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HEALTH CARE AND INCLUSIVE GROWTH

Dr. Surya Rao
Director, P.G. Courses & Research Centre,
D.N.R. College, Bhimavaram

Dr. P. Lakshmi Narayana
Department of Economics,
Andhra University, Visakhapatnam

From ancient times, health of people is regarded as their wealth. It is because a healthy person can whole heartedly contribute his best share to the national income. Hence, health hazards of individuals are to be regarded as not only individual loss, but also to be viewed as social loss. In other words, ill health of individuals is to be regarded as not only costs of individuals, but also viewed as social costs. It is in this context, health care is to be regarded as an important ingredient, which needs attention and focus, so as to achieve growth and sustainable development.

Health care is identified as an important requirement of human beings next only to food, shelter and clothing. Health, according to constitution of WHO is "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". This health care can be considered as a matter of Human Rights. WHO also defined "health is a state of complete physical, mental, and social well-being and not merely an absence of disease or infirmity". In recent years it has been further elaborated to include "ability to lead a socially and economically productive life". However, health of individuals to a large extent depends on the health care delivery system which an economy affords to provide to its population.

As, it is a fact that poor health standards people not only affect the wealth of individuals, but also often come in the way of production and productivity aspects of work place causing fall in national income, government should pay attention for improvement in health care of public. Against this background, an attempt is made in this paper to focus on need for inclusion of health care in the process of economic growth. It is because; inclusive growth by its very definition implies an equitable allocation of resources with benefits accruing to every section of society. But the allocation of resources must be focused on the indented short and long terms benefits and economic linkages at large and not just equitable mathematically on some regional and population criteria.

Government Policy:

The Government of India's effort and concern relating to public health have been focused on Five Year Plans, on coordinated planning with states and on sponsoring major health programs. Government expenditures are jointly shared by the central and state governments. Goals and strategies are set through central-state government consultations of the Central Council of Health and Family Welfare. Central government efforts are administered by the Ministry of Health and Family Welfare, which provides both administrative and technical services and manages medical education. However,

until 1983, no explicit health policy was evolved by the Government. Thus, 'The National Health Policy 1983' was endorsed by the Parliament of India, so as to provide 'Health for All by 2000 AD'. However, in view of changed circumstances, the Government of India announced New National Health Policy 2002.

The main objective of The National Health Policy 2002 is to achieve an acceptable standard of health for population of the country. In order to achieve the objective, a road map was prepared by the Eleventh Five Plan and accordingly designed a comprehensive approach, so as to include improvement in individual health care, public health, sanitation, safe drinking water, access to food and knowledge of hygiene and feeding practices. Moreover, special attention was given to the health of marginal groups like adolescent girls, women, children, the older persons, disabled and tribal groups. Further, National Rural Health Mission (NRHM) was formally launched in 2005, so as to achieve improvements in the standards of public health care in rural areas by strengthening institutions and encouraging community participation.

Inequalities in Health Status:

Though improvement in various indicators are observed over time, yet inequalities between various states apart from area wise and gender wise are observed. Let us look at some health indicators.

Crude Birth Rate (CBR) as per Sample Registration System (SRS) at the national level has declined from 40.8 per 1000 population in 1951 to 22.8 per 1000 population by 2008. Among major States, by 2008, Uttar Pradesh recorded the highest crude birth rate 29.1 per 1000 population than the national average followed by Bihar (28.9), Madhya Pradesh (28.0), Rajasthan (27.5), Assam (23.9) and Haryana (23.0) in that order. Among smaller States/UTs, D&N Haveli experienced the highest crude birth rate 27.0 per 1000 population followed by Chhattisgarh (26.1), Jharkhand (25.8) and Meghalaya (25.2) in that order. However, among major States the lowest birth rate was recorded in the state of Kerala (14.6), while Tripura recorded the lowest birth rate 15.4 during 2008 among smaller States/UTs. Moreover, CBR is found to be 24.4 per 1000 population during 2008 in rural areas, while the same is 18.5 per 1000 population in urban areas.[1]

Crude Death Rate (CDR) as per SRS, at the national level declined from 25 per 1000 population in 1951 to 7.4 per 1000 population by 2008. Among states by 2008, Orissa recorded the highest CDR 9.0 per 1000 population than the national average followed by Assam and Madhya Pradesh (8.6), Uttar Pradesh (8.4), Chhattisgarh (8.1) and Bihar (7.3) in that order. At the same time, among the smaller states and UTs, Meghalaya (25.2) & Puducherry (16.4) have recorded the highest CDR than the national average. CDR is noticed to be 8 per 1000 population in respect of rural areas, while the same is seen to be 5.9 per 1000 population in urban areas.[2]

Infant Mortality Rate (IMR) at the national level declined from 146 per 1000 live births in 1951 to 53 per 1000 live births as per SRS 2008. The State of Madhya Pradesh experienced the highest IMR 70 per 1000 live births than the national average, followed by Orissa (69), Uttar Pradesh (67), Assam 64, Rajasthan (63), Chhattisgarh

(57) and Bihar (56) in that order. The state of Kerala has the lowest IMR at 12 followed by Tamil Nadu (31), Maharashtra (33) and West Bengal and Delhi (35) in that order. Rural IMR is found to 58 per 1000 live births, while the same for urban areas noticed to be 36 per 1000 live births. Sex wise details of IMR recorded the rates of 52 and 55per 1000 live births respectively for males and females.[3]

As per SRS estimates, the Child Mortality Rate has come down from 57.3 per 1000 children in 1972 to 15.2 per 1000 children by 2008. The Child Mortality Rate has been recorded the highest in Madhya Pradesh 22.6 followed by Uttar Pradesh (21.6), Assam (21.4), Orissa (19.5), Rajasthan (18.8), Chhattisgarh (17.1) and Bihar (16.3) in that order. Child Mortality Rate is the lowest in Jammu & Kashmir 1.6 per 1000 children followed by Kerala (2.4), Tamilnadu (7.3) in that order.[4]

As per the NFHS – 3, Thirty-nine percent of deliveries took place under the care of a doctor or ANM, while the rest took place at home without proper health facilities. Overall, girls and boys are about equally likely to be undernourished. Under nutrition is substantially higher in rural areas than in urban areas. 33 percent of children are underweight. Inadequate nutrition is a problem throughout India, but under nutrition is most pronounced in Madhya Pradesh, Bihar, and Jharkhand. Almost 7 in 10 children age 6-59 months are anaemic, including 40 percent who are moderately anaemic and 3 percent who are severely anaemic. Anaemia is very common in India. The only states in which less than half of children are anaemic are Goa (38 percent), Manipur (41 percent), Mizoram (44 percent), and Kerala (45 percent). Anaemia is a major health problem for adults affecting 55 percent of women and 24 percent of men.[5]

Similarly, safe delivery rate of pregnant women is observed to be 56 per cent in Andhra Pradesh, 96 per cent Kerala, 80 per cent in Tamilnadu and 62 per cent Karnataka, while preventive disease vaccination rate is found to be only 72 per cent in Andhra Pradesh as against that of Kerala (91 per cent), Tamilnadu (92 per cent) and Karnataka (81 per cent).[6]

Nationally, 34 percent of men age 15-49 have a BMI below18.5, and more than half of these men are moderately to severely under nourished. The highest proportion of undernourished men, two in five, is in Madhya Pradesh and Rajasthan. The proportion of women who are undernourished is highest in Bihar (45 percent), Chhattisgarh (43 percent), Madhya Pradesh (42 percent), and Orissa (41 percent). It is lowest in Sikkim (11 percent) and Mizoram (14 percent).[7]

According to self reports, over two percent of women and men age 35-49 are suffering from diabetes. By age 50-54, over five percent of men are suffering from diabetes. Less than two percent of adults suffer from asthma (1,600 persons per 100,000).[8]

In India, about 1.5 million cases of Tuberculosis cases identified and more than 300000 deaths occur every year Between NFHS 1 and NFHS 2 and the prevalence has increased from 467 per lakh population to 544. Unfortunately, prevalence among working age adults (15-59) is even higher as 675. About 2 million cases of malaria are recorded all over India every year with seasonal high incidence and local failures of

control. About 2.3 million people in India are living with HIV/AIDS, of which an estimated 39 per cent are females and 3.5 per cent are children.[10]

Health Infrastructure Inequalities:

As per provisions of Indian constitution, health care by public sector is a shared responsibility between the Centre & States. In rural areas, primary health care services are provided through 3-tier public health infrastructure comprising of 1,46,036 Sub-Centres, 23,458 Primary Health Centres (PHC) and 4,276 Community Health Centres (CHC) as on March 2008.[11] In urban areas, there are 33,855 dispensaries and hospitals with 15,72,363 nursing personnel and 84,852 doctors.[12] Moreover, for every district one Mobile Medical Unit has been provided with the objective to take health care to the door step of the public in the rural areas, especially in under-served areas. So far, 1031 Mobile Medical Units are operating in different States. Selection of 7,49,440 Accredited Social Health Activists (ASHAs) have been done in the entire country and were given orientation training and positioned in villages. 5.20 lakhs ASHAs have been provided with drug kit. Further, 11,084 Doctors and Specialist, 46,690 ANMs, 26,793 Staff Nurses, 14,490 Paramedics have been appointed on contract by states.[13] Further, hospital bed per number of persons in rural areas is fifteen times lower than that for urban areas. Similarly doctor per number of persons in rural areas is almost six times lower than that in the urban population.

Health Expenditure Inequalities:

Central government Expenditure on health as percentage of GDP varied between 1.16 per cent to 1.45 per cent during 2004 – 10, while health expenditure as percentage of total expenditure in various budgets during the same period varied between 4.3 per cent to 4.8 per cent.[14] Per capita expenditure on public health is seven times lower in rural areas, compared to government health spending for urban areas. Only 17 per cent of all health expenditure in the country is borne by the state, and 83 per cent borne by the people. This makes the Indian public health system grossly inadequate and under-funded. Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia)[15]. Per capita expenditure of government on public health is seven times lower in rural areas compared to that for urban areas.

Conclusion:

Despite the health infrastructure build up by the government, still there exists wide spread inequalities in the health care as the whole administrative set up may appear large but most of the health care facilities are under staffed, and understaffing is most prominent in the rural health care sector. Nearly two-thirds of all households (65 percent) in India generally seek health care from the private medical sector, while one-third of households use the public medical sector. Forty-six percent of urban households and 36 percent of rural households go to a private doctor or private clinic for health care. 15 % of Indian population do not have access to health care due to reasons of unavailability or due to economic reasons. Expansion of health care in India has been mostly urban oriented when major part of population lives in rural or

semi-urban locations. Mushrooming of private hospitals in India has been in the urban areas and common people may not afford to bear the health costs. Poor housing conditions, exposure to excessive heat or cold, diseases, air, soil and water pollution along with industrial and commercial occupational risks, exacerbate the already high environmental health risks for the urban poor. Lack of safety nets and social support systems, such as health insurance, as well as lack of property rights and tenure, further contribute to the health vulnerability of the urban poor.

Despite the emergence of a number of health insurance programmes and health schemes, only 5 percent of households report that any household member is covered by any kind of health insurance. Further, Insurance system may not suit Indian conditions since a very large section of rural population would not be able to afford it, and the governments (central or state) may not find the required budget.

There are gender bias, economic bias, status bias, and bias of availability of funds within the health care delivery in India. There are differences in the accessibility of resources. To remove the socio-economic bias rural health care systems will have to be strengthened. It is quite often happen that a doctor posted in rural area is reluctant to join and somehow manage to get transferred to nearby towns. In fact government of Andhra Pradesh announced weightage in PG seats for rural service, yet there is no expected response from doctors. Such problems can only be solved by providing infrastructure in villages through improving connectivity, security and facilities. Steps should be initiated to remove gender bias through creating awareness among people not to show any discrimination between a male and female particularly with regard to nourishment, health, education. Funds for health care will have to be made available to the urban and rural sector on equitable basis. Even the resources of the society will have to be spent in an equitable manner between the rich and poor.

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