF (The United Nation Children’s Emergency Fund) report, ‘Alternative Approaches to Meeting Basic Health Needed in Developing Countries’ was released. That states the principal causes of morbidity in developing countries were malnutrition and vector-borne diseases that were themselves the result of poverty and ignorance. The report also examined successful primary health care experiences in developing countries like India, China, and Cuba to categorize the critical factors in their success. This report shaped WHO ideas on primary health care. In the 1976 World Health Assembly, WHO proposed the goal of ‘Health for All by the Year 2000’ [1]

## 2. Establishing priorities for Health Care

### 2.1 Alma-Ata Declaration

The milestone occasion for primary health care<sup>1</sup> was the International Conference on Primary Health Care (PHC). The Alma-Ata Declaration<sup>2</sup> was adopted at Almaty, Kazakhstan, 6-12 September 1978. The conference called for urgent and compelling action to build up and execute primary health care throughout the globe and particularly in developing countries in keeping with a New International Economic Order. It was the first international declaration mentioning the importance of primary health care. It emerged as a significant milestone in the field of public health, identified primary health care as the key to the accomplishment of the goal of 'Health for All.' [2]

The Alma-Ata Declaration generated numerous reactions and criticism worldwide. Marcos Cueto in his article 'The Origins of Primary Health Care and Selective Primary Health Care', claims that the declaration was damned as being idealistic, unrealistic with an unspecific methodology. It did not have clear targets, was too broad and unattainable. [3]

### 2.2 Selective Primary Health Care

As an outcome of these criticisms, the Rockefeller Foundation supported a Conference entitled 'Health and Population in Development' held at Bellagio, Italy in 1979 to address several concerns. A new concept of Primary Health Care (PHC) was established on a paper by Julia Walsh and Kenneth S. Warren – 'Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries'. The major infectious diseases were ranked by putting forward a specific methodology according to prevalence, the risk of mortality, morbidity and the feasibility of control that encompass effectiveness and cost of available cures. [4] For those interventions low-cost methods have already proven efficacy, a team should restrict their activities to those minimum number of health problems affecting a maximum number of people. [5]

---

<sup>1</sup>Primary health care is judged as essential health care based on scientifically proven and socially acceptable methods that are universally acceptable and accessible to the individuals at a cost that community and country can afford and maintain self-reliance. 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)

<sup>2</sup>Alma-Ata declaration defined an acceptable level of Health for All by the year 2000, can be attained through the better use of world resources in favour of health and in particular to accelerate the social and economic progress of which primary health care should get its proper share.

The concept of SPHC faced criticism, it aimed at children less than three years old and women of childbearing age, the issue was monitoring of growth of child was difficult since it required the use of charts by illiterate mothers. As breastfeeding confronted powerful food industries and third world nation accounted for 50 percent of the sale. Health advocates boycotted against Swiss multinational Nestle; the main problem was the availability of unsafe water for bottle feeding. Similarly, oral rehydration solutions were a Band-Aid in places where safe water and sewage systems did not exist. [6] There were other significant issues with SPHC; emphasis is only given to people with priority diseases. There should be other sufferings also that are in need to be addressed and which might have been solved with an integrated or broader approach. [7] Like other selective programs undermines the local definition of needs and knowledge sharing by local organizations. This practice is not fruitful for the countries in the long run. [8] Support system for all interventions are required and are very cost intensive. Therefore, the criterion of cost-effectiveness does not count eventually. [9]

### **3. India's Health System**

The existing health structure has an evolutionary history. India's health system can be divided into three distinct phases. The initial phase, 1947-1983, health policy was undertaken on two principles; none should be denied care despite the inability to pay, and it was the responsibility of the concerned state to provide health care to the people. The second phase, 1983-2000, saw the first National Health Policy (NHP) of 1983 that articulated the need to inspire private initiative in health care services. Along with that access to publicly funded primary health care was expanded, an expansion of health service for providing primary health care in rural areas. During the decade following the 1983 NHP, an extensive program of expansion of primary health care services was undertaken in the 6th and 7th Five Year Plan (FYP) and rural health care received particular attention. The third phase, post-2000, witnessed a further shift that affects the health sector in three essential ways. There was an increase in desire for utilization of private sector resources to address public health goals. New avenues are generated for health financing due to the liberalization of the insurance sector and change in the part of the state from being a provider to a financier of health services. [10]

### **3.1 National Health Policy (NHP) 1983**

The National Health Policy was not framed until 1983, yet India has built up a significant health infrastructure and initiated many national health programs over last few decades. The NHP 1983 was announced during the Sixth Plan period, with the aim to achieve the goal of 'Health for All' by 2000. This is the first time after the Bhore Committee report that Directive Principles of state policy recommends universal, comprehensive PHC services.

During the following decade, a massive program of expansion of primary health care facilities was taken place, and rural health care received particular attention. However, various studies suggest that despite the fact that health infrastructure is at a place in most areas they are underutilized. There was a mismatch of training and work allocation for the workers. Family planning gets a significant share of health workers productive work time. There has been no community participation because the model of primary health care was not acceptable to the local rural people. They continue to use private care and rural health care system not been able to provide epidemiological bases as recommended. About demographic targets, the only indicators on the schedule were crude death rate and life expectancy. Fertility and immunization targets are much below expectancy. Even the resurgence of communicable diseases was noticed.

NHP 1983 talks about a cost that people can afford indicate that health care services won't be free. This favours privatization of curative care, keeping in mind the state suffers from a constraint of resources. A report by National sample survey 1987 suggests morbidity and utilization of medical services made it evident that private health sector accounts for 70 percent of all primary health care treatment and 40 percent of all hospital care, which is not a healthy sign for a population whose 75 percent lives below subsistence levels. [11] The above analysis indicates that the 1983 NHP goal, Universal, comprehensive, primary health care services are far from being achieved.

### **3.2 Structural Adjustment Policy**

The 1980s Balance of Payment Crisis followed by conditionality imposed by Bretton Woods's results in Structural Adjust Policy (SAP). It led to the introduction of health sector reforms in India. In the 1990s when the SAP was formally accepted, and a cutback in the welfare sector was

introduced, PHC suffered a further setback. The proposed health sector reforms imparted a direct impact on PHC because intersectional strategies were undermined by a disrupted food security system, massive unemployment and loss of subsistence for many Indians. [12]

In the 1980s medical care was open up for market expansion with many international players including the World Bank, getting interested shaping this sector. The seventh plan (1985-90) scaled up investment in family planning and opened up to private sector partnerships and NGO's under the enhanced pressure of neo-liberal policies. The introduction of health sector reforms leads to cutbacks, private investments in public hospitals, purely techno-centric public health interventions and an introduction of user fees. There have been significant changes in the emergence of the middle class, demanding advance medical services. Medical bureaucracy supported this trend, professionals grown with a biomedical mindset has supported. These together assisted the state in its neo-liberal policy shifts over the 1990s.

During eighth plan (1992-97) slogan of 'health for all' was changed to 'health for underprivileged', it reduced the comprehensiveness and talked about the privatization of medical care. The conditionality imbibed in the reforms unfolded further over the ninth and tenth FYP results into an expansion of an unregulated growth of the subsidized medical market. By promoting tertiary care and private insurances the reforms, in fact, squeeze providers of medical services for a majority. The introduction of user fee further marginalized the mass. In the late 1990s despite improved economic growth rates and a flourishing middle class, it did not bother to provide national insurance system, health co-operatives, health cess or free services for the poor.

### **3.3 National Health Policy 2002**

During the 10th Plan, the Draft National Health Policy 2001 was announced. For the first time, feedback invited from the public. No mention of NHP 1983 goal of Universal, comprehensive, primary health care services was done in the NHP 2001. The NHP 2002 showed its concern for regulating the private health sector by creating a regulatory mechanism for introduction of statutory licensing and monitoring minimum standards. It helps to build accountability within the private health sector. Besides this, concern for improving health and demographic statistics,

including national health accounts, to assure a mechanism of statutory reporting both by public system and a private sector. It is considered as an urgent requirement to obtain meaningful data through health information systems to plan policies and programs.[13]

The primary objective of NHP 2002 is to achieve a reasonable standard of health amongst the general population of the country. Again the goals given in the policy document are laudable but no specific time frame was provided to achieve them. For instance, one purpose mentioned in the document says, increase utilization of public health facilities from a current level of 20 to 75 percent is indeed remarkable. The existing utilization patterns are in reverse order, which favours the private health sector; moreover, many recommendations favour policy strengthening of the private health sector and hence are contrary to this goal. In sum NHP 2001 is a mere collection of unconnected statements, it unabashedly promotes the private health sector and dilute the role of public health services envisaged in the earlier policy.

In the field of health, two important things happened in India in the year 2000 itself. For the first time, the Indian government announced the National Population Policy (known as NPP 2000), and India became one signatory to commit to Millennium Development Goals (MDG). After two years India announced the National Health Policy – 2002, that reflects the concerns of Millennium Development Goals. The NHP – 2002 may be considered as the forerunner of NRHM which was to start from 2005. The guidelines of national population policy and national health policy documents focus on demographic achievements. This demographic obsession is the basis for turning National Rural Health Mission (NRHM) into medicalized health care rather than comprehensive PHC.

### **3.4 National Rural Health Mission (NRHM)**

NRHM has been viewed as the state governed holistic mission mode intervention in the field of health. The state has extended it till 2017, assuming the significance of NRHM in improvement, in particular, Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) and improving general health conditions. The Twelfth Five Year Plan has extended NRHM to 'urban poor', calling it a National Health Mission (NHM) instead of National Rural Health Mission (NRHM).

The cornerstone of NRHM was decentralized planning and enabling states to address their priorities. It introduced provisions of untied funds, public-private partnership, convergence of health sector, involvement of Panchayati Raj Institutions (PRIs), and other determinants of health (e.g. water, sanitation, education, nutrition, social and gender equality) were created to develop a fully functional health system at all levels, from the village to the district. Increasing women's access to health care services and focusing on gender equity.

International Institute for Population Sciences (IIPS), Mumbai [14] has produced a sheet of Concurrent Evaluation of National Rural Health Mission 2009; this document pronounced inequalities between States and the achievements are far from being satisfactory. Sample Registration Scheme, Special Bulletin on Maternal Mortality in India 2007-09 [15] showed that though the national Maternal Mortality Ratio (MMR) numbers look fair, the inter-state variation is huge, i.e. 81 in Kerala to unexpectedly high 390 in Assam. Fifth Common Review Mission reports [16] state Uttar Pradesh report shows that the newly constructed PHCs are lying locked due to non-availability of Staff; equipment needing repairs are lying dysfunctional and defunct. District priorities for infrastructure are not reflected in State PIP; there is a severe shortage of Specialist/Medical Officers/Nurses. There is a lack of priority to training and deficit of training institutions. Eleventh Five Year Plan document [17] recognizes the inability of a system to mobilize services of nutrition, safe water, sanitation, hygiene (critical determinants of health)—lack of convergence. It accepted that the country did not have the serviceable institutional capacity to receive all expecting mother giving birth each year. Half of the maternal deaths occur in pregnancy, abortions, and postpartum complications. In the new liberal regime, the primary health care system seems to be weakening despite the creation of Aanganwadi Workers, ASHAs, and the emergence of health insurance for the poor. [18]

The National Health Bill-2009 grants health as a fundamental human right [19] and the 65<sup>th</sup> World Health Assembly in Geneva recognized universal health coverage (UHC) as the urgent imperative for all nations to unite the advances in public health. [20] Consequently, Planning Commission of India instituted a high-level expert group (HLEG) on Universal Health Coverage (UHC) in October 2010. HLEG gave its report in Nov 2011 to Planning Commission on Universal Health Coverage for India by 2022. [21]



### **3.5 The High-Level Expert Group on Universal Health Coverage**

The committee rejected user fees in both public and private institutions. It argued that Universal Health Care founded on social solidarity, and cross-subsidization can be a success. Hence, it proposed a universal method of financing via general and differential health taxation and suggested that 70 percent of it should go to PHC. [22]The 12th 5 Year Plan Approach Paper makes it clear that ‘publicly financed health care does not necessarily mean provisioning of services.’ It mentions regulation of private players and illustrates the importance of Public-PrivatePartnerships (PPP) such as social security scheme: RashtriyaSwasthyaBimaYojana, outsourcing diagnostics and of a UHC system on the same lines.[23]

The current status of the national programs was itonly provides universal coverage on specific interventions like maternal ailments that result from less than 10 percent of all mortalities. Around 75 percent of the communicable diseases are outside their purview, and only a limited number of non-communicable diseases were covered.As it stands, health will be recognized as a fundamental right only when three or more States request for it. Since health is a State subject, therefore, adoption by the respective States will be voluntary. The very objective of universal health coverage that hinges on portability will be defeated in the absence of uniform adoption across .

### **3.6 The Draft National Health Policy 2015**

This policy is being introduced almost 13 years after the last health policy was drafted. It put forward health as a fundamental right similar to education, thecreation of a health cess like an education cess for raising the money needed to fund the expenditure it would entail. Other than general taxation, taxes on tobacco, alcohol and from other specific industries should be imposed. [24]While the public sector has to focus on preventive and secondary care services, the draft policy stresses on the role of private sector to nonmedical services such as catering and laundry to the private sector.This policy proposes an achievable target of raising public health expenditure to 2.5 percent from the present of 1.2 percent of the GDP. [25]

The new policy determines that the present concept of primary healthcare covers hardly 20 percent of the health needs and accounts for hefty out of pocket expenditure is accounted as one

of the major contributors to poverty. Although bringing down expenses has been listed among the major objectives of spending of the new proposed policy, it has no ideas on how to do it. It is silent, for example, on regulating the private healthcare sector. The draft distinctly focuses on 'urban poor' health and defines the need to step up National Urban Health Mission (NUHM). But, they remain strangely silent on what the suggested measures are?

The cess will come from unhealthy and toxic industries and have a negative impact on human health. The overt allowing of unhealthy industry and development also contradicts the preventive and promotive health component the document itself stresses. The draft document points out that the private healthcare industry will receive a significant variety of exemptions and benefits (higher reduction in medical equipment cost, custom duty exemptions for imported equipment that are lifesaving, preferential and subsidized allocation of land under the public acquisitions Act). However, while several private hospitals are refraining from their part of the memoranda of understanding (MoU) to mandatory offer 10 percent free beds and treatment to the underprivileged, the document says nothing about regulation, monitoring or accountability. It is a huge disappointment to realize that the State continues to perceive women and their healthcare needs only regarding reproductive needs. Mainstreaming of women's health and gender under the RCH indicates the misplaced emphasis on population stabilization, ignoring evidence from around the globe contrary to the idea that reduced fertility rates contribute to enhancing socio-economic opportunities. The paradox of this draft national health policy is that it is self-defeating. [26]

### **3.7 National Health Policy 2017**

After a gestation period of about two years that face extensive public dictum and strident debate within the government, the policy finally emerged. The high points were health promotion and prevention, financial protection, and resilient partnership with the private sector and levitate public health spending to 2.5 per cent of the GDP 'in a time-bound manner' (the draft says by 2020 and policy document raise the timeline to 2025). When the question arises how does the NHP 2017 propose to organise healthcare services? The answer stated was 'health assurance'.

The policy document suggests government's role as benefactor of healthcare services by stressing its role as a 'strategic purchaser' of services.

“The health policy recognizes that there are many critical gaps in public health services which would be filled by ‘strategic purchasing’. Such strategic purchasing would play a stewardship role in directing private investment towards those areas and those services for which currently there are no providers or few providers.”[27]

The overall prescriptions in the policy regarding insurance schemes that rely primarily on private sector provisioning in cases of secondary and tertiary level care are designed to strengthen the private sector further and denude the public sector.

The recommendation in the NHP 2017 to increase the government’s expenditure on health from the existing 1.15 to 2.5 percent of the GDP by 2025 finds no replication in the Union budget 2018-19. The share of NRHM in total expenditure has fallen further from 52 percent (2015-16) to 44 percent this year. Within the NRHM, cuts were fairly radical for reproductive, and child healthcare and communicable diseases care but an increase in funds for strengthening health systems which are presumed to be for setting up the 1.5 lakh ‘health and wellness centres’ as mentioned in the budget speech. The allocation of 1,200 crores for 1.5 lakh wellness centres means an average of 80,000 per centre. Their effectiveness in the absence of a supportive infrastructure is questionable. According to the Rural Health Statistics 2016[28] there are existing shortfalls in primary health care facilities which are unlikely to be addressed due to shortage of rural public health infrastructure.

The government of India announced the launch of a comprehensive national health insurance scheme to cover ten crore families for treatment at secondary and tertiary health care centres. Insurance as a substitute for public health infrastructure can be counter-productive. First, it will expand space for the unregulated private sector which can inflate healthcare cost and hike the insurance premiums which are to be borne by the state. Second, it will not make up for the absence of the public health infrastructure in underserved areas.

#### **4. Concluding Remark**

The fortieth anniversary of Alma Ata Declaration will be observed this year however; the goal of primary health care could not be realized. The huge out-of-pocket expenditure to avail healthcare

services clearly indicates the unavailability of primary health care and low government spending on health service system. The announcement of world's largest health care programme-- the National Health Protection Scheme, a massive insurance scheme for 50 crore of India's poorest sound impressive. Conversely, what appeared less important was the promise of Universal Health Coverage and what went utterly missing was health as a fundamental right. The emphasis is shifting from public provisioning of services to merely ensuring universal access to services. While there is a lot that needs to be said about the shortcomings and directions for our Health System, the aforementioned points have been the basic thematic rationale of the system that can respond to the needs of majority. Much can be learnt by doing, is a remark in Alma-Atta declaration, this paper therefore has only attempted to highlight the major roadblocks and the basic foundational changes that must precede any meaningful change.

## References

- [1] [6] Cueto, Marcos. "The Origin of Primary Health Care and Selective Primary Health Care" *American Journal of Public Health* (November 2004)
- [2] WHO & UNICEF "Primary Health Care", International Conference on Primary Health Care Alma-Ata, USSR Geneva: World Health Organization (1978), 1-79
- [3] R G Boland, M E Young. "The strategy, cost, and progress of primary health care." *Bulletin of the Pan American Health Organization* (1982), 233-41
- [4] Warren, K. "The evolution of SPHC." *Social Science and Medicine* (1988), 891-898
- [5] [9] Banerji, Debabar, "Primary health care: selective or comprehensive?" *World Health Forum* (1984), 312-315
- [7] Warren, Julia A. Walsh and Kenneth S. "Selective Primary Health Care — An Interim Strategy for Disease Control in Developing Countries." *The New England Journal of Medicine* (1979), 967-974
- [8] H, Luce. "GOBI versus PHC: Some dangers of selective Primary Health Care" *Social Science and Medicine* (1988), 963-969
- [10] Report of the National Commission on Macroeconomics and Health, New Delhi: National Commission on Macroeconomics and Health, Ministry of Health & Family Welfare Government of India, New Delhi, 2005

- [11] National Sample Survey 43rd Round, New Delhi: Ministry of Statistics and Programme Implementation (MOSPI), 1987-88
- [12] VikasBajpai, AnoopSaraya "Factors that influenced the development of health services in India." The national medical journal of India (2013), 231-235
- [13] Ministry of Health and Family Welfare, National Health Policy – 2002. [https://www.nhp.gov.in/national-health-policy-2002\\_pg](https://www.nhp.gov.in/national-health-policy-2002_pg) [assessed on 27 January 2018]
- [14] International Institute for Population Sciences, 2010. Concurrent Evaluation of National Rural Health Mission (NRHM), Fact Sheet States and Union Territories, 2009, Mumbai: International Institute for Population Sciences
- [15] Special Bulletin on Maternal Mortality in India 2007-09, Registrar General - Sample registration system bulletin, 2011
- [16] Fifth Common Review Mission: Uttar Pradesh [http://www.mohfw.nic.in/NRHM/CRM/CRM\\_files/5th\\_CRM/PPT/Uttar%20Pradesh.pdf](http://www.mohfw.nic.in/NRHM/CRM/CRM_files/5th_CRM/PPT/Uttar%20Pradesh.pdf) [assessed on 28 January 2018]
- [17] Eleventh Five Year Plan, 2007-2012. Vol I: Planning Commission; 2008, Government of India
- [18] Sharma, A K. "Sociological Critique of the National Rural Health Mission: Issues and Priorities."(n.d.)
- [19] The National Health Bill Working draft– 2009, Ministry of Health and Family Welfare, GOI 2009. Available from: <http://www.mohfw.nic.in> [assessed 26 January 2018]
- [20] Thakur, J S. "Key Recommendations of high-level Expert Group Report on Universal Health Coverage for India." Indian Journal of Community Medicine (2011), 84-85.
- [21] High-Level Expert Group Report on Universal Health Coverage for India, New Delhi: Planning Commission; 2011.
- [22] Qadeer, Imrana. "Universal Health Care in India: Panacea for Whom?" Indian Journal of Public Health (2013), 225-230.
- [23] Faster, Sustainable and a more Inclusive Growth an Approach Paper to the 12th Five Year Plan, 2012-2017. New Delhi: Planning Commission; 2012.
- [24] Centre moots health as a fundamental right. New Delhi: The Hindu, 1 January 2015. <http://www.thehindu.com/news/national/centre-moots-health-as-a-fundamental-right/article6742882.ece>

- [25] National Health Policy 2015 Draft, New Delhi: Ministry of Health & Family Welfare, December 2014. [https://www.nhp.gov.in/sites/default/files/pdf/draft\\_national\\_health\\_policy\\_2015.pdf](https://www.nhp.gov.in/sites/default/files/pdf/draft_national_health_policy_2015.pdf) [assessed 26 January 2018]
- [26] Forum for Medical Ethics Society, "National Health Policy 2015 Mapping the Gaps" *Economic & Political Weekly* (September 5, 2015), 21-23.
- [27] National Health Policy 2017, Ministry of Health and Family Welfare: 2017, Government of India <https://mohfw.gov.in/documents/policy>
- [28] Rural Health Statistics 2016, Health Management Information System, Ministry of Health & Family Welfare, Government Of India, New Delhi, 2016
- [29] The government of India Report of the 12th Plan Steering Committee on Health, New Delhi: Planning Commission; 2012
- [30] Leena V Gangolli, Ravi Duggal, AbhayShukla. *Review of Healthcare in India*, Mumbai: Centre for Enquiry into Health and Allied Themes, 2005.
- [31] Priya, Ritu. *Public Health Services in India: A Historical Perspective*, Mumbai, 2005.
- [32] *World Development Report 1993: Investing in Health*. New York: Oxford University Press, 1993.
- [33] World Health Organization, Primary health care. [http://www.who.int/topics/primary\\_health\\_care/en/](http://www.who.int/topics/primary_health_care/en/) [assessed on 28 January 2018]