PROBLEMS OF PRESENT HEALTH SYSTEMS AND ALTERNATIVES

HEALTH SYSTEMS: HISTORY & DEVELOPMENT

Vedic Periods to Colonial Phase:

Records of Health writings and Health care in India date back to over 5000 years. Some significant aspects of these are:

1) The concepts and technology of sanitation in the Indus Valley (3000 B.C.)
2) The evolving of formalized health care systems like Ayurveda, Yoga, Siddha, Unani, etc.
3) The concepts and practice of vaccination and plastic surgery (600 B.C.)
4) The development of Social Medicine and Hospitals for humans and animals during the Ashoka / Maurya Phase (279 – 236 B.C)

EACH CULTURE HAS CATERED TO ITS LIFE-STYLE AND PATTERNS OF ILLNESS WITH AN INDIGENOUS RESPONSE. WITH A FEW EVOLVING INTO FORMALISED SYSTEMS.

Eg : Ayurveda / Siddha / Unani

COLONIAL PHASE:

In the 16th century, the Portuguese first introduced Western Medicine into Goa. The British colonial phase saw its spread and adoption all over the country. It was aimed at serving the rulers and the elite of the developing towns and cities.

The rural areas were generally neglected and continued dependence on indigenous systems. The positive aspects were, because of the Public Health Revolution in Europe during mid nineteenth century affecting the process in India. They include

- Public Health concepts in tackling epidemics and other forms of disease prevention.
- Focus on women and children by the Missionary sector, and
- Training of local people as health professionals, after initial hesitation.

BHORE COMMITTEE / SOKHEY REPORT:

The Health and Development Committee during 1943 – 46 drew up a comprehensive blue – print for Health Services for India. The Sohkey report of the Indian National Congress was a fore – runner to the new vision of Health / Health care in India.

Some highlights of the Bhore Committee recommendations were –

- Health should be an integral part of socio-economic development;
- Adequate and Free Health care for all.
- Reach out to vast rural population and correct rural – urban imbalance.
- Emphasis on prevention, promotion and education.
- Health as an individual’s responsibility

In retrospect some flaws in this expert prescription were:

- Unrealistic targets
- Vague budget allocations and distribution
- Complete by-pass of the indigenous systems
- Abolishing of licentiate doctors training.

THE BHORE REPORT BUILT THE FRAMEWORK AND REMAINED THE INSPIRATION FOR MUCH OF THE POST-INDEPENDENT HEALTH PLANNING IN INDIA.

POST – INDEPENDENT INDIA

The Constitution of India adopted in 1950 clearly recognizes the Government’s responsibility for the health of all people.

This commitment led to the evolution of a large number of health programs. They include

- The means of develop the above in terms of Research, Training, Technology development institutions
- Establishment of PHC’s (Primary Health Centres) since 1952 for every one lakh population (now 30,000)

These are the mainstay of Health Services.

- Clear emphasis on population control since mid 1960’s
- Launching of sanitation and drinking water supply programs from the 5th five year plan.
- Launching of Integrated Child Development Services (ICDS) program for pregnant and lactating mothers and pre-school children in 1975.
- Launching of a package of minimum needs programs from early 1980’s

CONSTITUTIONAL PLEDGES

The state shall regard the raising of the level of nutrition and standard of living of its people and the improvement of Public Health as among its Primary duties.

It shall ensure
- that the health and strength of workers, men and women and the tender age of children are not abused……
- that children are given opportunities and facilities to develop in a healthy manner……
It shall make

- provisions for securing just and human conditions of work and maternity relief…..
- for public assistance in cases of unemployment old age, sickness and disablement and in other cases of underserved want.

- Constitution of India

ACHIEVEMENTS & FAILURES:

A study group of ICMR and ICSSR in 1984 listed these out as

Achievements:

- Life expectancy doubled
- Health care services expanded
- Manpower training centres increased
- Small – pox eradicated
- Plague, Cholera and Malaria controlled
- MCH and Immunization programs increased
- Largest Family Planning program in the World.

Failures:

- Health not integrated with Development
- Little dent on Malnutrition and Environmental Sanitation
- Morbidity patterns not materially changed
- Health Education neglected
- TB, Leprosy, Filaria yet to be controlled
- Infant and maternal mortality rates still very high
- Population stabilization – a long way to go.

Overall:

1) The model of health care was out-dated and counter-productive beneficial and rich and well to do upper and middle classes.
2) Health was a low priority national investment.

Many other expert committee reports and policy statements of the seventies began to make criticism observations about the inadequacies of the health care model and exhorted all concerned to search for more relevant alternatives and approaches.

India was a signatory to the Alma Ata declaration in 1978 where member countries of the WHO agreed on the Primary Health Care Strategy,

- Which sees people as active partners
- Is most suited to answer their needs and
- Can provide the basis for Health for All.
The National Health Policy of 1981 takes into account all of our country’s health needs and lays down guidelines to meet them.

The ICMR / ICSSR report is after all these!

**The Situation Today:**

1) There is a dramatic decline in death rates, through skewed in favour of the urban people.
2) A status of health comparable to the best in the world in some states, while many are lumped with the worst in the world.
3) The female still dies more frequently in childhood and the child-bearing ages.
4) The sharp differences cited above directly linked with the percentage of people living below the poverty line in both rural and urban areas.
5) A continuing morality due to communicable diseases like TB, Malaria, Filariasis, Diarrheal diseases, etc., addition to the list with Japanese encephalitis, Kala-azar, AIDS, Cancers and the latest being plague.

Despite a quantitative increase in the health care facilities, studies on the utilization of these services reported by various agencies reveal that

1) Only 6.3% deliveries are institutional, and only 18% births are attended by trained personnel.
2) Only 31% of the population utilizes the PHC Services, though 90% are aware of them. The reasons being –
   - 65% because services are poor.
   - 55% complain of distance.
3) There has been an incredible growth in the private sector. About 78% of doctors work in this sector – mainly in urban areas.
4) The Voluntary Sector (roughly 7,000 organizations) are working in health, they started with hospitals and institutionalized services and have pioneered many new approaches discussed later in Community Health. They are small in size and reach and involved in filling up critical gaps in health care depending on local needs.

**PROBLEMS**

The main problems with the present health care systems can be summarized as

a) Over-professionalization and mystification
b) Lack of flexibility to changing local needs
c) Inadequate and Ineffective decentralization
d) Passive participation of states in centrally sponsored ‘National’ programs
e) A lack of faith in the system from people and hence minimal participation
f) Inadequate Health Education.

These need to be understood in the context of the Indian situation, where
a) Diseases of poverty co-exist with those of affluence (the latter comes all resources)
b) The burden of Health Care is considered the exclusive responsibility of Health Care Systems
c) Yet, the production and availability of drugs is determined by the Ministry of Industries and Chemicals. We do not have a rational drug policy which enables production to meet needs.
d) There is an exclusive dependence on the Western Systems / models of Health Care.
e) The declining budget for health care is accepted due to other reasons / imperatives.

ALTERNATIVES:

What are the alternatives in such a situation? Since early 1970’s, many voluntary organizations have been successful in meeting local needs in various ways. Planners have been looking for “models” which can be up-scaled country wide, and find that it cannot be such a thing as a ‘model’. Yet underlying principles could be utilized.

A gradual recognition of the need for a social model of health has been the learning from numerous grass – roots efforts.

The paradigm shift needed from ‘Medical’ to the ‘Social’ model of health is enumerated below.

THE PARADIGM SHIFT

\[
\begin{array}{ccc}
\text{MEDICAL MODEL} & \quad & \text{SOCIAL MODEL} \\
\text{Individual} & \rightarrow & \text{Community} \\
\text{Disease} & \rightarrow & \text{Health} \\
\text{Providing} & \rightarrow & \text{Enabling} \\
\text{Drugs / Technology} & \rightarrow & \text{Knowledge / Social processes} \\
\text{Professional Control} & \rightarrow & \text{Demystification} \\
\end{array}
\]

A broad definition of Community Health emerging from this is

“Community Health is a process of enabling people to exercise collectively their responsibility to their own health and demand health as their right. It involves the increasing of the individual, family and community autonomy over health and over organizations, means opportunities, knowledge, skills and supportive structures that make health possible.

The Technological / Managerial components of the new paradigm include

a) Integration of Health with development
b) Education for health
c) Community Organisation and participation
d) Community support 0 finance / resources
The Critical issues / values of the new paradigm include

a) Community building efforts
b) Social analysis and conflict management
c) Individual / Community autonomy
d) Participatory / Team decision making
e) Demystification and skill transfer
f) Medical pluralism
g) Accountability / Socio – medical audit

These involve, apart from the above, confronting with realities, the medicalized health system to become

- more poor – people oriented
- more community oriented
- more socio – epidemiological oriented
- more democratic, and
- more accountable

As Dr. D. Banerji postulates, the development of health services in a country is on three – tiers, starting with

a) a socio – cultural process, then
b) a political process, and finally
c) a technological and managerial process with a socio – epidemiological perspective.

There is a lag between the phases (a) to (b) and (b) to (c). The task is to narrow if not totally eliminate tags that exist within the three tiers. Readymade solutions are not available, and the health services need to be built as we learn.

REFERENCES

1) In search of a diagnosis, m.f.c…. 1977.
3) Health Care in India, George Joseph et al, 1983
4) Under the lens – Health and Medicine, 1986
6) Health Status of the Indian People.
7) Park’s Text Book of Preventive and Social Medicine, 13th Edn., 1991.