



Cover Page



HEALTH CONSCIOUSNESS AND CARE IN INDIA: A SOCIOLOGICAL PERSPECTIVES

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Abstract

Health and health care need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter.

Health is clearly not the mere absence of disease. Good Health confers on a person or groups freedom from illness - and the ability to realize one's potential. Health care covers not merely medical care but also all aspects pro preventive care too. Nor can it be limited to care rendered by or financed out of public expenditure-within the government sector alone but must include incentives and disincentives for self care and care paid for by private citizens to get over ill health. Where, as in India, private out-of-pocket expenditure dominates the cost financing health care, the effects are bound to be regressive. Health care at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible hand of the market. Nor can it be established on considerations of utility maximizing conduct alone. This research paper to be discussed on Healthcare System in India and Its problems and prospects.

Key Words: Healthcare System, Financing Healthcare, Health Consciousness, Private Health Sector, Seasonal Diseases, Healthcare Life Style.

Introduction

Historically the Indian commitment to health development has been guided by two principles-with three consequences. The first principle was State responsibility for health care and the second (after independence) was free medical care for all (and not merely to those unable to pay),

The first set of consequences was inadequate priority to public health, poor investment in safe water and sanitation and to the neglect of the key role of personal hygiene in good health, culminating in the persistence of diseases like Cholera.

The third set of consequences appears to be the inability to develop and integrate plural systems of medicine and the failure to assign practical roles to the private sector and to assign public duties for private professionals. To set right these gaps demanded patient redefinition of the state's role keeping the focus on equity. But during the last decade there has been an abrupt switch to market based governance styles and much influential advocacy to reduce the state role in health in order to enforce overall compression of public expenditure and reduce fiscal deficits.

People have therefore been forced to switch between weak and efficient public services and expensive private provision or at the limit forego care entirely except in life threatening situations, in such cases



Cover Page



sliding into indebtedness. Health status of any population is not only the record of mortality and its morbidity profile but also a record of its resilience based on mutual solidarity and indigenous traditions of self-care - assets normally invisible to the planner and the professional. Such resilience can be enriched with the State retaining a strategic directional role for the good health of all its citizens in accordance with the constitutional mandate. Within such a framework alone can the private sector be engaged as an additional instrument or a partner for achieving shared public health outcomes. Similarly, in indigenous health systems must be promoted to the extent possible to become another credible delivery mechanism in which people have faith and away fond for the vat number of less than folly qualified doctor in rural areas to get skills upgraded. Public programs in rural and poor urban areas engaging indigenous practitioners and community volunteers can prevent much seasonal and communicable disease using low cost traditional knowledge and based on the balance between food, exercise medicine and moderate living. Such an overall vision of the public role of the heterogenous private sector must inform the course of future of state led health care in the country.

Health is therefore best understood as the indispensable basis for defining a person's sense of well being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care and current bio-medical understanding about health and illness.

Forecasting in Health Sector

In general predictions about future health - of individuals and populations - can be notoriously uncertain. However all projections of health care in India must in the end rest on the overall changes in its political economy - on progress made in poverty mitigation (health care to the poor) in reduction of inequalities (health inequalities affecting access/quality'), in generation of employment /income streams (to facilitate capacity to pay and to accept individual responsibility for one's health) in public information and development communication (to promote preventive self care and risk reduction by conducive life styles) and in personal life style changes (often directly resulting from social changes and global influences). Of course it will also depend on progress in reducing mortality and the likely disease load, efficient and fair delivery and financing systems in private and public sectors and attention to vulnerable sections- family planning and nutritional services and women's empowerment and the confirmed interest of me siat-e 10 ensure just health care to the Largest extent possible. To list them is to recall that Indian planning had at its best attempted to capture this synergistic approach within a democratic structure. It is another matter that it is now remembered only for its mixed success.

Available health forecasts

The key conclusions must be understood keeping in the mind the tact that the concept of DALYs incorporates not only mortality but disability viewed in terms of healthy years of life lost. In this forecast, DALYs are expected to dramatically decrease in respect of diarrhoeal diseases and respiratory infections and less dramatically for maternal conditions. TB is expected to plateau by 2000, and HIV infections are



Cover Page



expected to rise significantly up to 2010. Injuries may increase less significantly, the proportion of people above 65 will increase and as a result the burden of non-communicable disease will rise. Finally cardiovascular diseases resulting any from the risk associated with smoking urban stress and improper diet are expected to increase dramatically.

Under the same BOD methodology another view is available from a four - state analysis done in 1996 these four states- AP, Karnataka, West Bengal and Punjab - represent different stages in the Indian health transition. The analysis reveals that the poorer and more populated states. West Bengal, will still face a large incidence of communicable diseases. More prosperous states, such as Punjab further along the health transiting will witness sharply increasing incidence of non- communicable diseases especially, in urban areas. The projections highlight that we still operating on unreliable or incomplete base data on mortality and causes of death in the absence of vital registration statistics and know as yet little about how they differ between social classes and regions or about the dynamic patterns of change at work. It also highlights the policy dilemma of how to balance between the articulate middle upper class demand for more access to technologically advanced and subsidized clinical services and the more pressing needs of the poor for coverage of basic disease control interventions. This conflict over deployment of public resources will only get exacerbated in future. That tradition has been totally replaced by the currently dominant school of international thought about health which is concerned primarily with efficiency of systems measured by cost effectiveness criteria. Future of State Provided Health Care.

Key Achievements in Health

Our overall achievement in regard to longevity and other key health indicators are impressive but in many respects uneven across States, The two Data Annexure at the end indicate selected health demographic and economic indicators and highlight the changes between 1951and 2001. In the past five decades life expectancy has increased from 50 years to over 64 in 2000. IMR has come down from 1476 to 7. Crude birth rates have dropped to 26.1 and death rates to 8.7. At this stage, a process understanding of longevity and child health may be useful for understanding progress in future. Longevity, always a key national goal, is not merely the reduction of deaths as a result of better medical and rehabilitative care at old age. In fact without reasonable quality of life in the extended years marked by self-confidence and absence of undue dependency longevity may men only a display of technical skills. So quality of life requires as much external bio-medical interventions as culture based acceptance of inevitable decline in faculties without officious start at sixty but run across life lived at all ages in reduction of mortality among infants through immunization and nutrition interventions and reduction of mortality among young and middle aged adults, including adolescents getting inform about sexuality reproduction and safe motherhood.

Health Status and issues

The difference between rural and urban indicators of health status and the wide interstate disparity in health status are well known. Clearly the urban rural differentials are substantial and range from childhood and go on increasing the gap as one grows up to 5 years. Sheer survival apart there is also the we known under provision in rural areas in practically all social sector services. For the children growing up in rural areas the disparities naturally tend to get even worse when compounded by the widely practiced discrimination against women, starting with foeticide of daughters.



Cover Page



In spite of overall achievement it is a mixed record of social development specially failing in involving people in imaginative ways. Even the averaged out good performance hides wide variations by social class or gender or region or State. The classes in many States have had to suffer the most due to lack of access or denial of access or social exclusion or all of them. This is clear from the fact that compared to the richest quintile, the poorest had 2.5 times more IMR and child mortality, TFR at double the rates and nearly 75% malnutrition - particularly during the nineties.

Not only are the gaps between the better performing and other States wide but in some cases have been increasing during the nineties. Large differences also exist between districts within the same better performing State urban areas appear to have better health outcomes than rural areas although the figures may not fully reflect the situation in urban and peri-urban slums with large in migration with conditions comparable to rural pockets. It is estimated that urban slum population will grow at double the rate of urban population growth in the next few decades. India may have by 202 a total urban population of close to 600 million living in urban areas with an estimated 145 million living in slums in 2001. What should be a fair measure for assessing success in enhancing health status of population in any forecast on health care?

Reduction in child mortality involves as much attention to protecting children from infection as in ensuring nutrition and calls for a holistic view of mother and child health services. The cluster of services consisting of antenatal services, delivery care and post mortem attention and low birth weight, childhood diarrhoea and ARI management are linked priorities.

In this context we may refer to the large ratio-based rural health infrastructure consisting of over 5 lakh trained doctors working under plural systems of medicine and a vast frontline force of over 7 lakh ANMs, MPWS and Anganwadi workers besides community volunteers. The creation of such public work force should be seen as a major achievement in a country short of resources and struggling with great disparities in health status.

On any count these are extraordinary infrastructural capacities created with resources committed against odds to strengthen grass roots. There have been facility gaps, supply gaps and staffing gaps, which can be filled up only by allocating about 20% more funds and determined ill to ensure good administration and synergy from greater congruence of services, but given the sheer size of the endeavor there will always be some failure of commitment and in routine functioning. These get exacerbated by periodic campaign mode and vertical programme, which have only increased compartmentalized vision and over-medicalization of health problems. The initial key mistake arose from the needless bifurcation of health and family welfare and nutrition functions at all levels instead of promoting more holism. As a result of all this the structure has been precluded from reaching its optimal potential. It has got more firmly established at the periphery/sub-center level and dedicated to RCH services only. At PHC and CHC levels this has further been compounded by a weak referral system. There has not been enough convergence in "escorting" children through immunization coverage and nutrition education of mothers and ensuring better food to children, including cooked midday meals and health checks in all schools. There has also been no constructive engagement between allopathic and indigenous systems to build synergies, which could have improved people's perceptions of benefits from the infrastructure in ways that made sense to them.



Cover Page



One key task in the coming decades is therefore to utilize fully that created potential by attending to well known organizational motivational and financial gaps. The gaps have arisen partly from the source and scale of funds and partly due to lack of persistence, both of which can be set right. PHCs and CHCs are funded by States several of whom are unable to match Central assistance offered and hence these centers remain inadequate and operate on minimum efficiency. On the other hand over two thirds cost of three fourths of sub-centers are fully met by the Center due to their key role in family welfare services. But in equal part these gaps are due to many other non-monetary factors such as undue centralization and uniformity, fluctuating commitment to key routines at ground level, insufficient experimentation with alternatives such as getting public duties discharged through private professionals and ensuring greater local accountability to users.

Major Disease Control Efforts

A careful analysis of the Global Burden of Disease (GBD) study focusing on age-specific morbidity during 2000 in ten most common diseases (excluding injuries) shows that sixty percent of morbidity is due to infectious diseases and common tropical diseases, a quarter due to life-style disorders and 13% due to potentially preventable perinatal conditions. Further domestic R&D has been so far muted in its efforts against an estimated annual aggregate health expenditure in India of Rs-80,000/-crores R&D expenditure in India for public and private sector combined was Rs 1150 crores only. India must play a larger part in its own efforts at indigenous R&D as very little world-wide expenditure on R&D is likely to be devoted to infectious diseases. For instance out of the 1233 new drugs that came into the market between 1975 and 1997 only 11 were indicated specifically for tropical country diseases.

We have already the distinction of elimination or control acceptable to public health standards of small pox and guinea worm diseases. In the draft National Health Policy -21 It has now been proposed to eliminate or control the following diseases within limits acceptable to public health practice- A good deal of the effort would be feasible.

- Polio Yaws and leprosy by 2005 which seems distinctly feasible though the removal of social stigma and reconstructive surgery and other rehabilitation arrangements in regard to leprosy would remain inadequate for a decade or more.
- Kalaazar by 2010 and Filariasis by 2010 which also seems feasible due to its localized prevalence and the possibility of greater community based work involving PR institutions in the simple but time-limited tasks or public health programs-
- Blindness prevalence to 0.5% by 2010 seems less feasible due to a graying population. At present the programme is massively supported by foreign aid as there are many other legitimate demands on domestic health budgets-
- AIDS reaching zero growth by 2007 appears to be problematic as there are disputes even about base data on infected population. On most reckonings, affordable vaccines are not likely to be available soon nor anti-retroviral drugs appear likely at affordable prices in the near future. Further the prevalence curve of Aids in India is yet to show its shape. There is also larger unresolved question of



Cover Page



where HIV/AIDS should be fitted in our priorities of public health, especially in this massively foreign aided programme what happen if aid does not become available at some point.

Unfinished burden of communicable diseases

Apart from the above, there remains a vast unfinished burden in preventing controlling or eliminating other major communicable diseases and in bringing down the risk of deaths in maternal and peri-natal conditions. Endemic diseases arising from infection or lack of nutrition continue to account for almost two thirds of mortality and morbidity India. Indeed eleven out of thirteen diseases recommended by the Bhore Committee were infectious diseases and at least three of them may well continue to be with us for the next two decades Baring Leprosy which is almost on the path to total control by 2005, the other key communicable diseases will be TB Malaria and Aids- to which diarrhoea in children and complicated and high risk maternity should be added in view of their pervasive incidence and avoidable mortality among the poorer and under served sectors.

Tuberculosis

Tuberculosis has had a world wide resurgence including in India. It is estimated that about 14 million persons are infected, i.e. 1.55% of total population suffer from radiologically active Tuberculosis. About 1.5 million cases are identified and more than 300000 deaths occur every year Between NFHS 1 and NFHS 2 the prevalence has increased from 4678 per lakh population to 544. Unfortunately, prevalence among working age adults (15-59) is even higher as 675. All these may well be underestimates in so far as patients are traced only through hospital visit. Only about half reach the hospital. Often wrong diagnosis by insufficiently trained doctors or misunderstood protocols is another key problem both public and private sectors. TB is a wide spread disease of poverty among women living and working in ill ventilated places and other undernourished persons in urban slums it is increasingly affecting the younger adults also in the economically productive segments.

Improved diagnosis through better training and clear protocols and elimination of drug resistance through incomplete cure should be priority. Treatment costs in case of drug resistance can soar close to ten times the normal level of Rs. 3000 to 4000/-per person treated. Similarly even though the resistant strain may cover only 8% at present, it could suddenly rise and as it approaches 20% or so, there is a danger that TB may get out of control. The DOTS programme trying for full compliance after proper diagnosis is settling down but already has some claims of success. There is reason to hope that DOTS programs would prove a greater success over time with increased community awareness and generation. The key issue is how soon and how well can it be integrated into the PHC system and made subject to routines of local accountability, without which no low cost regime of total compliance is feasible in a country as large as India.

An optimistic assessment could be that with commitment and full use of infrastructure it will be possible to arrest further growth in absolute numbers of TB cases keeping it at below 1.5 million till 2010 even though the population will be growing. Once that is done TB can be brought down to less than a million lie within internationally accepted limits and disappears as a major communicable disease in India by 2020.



Cover Page



Malaria

As regards malaria, we have had a long record of success and failure and each intervention has been thwarted by new problems and plagued by recrudescence. At present India has a large manpower fully aware of all aspects of malaria about often low in motivation. It can be transformed into a large-scale work force for awareness generation, tests and distribution of medicine. In spite of past successes, there is evidence of reemergence with focal attacks of malaria with the virulent falciparum variety especially in tribal areas. Priority tribal area malaria stands fully funded by the center.

About 2 million cases of malaria are recorded all over India every year with seasonal high incidence local failures of control. Drug resistance in humans and insecticide resistant strains of mosquitoes present a significant problem. But there is a window of opportunity in respect of DDT sensitive areas in eastern India where even now malaria incidence can be brought down by about 50% within a decade and be beneficial for control of kala-azar and JE. There is growing interest and community awareness of biological methods of control of mosquito growth. Unfortunately diligent ground level public health work is in grave disarray in these areas but can be improved by better supervision greater use of panchayatraj institutions and buildings on modest demonstrated successes. As regards a vaccine, there seems to be no sufficient incentive for international R&D to focus on a relatively lower priority or research. Roll back malaria programmes of the WHO are more likely to concentrate on Africa whose profile of malaria is not similar to ours. The search for a vaccine continues but has little likelihood of immediate success.

What need to be done?

Health perceptions play an important part in ensuring sound health outcomes. To a large extent they are culturally determined but also subject to change with economic growth and social development. People intuitively develop capacity to make choices between being treated under the western or indigenous systems of medicines, keep a balance between good habits traditionally developed for healthy living and modern lifestyles, decide on where to go for chronic and acute care and how to apportion intra-family utilization of healthcare resources. The professional is generally bound by his discipline and its inherent logic of causation and effect and tends to discount even what works as successful practice, if it does not fall within the accepted understanding of his profession. Some movement is occurring among eminent allopathic doctors trying, for instance, to rework Ayurveda theory in a modern idiom starting from respectful reverse analysis for actual successful contemporary practice of Ayurveda and provide a theoretical frame linking it to contemporary needs. There is evidence from public health campaigns in Tamil Nadu where every seventh person spontaneously expressed a preference for Siddha Medicine. Homeopathy for chronic ailment is widely accepted. The herbal base for Ayurveda medicine widely practiced in the Himalayan belt has drawn world attention a huge export market remains to be tapped according to the knowledgeable trade sources but the danger of bio-privacy remains and legal enablements should be put in place soon that would fully expand on our rights under the WTO agreements.



Cover Page



Summing Up

The next issue relates to the desirable level of public expenditure towards health services. China devotes 4.5% to its G-DP as against India devoting 5.1%. but this hides the fact that in China, public expenditure constitutes 38% whereas in India, it is only 15% of total health expenditure. An optimistic forecast would be that the level of public expenditure will be raised progressively such that about 30% of total health expenditure would be met out of public funds by progressively increasing the health budget in states and the central and charging user fees in appropriate cases. The figure mentioned would perhaps correspond to the proportion of the population which may still need assistance is social development.

Finally it is proper to remember that health is at bottom an issue in justice. It is in this context that we should ask the question as to how far and in what way has politics been engaged in health care? The record is disappointing. Most health sector issues figuring in political debate are those that affect interest groups and seldom central to choices in healthcare policy. For instance conditions of service and reward systems for Government doctors have drawn much attention often based on inter service comparison of no wider interest. Inter-system problems of our plural medical care have drawn more attention from courts than from politics. Hospital management and strikes, poor working of the MCI and corruption in recognition of colleges, dramatic cases of spurious drug supply etc have been debated but there has been no sustained attention on such issues as why malaria recrudescence is so common in some parts of India or why complaints about absence of informed consent or frequent in testing on women, or on the variations in prices and availability of essential drugs or for combating epidemic attacks in deprived areas seldom draw attention.

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