HEALTH CARE SYSTEM-RELATED FACTORS AFFECTING POPULATION CONTROL**

by

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THE population of India is increasing at the enormous rate of about 13 million a year. This means that every year nearly three times the population of Delhi or the entire population of Australia is being added to the country's population. Thus everyday we have 55,000 new borns—a record of two babies every three seconds. If the present growth rate, which is about 2.2 per cent continues in just about 30 years from now we will be more than one thousand million. This is a prospect which enlarges the area of darkness and it is a fact that unless the present rate of growth of population is checked, whatever progress the country may make will continue to be nullified. Already the country has 630 million people i.e. 15 per cent of the total population of the world, to carve out an existence in only 2.5 per cent of its total land area. The question that continues to stare us in our face is: Can this growth of population be an asset or liability? Understandably, the growth of population can be an asset only upto a point till it is backed by sufficient capital accumulation. Mere additions to labour force cannot create employment avenues. Most economists and health-planners would agree that it is capital formation, accumulation of surplus capacity, which triggers growth. It hardly needs to be emphasized that during the last two and a half decades population growth in India has maintained its pace ahead of economic development. Undoubtedly, the present pressure of population growth on our economy is such that we cannot easily wriggle the country out of poverty or economic bachkwardness. An addition of 13 million people every year has greatly hindered the economic growth and prosperity of our country.

Now even before independence, over a fairly long period, we had a population which could be considered as large in absolute size. Yet, it did not grow at a fast rate as during 1891-1921, a period of 30 years, the net increase in our population was only 12 million or slightly over 5 per cent. However, in the next 30 years i.e. from 1921-1951 the increase was 109 million or nearly 30 per cent. But in the following period of 20 years ending with 1971, it has been 190 million or 53 per cent. How this happened can be well understood if we look at the death rate in the country over this period. Despite the fact that the records on the birth rate and death rates were not very accurate they still revealed certain factors responsible for the acceleration of population growth. Actually, the spurt in population growth, specially since 1921 reflects the widening gap between the birth rates and the death rates. Thus while during 1890-1970 there was a spectacular fall in the death rate from 44 per thousand to 14 per thousand, the corresponding fall in the birth rate was from 41 to 39 per thousand. The factors responsible for maintaining a stationary equilibrium during the earlier period were no longer in operation. Obviously, this led to impressive additions to our population. How does increase in population correspond with the overall development and progress of the nation over this period? Before we started the five year Development Plan, the per-capita income has grown at the rate of only about 1 per cent per annum. Since 1950-1951 the average annual rate of growth increased in per capita income in the next 17 years had been about 4.5 per cent per annum. However, during the last decade, this rate has receded to about 3.5 per cent per annum. This has been corresponded by a net growth of population at around 2.2 per cent per annum. Thus upto the present day the net growth of income has been just sufficient to offset the next growth of population and there has been no significant economic progress in the sense of a consistently rising per capita product. It is in this background of a serious failure to attain a faster rate of economic growth that the question of population explosion needs to be considered. Let's for a moment look at the way the government of India tried to solve the problem of population explosion.

Family Planning: An Historical Perspective

Family Planning as an official programme to reduce fertility levels was started by the government in 1952. Earlier there were certain programmes of family planning, mostly clinics in Urban centres, organised by the private and voluntary agencies. During the first and second

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Five-Year Plans, the approach of this programme was predominantly clinical. However, in the third Five-Year Plan an extension approach was introduced to make family planning more effective. The main focus of this approach was on (i) creating a group norm for a small family through educating the community and the leaders and (ii) providing information and advice to couples in the reproductive age groups through Auxiliary Nurse Midwives (ANMs) and Health Assistants. In 1966, a full fledged department of family planning was established in the Ministry of Health, Family Planning and Urban Development. During the annual plans (1966-1969) the Family Planning programme was made time bound and target oriented. An effort was also made to integrate family planning with maternal and child health. In addition, the 'Cafeteria' approach or the so-called 'Free choice' approach was introduced to provide sufficient freedom to the couples to choose a method of their choice from any of the several methods made available. But somehow it did not work as during this period the main stress was laid on sterilization. From 1975 onwards, the government has initiated a more development oriented programme. But there is one significant difference between the population policy adopted by the previous government, and that which has been initiated by the present government. While the present government is opposed to compulsion in any form for all time to come and makes family planning entirely voluntary the former government spoke of a direct assault on family planning without waiting for education and economic development to bring down fertility levels. We have already revised our targets twice, the earlier demographic target of crude Birth Rate of 25 per thousand by 1975-76 was revised in 1978 to a new target of achieving the birth rate of 23 per thousand by 1978-79. And following a recent decision, the earlier target of 30 per thousand in 1978-79 has now to be achieved in 1982-83. With 1976-77 record of more than eight million sterilization the birth rate had come down to 33 per thousand. It was targeted to reach 30 per thousand, at the end of fifth plan in 1978-79. The regression of 1977-1978 resulted in the postponement of this target of 30 to 1982-1983. Thus this four year slippage has brought an extra burden of 10 million births over and above 13 million expansion that takes place every year.[2] The sterlisation performance from April 1977 to March 1978 (only 926,000 sterilizations were performed) was the lowest in the last decade. It needs to be emphasized that we need 1.3 million sterilization every year to keep birth rate static. This is because 2 million couples enter the reproductive age every year, while 0.6 million leave it. Besides, the fertility rate of 15-24 age group is three times of 40-45 age group. Yet what matters most is the quality of our people. Let's take a look at the health and nutritional status of our people particularly of children.

Health and Nutritional Status

A substantial proportion of our urban and rural population lives below the requisite minimum of calorie intake. Women in the reproductive period are among the worst sufferers of this deficiency. The overall average per capita calories and protein in our diets are 20,000 and 50 gms respectively. There is not only maldistribution of food among different regions or socio-economic groups, but also among the members of a family. More than 40 per cent of the population lives below the poverty line and thus remain exposed to a variety of illnesses and nutritional deficiencies. Moreover, children between 1-5 years, constituting the most vulnerable group in the population from 15 per cent of our total population as against 6-8 per cent in the advanced countries. Besides, nearly a million children die every year due to severe malnutrition. Moreover, there is a higher incidence of mortality and malnutrition among children of high parity.[3]

Obviously as Dr. Shanti Ghosh emphasises, there is a great need for laying adequate stress on the integrated approach to maternal health, family planning and childcare. However, child care would be of little or no help if it does not include systematic education of the parents, and formal and informal leaders of the community including the traditional birth attendants; application of the basic principles of the health care in children; adoption of culturally acceptable changes in food habits and child rearing practices with particular emphasis on breast feeding and gradual weaning; increases in the spacing of birth; recognition of the risks involved in frequent pregnancies; immunizations; treatment of common ailments and improvement of child's physical and socio-economic environments.[4] All this throws heavy responsibility on the centrally-sponsored system of health care in India. The government is trying to solve the family planning problem mainly through the health care system without ever trying to look into the varied deficiencies. It is well known that the health care system in India has all though been a "disease tackling" system, for even the couples seeking family planning are identified as patients. The major focus of medical education continues to be on the disease rather than on the person. Who suffers from it and what are some of the inadequacies of this system that has led to poor performance in the area of health in general and family planning in particular?

Inadequacies of the centrally sponsored health care system

(a) **Inadequacies related to health manpower and services:**

(i) While more than 80 per cent of our population lives in the rural area, three-

fourths of our doctors, trained in cosmolitan medicine, work in the urban areas;

(ii) While three-fourths of incidence of diseases is preventable, three-fourths of the health budget is spent on providing curative health services;

(iii) Nearly 70 per cent of the health care needs of our people are presently being met by various types of practitioners of indigenous systems of medicine who do not form a part of the centrally sponsored health care system;

(iv) The effective area of coverage of an average primary health centre in a community development block still remains confined to a radiaus of about 3-4 miles;

(v) The doctors posted in the rural areas continue to spend a major part of their time on curative medicine rather than on preventive medicine;

(vi) The country has not yet produced a "basic doctor" who could adequately meet the requirements;

(vii) The newly started Community Health Workers Scheme has yet to prove its worth in the Indian Cultural setting; and

(viii) The existing rural health centres continue to suffer from many inadequacies, including regular supply of drugs and availability of refrigeration facilities for keeping the vaccine for immunization.

(b) **Inadequacies related to the Training of doctors & para-medicals**

(i) The training of doctors is largely geared to curative hospital medicine where the young medical students witness many exciting aspects of modern medicine. They find working in the urban hospitals more stimulating than doing a bothersome job of putting malnourished children on the road to better health by immunising them and treating them for minor infections. In fact, they readily adopt themselves to the values of modern medical education system and thus place a low prestige value both on preventive medicine and on working in the rural areas.

(ii) The discipline of social and preventive medicine which was introduced as a major subject to facilitate specialization in the preventive aspects of community medicine has failed far short of its laid down objectives. At many places, these departments have taken those people on the teaching staff who are 'left overs' from other medical departments. By and large they have failed to create a genuine interest among medical students in the field of Community Medicine, including Family Planning. They get little or no training even to perform sterilizations, particularly tubectomies. When posted in the rural areas they feel bored and frustrated. They fail to look at the health problems of the people from a "holistic" point of view. There are not many who can act as effective leaders of the health team. Thus, in a way, poor performance of centrally sponsored health care system in the area of family planning can be attributed to lack of leadership at the health centre level.

(iii) Even the training of nurses is geared to hospital nursing. The nurses get little or no training in community health work. Yet they are the most useful members of health team.

(iv) The present pattern of training of multipurpose health workers and also of community health workers poorly prepares them to perform all the tasks that have been assigned to them.

By way of conclusion we may say that if the purpose is to foster economic growth and development by restricting the present rate of population growth, the above inadequacies of the centrally sponsored health care system have to be met in an effective manner. The hope lies not only in careful analysis of our problems but also in timely implementation of our health and family planning programmes.

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