Public health in private hands? A note on the Public Health Foundation of India

MOHAN RAO, K. R. NAYAR

We live in a world of profound, and growing, inequalities. Changes in the global economy over the past three decades have been accompanied by dramatic reversals of health gains made in the post-Second World War period. While some countries have witnessed stagnation in health indices, others have seen dramatic declines. At the same time, what is termed the health divide—between rich nations and poor nations, and between the rich and poor within countries—is increasing remarkably. Thus, for example, the gap in the under-5 death rate, considered a sensitive indicator of social and economic development, has widened between the rich countries and the poor. The under-5 death rate gap increased from a ratio of 7.8 in 1978 to 12.5 in 1998. Similarly, the death rate ratio in the age group 5–14 years also increased from 3.8 in 1950 to 7 in 1990.

It is widely accepted that these widening health inequalities are the consequence of the imposition of the World Bank and International Monetary Fund (IMF)-led policies of structural adjustment and the accompanying health sector reforms around the globe. Over the same period, the role of the WHO has shrunk, with the World Bank increasingly setting the agenda for health. World Bank loans for one disease alone, malaria, exceed the entire budget of the WHO.

In addition to reducing state commitment to health, typically, these health prescriptions of the World Bank are committed to methodological individualism and to behaviourism; they do not recognize the structural factors that govern and contour the health or ecology of disease. As a result, interventions tend to be disjointed (oral rehydration solution [ORS] for diarrhoea rather than emphasizing on water supply and sanitation; focusing on anaemia in pregnancy, but not anaemia in the general population), and of a technical nature—what is referred to as the biomedical approach in public health. This has led to the growth of disease-centric vertical programmes. Globally—and reflected even in India’s National Health Policy 2002—it is recognized that one of the failures of health sector development in the past has been due to such vertical programme approaches. Assuming there is a grave fiscal crisis—which still seems to allow for subsidies to be given to the rich in a variety of areas—these prescriptions typically include fee for services. Again, the global experience has been that this excludes the poor from access to health services. Indeed, even in the USA, data on life expectancy by race, a crude indicator of inequality, shows increasing divergence between whites and blacks beginning in the Reagan years. The most telling data are from the UK that reveal increasing mortality differentials by class. The Black Report showed a substantial increase in mortality differentials by social class; the mortality rates among unskilled working-class men in 1981 were higher than they had ever been in the twentieth century, deteriorating after 1971.

This is despite the fact that developed countries spend much more on health than India does, not only in absolute per capita terms but also as shares of national income or public budgets. The UK spends 6% of its budget on health, India now less than 1%. In contrast, the USA spends 12% of its budget on health. The UK relies on universal coverage and a state-supported and-led National Health Service. It has better health indices than the USA despite spending less on health. In the USA, for instance, about 40 million people obtain no health coverage. Infant mortality rates (IMRs) and under-5 mortality rates (USMR) are significantly higher than in the UK. This calls for rethinking of some neo-liberal shibboleths such as the supposed inefficiency of the public sector and the greater efficiency of market-driven private behaviour. Sri Lanka offers an excellent example of state-led quality healthcare provision. In Sri Lanka, about 97% of inpatient care and 83% of outpatient care is in the public sector, where they have also integrated the so-called indigenous systems of medicine.

India is yet to achieve the National Health Policy 1983 target of reducing the IMR to less than 60 per 1000 live births. More serious is the fact that the rate of decline in the IMR, which was significant in the 1970s and 1980s, has markedly decelerated in the 1990s. The percentage decline in IMR between 1971 and 1981 was 14.7; between 1981 and 1991 it was even greater at 27.3. However, in the period 1991–99, there has been a stagnation, with the rate of decline in the IMR at 10%. Similarly, while there has been a decline in the USMR, the pace of decline has come down and the USMR is currently hovering around 95. During 1971–81, the percentage decline was 20.6. The decline was much sharper during the 1980s, with a percentage decline of 35.7. However, during the 1990s, with the onset of policies of liberalization, the rate of decline fell to 15.1.
Other changes have been equally important. Interregional, rural—urban, gender and economic class differentials in access to healthcare in India are well documented. But since the onset of liberalization policies, these have widened considerably. The decline in public investments was matched by growing subsidies to the private sector in healthcare in a variety of ways. State support for private healthcare grew with the initiation of private—public partnerships that took a variety of forms. At the same time, there were far-reaching changes in drug policies. Thus India—earlier characterized by relatively low costs of drugs and pharmaceuticals, along with major indigenous production of drugs—has witnessed a greater concentration of drug production, a larger role for multinationals, a higher proportion of imported drugs and unbellevably steep rises in the costs of drugs.

Concurrently, marked shifts have occurred in healthcare utilization. Among people who sought outpatient services in 1995–96, more than 80% did so in the private sector, a sharp increase in even the poorer states of the country. In 1995–96, 55% and 57% of people in rural and urban areas, respectively, were hospitalized in the private sector compared to 40% in 1986–87. The National Sample Survey (NSS) data indicate greater inequality in the use of health facilities by economic class gradients. In rural areas the class gradient in inpatient use of public hospitals—which was insignificant in the mid-1980s—turned statistically significant in the mid-1990s. In urban areas, inequality in the use of public facilities did not worsen significantly, but inequality in the use of private facilities did. The steep fall in rural hospitalization rates, along with increasing use by the better-off indicates that the poor are being squeezed out. Fee-for-services is undoubtedly one important mechanism that has succeeded in doing this. In other words, World Bank policies on health, contained in the influential _World development report 1993_ succeeded in doing exactly the opposite of what was ostensibly its _raison d’être_: reduce the utilization of public services by the better-off to increase access to the poor.

Costs of both outpatient and inpatient care have increased sharply in both rural and urban areas, compared to the mid-1980s. Private outpatient costs increased by 142% as against 77% in the public sector in rural areas. In urban areas, private outpatient costs increased by 150% compared to 124% in the public sector. The increase in costs in inpatient care is even more striking: average costs rose by 436% in rural and 320% in urban areas. Thus, it is not surprising that, as the National Health Policy 2002 notes, medical expenditure has emerged as one of the leading causes of indebtedness. At the same time, the proportion of people not availing any type of medical care due to financial reasons between 1986–87 and 1995–96 increased from 10% to 21% in urban areas, and from 15% to 24% in rural areas.

What we need is state-led support to primary healthcare in all its dimensions. Efforts to do so through the National Rural Health Mission appear diminished in vision, and totally lack a systemic perspective. It is also seriously underfunded. Thus, the need is to concentrate on strengthening the entire primary healthcare (PHC) system—which includes efficient referral systems to secondary and tertiary levels of care. State governments are facing huge financial problems in doing so. There are massive shortages of human resources such as public health nurses, auxiliary nurse—midwives, male multipurpose workers, etc. not to mention specialists. This is especially the case in states with poor health indices. Given the low financial outlays, a large part of the health budget goes towards salaries. Without resources, time, support staff and drugs to provide effective public healthcare, doctors lose motivation and seek alternative work. In this situation the PHC system offers little other than family planning and oral polio vaccination, driving people, the poor included, into the private sector. In this situation of state-led collapse of the public health structure, community initiatives are both inadequate and regressive. Accredited social health activists (ASHAs) cannot function in a dysfunctional healthcare system. A further drain on public resources is through knee-jerk initiatives such as increasing public—private partnerships (PPP) or ‘NGOization’.

It is against this backdrop that the effort to create a Public Health Foundation of India (PHFI) needs to be critically examined. This is apparently an autonomous institution with 15% of funds from the government and the rest from other sources. State governments are expected to provide land and other infrastructure facilities. The PHFI will create 5 new institutions for training in public health, commencing initially with 2 schools. We understand that recruitment of faculty has already commenced in schools of public health in the USA (the last date for applications was 9 March 2006, as per a circular to Deans and Assistant Deans of schools of public health in the USA; the PHFI was inaugurated on 28 March 2006).

There are a number of issues with regard to the new-found love for world-class ‘India-centric, India-relevant and tailored to India’ public health. It is apparent that dual systems of healthcare will now extend to dual systems of training in public health. This includes possibly dual salary structures, leading to internal brain drain.

The question that needs to be seriously considered is the system of public health that is now being considered worthy of emulation. As we noted earlier, one model of healthcare that should not to be emulated is the American model. It is not only much more expensive, but also leaves out substantial sections of the population. Indeed, it would not be an exaggeration to state that the aim of the American system of public health is the creation of markets in healthcare. Under the influence of such a system, the global industry in health has increased from US$ 396 billion in 1976 to US$ 786 billion in 1990.

It is in this context that one should examine the role of the Harvard School of Public Health, indeed, the American system of public health schools, in shaping public health education and research in India and in many other developing countries, including China. Scholars such as Hugh Leavell, Benjamin Paul, John Gordon, Carl Taylor, Theodore Ingalls, James Simmons and John Wyon, collectively known as the ‘Harvard group’, were instrumental in shaping the population control agenda with a neo-Malthusian bias in the early 1960s. The damage this has caused to health sector development in India is well known. Their ethnocentrism was evident when one of their influential studies concluded: ‘Westerners have strong feelings about the value of children not shared by Punjabi villagers.’

However, perhaps more important is the shaping of the curriculum of Preventive and Social Medicine by scholars such as Carl Taylor who chaired the Department of Preventive and Social Medicine (PSM) of the Christian Medical College in Ludhiana. No doubt, at that time as well, the curriculum was India-relevant as it was based on the well-known ‘internship studies’ undertaken by the Harvard group. The approach was strikingly similar to colonial anthropology, that of studying the ‘natives’. A survey undertaken in 1959 of the teaching of PSM revealed that rural internship programmes were in serious trouble. It was found that rural health centres for training interns had evolved without proper planning. The major problems were inadequate staffing,
equipment and accommodation. There was widespread apathy among the internists regarding the purpose of the programme. Following this, a project on rural orientation of physicians was undertaken on a request from the Minister of Health, Government of India by the PSM Department of the Ludhiana Medical College under the leadership of Carl Taylor. The project was funded through a PL-480 grant from the Bureau of Educational and Cultural Affairs of the United States Department of State. The study reinforced the internship approach by expanding the practical training over 4 levels of facilities: teaching hospitals, average district hospitals, teaching health centres and average health centres, and suggested the philosophy of 'medical colleges without walls'. Despite such heavy foreign funding and American 'wheat' funding, the quality of public health teaching could not be salvaged.

The intervention of the Medical Council of India (MCI) and recommendations of the Srivastava Committee led to further shifts in the teaching of public health in medical colleges. The important shift was the introduction of the Reorientation of Medical Education (ROME) scheme in 1977. The objectives of the ROME scheme were to involve medical colleges in direct delivery of health services to the rural population as well as expose students to the rural environment. Some foreign governments even donated huge mobile clinics for rural areas under the programme, which of course did not serve the purpose since these large vans could not traverse narrow, unpaved rural roads. The ROME scheme was implemented initially in 25 medical colleges and was extended to all the medical colleges recognized by the MCI. It can now be safely asserted that the present poor state of PSM education in medical colleges in India and the failure to produce a 'managerial physician' could be attributed to the original sin committed in the 1950s. Further cosmetic changes did not succeed due to the poorly envisioned curriculum that continued to remain unattractive.

It is evident that without strengthening the existing public health teaching in medical colleges—there are 120 of them throughout the country at present—it will be impossible to create a 'managerial physician' who needs to provide effective leadership in the health services system. An elite-oriented public health education on such a large scale and in a vertical fashion may not achieve such an objective.

It appears that planners in India seek to bring back this variety of American-exported public health. Once famously described as a-theoretical, a-political and a-historical, this is now touted as a 'managerial physician' education in India as has been proposed through the PHFI? When such a public health orientation is no doubt that the duality in public health education will breed elitism and produce an unfit and unwanted class of professionals. What it will also do is produce public health staff for the First World, at a cheaper price. Currently 4000–5000 doctors trained at public expense emigrate every year, at an estimated cost of US$ 160 million to the Indian exchequer.9

It is also necessary to mention the role of private foundation funding in this whole process. For instance, the Bill and Melinda Gates Foundation is a major partner in PHFI. The 'grand challenges' proposed by the Gates Foundation have turned critical challenges in public health into a narrowly conceived understanding of health as the product of technical interventions divorced from the economic, social and epidemiological contexts.10 Six of the 14 grand challenges in public health relate to vaccine development. It is possible that such a narrow technology-driven vision of public health will be the paradigmatic basis of the grand new public health in future. Should such a public health orientation set standards and determine the accreditation of public health education in India as has been proposed through the PHFI? When the market starts dominating the discourse of public health, it will only undermine academic autonomy as is already the case in management education. Indeed, it will create a discipline based on the rules and games of the market including profits and student-customers who can buy such an education.

A further substantial part of the PHFI's budget is to come from unspecified private sector contributions. This is even more undesirable as it will distort public health priorities even further towards profitable interventions alone. Examples are legion of private sector funding skewing research agendas and findings. Thus, for instance, the ban on routine inclusion of antibiotics in animal feed in order to reduce antibiotic resistance in the general human population, effected in England after the outbreak of

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**Table I. Manpower requirement in rural primary healthcare institutions**

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirement 1991</th>
<th>In position 30 June 1996</th>
<th>Number sanctioned 1995</th>
<th>Posts needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialists at CHCs</td>
<td>22 348</td>
<td>2751</td>
<td>4763</td>
<td>17 585</td>
</tr>
<tr>
<td>Doctors at PHCs</td>
<td>22 349</td>
<td>26 930</td>
<td>32 074</td>
<td>0</td>
</tr>
<tr>
<td>BEE/Health educator</td>
<td>22 349</td>
<td>5621</td>
<td>6287</td>
<td>16 062</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>27 936</td>
<td>20 022</td>
<td>21 790</td>
<td>6146</td>
</tr>
<tr>
<td>Laboratory assistant</td>
<td>27 936</td>
<td>9711</td>
<td>12 371</td>
<td>15 565</td>
</tr>
<tr>
<td>X-ray technician/Radiographer</td>
<td>5587</td>
<td>1288</td>
<td>1596</td>
<td>3991</td>
</tr>
<tr>
<td>Nurse/Midwife</td>
<td>61 548</td>
<td>12 683</td>
<td>16 754</td>
<td>44 704</td>
</tr>
<tr>
<td>Health assistant (male)</td>
<td>22 349</td>
<td>15 745</td>
<td>18 323</td>
<td>40 26</td>
</tr>
<tr>
<td>Health assistant (female)</td>
<td>22 349</td>
<td>18 904</td>
<td>21 658</td>
<td>691</td>
</tr>
<tr>
<td>Health worker (male)</td>
<td>134 108</td>
<td>62 229</td>
<td>71 165</td>
<td>62 943</td>
</tr>
<tr>
<td>Health worker (female)</td>
<td>156 457</td>
<td>133 773</td>
<td>140 751</td>
<td>15 706</td>
</tr>
</tbody>
</table>

CHC: community health centre; PHC: primary health centre

bovine spongiform encephalitis (mad cow disease), has been bitterly contested by public health scientists in the USA on the basis of research funded by the animal foods industry.\textsuperscript{12}

It is not our argument that public health training does not need strengthening or that institutionalized education in this matter is not necessary. Both are very important. However, before we set up new institutions at great cost—whatever the source of funds—we must examine what ails the existing system. India already has institutions such as the National Institute of Health and Family Welfare, the National Tuberculosis Institute, the All India Institute of Hygiene and Public Health and so forth—some of which did remarkable public health work in the past. There are, however, problems with many of these institutions, such as lack of funds, lack of autonomy and so on, which need to be dealt with. Without doing so, to start new institutions is not only undesirable, but in a situation of fund constraint, also hugely wasteful economically.

ACKNOWLEDGEMENTS

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REFERENCES