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Revamping Health Infrastructure In India - Need For A Missionary Approach

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In winning the sprint for economic growth, most of the developing nations seem to have failed in assessing the size of the pool of their latent energy and visualizing whether they have enough strength to achieve their coveted target. It has now been universally acknowledged that a healthy society is a better bet for a country's development than a wealthy society comprising only a small fraction of its population. The history of the developed nations of the world gives enough testimony to the fact that creating healthy people is fundamental to the well-being of a nation and economic prosperity would follow if it is supported by growing size of human capital. The less developed nations are yet to identify the role of public health in the march towards their overall development. In common parlance, health care means diagnosis and cure of any disease, but, as the World Health Organisition holds, it encompasses the preventives which eliminate or atleast minimize the possibities of the occurrence of diseases, the curatives which imply diagnosing the ailment and curing the patient, and also the rehabilitative measures aimed at rehabilitating the victims of some fierce diseases.

It has been disappointing to find that the healthcare, has always failed to find a place in the India's schema of economic development, which was prevaricated to care for social concerns on the lines of the concept of basic minimum services which, as the Approach Paper of the Ninth Plan announced, included, "universal pre education, primary health care, safe drinking water and shelter for all. It was also promised that the State would address these social issues by allocating sufficient funds for them from its Exchequer. But, in practice, of all these areas, the health sector was never placed on priority of the Indian Political agenda. It might have perhaps been non-pragmatic and illogical for the Government to acknowledge the fact that a healthy society can contribute to economic growth many more times than a community which is devoid of the endowment of sound health. Besides, a more noticeable fact, which our governments kept ignoring is that despite enjoying an emerging economic super power status, India can't claim to be a really developed country if it continues to fare badly in reference to the human development index which is indicative of its tacit apathy towards the fulfillment of the primary needs of the society including health care. It is also appropriate to comprehend that the level of economic prosperity of a country, howsoever fast growing it is, turns out to be of earning insignificant amount of 'social sanction and credibility, if it is not being shared by the majority of its people, and hence, what is really desirable here is that the people be made capable of sharing the fruits of economic growth, and health is obviously the most potent factor which builds up-this capability, as the two pronged strategy for poverty reduction evolved by the world Development Report, 1990, reveals, "countries that have been most successful in attacking poverty have encouraged a pattern of growth that makes efficient use of labour and have invested in human capital for the poor. Both elements are essential. The first provides the poor with opportunities to use their most abundant asset-labour. The second improves their immediate well-being and increases their capacity to take advantage of the newly created possibilities. Together, they can improve the lives of most of the worlds poor."

It is relevant here to outline the experience of different nations in this context, which prompts that while unplanned state intervention produced negative results to the development of the countries like Chila, Uganda, Argentina, and Pakistan, countries like china and Sri Lanka have proved that overall development with a strong social sector and successful performance in education, health and basic consumption is possible, only through carefully planned state intervention.

It has been categorically proved time and again that leaving people's social well-being to the mercy of forces of market and rising incomes, has always amounted to the disdain of the very fundamental intent of the Indian Constitution which guarantees social equity to every citizen of the country. Moreover, promoting social welfare needs regular monitoring of the actions and their results reflecting changes in the realm of

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social concerns, and if the efforts are found short of people's needs and expectations, the Government must always be prepared to choose any other more appropriate course of action to redeem the loss caused to society in this regard. As Amartya Sen has put it, "all policies of growth have to be judged from the point of view of the real life situation at that time. Therefore, no model of growth or policy can be accepted, to be applicable for all times.

However, it would not be out of context to mention here that to provide the health care facilities to every citizen, in a heavily populated country like India is a not an easy task. Public expenditure on health, therefore, should be intensively monitored right from the stage of planning till the achievement of the final results. Markets also have to play their role especially in case of costly health care services particularly in urban sector where investments are large and returns also are attractive unlike incase of primary health care services especially in rural sector, which can never lend rapport to the fundamental aim of earning profits.

There has been, as the officially released statistics suggest, a considerable increase in the health care infrastructure over the Planing period, which is represented by the following table.

However, there is still a shortage of 20,486 sub centres, 4477 PHCs, and 2337 CHCs as per 2001 population norms. Further, almost 40 percent of the existing health infrastructure is operating in rented buildings or rent-free panchayat/ voluntary society buildings.

The physical framework of the existing public sector health care infrastructure in India is an example of shocking oversight. A large number of structures which are meant to house Primary/ Community Health Centres, particularly in rural areas, are suffering from extremely poor upkeep and maintenance. They are very poorly attended by the staff posted at these centres as well, and the doctors are rarely seen there to attend to the patients regularly, making their availability for private practice intact. Such cases are very common in case of centres operative in the villages. The inspections are generally cosmetic and end up with issuing only memos/ warnings to those found responsible for these irregularities.

Nevertheless, efforts are being made by the Government to expand the physical facilities in the health sector, and a perceptible improvement is also visible, as the following table exhibits:

It is evident from the table charted above that during 1951-2009 Crude birth rate per 1000 population declined from 40.8 to 22.5 and the crude death rate from 25-1 to 7.3 Total Fertility Rate (TFR) per women has been halved from 6 to 2.6 during 1951-2008. Infant mortality rate (IMR) dropped to 50 in 2009 as against 146 per 1000 live births during 1951-1961. Child mortality rate per 1000 children has recorded a steep fall from 57.3 in 1972 to 15.2 in 2008. The life expectancy at birth for male which was 37.2 in 1951 has risen to 62.6 during 2002-06 and for female it has gone up from 36.2 to 64.2. the basic reason for relatively higher rate of life expectancy for female vis-a-vis male might be attributed to greater vulnerability of male to deaths caused by accidents and professional hazards.

In addition, there has been uneven improvement across regions/states, gender, rural/urban areas etc. The Indian health system is a mix of public and private sectors with the NGO sector playing a small role. The country has built a well-structured three-tier public health infrastructure comprising Primary health centres (PHCs) and sub centres spread over rural and semi-urban areas as well as tertiary medical care consisting of multispecialty hospitals and medical colleges located almost exclusively in the urban areas. But inadequate health infrastructure, including shortage of doctors and paramedical professionals has resulted in restricted delivery of health services, particularly in rural areas. In order to bridge the gap in existing health infrastructure and to provide accessible, affordable and equitable health care, the Government of India has started a large number of programmes and schemes that include, inter-alia:

The National Rural Health Mission (NRHM)- which was launched in 2005 to provide accessible, affordable, and accountable quality health services to rural areas with emphasis on poor persons and remote areas. The achievements under NRHM as on **September 2010 are as follows:**

(i) 8.33 lakh accredited social health activities (ASHAs) have been selected. Of these, 7.82 lakh have received training in at least the first module and 5-7 lakh have been provided with drug kits in their respective villages.

(ii) Under NRHM 1572 specialists, 8284 MBBS doctors, 26734 staff nurses, 53552

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Auxiliary Nurse Midwives (ANMs), 18272 paramedics have been employed on contract.
(iii) A total of 16338 additional primary health centres (APHCs), PHCs and other sub districts facilities are functional on 24x7 basis.

Over 3.4 crore women have so far been covered under Janani Suraksha Yojana (JSY).

To be added about 381 Mobile Medical Units (MMUs) are functional under the NRHM so far.

4.95 lakh villages (78 percent) have their own village Health and Sanitation committees and each of them has been provided Rs. 10,000 as untied grant per year.

AYUSH: AYUSH services have been co-located in 14,766 heath facilities and 9578 AYUSH doctors and 3911 AYUSH paramedics have been added to system.

Village Health and Nutrition Days (VH & NDs): Thirty-five lakh VH & NDs in 2006-07, 49 lakh in 2007-08, 58 lakh in 2008-09, 58.7 lakh in 2009-10 and 34.6 lakh so far in 2010-11 have been observed to reach basic health services to rural areas.

To be added Programme Management Units: Under the NRHM, 627 district programme managers, 618 district accounts managers, 539 district data mangers, 635 district programme management units (DPMUs), 3529 block managers, 3261 accountants, and 3529 Block PMUs have been added.

Pradhan Mantri Swasthya Suraksha Yojana (PMSSY): The PMSSY has been launched with the objectives of correcting regional imbalances in the availability of affordable/reliable tertiary healthcare services and augmenting facilities for quality medical education in the country. The PMSSY has two components in its first phase. The first is the setting up of six All India Institute of Medical Sciences (AIIMS)- like institutions. The civil works related to the construction of medical colleges and hotels have commenced in all sites. The construction of residential complexes in Rishikesh and Patna is expected to be completed by March 2011 whereas in Bhopal and Bhubaneswar, it is likely to be completed by June 2011 and August 2011 respectively. As regards the work on hospital complexes, lay-out work is under way for all the institutions. The second component of the PMMSY is the up gradation of 13 existing Government medical college institutions. Civil works under this component have been completed in the medical colleges in Trivandrum, Salem, Bangalore, and Lucknow, are on the verge of completion in Hyderabad, Kolkata, Jammu, Tirupati, and Mumbai , and in Varanasi, Srinagar, Ahmadabad, and Ranchi are likely to be completed by mid-2011. In the second phase of the PMSSY, two more AIIMS-like institutions will be set up and up gradation of six more medical colleges is being taken up.

National AIDS Control: According to recent HIV estimates based on HIV Sentinel Surveillance 2008-09, the number of people living with HIV in India in 2009 was 23.9 lakh, with an adult HIV prevalence of 0.31 percent. Adult HIV prevalence at national level has declined from 0.41 per cent in 2000 to 0.31 per cent in 2009. The epidemic is concentrated with high prevalence among the high risk groups (HRGs), Injecting Drug Users (IDUs) (9.2 percent), men who have sex with men (MSMs) (7.3 per cent), female sex workers (FSWs) (4.9 per cent), and sexually transmitted infection (STI) clinic attendees (2.5 per cent).

Others: other programmes like the revised National TB control programme (RNTCP), National Vector Borne Diseases Control Programme (NVBDCP) etc. A total of 553 outbreaks were reported and responded to by states in 2008,799 in 2009 and 938 in 2010 (up to December).

The demand for health services is likely to rise considerably in the future with increase in health-seeking behaviour resulting from better levels of education, income status, and urbanization.

Central Government also provides financial assistance to State Government medical colleges for increasing the postgraduate seats to strengthen the existing public health delivery system. 34 Government medical colleges have been approved for Central assistance during 2010-11. With the implementation of the scheme by 2011-12, approximately 4000 additional P.G. seats would be available.

Deficiencies in India's Health Care System:

Since Independence, successive governments in India have been trumpeting their promises to provide health for every citizen of the country. However, the efforts don't seem to match the secularly increasing needs of health care-particularly on account of population growth neutralizing the improvement of health sector in India. The factors that influenced the performance of health sector have been the proportionately declining share of investment on health as compared to total plan

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outlay and lack of political will to prioritize this sector in the planning process. Traditionally, therefore, the soial sector appears last in the list to be considered as a claimant for additional resource allocation. On the contrary, when there is need to prune the budget, the social sector appears first in the list for scaling down the allocation. It is because the reduction in the expenditure is easily achieved, less conspicuously felt and least opposed by pressure groups.

Despite having a gigantic network of public, voluntary and private health infrastructure manned by an equally large number of medical and paramedical personnel, our health care system is subjected to a number of deficiencies.

India continues to fare poorer in comparison to several other countries of Asia in terms of life expectancy at birth, infant and maternal mortality rates. As against life expectancy of 71 in china and 74 in Sri Lanka the corresponding figure of India has been 63.5 in 2002-06. IMR in china and Sri Lanka stood at 30 and 13 in 200.3 respectively as against the tally of 50 for India in 2009.

Besides, the high inter-regional and inter-state disparities are the fundamental features of the health care infrastructure in India limiting the access of the rural poor to the basic health facilities. Usually poverty is considered to be one of the most critical reasons for poor quality healthcare available particularly in the rural areas. But even the government recognizes that high growth of economies is by itself not enough to improve the quality of life of the poor. Unless certain basic minimum services are made available to the common man, the living conditions can't improve.

The system of public health services in India is also plagued with high incidence of absenteeism in public hospitals especially located in rural/hilly/tribal areas.

India's approach to health sector development has not been properly integrated with overall process of development. The fact of the matter is that, issues related to public health cannot be discussed in isolation, since it is an dependent variable, which cannot portray the complete picture of a country's social status unless it is converged with other areas belonging to the same group like education, sanitation and public hygiene.

Thus, there is a symbolic synergy amongst the various components of the social sectors. For example, education on the one hand and health care on the other hand are closely linked. High mortality rate in the rural areas, for instance, has been largely due to improper knowledge about many diseases and the location of health care centres. Likewise, high birth rate which is the hallmark of rural population of India is, to a large extent, attributable to lack of education leading to lack of awareness about how to contain the hazards of the swollen size of the families. This is reflected in the absence of adequate and effective coordination between health, primary education, sanitation and public hygiene related to programmes thereby reducing the impact of sectoral synergies.

It is really painful to gather that even the public health, which is the most basic ingredient of mass welfare, has not been left free from the clutches of corruption. Thus, health care, both tangible and intangible, are made readily available for those who can afford to bribe for them, and those who cannot, suffer due to their economic vulnerability. . Poor people know little how to get their grievances redressed when officials abuse their position and as such they are vulnerable to giving bribes of having the desired health care.

Though there have been distinct improvements in health indicators like the lowering of crude birth rate, infant mortality rate, enhancement in life expectancy largely on account of expansion in the infrastructure and facilities, Unfortunately, this progress has, by and large remained confined to urban areas only leaving the rural areas treated apathetically.

As the Ninth Plan has highlighted, the major areas of concern regarding health are (1) continued morbidity due to communicable diseases (ii) rising disease burden due to non-communicable diseases, and (iii) escalating cost for health care. While the first two of these seem to have been addressed consciously by the government, the last one, i.e. the cost of health care seems to be hardly heeded to by it. As a recent study conducted by ASSOCAAM Eco Pulse (AEP) has revealed, whole India with its unstated growth momentum stands out of preferred investment destinations, the country lags far behind its peers in social sector achievements. The study says that despite the sustained rise in budgets over the years, India's public spending on health is a percentage of GDP is second lowest among BRIC countries and lowest in terms of education. Thus public health expenditures among the BRIC countries revealed that

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India's public expenditure on health stood at 5% of GDP in financial year 2005-06. In comparison, Brazil and Rusia spent 7.9% and 5.2% on health as a percent of GDP in financial year 2005-06.

Another very important indicator of the state of human health is the provision of safe drinking water. In India, about half of all villages do not have any source of protected drinking water. The existence of some source of drinking water in rural areas is one of the most important indicators of development.

Perhaps one of the most critical issues revolves around a very relevant question faced by our planners-how far public-private participation in building up health infrastructure would be practically feasible? Infact such projects which may be conceived of as suitable for such a participation may have to render serious thought to the following questions:

What would be the size of investments from the private sector.

Whether private investors would be interested in making their money injected into such a project.

Since such projects would understandably involve, large funds as also long gestation periods along with low returns compared to other commercially viable ventures, the private entrepreneurs would not consider them safe destination for their investments. Furthermore, such private investments would hardly be coming up in rural areas, since their economic viability would always be in jeopardy on account of lack of the financial affordability of the local inhabitants for the services proposed to be offered by them. However, health, which is the primary responsibility of the State, should not be left to the mercy of those, whose chief concern is profit maximization rather than maximization of social advantage.

For proper development planning-at the regional level, one needs to know at what distance is the infrastructure facility available to the people. More infrastructure may not essentially be better, especially when it is in tune with the economic trends of the region. A predominantly agricultural region, for example, requires different types of infrastructure than a pre-dominantly industrial region. There are chances that two regions may be having similar population and identical number of health care centers but, if one region has all the health centres existing around the headquarters and the other has them scattered unevenly, the degree of accessibility will be varying comprehensively between both the regions, though on an average both of them will be showing the same quantum of health infrastructure statistically.

A very common feature of rural India is an absolute diversity in the degree of their physical connectivity. If a health care centre, for example, is only 5 Km away from the people who need its services and there is no road link, it would be really an uphill task for them to have an easy access to its services even if they can afford to pay for them.

The Dichotomy of correlation between developments of human resource and eco growth

Conceptually, economic growth has a highly positive correlation with the rate of development of human health which, coupled with development of education and sanitation, results in the enhancement of the overall well-being of people of the country. However, empirical studies, do not conclusively suggest that an improvement in health (and education for that matter) will automatically result in economic growth of a country in question. There are cases where sustained improvement in human development indicators have not led to higher economic growth. Rather, development of human resources can't be sustained over a long period unless it is supported by economic growth. A dichotomy between human development and economic growth, often leads to social tensions. Such tensions generally force the governments to focus on the issues which would have otherwise been sidelined. It is therefore, feasible that two different sets of strategies be framed for pushing up economic growth and promoting well- being of people separately. History very overtly unfolds the fact that both economic and social concerns are independent variables and it is not for sure that laying emphasis on the promotion of any of these areas will give boost to the other automatically. It has also been observed that the budgetary allocations which are already inadequate for health care, are further pruned, resulting in smaller funds left actually available for the purpose. On the contrary, many non-social sectors like Railways enjoy a better deal than education and health sectors. It is really a matter of grave concern for those who find it really hard to explore any genuinely sound logic behind government's lukewarm attitude towards this issue.

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Traditionally, there is a hierarchy in healthcare services with doctors as the top, nurses below and other supporting staff-cleaners and helpers at the bottom. Caring, compassion, warmth and kindness rank high in the expectations of most patients. These factors can't be easily measured and are a casualty when costs are the main criteria of efficiency. But the doctors usually don't see the vital importance of working with other health care workers in the context of patients, and there is the tendency to shift responsibilities to less paid workers like nurses. In India, this is a general phenomenon.

Another issue, and perhaps the more relevant one is to lay stress on ensuring the quality and effectiveness of the output that is served to the society in the form of health services, besides focusing on the quantity of government expenditure earmarked for the purpose.

Suggestions for improving the system of Public Health Services :

The foregoing analysis of the outcomes of health sector achieved over last six decades reflects considerable inequality in the level of health indicators based on gender, income, place and social segments. Reducing these inequalities in health outcomes requires wide ranging reforms to policy and administrative interventions which should be properly addressed.

Easy access to basic health care may easily be considered as the most critical factor which warrants the creation of intensive and extensive network of health facilities in the areas which need it. In the recent years, the costs of health care services have sky-rocketed basically on account of participation of the private sector in their field. This calls for the supply of essential drugs and basic facilities by the public health system on affordable price or even free of cost to the poor.

Besides, the hospitals should be equipped with qualified professional staff. Allocation of resources with regard to infrastructure, manpower and funds, are to be ensured to give value added services to the needy people. It is generally observed that a sizeable number of patients reaching the health care centres need immediate attention, and therefore, the hospitals must be ready to attend them without delay with utmost personal care. Maintenance and hospital services should be brought to the highest possible level. Availability of life, saving drugs must be ensured, and finally, delivery of public health care services should be improved by considerably increasing the accountability of policy makers, administrators and providers of such services. It is highly desirable that hospital as should be equipped with qualified professional staff. Allocation of resources with regard to infrastructure, manpower and funds are to be ensured to give value added services to the needy people especially in rural areas. Vacancies should be filled numerically to technical and non-technical staff. Availability of energizing and life saving drugs must be made ready in the campus.

It can, thus, be concluded that although the Government has started giving impetur to promote health care of the people, much is shileft to be done in this regard, in view of their needs and expectations.

India's approach to health sector development has not been properly integrated with overall process of development. The fact of the matter is that, issues related to public health cannot be discussed in isolation, since it is an dependent variable, which cannot portray the complete picture of a country's social status unless it is converged with other areas belonging to the same group like education, sanitation and public hygiene.

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Another very important indicator of the state of human health is the provision of safe drinking water. In India, about half of all villages do not have any source of protected drinking water. The existence of some source of drinking water in rural areas is one of the most important indicators of development.

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country. However, empirical studies, do not conclusively suggest that an improvement in health (and education for that matter) will automatically result in economic growth of a country in question. There are cases where sustained improvement in human development indicators have not led to higher economic growth. Rather, development of human resources can't be sustained over a long period unless it is supported by economic growth. A dichotomy between human development and economic growth, often leads to social tensions. Such tensions generally force the governments to focus on the issues which would have otherwise been sidelined. It is therefore, feasible that two different sets of strategies be framed for pushing up economic growth and promoting well- being of people separately. History very overtly unfolds the fact that both economic and social concerns are independent variables and it is not for sure that laying emphasis on the promotion of any of these areas will give boost to the other automatically. It has also been observed that the budgetary allocations which are already inadequate for health care, are further pruned, resulting in smaller funds left actually available for the purpose. On the contrary, many non-social sectors like Railways enjoy a better deal than education and health sectors. It is really a matter of grave concern for those who find it really hard to explore any genuinely sound logic behind government's lukewarm attitude towards this issue.

Traditionally, there is a hierarchy in healthcare services with doctors as the top, nurses below and other supporting staff-cleaners and helpers at the bottom. Caring, compassion, warmth and kindness rank high in the expectations of most patients. These factors can't be easily measured and are a casualty when costs are the main criteria of efficiency. But the doctors usually don't see the vital importance of working with other health care workers in the context of patients, and there is the tendency to shift responsibilities to less paid workers like nurses. In India, this is a general phenomenon.

Another issue, and perhaps the more relevant one is to lay stress on ensuring the quality and effectiveness of the output that is served to the society in the form of health services, besides focusing on the quantity of government expenditure earmarked for the purpose.

Suggestions for improving the system of Public Health Services :

The foregoing analysis of the outcomes of health sector achieved over last six decades reflects considerable inequality in the level of health indicators based on gender, income, place and social segments. Reducing these inequalities in health outcomes requires wide ranging reforms to policy and administrative interventions which should be properly addressed.

Easy access to basic health care may easily be considered as the most critical factor which warrants the creation of intensive and extensive network of health facilities in the areas which need it. In the recent years, the costs of health care services have sky-rocketed basically on account of participation of the private sector in their field. This calls for the supply of essential drugs and basic facilities by the public health system on affordable price or even free of cost to the poor.

Besides, the hospitals should be equipped with qualified professional staff. Allocation of resources with regard to infrastructure, manpower and funds, are to be ensured to give value added services to the needy people. It is generally observed that a sizeable number of patients reaching the health care centres need immediate attention, and therefore, the hospitals must be ready to attend them without delay with utmost personal care. Maintenance and hospital services should be brought to the highest possible level. Availability of life, saving drugs must be ensured, and finally, delivery of public health care services should be improved by considerably increasing the accountability of policy makers, administrators and providers of such services. It is highly desirable that hospital as should be equipped with qualified professional staff. Allocation of resources with regard to infrastructure, manpower and funds are to be ensured to give value added services to the needy people especially in rural areas. Vacancies should be filled numerically to technical and non-technical staff. Availability of energizing and life saving drugs must be made ready in the campus.

It can, thus, be concluded that although the Government has started giving impetur to promote health care of the people, much is shileft to be done in this regard, in view of their needs and expectations.

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