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## Health in India: Need for a paradigm shift

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### Abstract

Three of the Millennium Development Goals call for specific health improvements. This paper seeks to estimate how far the BRIC nations are from meeting their health MDG commitments. The factors responsible for India's poor performance on the health MDGs are poverty, illiteracy, gender bias, urban bias, poor quality health services and lack of access to proper health services. India has one of the lowest per capita health expenditures in the world and government health expenditure is completely inadequate. Improvements in public health require a paradigm shift in the government's approach to health.

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### 1. Introduction

In an increasingly inter-connected world, the emerging economies have become the drivers of economic growth worldwide. One such collective of emerging economies is the BRIC nations - Brazil, Russia, India and China, which have made impressive economic gains. But have they made similar progress in the arena of economic and human development, in areas such as reduction in levels of poverty, inequality and deprivation, improvements in health, literacy, gender equality, and the like?

In September 2000, 189 member countries of the United Nations began the new millennium with an ambitious development agenda summarized in the Millennium Development Goals (MDGs). The United Nations adopted eight Millennium Development Goals (MDGs), representing commitments by member

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governments to do more to reduce poverty and hunger and to tackle ill-health, gender inequality, lack of education, lack of access to clean water, environmental degradation, and also commitments to reduce debt, increase technology transfers and build development partnerships. Although enunciated as separate, distinct goals (see Table 1) the MDGs should really be considered as a mutually reinforcing framework contributing interactively to human development (WHO 2011).

The MDGs were broad statements relating to human developmental issues, but the Millennium Summit concretised these by preparing a road map establishing specific goals and targets to be reached by 2015. Thus the policy-level MDGs were translated into operational targets, which in turn can be measured through progress on internationally comparable indicators.

Table 1: The Millennium Development Goals

No.	Goal
1	Eradicate extreme poverty and hunger
2	Achieve universal primary education
3	Promote gender equality and empower women
4	Reduce child mortality
5	Improve maternal health
6	Combat HIV/AIDS, malaria and other diseases
7	Ensure environmental sustainability
8	Develop a Global Partnership for Development

The countdown to the date set for achievement of the MDGs has begun. During the years since the enunciation of the MDGs, the BRIC economies have enjoyed notable economic progress. This paper begins with an overview of the recent economic performance of the BRIC economies and their place in the world economy. It proceeds to examine the position of these nations on the various Health MDGs and targets, and to estimate, going by current trends, when they are likely to actually achieve these targets. Coming to India in particular, the paper attempts to identify the factors responsible for the shortfalls and reviews various issues and challenges that will be critical in achieving the goals. The paper further proposes that a new public health paradigm be adopted if India is to experience equitable and inclusive growth.

## 2. Data and methodology

The study uses the information contained in various reports and databases of official agencies such as the International Monetary Fund, World Health Organization and the United Nations. Relevant country-wise data has been culled and analyzed, and conclusions drawn.

## 3. The economic performance of the BRIC nations

The emerging economies, led by China and, to a lesser extent, India, have been the epicentres of growth in the 21<sup>st</sup> century. China has seen its share of world GDP more than triple in just 20 years, while India's share has doubled over the same period. While Russia's performance has been erratic, China and India have grown steadily, except for the recent period of global recession. Over the two decades in question China has averaged a growth rate of close to 13 percent per annum, India more than 9 percent,

Brazil 5.5 percent and Russia 4 percent. The BRIC nations together now account for 25 percent of world GDP. It is expected that their economies will overtake those of the G-7 by 2030, and that by 2050, they will, with the US, be the world’s dominant economies (Aziz 2011). Table 2, Figure 1 and Figure 2 demonstrate the growing economic importance of the BRIC nations on the global stage.

Table 2. GDP of BRIC nations 1990-2010

Year	Brazil			Russia			India			China			BRIC		
	GDP PPP \$ billion	% of world total	growth rate % p.a.	GDP PPP \$ billion	% of world total	growth rate % p.a.	GDP PPP \$ billion	% of world total	growth rate % p.a.	GDP PPP \$ billion	% of world total	growth rate % p.a.	% of world total	growth rate % p.a.	
1990	782	3.34	-	NA	NA	-	750	3.09	-	910	3.89	-	-	-	
1991	818	3.31	4.61	NA	NA	-	793	3.09	5.76	1029	4.16	13.08	-	-	
1992	833	3.00	1.81	1169	4.21	-	847	2.93	6.86	1203	4.33	16.9	14.47	-	
1993	893	3.08	7.24	1091	3.77	-6.68	909	3.02	7.26	1401	4.84	16.52	14.70	5.98	
1994	966	3.16	8.08	972	3.19	-10.86	985	3.11	8.44	1618	5.30	15.48	14.76	5.76	
1995	1027	3.18	6.39	952	2.96	-2.1	1080	3.22	9.59	1832	5.68	13.21	15.04	7.7	
1996	1069	3.14	4.1	935	2.75	-1.77	1184	3.34	9.61	2054	6.03	12.09	15.25	7.17	
1997	1125	3.12	5.2	965	2.68	3.17	1329	3.36	12.28	2284	6.34	11.23	15.50	8.8	
1998	1138	3.04	1.17	923	2.47	-4.28	1415	3.47	6.48	2490	6.66	9.02	15.64	4.63	
1999	1158	2.94	1.73	996	2.54	7.92	1483	3.59	4.79	2719	6.92	9.18	15.99	6.52	
2000	1234	2.93	6.57	1120	2.67	12.43	1582	3.62	6.7	3011	7.15	10.75	16.37	9.3	
2001	1278	2.90	3.6	1204	2.74	7.47	1681	3.68	6.23	3334	7.58	10.74	16.90	7.92	
2002	1333	2.90	4.32	1281	2.79	6.44	1786	3.74	6.25	3697	8.04	10.87	17.47	8.01	
2003	1378	2.83	3.32	1404	2.89	9.56	1949	3.86	9.15	4158	8.55	12.47	18.13	9.77	
2004	1495	2.85	8.48	1547	2.95	10.17	2162	3.99	10.88	4698	8.95	12.99	18.74	11.38	
2005	1585	2.80	6.02	1697	3.01	9.69	2434	4.17	12.62	5364	9.41	14.18	19.39	11.91	
2006	1701	2.78	7.34	1895	3.08	11.68	2756	4.37	13.23	6242	10.00	16.36	20.22	13.67	
2007	1858	2.80	9.21	2117	3.17	11.73	3118	4.54	13.12	7338	10.76	17.55	21.27	14.58	
2008	1996	2.87	7.43	2277	3.25	7.54	3390	4.74	8.72	8217	11.45	11.99	22.31	10.04	
2009	2010	2.88	0.73	2116	3.02	-7.06	3615	5.05	6.65	9047	12.56	10.1	23.51	5.72	
2010	2182	2.92	8.52	2219	3.02	4.85	4001	5.28	10.67	10084	13.27	11.47	24.48	10.11	

Source: International Monetary Fund (2010)

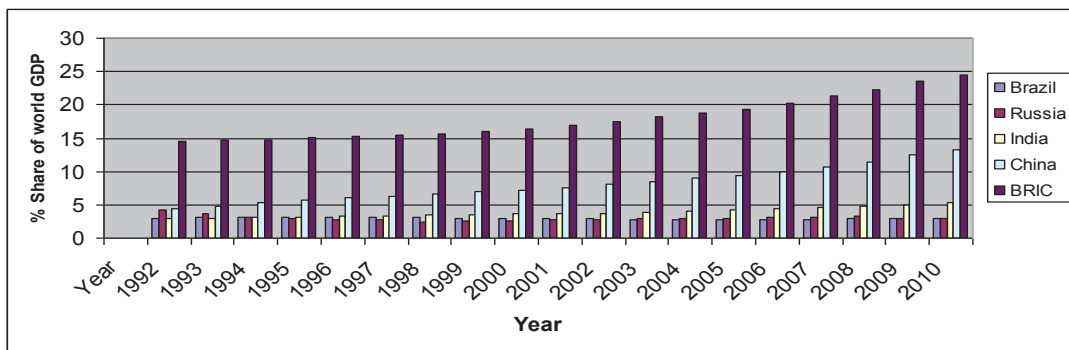


Figure 1: Share of BRIC nations in World GDP, 1990-2010 (Source: Table 1)

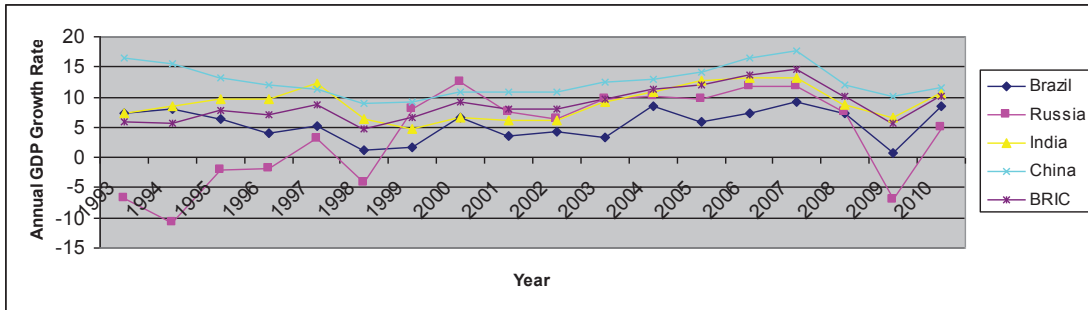


Figure 2: Annual Growth Rate of BRIC nations in World GDP, 1993-2010 (Source: Table 1)

The crucial question, however, is whether this growing economic strength has translated into economic and human development. Development, as it is widely understood today, implies an improvement in human welfare as measured by a variety of indicators reflecting advances in health, education and equality. In order to comprehend these countries' development gains, it would be worthwhile to see where they are on their MDG achievement paths.

#### 4. The health millennium development goals

Health is central to the achievement of the Millennium Development Goals - both by itself, and as a contributor to several others. Three of the eight goals – MDGs 4, 5 and 6 – are health-related; in addition, eight of the twenty-one targets and twenty-two of the sixty indicators of progress are health-related. Improvements in health are important in their own right, but better health is also a prerequisite and a major contributor to the achievement of other MDGs. For instance, ill health among the poor is the rule rather than the exception since they do not have the resources necessary either for prevention or cure; conversely, ill health can also be an important cause of poverty through loss of income, crippling health expenses, and orphanhood. It will be impossible to achieve a reduction in income poverty (MDG 1) without taking steps to ensure a healthier population. Societies burdened by large numbers of sick and dying individuals cannot escape from poverty (Sachs 2004). Similarly, eliminating gender disparities (MDG 3) and increasing enrolment rates for primary education (MDG 2) are prerequisites for success in improving health outcomes.

This section examines the position of the BRIC nations on the health MDGs and targets. The Health MDGs are

MDG 4 – Reduce Child Mortality

MDG 5 – Improve Maternal Health

MDG 6 – Combat HIV/AIDS, malaria and other diseases

As mentioned in the section on Data and Methodology, the paper only reviews performance in respect of the critical targets for which data is available.

MDG 4: Reduce Child Mortality

Target 4A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Looking at Table 3 and Figure 3, it is quite clear that Brazil, Russia and China are well within reach of the target, and India is the only country in the group which, at the present rate of decline in under-five mortality rates, will not achieve the target by 2015. A closer look at the data reveals some interesting trends:

- for all the four nations, 1997/1998 saw a marked improvement in the rate of decline of the under-five mortality rate

- for the Russian Federation, the year 2002 saw another significant improvement in the rate of decline of the under-five mortality rate

Table 3: Under-Five Mortality Rate (per 1000 live births)

Country	Brazil		Russian Federation		India		China	
Year	UFMR	Annual % decline	UFMR	Annual % decline	UFMR	Annual % decline	UFMR	Annual % decline
1990	55.7		27.0		118.2		45.5	
1991	52.9	5.03	26.5	1.85	115.1	2.62	45.6	-0.22
1992	50.2	5.10	26.6	-0.38	112.8	2.00	45.6	0.00
1993	47.7	4.98	26.7	-0.38	111.0	1.60	45.4	0.44
1994	45.7	4.19	26.9	-0.75	109.2	1.62	45.2	0.44
1995	43.9	3.94	27.0	-0.37	107.4	1.65	44.9	0.66
1996	42.1	4.10	27.1	-0.37	105.7	1.58	44.7	0.45
1997	40.2	4.51	26.3	2.95	104.0	1.61	44.5	0.45
1998	38.0	5.47	25.4	3.42	100.1	3.75	41.5	6.74
1999	36.0	5.26	24.6	3.15	96.3	3.80	38.6	6.99
2000	34.0	5.56	23.9	2.85	92.7	3.74	36.0	6.74
2001	32.2	5.29	23.1	3.35	89.2	3.78	33.6	6.67
2002	30.5	5.28	21.4	7.36	85.8	3.81	31.3	6.85
2003	28.8	5.57	19.8	7.48	82.6	3.73	29.1	7.03
2004	27.2	5.56	18.3	7.58	79.5	3.75	27.2	6.53
2005	25.8	5.15	16.9	7.65	76.5	3.77	25.3	6.99
2006	24.4	5.43	15.7	7.10	73.6	3.79	23.6	6.72
2007	23.1	5.33	14.5	7.64	70.8	3.80	22.0	6.78
2008	21.8	5.63	13.4	7.59	68.2	3.67	20.5	6.82
2009	20.6	5.50	12.4	7.46	65.6	3.81	19.1	6.83
Avg. Annual % decline		5.10		3.96		3.05		4.41
2015*	18.6*	0.33**	9.0*	0.57**	39.4*	4.37**	15.2*	0.65**

\* Target to be achieved by 2015; \*\* Required rate of decline from 2009 in order to achieve the target by 2015

Source: United Nations (2011) Country Level Data

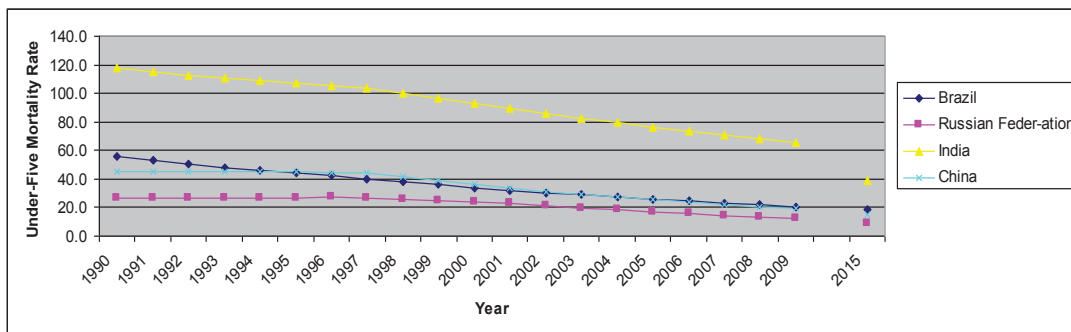


Figure 3: Under-five Mortality Rate (per 1000 live births) (Source: Derived from Table 3)

What do these trends suggest? It would seem that the declaration of the MDGs had a beneficial effect on the under-five mortality rate only in the Russian Federation; in all the four nations, the secular decline in child mortality rates had already begun to accelerate in the late 1990s. Russia appears to have stepped up its efforts still further, consequent upon which it will reach the target on time. If India had responded in a similar manner, India would also have been on track to achieving this important goal.

MDG 5: Improve Maternal Health

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Table 4: Maternal Mortality Ratio per 100,000 live births

Country	Brazil		Russian Federation		India		China	
Year	MMR	Average Annual % decline	MMR	Average Annual % decline	MMR	Average Annual % decline	MMR	Average Annual % decline
1990	120		74		570		110	
1995	98	3.67	72	0.54	470	3.51	82	5.09
2000	79	3.88	57	4.17	390	3.40	60	5.37
2005	64	3.80	39	6.32	280	5.64	44	5.33
2008	58	3.13	39	0.00	230	5.95	38	4.55
Average Annual % decline		3.62		2.76		4.63		5.08
2015*	30*	6.90**	19*	7.33**	143*	5.40**	28*	3.76**

\* Target to be achieved by 2015; Source: United Nations (2011) Country Level Data ; \*\* Required average rate of decline from 2008 in order to achieve the target by 2015

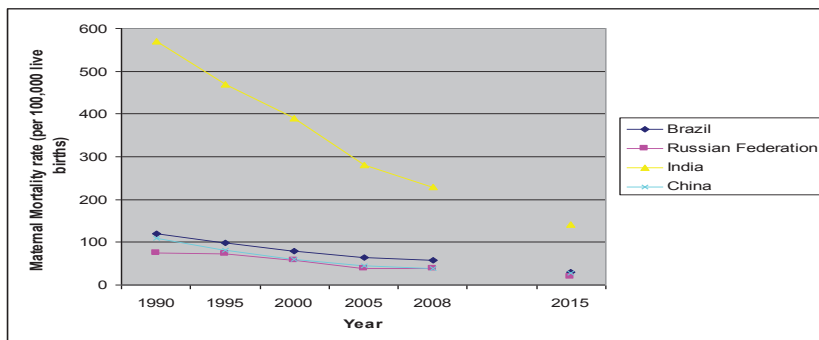


Figure 4: Maternal mortality ratio per 100,000 live births (Source: Derived from Table 4)

A reading of Table 2 and Figure 2 suggests that going by present indications, only China is within reach of the target set for maternal mortality rates except for India, the period 2005-08 saw a slowdown in the improvement of this health indicator, which could perhaps be linked to the global recession that set in at this timepost-Millennium Summit improvements in the indicator are significant only for India and Russia.

Going by current trends, it is evident that none of the BRIC nations will reach 100 percent contraceptive prevalence rate – one of the prime indicators of access to reproductive health – by 2015. India in particular has a very dismal performance with less than 60 percent of married women admitting to contraceptive use, while the other three countries have contraceptive prevalence rates of at least 80 percent.

Target 5.B: Achieve, by 2015, universal access to reproductive health

Table 5: Contraceptive prevalence rate (current contraceptive use among married women in the age group 15-49 years)

	Brazil	Russian Federation	India	China
1992	-	-	-	84.6
1993	-	62.5	40.7	-
1994	-	66.8	-	-
1995	-	63.4	-	-
1996	76.7	65.3	-	-
1997	-	-	-	83.8
1998	-	-	-	-
1999	-	-	48.2	-
2000	-	-	46.9	-
2001	-	-	-	86.9
2002	-	-	-	-
2003	-	-	-	-
2004	-	83.8	53.0	-
2005	-	-	-	-
2006	80.3	-	56.3	84.6
2007	-	79.5	-	-
2015	100	100	100	100

<sup>a</sup> - indicates data not available

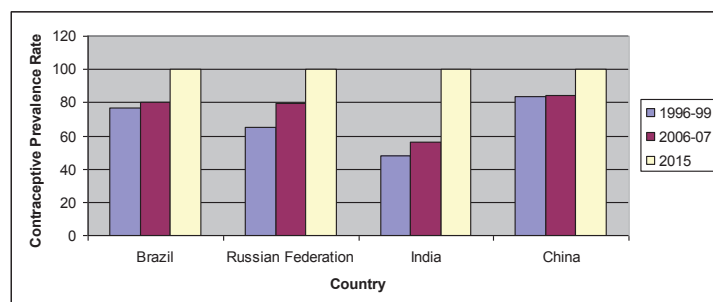


Figure 5: Contraceptive prevalence rate *Source: Derived from Table 5 (Source: United Nations (2011) Country Level Data)*

## MDG 6: Combat HIV/AIDS, malaria and other diseases

### Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Of the BRIC nations, India seems to be the only one to have reached the target ahead of schedule - the spread of HIV/AIDS was arrested by 2004-05 and has begun to reverse itself. In China the disease appears to have stabilized, although it has not reversed. In Brazil, the data suggest that the spread of HIV may have picked up recently after several years of remaining steady. Russia presents the greatest challenge, with HIV prevalence growing at quite an alarming rate.

Data for the other indicators of this target, viz. use of condoms at the last high-risk sex, youngsters with comprehensive correct knowledge of sex and school attendance of orphans, is too scanty to permit of any meaningful comparison.

Table 6: People living with HIV, 15-49 years (%) (lower &amp; upper bounds)

	Brazil		Russian Federation		India		China	
	Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound
1990	0.3	0.6	0.0	0.0	0.0	0.1	0.0	0.0
1991	0.3	0.6	0.0	0.0	0.1	0.1	0.0	0.0
1992	0.3	0.6	0.0	0.0	0.1	0.1	0.0	0.0
1993	0.3	0.5	0.0	0.0	0.1	0.2	0.0	0.0
1994	0.3	0.5	0.0	0.0	0.2	0.2	0.0	0.0
1995	0.3	0.5	0.0	0.0	0.2	0.3	0.0	0.0
1996	0.3	0.5	0.0	0.0	0.3	0.3	0.0	0.0
1997	0.3	0.5	0.0	0.0	0.3	0.4	0.0	0.0
1998	0.3	0.5	0.0	0.1	0.3	0.4	0.0	0.0
1999	0.3	0.5	0.1	0.1	0.4	0.4	0.0	0.0
2000	0.3	0.5	0.2	0.3	0.4	0.5	0.0	0.1
2001	0.3	0.5	0.4	0.6	0.4	0.5	0.0	0.1
2002	0.3	0.5	0.5	0.8	0.4	0.5	0.0	0.1
2003	0.3	0.5	0.6	0.9	0.4	0.5	0.0	0.1
2004	0.3	0.5	0.7	1.0	0.4	0.5	0.0	0.1
2005	0.3	0.5	0.7	1.1	0.3	0.4	0.0	0.1
2006	0.3	0.5	0.8	1.1	0.3	0.4	0.0	0.1
2007	0.3	0.5	0.8	1.1	0.3	0.4	0.1	0.1
2008	0.3	0.6	0.9	1.2	0.3	0.4	0.1	0.1
2009	0.3	0.6	0.9	1.2	0.3	0.4	0.1	0.1

Source: United Nations (2011) Country Level Data

#### Target 6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it

Table 7: Access to Antiretroviral Therapy for HIV-infected population

	Brazil		Russian Federation		India		China	
	Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Upper Bound
ARV therapy among people with advanced HIV infection (%)								
2004	50	61	1	2	2	3	4	11
2005	54	65	2	3	4	5	8	19
2006	52	62	4	7	7	8	12	27
2007	51	61	8	12	11	14	12	26
2008	52	62	13	19	17	21	15	30
2009	50	60	16	24	23	28	19	38
% of HIV-infected pregnant women who received ARV therapy								
2004	63	95	40	95	5	14	2	6
2005	59	95	39	95	3	8	2	7
2006	56	95	41	95	9	25	7	29
2007	53	95	41	95	12	33	6	25
2008	49	95	51	95	15	43	9	39
2009	49	95	57	95	17	48	14	59

The progress in ensuring access to ARV therapy has been extremely slow in all the BRIC nations; Brazil has perhaps the best record on this indicator, while India and China are the worst-off.



Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Brazil and China display a clear downward trend in the incidence of tuberculosis. In India, after a sharp drop in 1993, the prevalence of the disease appears to have more or less stabilized; the same can be said for Russia in recent times. India currently has the highest prevalence rate of this disease, almost double that of China and Russia and five times that of Brazil. Linked as it is to poor nutrition, poor hygiene and improper sanitation, the arrest of this disease requires increased focus on essential public services

Malaria is virtually non-existent in Russia and China. In the absence of data for earlier years, no conclusions can be drawn about whether or not the spread of the disease has been halted and reversed in Brazil and India. In any case the incidence of the disease is unacceptably high in India – again the outcome of poor hygiene and improper sanitation

Table 8: Tuberculosis prevalence rate per 100,000 population

	Brazil	Russian Federation	India	China
1990	135	220	337	280
1991	127	220	336	274
1992	118	215	337	270
1993	118	209	247	262
1994	111	199	242	250
1995	104	184	234	237
1996	98	169	233	228
1997	92	161	238	225
1998	90	133	243	223
1999	87	175	245	220
2000	89	179	247	214
2001	84	159	256	209
2002	80	153	260	200
2003	64	144	261	185
2004	70	136	260	167
2005	60	146	257	154
2006	59	137	254	145
2007	55	140	251	141
2008	54	135	249	139
2009	50	132	249	138

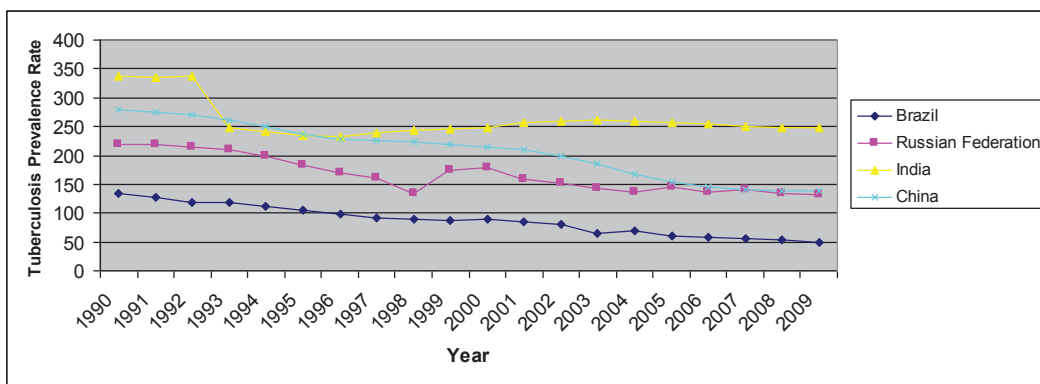


Figure 6: Tuberculosis prevalence rate per 100,000 population Source: Table 8

Table 9: Malaria prevalence rate per 100,000 population, 2008

Country	No. of cases
Brazil	210
Russia	-
India	1124
China	3

#### 4.1. To summarize the position of the BRIC nations on the health MDGs

Brazil is on track for achievement of MDGs 4 and 6. In the case of maternal health, i.e. MDG 5, much more needs to be done, but it is not an impossible task – a substantial scaling up of efforts will enable the country to reach its targets here as well. In Russia HIV/AIDS is the biggest worry; there is no sign of any let-up in the spread of the disease. Indications are that Russia will miss this health MDG. India will almost certainly miss the deadline of 2015 for achieving the stipulated targets. China is well within reach of the MDGs and the individual targets within the stipulated timeframe; in fact China will go beyond the set targets in critical areas such as reducing child and maternal mortality.

### 5. Public health in India

The previous section has clearly established that except for India, the other nations in the group are either on track to achieve the MDGs or can do so by making a concerted, deliberate effort in the time remaining to the countdown. Where has India gone wrong?

Starting from MDG 4, viz. reduce child mortality - while pneumonia is a leading cause of deaths of infants and young children in India, accounting for about 30 per cent of the under-five deaths, the major causes of infant mortality are premature birth and low birth weight, poor intra-partum and newborn care, diarrhoeal diseases, acute respiratory infections and other infections. It is a tragic stark truth that malnutrition and anaemia are contributory factors in over 50 percent of under-five deaths in the country (WHO 2005). The roots of high child mortality are to be found in poverty, illiteracy, lack of access to health services and poor status of women, particularly in rural areas.

Considering MDG 5 which seeks improvement in maternal health, the immediate causes of poor maternal health in India are high-risk pregnancy behaviour, low levels of institutional deliveries and poor implementation of Government-sponsored schemes and programmes. The pregnancy pattern in India – too early, too many, too close together – enhances the risk of maternal mortality. Rural ratios are typically two to three times higher than urban ratios. This abnormal difference between rural and urban areas is a telling comment on the pathetic conditions prevailing in rural India. Institutional deliveries, which are a critical factor in determining maternal deaths, are low all over the country, and more so in rural areas. As with child mortality, poor maternal health can also be attributed to poverty, illiteracy, lack of access to health services and poor status of women, particularly in rural areas.

Finally, coming to MDG 6 which relates to the halt of the spread of AIDS, malaria and other diseases - India is highly vulnerable to an AIDS epidemic on account of widespread poverty, illiteracy, poor nutritional and health status, social inequalities based on caste and gender, inadequate health infrastructure, taboos about sex, the social stigma and discrimination associated with the disease, lack of political commitment, and a persistent denial of the AIDS epidemic in many States. The government's malaria control and eradication programmes have run into difficulties due to the fact that industrial growth, deforestation, poor sanitation and the emergence of slums in urban areas have increased the breeding sites of mosquitoes and are the cause of malaria incidence in urban areas. Technical obstacles like development of Chloroquine resistance and insecticide resistance in malaria vectors pose a further

challenge to malaria control efforts. Further, urbanization, migration and climate change serve as aggravating factors for malaria transmission. The tuberculosis burden in India is huge and controlling the disease is a tremendous challenge. The TB control programme is weakened by low coverage of DOTS (Directly Observed Treatment – Short course), an inadequate health system, low levels of awareness and the stigma and discrimination associated with the disease. Compounding the difficulty is the fact that TB is the most common opportunistic infection for HIV-infected people in India. HIV is also the most powerful risk factor for progression from TB infection to TB disease. There is a common thread running through the challenges that the Health MDGs pose for India. The poor levels of achievement of targets and the very high probability that India will miss the deadline can all be traced to a few factors – poverty, illiteracy, gender inequality, improper hygiene and sanitation, lack of access to public health services and poor quality health services. Coverage of high-priority interventions remains inadequate, efficient management and governance is lagging, and inequities further complicate delivery and uptake (Towle 2011). Alongside these communicable diseases, non-communicable chronic diseases are also emerging as major contributors to the disease burden of the country. The four major NCDs are cardiovascular disease, diabetes, chronic obstructive pulmonary disorder and cancer. The prominence of these diseases has led Governments at the Centre and State level to divert resources away from primary and towards secondary and tertiary healthcare, making it even more difficult for the poor and marginalized to get proper and timely treatment. Health spending in India is yet another problem. Total expenditure on health as a percentage of GDP is a meagre 4.2 percent, and close to 70 percent of this total expenditure is borne by individuals themselves (WHO 2010). What is more, out-of-pocket expenditure accounts for almost 75 percent of private health expenditure. As far as the government is concerned, expenditure on health accounts for just over 4 percent of its total spending. All these figures indicate the low priority accorded to health in India, the disproportionate disease and economic burden on the poor and the complete inadequacy of resource allocation by the government.

## **6. A new health paradigm for India**

Public health in India is not improving at a sufficiently rapid pace, and as discussed earlier in this paper, the country is sadly off course in the journey toward 2015 and achievement of the MDGs. A new health paradigm is needed, if large numbers of India's millions are not to be left out of the growth story. What would be the elements of this new paradigm?

As a very first step, the right to health and wellness should be declared a fundamental right, as has been done in the case of primary education. This might seem bold and unrealistic, but the time for timidity and half-measures is past. Such an announcement will ensure the commitment of a greater volume of resources for this sector. While it is true that greater public health spending need not necessarily result in improvement in public health, it is equally true that improvements are impossible without more resources. Increased public spending is a necessary but not a sufficient condition for improving public health in India.

The second aspect of the paradigm, therefore, is a step-up in public spending on health. This increase should be large enough to make a difference. There is absolutely no doubt that India should be allocating substantially more of her national budgetary revenues to the health sector. A target of 9-10 percent of GDP, with the bulk coming from public rather than private sources, would be more meaningful. Furthermore, it is vital that public spending have a large enough long-term investment component to ensure the sustainability of improvements in public health parameters. This investment would be in physical capital (clinics, hospitals, training centres) and in human capital, i.e. health professionals such as doctors, nurses, community health workers, etc. Another critical aspect of public spending is that spending on health must be dovetailed with spending on water, nutrition, sanitation, housing and urban development. As long as these are the responsibilities of different ministries, the approach to public health improvement will be compartmentalized and ineffective. The government could also give serious thought

to the public-private partnership model - PPP model – to implement public health programmes. Committed, genuine NGOs could be roped in to generate awareness, particularly in rural areas, about diseases, their prevention and cure, the importance of hygiene and sanitation and the savings that could be generated through simple preventive and precautionary measures.

MDG 8 is about global partnerships in the cause of development, which basically imply assistance flowing from the advanced to the developing nations to help them achieve their MDGs. The United Nations member governments have reaffirmed these commitments several times since the Millennium Summit, including at the International Conference on Financing for Development (Monterrey, Mexico, March 2002) and the World Summit on Sustainable Development (Johannesburg, South Africa, September 2002). In the Monterrey Consensus, the poor countries accepted the responsibilities of good governance, serious policy design, transparency and openness to real implementation, while the rich countries accepted the responsibilities of greatly increased donor financing. It is in this context that the third element of the new paradigm emerges; India must chalk out an aggressive strategy for scaling up health services and then look to donor financing. The strategy should be ambitious enough to enable the country to meet the health MDGs, and must pay special attention to the needs of the poorest sections of society. The strategy must necessarily contain detailed plans of implementation, accompanied by a financing plan, clearly indicating the sources of funds needed for the implementation. These plans must be incorporated into the Poverty Reduction Strategy Paper (PRSP) that India, like other developing countries, submits to the IMF and the World Bank (Sachs 2004).

## 7. Conclusion

The MDGs are of strategic importance for governments as they provide a focus and a way forward for development efforts. Comparing the performance of the BRIC nations on their MDG achievement, we find that India is the only member of the group which will be unable to meet any of the set and agreed targets. The factors that are ultimately responsible for this poor performance are poverty, illiteracy, gender bias, urban bias, poor quality health services and lack of access to proper health services. India has one of the lowest per capita health expenditures in the world, and government spending is woefully and criminally inadequate. Consequently the burden of healthcare falls upon individuals, eating into already low incomes and meagre savings. The paper identified a new health paradigm, which requires first and foremost that health be declared a fundamental right. Second, the government should ramp up its expenditure on health taking care to incorporate all types of expenditure, especially investment in physical and human capital. And lastly, India should demand that advanced nations meet their own targets under MDG 8 and donate generously towards the scaling up of health services in the country.

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