

The Health Transition in India: Public Health, Governance and the Market

Date: February 19 -21, 2008

Population health is an outcome of a complex of factors: nutrition, epidemiological and social environment, education, familiar constraints, access to information, behaviour relating to health, adequate prophylaxis against infectious diseases for children and adults and finally, access to proper medical and surgical care in case of illness. It is because of this complexity that international research requires an interdisciplinary approach. International and national health research therefore requires a regional focus as well.

The research competencies of health economists and other social scientists of the IDSK and of health specialists connected with the South Asia Institute, Heidelberg University, Germany were combined in an international seminar that the IDSK organized from February 19 to 21, 2008 on *The health transition in India: Public health, governance and the market*. In this seminar the contextual factors – cultural, political, institutional and environmental-affecting public health and the coming "health transition" in India were discussed and debated.

A Brief Report

HEALTH TRANSITION IN INDIA: TRENDS AND CHALLENGES

By

Bijoya Roy, Bidhan Kanti Das, and Saswata Ghosh
(Institute of Development Studies Kolkata)

Health is the outcome of interaction among social, political, and economic conditions. Contextual factors affecting public health and the challenges associated with health transition in India have emerged as a major issue to be discussed, debated and researched with an interdisciplinary approach. Keeping this backdrop in view, the Institute of Development Studies Kolkata (IDSK) organized an international conference on 'Health Transition in India: Public Health, Governance, and The Market', on February 19-21, 2008. The conference was also sponsored by Indian Council of Social Science Research (ICSSR).

There were sixteen presentations by social scientists, public health practitioners and research scholars who covered a wide field such as trends in mortality and morbidity, determinants of health, challenges of health care delivery, and innovations in policy and governance.

In his welcome address Amiya Kumar Bagchi, Director of IDSK stressed that despite some successes such as ICDS programme, Panchayati Raj, and the regional successes of certain states like Kerala, health indicators in India are still poor and the halting progress in health transition will make the situation more complex. The papers brought out the nature and complexities of transition in epidemiological profiles and health care delivery system, in contemporary India. Social, political, economic and historical factors contributing to these complexities were also deliberated upon.

Trends in Mortality and Morbidity

The rural-urban and gender differentials in mortality rates among adult age groups in India have been narrowing since the 1970s. N. Krishnaji, National Fellow, ICSSR in his paper on Changing Patterns of Adult Mortality in India has further probed this aspect. The most significant finding is

that there is a virtual lack of improvement in the mortality rates among urban adult males in recent years.

By calculating survival probabilities beyond age 60 among persons attaining the age of 30, he has shown that the percentage changes during 1970 to 1997 were lower among urban population than among their rural counterparts. Krishnaji also argued that 25 years of survival rate for women age of 15 is significantly and positively correlated with safe motherhood index and mortality rate in the age group of 15-29 has considerably declined. Thus, his overall analysis "reveals much regional variation in mortality rates across rural/urban areas in the different states".

Saswata Ghosh of IDSK in his paper argued that epidemiological transition in India is taking place with substantial variation among states, regions and population sub-groups over the past thirty years or so, though at a slow pace. By analyzing the data on the causes of death in India and its states, his analysis indicates that in the demographically backward states poverty related diseases are still taking a large toll notwithstanding the overall declining trend of infectious diseases.

'Accidents and injuries' and diseases of central nervous system are increasing, whereas communicable diseases, mainly 'coughs' and fever are on decline. He has also argued that the better off, higher educated and urban people are more likely to suffer from non-communicable and degenerative diseases than their rural counterparts. Lastly, using NFHS -2, 1998-99 data he has shown the resurgence of communicable diseases in the economically progressive states such as Haryana and Gujarat in recent times, the cause of which needs to be investigated in detail.

In recent times the rate of decline of IMR has slowed down and according to D. Narayana of Centre of Development Studies, Thiruvananthapuram, environment-related diseases in the economically well-performing Indian states are increasing. In his paper Narayana investigated this pattern and attributed the causes primarily to female-male mortality inequality during infancy on the one hand and low availability of the basic amenities such as potable drinking water, safe sanitation, electricity and poor attention towards garbage disposal on the other even in well-performing states. He also argued that with a few exceptions, though large private investment has been made in these states in digging up wells and construction of latrine, etc., due to lessened public health concerns, complementary public investment is poor in these areas of public health.

Mental health problem is a growing concern in India. Presenting a case on traditional vs. modern mental health care in Maharashtra, Johannes Quack of University of Heidelberg, Germany tried to analyse questions like why a large majority of the Indian population consults so-called "traditional healers", what actually counts as "existing infrastructure". Should "modern" and "traditional" mental health therapies be combined, separated, or regarded as complementary? This paper attempted to delineate the processes of mental health therapies based on anthropological methods. It tried to provide an overview of studies, arguments and problems connected to these questions in the light of health transition in India.

Determinants of Health

Keeping in mind the widening socioeconomic disparities between and within nations and emphasis on public health individualism, K.S. Reddy, President, Public Health Foundation of India, stressed the need to focus on social determinants, referring to Rudolf Virchow and

Michael Marmot's views. This was elaborated by taking the cases of smoking, cardio vascular diseases and obesity.

He urged the scholars and practitioners to look beyond the immediate risk factors and broaden their view to include the web of factors. Health intervention should be based on understanding of social and economic determinants focusing on multi-sectoral action as the principal pathway for health by moulding markets, making consumers conscious of their rights and encouraging interdisciplinary research at the policy level.

Two scholars evaluated workers' health during colonial and post-colonial period in India. Both the papers tried to capture the social and economic determinants resulting in particular health trends within specific population groups. Nitin Varma of South Asia Institute of University of Heidelberg, Germany in his paper analysed public health issues among plantation workers of Assam in historical framework.

He carefully documented the continuities and changes in relations of state, capital, market and a labouring population during colonial regime. His paper stressed the necessity of public health research, policy and action considering regional, social and cultural variations as well as complexities therein. According to Verma, understanding the historical construction of the bureaucratic medical infrastructure would be another critical aspect of research into public health in India.

The question of the narrowness of the construction of public health care infrastructure also came up in the paper by Debdas Banerjee of IDSK. His paper provided a detailed analysis of the changing health risks of the workers covered (or, *de jure* covered) under the Employees State Insurance Corporation (i.e., ESIC) in the changing conditions of the labour market. International agencies like WHO generally favour measuring health inequality across individuals or income classes rather than across social groups. Banerjee pointed out, however, that health risks of the mineworkers, workers in the 'traditional' industries, the stone-crushers, or the condemned ship-breakers are different from those of individuals in the same income-group but performing safer jobs.

In other words, health expectancy of different occupational groups is different. Moreover, the problems of organizing and funding the health sector are central to health inequalities in the developing countries. Growing casualisation and outsourcing of jobs, frequency of lockouts (of longer duration), incidence of 'diverting' ESI contributions by the employers, all have generated processes through which a large number of the workers (and their families) lose access to the otherwise well developed ESI health support system. Banerjee also mentioned that 'funds' are not a problem in this case, as ESIC generates a large annual surplus.

Challenges of Health Care Delivery

V Raman Kutty of Achutha Menon Centre for Health Science Studies in his paper pointed out that over the two decades (1986-2004), private medical care sector in Kerala has changed radically with a shift towards large hospitals. Despite tremendous progress earlier, in Kerala, the public and private health care systems are failing to address the emerging disease burden with the resurgence of viral illness and increase in mortality due to non-communicable diseases.

The success of government health care services has generated demand for high quality services that has been partly addressed by the private sector. Partly on the basis of a study carried out by Health Action by People, Trivandrum he indicated the prevalence of high mortality rates due to non-communicable diseases among different socio-economic groups. He also

found that the lowest socio economic group reported the maximum burden of household expenditure on health care and of high mortality rates due to infection, non-communicable diseases, and suicide.

Reform initiatives in the public health sector have tried to respond to the emerging complexities but are yet to show significant improvement. In a situation of narrow disparity in health indices across the various groups in Kerala, Kutty highlighted the need for access to good quality and affordable care for the poor and marginalized group.

The health care service situation in West Bengal was given a special emphasis in the conference. Bijoya Roy of IDSK delineated the changing scenario of the hospitals in public and private sector in West Bengal. Unlike Tamil Nadu, Maharashtra, Andhra Pradesh, in West Bengal the entry of big entrepreneurs in hospital and its allied sectors was late.

It was only in the mid-nineties that the public sector hospitals in West Bengal, which have been the major providers of health care in the state, began implementing a series of reforms bringing about changes in provisioning and financing of services. The state welcomed the private sector as providers and investors, assuming their resources and expertise would revitalize the public sector hospitals. The paper argued that on the one hand corporatisation of private hospitals and on the other privatization of many services provided by public sector hospitals are raising critical issues in terms of equity, cost, and quality of care.

Debashis Mazumdar of Bongabasi College, Suman Ray of IDSK and Anupam Maity of Krishnanagar Government College in their paper focused on critical gap in primary health care services in inaccessible areas of delta region, Sunderban. One third of the villages in Sunderban area did not have access to health care facility. They developed Health Infrastructure Index (HII) for blocks of Sundarban area which when compared with the RCH (Reproductive and Child Health) ranking used by the Government of West Bengal showed similar rankings for the blocks.

The first referral units in two blocks of Gosaba and Basanti, areas of Sunderban projected inadequate physical and human resources necessary for efficient functioning. Highlighting the inadequacies in health care provisioning at the primary level, the authors fostered the need to make primary health care functional by collaborating with the locally available resources like student health volunteers, RMPs, local NGOs and medicine shops.

Subrata Mitra and Anja Kluge of University of Heidelberg, Germany engaged in understanding the roles played by different agencies, institutional arrangements and policies in shaping the health care delivery system and the differences in levels in Tamil Nadu and Orissa. Through the identification of a set of state health department, institutions, different agencies (private- for profit and voluntary) providing health care services and national health programmes, differences in health care were evaluated respectively. Tamil Nadu, which is a well performing state than Orissa shows the development of certain unique schemes like 24 hour primary health centre, availability of specialized services through camps in rural areas. In Orissa, many health care programmes have been started through external assistance, but are yet to create a positive impact on the basic health indicators and their implementation is weak.

Innovations in Policy and Governance

Rainer Sauerborn of University of Heidelberg, Germany explored the potentials of synergy between micro-health insurance and micro-credit in developing countries. He emphasized on

mixed schemes which offer health insurance as part of a wider social and economic agenda including giving out micro-credits.

Considering the common problems such as moral hazard, adverse selection, fraud/corruption, high dropout rates dependency from external support and questionable sustainability of micro finance and micro-insurance, he tried to argue from the success of *Vimo* SEWA (In Gujarati, *Vimo* means insurance) that provision of micro finance and micro health insurance benefits under the same organizational umbrella to the female informal sector workers of Gujarat enhances both the objectives. During the discussion it was pointed out that the motivation for health insurance among the poor is the most important problem that needs to be addressed.

In a joint paper presentation by Sylvia Sax of Public Health and William S. Sax of Anthropology Department, South Asia Institute of University of Heidelberg, Germany argued that indigenous management structure create obstacles in implementing models prepared by donor agencies in health care management. The donors believe that these are due to apparent unwillingness, or inability of local health managers. According to them, indigenous bureaucratic structure tends to inherently maintain bureaucratic power though the exogenous model for health care management, which may require a decentralization of decision-making. To achieve health management goals, the best way is to work within the indigenous structure.

Achin Chakraborty and Subrata Mukherjee of IDSK in their paper examined the levels of institutionalization of community health care monitoring by the lowest rung of Panchayat Raj Institutions and its impact on various levels of stakeholders for improving health indicators in West Bengal. Inter and intra district variation is observable in terms of implementation process. Reasons are varied from active Gram Panchayat (GP) leadership, SHG involvement in GP areas to existence of active NGOs for successful implementation.

Authors argued that as PRI functionaries lack motivation in general there is a need to sensitize PRIs along with capacity building exercises. They suggested for some degree of financial devolution to institutionalize the process by increasing manpower to build capacity at various levels as well as to sustain motivation of SHGs involved.

In public health decisions often the dominant groups give lip service to the needs and values of the community. Gavin Mooney from Curtin University, Australia in his paper stressed the need for public health in terms of community autonomy, on values derived from the populations involved, through some form of 'deliberative democracy' like citizens' juries that might serve as a vehicle for setting principles or a constitution for public health.

Citing case study from Australian Aborigines in Australia, he advocated for listening the voices of the marginalized "in not only planning public health but also defining public health". He also argues that there should be changes in global as well as national level institutions after examining the existing power structure in public health issues. These institutions should be driven more by relevant community values and less by neo-liberal individualistic values thus, questioning current governance structure of public health.

Finally, Michael Marx of Tropical Hygiene and Public Health, University of Heidelberg in his paper discussed the impact of increased migration and forced mobility due to globalisation in terms of health risks of the populations. On the other hand, health care systems are increasingly facing unknown challenges in having to cope with new risks and threats. According to him, diseases like SARS, influenza demonstrate the fragility of existing health care systems, especially in resource-poor countries and not always prepared to handle the situation. This

paper discussed dimension and the determining factors of the impact of mobility on health care systems across different regions and countries.

The debates in the conference clearly brought out that the epidemiological pathway from infectious diseases to non-communicable diseases is not linear as Omran's health transition theory suggests. Increase in non-communicable diseases and resurgence of different types of fever reflected the complexity in health transition. The discussions reinforced the need for exploration of patterns (mortality and morbidity) within countries along with gaining insights into the community level needs and intervention. Health transition cannot be understood in isolation of the changing social and economic factors that bring about changes in the mortality and morbidity. The factors (physiological and epidemiological factors, health care provisioning, policy, and governance) determining the health of a population were discussed and analysed. It was stressed that to understand the morbidity pattern of a population it is important to take cognizance of the mental health problems as well. Through various discussions the dangers posed by the retreat of the state in low-income economies from the provision of health care services and the need for regulation of the unregulated proliferation of the private sector were stressed.