Editorial

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Global Health Challenges: The Indian Conundrum

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Introduction

The huge disease burden and vast health inequalities and given that one in six person in the world is an Indian on the one hand, and the country's recent economic rise and its intellectual capital in-country and also overseas on the other hand, has created the Indian conundrum for global health challenges. India is now both: the problem – as it contributes to the challenges, and the solution – if it can mobilise its resources. This short paper will expand on the theme and especially explore how the Indian Diaspora in the UK can help to ensure good health and affordable health care to the needy.

The problem: Global health challenges

The World Health Organisation (WHO) has established the ten facts on the global disease burden (Table) [1] and its 2008 report: Primary Care: Now More than Ever [2] has identified the five global challenges in ensuring health care (Box).

As would be expected the situation in India confirms these facts and challenges.

TABLE : FACTS ON THE GLOBAL BURDEN OF DISEASE (Source: www.who.int)
1. Around 10 million children under the age of one year die each year
2. Cardiovascular diseases are the leading cause of death worldwide
3. HIV/AIDS is the leading cause of adult deaths in Africa
4. Population ageing is contributing to rise in cancer and heart disease
5. Lung cancer is most common cause of deaths from cancer in the world
6. Complications of pregnancy account for 15% of deaths in women of reproductive age worldwide
7. Mental disorders such as depression are among the leading causes of disability worldwide
8. Hearing loss, vision problems and mental disorders are the most common causes of disability worldwide
9. Road traffic injuries are projected to rise from the ninth leading cause of death worldwide in 2004 to fifth in 2030
10. Under-nutrition is the underlying cause of death for at least 30% of children under five years of age

BOX: FIVE COMMON SHORTCOMINGS OF HEALTH-CARE DELIVERY (Source: WHO Report 2008)

Inverse care. People with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least. Public spending on health services most often benefits the rich more than the poor in high- and low income countries alike.

Impoverishing care. Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. Over 100 million people annually fall into poverty because they have to pay for health care.

Fragmented and fragmenting care. The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced, while development aid often adds to the fragmentation.

Unsafe care. Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health.

Misdirected care. Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health.

As would be expected the situation in India confirms these facts and challenges. There is a lot of health information for India in the public domain [1,3] although the nature and detail could be improved. Like in many other developing countries the life expectancy has increased and although improved health has led to further economic welfare in India, the country is currently experiencing the triple whammy of the disease burden due to communicable (CD) and non-communicable (NCD) diseases and injuries. Communicable diseases account for about 38% of the

disease burden – not only are the 'traditional' CDs like malaria rife, the country has seen a big increase in new infections like HIV/AIDS. NCDs including diabetes, heart disease and cancers account for 53% percent of all deaths in the age group 30-59 years in 2005. It is projected that by 2015, 59% of the total deaths in India would be due to NCDs. With 47% of men and 15% of women being regular consumers, tobacco remains the single biggest preventable risk factor. Whilst the developed world is seeing a reduction in deaths due to road traffic accidents, these injuries are projects to rise by nearly 150% in SE Asia region including India.

This health picture is compounded by the lower human development, largely due to poverty – a situation that has not been addressed despite recent economic successes, as bemoaned by Amartya Sen [4]: "Yet even a hundred Bangalores and Hyderabads will not on their own solve India's tenacious poverty and deep seated inequality. The very poor in India get a small- and basically indirect-share of the cake that information technology and related developments generate. The removal of poverty, particularly of existing poverty, calls for more participatory growth on a wide basis, which is not easy to achieve across the barriers of illiteracy, ill-health, uncompleted land reforms and other sources of severe societal inequality. The process of economic advancement cannot be divorced from the cultivation and enhancement of social opportunities over a broad front".

India's health sector is diverse and includes not just modern medicine but also a range of traditional systems like Homeopathy, Ayurveda and Unani. The overall governmental expenditure on health has been rather low (0.9% of GDP, whilst the total expenditure is about 5%), with 75% of it being borne by patients and, over 90% of the latter being out of pocket due to a lack of organized insurance. Being sick has meant being bankrupt for a substantial number of rural poor Indians.

There is a burgeoning private sector that is driving the specialist end of the provision, with rather poor and often outdated primary care services. The cost of health care keeps going up with little or no assurance that services are appropriate or safe, and the regulatory mechanisms are few.

The bottom line in India is that good health happens by chance and good quality health care is a privilege and not a right.

The solution: Add value to planned developments in India

Although it may not seem like it, there is a comprehensive plan to develop national health policy and address some of the fundamental challenges, the following are some of the highlights stated by the Government [1,5]:

- "Commitment of the Government to increase public health share to at least 2% of GDP
- Efforts to develop regulatory frameworks and options for alternative financing mechanisms including insurance
- National Rural Health Mission and Reproductive & Child Health Programme. Integrated Management of Newborn and Childhood Illnesses (IMNCI) pre-service and home-based newborn care activities initiated. Multi-skilling of health providers for Emergency Medical Obstetric Care. Introduction of Accredited Social Health Activists (ASHAs). Increased attention to women's health in national Schemes
- Increased commitment to health system strengthening, use of capacities in other sectors, and effective partnerships. Enhanced nursing profile and increasing nursing autonomy in practice.
- Public health education, job descriptions and career paths under review; expanding efforts for multi-disciplinary and multi-sectoral approaches; establishment of the Public Health Foundation.
- Ongoing capacity building to deal with international agreements and strengthening of the World Trade Organization (WTO) cell in the Union Ministry of Health.
- Increased commitment and investments, and significant progress in the control and/or elimination of communicable diseases like yaws, leprosy, tuberculosis and several vaccine preventable diseases."

Overall, there is action at all levels: national, state, institutional and individual and across the range of necessary issues: policy, regulation, resourcing, provision and capacity building by both, public and private sectors. The two key questions for the Indian Diaspora, however, are:

a. Can we help accelerate these developments?
b. How can we ensure that these become sustainable?

There is no denying that many individuals from the UK have been, and continue to be, involved in various efforts back in India; be it fundraising, community development, school education or direct clinical provision. In addition, there are various organisations like BIDA, IMA and BAPIO who have potentially the infrastructure albeit their focus has largely been on activities within the UK. The UK Government has recognised its responsibility in supporting international efforts as part of the recent Health is Global Strategy [6], and this provides another timely opportunity. From both, philanthropic and business angles, it makes sense to create a robust Indo: UK collaboration around health and

education given common heritage and needs and opportunities on both sides. In addition to working on discrete areas like patient safety [7] or public health capacity building [8] an important first step would be to create a mechanism for regular dialogue in order to identify and progress priority projects of mutual interest.

Conclusions

India has come a long way since its independence and given its size and complexity continues to have ongoing challenges [9, 10,11]. It is essential to recognise that health is not a consumptive sector, but by creating healthy people, free from illnesses, can be a productive sector.

The basic message of this paper is that being a physician in India in the 21st century is both, a privilege – given the ancient history and traditions and recent economic successes, and a responsibility- given that despite being the world's largest democracy and an economic superpower there are vast health inequalities and lack of safe, affordable basic health care to a large proportion of the citizens in India.

At the time of writing this paper, there is intense debate about the NHS in the American press triggered by President Obama's attempts to reform US health care. No doubt whilst things could be better in the NHS, there is still a lot that the world, both developed and developing nations, can learn from the NHS [12, 13] . Indeed best practices, regardless of whether they come from US, UK or anywhere else could, and should, be adapted to support ongoing efforts in India.

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References

1. World Health Organisation. www.who.int and http://www.who.int/countries/ind/en/
2. The World Health Report 2008: Primary care: now more than ever. http://www.who.int/whr/2008/whr08_en.pdf
3. Raban MZ, Dandona R, Dandona L. Essential health information available for India in the public domain on the internet. BMC Public Health 2009; 9:208 (http://www.biomedcentral.com/1471-2458/9/208)
4. Sen A. The argumentative Indian: writings on Indian history, culture and identity. Allen Lane, an imprint of Penguin books, 2005 (ISBN 0-71399-687-0)
5. Ministry of Health and Family Welfare, India: www.mohfw.nic.in
6. Department of Health, UK. Health is global: a UK Government strategy 2008-13. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702
7. Indian Confederation for Health Care Accreditation www.ichapatientsafetycon.com
8. Heller RF, Chongsuvivatwong V, Hailegeorgios S, Dada J, Torun, P, Madhok R et al on behalf of the People's Open Access Education Initiative. Capacity building for public health: http://peoples-uni.org. WHO Bulletin 2007: 85 (12). (http://www.who.int/bulletin/volumes/85/12/07-044388/en/index.html)
9. Nilekani N. Imagining India: Ideas for the new century. Allen Lane, Penguin books, 2008 (ISBN: 9780670081967)
10. Guha R. India after Gandhi: The history of world's largest democracy. Pan books, 2007 (ISBN: 978-0-330-39611-0)
11. Roy A. The algebra of infinite justice. Flamingo, an imprint of HarperCollins 2002 (ISBN: 0 00 714949 2)
12. Madhok R. Crossing the quality chasm: lessons from the NHS in England. BUMC Proceedings 2002; 15: 77-83.
13. Madhok R. Implications of US Managed Care for the British NHS. J Managed Care 1999; 3; 93-99