DETERMINANTS IN MAKING PUBLIC HEALTH SYSTEM OF INDIA – A COMPREHENSIVE STUDY

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ABSTRACT
The Indian healthcare system is rapidly changing. Healthcare at its essential core is widely recognized as public good. This cannot be left in the hands of the market forces although role of private sector may be present as supplementary. It is known that the social determinants of health in which people grow, live, work and age are very important for the health status of the people. At the same time the socio economic status like income levels, gender and caste affect healthy life. This paper deals with the determinants influence the public health system of India and its impact on individuals.

KEY WORDS: Healthcare; Healthy Life; Health Crisis; Health Condition; Expenditure.

INTRODUCTION
Public health in the 21st century is a multidisciplinary endeavour ranging from the surveillance of health and disease in populations, through to the provision of health advice and information. It occurs at all levels, from the actions taken by individuals through to those taken by national and international agencies. It also takes place in many different settings; for example, in homes, workplaces, schools, hospitals, youth centres, nightclubs, and on the street. There is a misconception regarding the idea of the public health system and medical facilities funded by the government at any level, be it the union government or the state or any local body. Public health actually means the overall situation of the health condition of the people of a country. It is dependent not only on availability of nutritious food, pure drinking water, but also regular source of income, quality of work, less environmental hazard, easy reach of health centres, immunization programme of a country, etc. There are other factors in India such as social caste, literacy and level of education, level of superstitions, etc. which affect the health condition of its citizens. Good health offers a person or group freedom from illness - and the ability to realize one's potential. Health is therefore best understood as the indispensable basis for defining a person's sense of well being. Heath care at its essential core is widely recognized as public good. This cannot be left in the hands of the market forces although the role of private sector may be present as supplementary.

There are a lot of studies on different aspects on public health in India. Here some of the findings of a very important study (EPW May I012). The access to public health is affected by the location of the villages and availability of all-season transport to health centres. This in turn depends on the development of states and the local areas. The study found that Tamil Nadu, in this regard, is the best state in India whereas Maharashtra (MH), HP and MP are in the lower rungs. Curiously enough the health centres are generally at the central places locality or a village, where upper caste people stay. The lower caste people and other marginalized groups (Muslims, Christians, etc.) are at the periphery of the villages and get fewer benefits from the health centres.
HEALTHCARE SCENARIO
The unsatisfactory health condition of the economically and socially deprived sections of the communities is caused by unequal distribution of income, goods and services. Their vulnerability makes it difficult for them to achieve satisfactory health status since they are continuously affected by poor social policies and programmes, unfair economic arrangements and decades of economic and social deprivation. Their health condition can be substantially altered only by a social determinants approach, which improves their daily living conditions, help to tackle inequitable distribution of power and resources. Health statuses in some places in India are dependent on caste-based location of the rural people which in turn decides economic status and political power in several places. The situation also varies among states. For example, it is not the same among the schedule castes of TN and those of MH. Gender decides health condition in India. In TN, MH and HP alcoholism was found to be the major cause of death among the males. Whereas in UP it was occupation related injuries, such as silicosis and tuberculosis that led to a larger number of deaths among males.

Social determinants influence a wide range of health vulnerabilities and capacities, health behaviours and health management. Individuals, communities and nations that experience inequalities in the social determinants of health not only carry an additional burden of health problems, but they are often restricted from access to resources that might ameliorate problems. Not only do social determinants influence diverse dimensions of health, but they also create health issues that often lead to circumstances and environments that, in turn, represent subsequent determinants of health. For instance, living in conditions of low income have been linked to increased illness and disability, which in turn represents a social determinant, which is linked to diminished opportunities to engage in gainful employment, thereby aggravating poverty.

Juvenile sex ratio (0-6 years) is also a matter of public health. It shows whether the number of girls per 1000 boys goes against girls or not. It is found to be the lowest, less than 800, in Meerut district. In several backward villages of better performing states of TN, MH and HP the ratio is very low which going against girls. Interestingly, in some of the less developed districts of flow performing states like MP, UP and Odisha (OD) the sex ratios are high in favour of the girls. The study considers that in very underdeveloped places there is little scope of health facilities and no sex selection technologies. Curiously enough, under-development of some regions can play a positive role! In Meerut district it is reported that sex selection is practised by relatively affluent, upper caste families.

The livelihood and income of the people are connected with economic status. They in turn determine the accessibility of health facilities and medical care. In agrarian economy the pattern of landholdings, wage rate, the numbers of days to be employed, road connectivity of the villages and markets, irrigation facilities, etc. are matters to be considered as agricultural income of the rural people. Presently agricultural economy has been losing its status for several reasons. As more than 60% of the people are involved directly or indirectly in this sector, public health of a large section of people is deteriorating.

The tribal people are also in a crisis as ‘development terrorism’, as has been stated by Professor Amit Bhaduri, is thrust upon them. These people fear losing their age old livelihood due to threat of development projects of the big corporates. This will affect the health condition of the entire community.
Table-1: Public Expenditure on Health, 2010

<table>
<thead>
<tr>
<th>Region</th>
<th>As a share of GDP (%)</th>
<th>As a share of total health expenditure (%)</th>
<th>In absolute terms (2005 PPP international dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>1.2</td>
<td>29</td>
<td>39</td>
</tr>
<tr>
<td>South Asia</td>
<td>1.2</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>Sub-Saharan Africa*</td>
<td>2.9</td>
<td>45</td>
<td>66</td>
</tr>
<tr>
<td>East Asia &amp; Pacific*</td>
<td>2.5</td>
<td>53</td>
<td>167</td>
</tr>
<tr>
<td>Middle East &amp; North Africa*</td>
<td>2.9</td>
<td>50</td>
<td>199</td>
</tr>
<tr>
<td>Latin America &amp; Caribbean*</td>
<td>3.8</td>
<td>50</td>
<td>424</td>
</tr>
<tr>
<td>Europe &amp; Central Asia*</td>
<td>3.8</td>
<td>50</td>
<td>424</td>
</tr>
<tr>
<td>World Average</td>
<td>3.8</td>
<td>65</td>
<td>585</td>
</tr>
<tr>
<td>European Union</td>
<td>8.1</td>
<td>77</td>
<td>2499</td>
</tr>
</tbody>
</table>

- Calculate from per capita expenditure on health and share of public health expenditure in total health expenditure.

* Developing countries only.

**Sources:** World development – Indicator (online, 1st January 2013)

The body mass index is one of the important determinants of health of people. It is found that even in the better performing states like TN, 70% of the adult population is undernourished. It is noteworthy that at the time of the study TN was the only state which had universal access to PDS with more than 90% of the households possessing ration cards. It is also found in UP where almost all the population was undernourished. In India possession of ration cards does not mean receiving allocated commodities.

**Fig-1: India’s Health Care Crisis**

It is known that the social determinants of health in which people grow, live, work and age are very important for the health status of the people. At the same time the socio economic status like income levels, gender and caste affect healthy life. It is claimed from different
quarters that the status of public health depends on the economic growth of a country. But the logic is not on a solid basis. As ‘many countries have been able to achieve big improvements in the health and nutrition status of their respective populations in a shorter time, even with lower rates of economic growth’ (Dreze & Sen: An Uncertain Glory). In a short period of time how several countries like China Brazil, Mexico, and Thailand, have achieved considerably high status in public health is an inspiring guideline to Indian policy makers. In India also one can find in TN and Kerala where health services have been in a better position. Dreze & Sen think the commitment to universal health coverage would require a major transformation in Indian health care mainly in two respects. First, they consider we should stop believing that India’s transition from poor health to good health could easily be achieved through private health care and insurance. Actually the overarching objective of ensuring access to good health ‘to all members of the community irrespective of their ability to pay’ is intrinsically a public responsibility. Secondly, there is a need to go ‘back to basic’ as far as public provision of health care services- both of a preventive and curative kind- is concerned, with renewed focus on primary health centres, village level health workers, preventive health measures, and other means of ensuring timely health care on a regular basis.

More than a fifth of under five-year-old child deaths in the world in 2012 occurred in India. A UNICEF report published in the month of September 2013 observes that 6.6 million children worldwide died before reaching their fifth birthday in 2012. About half of deaths occurred in only five countries, i.e. China, Congo, India, Nigeria and Pakistan. Healthcare is a priority area in the 12 Plan and Approach Paper had declared that the main focus of the plan would be on health sector reforms, especially the strengthening of primary healthcare, based on availability of more health personnel and on extending these facilities to remote and inaccessible areas. The budgetary allocation made by the Government of India is just about 7% of the total expenditure plan during the year 2012-13. Incidentally, medical and public health’s share in the total plan expenditure was 8.7% ten years ago, in 2004-05.

CONCLUSION

The world Health Organisation (WTO) is concerned about the growing out-of-pocket (OOP) medical expenditure incurred by Indians. One out of every three rural Indians cannot afford to go to hospitals. One out of every five urban Indians remain under-treated due to financial problems. According to Dr. Kathleen A Holloway, regional adviser of the WHO, about 70% Indians are spending their OOP income on medicines and healthcare services in comparison to 30% - 40% in other Asian countries. India stood second in terms of OOP expenditure amongst BRICS countries in 2011. Russia’s OOP expenses stood highest at 89.9%, followed by Indian 86%, China 78.8%, Brazil 57.8% and South Africa 13.8%. On the other hand, the corresponding expense figure in developed economies such as the US and the UK stood at 20.9% and 53.1% respectively. The increasing trend of OOP expenditure to pay for healthcare costs is a growing problem in India. About 39 millions Indians are pushed poverty because of ill health every year.

The new agenda for Public Health in India includes the epidemiological transition, demographical transition, environmental changes and social determinants of health. Based on the principles outlined at Alma-Ata in 1978, there is an urgent call for revitalizing primary health care in order to meet these challenges. The role of the government in influencing population health is not limited within the health sector but also by various sectors outside the health systems. This article is a literature review of the existing government machinery for public health needs in India, its success, limitations and future scope. Health system strengthening, human resource development and capacity building and regulation in public health are important areas within the health sector. Contribution to health of a population also
derives from social determinants of health like living conditions, nutrition, safe drinking water, sanitation, education, early child development and social security measures. Population stabilization, gender mainstreaming and empowerment, reducing the impact of climate change and disasters on health, improving community participation and governance issues are other important areas for action. Making public health a shared value across the various sectors is a politically challenging strategy, but such collective action is crucial.

REFERENCES