

## Introduction

**G**ood health is universally acknowledged to be of intrinsic value and therefore constitutes an integral element of development. One can be rich but sick enough to not enjoy any opportunities that wealth opens up, and poor health may translate into worsening economic opportunities as well. In fact, one can also be healthy but too poor to pursue valued objectives.

A new awareness of the multidimensional nature of development as a process much broader than economic growth and with health as a crucial ingredient, emerged with the Human Development Index, the Gender Development Index and the Human Poverty Index by the United Nations Development Programme. With the introduction of indicators to evaluate and rank countries on the basis of achievements that affect quality of life, reduce deprivation to basic necessities and gender equality, governments have been forced to redefine development. The annual publication of these indices and the associated discussions around them have, over the years, contributed to the increasing acceptance of the idea that development ought to be viewed in terms of the extent to which individuals are able to live in the manner they find fulfilling.

These ideas have profound implications for countries such as India and Africa which have large populations fighting for mere survival. For them the choices of enjoying basic freedoms that are so routinely guaranteed to people living in developed countries are dependent on the more fundamental issue of 'if alive'. With millions dying prematurely due to the non-availability or unaffordability, or both, of medical attention, it is only reasonable that the focus of development should be on matters related to providing universal access to health and its determinants such as water, sanitation, nutrition, primary education, communication and employment. Macroeconomic environments that pursue such compatible policies view health as central to development, a vital public good, and a basic human right.

### India's achievements and the unfinished agendas

Improvements in socioeconomic conditions during the last five decades yielded India successes she can take pride in – doubling of longevity from 32 in 1947 to 66; the fall of IMR by over 70% points between 1947-1990; containment of malaria at 20 lakh cases; eradication of small pox and guineaworm and the near certainty of the elimination of leprosy and polio in the next few years; averting over five hundred thousand deaths in the last five years due to the upscaling of DOTS and reducing every year an estimated 9% deaths due to TB. And the technical proficiency of Indian doctors and professionals to perform sophisticated procedures and deliver services of comparable quality as available in the most advanced countries at a fraction of the cost.

However, these achievements, remarkable though they may be, cannot mask India's failure to arrest the unacceptably high levels of morbidity and mortality, particularly due to communicable and infectious diseases. The 1990s saw the stagnation of the levels of malnutrition, infant and maternal mortality. Despite India's widely acknowledged intellectual prowess, an inherent capability to adapt and innovate, and a relatively well performing economy, the record on ensuring good health to its citizens' has been below its potential. The decline in public investment in health, the unpredictability of illness and the absence of any form of social insurance have increased vulnerability, heightening insecurities and a sense of powerlessness, particularly among

those too poor to afford private treatment and too dependent on the breadwinners to neglect their need for treatment, no matter the costs. The not so poor households live on the brink – ever vulnerable to having their life's savings and assets being irreversibly eroded. It is estimated that hospitalization expenditures result in the impoverishment of 330 lakh persons annually, with adverse consequences on the future well being of their children as well. Clearly, if India, like China, is to reap the benefits of a demographic dividend and become an economic powerhouse in 2030, it will have to ensure that people are healthy, live long, produce wealth and shake off the tag of a 'high risk country'.

As can be seen from the Table A, under every indicator India's performance has been low. Even more telling is the fact that similarly placed countries, in terms of historical legacy or economic pressures, like Bangladesh, Sri Lanka and Nepal have better health indicators. Against India's IMR of 68 per 1000 live-births, Bangladesh is 66, Nepal 64 and Sri Lanka 8. Again the Under-5 mortality rate is higher at 87 per 1000 live-births in India compared to Bangladesh's 69, Nepal's 82 and Sri Lanka's 15. Bangladesh and Sri Lanka have a longer life-expectancy at birth at 63 and 71 against 62 of India.

Although we account for 16.5% of the global population, we contribute to a fifth of the world's share of diseases; a third of the diarrhoeal diseases, TB, respiratory, and other infections and parasitic infestations, perinatal conditions, a quarter of maternal conditions, a fifth of nutritional deficiencies, diabetes, CVDs, and second largest number of HIV/AIDS cases after South Africa.

Within the country, there is a north-south divide and persistence of extreme inequalities and disparities both in terms of access to care as well as health outcomes. While Kerala's life-expectancy at birth is 74, MP is 56-indicating a 18-year gap. A few States and approximately a quarter of the districts account for 40% of the poor and over half of the malnourished, nearly two-thirds of malaria and kala-azar, leprosy, infant and maternal mortality – diseases that can be easily averted with access to low-cost public health interventions such as universal immunization services and timely treatment. These are also the States that have an acute crises of human and financial resources.

## Future direction to face the challenges of tomorrow

India faces a dual challenge. Even as it needs to contain and reduce prevalence levels of pre-transitional diseases, it is burdened with a growing increase of HIV/AIDS infections alongside the emergence of non-communicable diseases which are very expensive to treat, such as diabetes, vascular diseases, hypertension, mental health, cancers, injuries, respiratory infections, etc. Worse, there is increasing evidence that these 'lifestyle' diseases affect the poor due to low resilience to infections, poverty-induced malnutrition and stress. Coping with these set of new diseases along with the pre-transition diseases calls for reforms in India's health system. We need to address the demand for new skills such as counselling, psychiatry, trauma care, etc. We also need to reorganize the financial systems that provide incentives to providers and patients for adopting rational and cost-effective health practices based on core values of patient safety and adherence to ethical norms of conduct. Convincing scientific evidence at the global level demonstrates that appropriate interventions in the organizational and financial structures, holding income and growth constant, can improve health indices.

Given the fact that India has limited resources, we need to achieve higher returns on investments already made in health infrastructure. India will also need to focus on taking a quantum leap to utilize government resources for public information and dissemination of health messages, through compulsion or persuasion, sound dietary and life-style habits. Australia brought down accident rates by enforcing laws related to use of helmets and seat belts. Malaysia reduced cholesterol levels by substituting palm oil with soya. The US and other developed countries have resorted to extensive financial and legal instruments to deter people from smoking. Such actions help reduce overall morbidity and social costs. India cannot afford to have over 35 lakh people, with 50% from the productive age groups, die of heart diseases or provide treatment to 690 lakh cases of heart ailments or 200 lakh of HIV/AIDS cases in 2015. Investments on setting up the required health infrastructure for providing treatment will be clearly unaffordable and staggering. Therefore, these diseases have to be prevented by stepping up a multipronged effort. aimed

**Table A**

### India in comparison with other countries

Indicator	India	China	USA	Sri Lanka	Thailand
IMR/1000 live-births	68	<30	2	8	15
Under-5 mortality /1000 live-births	87	37	8	15	26
Fully Immunized (%)	67	84	93	99	94
Births by skilled attendants	43	97	99	97	99
Health expenditure as % of GDP	4.8	5.8	14.6	3.7	4.4
Government share of Total Expenditure (%)	21.3	33.7	44.9	48.7	69.7
Government health spending to total government spending (%)	4.4	10	23.1	6	17.1
Per capita spending in international dollars	96	261	5274	131	321

Source: WHR, 2005

at, for example, reducing unsafe sex, increasing awareness on diet and need for exercise, hygiene, reduced alcohol and tobacco consumption, promotion of yoga which is universally recognized to be the cheapest way of reducing stress, a range of chronic ailments and staying healthy. India will also have to expand the range and skill base of human resources – public health specialists such as epidemiologists, biostatisticians, entomologists, trained regulators, hospital managers and administrators, health economists, cost accountants, doctors, nurses, technicians, etc., to sustain a more modernized and professionalized health system. In fact under-funding apart, India's efforts to scale up interventions to achieve global commitments made at the Millennium Conference in 2000 to reduce infant and child mortality by two thirds; maternal mortality by three quarters; and reverse the spread of HIV/AIDS, TB and malaria by 2015, risk being unfulfilled due to lack of adequate human resources. India has an acute shortage of doctors at 59 per 100,000 population compared to nearly 200 in most developed countries; the shortage of nurses is even more acute.

Another area of concern is increasing R&D activity in the field of drug production and medical devices. To ensure self-sufficiency and security against the vagaries of market fluctuations, we need an increase in budgetary allocations for R&D. Our greatest strength has been access to high-quality affordable drugs manufactured by a highly skilled local pharmaceutical industry. This advantage needs to be protected and adequately supported, possibly with public funding, to ensure that the best minds are engaged in finding solutions for diseases that affect a majority of the country's population and make us self-sufficient in getting access to basic drugs and vaccines.

Doing all the above and more requires adequate funding. India is one of the five countries in the world where public spending is lesser than 0.9% of GDP and one of the fifteen where households account for more than 80% of total health spending. The need to increase spending on health is well recognized. The Common Minimum Programme of the current Government has committed itself to raise public health spending to 2%-3% of GDP. Such an increase would be required for strengthening the regulatory aspects of governance, expand-

ing the scope and institutional capacity for intensive health education and dissemination of public information, disease surveillance and research. In addition, there is need to strengthen delivery of health services, decentralize systems for monitoring and oversight by involving civic bodies and establishing systems for ensuring accountability and providing financial risk protection.

These are challenging times. India can look forward to achieving a better quality of life for its people by taking advantage of the heightened level of interest among the wider global community to engage in global health issues and the rapid technological advances. The ease and fluidity with which people and disease are able to cross national boundaries make all nations vulnerable to microbial infections as witnessed in the SARS and avian flu epidemics that adversely impacted China and Southeast Asian countries. This calls for strengthening our public health vigilance and developing a measure of self-reliance in matters of access to essential drugs and vaccines.

In conclusion, it is clear that the need of the hour is for reorganizing and increasing investment in health and related sectors. Current government expenditures could be made more efficient by restructuring the financing and organizational systems to get over the pre-transition diseases and also to develop the capacity to cope with the huge epidemic of non-communicable diseases which are more expensive to treat; and address the key barriers – human resources and institutional capacity to achieve higher levels of access, efficiency and quality. The foundation for such a strategy will, however, need to be based on three principles: basic values of equity, compassion for the suffering and an unswerving focus on the poor and the underprivileged; a bold evaluation of what went wrong and why, preceding the formulation of future strategies; and finally, the recognition of the centrality of health to poverty alleviation and overall economic development.

The Commission Report attempts to undertake such a process of critical enquiry and provide some options for future action over the short, and medium- and long-term so that the universal aspiration of all Indians to have access to an equitable, efficient and quality health system is realized by 2025.