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What Went Wrong with Public Health in India

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Half a century has passed since India's political independence. Beginning from almost nothing, achievements have been tremendous; total transformation has taken place in the public health system and should not be belittled. A huge health infrastructure has been created for the provision of comprehensive health care, even in remote areas. (Table 1) The health profile has improved considerably, (Tables 2 and 3) with life expectancy increasing from 32.1 years (1941-51) to 59.4 years (1989-93). However, performance in primary health care provision is not satisfactory, and we are unhappy with the state of our public health system. The goals established in the national health policy for 2000 are unlikely to be met, except for the crude death rate. Staggering regional diversities and disparities between the states and districts cause complex problems, because of historical, social, political, cultural, and economic factors and their ramifications. (Tables 3 and 4) Special plans and programs are prepared for the tribal

Table No. 1: Health Indicators - Then and Now

Indicator	1951-56	1995
Primary Health Centers	725	22,156
Hospital Beds	0.125 million	0.6640
Medical Colleges	42	>146

Table No. 2:: Other Health Indicators - Then and Now

Indicator	Then	Now
Smallpox-Cases	44,887(1995)	Nil since 1985
Guinea- worm	39,792(1984)	Nil since1997
Plague- Cases	78,937(1947)	nil since 1969
Malaria -Cases -Deaths	10million (1945) 1.0 million	2.5 million(1994) >1,122
Cholera - Cases -Death	47,637(1961) >16,000	4,958(1994) 52
Water Supply + Sanitation	4.5%(1947) 2.0%	80%(1995) 50%urban 10%Rural

people, but implementation is unsatisfactory. It is not recognized that poverty is a primary health problem. The system helps the poor in distress, but does little to nurture them as productive and creative beings so that they may improve their standing in society through their own initiative and efforts. This regional conference of the World Health Organization (WHO) signifies that the status of pubic health and primary health care is not up to expectation in South-East Asia and other areas of the world. Why? What went wrong?

Several factors and situations have led to the failures, with a variable mix of general management and technical/professional problems. However, it is pertinent to realize that, in India, large regional and inter-state variations and disparities exist. Hence, a complete set of factors leading to failures is not necessarily valid and consistently applicable for all areas of India. Basically, each state, and even district, should be viewed as a unit for assessment and decentralized planning. This analysis of the "errors" may be relevant and true of some other countries to a varying extent. Let us consider the major issues in the following discussion.

Lack of Popular Support to Public Health

The basic problem is lack of political support and technical commitment for health development. The greatest drawback of health promotion efforts is that people feel the need for health only when it is lost. Public health is remembered only during an outbreak of a major epidemic or disaster and forgotten soon after the event is over. Political support is for sophisticated medical care in "five-star" hospitals, rather than for the provision of basic health needs. It is all too easy to treat a patient in a life-threatening situation and to overlook

Table No. 3: Health Indicators - Then and Now

Indicator	Then (1940'S)	Now (1996)	Variation	
			High	Low
Birth Rate (per 1000 population)	39.9	27.5	34.0 (U.P)	18.0 (Kerala)
Death Rate	27.4	9.0	11.1(M.P)	6.2 (Kerala)
I.M.R	134	72	97 (M.P)	14 (Kerala)
Exp. of Life	32.1	59.4 (1989-93)	74.7(Kerala-RF)	53.8(M.P-RF)

Table No. 4: Rural Health indicator in selected states by extent of empowerment of Panchayati Raj Institutions (PRIs).

States ↓	Categories →	CBR	CDR	IMR	EL	TFR	P<15	LR
With Empowered PRIs								
Maharashtra		24.9	8.7	58	62	3.2	35.6	52.3
Tamil Nadu		19.9	8.7	60	60.5	2.2	32.2	51.3
Gujarat		26.8	8.2	68	59.1	3.3	34.2	48.6
Andhra Pradesh		23.5	9.1	73	59.7	2.7	33.7	32.7
Karnataka		24.1	8.6	6	60.1	3.1	3.1	44.3
West Bengal		25.3	8.0	57	60.0	3.4	37.8	46.7
Average for India		29.3	9.7	78	58.0	3.8	37.6	39.3
With Disabled PRIs								
Uttar Pradesh		35.2	10.6	88	55.0	5.6	39.9	25.3
Madhya Pradesh		34.2	11.8	102	52.3	4.7	38.3	28.9
Rajasthan		33.9	9.5	90	55.6	4.8	39.6	20.4
Bihar		33.1	10.6	74	57.7	4.2	41.6	22.9
Orissa		33.1	11.1	98	54.9	3.2	34.4	34.7
Assam		28.9	10.1	7	54.1	3.6	40.6	43.0

Source: Foundation for Research in Health Systems(1997), Health Monitor, Ahmedabad.

Note:-
CBR:-Crude Birth Rate, 1996
IMR:-Infant Mortality Rate, Rural 1996.
El:-Expectation of Life at Birth, Rural, 1989-93
P<15:-Pecentage of the population below 15 years of age
CDR:- Crude Death Rate, Rural, 1996
TFR:- Total Fertility Rate, 1996
LR:- Literacy Rate, Rural, 1996

problems that the patient and his/her family and neighbors have confronted, and will continue to confront, as the roots of the disease. It is not realized that the clinical disease is claimed to be cured, but the multiple factors causing disease are left untreated. The advances of science and technology in the diagnosis and treatment may have helped add years to lives, but have not rendered the community, at large, healthier. Under these circumstances, the unfavorable "anti-health" attitude of the community and political leadership have resulted in gross neglect of basic public health requirements, such as sufficient supplies of safe drinking water and sanitation. Moreover, medical specialists and bureaucrats do not have adequate interest in public health. They have failed to influence and muster political will, in order to improve the health status of the people vis-à-vis medical care.

Leadership Crisis

It is said that "leaders are people who do the right things; managers are people who do things right." By and large, the public health system in India has failed with both; medical leadership does not have adequate interest and technical insight into public health. With weak and ineffective leadership during the last few decades, epidemiology and management have been neglected, while clinical medicine and "five-star" hospitals have received the highest priority, resulting in a decrease of the quality of community health. With failure of the technocrats, bureaucrats have taken control, but they do not adequately understand public health problems.

Directors and other upper level health administrators are not public health specialists. They are medical professors or clinical specialists without formal training, abilities, or skills in public health administration and management. Similarly, most of the district health officers/chief medical officers do not necessarily have training in developmental administration and public health practice. The procedures, rules, and methods of selection of health managers ensure appointment of unsuitable persons, "a square peg in a round hole." Fortunately, by chance, some appointees have a proven track record of leadership and management. Even the best and most successful senior health officers from the state government cadre find no lateral entry to the top posts in the central health services, because this cadre caters to federal administration and territorial functions.

The population explosion has certainly been a major underlying factor of all the problems. India was the first nation to adopt a national family planning program, which was to be implemented by the health department. However, despite huge inputs, progress has not been satisfactory. Poor performance is mainly due to the focus on sterilization operations and contraceptives; anti-fertility measures were totally neglected. Notwithstanding this failure, the damage went much deeper: overemphasis on family planning programs destroyed the primary functions of the public health system. Basic fertility control measures and objectives of developing a welfare society were neglected by other social development sectors. Major resources and time schedules of the health services were stretched, to attain the goals of sterilization operations and other projects. The titles of the programs were just changed, and "the old wine was filled in new bottles." To illustrate, the title of Reproductive and Child Health, which was adopted under international influence, has not yet improved the quality of maternal and child health services. Anything which was integrated with family planning (maternal and child health, general health services) was adversely affected and lost public support. Poor performance and impact encouraged development of modified approaches and strategies for the control of population growth. At the same time, the unique recommendations of the Swaminathan Committee were not yet seriously considered.

Despite the national commitment to provide Health For All by 2000 through a primary health care approach, a critical failure was the inability to grasp and fully appreciate the precise meaning, scope, and implications of the term, primary health care, even by upper level administrators and planners. Contrary to common belief, primary health care is the following:

- Not just better or universal medical care, but truly a new public health
- Not a program, but an approach

- A composition of elements that are essential health needs, constituting an indivisible package.

Some voluntary organizations successfully developed alternative approaches for the delivery of comprehensive health care to the poor, despite limited resources. Yet, in practice, substandard medical services were misnamed and marketed by the government in primary health care, by extending traditional "health services" in the remote areas and urban slums and disregarding the very essence: the nine elements of primary health care. Emphasis on people's empowerment and prevention have remained on paper and have never been attempted. Public health and hygiene also continue to remain taboo.

Violation of National Health Policy

The national health policy statement is highly critical of the existing situation, and its directives are laudable. However, major mandates have been ignored, remaining on paper and even negated. Some examples follow.

- Instead of integrating existing vertical programs, new vertical programs are added.
- Rather than strengthening general health services, they are neglected.
- A failure to decentralize and place people's health in their own hands exists.
- A disregard for the provision of comprehensive primary health care to the poor is evident.

Briefly, the policy has been suffering from contradiction between its profession and practice from its inception.

For several reasons, the environment is progressively deteriorating. Pollution levels of harmful environmental agents have already reached beyond safe limits. Yet, contrary to the policy statement, environmental health is neglected. Unsafe drinking water accounts for 80 to 85 per cent of the country's illnesses. Under these circumstances, satisfactory control of diseases, such as cholera, diarrhea, dysentery, infectious hepatitis, and typhoid fever, is out of the question. Moreover, environmental health has remained outside the domain of health authorities. Also, the rapidly deteriorating urban health environment is not receiving adequate attention. Fortunately, the recently announced Environmental Action Plan of the Ministry of Environment and Forests of the Government of India will work to control pollution nationally, which provides a "silver lining to the dark clouds."

The Out-dated Organization of Health Ministries and Departments

The organization has failed to stay current with changing technology, functions, and responsibilities. Establishment of primary health center complexes in the rural areas is a big achievement; however, there is an urgent need to improve functioning to the satisfaction of the people. At the central and state levels, huge administrative organizations are unjustified and ineffective. District level organizations are weak, with no coordination between divisions and programs. The central governmental health administration has failed to differentiate federal functions from those designated for the local health administrations of Delhi and other union territories, resulting in considerable neglect of federal duties. In addition, with undue centralization of authority at the national level, state health directors have lost initiative and have become passive partners in the process of health development. Guidelines issued by the Center are blindly followed, even if they are inappropriate, in spite of the fact that, constitutionally, health is a state issue. State health departments have failed to take responsibility to provide "public health" services to the people.

The Indian Medical Service was an efficient and well-organized cadre, but, after independence, this cadre was abolished and replaced by the Central Health Service, which was a major mistake. The Indian Health Service was not reintroduced, in spite of Parliament's resolution to do so. Central Health Service's narrow interests and compulsions overshadowed the establishment of a strong public health system in India. Furthermore, integration

of public health and medical services at the central and state levels was a disaster. With the resultant leadership crisis, integration has caused disintegration of India's public health system.

Professional Inadequacy and Apathy

This was an important reason for failures; lack of interest in health development and neglect of health services research resulted in ad-hoc actions by health authorities. With the collapse of the public health system, epidemiology has been largely neglected. A lack of competent epidemiologists and failure to develop effective epidemiological services and surveillance systems have been the major constraints. A basic deficiency in public health management has been evident by the late recognition and diagnosis of epidemics; inappropriate control measures are often instituted so late that, by the time an epidemic is analyzed, it is on its natural decline.

Management of communicable disease control programs was effective for about two decades. By 1965, malaria had decreased to minimal levels, and smallpox and guinea worm diseases had been eradicated. However, the communicable disease control programs have failed to keep pace with epidemiological transitions and have become inefficient. Programs continue as vertical programs, despite national health policy mandates and rapidly diminishing returns. Due to inadequate technical insight and competence, management has failed to introspect, to resort to epidemiological tools, and to find new directions and innovative methods for effectiveness and efficiency. Because of pressures from international and other external funding agencies, sometimes national priorities have been distorted. Some examples of these problems are: DOT strategy for tuberculosis control, impregnated mosquito nets for malaria control, and high priority for AIDS and HIV control.

In spite of a good beginning and positive results, the health system has failed to perceive the high potential of Multi-purpose Health Workers' (MPW) and Community Health Workers' (CHW) Schemes towards the goal of Health For All. These innovative programs were progressive in the empowerment of the community to attain self-reliance in health care. However, they were rapidly and prematurely expanded, without necessary prerequisites, resources, and refinement. With the inept handling, the CHW (Health Guide) scheme is now defunct, and the functioning of the MPW scheme is far from satisfactory.

Owing to casual and unsustained efforts, as well as the neglect of information in daily work, an effective health management information system has not evolved. No system for comprehensive epidemiological surveillance has existed. Use of aggregate data at the national level has camouflaged the local level reality. To illustrate the staggering disparities: in 1994, the lowest birth rate was 17.3 per 1000 live births in Kerala and the highest birth rate was of 35.2 per 1000 live births in rural Rajasthan.

No policy exists for health manpower development, and ad-hoc training programs have resulted in imbalance and distortion of health manpower. Approximately 17,000 medical students have graduated every year. The physician-nurse ratio is adverse (3:1), and training is poor, with practical training and skill building overlooked. These problems have resulted in the following:

- Postgraduate education in public health is neglected.
- Medical college departments of preventive and social medicine/community medicine have failed to integrate preventive medicine into clinical practice, and real danger exists of "clinical epidemiology" functioning as an oxymoron.
- There are few public health specialists who possess the necessary knowledge, skill, experience, efficiency, and ability to manage health and community development programs. Lack of career opportunities for public health students, as compared to clinicians, have deterred talented students from choosing a public health speciality as a profession.

Lack of aptitude and health systems research (including the trial and error method) has been detrimental to better performance. Biomedical research

has been mostly repetitive and has not been designed to solve health problems or generate a planning database. The need for health systems research for the effective application of available scientific knowledge and technology for welfare of the people is still not recognized. Interventions are selected without field trials for efficacy and feasibility, and cost-effectiveness has never been established.

Conservative Bureaucratic Administration

With the bureaucratic system's characteristic avidity, negative attitude, and skepticism, the basic support for placing people's health in their own hands has remained a dream. Because of the lack of flexibility, local requirements were not granted, and the varied needs of different states could not be adjusted and accommodated. Facilities and working conditions at health centers and hospitals have not been satisfactory, and even the poor have been dissatisfied, causing them to turn to private practitioners. Credibility of the government health services and hospitals was dubious, and public health institutions were neglected and under-utilized. No attention was paid to coordination within the health sector itself, with the basic cause of failure being the lack of accountability.

Shortsightedness has been another problem of the administration. With the initial success and popularity of the Community Health Worker's Scheme, the program was transferred from the Health Department to the Family Welfare Department. The very soul and logical concept of the scheme were destroyed, and the program soon disintegrated.

Over-standardization is evident, and the same strategies and interventions have been used uniformly to solve the health problems in different states and districts, ignoring wide disparities and imbalances, as well as specific epidemiological and socioeconomic characteristics. States such as Maharashtra, Tamil Nadu, and Punjab are more progressive in socioeconomic and health development than most of the northern states. Despite this fact, none of the national health programs recognizes this factor in planning and management. For instance, although infant mortality rate in Kerala is 13 per 1000 live births, compared to 97 per 1000 live births in Madhya Pradesh, measures to reduce infant mortality are the same in the two states. Failure to concentrate on the northern states, which have poor development, was a big mistake.

Decentralization is taking place very slowly and half-heartedly. In this regard, state governments are no better than the local self-governments. State authorities are reluctant to decentralize and empower Panchayati Raj Institutions (PRIs), and genuine efforts have not been made to institute local governance and control. This is interesting because there is a parallel between the performance for improving the health status and the effective decentralization and empowerment of the PRIs. (Table 4) The data show that the vital statistics and demographic indicators are superior to those for all India in the states in which the PRIs have been empowered, while they are inferior in the states where the PRIs are not as empowered, and decentralization is inadequate. However, since there are other factors that influence these indicators, further study and analysis are required for confirmation of this conclusion and for exclusion of possible confounding factors.

Expert committees are often appointed by the government to critically appraise various health programs. The follow-up of their recommendations, has, however, been fairly haphazard. For instance, the most important recommendations are ignored without explanation, and minor ones are accepted. For example, the MPW scheme was not applied to the district level health administrations, and community health centers became thirty bed rural hospitals, instead of sanitation-cum-epidemiological centers.

Health departments have been negligent and indifferent in taking the initiative and ensuring sectoral participation and collaboration of health development. There has been no vigilance for safeguarding health from the adverse effects of development in other sectors; for instance, irrigation projects create malariogenic conditions, while urbanization causes slums and pollution due to industrial growth and motor vehicles. No coordination and genuine partnership between the government and voluntary organizations has existed. It has not been recognized that voluntary

organizations play specific roles, which are complimentary and not subordinate, to those of the governmental agencies.

Financial Constraints

Budgetary allocations have progressively declined in real terms, while the needs have considerably increased. To make matters worse, because of structural adjustments, the budgetary deficit *is* being contained by reducing operative and capital expenditures; thus, materially increasing the proportion of non-operative expenditures, such as salaries of the staff.

Limited financial resources are misallocated. Available funds are neither fully utilized nor used cost-effectively. Much greater funds are provided for medical education and tertiary high-cost medical care for a few people, leaving only a meager fund for primary health care facilities to the common people. Medicines, hospital services, surgery, and diet are provided free of cost to the rich, often by depriving these facilities to deserving poor patients.

State government expenditures for progressive and preventive health care has been insignificant. Callousness exists to the extent that, if the central funds or free supplies are inadequate or unavailable, major services, such as immunizations and malaria, leprosy, or tuberculosis treatment, come to a standstill, as state funds are not sanctioned to procure necessary drugs.

When critically assessing the developments of public health practice in India and as personally witnessed and experienced, I have presented a list of the problems in public health. Yes, we have made mistakes; we could have been there – further ahead! Yet, we have moved quite a long way. Notwithstanding these errors, the health profile of India has improved considerably. We have outstanding human resources and good reasons for optimism. With corrections and area-specific decentralized planning, development can be accelerated, and disparities eliminated. The empowerment of people and the promotion of self-reliance are important issues.

Solutions and corrections are not included in this presentation, but are described in the publications mentioned in the bibliography. I am proud to be a member of the Independent Commission on Health in India, which has deliberated for over two years, researching data, commissioning papers, interacting with consultants and holding public hearings. The Prime Minister of India released the Report of the Independent Commission on Health in India, published by the Voluntary Health Association of India, New Delhi, in May 1998. It deals extensively with these subjects and provides comprehensive recommendations. It is gratifying to note that governments of some major and smaller states have already initiated dialogue with this Commission for its assistance in preparation of state-specific action plans for the implementation of the recommendations.

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