



Public Health and Policy Infidelity:

An Enquiry into the nature of health provisioning in India

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Governance in Health care: Ethics, Equity and Justice

Theoretical Framework: An Ethico-political Approach

- **Governance and Ethics**
 - Governance, a political obligation of the state
 - Ethics – a principle in moral philosophy
- **Theory of Social Contract**
 - Thomas Hobbes – *Leviathan*
 - John Locke – *Second Treatise on Government*
 - Jean Jacques Rousseau – *The Social Contract*
 - John Rawls – *A Theory of Justice*
- **Health as one of the promises of the Social Contract**
- **Health as a resource – a question of distributive justice**
- States come into existence to protect and safeguard the life and liberties of the individuals, the legitimacy of the government (sovereign) comes from will of the people
- That in stateless situations (state of nature), the might of the powerful would always prevail, but it is only in a state governed by a democratic sovereign that the legitimate rights of the weakest members will also be protected.

Important Landmarks:

- **Health Survey and Development (Bhore) Committee (1943-46)**
- **Health Survey and Planning (Mudaliar) Committee (1959-62)**
- **Committee (Chadha) on entry of NMEP into the Maintenance Phase (1963)**
- **Committee (Mukherji) on Basic Health Services (1963-66)**
- **Committee (Jungalwala) on Integration of Health Services (1964-67)**
- **Report of the Committee on MPWs under Health & Family Welfare Programme (Kartar Singh) (1971-73)**
- **Committee (Dr. B.A. Rao) to determine alternative strategy under NMEP (1974)**
- **Medical Education and Support Manpower (Shrivastav) (1974-75)**
- **Committee on Drugs and Pharmaceutical Industry (Hathi) (1974-75)**

Important Landmarks (contd.):

- International Conference on Primary Health Care, Alma Ata 1978
- Report of the Working Group on Health for All by 2000 (1980-81)
- Working Group report on Population Policy (1980)
- National Health Policy 1983
- Report of the Medical Education Review (Shantilal Mehta) Committee (1982-83)
- Expert Committee (J.S. Bajaj) for Health Manpower Planning, Production and Management (1985-87)
- National Population Policy 2000
- Millennium Development Goals 2000
- National Health Policy 2002
- National Commission on Macroeconomics and Health (2005)
- National Rural Health Mission (2005-12)

- **Bhore Committee (1946):**
 - **No individual should, fail to secure adequate medical care because of in ability to pay for it**

- Out of Pocket expenditure for health care is 2nd major cause of indebtedness in rural India. 70% of total health expenditure in India is out of Pocket.
- 80% Health needs are met from the private sector
- 3% of the population is indebted every year to meet expenses related to health care

- **Bhore Committee (1946):**
 - **Health Services should be placed as close as possible to people in order to ensure the maximum benefit is served to the communities**

- **NSS, 65th round:**
 - In the year 2008-09, people of India spent Rs. 23000 crores commuting to access health care which is 30% more than the Union Health Budget
 - Of the 126 million trips of commuting to access health care, 86% was spent by rural India, proportionally, the poorest spent much more than the rich



- **Bhore Committee (1946):**

- For ensuring adequate health care, the most satisfactory method of meeting the situation would be to provide a whole-time salaried service, thus enabling Governments to ensure that doctors are made available where their services are most needed
- Presently under NRHM, almost all appointments are being made on contractual basis, contracts to be renewed after 11 months
- From doctors, nurses, pathology to computers...almost all services are being outsourced

Facts as they are!

- **Total Health Expenditure in 2004-05 – Rs.1,337,763 mn
4.25% GDP**
 - **Private Sector- 78.05%**
 - **Public Sector- 19.67%**
 - **External Flows- 2.28%**
- **Out of total HE, Household spent 71.13%(Rural-62%, Urban 38%), State Govt. 12% , Central Govt. 6.78% and firms 5.73%**
- **77.96% money is spent on curative care, households spent 90% on curative care**

Source: National Health Accounts India 2004-2005



Bhore Committee (1943-46)

- No individual should fail to secure adequate medical care because of inability to pay for it
- 1 PHC for 10000-20000 population with 75 beds
- Inter-sectoral approach to health services development
- 1 PHC for **1 lakh population** (First Five Year Plan 1952)

Mudaliar Committee (1959-62)

- 1 PHC for 40000 population
- 10 bedded PHC at Taluka level, 4 bedded at peripheries
- Peripheral institutions cannot be built in near future, therefore focus on developing District and sub-district hospitals, Mobile medical services in rural areas for the time-being
- Laboratory facilities to be available in Block PHCs
- Integrated comprehensive services for health and disease control
- User fee for IPD and OPD services, except “truly indigent” !



Chadda Committee (1963) and Mukherjee Committee (1965)

- Concerned on Malaria Control (Chadda Committee) and Family Planning (Mukherjee)
- The recommendations of the Chadda Committee, were found to be impracticable because the basic health workers, with their multiple functions could do justice neither to malaria work nor to family planning work.
- Mukherjee committee recommended delinking of Malaria and Family Planning activities and the separate responsibilities of the field staff

Jhunjunwala (1964-67) and Kartar Singh committee (1971-73):

- Abolition of private practice by doctors (Jhunjunwala committee)
- 1 PHC at 50,000 Population (KS)
- Constituted to form a framework for integration of health and medical services at peripheral and supervisory levels
- Amalgamation of peripheral staff into MPW (Male and Female)

National Health Policy (1983):

- Coincided with the sixth Five Year Plan (1980-85) which marked the beginning of economic liberalisation in India
- Elementary Health problems can be solved by people themselves, emphasis on 'health education'
- Intermediation through 'Health volunteers' having appropriate knowledge, simple skills and requisite technologies
- Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level
- Speciality and super-speciality services through private investments for patients who can pay.

Eighth Five year Plan (1992-97):

- "In accordance with the new policy of the government to encourage private initiatives, Private hospitals/clinics will be supported, norms for minimal facilities and accreditation of private hospitals/clinics would be developed"



National Population Policy (2000)

- Target-free Population Stabilisation programme
- To ensure that the unmet needs of contraception are met
- Integrated services for basic RCH care

National Health Policy (2002):

- **Acknowledges declining trend in health financing**
 - From 1.3 % of GDP in 1990 to 0.9% in 1999
 - State budget decline from 7% to 5.5%
 - 58% of Shortage of CHC in the country
- **Suggests creating new infrastructure and upgrading existing ones**
 - Increasing health investment to 6% of GDP, 2% by 2010, state investment to increase to 8% of state budget, increase central govt. contribution from 15% to 25% by 2010, 55% of total expenditure to be on Primary Health
 - Programme Implementation through autonomous bodies at state and district levels coupled with decentralisation and local participation
 - Integration of vertical programmes
 - Provisioning of essential drugs at local level
 - Mandatory two year rural posting for medical students
 - Minimal statutory norms for deployment of doctors and nurses at medical institutions
 - Medical Grants Commission for funding new medical and dental colleges and up gradation
 - Use of generic drugs and vaccines
 - Encouragement of PPP

National Commission on Macro-economics and Health (2005):

- Three phases: 1947-1983, 1983-2000, 2000 onwards
- 2000 onwards – Private sectors as indispensable,
- Acknowledges role of the state changed from a **provider** to **financer** of health services
- “A villager has to travel for 2 kms to a health post get a tablet of paracetamol, 6 kms for a blood test and nearly 20 km for hospital care”

National Rural Health Mission (2005-2012):

- Claimed to be an Architectural correction of health services
- However,
 - Verticalisation under the shadow of integrated umbrella
 - Fragmented nature of financing and performance based
 - Programme driven up-gradation of infrastructure
 - Contractual employment, Multi-skilling (Recall Bhore Committee!)
 - Public Private Partnership
 - Heavy reliance on Community Health Volunteer for health change



The Broken Promises: Field notes form Bhagalpur, Bihar

- **Bhagalpur: A rural district in south-west Bihar, routinely affected by floods and draught**
- **25 lakhs Population, over 80% rural population, more than 50% HH is BPL**
- **Diseases like Tuberculosis, Malaria and Kala Azar are endemic**

Infrastructure:

- **1 District Hospital, 13 PHC, 39 APHCs and 280 HSCs**
 - **Of 280 HSCs, only 54 have building**
 - **APHCs provide only OPD services for few hours on 3 days a week**
 - **Each PHC caters to approx 2 lakh population with only 6 beds**
 - **Average no. of deliveries is around 30-35 per day in some institutions**
 - **Bhagalpur has only 20 Specialists, of which only 1 Anesthetist, 1 Physician, 9 O&G and NO pediatrician**
 - **Only 1 Blood bank and 1 BSU in the entire district of 25 lakh people**



Public Health Services in India:

- Huge gap between what is promised/planned and what is provided
- Narrowing down
 - At the level of conceptualisation of what is possible
 - At the level of what is provided
- Over the years, link between health policies and The Constitutional promises have not been forthright
- Bureaucracy driven, Lack of Political accountability
- Remedial in approach

- The Paradox of huge promises and little fulfillment has had its own effects
 - The expansive nature of policy declarations have only succeeded in containing mass discontent over poor quality of health services

- *Enlargement of PROCEDURAL democracy
and Curtailment of SUBSTANTIVE democracy for the people*

- Have we been able to provide justice to the poor and vulnerable?
- Have we been able to translate promises to Action?
- Have we conformed to the tenets of guiding principle of governance?
- Have we been able to fulfill the directive principles of state policy?

WE, THE PEOPLE OF INDIA,
having solemnly resolved to
constitute India into a **SOVEREIGN
SOCIALIST SECULAR
DEMOCRATIC REPUBLIC** and to
secure to all its citizens:
JUSTICE, social, economic and
political;
LIBERTY of thought, expression,
belief, faith and worship;
EQUALITY of status and of
opportunity;
and to promote among them all
FRATERNITY assuring the dignity
of the individual and the unity and
integrity of the Nation;
IN OUR CONSTITUENT ASSEMBLY
this twenty-sixth day of November,
1949, do **HEREBY ADOPT, ENACT
AND GIVE TO OURSELVES THIS
CONSTITUTION**



Thank You

