UNIT 9 DEBATES ON ENVIRONMENT AND HEALTH

Structure

9.0 OBJECTIVES

After reading this Unit, you will know:

- How health system evolved in India in accordance with World Health Organization (WHO);
- About various policies regarding Indian health system;
- About transition of health services from public to private sector and its implications;
- About various legislative and policy development in field of environment; and
- How development and environment are related to each other.

9.1 INTRODUCTION

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

- Constitution of World Health Organization

"The term environment is used to describe, in aggregate, all external forces, influences and conditions which affect life, nature, behaviour and growth, development and maturity of living organisms."

Health means more than an absence of disease as is recognized in WHO definition of health. Health is only possible where resources are available to meet human needs and where living and working environment is protected from life-threatening and health-threatening pollutants, pathogens and physical hazards. Health also includes sense of well-being and security. Deficient living and working environments are associated with both physical and psychosocial health problems. The complex relationship between health and environment extends the responsibility for promoting health to all groups in society.

Humans interact with environment constantly. These interactions affect quality of life, years of healthy life lived and health disparities. Environmental health consists of preventing or controlling disease, injury and disability related to interactions between people and their environment. Meeting needs of the present and future world population for air, food, water, space and energy without depleting or damaging global resource base, while avoiding adverse health and environmental consequences of industrialization and uncontrolled urbanization, can be achieved only if people have knowledge and means to influence action. Many aspects of our environment – both built and natural environment – can impact our health. It is important that we interpret health issues in wider context of our environment and where we live.

9.2 HEALTH

According to WHO health has been defined as a state of complete mental, physical and social well-being with strong focus on primary health care (PHC) and equity. In 1946 Constitution of WHO adopted a futuristic goal of affirming that highest attainable standard of health is ideally fundamental right of every human being. In 1948 the said right to health was incorporated in article 25 of Universal Declaration of Human Rights and endorsed by international law in 1966 International Covenant on Economic, Social and Cultural Rights.

9.2.1 Alma-Ata Declaration

It was the first international declaration mentioning importance of primary health care. Concept of universal health care (UHC) was developed at the landmark Alma Ata Conference in 1978 wherein most of the countries of the world affirmed their resolve to provide "Health for All". The said conference focused on immediate action to strengthen and execute basic health care throughout the

world especially in Third World/developing countries within framework of a new international order. It was indeed first step in internationalisation of the issue.

The declaration was not without flaws as it was too broad and idealistic in its approach and adhered to an unrealistic timeline. In fact, its slogan "Health for all" was an impractical idea. Flaws in its policies prompted Rockefeller Foundation to sponsor Health and Population Development Conference which was held in Italy at Bellagio Centre in 1979 just a year after Alma-Ata. Basic idea of the said conference was to focus on objectives of PHC and adopt intensified approaches. In contrast to inclusive PHC of Alma-Ata Declaration the Selective PHC focused on low-cost solutions to basic causes of death. Objectives and effects of Selective PHC were focused, precise, measurable and easy to oversee and monitor. This is because Selective PHC had explicit areas of focus that were believed to be most important. They were known as GOBI (growth monitoring, oral rehydration treatment, breastfeeding and immunization) and later GOBI-FFF (adding food supplementation, female literacy and family planning). Unlike Alma-Ata Declaration these aspects were very specific and concise, making global health as successful and attainable as possible. Nonetheless, there were still many supporters who preferred comprehensive PHC introduced at Alma-Ata over Selective PHC, criticizing latter as a misrepresentation of some core principles of original declaration. Main critics are towards selective care as restrictive approach to health. Therefore, such approach to primary care does not contribute toward integral care (globality) and does not address social determinants as a fundamental aspect of illness and, thus, essential to health care planning.

9.2.2 India's Health System: The Debate

The current health care structure has a constant evolutionary history. India's health care system can be divided in to three phases:

1) In initial phase, starting from 1947 to 1983, health policy was primarily based upon two principles:

a) No one can be refused from health facility owing to his/her inability to afford treatment, and

b) The concerned state was responsible for health care of people.

2) Second phase starts with first National Health Policy (NHP) in 1983. It brought out importance of private initiative in health care facilities. Along with that publicly funded health care system was expanded to provide basic health facilities in rural parts of India. Following NHP-1983 primary health care was extensively expanded during 6th and 7th Five Year Plan to reach every corner of the country, especially remote areas.

3) Post-2000 third phase witnessed a paradigm shift in health sector. Emphasis was given to pool in private sector resources to attain public health goals. Relaxation in insurance sector led to expansion in health financing facilities and finally, state became a financer for health services rather than being a provider.

Imrana Qadeer intervenes in debate on current notion of Universal Health Care (UHC) and after examining key legal and policy documents she argues that recommendations for UHC in these suggest further abdication of state's responsibility in health care, with emphasis shifting from public provisioning of services to a market-driven strategy for accessing health services. Acts of commission (recommendations for Public-Private Partnership [PPP], definition and provision of an essential health package to vulnerable populations to ensure universal access to care) and omission (silence maintained on tertiary care) strengthens corporate sector at cost of public health care services and access to care for the marginalized. Thus, current UHC strategy uses equity as a tool for promoting private sector in medical care rather than health for all. Withdrawal of government from health services has environmental impact too. While analysing governmental vis-à-vis private sector enterprise debate since 1980s in health care in which closure of primary health care facilities by publicly run institutions, privatisation of health services and free operation of corporate bodies due to which the cost of medical treatment goes up substantially and significantly, she states that this process has serious implications on the way environmental and health concerns shape up, with government's removal of taking up environment-friendly measures with respect to both environment and health care.

9.2.3 National Health Policy (NHP) 1983

'Health for All' by 2000 was primary goal of NHP-1983. It was announced during 6th Five-Year Plan. Next decade witnessed plethora of programs aiming at expansion of primary health care facilities wherein rural health care received particular attention. There was great expansion in health infrastructures in most of areas but they could not be utilized properly. Health workers were not trained according to their duties and responsibilities. Most of the productive time of health workers was spent on family planning. One of major setbacks was that local rural people could not accept new model of primary health care and, thus, community participation was almost negligible. In case of demographic targets, it only included crude death rate and life expectancy. Even fertility and immunization programs could not meet targets and resurgence of communicable diseases was also noticed. NHP-1983 talked about a cost that people can afford indicating that health care services won't be free. This favoured privatization of curative care, keeping in mind that state suffers from a constraint of resources. According to a report by National Sample Survey-1987 private health sector accounts for 70% of all primary health care treatment and 40% of all hospital care which is not a healthy sign for a population whose 75% lives below subsistence levels. Above analysis indicates that 1983 NHP goal of universal, comprehensive, primary health care services was far from being achieved.

Check Your Progress Exercise 1

1) When was Alma-Ata Conference held?

2) Describe evolutionary phases of Health Care System in India.

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3) What was primary goal of NHP-1983?

9.2.4 Structural Adjustment Policy

Structural adjustment is a set of economic reforms that a country must adhere to in order to secure a loan from International Monetary Fund (IMF) or World Bank. Structural adjustments are often a set of economic policies including:

1) reducing government spending,

2) opening to free trade etc.

Because of foreign debts mounted in 1980s and 1990s third world countries had to reduce public expenditure on health. In addition, they were compelled by international donors to adopt market-driven economic reforms to receive foreign aid and debt relief. As part of structural adjustment programs developing countries disinvested in public sector and PHC suffered further setback. In seventh plan (1985-90), with introduction of neo-liberal policies, private sector partnerships and NGOs came up in picture. Health sector policies now included:

1) cutback in public health care,

2) private investments in public hospitals,

3) purely techno-centric public health interventions, and

4) introduction of user fees.

With expansion of industrial capitalism and rise of big corporations there was emergence of "new middle class" demanding advanced medical services. Medical bureaucracy as well as biomedical professionals supported this trend. These together assisted the state in its neo-liberal policy shifts over 1990s.

Eighth plan (1992-97) was announced with a new buzzword "health for underprivileged" instead of "health for all". It reduced inclusiveness and focused on privatization of health care. This idea got further boost during ninth and tenth plans and resulted into haphazard growth of a subsidized medical market. Promotion of tertiary care and private insurance players have only led to reduction of such facilities in proportion to demand of the population. User-fee introduction has further driven away masses from essential services. Despite a flourishing middle class and an enhanced economic growth rate in 1990s the scheme failed to provide for:

1) a national insurance system,

2) health cess,

3) health co-operatives, and

4) free services to needy poor.

9.2.5 NATIONAL HEALTH POLICY 2002

NHP-2002 raised its concern for regulating private health sector by forming a regulatory mechanism for implementation of statutory licensing and monitoring minimum standards. It focused on building 'accountability' within private health sector. It also showed its concern for improving health and demographic statistics, and national health accounts by ensuring a mechanism of statutory reporting by public system and private sector. There was an urgent need to get meaningful data via health information systems to make policies and programs.

Main objective of NHP-2002 was to attain a basic standard of health amongst general population of the country. Targets recorded in the policy were good but no particular time frame was given to achieve these goals. For example, one goal in the policy emphasised increased utilization of public health care facilities from current level of 20 to 75%. It is remarkable, indeed. However, existing utilization patterns were in negative as these were more focused on private health sector; in fact, many recommendations favoured polices which made use of private health sector stronger and, hence, were contrary to the targeted goals. To sum up, NHP-2002 was a mere collection of disjointed policies which confusedly focused on advancement of private health sector and decreased role of public health services designed in earlier policy.

There were two major developments in India in 2002:

1) announcement of National Population Policy (known as NPP-2000) by Indian government by which India was signatory to seriously commit itself to Millennium Development Goals (MDGs)

2) announcement about National Health Policy-2002.

NHP was more concerned about accomplishment of MDGs. NHP-2002 might be considered as precursor to National Rural Health Mission which was supposed to begin from 2005. Recommendations of national population policy and national health policy zeroed in on demographic improvement and growth. This demographic concern was an important junction in turning National Rural Health Mission into a medicalized health care system instead of comprehensive PHC.

9.2.6 National Rural Health Mission (NRHM)

NRHM can be been seen as state-governed intervention in field of health. State has extended its existence till 2017, considering the significance of NRHM in improving, in particular, Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) and making contributions to general health conditions. Twelfth Five-Year Plan extended NRHM to "urban poor", naming it as National Health Mission (NHM) rather than National Rural Health Mission (NRHM). It also

highlighted the idea of untied funds, public-private partnership, merging of health sector, participation of Panchayati Raj Institutions (PRIs) and other aspects of health (e.g. water, education, nutrition, sanitation, social and gender equality) were added to create a fully functional health care system at each level, right from village to bigger units like districts. It also focused on enhancing women's access to health care services and idea of gender equity.

The accomplishments of Rural Health Mission-2009 are far from being what was expected and required. There were various inequalities at different levels between states. Though national Maternal Mortality Ratio (MMR) numbers look good, inter-state variation between different states was huge: from 81 in Kerala to an unexpectedly high 390 in Assam. The report significantly shows that newly constructed PHCs are not used and locked due to non-availability of staff, faulty and outdated equipment which needs repairs and is lying dysfunctional and useless. Districts prioritizing infrastructure are not seen in State PIP (Programme Implementation Plan); there is severe lack of specialists, doctors, medical officers and nurses. There is lack of training and severe deficit in training institutions. Eleventh Five-Year Plan acknowledges inability of an institution to improve services like nutrition, safe water, sanitation, hygiene which are critical determinants of health for a country. It admitted that the country did not have good institutional capacity to provide healthcare to all, especially expecting mothers giving birth every year. Half of maternal deaths occur during abortions, pregnancy and postpartum related complications. In new liberal regime primary health care system appears to be weakening despite involvement of Aanganwaadi workers, ASHAs and introduction of health insurance for poor.

9.2.7 High-Level Expert Group on Universal Health Coverage

National Health Bill-2009 declares health as a fundamental human right and 65th World Health Assembly in Geneva also recognized universal health coverage (UHC) as urgent and immediate imperative for all nations to work together in advancement of public health care. Later on, in 2010 Planning Commission constituted a High-level Expert Group (HLEG) committee. Members of HLEG were public health professionals. They believed in principles of:

1) equity, and

2) universality.

According to the committee the state must be principally and primarily responsible for UHC which is a right to comprehensive health security including a wide range of welfare services. Hence, public health sector services must be strengthened, improved and brought into light to ensure quality services and access to all sections of society. Committee rejected both user payment in public institutions and private insurance and suggested genuine participation of public. It argued that UHC can succeed only if it is formed on social cross-subsidization and solidarity. Hence, it suggested a simple universal method of financing

through general and differential health taxation and also went on to recommend that 70% of it should go to PHC.

Based on these recommendations four basic problems came up:

1) The recommendation to improve services was accompanied with an idea that private sector institutions and individuals could be included in a contractual way. It included specific health packages under clearly prescribed contractual conditions which remain unidentified and it also witnessed absentia of an adequate structural regulatory mechanism.

2) Second problematic question was package of services which was left to experts and bureaucrats. Unfortunately, they have not found a mechanism to integrate vertical programs. They could not clearly demarcate domains of:

a) medical service,

b) health care service, and

c) health system.

Nor could they accept that success is vested in same social factors that cause failure of healthcare.

3) The recommendations completely ignored huge presence of traditional healthcare practitioners and the fact that about 20-98% (average 57%) of population in 18 major states were found to use their services.

4) Fourthly, there is no proof to demonstrate importance of the impact of availability of food, drinking water and sanitation for improving health conditions and also how these will impact social determinants. As a result, these are again left to their particular respective departments ignoring intra-systemic techno-managerial solutions. UHC, then, might end up only in rendering services rather than providing health for all.

9.2.8 National Health Policy 2017

2017-policy aimed to project an additional assurance-based approach. It was founded on changing priorities in India's huge healthcare delivery system. This involved developing a more 'robust health care industry', decreasing, thus, the 'leviathan expenditure'. It focused on healthcare costs and aimed at enhancing 'fiscal capacity' to meet a huge healthcare financing deficit. NHP-2017 showed a policy proposition which was high on hope and word and jotted down in elegant prose but opens itself into two kinds of criticism:

1) agency-capability

2) feasibility

NHP-2017 also mentions the requirement to address issues related to women's access to healthcare in rural-urban areas, rising gender-based discrimination and violence incidents in hospitals, emergency care and disaster preparedness by

hoping to create "unified emergency response system" linked to a dedicated universal access number. It also focuses on:

1) mainstreaming indigenous medical knowledge systems via AYUSH;

2) dealing with mental health related problems (taking into consideration some of the provisions of National Mental Health Policy 2014);

3) improving life expectancy target (from 67.5 to 70% by 2025);

4) improving state-sector health funding to more than 8% of their budget by 2020 and other important public health care factors.

In reviewing NHP-2017 one can see the result of an extensive multi-stakeholder consensus-based policy approach where policy more effectively identifies requirement to address problems with respect to three A's (access, affordability and accountability) of healthcare services in India. But the policy fails miserably to provide a cohesive, practical action plan to resolve problems pertaining to any of the A's – especially when existing public healthcare machinery is useless under macro and micro-managerial inefficiencies and inadequate funding from government and is inefficient on training and capacity-building efforts.

The policy accepts that there are many dangerous gaps in public health services which might be filled in by 'strategic purchasing'. Such strategic purchasing would play leading role in taking care of private investments and pushing them towards those areas and services for which right now there are no providers or very few providers. Overall objective of the policy is to:

1) strengthen private sector insurance schemes in domain of tertiary and secondary health care, and

2) undermine public sector.

National Health and Family Survey points out some noteworthy observations about patient healthcare option pattern in India. Despite the fact that in the past both private and public sector heath care have failed its patients, with Fortis slapped with a lawsuit for overcharging treatment of a seven-year-old dengue patient and also against a government hospital in Uttar Pradesh reporting death of 23 children because of lack of oxygen. Nearly 52% of Indians still definitely choose private medical institutions over public institutions. This preference for private institutions is huge in urban areas where number of private healthcare hospitals is also high. However, this survey has highlighted major issues behind this preference of people despite availability of cheaper, public healthcare centres which are not preferred because of:

1) longer waiting time,

2) lack of resources,

3) constant absence and rudeness of medical staff,

4) lack of infrastructure, and

5) low quality of healthcare services.

Even rural population now prefers to go to nearby urban centres for their healthcare requirements. This has made current government to convert PHCs into "Wellness Centres", giving them necessary change and improvement they needed. Most shocking data comes from states which are seemingly not rich or comparatively less developed than other states of India:

1) Nearly 80% people in Uttar Pradesh prefer to go to private hospitals for healthcare needs.

2) Uttar Pradesh is followed by Bihar at 77.6% and Punjab at 72.9%.

Apart from this another major and noteworthy problem is that in spite of AYUSH department's efforts only 0.5% of urban population and 1.2% of rural population go for alternative medicines. National Commission Medical Bill-2017 has suggested a bridge course for Indian traditional medicine practitioners which will now allow them to prescribe allopathic medicines for basic health issues. Despite that this move is not only being contested by allopathic and homeopathic practitioners alike but has also become a debatable issue.

Check Your Progress Exercise 2

1) What is Structure Adjustment Policy? Write about its implications.

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2) Highlight drawbacks of HLEG committee report.

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9.3 ENVIRONMENT

Man and environment have been existing together since times immemorial. It is noteworthy that human relationship with environment has been quite dynamic

and has passed through several stages. Since primitive times humans have had symbiotic relationship with nature. Gradually this interdependence was replaced by human mastery over nature. In present scenario demands of industries have resulted into a material-intensive growth. It may be noted that relationship between population, environment and development is quite intricate. These entities even regulate each other. Development and environment can be seen to be affecting each other at several levels. It is because of this reason that attention of policy-makers is drawn to both simultaneously. One without the other is incomplete.

9.3.1 Importance of Environment

Economy of any region is directly related to its environment. Economic significance of environment of any area can be best understood through various ecosystem services that particular environment in that region fosters. These ecosystem services include:

1) provisioning services like irrigation, food, drinking water;
2) regulating services such as water quality regulation, climate regulation;
3) supporting services like nutrient recycling, soil formation; and
4) cultural services like religious and recreational services.

It is worth noting here that millions of households and developmental activities make use of these services for production and consumption.

9.3.2 Relation of Environment with Development

Industrialisation followed by urbanisation has been instrumental to bring in desired economic development. It is worth noting that it has resulted in growth in per capita income. However, these income-generating activities as such have only resulted in negative impact on environment. Population growth is one of these areas. Noticeably, environmental quality is being compromised for goals of mass employment generation and poverty reduction. It was generally assumed that rising income levels, better quality of life and technological improvement would help in restoring environment. However, this idea turned out to be a farce. It has been noticed that with growth in technology and income levels environment has continued to suffer immensely.

Environmental sustainability has been greatly affected because of lack of environmental compliance. Result of this non-compliance has been witnessed in form of natural hazards leading to number of avoidable causalities. Execution of any scientifically evolved mechanism to ascertain risk emanating from these hazards have barely been witnessed. Unscientific cutting of slopes into hills and unregulated quarrying have resulted in greater soil erosion and increased risk of landslides. To ameliorate sufferings of vulnerable population government has introduced number of subsidies. It is, however, noteworthy that even these subsidies have their own negative impacts on environment. Subsidised services in

form of energy and electricity have been seen to be abused and overused. All this has great impact on environment sustainability.

Since accessibility to environment is for all and sundry, onus of degrading environment, therefore, does not lie on a single individual. Misuse, overuse and abuse of environment leads to imbalance in nature. This can be seen in direct as well as indirect ways. Direct misuse can be seen in cutting forests while indirect impact can be seen in lack of generated oxygen as a result of clearing trees. Another indirect affect can be seen in increased levels of carbon dioxide. Increase in population disturbs linkage between underdevelopment and environmental degradation. To add to the injury, incentivisation promotes large migrations. All this puts bigger pressure on urban areas which are otherwise environmentally sustainable. It may, thus, be noted that poverty as well as incentivisation damage the environment to great extent.

9.3.3 Legislative and Policy Development

It may be noted that even before 1990 India had a series of legislative development: starting from Wildlife (Protection) Act in 1972, Water Act of 1974, followed by Forest Conservation Act in 1980, Air Act of 1981 and Environment (Protection) Act of 1986. Environment versus Growth debate has assumed really complex dimensions. Since development resulted in deteriorated state of environment in post-reforms India, its discussion being far from an elite idea and confined to seminars, conferences and workshops, it has gradually become voice and concern of common man. This could be seen and reflected in daily lives of people, their health concerns and livelihoods. Depleting water tables in Punjab and extended drought and femine in Vidarbha region is an excellent example to understand this trend. Rising pollution levels in Chandrapur in Maharashtra as a result of mining and use of poor-quality coal in thermals power plants affected more than 10000 people in the region who were found to be suffering from respiratory diseases. Sewage treatment and effluent treatment facility on the Ganges is not even capable of treating half pollutants pumped into the sacred river on everyday basis. Result is that effects can be seen on wider population including so-called elite sections of society. This is evident from Delhi's rising pollution level in winters or fire in Deonar dumping group in India's most populated city Mumbai. Everywhere, human impact of environmental pollution is surfacing very starkly.

Rio Convention (1992), Kyoto Protocol (1997) and annual summits on climate change in Paris Agreement (2015) have established that environmental concern is a global issue. In Indian context Right to Information (RTI) through extracting information from government and Non-Government Organizations (NGOs) through Public Interest Litigations (PILs) have played significant role in exerting pressure on government. Judicial activism has further enhanced pace of reforms and implementation of policies. This is evident in Supreme Court's verdict in 2002 wherein it talked about setting up Central Empowered Committee (CEC) which is a quasi-judicial body and whose work is to:

1) monitor implementation of hon'ble court's order

2) bring to its notice issues of non-compliance of its orders related to forestry

The committee has been endowed with sweeping powers. Since then CEC has continuously been working as its watch dog. role of this judicial activism can be seen in the fact that entire fleet of Delhi Corporation Buses was converted from diesel to CNG in 2001. On similar but important note could be witnessed in establishment of National Green Tribunal (NGT) in 2011. Interestingly, it is none other than NGT which has forced government to deregister 15 years old petrol and 10 years old diesel vehicles in NCR (National Capital Region).

9.3.4 Growth with Sustainable Development

Keeping these developments in view the new catch phrase that has emerged is "balancing growth with sustainable environment". No doubt, it has led to emergence of new technologies. However, it may be noted that we have not yet been able to develop mechanisms that strike this sort of a balance. For instance, environmental issues in case of Sardar Sarovar Dam, Jaitapur Nuclear Power Plant and tanneries of Kanpur still remain unaddressed. Situation is really worrisome when we take into account statistics of NGT. It is curious to note that the Tribunal is in receipt of more than 1600 cases in just few years. Close analysis of these contestations in the last decade implies that conservation of environment and economic development are not an 'either-or' choice. It is, therefore, at this point that we need to strike a balance which is only possible if we can think creatively.

Need of the hour is to have smarter regulations which make best use of latest technology. We certainly cannot expect environmental laws to be like licence-quota-inspector raj of yore years. For instance, we have had Emissions Trading Scheme conceived by Ministry of Environment & Forests and Abdul Latif Jameel Poverty Action Lab (J-PAL) in 2011 where real-time emissions' monitoring and trading (modelled on famous 'Acid Rain' program of US) was launched in selected industrial clusters. Need of the hour is to have more of such schemes being streamlined. Outdated regulatory tools too need to be revamped. The present Environmental Impact Assessment (EIA) in India needs to be strengthened. It has been noticed that consultants hired for assessment hardly take into account wider public view on the ground. The outcome lacks integrity and fails to incorporate real damage assessment. Therefore, EIAs need to be carried out by accredited professionals following updated tools that can quantify economic benefits and environmental costs. Trade-offs need to be brought to fore and mitigation measures need to be outlined.

Last but not the least, there is need to strengthen institutional mechanism. India needs to have an autonomous and professional environment regulator. For this a detailed roadmap in context of a National Environmental Appraisal and Monitoring Authority (NEAMA) was put in place in 2011. It had to be a thoroughly professional body with adequate powers and expertise to:

1) assess and appraise the projects, and

2) ensure adherence to rules through monitoring.

1991-reforms were result of an economic turmoil. Taking notice of the situation India's economic policy came out with an innovative path. No doubt, today the country is in great environmental crisis. It is, therefore, imperative that we come out with innovative methods and strategies and chalk out a plan for India's ecological future.

Check Your Progress Exercise 3

1) Enumerate some ecological services provided by environment.

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2) When was Wildlife (Protection) Act introduced in India?

3) What is the role of Central Empowered Committee?

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9.4 SUMMARY

Even after four decades of Alma-Ata Declaration the goal of primary health care could not be achieved. Huge out-of-pocket expenditure to avail healthcare services clearly indicates unavailability of primary health care and low government spending on health service system. Announcement of world's largest health care programme – National Health Protection Scheme – a massive insurance scheme for 50 crores of India's poorest sound impressive. Conversely, what appeared less important was promise of Universal Health Coverage and what went utterly missing was health as a fundamental right. 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 shortcomings and directions for our health system, aforementioned points have been basic thematic rationale of the system that can respond to needs of majority.

Development is a complex phenomenon as it is a pursuit as well as a challenge for humanity. In spite of unprecedented social and economic progress which has been made in last couple of decades famine, poverty and environmental degradation can still be seen persisting on global scale. Added to it, irrevocable damage to environment can also be witnessed on grand scale. Developmental goals, therefore, should not be pursued without taking into consideration environmental regulations.

9.5 KEY WORDS

World Health Organization (WHO): A specialized agency of United Nations responsible for international public health. WHO constitution which establishes its governing structure and principles states its main objective as "attainment by all peoples of highest possible level of health".

Primary Health Care (PHC): It refers to "essential health care" that is based on scientifically sound and socially acceptable methods and technology. This makes universal health care accessible to all individuals and families in a community.

Universal Health Care (UHC): Health care system in which all residents of a particular country or region are assured access to health care.

National Health Policy (NHP): Central government of India periodically publishes National Health Policy to guide future health programs. In 1979 Journal of Indian Medical Association published a review of the policy. First NHP in 1983 had as its goal access to primary care for everyone in India by 2000. Indian Dental Association made oral health recommendations in 1986. Central Council of Health and Family Welfare accepted these for inclusion in future planning. Ayushman Bharat is one of the implementations of 2017 NHP. Latest discussion involves National Health ID system.

National Green Tribunal (NGT): NGT Act, 2010 is an Act of Parliament of India which created a special tribunal to handle expeditious disposal of cases pertaining to environmental issues. It draws inspiration from India's constitutional provision of (Constitution of India/Part III) Article 21 – Protection of life and personal liberty – which assures citizens of India the right to healthy environment. Delhi Pollution Control Committee (DPCC) is a department to control pollution in Delhi.

9.6 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1) 1978

2) See Subsection 9.2.2

3) Health for All

Check Your Progress Exercise 2

1) See Subsection 9.2.4

2) See Subsection 9.2.7

Check Your Progress Exercise 3

1) See Subsection 9.3.1

2) 1972

3) See Subsection 9.3.3

9.7 SUGGESTED READINGS

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