India’s Health-Issues and Challenges

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Public health is squarely a state responsibility and particularly so in a developing country. It has to go hand-in-hand with sanitation, drinking water, health education and disease prevention.

The challenges facing India’s health sector are mammoth. They will only multiply in the years ahead. Surprisingly many of the challenges are neither a result of the paucity of resources nor of technical capacity. These hurdles exist because of a perception that the possible solutions may find disfavour with voters or influential power groups.

The first malady has been the utter neglect of population stabilisation in states where it matters the most.

The second is the monopoly that an elitist medical hierarchy has exercised for over 60 years on health manpower planning. The result has given a system where high-tech speciality services are valued and remunerated far higher than the delivery of public health services. The latter ironically touches the lives of millions.

Related to this is the third big challenge — how to make sure that doctors serve the growing needs of the public sector when the working conditions are rotten, plagued by overcrowding, meagre infrastructure and a virtual absence of rewards and punishments.

Divergent Attitudes to Birth Control.

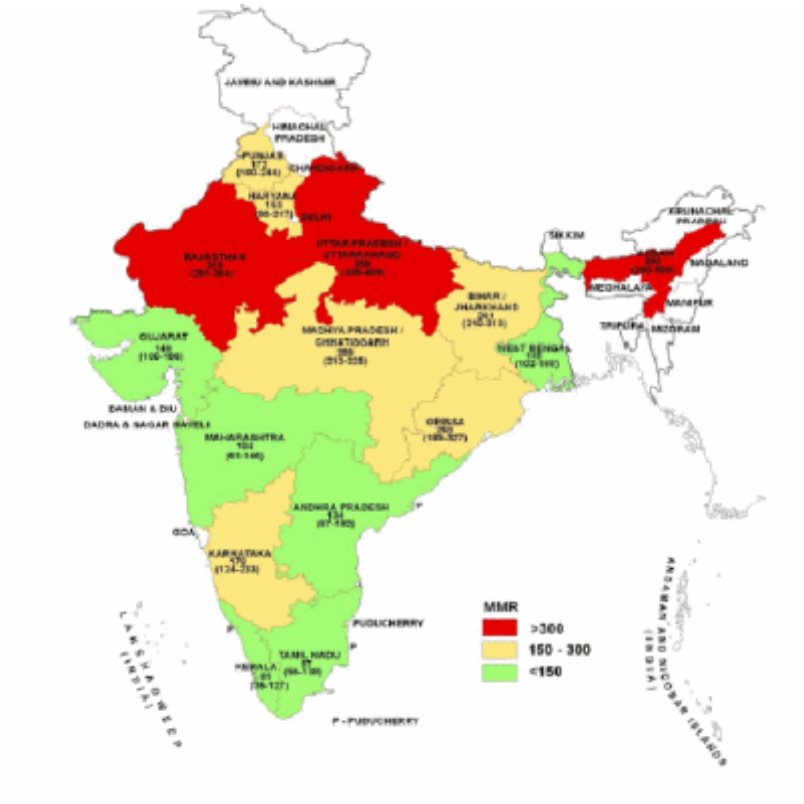
In the aftermath of the 1975 Emergency and the odium of forced sterilisations, the emphasis on population control shrivelled in most of North India. While countries like Korea and Iran which then had fertility rates far higher than ours, embraced the joys of planned parenthood, India dodged the subject. In 1994 the country adopted a target free policy and the states were encouraged to implement a “cafeteria approach” while supplying contraceptives.

However the southern states of Kerala and Tamil Nadu unlike the rest of the country went full force to make family planning their top-most priority. No matter which party came to power, political support was there in abundance. In the mid- eighties the programme was spearheaded by no less than the state Chief Secretary of Tamil Nadu, Mr.T V Anthony, (nick-named Tubectomy-Vasectomy Anthony)which speaks for itself. With enthusiastic politicians, civil servants and doctors joining hands, Kerala and Tamil Nadu reduced fertility rates to equalise European levels. That was more than 20 years ago. Meanwhile, North India (where most of the emergency driven sterilisations had taken place) recoiled from the very mention of family planning- a mind-set that persists even to this day.

The Challenge of Reducing Maternal and Infant Mortality

There is a clear correlation between the health of the mother and maternal and infant mortality. In the northern states more than 60% of the girls and boys (respectively) are married well before the legal ages of 18 and 21. The repercussions of early pregnancy and child birth have not even dawned on the pair when they wed. The first child arrives within the year when most adolescent girls are malnourished, anaemic and poorly educated. With no planned spacing between the births, another child is born before the young mother has rebuilt her strength or given sufficient nutrition and mothercare to the first born. These are among the main causes of high deaths of young women and infants. The chart and tables below clearly show the regional difference in maternal, infant and child mortality. Narrowing the gaps poses one of the biggest health challenges.

Regional Variations: Maternal Mortality Ratio* (MMR)



Extract from – Special Bulletin (June, 2011) on Maternal Mortality in India 2007-09 (Sample Registration System) Office of Registrar General, India
*MMR: Maternal deaths per 1,00,000 live births

The regional variations in the deaths of mothers in the states of Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Odisha, Rajasthan and Assam show that the percentage of maternal deaths is 6 times higher than in the Southern states.

Table 1: Levels of MMR by Regions 2007-09

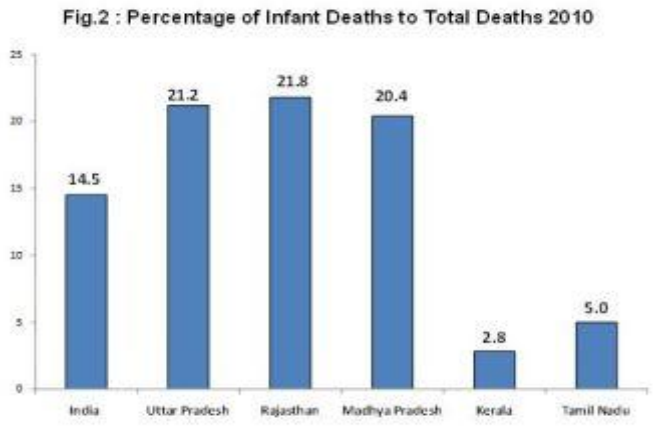
Region	MMR	% to Total Maternal Deaths
EAG* states & Assam	308	61.6
Southern states	127	11.4
Other states	149	27.0
India	212	100.0

In the Industrial countries the average MMR (adjusted 2008) **is 14**

EAG* (Empowered Action Group) states are Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand

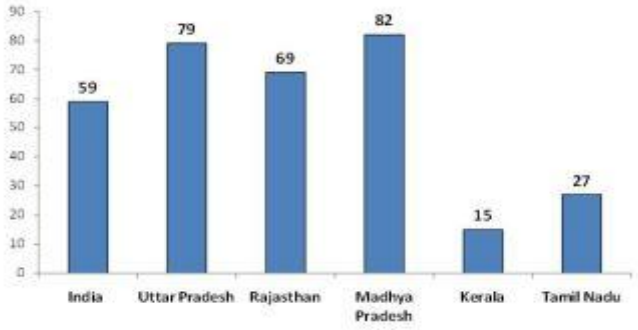
Source: Special Bulletin on Maternal Mortality in India 2007-09 (SRS, 2011) Office of Registrar General, India and Unicef SOWC, 2011

Taken together the EAG States and Assam account for 62% of the maternal deaths. Schemes for nutrition, supplementary feeding, literacy, the right to education and health care remain hollow expressions without any meaning as long as women (and chiefly adolescents) have no control over pregnancy. Unlike other South and South East Asian countries the use of IUD and injectibles has not taken off in India -nor are these the thrust areas for family planning anywhere in the country. Although long term, reversible methods of preventing pregnancy are available, young mothers and children continue to suffer or die. The challenge lies in bringing the issue to centre – stage and not wait for incremental improvements to take place in the fullness of time. The charts below show the colossal difference that has been achieved by the southern states that invested heavily in family planning (albeit through the adoption of terminal methods like sterilisation which can be avoided today.)



Source: Registrar General of India, Ministry of Home Affairs (SRS, 2011)

Fig. 3: Under-Five Mortality Rates 2010



Source: Registrar General of India, Ministry of Home Affairs (SRS, 2011)

Health Management and Manpower Planning

The second challenge relates to a obsession for exclusivity that has consumed the medical sector for too long. The Councils that regulate education and register the practitioners (Medical Council of India (MCI), Dental Council, Pharmacy Council, Nursing Council) were established with laudable goals- to elect a cross section of doctors and other health professionals democratically and to entrust to them the responsibility for designing and executing professional corses. It was expected that the country's needs for professional health manpower would be met both qualitatively and quantitatively. But because the Councils were constituted through a political process of elections, the baggage of money, patronage and quid pro quos became a predictable accessory. Today, gaining entry to professional colleges has become highly commercialised-ultimately reflecting in the aspirations of the health fraternity to reap back benefits from huge investments incurred. As the quest to produce specialists and super specialists grows, the production of qualified technical manpower has declined severely creating a mis-match which cannot be corrected by people who work in silos and lack the understanding and vision to think of the country's health needs in totality.

The Challenge of Establishing NCHRH.

The neglect of public health is one of the fallouts of the elitism that has pervaded medical education. Whereas cities and towns at least have alternatives available- at a price- epidemics and acute illnesses that occur in rural areas often leave people in the hands of fate. The erstwhile elected MCI had relegated public health to the lowest rung of the health hierarchy and the doctors that once decimated dreaded diseases like malaria and smallpox are not to be found. The complement of technical staff, nurses, pharmacists, dentists, lab technicians and operation theatre staff are all in short supply outside the urban areas as the bodies that register them do not work in tandem. More importantly no Council has a stake in health care of any particular state- leave alone the country.

The proposal to set up a National Council for Human Resources in Health (NCHRH), far from being a bureaucratic response was a well thought out strategy having its roots in the recommendations of independent think tanks and expert committees. The rationale for setting up such an umbrella body was to see that the goals of health

manpower planning, the prescription of standards, the establishment of accreditation mechanisms and preservation of ethical standards were served in a co-ordinated way, on the lines of structures that operate successfully in other countries.

The Indian Medical Association in particular and doctors in general have been arguing against the need for such a body because they perceive it as a threat to their autonomy and a camouflage for political and bureaucratic meddling. The fact that health manpower planning was simply ignored, that there was a complete lack of coordination between the councils and most important of all the fact that public health had become a low priority have been overlooked in the fire and fury of opposing the NCHRH concept tooth and nail. The challenge today is how to ensure that the health sector produces adequate professionals as required for the primary, secondary and tertiary sectors, both for the public as well as the private sector health facilities. If the NCHRH Bill before the Standing Committee of Parliament does not see light of day, the resurrection of the superseded scam-ridden MCI is a foregone conclusion.

The Challenge of Allopathy and AYUSH[1].

Public health cannot be run on contract basis and much less be farmed out to private insurance companies and HMOs (Health Management Organisations) as a recent report on Universal Health Coverage seems to suggest. Public health is squarely a state responsibility and particularly so in a developing country. It has to go hand-in-hand with sanitation, drinking water, health education and disease prevention. The National Rural Health Mission (NRHM) which is a public-sector programme has registered an encouraging impact in even the most intractable regions of the country. A UNFPA study has shown that nearly three quarters of all births in Madhya Pradesh and Odisha had been conducted in a regular health facility. The percentage of institutional deliveries in Rajasthan, Bihar in Uttar Pradesh was lower but even so, accounted for almost half the deliveries conducted in those states. Indeed these achievements are immense.

Having said this, institutional deliveries alone cannot be the answer to all the problems that beset the rural health sector. A visit to any interior block or taluka in the Hindi belt states shows that most primary health centres beyond urban limits are bereft of doctors, except sporadically. Some state governments have taken to posting contractual AYUSH doctors engaged under NRHM to man the primary health centres. These doctors dispense allopathic drugs, prescribe and administer IV fluids, injections and life-saving drugs, assisted by AYUSH pharmacists and nursing orderlies. This reality must be confronted. If an AYUSH is doctor has been entrusted with the responsibility of running a primary health centre, and found in shape to handle the national programmes, the controversy over what AYUSH doctors can and cannot do must be settled. The trend of AYUSH doctors working in as registrars and second level physicians in private sector hospitals, clinics, and nursing homes is wide-spread in states like Uttar Pradesh, Maharashtra, and Punjab; so also in Delhi and Mumbai. The challenge lies in understanding what can be changed and what cannot be changed, without getting intimidated by protests from Medical Associations that will always protect their turf to retain primacy.

[1] AYUSH refers to Ayurveda, Siddha, Unami and Homeopathy medical systems, supported by Yoga therapy.

The Challenge of Retaining Doctors.

The most important concern by far is to decide what kind of medical and public health cover is necessary and feasible to be given to people living beyond the bigger towns and cities. If all general duty doctors are making a beeline for post graduation- failing which opting for management, administration and even banking jobs (because cities are better places to live in,) the facts must be faced. Pursuing post-graduation, migrating abroad and prospecting for jobs outside the medical sector cannot be stopped by any Government. But fixed term requirements to stay bonded to the public sector can certainly be insisted upon for state sponsored medical graduates. But equally the working conditions, facilities and remuneration of such doctors should be respectable. In the state of Jammu & Kashmir the compensation given for working in more difficult areas has been graded. Such practical solutions can greatly bolster doctor retention.

At the end of the day, the challenges of the health sector can only be met if doctors, essential drugs and supporting staff are available in the health facilities. The biggest transformation will come if wriggling out of postings and manipulating things through political patrons stops. The doctors will fall in line only if postings are notified through a transparent and fair process and no exceptions whatsoever are allowed. Only the state Chief Ministers and Health Ministers can make this happen. But will they?