PUBLIC HEALTH

https://frontline.thehindu.com/cover-story/continuing-tale-of-state-neglect/article9820913.ece

Continuing tale of state neglect

AMIT SENGUPTA

Print edition : September 01, 2017T+ T-

At a primary health centre in Birbhum district of West Bengal. Photo: PTI

Sir Joseph Bhore. Photo: THE HINDU ARCHIVES

Patients wait at a private hospital in Gurgaon. A file picture. Investment in the private hospital sector was very low in the 1970s but it has grown at an exponential rate since then.

At a special medical camp for malaria-affected villages in Visakhapatnam district of Andhra Pradesh in July.

At a pulse polio immunisation camp in Coimbatore, Tamil Nadu, on April 2. Public health in the post-Independence period came to mean disease control programmes. Photo: M. PERIASAMY

JUNE 4, 1973. Staff explain details of various contraceptive options at a health centre near Chennai. Photo: THE HINDU ARCHIVES

One of the beneficiaries of the Centre's Janani Suraksha Yojana (mother security scheme) under the NRHM, in Sitapur, Uttar Pradesh, on July 16. Photo: RAJEEV BHATT

Decades of flawed policy and meagre state funding, followed by the era of neoliberal reforms, have resulted in the poor state of the country's public health systems.

Health-care services in India at the time of Independence were a function of the socio-economic and political interests of the colonial rulers. The availability of health-care services in modern medicine was largely concentrated in big cities. Wide-ranging discussions took place in the 1940s about possible strategies directed at providing comprehensive health care and extending the infrastructure of health services in independent India.

In a report submitted in 1946, the Health Survey & Development Committee, known as the Bhore Committee, formulated a road map for strengthening health-care services across the country. Among its detailed recommendations were proposals to develop a nationwide network of health facilities. As a short-term measure it suggested the setting up of "one primary health centre for a population of 40,000, to be manned by two doctors, one nurse, four public health nurses, four midwives, four trained *dais*, two sanitary inspectors, two health assistants, one pharmacist and 15 other class IV employees". The committee's longer-term vision was even more ambitious: it proposed setting up primary health units with 75-bed hospitals for every population of 10,000 to 20,000, and secondary units with 650-bed hospitals networked around district hospitals with 2,500 beds each. It is interesting to note that the Bhore Committee's recommendations were far ahead of the current norm for primary care, which is one primary health centre (PHC) with four to six beds catering to a population of 20,000-30,000.

Decades of flawed policy and meagre state funding, followed by the era of neoliberal reforms, have resulted in the poor state of the country's public health systems.

Unfortunately, the Bhore Committee's recommendations remained on paper. A critical gap that was never addressed was the extremely low allocation of public funding for the health sector. The first three Five-Year Plans in India after Independence allocated just Rs.140 crore, Rs.225 crore and Rs.342 crore respectively for health, including for water and sanitation, amounting to just 5.9 per cent, 5 per cent and 4.2 per cent of the total Plan outlay. Underfunding of health-care services has been the bane of public health in India, which continues to date. Consequently, virtually all the aspirations reflected in various reports and recommendations to the government have remained unfulfilled. The first Five-Year Plan period saw a mere 0.22 per cent of the gross domestic product (GDP) being allocated for health care. This rose very slowly to above 1 per cent of the GDP in the 1980s and has stagnated at that level for almost four decades. In the late 1950s, the high-powered Health Survey and Planning Committee, known as the Mudaliar Committee, was tasked with suggesting a fresh road map to strengthen health-care services. The committee's report, submitted in 1961, pointed to the failure of the government in significantly enhancing public health spending. While again making useful recommendations to expand the public health infrastructure, the report also marked a new emphasis on population control. This was to become, in the next decades, one of the major planks of public health.

Since the Mudaliar Committee report, population control policies have been a major obsession among planners in India. While India has progressed to a phase where a demographic transition is under way in most parts of the country, leading to a slowing of population growth, population polices continue to target the poor and women. Population control strategies have tended to be paternalistic, prescriptive and coercive. They start from the belief that the poor breed prodigiously and that it is the nation's duty to cap their unbridled fertility. Such programmes are inappropriate not only because they victimise women, especially poor women, but also because they do not work. They have undermined the efficacy of the general health-care infrastructure as well as women's faith in this infrastructure to address their real concerns.

In the past couple of decades, driven by the growing consensus against coercive population control, the emphasis has shifted from population control to reproductive and child health. Unfortunately, the gaze of the programme is still firmly fixed on women as targets. Women need access to family planning services because of their own health needs. But such access has to ensure that women have a choice and that women are in a position to make decisions about their choice. In order for a policy to bring women's concerns and needs to the centre stage, it should revolve around strategies that address women's health in all its dimensions and not just their wombs.

Rise of private sector

Instead of securing access to comprehensive health-care services, public health in the post-Independence period came to mean disease control programmes (also called "vertical" programmes). They included the national programmes on tuberculosis, malaria, leprosy, immunisation, diarrheal diseases, blindness and family planning. With no integration at the delivery level, these programmes were insensitive to local conditions, unresponsive to local needs, highly bureaucratised and inefficient. They were accountable to officials situated in the national and State capitals and had little or no scope for flexibility based on local conditions. Local populations were indifferent and in some cases hostile to such programmes, resulting in fair measure to the very poor utilisation of government health facilities in many areas.

The government's failure to provide access to health-care services to the entire population was commented upon in India's first National Health Policy in 1983, which said that "the demographic and health picture of the country still constitutes a cause for serious and urgent concern". Nearly 35 years later, the continuing crisis relating to public services was echoed by the Economic Survey of 2017, which noted that a "distinctive feature of the Indian economic model is the 'weakness' of state capacity, especially in delivering essential services such as health and education".

In addition, an urban elitist bias in medical education as well as medical services impacted the state's ability to provide health care to the poor as well as those living in rural areas. Continued emigration of doctors, a rush for super-specialities, development of corporate hospitals and polyclinics, and an

extremely high and near-universal irrational use of drugs and technology emerged as clear trends within the first three decades after Independence. Nature abhors a vacuum, and in the case of health care, the absence of public services was invariably accompanied by a growth of private services.

Investment in the private hospital sector was very low in the 1970s but it has grown at an exponential rate since then. This was fuelled simultaneously by poor investment by the state and offer of incentives to the private sector in the form of soft loans, subsidies and tax exemptions. New medical technologies further added to the impetus, with increasing corporate participation in health care. This, coupled with the entry of insurance multinationals, cleared the path for the "marketisation" of health care.

Impact of neoliberal reforms

The shift towards a market-oriented policy for health care received substantial support with the initiation of neoliberal economic reforms in the country in 1991. These reforms marked a major shift in the government's policy towards social sectors such as health, and sought, by way of fiscal austerity measures, to cut government spending and subsidies in social sectors, reduce direct taxes, increase administered prices, liberalise trade by reducing tariff rates and providing other incentives for foreign investments, privatise public enterprises, deregulate the labour market, and so on. The policies were designed to clear the path for the state's withdrawal from social sectors such as health, education and food security. The immediate impact on health was a cut in budgetary support to the health sector. The cuts were severe in the first two years of the reform process, followed by some restoration subsequently. Thus, the outlay for health fell from 1.9 per cent to 1.6 per cent in the first two years of the 1990s, and then increased marginally to 1.8 per cent in the 8th Plan outlay. Health care was a major casualty as the share of States constitutes a major portion of expenditure. As a result of the rollback on expenditure on health care, the expenditure by the government on health care fell from 1.4 per cent of the GDP in 1991 to 0.9 per cent in 2002.

The reforms of the 1990s proved catastrophic for public health services, and an already underfunded system was virtually brought to its knees. The very low level of public spending placed a huge financial burden on households. By 2004-05, per capita public spending on health was Rs.242, while private spending was almost four times at Rs.959. As a consequence, the number of people pushed below the poverty line because of catastrophic out-of-pocket expenses incurred on health care rose from about 26 million in 1993-94 to 39 million in 2004-05, and to an estimated 70-90 million in 2012-13.

In 2004, when the United Progressive Alliance (UPA) government was voted to power, its Common Minimum Programme promised an expansion of health-care services. With this in view, the National Rural Health Mission (NRHM) was launched in 2005. While the NRHM, or the NHM (National Health Mission) as it is now called, did lead to an expansion of public services, it failed to match expectations. Its ambition was curtailed over the years, as was its funding, when compared with the original design. The underfunding of the NHM should be seen in the light of a comment in the first draft of the new National Health Policy (available in 2015): "The budget received [for the NRHM] and the expenditure thereunder was only about 40 per cent of what was envisaged for a full revitalisation in the NRHM framework."

India's reforms in the health sector have been informed by the entire gamut of neoliberal prescriptions mentioned earlier. The direction of reforms has been uncannily similar to those pursued in a number of low- and middle-income countries, including the imposition of ceilings on public health expenditure, promotion of cost recovery (user fees) in public institutions, segmentation of the health-care system into "basic" care for the poor and private care for the rich and outsourcing of functions to the private sector.

Currently, India's health-care system is one of the most privatised in the world and its public expenditure one of the lowest. Of the total expenditure on health care in India, only 32 per cent is public expenditure—the 16th lowest among 190 countries in the World Bank Database, keeping India in the august company of countries such as Sierra Leone, Afghanistan, Haiti and Guinea. It performs even worse for public spending on health care as a percentage of GDP. At 1.1 per cent, India stands 12th from the bottom, keeping company with Myanmar, Haiti, South Sudan, Timor-Leste and Pakistan.

In addition to the setting up of the NRHM, a new development since 2007 has been the introduction of public-funded health insurance schemes, at both the State and national levels, including the Rashtriya Swasthya Bima Yojana. These schemes follow the neoliberal prescriptions developed under the framework of universal health coverage and explicitly separate financing and provision of health care. They allow beneficiaries to access care in accredited facilities, which may be in the private or the public sector. In practice, an overwhelming majority of the accredited facilities are in the private sector. These insurance schemes serve to further strengthen the private sector by utilising public finances. They only cover for hospital care, while the bulk of private expenses are incurred by non-hospitalised patients. The problem lies not only with inadequate coverage of costs but also with the way the system is milked by unscrupulous private providers for financial gains. These schemes, largely implemented through partnerships with private providers, have been indicted in several States for defrauding the system of hundreds of crores of rupees by performing unnecessary surgical operations (for instance, a huge rise in unnecessary uterus removal operations) and for not contributing to better health outcomes.

The bogey of "fiscal discipline" is now repeatedly raised to restrict public financing of health care. The impact of these policies is clearly being felt. The NHM's activities have faltered in many States and stuttered to a standstill in some others. The unstated strategy appears to be to cap public expenditure at a minimum level and at the same time, through public policy measures, encourage the growth of private providers. The government is also aggressively pushing for private health insurance; the 2015-16 Budget explicitly encouraged this by announcing tax relief to those who purchase private health insurance.

At the same time, several States such as Rajasthan and Madhya Pradesh are drawing up plans for leasing out existing rural public facilities to the private sector. More recently, NITI Aayog, the government policy think tank, unveiled a grand plan to lease out facilities in government-run district hospitals to private providers for a period of 30 years.

The current strategy of the government is a true reflection of the original neoliberal view of health sector reforms. This vision of health care has little role for public health services, which are to be increasingly outsourced to the private sector. Insurance mechanisms and not public provisioning is the linchpin of the so-called "health assurance" model.

We need to focus not on how public systems are to be privatised but on how public systems need to be made truly public. Reforms are necessary in public systems that free them from control by a self-seeking bureaucracy that is tied to neoliberal governments. Public systems need to be reclaimed by the public, shaped by the public and governed by the public. People have a stake and a definite role in reclaiming public systems and in transforming them.

Amit Sengupta is National Co-Convener, People's Health Movement—India (Jan Swasthya Abhiyan)