INVITED LECTURE

POLITICAL ECONOMY OF PUBLIC HEALTH AND RESEARCH IN INDIA:

IS IT A LACK OF POLITICAL WILL OR A FUNDING ISSUE?

Dr Shahid Perwez

M-CRIL, India

Abstract

In India there is one government doctor over 10000 patients (as opposed to WHO recommended doctor-patient ratio of 1:1,000) – and one nurse for about 500 patients. As a result, India needs 6,00,000 doctors and 20,00,000 nurses to meet the demands of an efficient public health care, according to the findings of a US-based Center for Disease Dynamics, Economics & Policy early this year.Even if we entirely depend on doctors n nurses, India will continue to face the burden of health care. So, to curve these issues, it's time to focus on prevention and rehabilitation with the contribution of social scientists and social work professionals and further research. In this article, I wish to highlight the need and value of social science, in general, and social workers, in particular, in tackling the challenge of an efficient public health system in the country.

Public Health in India

The need for a publicly financed national health services and system for comprehensive preventative and curative health care for all in India dates back to the recommendation of Bhore committee report in 1946. Hence, a public health agenda, as later set out at Alma-Ata Declaration of 1978, called for developing and strengthening primary health care in India through an integrated approach to epidemiological and demographic transitions, along with environmental changes and socio-economic determinants of health. However, this remains an unfinished agenda with inadequate health coverage and lack of access to quality care, largely due to 'insufficient public investments and failure to focus on the synergies between the role of the centre and the states' financing'.

Consequently, rising burden of chronic non-communicable disease like hypertension and diabetes coupled with an increasing elderly population, high levels of maternal and child mortality, HIV/AIDS pandemic, re-emerging TB and malaria and other such communicable

diseases continue to pose major challenges for our existing health system and provisions. State of public health and health care in India remains abysmally low. India's current health expenditure (as percentage of GDP) is just over 1 per cent (1.28%), as per the latest National Health Profile data (14th edition) released by Central Bureau of Health Intelligence (CBHI). Inadequate financial resources for the health sector continue to drive and reinforce health inequalities in India. It has been well established that the root causes of health inequalities primarily lie in the socio-historical, economic and political factors of a country (WHO, 2008). Several forms of health inequalities have existed in India since British colonial rule. One of these have been inequities in the availability, utilisation and affordability of health services. After independence, attempts have been made to expand the health services but remained inadequate to ensure universal quality care coverage. To ensure equitable healthcare for all, and in line with meeting the UN Sustainable Development Goals, India has once again officially embarked on the path to UHC since 2010 and have even included it in its 12th five-year plan (2012-17). The recent launch of an ambitious national health protection scheme called *Ayushman Bharat*is another step towards realising India's long-standing dream of health for all. It is in this context that public health in India has gained a new momentum and criticalityfor an ambitious agenda towards universalising healthcare.

In this article, I primarily ask: What is the status of public health and research in India? What has been the role of social workersin terms of their focus and contribution to health and health care in India? What are their future prospects in public health?

Before dwelling into these questions, let me first clarify two definitions here:

What is public health?

Public health refers to a branch of medicine that deals with 'preventing' disease (both communicable and non-communicable), prolonging life and improving the quality of health (both physical and mental) of communities through education, research, policy making and other organised efforts of society. In other words, the function of public health is to ensure a level of health for all that should lead them towards a socially and economically productive life – in line with an agenda of health as set by the World Health Assembly in 1977.

And…

What is a political economy of public health?

Political economy refers to a perspective that involves studying the embeddedness and interaction of both political considerations and economic factors by focusing how on power and resources are allocated, distributed and contested in a given context. More importantly, it focuses on the implications of results of such interactions for development outcomes and gains. It is particularly useful for a context of health such as in India where a roadmap for realising universal health coverage (UHC) is currently being laid out as part of meeting the sustainable development goals (SDGs). It can help refine existing national health policy in three specific ways:

- By way of generating a health stakeholder map, through an assessment of political and economic landscape of the health sector
- By focussing on how political strategies shape the possibility of a health policy reform
- Through monitoring and evaluating the progress of implementation vis-à-vis agenda setting

Even a brief application of political economy perspective to public health confronts us with the following challenges that India is currently facing.

- State of public health and health care in India remains abysmally low. According to the latest available National Health Accounts (NHA), patients in India bear a big chunk of health expensesby themselves, i.e., 61 per cent of the total health expenditure. While the share of government's health expenditure has increased over the years, it was still low at 31% in 2015-16 (National Health Accounts Estimates for India, 2018).
- India's current health expenditure (as percentage of GDP) is just over 1 per cent (1.28%), as per the latest National Health Profile data (14th edition) released by Central Bureau of Health Intelligence (CBHI). While it shows a little increase from the 1.02% in the previous years, it is still very low compared to other global economies like US. That is, Indian government spends as little as Rs.3 per day for its every single citizen. Even if it increases to 2.5% by 2025, as promised by the incumbent government at the Centre, it will be well below the minimum expected 5% of the GDP.

- Most crucially, the cost of treatment by patients has been on the rise leading to inequity in access to healthcare services. In short, India's current public health spending is one of the lowest in the world, even lower than countries like Sri Lanka, Nepal and Bhutan.
- The results of poor financing for public health were evidently reflected in some of the communicable diseases that took toll of Indian lives in 2018, as per the 14th edition National Health Profile data,
    - Pneumonia (30%),
    - Respiratory infection (27%),
    - Acute Diarrhoea (11%), and
    - Swine Flu (8%) along with typhoid, hepatitis, encephalitis.
- On the non-communicable front, incidences of the following disease were seen to be increasing,
    - Hypertension (6.19%),
    - Diabetes (4.75%),
    - Heart disease (0.30%),
    - Strokes (0.10%) and
    - Common cancers (0.26%).

In a nutshell, the economics of public health and its outcomes are not in a great shape at the national level. As a result, India currently faces the burden of unfinished agenda of communicable diseases, and the challenges of dealing with growing incidences of lifestyle-linked non-communicable diseases, in addition to the challenge of strengthening the weak health infrastructure in the country.

However, an inadequate public health system is not entirely due to lack of funding or poor economics behind health care. This is compounded by a parallel lack of political will. According to noted development economist, Jean Drèze "there are [also] issues of management, corruption, accountability, ethics and so on. The main problem is healthcare is way down the political agenda". Let us briefly consider the 'apolitical' nature of public health in India.

- While India has officially embarked on the path to UHC since 2010, the focus of public health remains on maintaining an ineffective primary healthcare by the successive governments. This is evident from the status quo of vertical programmes focusing on disease

like HIV/AIDS, TB, Polio, and even family planning programmes, which are driven by targets and financial incentives rather than specific health indexing as outcomes of a programme.

- This approach tends to serve the interest of large pharmaceutical companies for whom public health spending on tertiary care provides fertile grounds for the consumption of their goods and products. Politically speaking, there is neither a regulation of over-the-counter sale of drugs, prices of drugs and medical equipment nor a control over the private healthcare industry. This leaves good ground for various international lobbying groups and their representatives in India to become a dominant force to reckon with.
- Healthcare does not yet constitute a priority sector for the political parties and representatives alike vis-à-vis a focus on industry, trade, agriculture, and infrastructure. Demand for low cost, high quality and equitable healthcare has yet to become an electoral issue in India. Whatever little political representation is seen relates to mainly demand for tertiary care hospitals and provisions, including for more doctors and nurses. A review of political manifestos of major Indian political parties in terms of health promises made in the 16th Lok Sabha elections (2014) showed that only two parties mentioned health as their goals, largely in terms of processes and inputs; yet much of it did not find any space in the public debates.
- While there is a lack of political will on the part of political parties and their leaders at large to address the social determinants of health such as hunger and sanitation, citizens of the country have 'not taken the government to task' either. For example, no serious discussions and engagements were visible among the public when India was ranked 103 out of 119 countries on the Global Hunger Index in 2019.

As a result, political accountability in terms of policymaking for healthcare is glaringly absent and missing from a public debate and discussions – even in the case of massive restructuring of healthcare through universal healthcare coverage (UHC) programmes like National Rural Health Mission (NRHM) – now known as National Health Mission (NHM). Establishing public health as a national and political priority requires a politically challenging strategy of bringing medical education under rightful regulation, transparency and accountability.

Public health research in India

As India embarks on an ambitious agenda towards universalising health care, it is worth pointing out the grossly inadequate status of research studies undertaken thus far, which is increasingly being highlighted as a tool to guide health policy and practices in India. Health related research articles constituted a little above 1% of all annual research on health topics during 1992-2001. This was increased to a little over 3% during 2002. While there were relatively few systematic assessments of health research outputs in India a decade or two ago, a recent review article in Global Health Action (2015) showed that public health research output in India has significantly increased over the last one decade or so. However, about two-thirds of these research were undertaken in collaboration with international institutions, mainly from the UK and the USA. Ironically, north-eastern states continue to be under-represented in terms of location of health research, suggesting a very low research output from the region.

Even a cursory look at the status of public health research in India shows that it is grossly under-represented and a characteristic of the low priority to public health more generally, and with marked inequities in relation to geographical distribution of research, in particular. Three challenges in particular strike out – lack of adequate funding, institutional capacity and a focus on priority setting in terms of demand for research. When we read these issues in conjunction with a political economic view of public health in India, public health research requires strategic planning, investment, and resource support. Sometime, even when technical knowledge is available, political commitment, managerial competencies, and incentives for changing behaviour within health systems are often lacking. To achieve this, there is also a need for an enabling environment in terms of vision, capacity building, trainings and workshops and other measures of incentives to make research a career pathway.

To demonstrate this argument further, let me illustrate and highlight the role of Social Workers in public health.

Role of Social Workers in public health in India

Given the current levels of political zeal and the economic prospects of healthcare in the country, the role of social workers for the realisation of a comprehensive preventative and curative healthcare, in line with UHC commitment to health for all, becomes all the more relevant. While

the shortage and regional imbalance of physicians is a widely publicised issue, the same cannot be said about the lack of social worker presence in healthcare in India. Due to an excessive focus on the demand for doctors and nurses in India, the importance of social worker in healthcare in India is grossly undermined, both in policy and in practice. Both the political and economic dispensation in India focus disproportionately on the clinical vis-à-vis psycho-social intervention by calling for more doctors and nurses to resolve the public health crisis when it is actually the social workers who are indispensable for an efficient public health.

Doctors and nurses are required too, but as 'social physicians', who, in the words of 1946 Bhore committee report, needs to undergo a 3-months training in preventative and social medicine during medical education. Sadly, the very purpose and focus of this training had long been lost amidst commercialisation of health care. Hence, merely increasing the numbers of doctors in the hospitals might not yield into any productive gains, without the involvement of social workers given illness is rooted and embedded in social and cultural contexts. Social workers are also considered as crucial for breaking the paternalistic relationship between a doctor and his/her patient. It is well established that patients in a healthcare setting often experience personality and social environment challenges while responding to their disease. A social worker has knowledge and experience that can be used to reduce, and even prevent, negative social and psychological consequences of a disease, particularly those which can invite social ostracism, stigma and taboo such as HIV/AIDS, leprosy, TB, mental illness, and a host of other diseases. Apart from hospitals, they are also required in drug rehabilitation centres, old age and nursing homes, community health centres and mental health clinics. Their role often stretches beyond care, assessment and counselling to include advocacy and financial and legal assistance of the patients. More importantly, they are equipped to deal with social and emotional components of illness, in both rural and urban settings. They are trained to deal with patients who may experience social isolation as a result of loss of family and friend's support, relationship break up, or even financial stress. On the emotional front, they can help fight stigma, abuse, depression, memory loss, and self-devaluation. It is well worth recalling that the need and involvement of social workers for an efficient public health again dates back to the recommendation of Bhore committee report in 1946, which observed: "if the nation's health is to be built, health programme should be developed on a foundation of preventative health work and that such activities should proceed side by side with those concerned with the treatment of patients". Not surprisingly then, the first trained social worker in health care was appointed in

1946, in J.J Hospital, (then) Bombay, soon after by Lady Irwin Hospital in Delhi in 1950. Other hospitals slowly joined the fray, and later the state health service began to appoint them. Beginning with hospitals, social worker in healthcare has now spread all over the country, in clinics, in rehabilitation centres, in research institutes and very much part and parcel of community health programmes in India. Today, they form a growing body of professionals and can be seen working as patient navigators, counsellors, and therapists in medical settings.

The contribution of social workers working in a clinical setting is particular invaluable and unique, with regard to working with patients who are diagnosed with disease that require behavioural change. The rise of lifestyle linked diseases in India such as diabetes, cancer and other non-communicable diseases requires the increased role and participation by the social workers. They can fill the gap in creating awareness including early detection and speedy treatment, which is reportedly currently creating havoc both in terms of the treatment costs and the increasing deaths. In the wake of high hospitalisation costs and the lack of citizenry's trust in public healthcare, social workers can be brought in to restore faith and the missing link between patients and hospitals in such cases. To further highlight the role of social workers in disease prevention and rehabilitation, let us take the example of drug addiction. Substance abuse through illicit drugs and alcohol is a growing public health issue, in which a clinical intervention will amount to only a half-baked cake if done without taking a social worker onboard. No amount of medication and surgery can do good to a drug addict, except a social worker, who begins treating the patient with a comprehensive assessment, followed by counselling and education through collective/individual outreach. For drug de-addiction, social workers are regarded as the ultimate doctor in the development, administration and treatment of a drug addiction therapy. They are also increasingly involved in addition research and policy processes, albeit at a fragmented level.

Finally, I would like to close my article by highlighting an escalating challenge for public health in India and the contingent role of the social workers – namely mental health that seem to be dwarfing problems of physical health in India. Mental health disorder remains grossly under-reported due to prevailing stigmas and taboos around it, and yet affect 13% of the global population (data as of 2017). According to a survey in 2016, conducted by National Institute of Mental Health and Neurosciences (NIMHANS), about 14% of India's population suffers from some form of mental illness. Most people in India either do not have accessible mental health services or they are simply not affordable for them. Recognising the issue, a National Mental

Healthcare Act was passed in 2017, which ironically puts aside the social determinants of health, in a zeal to embrace the biomedical mode of mental healthcare. Mental illness in India is closely linked with poverty and feelings of relative deprivation, exclusion and isolation in the community. There are a very few psychiatrists available in India, and even much lesser psychologists. The challenges of growing mental health crisis rightfully call for the participation of social workers at large. It is well understood that tackling mental illness requires holistic psycho-social treatment skills under a proper rehabilitation programme, which social workers working in close coordination with psychiatrists and psychologists – rather than physicians – can effectively offer.