Editorial

The Exsanguination of Public Health in India

The Covid-19 pandemic brought India's health systems, both private and public, to their knees, exposing chinks that were hidden before. But India's public health system was already fragile when the pandemic struck. The Covid-19 pandemic not only exposed the hollowness of India's health systems, but like all pandemics in the past, highlighted faultlines in our society: of class, caste, region and gender.

Why does one say this? After all, India was attracting foreign exchange through medical tourism and reproductive health tourism—although surrogacy had its sleazy side. We were told our private hospitals offered the best in technology in keeping with high-income countries, although our incomes did not match, making them accessible only to a tiny elite and, of course, foreigners. Medical tourism might have brought in foreign exchange, but did nothing to strengthen the dilapidated public health system, and indeed fed off government's largesse.

Let us consider some facts about health in India. The average height of Indians has shown a decline, attesting to both chronic undernutrition, frequent illnesses and poor living and working conditions. Researchers exploring average adult heights between the National Family Health Surveys (NFHS)-II (1998–99) and III (2005–06), and IV (2015–16), found that the average height of women across age groups increased by a paltry 0.84 cm, but it declined between NFHS-III and IV in the age group of 15–25 years. Among men, both the age groups of 15–25 years and 26–50 years showed considerable decline in average height, particularly so in the poor strata and among the scheduled tribes.[1] This is not genetic, as the children of rich Indians show remarkable inter-generational improvements in their heights, as indeed those who have emigrated.

Furthermore, India has the largest proportion of undernourished children in the world. According to the Comprehensive National Nutrition Survey (CNNS) 2016–18, 35% of Indian children aged 0–4 years are stunted and 33% are underweight, with higher figures (around 40%) for states such as Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh. Children in the poorest wealth quintile are far more likely to be stunted (49%) compared with those in the richest quintile (19%), and about twice as likely to be underweight. Similarly, children from the scheduled tribes have high rates of underweight (42%) compared with scheduled castes (36%), other backward classes (33%) and other groups (27%). Vitamin A deficiency, for instance, is estimated at 18% for preschool children aged 1–4 years, 22% among school-age children aged 5–9 years and 16% among adolescents aged 10–19 years. Vitamin D, essential for bone health, was found deficient in 14%, 18% and 24% of these respective age groups. Zinc deficiency, associated with growth retardation, loss of appetite and impaired immune function, affects 19%, 17% and 32%, respectively.[2]

Life expectancy has improved enormously from 22 years in 1901—testimony to the devastation of colonialism—to 70.8 years today. But this is simply not as good as life expectancy in Sri Lanka (76.9) or Bangladesh (74.3).[3] Indeed, reports indicate that the life expectancy has come down by 2 years over the past 2 years.[4] A woman born in Kerala can expect to live 13 years longer than one born in Uttar Pradesh and 9 years longer than one born in Bihar. It is not enough to have average life expectancy. Social marginalization, along with economic marginalization, have both profound and long-term consequences. Adivasis have the lowest life expectancy in India. The differentials between Adivasis and Savarna Hindus is almost 4 years for women and 5 years for men. The gap between Dalits and Savarna Hindus is more than 3 years for both men and women. Life expectancy among Muslims is about 1 year lower than that of Savarna Hindus.[5]

India has one of the highest rates of maternal mortality in the world. This is indicative of chronic neglect of the health of women, their undernutrition, the neglect of primary healthcare, and above all, the unavailability of emergency obstetric care. Although the maternal mortality ratio (MMR) has declined to 113 per 100 000 lives births in 2016–18 from 122 in 2015–17, Assam has an MMR of 215, Uttar Pradesh 197, Chhattisgarh 159, Madhya Pradesh 173, Rajasthan 164 and Odisha 150. These are comparable to levels in Sub-Saharan Africa. Karnataka at 92 has the highest MMR in southern India and Kerala is the lowest at 43.[6] The magic wand of Janani Suraksha Yojana has not brought down the MMR: institutional birth does not necessarily mean safe birth. Let us also consider that Bangladesh has fewer institutional births than India, and yet a lower MMR.[7]

In addition to a continuing high load of infectious diseases, we are also facing an epidemic of non-communicable diseases. The latter do not, as in the West, stem primarily from lifestyle factors, but also poverty. It is well established that intrauterine nutritional and early childhood nutritional deficiencies cause diabetes and hypertension and even cancers in these individuals as adults.[8]

How did we come to this? Let us look at public health expenditures. After all these years of economic growth, India spends a pitiful 1.2% on health. In the global ranking of health spending by Oxfam in 2020, India fell to a lowly 152nd position, fifth from the bottom.[9] Out-of-pocket health expenditure has emerged as a leading cause of indebtedness, plunging millions under the poverty line each year, forcing patients to sell assets and borrow money from usurious moneylenders.[10]

We are woefully inadequate in terms of both physical and human resources in health. India also has the lowest number of hospital beds per 1000 people, at just 0.5; Russia has 7.12, China 4.3, South Africa 2.3, and Brazil 2.1. Even Bangladesh does better than India, with 0.87 beds per 1000 people.[3] The few countries with fewer beds than India per 1000 people include Afghanistan, Burkina Faso, Mali and Madagascar.[3] The WHO recommends at least 5 beds for 1000 people, ten times more than what India had accomplished in 75 years of freedom.

The government's response to this crisis in public health has been public funding for private medical care through schemes such as the Pradhan Mantri Jan Arogya Yojana (PM-JAY). This not only amounts to public funding for private medical care, further depleting public health systems of funds, but leads to profound moral hazard problems: of unnecessary investigations, of unwarranted interventions and so on. This also does not address the problem that the insurance mechanism addresses only inpatient care, when even outpatient care can be impoverishing.[11]

It is difficult to get out of this situation given the influence of the corporate sector in medical care, of doctors, of venture capital investors in health, of the World Bank and International Monetary Fund, who have together brought the system to where it is. We can make a beginning by teaching medical students that health is not an individual business but a public good.

As Covid-19 has taught us, and plague and Spanish influenza before, our class can only protect us so much from the ravages of disease. We need to strengthen public health systems, perhaps consider nationalizing health systems. Spain did it. We need a universal system of primary healthcare provided by the state, paid for by general taxation. The public subsidy to private care must stop. We are not short of funds: if corporate tax write-offs can be curtailed or a small wealth tax is introduced, we will have enough funds for universal health care and education.[12]

Conflicts of interest. None declared

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