Public health in India and the developing world: beyond medicine and primary healthcare

K S Jacob

Water, sanitation, housing, nutrition, education and employment as basic human rights

Despite many decades of independent planning and implementation, most populations living in the developing world have yet to reach the utopian ideal of health for all. This editorial critically considers the issues and the situation in India to suggest alternatives.

The survival of the human body is best explained by the materialist explanation that locates the variation in health and longevity to tangible resources.¹ The reciprocal relationship between poverty and disease had long been acknowledged by public health reformers² who advocated social reform on political, economic, humanitarian and scientific grounds.

Successive governments in India have come up with many schemes for the provision of safe water, sanitation, nutrition, vaccination coverage, education and employment. Despite the many attempts, millions of people do not have access to these basic needs,³ malnutrition is rampant in children⁴ and vaccination coverage is inadequate among the poor. Elementary education is substandard⁵ and unemployment widespread in rural areas. Despite increased budgetary support for such schemes, most states have pursued weak policies in this area and neglected the local governments, giving them a low stake in improving infrastructure. The enormity of the unfinished tasks is mind-boggling.

The context of public health in the developing world differs markedly from the social, economic and political environment in the West when public health became part of their culture and basic standard of life. The differences that need to be taken into account are as follows:

(1) *The antibiotic era:* The Western world completed its public health revolutions before the introduction of antibiotics and eliminated epidemics of infectious diseases through public health measures. The role of antibiotics in the prevention of diseases in

populations is negligible, and they worsen the situation by providing temporary relief to the suffering and allow the underlying causes for the epidemic to go untreated. The cycle and politics of cholera is an apt example.⁶

(2) *The illusions of curative medicine:* There is evidence that rates of tuberculosis in the West dropped long before the introduction of drugs for tuberculosis.⁷ The provision of adequate housing, the reduction of overcrowding and improved nutrition were the reasons for winning this war in the Western world. Sole reliance on the current curative approaches (eg DOTS (directly observed treatment, short course)) to problems that require long-term public health solutions will prove ineffective with the unchecked spread of infection.

(3) *The pharmaceutical industry challenge:* The pharmaceutical industry profits from disease and ill health. The straightforward concept of the oral rehydration solution, easily available in each household, introduced to prevent deaths, was taken over by the industry to net huge profits. The sale of the oral rehydration solution by the industry disempowered the population in managing diarrhoea using techniques easily available in every home.

(4) *Vaccinations as a panacea:* The elimination of small pox through vaccination was an outstanding example of disease prevention. However, not all infections follow similar patterns. The recent resurgence of polio in India is proof of this.⁸ The eradication of polio will surely also involve the provision of safe water and sanitation in order to prevent the spread of the virus. Similarly, the work on rota virus, Haemophilus influenza B and other vaccines being carried out in India pass into the hands of the

pharmaceutical industry and takes away from the task of providing basic public health needs for the community.

(5) *The medicalisation of public health:* Many inputs—engineering, political, economic, educational and religious, in addition to medical—were part of the effort in the West. The public health efforts in India are being based on the assumption that medicine has all the answers. The population control programme in India is an example. The programme has a solitary focus, a single solution—that is, women's fertility and sterilisation. It does not examine the complex interaction⁹ between livelihoods, social security, education, employment and infant mortality, but continues to view sterilisation of women as the only target.

The different context of the public health scene in India has resulted in errors in the approach and includes:

(1) *Using urgency-driven curative medical solutions instead of long-term public health policies:* Unsafe water and poor sanitation are such facts of life for the majority of Indians that they rarely come into consciousness. However, every epidemic of an infectious disease makes newspaper and television headlines. The government response is swift and curative. Alas, the media quickly moves on to the next crisis and the need for permanent public health solutions is forgotten. This is also true for the relationship between tuberculosis and housing or deaths due to starvation or chronic malnutrition and poor nutrition.

(2) *Mistaking primary care for public health:* Much of the efforts of the champions of public health end up in the provision of curative services, albeit at the small hospital, clinic or at the village level. A constant tension with the demand for better curative services, results in selective primary care, which ends up being diluted secondary or even tertiary care. They even thwart public health efforts by treating diseases and preventing death (and reducing their impact on society and on social consciousness), which should have been prevented in the first place using public health strategies.

(3) *Reducing public health to a biomedical perspective:* Public health requires the meeting of many disciplines to bring about the necessary revolution. Public health in India relies primarily on medicine to achieve its goals. The

recently launched National Rural Health Mission¹⁰ continues to focus and prioritise medical input and interventions. Public health issues, though mentioned, are clearly secondary.

The different scenario in India mandates a different framework and different solutions. The suggested alternatives include

- (1) *Social justice and the production of an egalitarian society*: The constitution of India clearly recognises the need for social justice and has many provisions to produce an egalitarian society. The upper classes have the financial capacity to buy their basic needs and consequently do not view these as crises. Surely, the majority of Indians, the rural poor, have a right to demand a substantial amount of governmental resources for meeting their basic needs. However, the influential minority ensure that the elected governments do not satisfy even the basic needs of the poor.
- (2) *Water, sanitation, housing, nutrition, education and employment as basic rights*: Basic needs are human rights that should be guaranteed to all in civilised societies. The rich and the powerful, who currently have the financial ability to buy these needs, should accept the need for a basic minimum standard for all. However, the fall of the Soviet Union (and with it socialism) and the rise of capitalistic thought have resulted in the side-stepping of such ideals.
- (3) *National statistics and the evaluation of government policies and programmes*: The right to health is a fundamental right and consequently can be used to evaluate the performance of elected governments. However, the government often prefers to confine the debate to the issue of resources for medical treatment as a means of

deflecting the debate from the true social and economic causes of physical and mental well-being. There is an urgent need for detailed re-examination of public health statistics for India (disaggregated by gender, caste and region) and an equally vital need to set policies and programmes to counter adverse trends in large sections of the population.

- (4) *Public health as national interest*: It does not make national sense to have the basic needs of the majority of the population unmet. However, many international aid agencies prefer to support specific and vertical health programmes for particular diseases. Nevertheless, the absence of basic public health needs will ensure the persistence and re-emergence of the very diseases targeted (eg, malaria, polio and tuberculosis). The West ensured development by providing a basic minimum standard of living and of health for all its citizens, and yet insists that the developing world focus on specific problems rather than on improving the general public health infrastructure. Similarly, many international banks focus on curative healthcare and side step the fact that even minimal improvements in the health of populations are determined by social and economic factors, rather than by medical input.

Lastly, the deprivation of basic rights for large sections of the population and the gross disparity between the rich and the poor over a long period of time leads to disillusionment in the democratic process among the disadvantaged. The naxalite (maoist rebels) movement, with its philosophy of armed revolution spreading through many poor and deprived parts of India, is a clear indicator of such a trend.

The context of public health in India and the developing world demands a different framework and different

solutions. There is a need for a people's movement that champions public health issues as basic rights. The egalitarian dream for India and the developing world should not die. The time for public health action is now.

ACKNOWLEDGEMENTS

I thank the CMC-Anveshi Group for the inspiration and support.

J Epidemiol Community Health 2007;**61**:562–563.

doi: 10.1136/jech.2006.059048

Correspondence to: K S Jacob, Christian Medical College, Vellore 632002, India; ksjacob@cmcvellore.ac.in

Competing interests: None.

REFERENCES

- 1 Hart N. The social and economic environment and human health. In: Detels R, Holland WW, McEwen J, Omenn GS, eds. *Oxford textbook of public health*. 3rd edn. Vol 1. Oxford: Oxford University Press, 1997:95–123.
- 2 Porter D. Public health and centralization: the Victorian British State. In: Detels R, Holland WW, McEwen J, Omenn GS, eds. *Oxford textbook of public health*. 3rd edn. Vol 1. Oxford: Oxford University Press, 1997:19–34.
- 3 Editorial. Wanted: a sanitation movement. The Hindu 12 April 2006. <http://www.hindu.com/2006/04/12/stories/2006041204871000.htm> (accessed 17 Mar 2007).
- 4 Unicef. Nutrition: the picture in India. <http://www.unicef.org/india/nutrition.html> (accessed 17 Mar 2007).
- 5 Venkatasubramanian K. Universalizing elementary education. The Hindu <http://www.hinduonnet.com/thehindu/op/2003/11/04/stories/2003110400110300.htm> (accessed 17 Mar 2007).
- 6 Zachariah A, Pai M, Chatterjee P. Resurgence of infectious disease and the Indian society. *Med Friends Circle Bull*, 1997; **March–April**, 240–241.
- 7 McKeown T. *The modern rise of population*. London: Edward Arnold, 1976.
- 8 National Polio Surveillance Project. Government of India. <http://www.npsindia.org/wildpolio06.asp> (accessed 17 Mar 2007).
- 9 Mamdani M. *The myth of population control: family caste and class in an Indian village*. New York: Monthly Review Press, 1972.
- 10 Government of India. National Rural Health Mission http://mohfw.nic.in/national_rural_health_mission.htm (accessed 17 Mar 2007).