

Documentation

HEALTH CARE IN INDIA TODAY. 1

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This documentation is classified into **seven main sections or themes**: I) Introductory Perspectives; II) Crisis in India's Public Health System; III) India's Health Scenario; IV) Root Causes of Today's Crisis; V) Recent Developments; VI) What Is to Be Done?; and VII) Signs of Hope. Parts II to IV deal with **the analysis of the situation** and Parts V to VII with **the urgently needed changes**.

Though we would have liked to make a more scientific, systematic and comprehensive study, we hope that these reflections will help us to identify the major issues, challenges, and possibilities for profound transformations and relevant involvements. *May all of us understand better what is going on in the society at large and the health field in particular, and may we discover the urgently needed responses, commitments and concrete actions!*

I. Introductory Perspectives

It may be fitting to begin with a few reflections on The Concept of Health (1), Health as Human Right (2), Basic Principles of Public Health (3), The Social Determinants of Health (4), and The Globalising Context of Today's Crisis and Struggles (5).

1. The Concept of Health¹

As often pointed out, **health** does not simply refer to the absence of disease, but to a state of well-being, wholeness, harmony, equilibrium, and quality or fullness of life. The WHO definition of health is well-known (above, p. 4).

*The references to newspaper articles and two reviews are given in the text itself with **DH** (Deccan Herald), **EPW** (Economic and Political Weekly), **H** (The Hindu) and **HA** (Health Action) as **abbreviations**. The numbers in the parentheses indicate the day, month, year and page. Some **Notes** and **References** are also given at the end. **Cross-references** to this issue of *Integral Liberation* are indicated by the words *above* or *below*. The *National Health Policy-2002* is referred to as **NHP-2002**, and the "Conclusions" of the 2005 National Consultation "Healing as Mission" as **HM**.*

The 2005 Consultation "Healing as Mission" well expresses **this truly human, holistic and integral dimension of health**: "*The concern of health care is more in terms of securing and promoting life rather than merely treating some particular diseases*. Jesus also explicitly expressed the goal of his mission as promotion of life, life in all its fullness (Jn 10:10). This paradigm shift needs to be expressed in terms of holistic healing and the concerns of the healing mission should go beyond the promotive, preventive, curative, and rehabilitative aspects. *Today our healing mission should be holistic, influencing all the human dimensions: physical, psychological, spiritual and religio-cultural, as well as the socio-economic and political*" (HM, # 28).

A genuine "approach would be to see integrally the needs of the whole person and to get his/her restoration to health. Therefore, health would mean adequate food, housing, clean water, clean air, safe social milieu, healthy social and inter-personal relationships and non-oppressive and non-exploitative economic and social structures. In short, *it means a harmonious relationship with one another, with nature and with God.*" Today, we must acquire a more holistic understanding of health (HM, #31).

2. Health as Human Right²

According to the 1948 Universal Declaration of Human Rights, "*everyone has the right to a standard of living adequate for the health and well-being of himself and of his family*, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" [Art. 25(1)]. The WHO Charter further proclaims that "**the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being** without distinction of race, religion, political belief, economic and social condition".

The Indian Constitution speaks of the "right to life" (Art. 21). It also declares: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties..." (Art. 47). India has moreover

“acceded to the International Covenant on Economic, Social and Cultural Rights. Article 12 of the ICESCR refers to ‘*the right to the highest attainable standard of health*’, requiring availability, accessibility, acceptability and quality as imperatives in health care along with the universal access to the underlying preconditions of good health” (Rao, 2006).

Ajay Pandey comments: “The Supreme Court of India has categorically maintained that **the right to health is a part of the right to life itself**. ‘It is now settled law that the right to health is integral to the right to life. The Government has a constitutional obligation to provide the health facilities.’ Indeed, *the meaning of the right to life in the Indian legal context is so vast that it includes almost every human right in its ambit.*”³

The HM Consultation therefore concludes: “Governments are duty-bound to work for the holistic welfare of all the citizens, especially the poor and powerless. *Health is one of the constitutive dimensions of this holistic human welfare, for which governments are responsible.* Health care measures are not to be seen as charity by governments. *They are the people’s legitimate right.*” “**The right to health for all, in its fullest comprehensive sense, is intrinsically linked with the larger social transformations.** Transforming the conditions of Dalits, Tribals, women, fisherfolk and all the marginalised and enabling them to assert their own dignity and rights are some of the genuine challenges to establish creative health care ministries in the Church” (HM, #29-30). *This is also the responsibility of all health institutions.*

3. Basic Principles of Public Health

T. Jacob John thus explains **the basic concept of public health**: “The term was enshrined in the Public Health Act of the British Parliament in 1848, *placing responsibility on the government to protect the public from communicable diseases* transmitted via the environment. The discipline grew in modern times to cover all the causes of disease and death, including heart attacks and road accidents. **Public health is the art and science of preventing disease, promoting health and prolonging the quality of life.** Wherever typhoid, fever, cholera and tuberculosis are rampant, there is no functional public health” (H, 25/5/04/8).

Arati Rao highlights **some basic principles of public health**: “Way back in 1946, the Bhore Committee outlined *a universal health care plan*. Anticipating that large sections of the population may be unable to pay for health care, the committee recommended that *no person should be denied medical care because of an inability to pay for it*. It also recommended that health workers be on the public payroll, limiting the need for private practitioners. *The committee also laid special emphasis on preventive methods and communicable diseases*” (Rao, 2006).

“Moreover, recognising urban-rural disparities, it laid out an infrastructure plan for a comprehensive three-tier health care system at the district level in order to *provide preventive and curative health care to everyone*” (ibid.). According to this well-conceived scheme, “there is **a Community Health Centre (CHC)** for every 100,000 population. Under each CHC, the norm requires **four Primary Health Centres (PHCs)** serving approximately 25,000 people each and **24 subcentres**, each serving 4,000 to 5,000 people” (HM, #21).

The 1978 Alma Ata Declaration developed these principles. Defining health as “a fundamental right”, it reiterated “that ‘Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures’. The **Primary Health Care (PHCA) strategy** sought to establish the accountability of health workers and health ministries, with guarantees to meet the basic needs of all... *The all-inclusive equity-oriented approach to health was the most politically charged feature of Public Health Care.* It stressed the need for a comprehensive strategy that not only provides basic health services for all, but also addresses the pervasive underlying social, economic and political causes of poor health. *It linked health to a strongly participatory strategy*”, the organisation of the poor and underprivileged to secure their rights, and the reduction of poverty and gross inequalities, which are ‘politically, socially and economically unacceptable’. “**PHCA was seen as the key to attaining Health for All as part of development in the spirit of social justice.**”⁴

4. The Social Determinants of Health

As already mentioned, many environmental, educational, socio-economic, political and culturo-religious factors greatly impact people’s

health. On the other hand, health is an essential resource that enables individuals, communities and nations to overcome poverty and develop their potential. In this sense, health is a prerequisite for progress and development.

There has recently been much discussion on the social determinants of health (cf. above, pp. 5-6). S.G. Vombatkere for example wrote: *“The pathetically poor state of health of the vast majority of India’s population is the direct outcome of the skewed concept of development adopted with the New Economic Policy. The levels of nutrition have actually reduced since 1991 when India determinedly climbed onto the globalisation bandwagon.”* *“Ill-health is inevitably connected with poverty-related chronic hunger. India is ranked 94th in the world (behind Ethiopia) out of 118 countries according to the Global Hunger Index, and India is home to the largest numbers of undernourished people in the world. This background of hunger and malnourishment militates against the very idea of public health”* (HA, Dec. 2007, 4 & 7).

S. Ousepparampil rightly emphasised the close relationship between health and various other factors: *“The UN Millennium Declaration signed by 189 countries and the resulting Millennium Development Goals (MDGs) represent a commitment by the world’s leaders to reduce global poverty, close the gap between rich and poor and improve the health and welfare of the world’s poor within 15 years.”* *“The eight MGDs represent a unique global compact. Health is at the heart of the MDGs – a recognition that health is central to the global agenda of reducing poverty as well as an important measure of human well-being. Health is represented in three of the eight goals and makes an acknowledged contribution to the achievement of the other goals... We need to look beyond the health system and address the broad determinants of health like education, poverty, gender, environmental health, etc.”* (HA, May 2006, 3).⁵

On 12-14 June 2000, WHO organised a meeting on **“Partnership in Health and Poverty: Towards a Common Agenda”**. These are some of the main messages that emerged. 1) There is clear evidence that demonstrates *“the centrality of health in reducing poverty and other deprivations (such as gender-related disadvantages)*

and in promoting overall social and economic development”. *A Health Policy can thus be “a core instrument for poverty eradication”*. 2) This is not recognised enough in both the health and development sectors. 3) Both the health and the development actors or activists must adopt an integrated approach to the struggle for health and development. 4) *“Health actors need to recognise that health – like all sectors – is embedded in politics. If health actors are to rise to the challenge of being effective political players, they will need to move beyond the narrow biomedical paradigm, equip themselves with requisite advocacy skills and tools, and participate vigorously in the politics of development.”*⁶

Good health is a vital and often the only asset of the poor to sustain their survival and livelihood. **A twofold strategy is required to promote health for the poor:** *“raising their access to affordable, appropriate, good-quality health services as well as creating an enabling environment to protect their health (cf. above, pp. 12-13). This can only be achieved by developing collaboration between all sectors to address the determinants that influence the health of poor people.”* For this, we need a strong commitment by one and all and the adoption of a participatory and rights approach. *Strategic actions must be identified to develop “a common agenda on promoting both the health of the poor and the role of health in development”*.⁷

“In 2005, the second global People’s Health Assembly emphasised that Governments have a fundamental responsibility to ensure the universal access to quality health care, education and other social services according to people’s needs, not according to their ability to pay. Health is primarily determined by the political, economic, social, physical and environmental conditions and should, along with equity and sustainable development, be a top priority in local, national and international policy-making. The participation of people and people’s organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes. The people should develop a mechanism to hold local authorities, national governments, international organisations and corporations accountable” (HM, #20).

5. The Globalising Context of Today's Crisis and Struggles

Many writers rightly situate their health analyses and action proposals in the context of globalisation. The HM Consultation for example declares: "Despite the tremendous medical advances and increasing average life-expectancy, *health services world-wide have become increasingly inaccessible, inequitable in distribution and inappropriate in emphasis and approach.* Enduring poverty, renewed onslaught of communicable diseases, including the HIV/AIDS pandemic are leading to reversals of the previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial, caste, and gender imbalances. *These trends are to a large extent also the result of the distorted structure of the world economy,* which has been further skewed by structural adjustment policies, persistent indebtedness of the South, inequitable world trade arrangements and uncontrolled financial speculation – *all part of the iniquitous process through which the impersonal corporate capitalism is globalising itself*" (HM, #2).

Governments all over the world are withdrawing from health care. They "are reducing their spending on the social welfare sector – education, health and family welfare, water supply, sanitation and housing. *The primary health care system of the government today is not responsive to the demands and needs of the people... (India's) health sector is highly affected by the onslaughts of globalisation.* The liberalisation and free-market trends have come to reign in this field. Highly advanced technology has become an important component of health. Hence, the cost element has become too exorbitant. It looks as if only the rich have the right to live today, and be liberated from diseases by accessing the highly specialised modern medical care." **Today's Indian health situation "makes us both sad and angry"** (HM, 3-4).

The National Health Policy–2002 also acknowledges the threat of globalisation: "There are some apprehensions about the possible adverse impact of economic globalisation on the health sector... Global experience has shown that *the introduction of a TRIPS-consistent patent regime for drugs in a developing country results in an across-the-board increase in the cost of drugs and medical*

services. NHP-2002 will address itself to the future imperatives of health security in the country" (NHP-2002, #2.26.1, cf. #4.26.1).

It is therefore in the basic context of globalisation that the HM Consultation tries to understand the international responses of the WHO, the MDGs, the CSDH and the global People's Health Assembly as well as the national responses of the Govt. through the NHP-2002 and the NRHM and those of the voluntary organisations through **the 2000 National Health Assembly and People's Health Charter** (HM, #17-24).

II. Crisis in India's Public Health System

Mahatma Gandhi thus proclaimed India's ideal in 1940: "*We should no longer be guilty of the neglect of the health of our people.*" P Sainath however declared in 2007: "**Few nations have addressed the health needs of their people with such callousness and contempt.**"⁸

Several articles on our public health care system in the last 10-15 years are extremely critical. They state that our system experiences severe strains and is in shambles or in crisis. They speak of its "virtual collapse", "advanced state of decay", or "deteriorating state". S.G. Vombatkere even writes: "Naming what exists a 'health care system' may not be accurate because it largely concerns the management and treatment of sickness and disease rather than health, and merely attempts to restore the patient to a state of absence of disease, not to vibrant good health." Longevity has not been accompanied by good health. "*This has been criticised as 'adding years to life without adding life to years'.*" (HA, Dec. 2007, 5-6).

Though we should not belittle the achievements of the past 60 years and should strongly oppose the tendency of the private sector and a section of the media to systematically denigrate the public health system,⁹ **there are solid grounds for severe criticisms.**

The NHP-2002 describes the prevailing situation as follows: "*The existing public health infrastructure is far from satisfactory.*" In the OPD sector, "funding is generally insufficient; the presence of medical and para-medical personnel is often much less than that required by prescribed norms; the availability of consumables (or essential drugs) is frequently negligible; the equipment is often

obsolescent and unusable; and the buildings are in a dilapidated state.” The indoor facilities are no better, leading to over-crowding. “As a result of such inadequate public health facilities”, less than 20% and 45% of those who respectively need outdoor and indoor treatments avail of public hospitals. This is so despite the fact that most poor patients pay for private health services at the cost of such items as basic nutrition (#2.4.1). “Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, *the wide inter-state disparity implies that, for vulnerable sections of society in several states, access to public health services is nominal and health standards are grossly inadequate*” (#2.2.1).

According to CEHAT (Centre for Enquiry into Health and Allied Themes) findings, “*only 38% of all PHCs, which form the bedrock of the rural health care structure, have all the critical staff. Despite the high maternal mortality ratio in India, 8 out of every 10 PHCs had no Essential Obstetric Care drug kit. Only 34% of them offered delivery services and only 3% could offer safe abortion facilities. Eight of 10 had no paediatrician and 7 out of 10 had no obstetrician*” (Kalpana Sharma, H, 8/6/04/8). According to the NHP-2002 itself, the shortfall in the number of CHCs (Community Health Centres) was as high as 58% in 2000 – though the aggregate shortage of CHCs, PHCs and subcentres was only 16% (#2.2.1).

Jean Drèze further points out: “Recent health facility surveys conducted by the International Institute for Population Sciences (Mumbai) give a chilling picture of the state of PHCs around the country. To illustrate, *only 69% of the PHCs have a least one bed, 20% have a telephone, and 12% enjoy ‘regular maintenance’*. These are national averages, and the corresponding figures for the poorer States are much worse.” “According to a forthcoming Harvard study, *the absence rates among health workers range between 35 and 58% in different Indian States*” (H, 12/3/04/10).

What should therefore be done? According to Amartya Sen, there are “*areas where the government needs to be more active*” and where private enterprise is counter-productive. “I don’t know of any country in the world where it has been possible to have successful healthcare for all without the state playing a major part in it.” *In India today, “there is a tremendous need for a larger and more*

effective public service in health care and education”. China wrongly abolished its social health insurance in 1979. In spite of unprecedented economic growth, the mortality reduction and life-expectancy expansion then slowed down (DH, 17/12/06/7).

According to Sen, **the solution lies “in the classical method of a greater amount of government investment in both education and healthcare**, an end to the negligent attitude towards women and a more collaborative engagement with the various unions”. “He cited the example of pre-1979 China, Japan, the US as well as various European countries where public expenditure on education and healthcare had preceded the introduction of reforms aimed at economic expansion.” “*‘The traditional alternative has never been seriously tried in India’*, Dr. Sen said” (H, 14/2/07/15).

III. India’s Health Scenario

To understand better India’s Health Scenario, mainly from a public health viewpoint, we shall briefly consider some Global Health Data and Trends (1) as well as India’s Health Achievements and Failures (2), Scandalous Inequalities and Inequities (3), India’s Nutritional Crisis (4), and a few Other Major Concerns (5). Though the data may not always be very accurate and may vary in different studies, **an overall picture clearly emerges**.

1. Global Health Data and Trends

* “*In developing countries, more than 13 mn children die each year before their fifth birthday*. At least 70% of these deaths can be avoided by simple, low-cost interventions that would have a positive impact on maternal and infant health... About 40 mn people live with HIV worldwide; tuberculosis caused the deaths of 1.7 mn people in 2003; and a preventable disease like malaria kills a million children each year. *Death and disability from many of these conditions can be vastly reduced by low-cost health care interventions*” (Editorial, H, 7/4/06/10).

* The 2005 WHO Report “points out that globally about 530,000 women die annually in pregnancy or childbirth, more than 3 mn babies are stillborn, over 4 mn newborns die within a few weeks of life, and altogether 10.6 mn die before their fifth birthday. *Of these, India accounts for significant numbers – 136,000 maternal and a*

million newborn deaths occur annually in India. **Most of these deaths are avoidable.** They occur not because of incurable diseases but because of unsafe water, unhygienic environment, malnutrition and common childhood diseases” (Editorial, DH, 9/4/05/14).

The Millennium Development Goals “had stressed the need to reduce the under-five mortality by two-thirds and maternal mortality by three-quarters between 1990 and 2015. The (WHO) Report reveals that 93 countries are on track to achieve these goals. *Fifty-one countries, including India, are making slow progress and in 43 countries the situation has either stagnated or is worsening. Clearly, much more needs to be done to meet the 2015 deadline*” (ibid.).

* **The current state of health in developing countries “is characterised by three major trends:** 1) *a slowing of health gains in poor countries and, as a result, a widening health gap between rich and poor nations;* 2) *an increasingly complex burden of disease;* and 3) *the globalisation of adult health risks*” (2006 WHO Report, cf. HA, May 2006, 7). In 1990 for instance, “there were 180 deaths per 1000 live births in sub-Saharan Africa and only 9 per 1000 in industrialised countries – *a 20-fold difference. In 2000, this gap had increased to 29-fold* with mortality rates of 175 and 6 per 1000 children in sub-Saharan Africa and industrialised countries respectively. In South Asia, over 3.7 mn children die every year before they reach five years of age, which is 34% of the total child mortality globally” (S. Hense & A. Kumar, HA, Feb. 2008, 15).

* **“The Health transition,** whereby non-communicable diseases (NCDs) become the dominant contributor to the Burden of Diseases (BODs), is principally due to a combination of demographic and lifestyle changes resulting from socio-economic development. The demographic transition is characterised by changes in population age structure with a decline in fertility and an ageing population. As more individuals survive to middle age, the years of exposure to the risk factors of chronic diseases increase. Simultaneously, urbanisation, industrialisation, and globalisation are often accompanied by undesirable lifestyles alterations: a diet rich in saturated fat, salt, and excess calories, decreased physical activity, addictions such as tobacco and alcohol, and the augmentation of psychosocial stress.” Though still at an early

stage of the health transition, “*India contributes substantially to the global burden of NCDs.* In 1990, India accounted for 16% of all NCD deaths, and 17% (2.4 mn) of all deaths due to cardio-vascular diseases (CVDs)” (Nanda/Ali, 22).

* “In the contemporary world, social justice is noticeably absent in many social domains, including the domain of health. Some populations enjoy much better health and access to health care than do others.” Yet, as interdependence becomes increasingly evident, “**social justice is a precondition for health, and vice versa.** *More broadly, health and social justice are major, mutually reinforcing pillars of human security*” (N. Swaminathan, HA, May 2006, 24).

2. India’s Health Achievements and Failures

* “The Report of the National Commission on Macroeconomics and Health of the Ministry of Health and Family Welfare (2005) says that **India has substantial achievements to its credit.** Longevity has doubled from 32 years in 1947 to 66 years in 2004; the Infant Mortality Rate (IMR) has fallen by over 70% points between 1947-1990; malaria has been contained at 2 mn cases; smallpox and guinea worm disease have been completely eradicated and leprosy and polio are nearing elimination. In the last five years, over 500,000 deaths have been averted due to the scaling up of the Directly Observed Treatment Short-Course (DOTS) for controlling TB. Indian doctors are comparable to the best in the world” (S. Ram Murthy, HA, June 2006, 8).

* In developing countries like India, “some or most of the health indicators are improving over the years and we do appreciate that. *But if we compare these health indicators with those of developed countries, we can see that there are vast gaps.*” For example, the IMR in India was 102 in 1981, 86 in 1987, and 62 in 2004; but in 2004, it was between 4 to 6 in developed countries like Canada, Denmark, France, Germany, Italy, Netherlands, Spain, UK and USA. Similarly, the Neonatal Mortality Rate (NMR) in India was 60 in 1981, 53 in 1987 and 43 in 2000, but it was only between 3 and 5 in the above countries in 2000. In 2004, the Prevalence Rate of Tuberculosis was less than 10 in the above countries, but as much as 312.2 in India. One may tend “to underestimate the challenges of the poverty of health in India as the country is developing, but *high*

population with low literacy rate, low income and low health infrastructure, encourages a high level of poverty of health compared to developed countries” (P.S. Datta, HA, Jan. 2008, 8).

“Despite having over 17,000 hospitals, 24,000 primary health centres (PHCs) and 140,000 sub-centres as well as over 550,000 registered allopathic doctors, 1.8 mn children die every year in India before they reach five years of age. Most of these deaths are avoidable. In addition, 130,000 women die each year during childbirth and from pregnancy-related problems. Instead of declining, the Maternal Mortality Rate (MMR) has increased in the last decade from 424 deaths per 100,000 live births in 1991-92 to 540 in 1997-98. This is inexcusable” (Kalpana Sharma, H, 8/6/04/8).

3. Scandalous Inequalities and Inequities

It is well-known that most health indicators in our country are rather dismal. It is however often forgotten that *the state-wise, urban-rural, class/caste and other health inequalities make the conditions of the poor much worse than indicated by the national averages. This makes the situation all the more unjust.*

Table 1, taken from the NHP-2002 (#2.2.1), shows *how uneven the health indices are across the rural-urban divide and between the better-performing and low-performing States.* Table 2 similarly shows some striking differentials among socio-economic groups (#2.2.2). *It is therefore “a principal objective of the NHP-2002 to evolve a policy structure that reduces these inequities and allows the disadvantaged sectors of society a fairer access to public health services” (ibid.).*

Though referring to earlier decades, Table 3 gives us an historical perspective (Ravi Duggal, 50). One can see that around 70% of the doctors and nurses (and a considerable ratio of even the midwives and other health workers) were in urban areas in 1981. *This ratio has probably become still more one-sided after 1981.*

The inequalities in health status are often highlighted. It may be useful to give a few more details. A “problem thrown up by the decline in the public health care system and the high drug prices is *the growing disparity in the health status of the rich and the poor.* For instance, the IMR among the poorest 20% of India’s

Table 1
Rural-Urban and State-Wise Health Differentials

Sector	Population BPL (%)	IMR (1999 -SRS)	Under-5 MR (NFHS 1998-9)	Under-3 under-weight (%)	MMR per lakh (2000 Report)	Leprosy cases per 10000
India	26.10	70	94.9	47.0	408	3.70
Rural	27.09	75	103.7	49.6	-	-
Urban	23.62	44	63.1	38.4	-	-
Better – Performing States						
Kerala	12.72	14	18.8	27.0	87	0.90
Maharashtra	25.02	48	58.1	50.0	135	3.10
TN	21.12	52	63.3	37.0	79	4.10
Low – Performing States						
Orissa	47.15	97	104.4	54.0	498	7.05
Bihar	42.60	63	105.1	54.0	707	11.83
Rajasthan	15.28	81	114.9	51.0	607	0.80
UP	31.15	84	122.5	52.0	707	4.30
MP	37.43	90	137.6	55.0	498	3.83

Table 2
Health Differentials Among Socio-Economic Groups

Indicator	IMR	Under-5 MR	% Children Underweight
India	70	94.9	47.0
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

Table 3
Rural-Urban Distribution of Health Personnel (%)

Year		Doctors	Nurses	Midwives & H. Visitors	Other Health Workers
1961	Rural	29.5	38.2	66.4	45.2
	Urban	70.5	61.8	33.6	54.8
1971	Rural	39.4	30.6	65.3	39.0
	Urban	60.6	69.4	34.7	61.0
1981	Rural	27.2	31.3	59.9	48.1
	Urban	72.8	68.7	40.1	51.9

population is 15 times higher than the richest 20%.” Similar differences exist in other health indicators, including attended births (K. Sharma, H, 8/6/04/8).

* A.R. Nanda and Almas Ali add: “A comparison of data from the National Sample Survey (NSS) in the late 1980s and mid-1990s points to significant increases in the cost of both in-patient and out-patient healthcare in rural and urban areas. A detailed analysis of the NSS data shows that *untreated illness among the poor has clearly increased due to financial constraints*. **Inequality** as measured by figures of the household consumption expenditure group appears to have worsened, and *the divide between rich and poor in terms of untreated illness and expenditure on health services, as well as their use of both public and private health care institutions, has grown*. The rich are now the major users not only of private but also of public hospitals. Increased drug costs and rising fees for different health services in both the private and public sector seem to have played a major role in this” (2006, 27).

The 2003 World Health Survey in 6 Indian states showed that **“large interstate variations and poor-rich inequalities” are some of the main concerns**. “One in 10 urban households and three in 10 rural households do not have access to safe drinking water and seven in 10 households do not have access to improved sanitation. Obviously, the inequalities in risk factors greatly affect the poor, women, elderly and rural population and these are the effect of economic inequalities. Although the States differ in socio-economic and health transition, the survey found that *overall, men as compared to women, urban as compared to rural, younger as compared to the elderly and educated as compared to the uneducated reported a better state of health*” (Editorial, EPW, 3/2/07/341).

These disparities and inequities in health status are to a great extent explained by the unequal distribution of health facilities and personnel. “*The ratio of hospital beds to population is 15 times lower in rural areas than in urban areas. The ratio of doctors to population is six times lower in rural areas than in urban areas. Government health spending in rural areas is seven times lower than in urban areas*” (Sharma, op. cit.). “About 75% of the health infrastructure is concentrated in the urban areas where

there is just 27% of the population, thus indicating the serious problem of urban-rural disparities in the distribution of the health infrastructure” (M. Karne, HA, Dec. 2007, 10, cf. also Table 3).

4. India’s Nutritional Crisis

* The findings of “the National Family Health Survey (NFHS-III), conducted in 29 States in 2005-2006, indicate that **the health and nutrition status of India’s women and children is in vast and systemic crisis**. *At the all-India level, 45.9% of children below the age of three – that is, about 45 mn little girls and boys – are underweight or malnourished in terms of the standard weight-for-age criterion*. The corresponding proportion in 1998-99 was 46.7%. The change (0.8%) over the intervening seven years in this key indicator of child malnutrition has thus been negligible” (Editorial, H, 2/3/07/12).

“*Among married women in the 15-49 age group, the prevalence of anaemia has risen from 51.8% in 1998-99 to 56.1% in 2005-06*. No less than 57.9% of pregnant women suffer from anaemia, which has also risen among children aged 6 to 36 months – 79% were anaemic in 2005-06 compared with 74.2% in 1998-99. *There are of course wide variations across States in both levels and trends in indicators of health and malnutrition*. While Punjab and Kerala report the lowest proportion of underweight children (27% and 28.8% respectively), in Jharkhand and Madhya Pradesh more than 59% of children below the age of three were underweight. **Child malnutrition has actually risen in seven States**, most rapidly in Madhya Pradesh and Haryana” (ibid.).¹⁰

“The NFHS-III estimates of health and nutrition among women and children... come as a grim warning to policy-makers that *high rates of economic growth alone will not bring about improvements in public health and nutrition*. Many countries that are lower than India on the GDP ladder have taken better care of their children” (ibid.). A.K. Shiva Kumar points out that “*the corresponding levels of child malnutrition are much lower in most other countries – 28% in Sub-Saharan Africa and 8% in China*. Scientific evidence suggests that compared with the risks a well-nourished child faces, the risk of death from common childhood diseases is doubled for a mildly malnourished child, tripled for a moderately malnourished child,

and may be even as high as eight times for a severely malnourished child” (H, 22/6/07/12).

Why are levels of child malnutrition so high in India? Several factors are at work. *First, the considerable proportion of babies weighing less than 2,500 grams at birth (20 to 30%) “suggests the onset of malnutrition in the womb itself and reflects an intergenerational transfer of malnutrition from the mother to the child”. “The second factor has to do with the limited reach of public health services” among children and mothers. In 2005-06, barely half (51%) of mothers across the country received at least three antenatal care visits during pregnancy; and less than half (48%) the births were attended to by a trained birth attendant.” Other key factors are the poor overall care of children, especially from birth to 18 months, and the limited opportunities (like literacy and education) available to women (Kumar, ibid.).*

* In his next article, Kumar highlights **why child malnutrition levels are not improving.** *He lists the following factors. “One, the improvements in expanding the reach and coverage of public health services over the past seven years have been very limited. For instance, only 44% of children aged 12 to 23 months were fully immunised in 2005-06 – up from 42% in 1998-99... As a matter of fact, the immunisation coverage in urban areas has slipped from 61% in 1998-99 to 58% in 2005-06, and has increased only slightly in rural areas from 37% to 39%.” “Two, the access to critical components of treatment of childhood diseases has deteriorated over the past seven years. For instance, the proportion of children with diarrhoea who received oral rehydration salts (ORS) in the two weeks preceding the NFHS-3 survey had risen from 18% in 1992-93 to 27% in 1998-99; but since fell to 26% in 2005-06.” Furthermore, the health and care of women and mothers have shown little progress (H, 23/6/07/10).*

Kumar therefore concludes that *“the linkages of child malnutrition with women’s health and well-being are strong. Reducing child malnutrition requires enhancing women’s freedoms and promoting gender equality... But, above all, India’s high levels of child malnutrition reflect the continuing neglect of health, the inadequate reach and efficacy of health and child care services,*

and the failure of strategies to reach newborn children and those under the age of three. These deficiencies need to be addressed immediately” (H, 22/6/07/12).

5. Other Major Concerns

The 2005 HM Consultation lists, besides HIV/AIDS, **three other areas of concern:** “1) In spite of the National Leprosy Control Programme, the prevalence rates remain high. India has 60% of the world’s leprosy patients. 2) Only 35% of the population has access to essential drugs. The immunisation rate for measles vaccine for infants is 60%, while DPT for children under 12 years is 78%. 3) Of 25 million born in India every year, *nearly 2 million die before reaching the age of one.* Water-borne diseases like diarrhoea, typhoid, cholera and hepatitis account for 80% of India’s health problems and every fourth person dying of such disease is an Indian.” **“The statistics point to the dismal health situation in the country” (HM, #7).**

Of course, one could list many other problems and issues. The NHP-2002 for example identifies in its *Current Scenario* (Section 2) about 26 areas that need to be improved and transformed by *Policy Prescriptions* (Section 4). These include financial resources, equity, the delivery of public health and its infrastructure, the training of the personnel, health research, the role of government institutions, NGOs, and the private sector... Let us however conclude and analyse The Root Causes of Today’s Crisis.

We may conclude with a quotation from Sakuntala Narasimhan: **“Poverty is bad enough (and a national shame), but truncating the right to live, through inaccessible treatment, is nothing short of scandalous” (DH, 16/12/04/10).** In past generations, people with a wrong understanding of God and religion sacrificed children and women (e.g., through *sati*). One could say that today, the number of child and women sacrifices have increased beyond any imagination because of people’s unconcern and inhumanity, or at least their submission to wrong economic policies, priorities and systems.

IV. The Root Causes of Today’s Crisis

The previous sections have highlighted India’s disastrous health scenario and the failure of its public health system. **What are the root causes of today’s crisis?** This section explains and analyses

the interrelated reasons under seven headings: Meager Public Spending (1), Rising Drug Prices (2), Dominance of the Private Sector (3), Abuses and Malpractices (4), Lack of Regulation and Monitoring (5), Lack of Adequate Health Insurance Provisions (6) and Other Causative Factors (7).

1. Meager Public Spending

There has been a low and downward trend in government spending on health as proportion of the Gross Domestic Product (GDP). The combined health spending of the Central and State Governments has indeed come down from 1.3% of the GDP in 1990 to 0.9% in 1999 and 0.8% in 2005. This means a decline of 0.5% in 15 years – that is almost 38.5% of the 1990 proportion. From 1990 to 1999, “the central budgetary allocation for health... has been stagnant at 1.3%, while that in the States has declined from 7% to 5.5%”. The combined budgetary share of health has also come down from 3.5% in 1986 to 2.7% in 2001 and 2.4% in 2005. Thus, “the paucity of public health investment is a stark reality”, and “it is no surprise

The Global Experience

A further rationale for greater public investments in health “is provided by the global experience in evolving universal health care systems. There is a general tendency to move towards more organised national health systems and an increased share of public finance for health care (Roemer, 1985, OECD, 1990). Almost all developed capitalist (exception USA) and socialist countries have universal health care systems *where the share of the public sector is between 60% and 100% (ibid.). This trend is the consequence of the pursuit for equity and universal coverage.* Countries that have not set up such systems continue to experience high inequities. The USA is an outstanding example where still over 30 mn persons don’t have access to a reasonable level of health care... *The fate of most Asian and African countries is miserable – low public sector investment, large private sector, and wide-ranging inequities in the access to basic health care.”* In most Latin American countries, a large (though not universal) proportion of the population is covered by primary health care (Duggal, 27-8).

that the reach and quality of public health services has been below the desirable standard” (NHP-2002, #2.1.1 & 4.1.1).¹¹

Some comments and comparisons may be useful here. D. Varatharajan, now with the WHO, writes: “The 2002 NHP envisaged a (total) government spending of 2% of GDP by 2010 (including a budgetary increase by the States to 7% by 2005 and 8% by 2010). *Even this enhanced share is well below the global (3.8%) and low-income countries’ (2.4%) averages.* The actual government health spending in India is about 0.9% of GDP with a per capita spending of US \$5 (or Rs 200). The budgetary share of health is also low at 2.9%, much lower than (the average) 8.8% in other low-income countries. *The per capita government health spending falls well short of the spending (US \$34 or Rs 1,360) required to provide the basic essential health care services” (HA, Dec. 2007, 21-2).*

“The government’s failure to spend enough on health (particularly) affects the most needy population groups... Country experiences demonstrate a minimum government share of 40% in total health spending in order to effectively move towards universal access to health care.” **Both ethics and sound economics demand that the Indian government spends much more on health (ibid.).**

In its 2004 Common Minimum Programme (CMP), the UPA Government has promised to increase the public spending on health from 0.9% to 2-3% before the end of its term. *Since health is a state subject, the States contribute 80 to 85% to the total public spending.* The Union Government has increased its budgetary allocation by about 30% in recent years, but “in itself this makes a very small impact on the overall public budget. In 2006-07, this budget remains less than 1% of GDP. To reach 3% of GDP, both the Central and State Governments have to more than triple their budgets.” Hence, “the targeted increase to 3% of GDP will never be realised” with the current budgets (Sinha, 284-5, referring to Duggal’s analysis of the 2006-07 Union Budget).

Impoverishing Private Expenditure

“In fact, the Indian health system is almost totally privatised. Only 15% of the total health expenditure is public expenditure (cf. NHP-2002, #4.1.1); (most of) the rest is private expenditure, such as

over-the-counter drug purchases from chemist shops. *By contrast, the ratio of public expenditure to total health expenditure is 40% in East Asia, 50% in Latin America, 75% in Europe, and as high as 85% in Britain*" (Jean Drèze, H, 12/3/04/10). According to the NHP-2002 (#4.4.1.3), it is as follows: 17.3% (India), 24.9% (China), 44.1% (USA), 45.4% (Sri Lanka) and 96.9% (UK).

Our country's low public spending on health "puts India among the bottom 20% of countries". On the other hand, **private health spending "accounts for more than 80% of all health spending, one of the highest proportions of private spending found anywhere in the world. About 98.5% of the private spending in India is out-of-pocket at the point of service use, an inefficient way to finance health care that leaves people highly vulnerable."** As a result, "hospitalised Indians spend 58% of their total annual expenditure on health care. *More than 40% of hospitalised people borrow money or sell assets to cover expenses*" (D. John, HA, Dec. 2006, 8-9).

Health expenditure has thus become a major source of indebtedness and poverty in India. The 2005 Commission on Macroeconomic and Health has for example estimated that, every year, 2.2 mn people fall below the poverty line on account of health-associated expenditure (HA, Dec. 2007, 3), while "a study done for WHO in six Indian States found that 16% of the households it looked at were pushed below the poverty line by heavy medical costs" (ibid., 7). Worse still, "CEHAT estimates that between 1986 and 1995, *the number of people unable to afford health care had doubled. It had increased from 10 to 21% in urban areas and from 15 to 24% in the villages*" (K. Sharma, H, 8/6/04/8, cf. Nanda/Ali, above, p. 64). In fact, National Sample Survey data show that the rate of untreated ailments increased by 40% for the poorest expenditure decile" (Sinha, 278).

P. Sainath could therefore write in 2004: "*Health spending is amongst the fastest growing components of rural family debt. More so in Andhra Pradesh. For years, the State boosted the private sector in health, promoted corporate hospitals and pioneered the 'user fees' system in Government ones.*" *As a result, "the little access the poor had to health sharply declined" in the last decade.* In fact, there is a link between the suicides of farmers and the crisis of

health in Andhra. Many of those who take their lives have huge medical bills. Though some measures like user fees have been withdrawn, the damage has been done (H, 1/7/04/12).

2. Rising Drug Prices

Anurag Bhargava & S. Srinivasan wrote an enlightening article on the "**Price Regulation of Essential Medicines**" (H, 17/10/06/10). According to the WHO's World Medicines Situation Report of 2004, "*India has the largest number of people, an estimated 649 mn, without regular access to essential medicines...* This is because of poor availability of drugs in the public health sector and poor affordability in the private system." According to the National Sample Survey's 55th round, "*more than two-thirds of outpatients' expenses go towards the purchase of drugs...* The deregulation of drug prices has contributed to the increasing costs of healthcare and pushed millions into debt." "In 1995 for example, the price of a preparation for anaemia rose by 177%, while the price of anti-TB drugs rose by nearly 90%."

Medicines "are such a critical and essential commodity that governments all over the world, even in so-called market economies, regulate their prices. The anarchic retail prices of drugs outside price control provide the clearest evidence of the need for price regulation." For example, "Aventis charges Rs 95 for a 500 mg tablet of the antibiotic levofloxacin, while CIPLA charges only Rs 6.80 for the same tablet... *The real manufacturing cost is often a very small fraction of the retail price.* This is revealed by the prices of drugs in competitive tenders, the trade margins that companies offer, and the huge amounts they spend on drug promotion." For instance, the tender rates for bulk procurement of drugs in Delhi and Tamil Nadu "are as low as 2-20% of the market rate". Hence, "**price regulation is clearly a national policy matter**... If telephone tariffs, insurance premiums, electricity rates, and trading of shares are regulated in India, surely the regulation of drug prices is no less important."

Yet, "there has been a progressive decline in the number of drugs under price control – from 347 in 1977 to only 74 in 1995. Over the last 12 years no drug has been placed under price control, although many new ones have been introduced." "In 2003, a group of experts evolved **the National List of Essential Medicines** (354 in all),

which could take care of most of the healthcare needs of Indians.” After three years of deliberations, “the Minister of Chemicals in July 2006 circulated a Draft Policy to the Cabinet, which planned to regulate the prices of these 354 essential medicines.” “This welcome, and long overdue, correction in the policy, would have greatly improved the access to essential medicines. *Surprisingly, it faced opposition from within the Cabinet.* A new joint committee of 14 members, of which 11 represent the industry and three the government, has been constituted to again consider the draft policy and price regulation.”

In another article, “**Why Is Paswan’s Price Reduction a Let-Down?**” (EPW, 16/12/06/5101-5), Bhargava and Srinivasan discussed the results. In “November 2006, the Union Minister of Chemicals and Fertilisers, Ram Vilas Paswan came out with a list of 886 drugs whose prices were reduced, presumably at his behest. What does this reduction indicate? *Actually, for no disease and for no company have the top selling brands seen any price reduction. The reduction by a few companies of a few medicines, none of which are the brands most sold by these companies, or are the most prescribed, will not improve the access to affordable drugs for the consumers.*” “**The real issue is that in principle, the industry is opposed tooth and nail to price regulation as part of public policy,** because price regulation questions the price, profit and cost of the manufacture of a drug, imposes some discipline amidst the extraordinary anarchy in the Indian market, and keeps open the option of interventions in favour of ordinary people.”

The Patent Issue

* Since the people’s victory at the 2001 Doha deal, “*the price of HIV treatments in developing countries has come down dramatically, in some areas from \$10,000 a year per person to \$150.* ‘Those medicines were very expensive because they were all under patent’, explained Sarah Bowsley, health correspondent of the *Guardian*. ‘The Doha declaration was a way of actually allowing generics – cheap, copycat versions – into the field’ ... Tido von Schoen-Angerer of *Médecins Sans Frontières* said the old problem of expensive drugs is now re-appearing... ‘What we are seeing, five years after Doha, is that *prices are again on the increase*’, he said. ‘*If patients need newer drugs, that means the costs go up 10*

times – or, in some countries, up to 50 times. This is a very worrying trend” (Grant Ferrett, DH, 7/12/06/10).

“India had been the main producer of generic drugs, but in 2005, it was obliged to change its legislation to comply with the World Trade Organisation rules, meaning that drugs invented after that point cannot be made by the generic companies. Sarah Bowsley said that there is ‘a lot of pressure’ on the Indian Government by pharmaceutical companies, to stop the production of generic versions of the newer drugs. ‘*They know that after the second-line AIDS drugs, we’re also talking about cancer drugs, diabetes, heart disease*’, she said.” The debate is thus raging. **Much political will and leadership is needed to take coordinated and global action to safeguard the health interests of the poor!** (ibid.).

* “The international development and relief agency, Oxfam, has expressed concern over **the 2005 Third Patents Amendment Bill** passed by (the Indian) Parliament, saying that it will restrict the access to life-saving drugs for millions of people. While giving credit to the Left parties for having achieved a significant improvement in the new patents law compared to the original ordinance, it maintains that fundamentally the agreement on TRIPS is flawed and ‘draconian’”, and in need of basic reform (S. Ramchandran, H, 26/3/05/13). The NHP-2002 had, in fact, foreseen such difficulties (cf. above, pp. 56-7).

D. Ravi Kanth however feels that the TRIPS agreement may be manageable: “Thanks to the late Indira Gandhi and her refusal to adopt the product-patent regime in the late 60s, India became a beehive for the generic drugs industry.” With the March 2005 legislation, “the Indian government is supposed to have corrected the historical-deficit in Indian patent laws by international standards”. Yet, Novartis has challenged this law. “*The litmus test for the Indian government is whether it can invoke the so-called compulsory licensing provisions*”, as Thailand did recently, to produce drugs for the poor (DH, 21//07/10). Thanks to the August 2007 dismissal of Novartis’ writ petition by the Madras High Court, **there is greater hope, but the struggle must continue.**

Bangladesh had the courage to eliminate hundreds of ineffective combination drugs in its market, and Thailand to take a definite stand in favour of generic drugs. *Can India and many other countries*

throughout the world imitate these countries and be bold enough to adopt a relevant Drug Policy? **Can it clearly put people's health needs above the fear of antagonising powerful drug companies?** (cf. Sakuntala Narasimhan, DH, 16/2/07/13).

3. Dominance of the Private Sector

Undeniable Facts and Trends

Though the data are limited and sometimes vary, **the increasing growth and power of the private sector is undeniable.** *The private sector indeed employs most of the health professionals, owns around 70% of the hospitals, provides most of the health services, and controls the health industry. Its impact on health policies has also become preponderant.*

* By 2001, there was “a decline of over 30% in the proportion of patients seeking care in public health institutions” (Sinha, 284). “At the time of independence, the for-profit sector had a 5-10% share of the total patient care. Today, it accounts for 82% of outpatient visits, 58% of hospitalisation days, 40% of institutional deliveries, 35% of antenatal care visits, and 15% of child immunisation.” “Even for those living below the poverty line, the private sector accounts for 10% of child immunisation, 25% of antenatal care visits, 30% of institutional deliveries and 40% of hospital days” (D. Varatharajan, HA, Dec. 2007, 21).

* **“The private sector is already the major provider of curative care services in India.** The National Health Accounts show that 77% of the total health expenditure takes place in the private health sector... The private sector which accounts for 70% of the hospitals in the country, provides about 60% of all out-patient care and as much as 40% of in-patient care. **By 2010, it is expected to notch up to 80% of the health care market...** Today, the value of the health care sector is over \$34 bn, translating to roughly 6% of GDP, and the sector is projected to grow to nearly \$40 bn by 2012” (S. Ousepparampil, HA, Jan. 2008, 3).

* *“Three-quarters of the human resources and advanced medical technology, 68% of a total of over 15,097 hospitals and 37% of over 623,819 beds in the country are in the private sector (Directory of Health Services, GOI 1996).” The Government policies*

promote private initiatives and the private sector has probably grown since the mid-1990s (D. John, Jan. 2008., 9).

Tables 4 and 5 enable us to visualise the historical growth of the private sector (Duggal, 51 & 49). About 72.6% of the allopathic doctors were already working in the private sector in 1942-43. After a slight proportional decrease in the next 35 years, this percentage began to rise after 1984-85 to reach 77.1% in 1997-98. One should also note *the impressive increase of an average of 17,440 doctors per year from 1986-87 to 1997-98, about 2900 and 14,540 respectively in the public and private sector* (Table 4). Table 5 interestingly shows that in 1996, 68.1% and 61% of the hospitals and dispensaries were respectively in the private sector, but that only 36.6% of the hospital beds were in this sector. *The privatisation of hospital beds is also much slower than that of hospitals.*

Table 4
Allopathic Doctors in India

Year	Government Service		Private Sector		Total	
	Nos.	%	Nos.	%	Nos.	%
1942-43	13000	27.4	34400	72.6	47400	100
1963-64	39687	39.6	60502	60.4	100189	100
1978-79	69137	29.3	166494	70.6	235631	100
1984-85	81030	27.4	214799	72.6	295829	100
1986-87	88105	26.6	242650	73.4	330755	100
1997-98	120000	22.9	402634	77.1	522634	100

Table 5
Ownership of Hospitals, Dispensaries and Hospital Beds

Year	Hospitals		Dispensaries		Hospital Beds	
	Pub.	Pvt.	Pub.	Pvt.	Pub.	Pvt.
1974	81.4	18.6	-	-	78.5	21.5
1981	56.2	43.8	86.2	13.8	71.6	28.4
1986	54.7	45.3	-	-	73.9	26.1
1991	42.6	57.4	40.4	59.6	67.8	32.2
1996	31.9	68.1	39.0	61.0	63.4	36.6

Causes and Consequences

Perhaps minimising the strength and dynamism of the neo-liberal forces, many writers tend to explain the growth of the private sector by pointing out the deficiencies and shortcomings of the public sector. C. Chatterjee for example states: "Reasons for the drift from public provision to the private sector are mainly related to the problems of service quality (restricted opening times, rude staff, lack of drugs and equipment, poor facilities, illegal charging), and lack of accessibility, particularly in rural areas where facilities are spread thinly. As a result, even the poor make an extensive use of the private sector" (HA, Jan. 2008, 14). Ousepparampil observes: "As the public sector is ill-equipped in all respects, people seek care from the private sector" (op. cit.). And Varatharajan: "*The private sector's success is attributable less to its own efficiency and more to the government's failure*" (op. cit.).

Analysts sometimes blame the PHCs for their failure to provide preventive services. After considering the findings of various studies, Ravi Duggal interestingly concludes: "*The weakest component of the PHC services is curative care and this is the main reason why PHCs are so grossly underutilised – less than 8% of all illness care (NSS-1987, NCAER, 1991, Jesani, 1992) – and have so little credibility.* In the public opinion, the PHCs and subcentres are basically family planning centres. The effort to set up rural hospitals to fill the demand gap for curative care is woefully slow and is further made more difficult with the non-availability of medical personnel."

"Whereas the public health sector is inadequately equipped to meet the health care demands of the people, *the private sector meets them without consideration of quality, rationality and social concern.* Public opinion indicates that distance, hours of availability, waiting time, personal attention and supply of medicines are important factors that favour the use of private health care providers. Where these factors are favourable for public health facilities, the utilisation of the latter improves drastically" (2000, 27).

In any case, **the first consequence of the growth of the private sector is the rising cost of the health services.** As Shehla Raza Hasan points out, "*on average, private service is 60% more expensive than in government-owned service.*"¹² Varatharajan

explains: "The growing for-profit private sector, technological innovations and higher awareness levels among people are some factors responsible for pushing health care costs up many times more than general inflation" (op. cit.). From another viewpoint, C. Chatterjee adds: "Irrational therapeutics, over-prescription, unnecessary use of injections and over-investigation are pushing the cost of health care beyond the reach of the poor" (HA, Jan. 2008, 14).

An assessment of the private sector thus raises the issue of equity, for "only those who can pay have access to crucial (health) services. This demands drastic changes in health policy and the reorganisation of the entire health care system... (to) provide affordable health care to all." According to the author, public-private partnership (PPP) can contribute to improve and universalise health care (S. Ousepparampil, *ibid.*, 3).

According to private studies, about 88% of the private hospitals around 1992 "lacked sophisticated medical facilities". "The fast pace of development of the private medical sector and the burgeoning middle class in the 1990s have led to the emergence of the new concept in India of establishing hospitals and health care facilities on a for-profit basis."¹³ **What was most significant was however the transformation of people's mentality.** "As far back as the 1940s, an estimated three-fourths of the doctors were in private practice. But the ideological premise then was of the responsibility of society to ensure health care to all citizens. Health sector reforms over the 1990s changed **the conceptualisation of health care from a 'service' delivery to a 'commodity'**, with the coming in of the market system" (Sinha, 278).

Ravi Narayan adds: "The main medical education issues in our country today are the trends towards the commercialisation of medical education, complementing the larger trend towards the corporatisation of health care including the move towards medical tourism. *What is most disturbing is also that doctors are no longer being produced with a view to serve the community through general practice and primary health care.*" Thus, "medical education will become a market investment" and most doctors will go to private-corporate initiatives to get a return. The casualty will be the government services and the people who are poor, marginalised or socially excluded. *The community-oriented social physician – the Bhoré Committee dream*

– will become a myth.” “Apart from this, the continuing focus on bio-medical determinants rather than the deeper social determinants of health continues to be a challenge” (HA, Aug. 2007, 7-8).

T.R. Dilip further remarks: “*The private sector participation is very low in the provisioning of preventive and promotive care services.* These services include public health programmes relating to Tuberculosis, Malaria, HIV/AIDS, immunisation activities and maternity-related care. Incidentally, these are public health and maternal-child health issues, where poorer sections and under-developed regions lag behind richer sections and developed regions respectively. **Hence, there is an intrinsic polarisation in the national health system with the private sector focusing on curative care services and the public sector covering preventive care services and also (working) in areas where the outreach of the private sector is limited**” (HA, Jan. 2008, 4).

The State Contribution to the Private Sector

It is worth adding a few insights from Ravi Duggal’s book, **The Private Health Care Sector in India** (2000). For several decades, the Planning Commission was only concerned with the public sector. *The private sector was thus left out of the planning process and the data on it were not properly collected.* “Historically, **the private hospital sector** has been small in India as elsewhere in the world because state and charity (including religious missions) were regarded as the most appropriate providers of such care.” Since the mid-1970s, private hospitals have however increased from less than 20% in 1974 to 68% in 1996 (cf. Table 5, above). *This growth coincided with the development of new medical technologies and the much increased production of specialists.* **The organised corporate sector** is also getting more involved in the private sector and this process will be strengthened by the growth of private insurance (10-13).

“**The pharmaceutical industry in India** is very large and is able to cater to not only almost the entire demand for drugs in the country, but is also emerging as a major exporter at the global level.” The role of the public sector in drug production has however significantly declined in the last 15 years. “With a turnover of nearly Rs 160 billion (in 1999) and more than 90% of this being in the private sector, *the private pharmaceutical industry is the engine of the*

private health sector in India. It has penetrated the remotest of rural areas” and even the large unqualified segment of practitioners to expand its market. “The nonallopathic drug industry, mainly ayurveda and homeopathy, is also fairly large but organised information on it is not available.” During the past 2-3 years, the prices of many essential drugs have doubled. **The medical equipment industry** is much smaller, but “there is every indication that it is on the verge of growing very rapidly” (13-14).

Until the 1990s, “the entire burden of producing doctors and nurses was on the state”, but private medical colleges have been increasing rapidly in recent years, often without getting the necessary permission of the Medical Council in India. “*The outmigration of allopathic doctors remains very high* with about 4,000 to 5,000 doctors leaving the country every year, which at (the 1999) prices means a loss of at least Rs 4,000-5,000 million (US \$ 100-125 million), assuming a minimum of Rs 10 lakh as the cost of production of a doctor.” **This large-scale subsidisation of the private sector needs to be seriously questioned.** In contrast, the production of doctors in other systems of medicine is largely in the private sector, and the data are more scarce. Due to the absence of regulation of medical practice, cross-practice is very widespread (11-12).

It is important to emphasise “the role of the state in contributing to the growth of the private health sector”. *The following are some instances of direct and indirect support.*

1) “*Medical education is overwhelmingly state-financed* and its major beneficiary is the doctor who sets up private practice after his/her training; 75% of medical college graduates from public medical schools work in the private sector.” 2) “The government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals.” 3) “The government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes.” 4) “The government has pioneered the introduction of modern health care services in remote areas by setting up PHCs. While the latter introduces the local population to modern health care, by being inefficient it also provides the private sector an entry-point to set itself up.” 5) The introduction of fee-for-services at government facilities “amounts to privatisation,

for the utilisation of these services will now depend on the availability of purchasing power". This is particularly true for speciality departments (15-16).

Both micro and macro surveys have shown "the overwhelming dominance of the private health sector in India". "With an estimated 700,000 qualified practitioners of various systems and an equal number of unqualified practitioners in individual private practice, *we now have the largest private health sector in the world and one which is completely unregulated.*" "In today's liberalised scenario and with the World Bank's advice of the state's role being restricted to selective health care for a selective population, *the private health sector is ready for another leap in its growth and this will mean the further appropriation of people's health and a worsening health care scenario for the majority population*" (15, 12 & 16).

4. Abuses and Malpractices

The HM Consultation states that **the excessive commercialisation of medical care has paved the way for "the proliferation of unethical practices:** conducting unnecessary tests and investigations, especially by using the latest and costliest equipments; adopting unnecessary procedures and surgeries, such as caesarean sections, hysterectomies, MTPs, post-partum sterilisations, bypass surgeries, appendectomies, etc., for the sake of cut-backs; commercialisation of human organs, blood, skin, sperm and ovum; artificial prolongation of life by extraordinary means which are beyond the affordability of the relatives; refusing to admit, treat and operate people infected with HIV, Hepatitis B and C viruses; depriving the poor from having access to specialists; snatching good and efficient doctors with greater pecuniary temptations; practice of unhealthy competition, rather than cooperation in sharing resources and personnel" (# 41).

There is also so much shoddiness and corruption in our health care system.¹⁴ In the light of a 2005 survey in rural Jharkhand and West Bengal, *Amartya Sen strongly denounced the "non-performance, exploitation and deceit" that plague the healthcare sector.* He prescribed "greater regulation and monitoring, something comparable to the 'inspection system' of schools," and much greater control and supervision of the activities of doctors (H, 20/11/05/11).

S.G. Vombatkere adds that "the careless use of the allopathic medical system has resulted in the high incidence of iatrogenic diseases due to wrong medication, over-medication or side-effects of drugs". Further, "the rapidly growing numbers of organic and inorganic chemical compounds in our food chain, many of them toxic, have added to the diseases and ailments" (HA, Dec. 2007, 6).

5. Lack of Regulation and Monitoring

Many analysts moreover denounce the lack of regulation and monitoring. S. Ousepparampil even considers this the main concern in the assessment of the private sector: "Private medical practice has now existed too long without any control and regulation. For a couple of decades or so, increasing pressure is being exerted on the private health sector to put its house in order. *There is a need to bring in an entirely new range of comprehensive regulation...* But while making regulatory measures, *pro-profit and non-profit health care institutions should not be treated alike.* Non-profit organisations should be guided by a separate set of regulations. *So also, rural and urban institutions should be treated differently*" (HA, Jan. 2008, 3, cf. also Duggal, 17-8).

6. Lack of Adequate Health Insurance Provisions¹⁵

In his "Critical Appraisal of Micro-Health Insurance Laws" (EPW, 10/2/07/476-80), Alex George assesses **the health insurance coverage in India.** It "*is variously estimated by researchers to be between 3% and 10% of the population,* consisting mainly of employees in the organised sector and their families (Rao 2005; Devadasan et al 2005; Gupta and Trivedi 2005). *Workers in the informal sector of the economy, constituting 93.3% of the workforce, and their families... do not have any coverage, except a few NGOs schemes.*"

"The government of India, in union budgets 2003-04 and 2004-05, introduced a major initiative to subsidise health insurance coverage for the poor. *But these schemes run by the four public sector general insurance companies have not been able to reach out (much) to the poor.* In 2003-04, the schemes reached only 11,408 BPL (below poverty line) families till May 2004; in the second year, they reached only around 34,000 families till January 31, 2005 and have an extremely low claims ratio (GOI 2003-04; GOI 2004-05; Rao 2005)."

“There are (however) a few NGO and community-based organisation (CBO) initiatives to provide health insurance to the poor such as the Voluntary Health Services (VHS) and Action for Community Organisation, Rehabilitation and Development (ACCORD) in Tamil Nadu, Yashaswini and Karuna Trust in Karnataka, Vimo-SEWA in Gujarat, Raigarh Ambikapur Health Association (RAHA) in Chhattisgarh, the Students Health Home in West Bengal, PREM in Orissa, etc. (Devadasan et al 2004; Gupta and Trivedi 2004; George 2006). These schemes and other similar ones are referred to as ‘community health insurance’ or ‘micro-insurance’ schemes.”

The author’s conclusions include the following: “The civil society organisations, which conduct their own micro-health insurance schemes, need more accountability and transparency in their functioning. *Constituting a separate authority to regulate micro-insurance schemes* with the participation in its management of informal sector trade unions, cooperatives, women’s organisations, SHGs, NGOs, CBOs, etc, who are better informed and sensitive to the needs of the micro-insurance sector, will enhance the development of this sector and also ensure transparency and accountability.”

According to Ravi Duggal, **public rather than private insurance schemes are a must for the poor**: The introduction of private health insurance may bring about some relevant “changes like regulation, price control, quality assurance, rationality in practice, etc.”. **But the poor will not have access to this kind of system.** “Worldwide experience shows that private insurance only pushes up costs and serves the interests of the haves. If equity in access to basic health care must remain the goal, then the State cannot abdicate its responsibility in the social sectors.” *Without being the primary provider, “the State will have to remain a significant player” as long as there are poor!* (18).

7. Other Causative Factors

Several other contributing factors are also highlighted in the literature to explain India’s current health plight: the early political culture of public health before and after independence,¹⁶ the recent pro-profit forces of globalisation,¹⁷ the ‘vertical’ approach to primary health care, the neglect of the social determinants of health, the country’s limited resources and administrative capacities,¹⁸ the lack

of political will and especially the lack of political awareness to struggle for one’s rights and transform the health system (cf. Section VII in the next issue of *Integral Liberation*), etc. **The following passages may help us to reflect on some of these factors and thus identify the root causes of today’s crisis.**

Archana Sinha writes: “There can be two approaches to the primary level. One focusing on ‘vertical’ single-disease control programmes (for example, TB, malaria, leprosy, filariasis, AIDS) and the family planning/Reproductive and Child Health (RCH) programme. The second one, focusing on the comprehensive health services that deal with all general or common health problems. *Generally, there has been a neglect of the common health services that should cater to the immediate requirements of people...* There has also been a top-bottom development (that failed to understand) the common people and their realities” (282).

Partly on account of foreign influences, India failed to genuinely implement the primary health care approach. It rather “adopted a ‘selective-disease control’, with vertical, centralised, technology-oriented and one-disease-at-a-time model to control tuberculosis, malaria and leprosy, and more recently HIV/AIDS. *This approach was not integrated with the network of health centres. It arrested the growth of primary healthcare, public health and even systematic primary and referral medical care*” (T.J. John, H, 25/5/04/8, cf. also “Commodification...”). *The NHP-2002 also questioned this ‘vertical’ implementational structure* (# 2.3.2.1).

An *Editorial* from *The Hindu* stated: “It is inconceivable that a reduction in public health crises such as cholera and typhoid outbreaks can be brought about *without attending to the primary task of providing mass housing, a hygienic environment, safe drinking water, and sanitation.* Not enough attention is being paid to sanitation (and water supply) as the foundation of all health services. Most States have pursued weak policies in this area and neglected the elected local governments, giving them a low stake in improving the sanitation infrastructure. Full sanitation is not available even in metropolitan cities and their growing suburbs... Only with a change of attitude (among the masses) can speedy progress be made in this crucial area.” **India has missed its sanitation revolution and we need a sanitation movement** (H, 12/4/06/10).

India must moreover resist the market hegemony and change its priorities. “The state, which is supposed to monitor and eliminate both negligence and poverty, is too busy concentrating on city-centric super-speciality hospitals because that’s where the money is. *And in our market-driven policies, money and profits become the yardsticks, not equity or morality*” (S. Narasimhan, DH, 16/12/04/10).

Two passages may serve as summaries and conclusions: “Health is a complex issue. A simplistic approach to it is bound to fail. *Most of our earlier programmes were prefabricated, ill-conceived, ill-formulated and techno-centric vertical programmes which failed to make any visible changes in the health scenario... Health is also a political issue.* Parties of different hues always try to derive political mileage out of it... Incompetence, and the lack of feel of ground realities, on the part of the political and bureaucratic leadership of MOHFW and its advisors, contributed to a great share of the failure. *Corruption at various levels, games and gimmicks, lack of commitment, paucity of resources, faulty implementation and weak monitoring helped to make the collapse almost complete*” (S. Ousepparampil, HA, June 2006, 3).

S.G. Vombatkere lists several causes for the failure of the public health care system in India. He highlights the following: “*The medical system is being increasingly privatised and profit-oriented in preference to providing health cover to those who need it... (Our) Governments have failed to comprehensively provide primary health cover (very effective and cheap to deliver), but have instead favoured hi-tech, multi-speciality hospitals that treat complicated diseases at great expenses that the poor cannot afford... Unless there is a paradigm shift in the understanding of health and its implications, and the political will to provide health services to the majority of the population as a part of development along with the other basic needs, there cannot be any substantial improvement in the current pathetic status of public health care*” (HA, Dec. 2007, 7).

(To be Concluded in the June 2008 issue)

NOTES

1. See above, 3-4 & 17, and “Sharing the Fullness of Life”, #1. **2.** Premdas’ whole article deals with the right to health and healthcare (above, 3-15). **3.** Ajay Pandey, *Women’s Link*, Oct.-Dec. 2004, 41-3. **4.** “Commodification...”, 4, and George Joseph et al, *Health Care in India*, Centre for Social Action, Bangalore, 1983, 31-45. **5.** On the MDGs, see also HM, #18. **6.** “Partnership...”, Report of an International Meeting, Dept. of Health in Sustainable Development, WHO, 2001, 22-3 & 3. **7.** *Ibid.*, 23-5. **8.** Quoted by Amrith, 114. **9.** Date V. et al, 7. **10.** For detailed state-wise data on malnutrition among children in India in 1992-93, 1998-99 and 2005-06, see *Integral Liberation*, Sept. 2007, 225-8.

11. The quotations and the data for 1990 and 1999 are from the NHP-2002 (#2.1.1 & 4.1.1) and the statistics for 1986, 2001 and 2005 are from Sinha (2006, 284) and D. John (HA, Jan. 2005, 9). **12.** Shehla Raza Hasan, “India bids for health care tourism”, <www.atimes.com/atimes/South_Asia/EG19Df03.htm>. **13.** <http://en.wikipedia.org/wiki/Health_care_in_India>. **14.** Rao, 2006. **15.** On **Community Health Insurance**, see also HA, July 2006, and 6 or 7 articles in EPW, 10/7/04/3149-94. **16.** See especially Amrith’s article. **17.** See especially “Commodification...”. **18.** See Amrith and NHP-2002 (#1.8 & 5.2).

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6. “Healing as Mission, Conclusions” (HM), National Consultation, 12-16/12/05, Ishvani Kendra, Pune, in *Ishvani*, Jan.-Apr. 2006, 81-97. **7.** Nanda A.R. & Ali Almas, “Health Sector, Issues and Challenges”, in *India: Social Development Report*, Council for Social Development (CSD), Oxford University Press, 2006, 18-32. **8.** *National Health Policy – 2002 (NHP-2002)*, Govt. of India (GOI), 2002, Dept. of Health, New Delhi. **9.** Rao Arati (2006), “Universal care – still miles to go”, <www.indiatogether.org/cgi-bin/tools/pfriend.cgi>. **10.** *Sharing the Fullness of Life*, Health Policy of the Catholic Church in India, Commission for Healthcare, CBCI, 2005. **11.** Sinha Archana, “Health and the Common Minimum Programme”, in *Social Action*, July-Sept. 2006, 276-88.

12. “Health Action”, especially **2006**: May (“Millennium Development Goals & Health Challenges”), June (“The National Rural Health Mission”), July (“Community Health Insurance”), December (“NGOs in Health Care”), **2007**: August (“Reshaping Medical Education to People’s Health Needs”), December (“Public Health Care System – Why a Failure”), **2008**: January (“Role of Private Sector in Health Care”) and February (“Innovative Interventions in Health Care”).

Suggestions for Further Readings

As introductions, we would recommend the articles of Amrith, Rao, Sinha, the various issues of *Health Action*, and the HM document, the last one especially for Christians. Some of the other articles are more technical.