MUMBAI | FRIDAY, 11 MAY 2012 Business Standard

Healthcare needs a booster dose

Twenty-first century India cannot rely on a rickety healthcare system that pays little attention to medical professionalism

SONALDE DESAI

Nowhere is our one-size-fits-all approach to development more evident than in the health sector. Somehow, we have decided that what works for education and other social sectors must also work for the health sector. If the Indian health infrastructure is to keep pace with the changing disease profile that accompanies economic development, it must move away from excessive reliance on paramedics and community health workers to technically-competent laboratory and physician services that are essential to address non-communicable diseases like cardiovascular diseases and diabetes.

In the history of health policy in India, two documents are of critical importance. It's a pity that one was totally ignored. In 1946, the Bhore Committee laid out a far-reaching agenda for preventive and curative health services with the creation of National Health Service that was of a "minimum decent standard". The Bhore Committee recommendations focused on the professionalisation of health services and a combination of preventive and curative services. Had this roadmap been followed in Independent India, we would be looking at a very different health system today. Instead, little attention was directed to developing a health policy in the early decades after Independence and it was not until 1983 that the National Health Policy (NHP) was developed. The NHP is striking in its dissonance with the Bhore Committee report. It was critical of Western-style curative services and emphasised a "preventive and promotive" model through deprofessionalised services relying on part-time, low-cost community workers and paramedics. In effect, it led to government role being concentrated in prevention of epidemics, leaving curative services to the private sector. This is the model that has guided our health policy since the 1980s. Without a serious overhaul of our fundamental philosophy of the type of services to be provided by the public sector and who will provide it, we are unlikely to be in a position to meet the challenges of the 21st century.

Public health expenditure is set to increase from 1.4 per cent of GDP in the 11th Five-Year Plan to 2.5 per cent in 12th Five-Year Plan, but it is not clear whether this will prevent most Indians from continuing to rely on the private sector, however inadequate it may be. Statistics on the utilisation of public versus private health services are sobering. Four out of five patients are treated by private providers. This not simply a function of the absence of government services; the India Human Development Survey (IHDS) conducted in 2004-5 by NCAER and University of Maryland documents that 86 per cent of the sample population lived within 3 km of at least a sub-centre but even so, more than 80 per cent of these same respondents went to a private facility for even simple illnesses like cough, cold, fever and diarrhoea.

Statistics on the utilisation of public versus private health services are sobering. Four out of five patients are treated by private providers

In the past year, I have visited a large number of sub-centres, the primary point of contact between the rural population and government health services. It is easy to see why people are overwhelmingly voting with their feet and running away from government health services. In many of the Hindi-belt states, sub-centres are poorly staffed and facilities are decrepit. But even in south India, where we often see gleaming new buildings with a dutiful Auxiliary Nurse Midwife resolutely manning it, we see patients flocking to private doctors. The IHDS data document that even when there is no private doctor in a village, people do not turn to sub-centres for treatment of minor illnesses. They travel outside the village in search of a private doctor. It is only when a Primary Health Centre (PHC) with an MBBS doctor is available that there is greater use of government services.

Do these observations suggest a need to rethink our philosophy about public health service provisioning? Of course. Unfortunately, there is little attempt at exploring the underlying causes of public distrust in government services. When it comes to health, people – the poor and the rich alike – want the most competent advice they can afford. Expanding the base of community health workers and sub-centres staffed by Auxiliary Nurse Midwife may not serve this purpose. Most readers of this newspaper will be happy enough with government services if they can visit the All India Institute of Medical Sciences, or AIIMS, but they will certainly turn to a private doctor if their only alternative is a government paramedic. Why should we think poor people are any different?

A focus on community workers is particularly misplaced when it comes to non-contagious diseases. Community workers have an important role to play in spotting disease outbreaks and in educating their neighbours about disease prevention. But when it comes to diagnosing diabetes, high blood pressure or high cholesterol, more technical training and access to laboratory services is required.

As public health strategies for the control of vector-borne and vaccine-preventable diseases of the 20th century succeed and diseases like cholera, polio and smallpox recede, we are facing new challenges such as diabetes and cardiovascular diseases. Although characterised as life-style diseases, they attack the poor and the rich. They are far less susceptible to campaign-style approaches used for vaccination and require more day-to-day screening and behavioural as well as pharmacological management. This requires more professional input than what a community health worker with a minimum educational qualification till 8th class may be able to manage.

It is time to overcome the legacy of the 1980s when suspicions of Western-style curative services dominated and replace it with an integrated provisioning of health services that includes preventive and curative services. A focus on community health workers has many benefits but it is not the solution to the urgent need for professional training. Even after we recognise the urgency of increasing professional inputs, several decades will pass before sufficient numbers of doctors, nurses and laboratory technicians will be trained. It is imperative that we get started.

The author is Senior Fellow at NCAER and Professor of Sociology at University of Maryland. These views are personal