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India's Healthcare System for Poor and Marginal Section of Society

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Abstract*-Despite the significant growth of Indian Economy and health standard of the Indian citizens accessibility of the basic healthcare to majority of the people is a big challenge in developing country like India. The inequalities have been increased among the various sections of the society particularly in last two-three decades. The Indian state has been failed to distribute the benefits of the economy and health facilities equally. The three-fourth of the Indian population is still living in rural areas with about twenty percent of the health facilities. More than half of the children and women are suffering anemia, even 92% of the mother never heard the word malnutrition. Indian public healthcare system is able to treat only 40-45% of the In-patients and only 18% of the total out-patients. About 80% population is unable to get essential drugs for basic illness because public sector is unable to provide i.e. private sector becoming dominating, which is controlling about 80% of the health infrastructure and 85-87% of the total expenditure on health.*

Keywords:Unequal distribution, inequality, accessibility, health planning, health financing, section and sub-section of society, public sector, private sector, Scheduled Castes, Scheduled Tribes, medical tourism, rural areas, urban slums, infrastructure, medicine, provision, preamble, and Indian Constitution.

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INTRODUCTION

India is the largest democracy with second largest population in the world. More than 50% of her population is youth. India's economic growth and development in various sectors is appreciable across the world in previous few decades. This improvement coincides with enactment of various public health legislations and launching of national health policies and programs, establishing a wide range of health infrastructure, rise in expenditure on health particularly in private sector, increase in life expectancy, decrease in infant mortality and maternal mortality rates. However, these aggregations do not remove the inequity in accessibility of health within states, regions, social and economic groups, urban versus rural, and between developed and relatively remote areas. Marginalized sections of society continue to suffer with worst health indicators. Over the years, it has been observed that the majority of states have failed to achieve healthcare for all which pulls India to the lowest pedestal in the world for human development index. Even India has failed to improve on crucial indicators such as infant mortality rate (IMR), child mortality rate (CMR), life expectancy, status of malnutrition and communicable diseases in comparison to some of the neighboring countries like Sri Lanka, China and Bangladesh. Due to high degree of socioeconomic differentiation, there is a rise in lifestyle diseases among the rich and under-nutrition and communicable diseases in the poor. Wide inequities in accessibility of healthcare services have been observed on the basis of class, caste, religion, region, gender, etc. Private sector continues to dominate in providing health services to the people. However, scheduled caste and scheduled tribe (SCs and STs) sub-groups are not able to access it, who therefore depend

more on the public health sector where health facilities are deficient.

HEALTH REGULATIONS

The Indian Constitution has made healthcare services largely a responsibility of the state governments, but has left enough maneuverability for the central government because a large number of items are listed in the concurrent list. The center has been able to expand its sphere of control over the health sector. Hence the central government could play a far more significant role in the health sector according to the Constitution. The national health policy and planning framework has been provided by the central government. Due to various reasons, the states did not comply with the constitutional duties of healthcare delivery for the people. The central government has introduced and pushed various national health related programs such as program on prevention and control of leprosy, tuberculosis, malaria, smallpox, diarrhea, filaria, blindness, goiter, pulse-polio, and now HIV/AIDS. The center has also established various committees, launched national health policies, national rural health mission (NRHM) and health mission with the intention to support states. The states are acquiesced to improve health services using funding of central government. In spite of these efforts, health status of people remains unsatisfactory.

India was a signatory member of the United Nations which was started on October 30th 1945 and on December 12th 1948 when the Universal Declaration of Human Rights (UDHR) was proclaimed. The formulation of India's Constitution was certainly influenced by the UDHR and this is reflected in Fundamental Rights and the Directive Principles of State Policy. However, most of the civil and political rights are guaranteed under the Indian Constitution as Fundamental Rights. But most of the economic, social and cultural rights do not have such guarantee (health and education coming under these rights). The Constitution makes forceful appeal to the state through the Directive Principles to work towards assuring these rights through the process of governance but clearly warns that no court would enforce them to do so. However, the courts are able to intervene on some occasions bringing health and social issues under protection of the fundamental rights. But most of the times the ruling central and state governments ignore the court orders. Their motive remains political rather than fair distribution of resources and social security. For example, Article 46 of Indian Constitution has been implemented with a fair amount of seriousness through the policy of reservation for scheduled castes, scheduled tribes and other backward castes/classes because it is the most powerful tool for success in India's electoral politics, while Articles 41, 42, and 47, which deal with social security, maternity benefits and health, respectively, have been given low priority.

In early years of independence, the need for the regulation of healthcare was not acutely felt because the public sector healthcare had an edge in the provision of services and was expected to internally regulate through supervision. But, indirectly the government also started encouraging the private sector through promotional efforts such as providing subsidized land, low-cost training of health personnel at government colleges, free of license, free import duties, etc. However private sector did not change their motive of profit which led to exploitation of people by providing substandard health care services. This process fastened during globalization and economic reform necessitates the regulation of private healthcare establishments. The vulnerability of consumers to high cost,

low level of care and malpractices leads to risks to health and life of the people.

However, inadequate and ineffective regulatory arrangements to check these features have been widely documented. Bhatt *et al.* [18] argued that the institutions created to enforce the standards and medical ethics failed miserably to discharge their responsibility. The professional bodies have also failed to self-regulate. One can find the wide variation of quality of health services throughout India. Bhatt further argues that the consumers are dissatisfied with both sectors of healthcare (public and private); therefore more and more people are seeking redresses under the consumer protection law. The limitations of this law to address the grievances of patients are widely commented upon and there is need for a credible, effective and satisfactory alternative.

Mishra *et al.* [19] argues that the public health sector has failed to set standards and provide internal structure of self-regulation and clinical protocols. The interventions of the apex court have forced the government to take note of such deficiencies. The enactment of new health laws covering organ transplants, pre-natal sex determination tests and emergence of high technology interventions involving stem cells, genetics, *in vitro* fertilization, etc., has created new challenges for its implementation. There are off and on cases of violations reported in news dailies exposing their weaknesses. Due to lax regulatory regime and poverty of population, India has become an attractive destination for business processing outsourcing (BPO) for clinical trials. People fall prey to them to avail not only sophisticated surgical interventions but even basic healthcare at low cost in exchange for providing personal information and blood samples.

India constitutes nearly 16.5% of the world's population but has a share of 20% of the world's diseases. Indian government stated that around 26% of the total population lives below the poverty line (BPL) but according to the Tendulkar Committee and the Planning Commission report (2009), this figure is 37%, out of which more than 75% lives in rural areas. However, 80% of the total medical facilities are situated in urban areas where only 25% of the total population lives. In urban slums where 40% of the urban population lives health situations are worse than in rural areas. Two-thirds of Indian children and more than half of women are suffering from anemia and malnutrition. Nearly 80.5% of the Indian population lives on less than Rs. 20 per day, out of which more than 30% of the population lives on Rs. 10 per day [24]. On one side, India is rapidly emerging as a nation of medical tourism that indicates potential to provide high-quality health services, on other side, 80% of the Indian population is not able to get even the essential drugs. Availability of infrastructure is poor as 54% PHCs do not have a labor room and a laboratory; 80% PHCs do not have communication and transport facilities. 58% of the PHCs have facilities for conducting deliveries which are availed by 30% of pregnant women (70% of total deliveries are still conducted at home by the traditional *Dai*); 6% of PHCs conduct medical termination of pregnancy (MTP) and only 22% provide antenatal care (Facility Survey, Department of Family Welfare, Government of India 2003). Although, review of the NRHM has shown some improvements in all these indicators, but sustainability of health system remains a challenge.

On other side, private sector is growing very fast enforcing market principles. A system based on consumption and over-

professionalization is overburdened with a huge cost which is obviously unsuited to a developing country like India. It is therefore a tragedy for the nation that continues to persist with this model even when it is understood that it is not sustainable. Hence, it is essential for the nation to take a conscious and deliberate decision to abandon this model and strive to create instead a viable and economic alternative suited to our own conditions, needs and aspirations. The new model will have to place a greater emphasis on human effort and resources (for which we have a huge potential) rather than on monetary and material inputs (for which we have constraints).

As mentioned earlier, Indian public health sector does not have sufficient health infrastructure, health personnel and health regulation and provisions to provide healthcare for all. It is able to treat only 18% of in-patients and 40% of out-patients because the expenditure on public healthcare still remains very low, i.e., less than 2% of the GDP, whereas WHO and Bhore Committee recommended at least 5% of the GDP in 1940s. The growth rate of health infrastructure in public sector became negative, especially after economic reforms such as the growth rate in sub-centers was 79% growth during Fifth-Sixth Five Year Plans (1974–85), this growth became 0.77% in 2002 (Ninth Plan), i.e., 78.3% of reduction. The growth in PHCs was 66.2% in 1974–85 and 104% in 1985–90 which became minus 2% in 2002, i.e., 106% of reduction in the growth rate of PHCs. Similarly, there was 225.6% growth in the establishment of CHCs during Fifth to Sixth Plan which became 32.4% in 2002-07, i.e., 193.2% of reduction (Rural Health Statistics, 2007). On the other side, due to rise of private health sector, the out-of-pocket expenditure became too high and unaffordable to people, even government has started charging user fees in government hospitals. As Baru [21] argues that about 50–60% of out-patients were treated by private doctors and only 18% by public hospitals in both rural and urban areas in contemporary India. Even, the Health Minister as well as the Prime Minister of India also accept that so long as wide health inequalities, disparities and inadequacy of health facilities exist in our country and access to essential healthcare is not universally assured, we would fall short in both economic planning and in our moral obligation to all citizens (Mr. Manmohan Singh, Hon'ble Prime Minister, October 2005). The Prime Minister further argues that Indian public health system was able to treat 45% of out-patients and only 18% of inpatients (in 2007). Consequently a large section of the society, especially poor and marginal section of the society is not able to get adequate healthcare even nutrition whereas upper strata of society although small in number is consuming 80% of general and majority of super special health facilities. Inequity has been widening in accessibility of the healthcare facilities among people in the society.

SOCIOECONOMIC AND REGIONAL DISPARITIES

Several studies have revealed that marked disparities exist between socioeconomic groups and geographical locations in access and utilization of medical facilities, which make some sections of the population highly vulnerable. Though one of the main recommendations of *Bhore Committee* was the creation of 'Basic Doctors' in India, yet the Indian policy-maker (viz., the government) did not carry it forward properly. The basic weakness of the Indian health system is the absence of an accessible basic doctor. Even today, 70% of the primary healthcare is provided by unqualified practitioners [15]. India's infant mortality rate (IMR) is at 52 per

1000 live births as compared to 13 in Sri Lanka; similarly, life expectancy at birth is 64 years in India as against 69 years in Sri Lanka for the year 2013. Similarly, China has IMR 18 and life expectancy 74 years [9].

According to the National Family Health Survey-3 [31], there are large regional variations in medical facilities in India. Most of the healthcare facilities are situated in the southern parts of the country. There is a shortage of 70.2% doctors in rural areas which comprises 75% child specialists, 70.9% surgeons and 60% female specialists. The caste, class and gender disparities in health have persisted over the years. It has been observed that people in the same country live in two different worlds in terms of health, the burden of illness, malnutrition status and the burden of treatment. Nearly half (47%) of the children are born underweight in India as compared to the world average of 38% of total underweight children. It has been observed that underweight children are born in households from scheduled tribes (ST), scheduled castes (SC), illiterate mothers, women married at a young age and low socioeconomic household families. Around 75% of children (aged 6–35 months) suffering from anemia belongs to SC/ST communities [31].

Although socioeconomic factors contribute significantly to the accessibility of healthcare facilities, there is not only disparity of healthcare services but also the government's major programs like immunization and vaccination are affected. Pandey and Yazbeck [23] analyze inequalities in immunization in different regional and economic groups. They find the southern states have better immunization levels and lower inequality in immunization as compared to many northern states. Wealth and regional inequalities are co-related with overall levels of immunization in a non-linear fashion.

There are various disparities in immunization such as: it is lowest among schedule tribes, intermediate among scheduled castes and highest among non-scheduled communities. An interesting fact of the data is the indication that children of SC/ST and the bottom and middle MPCE groups rely almost exclusively on government agencies for immunization. In the urban areas, the non-scheduled groups and the top MPCE groups evidently rely on non-government agencies for immunization. A difference in vaccination according to MPCE and educational level of the adult female of the household is visible in the survey. The level of immunization seems to be lower among a household having two children aged 0–4 years in comparison to a single child household. The level of immunization is higher among self-employed households engaged in non-agricultural occupations and those that have regular income or employment. In rural Gujarat, the SCs and STs reported a higher proportion of medically attended birth than others, while in urban Gujarat there was no difference between the SCs and others, but the STs reported a lower proportion of attendance by medical personnel [31].

Raj and Raj [17] argue about the major variation among castes**,** place of residence, education of household, status of women and standard of living (socioeconomic differentials) in pattern of access to healthcare and utilization. The caste variation in reproductive health index (RHI) is the highest in West Bengal, followed by Orissa and Bihar. Caste variation in the RHI is discernible in all three states with upper caste women showing better reproductive health status

than lower caste women. Peters *et al.* [5] also analyzed the large disparities across India (based on region, caste/community and gender). The burden of diseases, medical cost, etc., fall mostly on the poor, women, scheduled castes and scheduled tribes such that 20% of the population of India has more than double mortality and malnutrition rates. The class and caste, gender and economic-based inequalities in access to healthcare services also continue to be severe. The development of health services in India has moved away from the people [4].

Dreze and Sen [8] argue that health has been one of the most neglected aspects of development in India. They further argue that inequalities in access to healthcare are particularly marked in India along with caste, gender, region and religion. In the Indian society, as the lower caste and class did not have adequate social and economic wealth, therefore, they have low nutrition and low standard of health. The social exclusion of SCs caused by caste discrimination and STs by ethnicity and Muslims by communal bias affects their access to health services. This is evident from the disparity in respect of health indicators belonging to the population of these groups when compared to the so-called general population [13].

The Planning Commission deputy chairman Montek Singh Ahluwalia (2010) also admitted that income distribution has never reached the desired level and inequalities increased in both the rural as well as in the urban areas. Correcting inequities in public health is a matter of social justice and an ethical imperative. He is confident that health inequities can be bridged in a generation, if all the stakeholders take it up seriously. Marmot [11] argues that a toxic combination of poor social policies and unfair economic arrangement are responsible for most of the avoidable health equities seen in today's world, especially in developing world like India.

HEALTH ACCESSIBILITIES FOR WOMEN

Women health is very poor; they do not have access to adequate healthcare, nutrition, and medical care in India. The number of women, who visited hospitals, is less than male patients in both public and private healthcare facilities among all sections of society in the rural and urban areas. Even the proportion of expenditure on women's healthcare is far less than the expenditure on men's healthcare both in out-patient care as well as inpatient care [24]. Policies concerning women's health have been focused only on family planning and reproductive health instead of other health issues. The Indian medical system has not achieved its target because 60% of the women are suffering from reproductive diseases, in which about 85% are suffering from pre-natal syndrome, 40% are suffering from leucorrhea, only 35–37% of the Indian married women (aged 13–49 years) are using modern contraceptive. Female sterilization is the main form of contraception. According to NFHS-1 (1992-3), more than 75% women gave birth to their children at home out of which more than 66% (2/3 of all) births were not attended by any trained medical person. The NFHS-3 shows that 56.18% of Indian women suffer from anemia. Due to anemia the chances of death during delivery is high.

However, some gender-related barriers also affect the accessibility of healthcare to women. These include unsuitable timings of facilities, insensitivity of healthcare providers, absence of privacy in the clinics, indifference to their problems by the family, attitude of self-denial by women themselves and failure of the existing programs to cover health

problems experienced by women [22]. This constrained accessibility of healthcare contributes to the adverse health outcomes, such as high level of MMR and IMR, low percentage of institutional deliveries, very high percentage (about 56%) of nutritional deficiencies, high incidence of anemia, and increased share of non-communicable diseases. There has been consideration for only reproductive and child health (RCH) issues of women's health and other health-related aspects (issues) have been neglected by the government, policy makers, public health experts as well as social activists [6]. Germain [1] argues that Indian women bear triple lot of health burden with the responsibility of child bearing and are more vulnerable to diseases like reproductive tract infection and sexually transmitted disease including AIDS/HIV.

CHILD HEALTH

According to new research "Save Children" (Latest Sample Registration Data), over 55% children under two years of age do not receive basic healthcare or immunization against diseases such as diphtheria, whooping cough, tetanus and measles. Study also shows that the highest numbers of children die in India among the 25 countries where diseases and conditions are mostly preventable and curable. As per a report of Save Children [25], India has the highest number of underweight children among all Commonwealth countries. About 64% of world's underweight children live in 54 Commonwealth countries, and India has both the highest number and the highest proportion of underweight children. Although these 54 countries have one-third (33%) of total world's children, but have two-third of underweight children or malnourished children under 5-year age group [3]. Thus, 43% of India's children are severely malnourished and 59% are suffering from moderate to severe stunting, viz., their height is much lower than the median height-for-age of the reference population. The survey found that the prevalence of malnutrition is significantly higher among children from low-income families. It is also found that children from Muslim or SC/ST households generally have worse nutritional indicators, i.e., 50% of the children born are underweight because of the lack of awareness among mothers about nutrition, 92% mothers had never heard the word malnutrition. No doubt the educational level of mothers also determines children's nutrition/health [25].

RURAL VERSUS URBAN INEQUALITIES

The disparity in the rural and urban healthcare facilities results in the mushrooming of private healthcare sector in the rural and sub-urban areas with the opening of nursing homes and maternity centers. It is not only the government policy failure that leads to the rise of private sector but growing per capita income, and doctors' vested interests also contribute to this new trend. We could see the double impact of mushrooming of private healthcare system in sub-urban area – first the accessibility to good healthcare (not at par with metropolitan) and second the rise in cost of treatment as there are no effective public policies to regulate the development of new small medical centers. Krishnan [28] argued in his paper, *Access to Health and Burden of Treatment in India: An Inter-State Comparison*, that the cost and burden of treatment are closely tied to access to healthcare. The cost of treatment is the highest in those states where public health infrastructure is least developed on account of private hospitalization and out-patient treatment. The high out-patient treatment cost for the rural population in backward states clearly indicates the failure to deliver primary healthcare. Sparse health facilities are likely to

increase the cost of treatment in government hospitals. The high cost of hospitalization may also act as a deterrent against treatment leading to mortality in severe cases, apart from acting as a catalyst for infection in the community in case of communicable diseases [28].

CONCLUSIONS

The Indian health system has been based on various Committee's reports and recommendations in post-independence era. As mentioned earlier, the responsibility to provide preventive, promotive and curative health services was entrusted to the government. The expenditure is generated from public funds; therefore, healthcare services are admissible to all without any discrimination and irrespective of the capacity/capability to pay for it. The rural-urban disparity in availability of healthcare was sought to be bridged by establishing healthcare units with an equitable spread in the rural areas and slums. The government obliged to constitute the instrument of delivery as well as provide finances for healthcare system, equitably to whole of the country till 1990s. Healthcare activities have been formulated through the Five Year Plans based on recommendations of various committees and commissions. For the Five Year Plans the health sector constituted a plan period with a specific number of schemes and over the years every subsequent Plan brought an addition or subtraction of the schemes. The Health Survey and Planning Committee (popularly known as Bhore Committee [29]) had recommended that health planning should be a part of national development planning. But within 15 years, the emphasis had diluted and focus had changed to family planning and privatization. The infrastructure of primary health care had become center of family planning and the private sector became dominant. With the formulation of National Health Policy (1983), the comprehensive healthcare has moved to selective healthcare issues. The priority of the nation could also be understood by the expansion of the primary healthcare infrastructure and expenditure on health.

Hence, India's healthcare system did not reach a satisfactory level. As mentioned earlier, its ratio in world's diseases and ratio of malnourished children and women is more high than its ratio in population. As mentioned, there are several reasons for this insufficient and unequal accessibility of healthcare. The globalization is a major reason to inaccessibility of healthcare for India's majority also, especially after 1990s. Prior to 1990s was a period of welfare state and government made norms and regulations, in terms of decision-making to set political goals, determining strategies to realize them, identifying agencies, structure for delivery and monitoring the outcomes for making corrective intervention, where necessary. But the backdrop of neo-liberal ascendancy of the global economy, the World Bank has transformed the meaning of governance to imply measures to replace the state with non-state agencies as instruments for implementation of decision and to facilitate the operation of market economy. It has shifted the policy setting to diverse actors across the world with different interests, priorities and commitments. The national governments are left without power to determine goals; they must promote but bear the responsibility to deliver outcomes of the policy settled externally. The national governments are unable to govern development. In the changed discourse, governance is increasingly viewed as a technocratic exercise which can be carried out by acting according to rationally laid-down norms. In this construct, neither can governance be de-linked from policy and its deeply conflicting dimensions nor can

the delivery system operate in a sanitized environment unaffected by tensions generated as a result of the unequal social structure and manipulative power of its dominant interests. The outcome of governance in such a frame would produce highly iniquitous outcomes and exacerbate conflicts. The Indian health system is an example of this conflict in the current discourse on governance. Another aspect is that from the Health Survey and Development Committee (Bhore Committee) to the National Health Policy (NPH-1) have many times recommended that the private health sector should be abolished or be regulated or controlled. But in practice this has not happened, even though it has been promoted and legitimized.

So, the poor condition of the Indian healthcare services is not just confined to the government's failure in the implementation; the effects of globalization and India's growing importance at the international level have also contributed to the degradation of public healthcare system and the rise in private healthcare sector. The effects of global healthcare trends could be witnessed on the Indian public healthcare system with implementation of policies of the world bodies funding healthcare services in India. There are several studies in this direction analyzing the impact of the international capital on the healthcare policies, such as that of Sathyamala [26] and Qadeer [6]. Sathyamala analyzes the negative impact of the World Bank's recommendations on health polices like charging user fees, insurance and privatization. She argues that "if the Indian government were to adopt the World Bank's recommendations, most of the illnesses of the poor will fall outside their list, in effect leaving them with little or no option for medical care." Sathyamala further argues that finance is also an important aspect of the problem faced by the public health sector; quality of services is the other important factor. There is not much debate on measures to improve the quality of services in the public sector as on finding financial support. In the absence of any real improvement in the quality of services, the introduction of "user fees" will result in weaning the "paying" patients away from the public sector making the whole exercise an exercise in futility. This could very well lead to further cost-cutting measures leading to complete discrediting of the functioning of public health sector.

Qadeer [6] criticizes the World Bank's recommendations about health (1993). As argued by Qadeer, the epidemic of reforms coming from the international pressure has diluted the responsibility of state and distorted national priorities. As Baru [21] argues, in case of India contrary to some other countries in the world, India had an opportunity to develop alternative choice for its health sector, but it was not done. The decision of the Bhore Committee after independence of putting the nation on the way of a national health system now seems outdated. Today's development of health as a tertiary sector largely through private enterprises is in contrast to what the WHO has promised for a country like India.

Vaguet [2] and Sarah Curtis argue about the globalization and the contradictions between global and local perspectives. The local or individual national governments are unable to prefer their citizens' health issues before the global market forces. They further argue that the recommendations of the World Bank (1993) are increasing inequalities between healthcare of the underdeveloped world and the developed nations. Because the World Bank has proposed to invest in the health sector and accepted the existence of market in this sector, it means that national

health priorities will be more and more driven by global capital and influenced by global market forces. It may be understood by citing an example. Thus cholera, leprosy, poliomyelitis and the so-called vaccine preventive diseases underline the boundary between the two worlds as these diseases remain present in developing nations.

The introduction of National Rural Health Mission (NRHM) during Tenth Five Year Plan period seeks to improve rural healthcare delivery in those states where it is weakest at present by ensuring a provider in each village, effective hospital care to the rural population and coverage action on health and the determinants of health for minimum impact. However, the NRHM is depending on public-private partnership (PPP) and PRIS to bail out the public health services without trying to understanding the complex reasons behind the stark failure of these services. There is no satisfactory improvement in delivery of healthcare for all. Hence, there is need to revise the Indian healthcare system according to people's requirement.

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