



## **The Right to Health in India**

### **Stakeholder Report on India - Submission by World Vision India**

### **For Universal Periodic Review, Thirteenth Cycle, May 2012**

#### **A. Scope of International Obligations**

India is a state party to the Convention on the Rights of the Child, the Convention on Economic, Social and Cultural Rights, the Convention on the Elimination of Violence against Women and other international, regional agreements and national constitution enshrining the human right to health. The Government is to be commended for its efforts in striving to achieve the Millennium Development Goals by 2015. However, in order to do so, India must take greater steps to ensure health for its people.

In the India commitment to the Every Woman Every Child Strategy, it says, “India is spending over US \$ 3.5 billion each year on health services, with substantial expenditure on services aimed towards women’s and children’s health. Currently, India is focusing on strengthening its efforts in the 235 districts that account for nearly 70% of all infant and maternal deaths. Between now and 2015, India will provide technical assistance to other countries and share its experience, and will support the creation of a platform for global knowledge management to oversee the dissemination of best practices”<sup>1</sup>

#### **B. Constitutional & Legislative Framework**

The Country also guarantees right to health for all citizens as mentioned in the Article 47 of the Constitution. The National Policy for Children, 1974, the National Nutrition Policy, 1993, National Plan of Action 1995 provides enough policy frame work for the right to healthcare of children. The children and pregnant and lactating women of the country also have a legal entitlement to access the services of the Integrated Child Development Services Scheme (ICDS)<sup>2</sup>.

#### **C. Right to an adequate Standard of Living**

##### **1. Health Budget & Spending**

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<sup>1</sup> [http://www.who.int/pmnch/activities/jointactionplan/100922\\_commitments\\_v3.pdf](http://www.who.int/pmnch/activities/jointactionplan/100922_commitments_v3.pdf)

<sup>2</sup> ICDS is India’s response to the challenge of providing pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, on the other.

The World Health Organisation recommends that the State allocates 15% of its national budget to health. India's public spending on Health is among the lowest in the world. Though the Government committed to increase the health budget by 2-3% of Gross Domestic Product, the share of health in the total expenditure of the government is only 2.4% which is just around 1% of the country's Gross Domestic Product.

Low investment in Public Health care system encourages the growth in people seeking private care. The proportion of private spending on health in India is among the highest in the world is 72% in 2008 and a National Sample Survey Report, 2004 points out that 40% of hospitalized people are forced to borrow money or sell assets to cover expenses. The National Family Health Survey 3 also reinforced this when it stated that 60% of households in the lowest wealth quintile rely on private medical sector.

The low investment in public health is pushing many people below poverty lines as over 80% of medical expenses are borne through 'out-of-pocket' expenses in India.

However, many states have also failed to spend their health budgets due to poor governance and low absorption capacity. In the year 2008, the total unspent amount of central funding within the National Rural Health Mission Scheme within Uttar Pradesh (U5 mortality 96.4) was 42%, much of the money which could have saved the lives of children.

Inadequate funding combined with misappropriation of funds impacts negatively on delivery of health services, especially in rural areas. India is asking and receiving donor support from various countries, consortia and World Bank for supporting medical-technological research programmes and non communicable diseases, which are not in the national priorities. This has had a negative impact on health sector effectiveness. The Government of India must be supported to have more autonomy with respect to its national health spending, along with the development of increased mechanisms for accountability.

### **Recommendations:**

*The Government of India must increase to 6 percent of the national budget to the health sector, and increase the per capita expenditure by at least US \$ 1 every year. Without increasing financial resources, efforts to expand and improve health services will fail to make real change.*

*The Government of India must work with development partners to fund the Health Sector Strategic Plan in accordance with the Paris Declaration on Aid Effectiveness of 2005 and the International Health Partnerships, with an emphasis on strengthening the health sector without compromising progress in disease-specific interventions around HIV/AIDS, tuberculosis, and malaria.*

## **2. Human Resources for Health**

The Primary Health Care Infrastructure has three levels with the Sub Centre, Primary Health Centre and Community Health Centre. Progress of Sub Centres, which is the most peripheral contact point between the Primary Health Care System and the community, is a prerequisite for the overall progress of the entire system.

In rural areas, staffing shortages are reaching emergency levels though it must be acknowledged that the National Rural Health Mission has been trying to solve the crisis. According to the Bulletin on Rural Health Statistics close to 20% of Primary Health Centres are without a doctor!

According to a Government Report in 2008, there was a shortfall of 72.1% specialists at the Community Health Centres (CHCs) as compared to the requirement for existing Community Health Centres.

There are nine beds and six doctors per 10000 populations. In Bihar, there is one Government Hospital bed for more than 4000 patients. The Third Common Review Mission reports that in Madhya Pradesh, (U5 MR is 94.2) 196 out of 1155 Primary Health Centres are functioning without any doctors and in Uttar Pradesh the percentage shortfall at PHCs is 79% for Medical Officers.

Stripped of access to skilled medical providers, primary healthcare for rural poor is delivered largely by untrained, unlicensed and unregulated private medical practitioners who are often called as 'quacks'<sup>3</sup>.

However, from the service provider point of view, there are few incentives and motivating factors to work in rural areas. Faced with a short supply of drugs and lack of essential equipments, many doctors face big challenges to deliver healthcare.

#### **Recommendation:**

*The Government of India must continue to address human resource constraints and aim to achieve 4 health workers per 1000 population. Recruiting, adequately training and retaining sufficient numbers of health workers must be at the cornerstone of the priorities of the Ministry of Health, taking into consideration recommendations from the World Health Organization with particular respect to the retention of health workers in rural and hard-to-reach areas.*

### **3. Healthcare Infrastructure**

One of the key focuses of the National Rural Health Mission is to strengthen infrastructure in rural health facility and has developed Indian Public Health Standards to improve the quality.

However, a report by the Comptroller and Auditor General of India found the ratio of population to health centres remained low with the targeted number of new health centres not being established. Basic facilities (proper buildings, hygienic environment, electricity and water supply etc.) were still absent in many existing health centres with many Primary Health Centres and Community Health Centres being unable to provide guaranteed services such as inpatient services, operation theatres, labour rooms, pathological tests, X-ray facilities and emergency care etc

According to National Family Health Survey 3 , the most commonly cited reason for not using government services was poor quality of care (58%).

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<sup>3</sup> A series of FGDs conducted by World Vision India in 2010, in – communities in 7 states of India also revealed communities resorting to quackery

The lack of infrastructure is seen from the fact that the average population served per government hospital is 97,958 and average population served per bed is 2,105. The Mid Term Appraisal of the XI Five Year Plan also states poor infrastructure as the major reason for poor health services.

The National Health Policy aims at ensuring at all times availability and accessibility of adequate quantities of affordable, efficacious, safe and good quality essential medicines and health supplies to all. Availability of quality controlled medicines is also a factor affecting quality healthcare delivery. A Planning Commission review found in the states of UP, Bihar and Rajasthan, less than 30% of Community Health Centres and Primary Health Centres have adequate stock of drugs.

With absence of facilities, poor people resort to private health care or end up paying for medicines and incur high Out of Pocket expenditure and entering into a cycle of debt. Focus Group Discussions by World Vision India in 2010, spelt out clear cases on debt bondage due to Out of Pocket.

#### **Recommendations:**

*The continuous availability of medicines, health commodities, and equipment for patients and health workers alike is a critical factor in the prevention and treatment of disease in this country. The funds, infrastructure and capacity to manage drugs and supplies in health centers and hospitals throughout the country must be prioritized as a central component to all other Ministry of Health efforts.*

#### **4. Socio-economic inequities**

Inclusive Growth has been the goal of the Eleventh Five Year Plan (2007-12). However interstate variation and intrastate variation in health indicators are very high. A study by Baru et al (2010) has shown inequities in accessing health services among caste, class and region and states socio-economic inequities in terms of caste, class and gender and inequities pertaining to availability, utilization and affordability as factors responsible for persistent inequities. The report also quotes 'commercialization' also perpetuates inequities while accessing services.

The India Human Development Report 2011 notes that the most striking short coming of the public health system is the failure to reach out to the bottom of the pyramid, the 800 million poor who are often excluded. The health indicators among the poor, especially those belonging to Scheduled Caste / Scheduled Tribe communities, especially in less developed states are the worst. Several studies have also pointed out discriminatory practices towards Scheduled Caste / Scheduled Tribe patients of public health services. In the field study by World Vision, it was observed that children and women from the *Sahariya Tribes* of Madhya Pradesh and Rajasthan were not able to access health services entitled to them and their rights much violated. In Uttar Pradesh, pregnant lower caste women do not get admission in government hospital: there are cases where caste women have delivered babies in the hospital compound without any assistance from the doctors within due to practice of untouchability.

It should also be noted that states with poor health indicators like Bihar, Jharkhand, Madhya Pradesh, Orissa, Chhattisgarh and Andhra Pradesh also account for almost half of the country's Scheduled Tribe population and 37% of Scheduled Caste population.

However, states like Tamil Nadu and Kerala with similar social groups have shown that good governance and inclusion of people from lower caste can achieve good results.

### **Recommendations:**

*Public Health care services planning must take into consideration plans to address socio-economic inequalities, especially, caste based discrimination and structural inequities.*

*Community based planning and monitoring and genuine participation of people, especially women need to be strengthened to facilitate improved access and governance of healthcare services.*

### **References:**

<http://www.nfhsindia.org/nfhs3.html>

[http://planningcommission.nic.in/plans/mta/11th\\_mta/MTA.html](http://planningcommission.nic.in/plans/mta/11th_mta/MTA.html)

### **Country Context**

The population of India is 1.2 billion as per the Census of India 2010 and children constitute over 40% of the population. An estimated proportion of 80% of the population live in rural areas and poverty levels stand at 71% of the total population.

India faces and experiences persistent ill health and deaths among children below the age of five, with implications on the quality of life for the future generation. The current under-five mortality rate is 54 deaths per 1000 live birth as compared to the MDG target of reducing it by one third (18) per 1000 live births (MDG report 2009). Overall, 2.1 million children are dying each year in due to Malaria, diarrhea, pneumonia and malnutrition. The health index has not shown significant improvement between 1999 – 2000 and 2007-08. In a recently conducted Annual Health Survey by the Census of India 2010-11, nine poorest states of India namely, Rajasthan, Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Orissa, Madhya Pradesh, Chhattisgarh and Assam constituted:

- 48 percent of country's Population
- 59 percent of Births
- 70 percent of Infant Deaths
- 75 percent of Under 5 Deaths
- 62 percent of Maternal Deaths

### **1.2 World Vision India – a brief overview**

World Vision India is a Christian, relief development and advocacy organization dedicated to working with children, families and their communities to reach their full potential by tackling the causes of poverty and injustice. World Vision India has a presence in over 165 districts in 24 states of the country and works with 5300 communities and civil society partners to enable children realize their well being aspirations of;

- good health,
- education for life,
- care protection and participation
- With opportunities to experience God's love and their neighbors.

Child health is one of the sector areas of focus alongside primary education and livelihoods. In terms of program delivery World Vision India links:

- Programmatic work at the district, community and family levels to advocacy at National, regional & global level
- Bringing the voices of communities to policy discussions
- Mobilising communities to create the pressure for basic health care service
- Ensuring a continuity of demand and provision

## 2.1 Review of the MDG targets

As observed in the recent MDG report (2009), India is unlikely to meet the targets set specifically in relation to MDG 4 and 5. The target for MDG 4 is to reduce the under-five mortality rate from 54 to 18 per 1000 live births by 2015. Currently, the under-five mortality rate is high due to diarrhoea, malaria, pneumonia and malnutrition which account for a high proportion of the children's deaths. The target for MDG 5 is to reduce the maternal mortality ratio from 324 to 131 per 100,000 live births, by 2015.

However, the Infant Mortality Ratio is high at 50 per 1000 live births (2009), Under 5 Mortality Rate is 64 per 1000 live births (2009) and Maternal Mortality Ratio is 212 per 10000 births (2008). The Infant Mortality Ratio, U5MR and Maternal Mortality Ratio continue to remain high above the MDG targets.

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