PUBLIC HEALTH IN INDIA: CHALLENGES AHEAD

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Abstract: As the world's largest democracy and the second most populous country in the world, India has experienced sea change since its independence in various facets of development. However as per public health is concerned, 22 % of our population is mal-nourished, 48 % of our nation's children are stunted (UNICEF report) and which is already responsible for the two-third morbidity burden. Adding to existing glaring difference in access and equity to people, the ratio of beds in hospitals available to population in rural areas is fifteen times lower than that for urban areas. The ratio of doctors to population in rural areas is almost six times lower than that in the urban population. The reduction on public health expenditure and the growing inequalities in health care are taking its toll on the marginalized and socially deprived population. The Infant Mortality Rate in the poorest 20% of the population is 2.5 times higher than that in the richest 20% of the population.

The paper acknowledges the persistence of inequities despite increased investment and some improvements in service provision in recent years. The paper delves into multiple areas such as a) legislative/regulatory issues, b) organization and operational matters and thirdly c) the competing demands for finite resources. In India, however, pre-existing inequality in the healthcare provisions is further enhanced by difficulties in accessing it. These access difficulties can be due to geographical, socio-economic or gender variables. The paper also seeks to provide an overview of some of the issues relevant to equity of access to health and personal social services in Indian context. It also addresses the question of the contribution of health services to health status and further examines the principle of equity which is one of the key principles underpinning the National Health Strategy. Suffice to mention here that while many of the initiatives listed have the potential to improve the public health scenario, coherent implementation and monitoring framework have remained the challenges.

India ranks third in the South East Asia region in highest out of pocket expenditure on health even behind Nepal and Pakistan which have 49 % and 41 % respectively. The poor state of health of our country is evident from the *WHO's world health statistics 2012*, where it was stated that in India 60 % of health expenditure was paid out of common man pocket in 2009. These health expenditures are exacerbating poverty with 39 million people going poor every year due to these expenditures. Per capita expenditure on public health is seven times lower in rural areas, compared to government health spending for urban areas. Though the spending on healthcare is 6% of GDP, the state expenditure is only 0.9% of the total spending and the rest of it is from people using their own resources. Thus only 17% of all health expenditure in the country is borne by the state, and 82% comes as 'out of pocket payments' by the people. This makes the Indian public health system grossly inadequate and under-funded. Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia).

Further this paper will discuss strategies for removing this inequity and how to provide equal access of these health services without creating any burden on them. The basic objective of the reforms to be brought should be to provide the whole nation with basic medical and health services as a public product, and ensure that everyone, regardless of location, nationality, age, gender, occupation and income, enjoys equal access to basic medical and health services. The Government with a similar *intention* in mind has taken a step forward in introducing the Universal Health Coverage (UHC) in the 12th five year plan. The Public Private Partnership (P-P-P) model is extensively being used to cover the gap between the demands of supply health care and by

making the public delivery system (primary healthcare facilities and hospitals) to deliver the agreed service package.
Therefore, until any concerted actions are taken to ensure that health systems are reached to the disadvantaged people more effectively, such inequities will continue. Undoubtedly, the menu of options are long out of which some are untried, but we cannot rely on a particular method since there is no guarantee that such method will be successful.

Keywords: Infant Mortality Rate; World health organization; Maternal Mortality Rate; Mal-Nourished; Stunted.

Introduction

'No individual should fail to secure adequate medical care because of inability to pay for it' - Bhore Committee Report, 1946).

A good healthcare system is considered as the most important factor in development and is the backbone of every country. The last two decades of India have been marked with persistent high economic growth. India being the world's largest democracy, the second most populous country in the world with 1.21 billion people (Census of India, Registrar General of India, 2011) and being the tenth largest economy (with a gross domestic product of US$ 1847.9 billion) in 2011 (WHO, Country Cooperation Strategy, 2012). India has undergone wonderworking and remarkable socioeconomic and demographic changes. But even after achieving so much in different sectors it has failed to keep up in its health sector. Our health system has remained bugged with the greatest problem of our country that is *inequity*. In India, a little has been done to remove it. Many committees had been setup to determine the causes of inequity but their recommendations has been left unattended and those which were considered were not implemented making it a fruitless exercise.

The Indian health system has been categorized as a vast public health infrastructure which is being insufficiently utilized, and a largely unfettered private market which furnishes to greater need for curative treatment. High out-of-pocket (OOP) health expenditures poses barrier to access for healthcare. According to one of the shocking actualities which was shown in a health report was that among those who get hospitalized, approximately 25% are pushed below poverty line by appalling impact of OOP expenditure in the health. Moreover, healthcare costs are spiraling due to epidemiologic, demographic, and social transition. Hence, the need for risk pooling is imperative.(Prinja, Kaur, & Kumar, 2012)

As per census estimates, India's urban population has grown from 290 million in 2001 to 377 million in 2011, accounting for over 30 percent of the country's population (Report of the Steering Committee on Urbanization, Twelfth Five Year Plan, Planning Commission of India, 2012). Between 1980 and 2011 India's Human Development Index improved by 1.51% annually from 0.344 to 0.547 and yet our country ranks 134th out of 187 countries when compared with others. (Human Development Report , 2011)
India in the past few years have started setting up the stage for improvement in their health system with introduction of several innovative and new pilot programmes in both public and private sector and one of the most noted projects of government was the National Rural Health Mission 2005. An equity-focused approach is needed to bring equality and access to a halt in our health system with special focus on caste, class, gender, rural-urban and regional disparities.

This paper will firstly try to scan various problems of health services in India. Secondly, we will make an attempt to discuss the access of health services across economic strata and gender sensitization discussing how much inequity is there in our present health system, and a need to change the system as quickly as possible. Finally, our paper will provide some suggestions and appropriate recommendations to overhaul our health policy mechanisms to improve access and quality of health services particularly for the deprived sections of society.

Public Health- Understanding the Concept

Public health is a science and art of preventing disease, prolonging life and promoting health through organized efforts and informed choices of society, organizations, public and private, communities and individuals (C.E.A, Winslow, 1920). It is concerned with threats to the overall health of a community based on the population health analysis. The population in question can be as small as handful of people or as large as all the inhabitants of several continents like for instance, in case of a pandemic. Public health is typically divided into, environmental, social, behavioral and occupational health, which form various subspecies under the genus of public health. Fundamentally, there are two distinct characteristics of public health that need to be remembered, namely: (1) It deals with preventive rather than curative aspects of health. (2) It deals with

population with population level, rather than individual-level health issues.

The goal of public health is to improve lives through prevention and treatment of disease. The U.N. WHO defines (United Nation World Health Organization) "*Health as a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity"*. That being so, the lack of a framework that works and delivers public health in India is a serious concern and needs to be addressed immediately.

Public Healthcare Delivery System in India

Poverty is the real context of India. More than three fourths of the population lives below or at subsistence levels. In such a context social support for health, education, housing etc. becomes critical. Ironically, India has one of the largest private health sectors in the world with over 80% health being supported by the Out of pocket expenses. (Nandraj, 1994)

The public health care delivery services are very inadequate. The public curative and hospital services are mostly in the cities where only 25 percent of the one and half billion people resides. Rural areas have almost preventive and promotive services like family planning and immunization. The private health care sector has virtual monopoly over the ambulatory curative services in both rural and urban areas and over half of hospital care. Further, a very large proportion of private providers are not qualified to provide modern health care because they are either trained in other systems of medicines like traditional Indian systems (Ayurveda and homeopathy) or worse, do not have any training. These, however, are the providers from whom the poor are most likely to seek healthcare. This put extra risk on the already impoverished population. The cost of seeking such health care is also growing. This means that the already difficult scenario of access to health care is getting worse, and not only the poor but also middle classes are being severely affected (52nd Round NSSO, 2000). Thus India has a large unregulated, poor quality, expensive, and dominant private health sector, and an inadequately resourced, and declining Public health sector. Health Indicators across the board are close to the worst and within the country, inequities across classes are very severe. This is visibly due to the inproper access to health care services, because even in conditions of poverty if access to public health care is universal then it can become a leveler of healthcare outcomes. The unfortunate reality is that even today during crisis this does not happen, and shamefully we experience starvation deaths in many places in India despite having overflowing storehouses of reserved food stocks under the control of state departments. With such inequities prevailing it is evident that the healthcare and food distribution systems are biased in favour of those with purchasing power and hence such a system is grossly discriminatory. It would be necessary for us to consider the present health care delivery mechanism m as provided by our government at the various administrative levels.

Challenges to Public Health

Even though there have been numerous significant developments in public health ever since independence, the prevailing public health conditions still face serious challenges in various areas. (Khot, Anagha , Menon, & Sumita, 2002) (1) Poverty (2) Inequity (3) Public Demands (4) Public Health Delivery (5) Epidemiological Transition (6) New Psychological Issues

Poverty

Poverty is the biggest epidemic that the global public health community faces. It underlies most cases of under nutrition, fuels the spread of many diseases and deepens vulnerability to the effect of illness and trauma. Poor countries are unable to give their health and social services adequate resources, resulting in a poverty of health systems that compounds poverty at a household and community levels. According to the official statistics of the World Bank, there are 74.94 % in rural areas and 54 %i urban areas. In urban areas who are below poverty line keeping the calories requirement as criteria and money required is 567 per capita per month in rural areas andf 718 in urban areas. (Mehta, 2004)

Inequality

Equity is a value of maintaining fairness in receiving a reward in proportion to one contribution. It is fairness or justice. Equity arises at many levels of the health care systems. For example, a national ministry of health may be concerned with the fair collection of budget dollars across regional health districts, as well as with equitable distribution of profeesionals throughout the country. The regional health districts with the fair allocation of primary and secondary health services between urban and rural population. Increasing levels of poverty have been accompanied by growing in equality. The assets of the top three billionaires are worth more than the combined GNP of all least developed countries and their 600 million people. International trade rules and regulations are stacked in favor of richer countries and multinational

corporations; debt cancellations is given at the whim of richer nation creditors rather than as a response to the pressing needs of citizens of poor countries. The conditions imposed upon poor governments by World Bank and international monetary fund are undemocratic such as the privatization of public assets, thereby affecting their Safety nets.

Lack Public Health Legislation and Delivery

The major concerns are equality, secularism, freedom, justice and dignity of the individual. Health services should be of quality which demands compulsory continuing of medical education, medical audit, etc. Delivery system is facing challenges in the following areas: (1) Health Sector Reforms, decentralization, of health care. (2) Appropriate use of health information technology and medical education. (3) Quality assurances, cost effective intervention and health economics, dealing with limited resources. (4) Ethical issues and public health laws, standardization and accreditation of public health.

Public Demands

Public demands for health services is increasing in majority of regions but there very little demand in most vulnerable section of society. Increasing demand for health services also increases the accountability and responsibility to community. Health services should be distributed with equity and preserve the human rights. Public demand is also increasing due to increase in population. This is an important concern.

Uneven Delivery of Healthcare Resources in India

This heading will deal with three main issues. Firstly, that health services in India have not been rendered sufficient priority in distribution of public funds. Secondly, health services are unevenly distributed across economic strata, location, (urban-rural), gender and regions in India. Last, but not the least our inadequate infrastructure, manpower and medicines, badly affect the provision and quality of health services of public organizations. (Ghuman & Mehta , 2009)

India's healthcare infrastructure has not kept pace with the economy's growth. The physical infrastructure is woefully inadequate to meet today's healthcare demands, much less tomorrow's (PWC-Emerging Market Report: Health in India, 2007).

Government's efforts to improve the present health system seems to be negligible which can be made out from various facts. Recent evaluations indicate that 93% of all hospitals, 64% of beds, 85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector in India (World Bank, 2001). Given the overpowering existence of the private sector in our health systems, various state governments in India have been discovering the possibility of involving the private sector and enter into PUBLIC PRIVATE PARTNERSHIP in order to meet the growing health care needs of the population. Comparing these with government of India statistics, there existed total 18,218 hospitals in 2000 out of which only two-third constituted public hospitals (Central Bureau of Health Intelligence. Directorate General of Health Services, Ministry of Health and Family Welfare. Health Information of India 2000&2001). In 2011, the ratio of doctors was (0.6 per 1000 people), whereas, the ratio of nurses was (1.0 per 1000 people), exposing our standing on the health structures showing the poor and lacking behavior of our government in improving India's sinking health system (World Bank, 2013). India has an annual pharmaceutical production of about 260 billion (INR) and a large proportion of these medicines are exported. By controlling the export of this large proportion of medicines, if government try and distribute these medicines in an efficiently manner by providing some subsidies on medicines to poor, it can help in reducing the high pocket expenditure of the people.

India's private sector in the health system is not only the most unfettered sector but also it's the most potent unexploited sector. Good quality is always costly, though, inequitable, expensive, the private sector is perceived to be easily accessible, better managed and more efficient than its public counterpart. It is assumed that partnership with the private sector in the form of Public/Private Partnership (PPP) would improve equity, efficiency, accountability, quality and accessibility of the entire health system bringing a new dawn in Indian health structure (Ramanand & Björkman, 2008).

The private health market is over Rs 71,000 crore, and another Rs 31,000 crore if pharmaceutical industry is included. It is expected to double to Rs 156,000 crore by 2012, besides an additional Rs 39,000 crore if health insurance picks up (CII-McKinsey, 2004). By 2012 it is estimated that the country will require an additional & 750,000 beds, 520,000 doctors and an overall investment of Rs 100,000- 150,000 crore, of which 80% has been projected as the share of the private sector. (National Commission on Macro Economics and Health , 2005) This uneven distribution of health resources further becomes apparent from the ratio of hospital beds

which is fifteen times lower in rural areas than that for urban areas. Similarly, if we take the ratio of doctors in the rural areas, it is almost six times lower than that of urban areas is almost six times lower than that in the urban population. (Central Bureau of Health Intelligence. Directorate General of Health Services, Ministry of Health and Family Welfare. Health Information of India, 2001).

Our health infrastructure and system compared to developed countries is considerably lower taking the example of beds per population in our country, India has very poor figure of (*1:1000 - bed: population ratio)* than the developed n ations, having the ratio of about (*7:100)*. This probably forces the less privileged to seek unregulated private healthcare with significant adverse impact on out-of-pocket (OOP) expenditure. (World Health Statistics, 2009). Since, health is a state subject and states are responsible themselves for health standards in their particular state, the conditions of health therefore have always been in a deteriorating platform. Health system, therefore, should be made a union subject so that the whole health system of India can grow together rather than leaving it on particular states because some states do not have that much budget to invest in all sectors by which the health infrastructure in those states are lacking behind.

As per the WHO's report our per capita expenditure on public health is seven times lesser in rural areas, compared to government health expenditure for urban areas. India's total health expenditure in terms of GDP is only 3.9 percent in 2011 (World Bank, 2013). Public health Expenditure has improved to reach at 31 % which is still considered as a very extremely poor figure and 59.4 % comes as 'out of pocket payments (World Bank, 2013) improved by 82 % (World Health Statistics, 2003) by the people making Indian public health system grossly inadequate and under-funded.

Such a dismal state of our health systems due to unequal spending on public health, has made our health infrastructure ineffective and insufficient. Most vital unit of India's public health infrastructure is a Primary Health Centres (PHC), out if which only 38% of such centres had all the essential staffs and only 31% have all the essential supplies. (Central Bureau of Health Intelligence. Directorate General of Health Services, Ministry of Health and Family Welfare. Health Information of India, 2001).

Difficulties in Accessing Health Care

As discussed above, as to how the unequal distribution of health resources are making the whole health system inefficient and hollow, these pre-existing inequality in the healthcare system is further enhanced by difficulties in accessing it. These access difficulties can be due to three reasons: (1) Geographical distance (2) Socio-economic distance (3) Gender distance

The problem of *geographic distance* is an important concern for such a diversified and a big country like India where there is limited means of communication and some areas are of such a nature that they are totally cut off from the real world, taking example of tribal areas or hilly areas like Leh Ladakh.

In 2008, more than 63,000 maternal deaths and 1 million Neonatal deaths happened in India, representing 20% and 30% of the global burdens, respectively (WHO, 2010). Out of these most deaths ensued because were made to deliver in risky environments because of lack of any medical facilities, specialized attendants lack of medical equipment's and hygienic conditions endangering their lives. Even today if we go to rural areas, 60% of the deliveries happens in the houses only without any medical supervisions (IIPS, 2010). The main barriers to access the health services in these areas is that firstly, since the people are illiterate and not that educated they causes delay in deciding whether to take access of these medical services, secondly, there is delay in reaching to the medical health centers because of their geographical distances since there is not good transport connectivity. Lastly, there is a delay in receiving those medical facilities leading to many deaths in rural areas. Our government has failed to provide enough incentives to the doctors and nurses to move to rural areas because of which no doctor wants to go to rural areas making our system more insufficient and ineffective. Neither our primary health care institutions in rural areas have proper equipment nor do they have proper supply of medicines. (International Institute for population sciences, 2010, district level household and facility survey (DLHS-3), 2007-08, 2010)

Maternal mortality rate is evidently considerably higher in rural areas (WHO, 2010) as access to trained medical or paramedical staff attendants and transport in case of pregnancy complications is difficult. Geographical problems in accessing

healthcare services thus is an vital factor, taken along with gender discrimination, which further contributes to higher maternal mortality in women living in remote areas.

The most serious problem of our country is *socio-economic gap* among different people of our society this has also extended to the inequity and access to health care systems. This problem is generally seen in cases of 'urban poor'. As per the (Third National Family Health Survey (NFHS-3, 2005-06)), almost half of children under five years of age (48 percent) are stunted and 43 percent are underweight. Urban residents have been extremely prone to macroeconomic blows that destabilize their earning capacity which further forces them to consume cheaper foods leading to more infant and under five mortality rates in urban areas making it as high as rural areas.

India alone shares the burden of 24% of world's under-five mortality. The United Nations Children's Fund (UNICEF) had found that children are more probable of dying before age five if they are born in rural areas, among the poor, or to a mother deprived of basic education (UNICEF, 2012). The National Family Health Survey in India (NFHS- 3 , 2007) have highlighted in its report that the rate of decline in under-five mortality rates has been much higher in rural regions as compared to urban areas, but these figures are qualified by wealth, educational and gender inequalities (NFHS- 3 , 2007).

Urban slums of India are often considered home to a widespread range of diseases due to lack of proper sanitation and water supply and other basic amenities. Lack social support systems, such as health insurance, further add to the health vulnerability of the urban poor. Though the healthcare facilities are overwhelmingly concentrated in urban areas, the 'socio-economic gap' have always prevented access to these facilities for those urban poor class. These socio-economic barriers include cost of healthcare, social factors, such as the lack of culturally appropriate services, language/ethnic barriers, and prejudices on the part of providers. All these factors lead to seeking an appropriate healthcare on the part of the poor. (WHO. Private Sector Involvement in City Health Systems proceedings of a WHO conference meeting , 2001)

The third most important problem related to accessibility and equity is due to *gender related issues*. There is a wonderful saying that women's health reflects the health of the Society. But this saying is entirely overlooked in a country like India where most of the Hindu gods are females. Gender discernment makes women more susceptible to various ailments and diseases related to morbidity and mortality. In India, women from the beginning

only are treated as being lower to men. They are socially, culturally, and economically dependent on men (Narayan, Patel, Schafft, Rademacher, & Koch, 2000). The combination of perceived ill health and lack of support mechanisms contributes to a poor quality of life

Effect of Economic Inequality on Accessiblity to Health System

Government's lack of interest on public health spending and the rising inequalities in health and health care infrastructure are making these already marginalized and socially destitute population of our society to suffer the worse conditions. Taking the facts an infant born in deprived family is two times more vulnerable to die in infancy, than in a better off family. (International Institute for Population Sciences and ORC Macro. National Family Health Survey (NFHS-II), India, 1998-99). Although, it has improved by the passing of time but still there is a lot to be done to remove this menace from India. Infant mortality rate is 47 per 1000 live births in India today which is more in rural areas compared to urban areas. It is 1.5 times than in urban areas. (G O I, Sample Registration System Bulletin, Registrar General, India. , 2009)

Similarly, a child in economically weaker group is four times more vulnerable to death in its childhood than in a better-off group. A Female child is 1.5 times more likely to suffer death before reaching to her fifth birthday as equated to a male child. (International Institute for Population Sciences and ORC Macro. National Family Health Survey (NFHS-II), India, 1998-99) Taking the most recent data in India only 59% out of the total births are attended by trained medical staffs. (World Bank, 2013)

These statistics state for themselves the condition of health system in India. This unequal distribution of resources is further complimented by inability of universal access to healthcare due to various access difficulties.

According to World Bank reports in 2001 the household health expenditure accounted for 89 %. It was more than two- thirds of total health spending, which is high compared to global standards. But since then it has improved in year 2011 and has now reduced to 59 % (World Bank, 2013)and India has been ranked at 42nd in Out of Pocket Expenditure

(WHS, 2011). Out of Pocket Expenditure accounts for an average increase in poverty by as much as 3.6 and 2.9 percent for rural and urban India respectively (Gupta, 2009)

Recommendations and Conclusion

Equity has become a long-lasting issue in health and health care delivery. The World Health Report, 2000 restates this problem by taking equity and efficiency as the most striking features of Health System Performance**.**

However, tumbling inequity in health needs not just development of indicators and measurement of the problems, but, more importantly, a policy, which puts equity on the agenda and inspires those, especially in economic decision-making positions, to reflect the equity insinuations of their policies. The health sector has a significant role to play here, but needs the relevant information and analytical skills to present it effectively.

The government of India should radically try to enhance their budget in health sector by reducing the household expenditure of people. Insurance facilities should be provided by the government to the poorest section of society in order to protect them from any inequity and socio- economic problems that may come while accessing the health system. Both outpatient and inpatient care should be included. Preventive services should be the mainstay of the program which should include immunization, antenatal care, health education, and screening for chronic diseases. Government should provide health packages which should be state specific as health requirements may differ from state to state and region to region.

Some of the recommendations are: (a) Shift from budgetary support to health policy dialogue and technical advice, and shift from replacing government services to strengthening the country's own capacity; (b) Strengthen interlocution with the states and presence across the country, with emphasis on establishing a network of regional hubs in support of states needing particular help in the areas agreed with the Government of India; (c) Take inter-sectoral action more seriously and engage with various stakeholders in fostering health actions. (d) Bring in international experience and strengthen India's health information and health intelligence. (e) Promote responsible management with the correspondingly increased demands in terms of accountability for results; and (f) Most of the policy documents including National Health Policy, 2002; and the National Rural Health Mission (2005-2012) recommended for increase in public health expenditure, this recommendation should be adopted with immediate effect. (g) Prioritized action plans to improve the public delivery system of health facilities. (h) States should try to reduce the rural urban divide and all the socio economic disparities existing in the society. (i) Government should try and fill the vacant seats of doctors and nurses and should take concerted steps to reduce doctor ratio per population in order to make the health institutions more accessible in rural areas. (j) Government should work in partnership with private players as the private sector has more presence in the health sector, so both will have to work together to remove these problems from the sinking health system. (k) Gender sensitization should be done among the masses for removing any discrimination and allowing the women of our society to easily access the health care institutions.

Although, Health equity is not a standalone phenomenon but related with accessibility, availability, quality of health services which again are rooted in to various social cultural realities of communities. The accessibility in developing countries is seen as a key aspect for health equity and this can be removed only by devising an effective and efficient responsive public health service delivery system. This can only be achieved when it touches to different sections of society especially to those who have stayed deprived of it because of social economic disparities.

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