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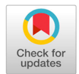
Editorial

# Challenges in Indian public health care management system in 2024

**Manoj Kumar Katual**[1]*

[1] *Dept. of Pharmacy, Guru Kashi University, Bathinda, Punjab, India*

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Public health, by virtue of its multidisciplinary nature, presents unique challenges in the education of students, researchers, and health professionals. The requisite skills must be drawn from a diverse array of fields, taking into account the complexity of factors that influence health and the effectiveness of interventions on population. This comprehensive approach necessitates an educational framework that not only imparts knowledge across various disciplines but also fosters an understanding of their interplay in addressing public health issues. Such an education system is pivotal in equipping future public health leaders with the ability to devise and implement effective strategies that are responsive to the multifaceted determinants of health.

The Indian healthcare scenario presents a spectrum of contrasting landscapes. At one end of the spectrum are the glitzy steel and glass structures delivering high tech medicare to the well-heeled, mostly urban Indian. At the other end are the ramshackle outposts in the remote reaches of the "other India" trying desperately to live up to their identity as health subcenters, waiting to be transformed to shrines of health and wellness, a story which we will wait to see unfold. With the rapid pace of change currently being witnessed, this spectrum is likely to widen further, presenting even more complexity in the future.

Our country began with a glorious tradition of public health, as seen in the references to the descriptions of the Indus valley civilization (5500–1300 BCE) which mention "Arogya" as reflecting "holistic well-being."[1,2] The Chinese traveler Fa-Hien (tr.AD 399–414) takes this further, commenting on the excellent facilities for curative care at the time.[3] Today, we are a country of 1,296,667,068 people (estimated as of this writing) who present an enormous diversity, and therefore, an enormous challenge to the healthcare delivery system.[4] This brings into sharp focus the WHO theme of 2018, which calls for "Universal Health Coverage-Everyone, Everywhere."

Another crucial aspect to consider in the education of those working in the field of public health is the mitigation of health disparities and the role of diversity and inclusion, particularly for minorities or discriminated populations. To address these issues effectively in both research and practice, a range of diverse competencies and soft skills is essential. This involves not only a deep understanding of the social determinants of health but also the ability to engage with communities in a manner that respects and values their unique perspectives and experiences. Cultivating such competencies enables public health professionals to develop and implement interventions that are culturally sensitive and equitable, thereby contributing to the broader goal of reducing health inequities and enhancing the wellbeing of all segments of the population.

In recent times, the COVID-19 pandemic has highlighted gaps in education and brought to the fore new challenges that have emerged. This unprecedented health crisis has underscored the necessity for public health curricula to

* *Corresponding author*.
*E-mail address*: drmanojkatual@gmail.com (M. K. Katual).

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be agile, adaptable, and responsive to emerging global health threats. The pandemic has not only exposed vulnerabilities in public health systems but has also called for a reassessment of how we prepare health professionals to navigate complex and rapidly evolving situations.[5,6] The integration of pandemic preparedness, digital health technologies, and crisis management into public health education has become imperative. Such an approach ensures that future public health professionals are better equipped with the knowledge and skills needed to effectively respond to and manage health emergencies, thereby safeguarding the health and wellbeing of populations worldwide.

What are the challenges in delivering healthcare to the "everyone" which must include the socially disadvantaged, the economically challenged, and the systemically marginalized? What keeps us from reaching the "everywhere," which must include the remote areas in our Himalayan region for instance, where until recently, essentials were airlifted by air force helicopters?[7,8]

While there are many challenges, some are for consideration:

1. Awareness or the lack of it: How aware is the Indian population about important issues regarding their own health? Studies on awareness are many and diverse, but lacunae in awareness appear to cut across the lifespan in our country. Adequate knowledge regarding breastfeeding practice was found in only one-third of the antenatal mothers in two studies.[9] Moving ahead in the lifecycle, a study in urban Haryana found that only 11.3% of the adolescent girls studied knew correctly about key reproductive health issues.[10] A review article on geriatric morbidity found that 20.3% of participants were aware of common causes of prevalent illness and their prevention.[11–14]
   Why is the level of health awareness low in the Indian population? The answers may lie in low educational status, poor functional literacy, low accent on education within the healthcare system, and low priority for health in the population, among others.
   The message is clear – we must strive to raise awareness in those whom we work with and must encourage the younger generation to believe in the power of education for behavior change.
2. Access or the lack of it: Access (to healthcare) is defined by the Oxford dictionary as "The right or opportunity to use or benefit from (healthcare)"[15] Again, when we look beyond the somewhat well-connected urban populations to the urban underprivileged, and to their rural counterparts, the question "What is the level of access of our population to healthcare of good quality?" is an extremely relevant one. A 2002 paper speaks of access being a complex concept and speaks of aspects of availability, supply, and utilization of healthcare services as being factors in determining access. Barriers to access in the financial, organizational, social, and cultural domains can limit the utilization of services, even in places where they are "available."
3. Absence or the human power crisis in healthcare: Any discussion on healthcare delivery should include arguably the most central of the characters involved – the human workforce. Do we have adequate numbers of personnel, are they appropriately trained, are they equitably deployed and is their morale in delivering the service reasonably high?
   A 2011 study estimated that India has roughly 20 health workers per 10,000 population, with allopathic doctors comprising 31% of the workforce, nurses and midwives 30%, pharmacists 11%, AYUSH practitioners 9%, and others 9%.[14] This workforce is not distributed optimally, with most preferring to work in areas where infrastructure and facilities for family life and growth are higher. In general, the poorer areas of Northern and Central India have lower densities of health workers compared to the Southern states.[16]
4. Affordability or the cost of healthcare: Quite simply, how costly is healthcare in India, and more importantly, how many can afford the cost of healthcare?
   It is common knowledge that the private sector is the dominant player in the healthcare arena in India. Almost 75% of healthcare expenditure comes from the pockets of households, and catastrophic healthcare cost is an important cause of impoverishment.[17] Added to the problem is the lack of regulation in the private sector and the consequent variation in quality and costs of services.
5. Accountability or the lack of it: Being accountable has been defined as the procedures and processes by which one party justifies and takes responsibility for its activities.[18]

In the healthcare profession, it may be argued that we are responsible for a variety of people and constituencies. We are responsible to our clients primarily in delivering the service that is their due. Our employers presume that the standard of service that is expected will be delivered. Our peers and colleagues expect a code of conduct from us that will enable the profession to grow in harmony. Our family and friends have their own expectations of us, while our government and country have an expectation of us that we will contribute to the general good. A spiritual or religious dimension may also be considered, where we are accountable to the principles of our faith.

In the turbulent times that we live in, the relationships with all the constituents listed above have come under stress, with the client-provider axis being the most prominently affected. While unreasonable expectations may be at the bottom of much of the stress, it is time for the profession to recognize that the first step on the way forward is the

recognition of the problem and its possible underlying causes. Ethics in healthcare should be a hotly discussed issue, within the profession, rather than outside it.[19]

The five as presented above present challenges to the health of the public in our glorious country. As we get ready to face a future which is full of possibility and uncertainty in equal measure, let us recognize these and other challenges and prepare to meet them, remembering that the fight against ill health is the fight against all that is harmful to humanity.[20]

This distribution underscores a predominant emphasis on shaping the foundational educational experiences of future public health professionals, while also acknowledging the importance of continuous learning and development for those actively contributing to the field. The diversity of article types reflects a comprehensive approach to exploring educational strategies, from theoretical frameworks and pedagogical innovations to empirical research and real-world applications, thereby providing a multifaceted perspective on education in public health.

## 1. Conflict of Interest

The author declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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## Author's biography

**Manoj Kumar Katual,** Dean and Associate Professor

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