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An Assessment of Public Health in India: An Overview

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Abstract

Health care and demographic variables, which also assess the effectiveness and performance of the government in the health sector, serve to illustrate the state of health in any given nation. Additionally, it is important for national growth. Governments have a duty to protect the public's health, which they can only do by implementing sufficient social and health policies. The government plays a multifaceted and multidimensional role in public health concerns, serving as an insurer, a supplier of service, and a supervisor of the industry. Great advancements made possible by the National Rural Health Mission (NRHM), which was established in 2005, include the development of a core group of Accredited Social Health Activists (ASHAs), managed to improve hospital care, decentralisation at the district level to enhance intra- and multi-sectoral integration, and efficient resource utilisation. Population expansion, poverty, unanticipated natural and man-made catastrophes, the worldwide AIDS or influenza (H1N1) pandemic, inadequate coverage in rural and isolated regions, and the on-going threat of biological warfare are just a few of the issues that the government is now dealing with. In large part, lifestyle illnesses are on the rise. There are several solutions that may be pursued, including quick and efficient delivery of health services, finance for health care, and health legislation measures that are crucial to safeguarding and protecting the public's health. These must be stringent and explicitly state the role and responsibilities of public health. Government should prioritise the establishment of varied job possibilities at specific local locations wherever feasible in order to increase the buying power of the community. Securing a safe workplace environment is necessary for the industries. The highest degree of physical, social, and psychological wellness for all employees in all communities should be the goal of the government. In order to maintain the idea of fairness, it is still the responsibility of the government to guarantee the availability, accessibility, quality, and accountability of medical care to the population. The need of the hour is therefore for a well-organized, decentralised public health service system that will prioritise its use of resources while ensuring strong political support, community involvement, health legislation, health investment, and, most importantly, making health care a top priority.

Keywords: Health Care; Enterotoxin; Public Health Issues; NRHM

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Introduction

More over 1.15 billion people are living in India now, which accounts for around 17% of the earth's population. An empirical validation of the nation's health-related indicators reveals unequal development in health factors across regions with inequalities in location (rural-urban) and gender (male-female). The government has started a lot of projects and strategies to close this gap and provide accessible, cheap, fair health care [1].

Two shades are cast over the nation: the well-known one of infectious diseases like malaria and TB, and the new and expanding one of non-infectious chronic illnesses. Ailments include cardiac illnesses and cancer. A thorough analysis of the qualitative and quantitative data available reveals wildly disparate health and development advancements across the nation. There are areas where little has changed since Independence, even among the states that do pretty well. The government sector is overly centralised, and as a result, there are issues with uneven planning, insufficient and imbalanced financial expenditures, a lack of accountability, unethical behaviour, and neglect of duty on the part of medical and nursing staff. In both primary and secondary health care across the nation, the private sector

has grown at an unparalleled rate. According to contemporary medical ethics and free-market, technology-driven operational principles, the private sector typically does not offer high-quality healthcare at a fair price.

Only 8% of all health facilities in India were in the private sector at the time of independence. Currently, the private sector accounts for 57 percent of inpatients, 80 percent of outpatients, 80 percent of physicians, 64 percent of beds, 93 percent of hospitals, and 80 percent of outpatients. The private sector has risen to prominence in all fields of medical education and training, medical technology and diagnostics, pharmaceutical manufacturing and sales, hospital construction and related services, and the delivery of health services. In order to fulfil its obligations under the national health programmes, the government has been striving to include the private sector. Increasing access to healthcare has been the main goal of this effort. But because there aren't any effective regulatory standards, the experience hasn't been great [2, 3].

Despite the many new techniques, the country's health indices remain low because of issues with compliance, participation, and teamwork. By 2015, we won't have accomplished the millennium development targets.

Current health status

Healthcare system and socioeconomic indicators, which also assess the effectiveness and performance of the government in the health sector, serve to illustrate the state of health in any given nation. Additionally, it is important for national growth.

The Human Development Index for our nation is 0.645, placing it 131th out of 189 countries. Despite economic progress, India currently has the second-highest population in the world, with the BPL rate at about 37.2%, according to the Tendulkar Report, and there are 22.7 lakh HIV/AIDS patients living in India, the third-largest country in the world, with an HIV prevalence rate of 0.22 percent in 2021–2022. Environmental deterioration has occurred, particularly as urbanisation has grown. By 2026, the city's metropolitan population will have risen by 77 percent, or 220 million people. Even in many Indian towns, there are still issues with basic sanitation and insufficient health care in rural and distant areas. Neonatal, Post neonatal, Infant, Child, and under-five mortality rates for 5-years periods preceding the survey by residence, India, 2019-21 are reflected in national health surveys, which are shown in Table 1. The country's demographic metrics reveal a literacy rate of 77.7%, a TFR of 2. 159%, a CBR of 17.44%, a CDR of 7.3%, and a sex ratio of 1020/1000. As a result, the pleasure we have in our rapid GDP growth must be balanced with the knowledge that a sizable segment of our nation remains distant from this affluence (Table 1).

One of the seven focus areas included in the National Common Minimum Program (NCMP) of the UPA government is health care, where it is projected to boost spending from the present level of 0.9 percent of GDP to 2-3 percent of GDP during the following five years. However, there are still 24% of poor people's diseases that go untreated in rural areas and 22% in urban areas. The causes of this include financial hardship (28% in rural areas and 20% in urban areas) and a lack of medical facilities (12%) (Rural) [4].

During 2004–2005, total health spending across all sources was 4.25 percent of GDP. According to preliminary estimates from 2005–06 to 2008–09, health spending as a percentage of GDP decreased to 4.13 percent in that year. Even if overall health spending has gone the percentage of health expenditures to GDP has gradually increased over time due to the GDP's correspondingly higher growth.

According to the WHO constitution, everyone has a basic right to the best possible level of health, regardless of ethnicity, religion, political beliefs, or economic or social circumstances. Governments have a duty to protect the public's health, which they can only do by implementing sufficient social and health policies. Additionally, the Indian Constitution states that "the state should regard enhancing the quality of nutrition and standard of life of its people and improving public health as among its major tasks." Therefore, the government must play a significant role through the ministry of health and other associated ministries for the advancement of the nation's health. The government plays a multifaceted and multidirectional role in public health concerns, serving as an insurer, a supplier of service, and a regulator of the industry. It's time to reassess how the government affects national public health [5, 6].

Evolution of public health in India

The government of India formed the Sir Joseph Bhore Committee (Health Survey and Development Committee) in 1943, and it delivered its renowned report in 1946. The guiding principle was that attention should be given to rural regions and that no one should be refused access to health care due to inability to pay. The idea of all-encompassing healthcare was developed. Following the Balwant Roy Mehta Committee's recommendations, the Community Development Program was established in 1952 with the goal of establishing primary health clinics that would offer integrated promotive, preventative, curative, and rehabilitative services to the whole rural population. The Central Government was compelled to carry out the Sokhey Committee's aim of having one Community Health Worker for every 1000 people to put "people health in people's hands" as a result of the convulsive political developments that occurred in the 1970s. India joined the list of nations that signed the Alma Ata Declaration on Primary Health Care in 1978. By vehemently criticising the health work done in the nation during the previous 35 years, the government made a significant political move in the area of health in 1982. Thus, the National Health Policy was established in 1982 to make structural changes to the healthcare sector. A general explanation of the policies was provided by the National Health Policy which, given the current state of the health sector, demands recommendations [7].

From 1992 to 1993, the UIP was strengthened and expanded, first becoming the Child Survival and Safe Motherhood (CSSM) Project. In 1997, the Reproductive and Child Health (RCH-Phase1) programme was introduced, which included family planning, treatment and control of reproductive tract infections, child health, and maternal health. Later, RCH Phase-2 (2005–2010) seeks to implement a sector-wide, outcome-oriented program-based strategy with a focus on decentralisation, monitoring, and supervision that results in a thorough integration of family

planning into healthy pregnancy, childbirth, and development. In order to uphold its obligations under the common minimum programme, the United Progressive Alliance government launched the National Rural Health Mission (2005–2012). The National Health Policy 2002 will be implemented using the NRHM as a strategic framework. It has incorporated important principles from the National Health Policy of 2002, such as equity, decentralisation, involving local governments and Panchayati Raj Institutions (PRIs) in managing primary healthcare, strengthening primary healthcare institutions, and suggestions for finding alternative sources of funding. The introduction of Indian Public Health Standards aims to raise the calibre of medical services. Only PHCs, SCs, and Community Health Centres are subject to these criteria [8].

Current role of Government

Major innovations made possible by the National Rural Health Mission (NRHM), which was established in 2005, include the development of a cadre of Accredited Social Health Activists (ASHA), improved hospital care, decentralisation at the district level to enhance intra- and inter-sectoral convergence, and efficient resource utilisation. Reproductive and Child Health-2 (RCH-2), National Disease Control Programs, and Integrated Disease Surveillance Project are included in the NRHM. The whole nation is covered by the mission, with 18 states receiving special attention because of their subpar infrastructure. In addition to Jammu and Kashmir and Himachal Pradesh, they include all 8 Empowered Action Group (EAG) states: Uttar Pradesh,

Madhya Pradesh, Rajasthan, Bihar, Orissa, Uttaranchal, Chhattisgarh, and Jharkhand. In Table 2, a few of the accomplishments are highlighted (Table 2).

Current challenges

Population expansion, poverty, unanticipated natural and man-made catastrophes, the worldwide AIDS or influenza (H1N1) pandemic, inadequate coverage in rural and isolated regions, and the ongoing threat of biological warfare are just a few of the issues that the government is now dealing with. In large part, lifestyle illnesses are on the rise. They are becoming more common as a result of the stress caused by industrialisation and urbanisation. People struggle to meet their fundamental health demands as a result of population expansion and the lack of possibilities. The price of healthcare has grown due to rising medical education costs.

Rural health care has been prioritised by the NRHM, however there are implementation issues that keep health care delivery from being as effective as it may be. The major causes of these issues include the physical infrastructure, medications, funding, lack of resources, and accessibility to health care, among other things. Lack of key cadres in rural areas, a lack of motivation or desire to serve in rural areas, absenteeism and irregular staff attendance, a lack of transparency in transfer and posting policies, a weak or non-existent accountability framework, insufficient incentive systems for all cadres, especially in difficult area postings, a lack of career advancement and standard protocols, etc. are issues with human resources [9. 10].

Public-Private Partnership (PPP) has emerged as one of the options to influence the growth of private sector with public goals in mind. Used judiciously and fitted to local circumstances, they clearly have the potential to drastically change the healthcare landscape in India. But PPPs will survive only if the interests of all stakeholders are taken a consideration. The private sector is typically unregulated and out of the reach of the poor due to its focus on maximising profits. Other significant problems with the private sector include inconsistent service quality, a lack of formal accrediting systems, a low insurance penetration rate, and inadequate service purchases by the government, and the industry's focus on curative and investigative treatment.

The majority of rural development projects are related to the implementation of PDS, which has grown to be a cornerstone of governmental development strategy. PDS is a significant and well-known indicator of how well the government is performing as well as a major influencer on public opinion. The ineffective targeting of recipients and the ensuing subsidy leakage are two of this system's major issues. With broad collaboration across the supply chain, there are several chances to influence the system. Transparency and accountability in system monitoring, issue scope, and quality, etc. are other linked challenges. For every Rs. 4 spent on the PDS, only Rs. 1 reaches the needy, and "57 percent of the PDS food grain does not reach the intended individuals," according to the Planning Commission.

Solutions

Health system provision should be based on community needs that may differ from area to area; therefore standards for the medical institution and its staff should be adaptable. Priority must be given to basic/preventive health care while maintaining complete intersect oral coordination and community involvement. Resources available must be taken into consideration, including the distance, topography, travel time, and social and cultural context. Additionally, we must build up and improve our health infrastructure. Establishing new medical, dental, nursing, and paramedical facilities using PPP in underserved region taking up instead of a disease-centric approach, a system-centric approach useful for the effective blending of finances and functions and employees of the NRHM.

Both for effectiveness and to support the activities taken to attain health goals, health care finance is crucial. To provide structured public health services and to improve access for the nation's poor and vulnerable population, particularly in rural, remote, and tribal regions, government should enhance its investment in health. An increase in public health spending on health should account for at least 2% of GDP, with a major portion of the spending going toward primary healthcare [11-13].

Health legislative actions are crucial to preserving and defending the public's health. The role and responsibilities of public health must be clearly defined in the health legislation, which must also be stringent. Therefore, we must enhance governance, accountability, and transparency in the provision of health care. The community, civil society organisations, and PRIs must all be involved in this. Legislative actions should be democratic, effective, and efficient and should focus on issues like general

cleanliness, preventing water and air pollution, controlling medical practise, providing health services in schools, and quarantine measures, among other things. It is crucial to develop surveillance and monitoring systems to keep track of the numerous communicable illnesses.

We must create regulatory rules for the health industry in the case of PPP. When purchasing health care from the private sector, new criteria must be created to provide uniform services. With reasonable rates and quality assurance. The effectiveness and equality of government programmes for BPL households would also be enhanced. A health care paradigm that combines curative, promotional, and preventative services must be constructed.

PDS is a crucial component of the plan for ending poverty and is designed to act as a safety net for the undernourished poor. Computerization of many system components is necessary to improve the system. A high-quality beneficiary data bank should be developed by the state government, ideally starting with a house-to-house survey. The beneficiary database must have information on all households in order to effectively eliminate Shadow and Bogus cards. All of the important offices of the Food Department, including the Secretariat, Commissioner cell, District Offices, Teshil/Block offices, and Whole Sale Points, will require the deployment of ICT infrastructure. In order to provide connectivity amongst the department offices, a state wide area network must be built. Through a computerised network, state governments may guarantee oversight of the Public Distribution System's operation at the level of fair pricing shops. The legal, technological, and administrative infrastructure advancements will assist the PDS system by improving targeting and increasing transparency, which will improve system performance and boost public support.

Government should focus on socioeconomic growth, human resource development, and education in order to raise the standard of healthcare. The development of state-specific human resource management policies, incentive structures for challenging areas, career advancement systems, improved drugs, diagnostics, and telelinkages, devolution of power and functions, local health care institutions, local communities, and Panchayats, training and utilisation of readily available paramedics, RMPs, and VHWs, as well as general capacity building, are possible solutions for human resources for health.

Proper nutrition must be guaranteed if the population is to remain healthy. To meet the nutritional needs of the expanding population and to build up buffer supplies, agricultural expansion must be taken into account. Some of the attempts to boost food production include increasing investment in irrigation, fertiliser production and subsidies, land reforms, lab-to-land extension teaching, and farm level purchase at minimum support prices. Additional steps to increase food security include enhancing food distribution through food distribution networks, reducing poverty through economic growth, and enhancing family food security through direct and indirect subsidies. It is essential to provide food supplements to the most disadvantaged groups, such as through ICDS, Mid-Day Meals, etc. The prevalence of Nutritional health issues may be significantly reduced by controlling communicable illnesses, controlling reproduction, and educating people about nutrition. Food safety regulations must be created at the local and higher levels of government with strict adherence to national standards [14].

Securing a safe workplace environment is necessary for the industries. The highest degree of physical, social, and psychological wellness for all employees in all communities should be the goal of the government. This aims to promote human productivity and wellbeing by achieving the greatest possible mutual adjustment between man and his work. The government must take into account different medical, engineering, and legislative actions for the various professions in order to achieve this.

Conclusion

Government continues to play a role in ensuring the availability, the availability, effectiveness, and responsibility of medical treatment the neighbourhood upholding the equality concept. thus, a centralised and decentralised system of public health services This will set priorities and utilise the resources appropriately also by guaranteeing a strong political commitment, engagement of the community, health laws, and health establishing health care as a priority and investment The immediate necessity takes precedence.

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