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KERALA: THE DEVELOPMENT EXPERIENCE:CRITIQUETHE PUBLIC HEALTH STATUS

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Abstract

Kerala, one of the southernmost Indian states has often been labeled a "Model of Development" for almost four decades byscholars of international repute. To a very great extent the uniqueness of such a model can be attributed to the untiring efforts of variousruling parties (pre and post-independence) in the fields of education and public health. However, the widely acclaimed Kerala Model of Health/Development has been showing some alarming trends over the last decade due to a multitude of reasons.Many historians observe that the Kerala Model Development is unsustainable because of economic crisis. Commodifying healthcare has adversely affected the much lauded 'model'. Despite this, Kerala's resilience in the face of the pandemic is a clear pointer that toning up the health care system and making it capable of ensuring equitable, efficient and good quality health care needs concerted actions from various stakeholders. The present paper is an attempt to critically analyze the current public health status in Kerala, identify the challenges and suggest remedial measures to effectively utilize various opportunities to strengthen the healthcare system.

Keywords : Model of Development, public health, health care

Introduction

Almost three decades ago, Kerala was held up to the world as a model of good health at minimal cost along with countries like China, Costa Rica, Cuba and Sri Lanka[i]. In 2011, Kerala attained the highest Human Development Index among all Indian states based on its performance in three key areas[ii]Lower infant mortality rate of 12/1,000 live births in Kerala vs. 40/1,000 live births in India, lower maternal mortality ratio of 66/100,000 live births in Kerala vs. 178/100,000 live births in India and higher literacy among both males at 96% in Kerala vs. 82% in rest of India and females with 92% in Kerala vs. 65% in India.[iii]

Kerala's mortality statistics through the 20th centuryshow steady improvement in the area of life expectancy. The health gains can be attributed to several factors, especially strong emphasis from the state government on public health and primary health care (PHC), health infrastructure, decentralized governance, financial planning, girls' education, community participation and a willingness to improve systems in response to identified gaps.[iv]However, it should be emphasized that changes in the health system (creating a network of government health institutions in almost

all rural areas catering to the general population) and implementation of most national health schemes also contributed to improving health status.From 1900 onwards multy speciality hospitals and scanning centers have mushroomed across in both rural and urban areas of Kerala.[v]

CHALLENGES

Over time serious questions were raised pertaining to the desirability of the Kerala 'model' in health because though mortality was low, the prevalence of morbidity was found to be quite high[vi]and this view was soon corroborated by a state-wide study undertaken by the Kerala Sastra Sahitya which showed that reported sickness in Kerala was indeed high.[vii] Kerala seems to be showing an epidemiological transition bywitnessing the reappearance/resurgence of infectious diseases: epidemics of dengue, chikungunya, rat fever and hepatitis which indicates large-scale environmental degradation. Pollution and waste disposal in urban areas posed insurmountable problems.Non-communicable diseases (NCDs) are on the rise whereas communicable diseases (CDs) also continue to be a public health problem and the agenda of high maternal and child mortality has not yet been tackled. The Office of Registrar General of India reports that NCDs cause of death in 42%, communicable diseases, maternal, perinatal and nutritional conditions in 38% and 10% deaths are due to injuries and ill-defined causes.[viii]The new agenda for Public Health takes into consideration the epidemiological transition (rising burden of chronic non-communicable diseases), demographic transition as well as environmental changes. Mental (psychological), neurological and substance abuse disorders contribute to the burden of disease and disability. The rising toll of road deaths and injuries are also considered 'silent epidemics'.

Health systems are trying to come to terms with the effects of existing communicable and non-communicable diseases and also to the increasing burden of emerging and re-emerging diseases (drug-resistant TB, malaria, avian flu, Nipah Outbreak and COVID pandemic). Inadequate financial resources at the disposal of the health sector and its inefficient utilization result in inequalities in health. Many studies point out that due to the high expenditure in healthcare many families were driven to financial ruin and suicide. The causes of health inequalities could be attributed to social, economic and political mechanisms that lead to stratifying society based on annual income, education, occupation, gender and race or ethnicity.[ix]Lack of adequate progress on these underlying social determinants of health has been acknowledged as a glaring failure of public health.

Soonthe private sector in health care exhibited an accelerated growth fuelled by the demand for medical care. The philanthropic character of the earlier private health sector soon gave way to a new league of commercialized and explicitly profit-seeking institutions. Large-scale privatization of health created a big market in health related goods and services, not all being necessary. Growth in international tourism in health and the successful marketing of Ayurvedic treatments contributed

to commercialization of health care. Though there are numerous allegation that the diagnostic imaging and clinical laboratory industry thrived through unethical practices such as cutbacks for referring doctors, though this could never be satisfactorily proved.

The private health sector thrived on one side while the public/government health sector underwent slow but drastic erosion in quality erosion. Public health training and rural posting of newly qualified doctors were de-emphasized; medical specialization was over-emphasized, which slowly led to a health sector clearly dominated by specialists and testing procedures, but deplorablebasic skills to address basic public health needs and functions. Furthermore, the almost exclusive focus on curative care in the state implied that public health functions were slowly neglected, leading to conditions ripe for occurrence and spread of epidemics and infectious diseases.

In 1996, the ruling party of the government in Kerala initiated a bold policy move bringing health institutions such as primary health centres (PHC) and community health centres (CHC) under local self-governments (LSG) with the expectation of creating accountable and efficientlyrun health institutions, thereby addressing many of the ills prevalent in the system.

In reality however, this created a wide gap in the quality of services offered by these institutions;due to various political and apolitical reasons, the key element of this failure was due to the fact that medical personnel of the health institutions were still answerable largely to the parent department, and felt no responsibility or need to satisfy the local government.

Despite these health improvements, Kerala's public health care sector has recently faced a number of challenges such as the epidemiological transition towards chronic disease[x], lack of public health funding[xi] and the continued dominance of private health care at much high cost[xii] have pushed the health system to its limits. The rise of non-communicable diseases in the state has challenged the healthcare system: Kerala has an extremely high prevalence of diabetes with 14.8 percent of its population (ages between 15and 64 years) is diabetic, compared to only 8 percent in rest of India [xiii]. In addition to this, the prevalence of many NCD risk factors in the state is found to be very high; a study conducted in 2010 showed that 42% of adult males smoked and that 40% of the adult population consumed very less fruits and vegetables, while 25% were overweight[xiv] .

Improvement in socioeconomic conditions led to growth of the private sector while the public sector failed to meet the increasing demand for quality care. The shift from the public to the private sector is alarming because individual household spending on health needs/ per capitaexpenditure is increasing while many public facilities remain underutilized and understaffed since the employees seeking higher-paying and more lucrative jobs in the private health care sector.

Commodifying healthcare has adversely affected the much lauded 'model' which is currently dominated by privatized health care, where quality of services offered to the unsuspecting public through advertising and various other inducements (mostly unethical, profit-making) are generally poor. Until recently, the public health sector caters primarily to the poorer/backward sections of society. But lately a policy thrust to draw the economically backward sections also to the private sector using the guise of insurance coverage was propelled by the national social health insurance scheme - the *Rashtriya Swasthya Bhima Yojana*. As a result, it isn't surprising that the public have almost lost trust in the health system (public and private). The Kerala model (with the assurance that the state would provide good quality health care) which once envisioned health security, despite one's station in lifeis threatened and seems to be deteriorating because today, health care availability is almost exclusively dependent on one's ability to pay, without an assurance of quality.

There are some pertinent questions that demand our immediate attention: (a) What are the principles upon which the so called Kerala 'model' of health was developed? (b) What are the factors that adversely affected this model causing it to deteriorate? (c) How do we overcome the challenges and move ahead to ensure the dream of health for all?In this scenario we are forced to admit that there never was a Kerala 'model' in health, *per se*asthere never has been a conscious effort to create an equitable health system that ensures and offers health security to all. The 'model' was merely a demographic transition that occurred faster here as compared to many other parts of the world. Death and birth rates were drastically lowered within the span of a single generation as a result of a political environment that emphasized rights and policies that ensured rights in education and health.

The fall in mortality will involve heavy investment in neonatal hospital care and supportive measures to ensure that infants survive into adulthood. Similarly, having ensured almost universal institutional pregnancy care, delivery and postpartum care (responsible for lowering maternal mortality) further involves investment in expensive services including ambulances and blood storage and delivery. An additional burden on the health services is the increasingly aging population that invariably faces a burden of susceptibility to non-communicable diseases and resultant treatment facilities. Health is also adversely influenced by developments in other sectors such as increasing traffic congestion, spike in levels of alcohol consumption, lifestyle disorders owing to increasing sedentary behaviours, environmental deterioration and stressors at various levels.

It is politically challenging to ensure public health becomes a shared value across the various sectors strategy, therefore collective action is required. Kerala was able improve to public health mainly by addressing the fundamental determinants of health and making investments in basic education, public health and primary care. Parallel developments in women empowerment[xv18] and

women-specific interventions in all policies, programs and systems need to be launched. Poverty eradication programs and microcredit schemes need to be strengthened for economic and social empowerment of women.[xvi19]Potential areas of community participation (lifestyle modification through physical activity and diet changes, intervention for prevention of alcohol dependence through active community-based methods) may ensure public support for policies and programs, generate compliance of regulations, ensure the implementation and perhaps even help alter personal health behaviours.

Conclusion

To effectively address public health challenges concerted activities of various sectors (public-private partnership), civil societies, government leaders, health workers, communities and relevant health agencies should be ensured. Strong health laws alone can help build resilient societies in the face of pandemics and/or public health emergencies. It is imperative then that the right to health be implemented, using the just and transparent methods while ensuring social equality. In today's fast changing world, with multifold challenges that threaten the general health and well-being of the population, it is the concerted efforts of the government and community alone that can help allface and overcome these challenges simultaneously, inclusively and in a sustainable manner.

A perfect health system would ensure that everyone, irrespective of their in, has access to a qualified physician and a reasonable range of health care options and medication at all times and just as importantly within easy reach. If public health needs are addressed with principles of justice, equality, universalism and dignity, only then can Right to Health become a reality and not a distant dream.

Kerala is no longer a resource-poor state and the times we live in now ensure that people who are involved in decision making can use technology in innovative ways to improve the health care performance. Overall, Kerala has made remarkable strides in strengthening its public health care system through investing in infrastructure, decentralized governance, and community engagement. Though many challenges remain, the state of Kerala is consistently working towards making health care accessible, affordable and responsive to an increasing burden of non-communicable diseases.

Despite this, Kerala's resilience in the face of the pandemic is a clear pointer that toning up the health care system and making it capable of ensuring equitable, efficient and good quality health care needs concerted actions from various stakeholders. It is therefore vital is to sustain this. The effective involvement of the private sector and with the aid of voluntary organisations this challenge is attainable.

On the political front, the need of the hour is to ensure a courageous, political leadership which can develop a vision for Kerala's health that will incorporate the ideals and principles discussed above and the will to implement it, for this alone can ensure the emergence of a new and sustainable Kerala 'model' for a healthy society.

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