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REVIEW

Models Of Health Care Development For Disease Free India

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ABSTRACT

Providing healthcare and disease prevention to India's billion plus population has always been challenging in the face of limited resources, the socialistic mindset, pluralistic systems of health, misgovernance and socioeconomic disparities. The Government of India needs to understand its limitations with respect to health entrepreneurship. India needs to repeat its successful privatization saga with respect to medical care, health infrastructure provisioning and maintenance and uplift its masses or else, its ambitious rural and urban health schemes will collapse and national health empowerment agendas will remain unfulfilled.

Key Words: national urban health mission, national rural health mission, accredited social health activist, health entrepreneurship

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Introduction

A sixth of the world's population lives in India [1], of which 70% suffers from the vagaries of rural health diseases and infirmities. The health responsibility of rural India is one of the main the health responsibilities of this nation and the state cannot afford to abdicate its responsibilities [2]. Since sixty years of its independent existence, Indian ministries on their part are striving for the attainment of better health goals through the massive National Health Care delivery system [1], [2].

Unserviced vacuums in health service provision in rural areas of India are said to be usurped by non-allopathic fee-for-service practitioners from a variety of systems of medicine (ISM) like Ayurveda, Unani ,Homeopathy and Siddha. Many "nonqualified" doctors in practice—people with no medical training of any sort, called compounders, are also illicitly, the unsolicited part of the Indian health system[1],[2],[3].Such unfortunate plurality of medical thoughts and illicit practices are said to have further accentuated the disease burdens due to differences in approach to the health management and have increased poverty due to out of pocket payments[1],[2],[3].Illicit therapeutic misadventures by quacks, absence of action against quacks by the medical and dental councils, mismanaged health situations by cross practitioners, misgovernance of public facilities and the overt commercialization of the medical education and practice have destroyed the credibility of the Indian health system [4],[5].This paper attempts to identify some deficiencies in the Indian health system and invites the health planners of India to explore some models for health care development in India.

Problems Of The Health System

The overburdened Indian health system [4] has always been plagued by serious resource shortfalls and the underdevelopment of the infrastructure [5].This has led to deficient health care for a majority of India and the system has been accused of red tape-ism, indifference, incompetence and gross inefficiency [5],[6] Resource crunch is accentuated by non-priority spends on plural systems of medicine and such parallel spends decrease the emphasis on the main health scourges endemic in the community [3],[5]. Sincere efforts are needed to provide universal health care for the health impoverished citizens of India, with smarter,

newer models of health caring and also an attempt to improvise the existing health schemes for a disease free India has to be made [3],[5],[6].

The fundamental flaw of the disordered Indian health system has been an absolute lack of financial accountability [3],[5],[6].Also, working in isolation, modern telecommunication networking and the use of intelligent tools like computers, or internet and communication technology tools is poor, in spite of India being an Information technology superpower [7]. So, this vast infrastructure is able to cater to only 20% of the population, while 80% of the health care inadequacies are salvaged by the private sector [6],[7].The cream of profits seem to go the private sector, while difficult to handle cases, or defeated health challenges get abandoned and referred to government hospitals [3],[5],[6].

In the light of India's evergreen health problems, India and its health planners [8] have been frequently on the road of planning for health, but have reached nowhere, thanks to the lax attitude in the implementation of health care programmes in the government ministries. There is a propensity for corruption at all levels and third world health care systems [9],[10] have breeded corruption to the core and greasing the palms of the health staff in charge in the nursing, paramedical or medical departments to get their routine health care rights is the Indian norm. Government staffs in general, are accused of fleecing the clients of the health system for private gain [9],[10].The impact of this is the accentuation of the out of pocket (OOP) payment resultant poverty, which has accentuated societal poverty and disparities [10].

An Independent Commission on Health in India [11], set up by the Voluntary Health Association of India, which submitted its report to the Indian Prime Minister in 1997, had pointed out that Indian public health services `are in an advanced stage of decay'. A survey conducted by the National Council of Applied Economic Research [12] in 1992 revealed that, among the poor, the expenditure incurred to meet the medical needs is the second most important cause of rural indebtedness. These surveys [11],[12] too drew a bleak picture – hospitalized Indians, on an average, spend 58% of their total annual income; over 40% of hospitalised Indians borrow heavily or sell their assets to cover expenses; over 25% of hospitalised Indians fall below the poverty line because of hospital expenses [11],[12].

Neglect of Rural Health: Rural India is suffering from a long - standing health care problem. Studies have shown that only one trained health care provider, including a doctor with any degree, is available per every 16 villages [13].Although more than 70% of its population lives in India's rural areas, only 20% of the total hospital beds are located there. The health workers have not been attracted to rural areas due to socio-cultural and infrastructural deficiencies in such areas. Recently, a rural conscription of health workers including fresh MBBS doctors has been proposed as a remedy to India's rural ills [14]. However, one has to realize that government's efforts alone are insufficient in any society which aims for the universal optimum utilization of health resources [15].A course called BRMS(Bachelor of Rural Medicine) has been proposed by the government [11],[12] [15].

Apparently India suffers from problems which are common in most developing societies- unfortunately, government efforts in education ,employment and delivery of health services seem to breed corruption [15] Also, the government efforts at times, lack community support, staff motivation, are drowned in casteism, corruption, illiteracy and other social ills [15]. The Government of India definitely needs help in improving its health standards by increased education, community participation and socioeconomic reformation. [11], [12] [15].

Defective Health System Design And Mismanagement

Some features of the present health system model seem to suffer from some critical defects in design, but there are also many defects in implementation [16].As a result, health mismanagement occurs and leads to a continuum of individual level health crises and community level health catastrophes [15],[16]. Adhoc-ism rules administrative cadres and bureaucracy stifles advances in management, research and system rectification [16].There seems to be no built- in health alarm system for epidemics or pandemics. There seems to be no efficient epidemic appraisal system and always, temporary solutions are attempted for every epidemic. Memories of epidemics are temporary within the system and the learning curve is long every time due to a short administrative memory mechanism

[16].No attempt to look for and screen or attempt futuristic health forecasting seems to be in place, or it is not given adequate importance [16].No mechanism seems to exist for fire fighting and damage limitation and every time a panic predominates the performance. The Indian health system seems to suffer from shortages in money, materials, memory, manpower, mechanisms and management skills [16].

Failure To Promote Career Interests Of The Health Professionals

Scientific education, especially in medical courses, is seen as an emancipator of one's own socioeconomic and religious problems [17] and hence, endows mobility to these professionals apart from increased societal worthiness and these professionals are keen to settle down where they perceive that greater worthiness exists [17]. Ultimately, health professionals are seen to settle where they gain a profitable permanent source (s) of income (s), as do intellectuals of the IT category or the like. Similarly, talented Professors and Clinicians of repute may look for greener pastures [17] than serving for the government.

At the governmental level, services by doctors in villages do not get rewarded, and, disillusionment can set in rapidly as encouragement does not come from most rural communities at times [17]Rural areas don't inspire young doctors on much counts-poor hospital attendance, poor quality of diagnostic or research material and poor incomes and educational advancement [17].Investing in social studies on the wants of the health professionals could do miracles –for the governments world wide and align the health professional career graph with societal health concerns [17].This would also prevent brain drain and preserve the health professionals as the health guardians of their own societies [17].

Societal Failure To Support The Health Professionals

Presently, not many health staff want to serve or stay in villages and unremunerative areas voluntarily [18].Attempts to invite or maintain talented doctors in villages have failed. Governmental attempts to help doctors and paramedics to settle down in villages and refashion them as family health practitioners or support them to settle down are surprisingly invisible [18], [19], [20].

Indian health system-Strong on Planning and Weak on Implementation

India has vast tracts of land where not even an educated person exists, let alone a doctor. [19],[20]. Experts have faulted the implementation system of the health planning in our country-as India has always been found to be weak on the implementation side, though it has been strong on planning [19]. No wonder, thus, the health performance in India has been persistently poor. Siphoning of funds allotted to the health sector occurs at all levels [19],[20]. The poor too prefer the private providers and the governmental effort is almost going waste [3],[19],[20]. The quality of health services provided in the government sector has always been poor and health workers who are associated with the government, are inaccessible, and have been often accused of absenteeism [20].

Since the Indian independence, at the cost of the tax payer, India has laboured to create a vast public health infrastructure of Sub-centres, Public Health Centres (PHCs) and Community Health Centers (CHCs) [21].There is also a large cadre of health care providers (Auxiliary Nurse Midwives, Male Health workers, Lady Health Visitors and Male Health Assistants). Paradoxically, much of this robust infrastructure is put to use by only a handful minority due to fundamental flaws in Health care planning and financing and faulty focii in implementation [21].

The Rural Mission: The National Rural health Mission: [22]

To address these concerns, India has created the National Rural Health Mission (NRHM) to carry out the necessary architectural correction in the basic rural health care delivery system. The National Rural Health Mission was launched in April 2005 and the duration of NRHM will be from 2005 to 2012 [22].The total allocation of funds for The Departments of Health and Family Welfare has been hiked ,nearly 10 times i.e.,from Rs. 8,420 crores to Rs. 90,103 crores in the budget proposals for the year 2007 - 08.The goal is to improve the availability of and access to quality health care in rural areas, especially the poor, women and children. [22]The nation has pledged to increase public spending on health to at least 2 - 3 % of the Gross Domestic Product (GDP) with a focus on primary health care. The Mission aims to provide accessible, affordable and accountable quality health services,

even to the poorest households in the remotest rural regions. The difficult areas with unsatisfactory health indicators were classified as special focus areas to ensure the greatest attention where needed [23].

Villages As Health Communities, schools as health transformation centre's:

The thrust is on establishing a fully functional, community owned, decentralized health delivery system, with inter sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition and social and gender equality [22]. It also aims at mainstreaming the Indian systems of medicine to facilitate health care [22] .The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into the district health system and operationalizing community health centers into functional hospitals which meet Indian Public Health Standards in each block of the country [22],[23].

Accredited Social Health Activists

The NRHM members are expected to cover all the villages in India's [18],[19],[20] states through approximately 2.5 lakh village - based "Accredited Social Health Activists" (ASHA) who would act as a link between the health centers and the villagers [22].One resident ASHA will be raised from every village, who would be trained to advise village populations about Sanitation, Hygiene, Contraception and Immunization, to provide Primary Medical Care for Diarrhoea, Minor Injuries, and Fevers; and to escort patients to Medical Centers [22],[23]. ASHA would also be expected to deliver direct observed short course therapy for tuberculosis and oral rehydration, to give folic acid tablets and chloroquine to malaria patients and to alert the authorities about unusual outbreaks [24].ASHA will receive performance – based compensation for promoting universal immunization, referral and escort services, for Reproductive and Child Health programmmes of the Indian government, for the construction of house - hold toilets and for other health care delivery programs [24].

The selection criteria for ASHA would be "women, residents of the concerned village, of 25 – 45 years of age, formal education up to the 8th grade, to be selected out of a panel by the village health and action committee of the village council" [22],[23],[24],[25]. The norm would be 1 per 1000 population, but this norm may be changed for different areas. There would be no pay or honorarium, but they will be given a compensation for various health services provided. They will be given a kit of suitable drugs [22]. They would be guided by existing Anganwadi Workers and Auxiliary Nurse Midwife s(ANMs), one of the main agents for increasing the utilization of health and family welfare services in India. In 4 years, 2.5 lakh ASHAs are proposed to be deployed [22],[23],[24],[25].

A Critical Reading Of The NRHM Proposals

NRHM aims at the empowerment of a community based semi-educated woman into the nitty-grittys of the medical profession and to enable her to treat anaemia, tuberculosis, malaria and other complex communicable diseases [25],[26]. The lady is not required to have a fundamental knowledge of science and is used for complex disease management. This flaw in the system will be the main reason for the failure of this scheme. While strengthening the public health systems is a laudable idea, the non use of ICT will be a drawback [25].ASHA's economic status being poor, the roles vested in her (ASHA) seem to be numerous and such heaping of responsibilities looks like a sure recipe for failure [26].Further, the scheme proposes-Mainstreaming of the Alternative Indian systems of Medicine, which should ideally happen at medical college levels, where Indian systems of Medicine can be integrated into modern medicine and respect has to be brought to such systems by inculcating a research attitude and mindset here.[25]

Neither the Medical Council of India nor the other professional councils seem to endorse the idea of mainstreaming the Indian systems of medicine [25]. Also, the basic medical sciences are poorly taught to the Indian Medical professionals. The proper use of the medical laboratory has to be taught to them. Improved management skills mean improved training and open thinking –which can be difficult in bureaucracy ridden health ministries. Evidence based planning may be too much for

ground level workers and may not work. Social participation or the emphasis on participatory medicine needs a high level of community involvement, quite an unseen Indian phenomena with regards to health [25],[26],[27].

The National Urban Health Mission (NUHM) [28]

Urban areas in India constitute about 30 percent of the population and 11% of this is in the Indian cities. The National Urban Health Mission (NUHM) is proposed to meet the health needs of the urban poor, particularly the slum dwellers, by making essential primary health care services available to them [28].This will be done by investing in high – caliber health professionals, appropriate technology through public – private partnership and health insurance for the urban poor. By recognizing the seriousness of the problem, urban health will be taken up as a thrust area for the Eleventh Five Year Plan [28].

Focus On The Urban Have Nots

The NUHM would cover all the cities with a population of more than 100,000 [28]. It would cover slum dwellers and other marginalized urban dwellers like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children and construction site workers who may be in slums or on the sites [28]. The existing Urban Health Posts and Urban Family Welfare Centres would continue under the NUHM. All the existing human resources will then be suitably reorganized and rationalized. These centres will also be considered for up-gradation. The intersectoral coordination mechanism and convergence will be planned between the Jawaharlal Nehru National Urban Renewal Mission which is in charge of the socio-economic reformation of the urban areas and the National Urban Health Mission [28].

Partnership is needed with the community for a more proactive involvement in the planning, implementation and monitoring of health systems [28].An e-health grid encompassing governmental partnerships with NGOs, charitable hospitals and other stakeholders will be desirable. The nation could envisage a two – tier system of risk pooling: (i) women's health committees to fulfill the urgent hard – cash needs for treatments; and (ii) an efficient Health Insurance Scheme and an efficient microfinance scheme involving the rural banks and post offices for enabling the urban poor to meet their urgent medical treatment needs [28]

The Challenges Before The National Health Missions

It is clearly a gigantic task to bring about major changes in outcomes by simultaneous action on a wide range of determinants of health. The NRHM [31] has identified communitization, flexible financing, innovations in human resource management, monitoring against Indian public health standards and building capacities at all levels as the principal approaches to ensure quality service delivery, the efficient utilization of scarce resources and most of all, to ensure service guarantees to local households[28],[29],[30].

Some social scientists have commented that health mission advisors may have suffered from massive blind spots [31]about the well established principles of public health practice when they developed their vision of the rural health services [31]. For instance, developing facilities for education and the training of Managerial Physicians who have the epidemiological, managerial, social and political competence to provide leadership in the administration of the health services in the country, ought to have found a key place in the in the Mission Document. The same argument holds good for the urban health mission [31].Ultimately, the success of both the missions will depend on the ability to galvanize the State Governments into action and to pursuing innovation and provide flexibility in all spheres of public health action [31]. Ensuring the availability of fully trained and equipped resident health functionaries at all levels and large scale financing under initiatives like the Janani Suraksha Yojana for institutional deliveries are a few priorities for action [31]. Partnerships with non governmental providers to strengthen pubic health delivery are also an important need, given the distribution of Specialist doctors in India [31].While India has 30,000 MBBS graduates graduating every year, the entire rural health system for more than 750 million people never has around 26,000 doctors. There is an urgent need to shift the decentralization of functions to hospital units/health centres and local bodies [31].

Health Services Prioritization & Other Solutions

Dr Mahal of the Harvard School of Public Health, [32],[33] asserts, "India needs to prioritize

interventions and targets". A range of low cost solutions include peer education, access to condoms, use of anti-retroviral drugs, life style modification and better hygienic practices [32],[33] .

Recruiting and retaining physicians to serve in rural areas is a difficult challenge due to the expectations and attitudes of the medical graduates and post graduates. Incentives to prospective health workers would be more effective in the form of packages and cuts as in Kerala[32],[33] . India needs to improve the way it plans for, educates and employs doctors, nurses and support staff, who make up the health workforce and provide them with better working conditions[32],[33] .

Social scientists have stressed that community participation will alone emancipate the people from health infirmities [32],[33] . But the reality remains, that Indians have been poor acceptors of government provided health services and have relied on their own resources and out of pocket payments for self health maintenance and servicing [34]. The governments should respect the public mandate in favour of private leadership in health caring, in spite of the fragmented nature of the private health sector. The government alone seems incapable, unable and inefficient in providing access to basic health care for all and needs support from the community, non-governmental organizations and donor groups and the private sector has a big role to play in health entrepreneurship [32],[33],[34] .As in other sectors of human development, the private capital alone can provide newer research products and hence, is desirable [34].

The Kerala Model Of Health Co-Operatives [35] be Expanded:

The state –of- the- art Cooperative hospitals in this state, currently under cooperative regulations, are prospering and are making their presence felt. The Kerala cooperative movement in the hospital industry has been successful even before the advent of the economic liberalization in the 1990s [35].The results of community domination in health caring are evident in this model of health caring and the resultant human development indices in the state of Kerala are better than anywhere else in the country [35],[36].

In rural Kerala, umpteen numbers of hospitals have sprung up and the migration of doctors from neighboring states to Kerala to equip those hospitals is seen [36],[37].This model is a superb example of what the private capital raised from community share holding can do, even in a communist thought dominated state-and is worth emulation [35],[36],[37]. State support to such ventures at every village and subdivision level will nurture the growth of hospitals; clinics, even in rural areas and also improve the competitive spirit between the hospitals [36],[37].

Proposed Reforms: Change The Defeatist Mindset

To make improvements in the delivery of health services, at least three reforms are urgently required [38]. First, it is time to accept the fact that the government has at best limited capability to deliver health services and that a radical shift in strategy that gives the poor greater opportunity to choose between the private and public providers is needed [38]. It is necessary to realize that the government has failed to provide health services since the past decades and has to engage institutions which have expertise than itself. At the same time, we have to understand that the government has constitutional mandates to look after its millions of poor and has to provide accountability to the tax payer's money which has been spent on the public health centres [38],[39],[40].

It means that the government has to move towards a different health services model [40] this model cannot be the age old government does everything model-i.e. the selection of the staff, management and the nitty gritty of running the public health centres;[40] and budgeting at state and central levels; by bureaucrats who know very little about health, or by clerks who are even less equipped [40],[41],[42].So, health governance has to shift to health management than the present model. The government instead can think of the public –private partnership route to health for all [40]. Indians have been excellent entrepreneurs and many health entrepreneurs do exist**.** India has recently witnessed the work of Sam Pitroda (the father of India's communication revolution)[43] and his vision-to provide telecom services to the nation. Today, more mobiles ring in the rural areas than in the urban areas and this is the magic of the private capital, clear-cut governmental policy guidelines, public sector competition and efficient commoditization. As a result, today, India is second to none, in certain sectors like computing and telephony, because of

the far reaching reforms and clear-cut policies for private competition.

The telecommunications sector and the economic reforms have enriched the country [43],[44]. Norms were built in the Insurance sector, banking, industries, as well as in telecommunications and slowly, the government disengaged itself from being a major services provider [45], [46], [47]. This set in competition and encouraged the growth of business houses. Today, every one of every class has access to mobile, as well as cable Television and insurance and banks have ATM machines 24x7. [46, 47] A similar revolution was not attempted in health care servicing and hence, we still languish with our ancestral diseases and nurse health infrastructural infirmities [47]. Fifteen years before today, all this growth was non existent. But the health situation fifteen years before and today is almost the same despite rapid the progress in Medicine and Pharmacology [46],[47].

Health Provisioning As A Business

There has been a wave of health sector reforms around the world, which commonly include the decentralization of public health services (Andreano, 1996). Experiments with decentralization have been underway since the late 1970s (Conn et al., 1996; Gilson and Mills, 1995; Leighton, 1996); [46],[47] more than 25 countries in Africa were implementing some sort of decentralization in the early 1990s (Adamolekun, 1991); [46],[47] In fact, it is good to envision the growth of major health care providers, to visualize chains of hospitals run by these health satraps and to encourage them to take over the government's health responsibilities [46],[47]. The governance has to ensure some proper policies-for health care privatization, to decorruptionise the approvals process and to encourage health care firms with good public confidence [47].While private health entrepreneurs work their way to decent profits and maintain public confidence, they can be even be trusted to run health infrastructures which are presently owned by the government on nominal profits or on a no-loss- no- profit basis [47].

Even a build- own -operate and transfer models have not been experimented as has been successfully done in the National Highways Authorities of India. [46-48] It is essential to recognize Indian entrepreneurial skills and to go forward in promoting health entrepreneurship. No amount of government investment will yield fruit unless you give back health responsibilities to the hands of the people [46],[47],[48]. The best way of implementing the Alma Ata declaration of Health for All, is to complement the existing socialistic model of primary health caring for free [49]. This phenomenon of self health management may in fact be better than the present indifferent approach [46],[47],[48].

Allow Private Hospitals To Exist, prosper, But Not Profiteer:

Certain non profiteering norms and strict norms about organ donation and a strong ethics management team are a prerequisite to the privatization of networks [46],[47],[48],[50]. The presence of health insurance has not bettered the health services delivery in Western nations like the USA [49],[51].and the insurance sector has been more of an exploiter of peoples and has made the system costlier. It has also made the system more instrument and procedure oriented than comfortable. Some form of Insurance in the health sector which is managed by the government as government sector health insurance, will be useful for the poor[49].

Limited Effective Privatisation Is Better Than Half Hearted Government Service: [51]

If private care can be better, it can be preferred even by the masses. Efficient governments do not provide half hearted services. If health care services are good in the private or in the public domain, people, even poor are ready to pay [51]. The government has to fill the pockets of the poor to pay for the services than engage white elephants to do simple health caring. [51], [53]. The government should liberalize investments in the health care sector, while setting the best practice norms which are acceptable world wide[51],[52].Till the privatization of highway ownership, Indians did not taste the true benefits of efficient road transport; today, we envy some of our roadways[52]. A similar attempt can be done in health services also. But unfettered commercialization without protection norms for the poor and a judicial system for health care improprieties, it is doubtful whether health sector liberalization will help [52],[53]. It may turn into rampant commercialization, misuse in favour of the rich, may widen health disparities, be in the strong holds of health insurance mafia and may lead to health ghettoisation of the health

impoverished. Enough safeguards have to be built forehand, even before health sector reformation [51],[53].

Let There Be Competition

A competion model of health caring is needed [54].Today, in the health sector, we don't have a competition to the best of the health services menu, especially by the corporate hospitals. The best experts in private health caring concentrate on the best hospitals and not on the poor infrastructure and the indifferent government sector. Hence, even medical research has languished [54].

Allow To Take Over Norms And Policies For Small Hospitals, Clinics And Research Establishments In Health

Proper research policies will be needed to be framed by the government of India. An efficient grading system is needed and health professions are to be graded as per their skill sets. The hospitals, clinics, health care establishments, research labs, laboratory services, colleges of health sciences, universities of health sciences, etc, all need to be graded on a national scale and online access to such data must be available [54],[55]. Also, it has to be networked or linked to international non profit health networks.

Use New Technologies: Since much of the data used and generated by health providers has a spatial dimension, geographic information system (GIS) is particularly useful to health professionals and administrators in planning and day-to-day health services management (Colledge et al., 1996) [63].Despite tremendous potential of GIS, the health sector in India has not fully explored it. Indian Planning commission has to apply such innovative technologies to map epidemics and rectify infirmities [63].

Majority of the health departments and research organizations need to adequately invest on GIS technology.GIS is a vital tool in strengthening the whole process of epidemiological surveillance information management and analysis [63].GIS provides excellent means for visualising and analyzing epidemiological data, revealing trends, dependencies and inter-relationships that would be more difficult to discover in tabular formats. Public health resources, specific diseases and other health events can be mapped in relation to their surrounding environment and existing health and social infrastructures. Such information when mapped together creates a powerful tool for monitoring and management of diseases and public health programmes [63].

Emergency Care

This can be best accomplished by providing the poor, cash transfers or Medical care coupons for services, for out-patient care and government aided and run insurance for in-patient care [57].The government should invest in public facilities, only in hard to reach regions and places where private health service providers may not emerge [57].It is rational to think of health as an industry. India need not despise quality health services oriented profit making, but at the same time health service providers should abhor profiteering in services [57], [58].

Secondly, the government must introduce at least two-year long training courses in allopathic pharmacology and diagnostics for the existing Indian systems of medicine practitioners, as outlined in the National Health Policy, 2002, [59] which envisages a role for paramedics, nurse practitioners and barefoot doctors elsewhere [59].Finally, there is urgent need for accelerating the growth of MBBS graduates to replace unqualified "doctors" who operate in both urban and rural areas. Bachelor of Dentistry (BDS) doctors should be used in providing rural health services [59] after 1 year training in Medicine, Surgery and Family Medicine.

The Indian Medical Council headed by board of governors and the health ministry perhaps needs to relax its medical college norms without diluting the quality of medical standards and the government needs to make salaries competitive to adequately staff the existing colleges and to open new ones [60]. The government has taken certain steps already, with respect to the relaxation of land area requirements and is encouraging the vertical growth of medical infrastructures [60].It should go the full way and encourage bigger multi-millionaire industrialists to directly take part in the medical services and the education industry [60]. A social service component of 50% free cases, concessional cases or the credit system can be built in to take the masses along. Private mega-hospitals for public caring can be successful if humane individuals and Non-governmental organizations encourage the paradigm shift from public caring to private managed public caring [60]. The total number of

medical colleges (allopathy, ayurveda, homeopathy, unani, dental, nursing and pharmacy) put together, stood at 2092 in 2005-06 [61].This was a sharp increase from just 817 medical colleges in 2004-05.Without maintaining quality, if such unfettered crass commercialization of health education continues, it will degrade the standards of medical education and this has to be guarded against [61].

Many reasons exist for the availability of poor health resources in the villages and slums of India. The significant reasons are the unnecessary governmentalisation of medical resources and the mismanagement of public health provisioning [61].Public health education can remain with the government. More emphasis should be on the privatisation of public health than on the scarcity of manpower [62], [63],[64],[65].. Manpower scarcity will automatically be improved as the market takes over [62]. India needs to repeat its privatisation saga with respect to medical care and health infrastructure provisioning and maintainance, but with a greater degree of compassion and this can ensure some safeguards before allowing full fledged competition [63],[64],[65].

Summary

National Health Missions may be considered as a paradigm shift in the way that healthcare delivery is to be executed, but India needs to introduce a managed competition concept and trigger the private management of health services. Healthy competition can be introduced between the governments and non –government sectors and the Government of India can do the magic again in the health sector, with respect to the telecom, transportation, television and insurance sectors. A lot more work is to be done in order to improve the quality of healthcare of the poor and disadvantaged, through multi-skilling and multi-tasking, multi-sectoral coordination and multi-agency management. However, today, the focus of the national health missions should be a healthy growth of an efficient convergence technology backed e-health network of hospitals and clinics with professional managerial approach. Such an e-health grid alone can help solve the health inequities problem and accomplish equitable distribution of health resources.

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