IN PURSUIT OF HEALTH EQUITY: THE KERALA-GLOBAL CONNECTIONS

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Introduction

I am honored to join Professor KN Raj and Dr. Mohandas in inaugurating the first "TN Krishnan Memorial Lecture" at the Sree Chitra Institute. I remember a breakfast meeting five years ago at the India International Centre in Delhi where Krishnan and Mohandas shared their vision for this Menon Centre. Krishnan and I were close friends; he treated me like a family member, Asian style. His affection, even protectiveness, towards me was perhaps honed by his responsibility for nurturing alone his two children after the untimely loss of his wife. Krishnan was very proud of his son, Santosh, a cardiovascular surgeon in the US, and his daughter, Suneeta, an epidemiologist at Berkeley. He would be very joyful today in celebrating the recent birth of his first grandchild, Ketaki, a healthy 8.5 lb baby girl!

TN Krishnan was undoubtedly one of India's top economists. He was highly regarded by his peers - Vaidyanathan, Amartya Sen, Manmohan Singh, Mrinal Dutta-Chowdhury, Arjun Sengupta, and the late S Guhan. They confided in him, and whenever they had a falling out, Krishnan was trusted as the conciliator. Krishnan had "leftist" leanings, but he was never partisan and always open to diverse viewpoints. True to his values, Krishnan's life work was not to attain wealth or social status, but to give back to Indian society.

Krishnan was fiercely loyal to Kerala and India in general and to the Centre for Development Studies, especially its graduates, in particular. To me, he was a "total South Indian." I was surprised to learn, for example, how little he had traveled in Northern India. We journeyed together for his first visit to Rajasthan where he reluctantly but happily tried on a Rajput turban! In various stages of his life, Krishnan was also part of the global Keralan diaspora - serving with the UN in New York and as professor at Harvard. He would approve, I think, the subject of my talk today: "In Pursuit of Health Equity: The Kerala-Global Connections."

The Kerala Experience

Krishnan co-authored with KN Raj, Iqbal Gulati, and other founders of CDS the classic 1975 United Nations study of Kerala's unique social and economic development. He updated that work in a key chapter for the 1985 book, "Good Health at Low Cost," published by the Rockefeller Foundation. These seminal publications described Kerala as a "superior health performer," paralleling the health achievements of China, Cuba, Costa Rica, and Sri Lanka.

In 1994, Krishnan co-authored a paper on Kerala's "social transformation" within a single generation. He wanted to underscore that Kerala's achievements were feasible within the power of public action. Throughout most of the 20th century, health conditions in Kerala were better than other Indian states, but not markedly so. It was after the amalgamation of socially-advanced Travancore-Cochin with more-backward Malabar in 1957 that Kerala experienced a health take-off, diverging from the rest of India. Good health with equity was attained through political will, strong public policies, and wise social investments.

For the world community, the intellectual impact of Kerala has been enormous -- an inspiration to an entire generation. The Kerala story countered the prevailing thinking that economic growth was the major route to development success. Kerala demonstrated that high income and economic growth were no guarantees of social development. Good health depended on a combination of political, social, educational, and health advancement.

Kerala Re-Visited

What would Krishnan think about Kerala today as we begin the 21st century? I suspect that he would say that Kerala's situation is complex, subtle, and decidedly mixed. Krishnan worried about foreign over-simplification or romanticization of the Kerala story. I remember him recounting how in the 1970s some foreign scholars visited the CDS and misinterpreted Kerala to the world. I will try to avoid the same mistake today!

The so-called demographic and health transitions are well underway in Kerala. Fertility is below replacement, generating smaller cohorts of school children and an ageing population, well described by Leela Gulati. The transition in health is producing three epidemiological clusters simultaneously -- a first generation of poverty-linked infectious diseases, a second generation of lifestyle-related chronic diseases, and the emergence of a "third wave" of fresh environmental, infectious, and behavioral pathologies.

Data from the recent National Family Health Survey II (1998-99) confirm Kerala's spectacular health achievement. Longevity continues to advance, now exceeding 70 years. Infant mortality is 13 per l,000 livebirths. Even the "paradox" of high morbidity with low mortality reported by Panikar and Soman seems better understood. According to surveys in 1987 and 1996 by the Kerala Sastra Sahithya Parishad analyzed by Raman Kutty, Thankappan, and their colleagues, morbidity and health care utilization are indeed high. But the morbidity burden may be declining. The paradox is apparently a real phenomenon, due to neither "error" nor "perception" factors.

Health care coverage in Kerala is nearly universal. Trained personnel, for example, attend over 95% of births. There is some bias towards curative medicine in comparison to preventive public health and perhaps an excessive reliance on medical procedures; C-sections, some unnecessary, have steadily climbed, reaching 21.4%. Private health care has experienced explosive growth, and medical costs are rising, neither cheap nor "low cost."

These health developments in Kerala were built on well-entrenched land reform, public provisioning, and social mobilization. Poverty levels are reportedly down to 25%.

Female literacy and years of schooling in Kerala are the highest in India. Health and literacy, however, do not necessarily translate into empowerment. Some see a "hidden face" of gender inequality in Kerala. Women are comparatively disadvantaged in employment and senior positions. There are also increasing reports of domestic violence, mental stress, and even suicides.

Krishnan probably would remind us that in Kerala, as elsewhere, all humans are mere mortals! There is no immortality or perfection in human health. All societies strive to solve continuously changing problems. Health is not simply an outcome, like health status; it is also a process, a dynamic way of living.

Globalization and Health Equity

After a five-year absence, I took this opportunity to revisit India, moving through Delhi, Mumbai, Bangalore, Hyderabad, before arriving in Trivandrum. In addition to friends, I searched out government officials, NGO leaders, academics, journalists, financiers, and high-tech entrepreneurs. I wanted to catch up with new developments. In these conversations, I was impressed with the confidence and dynamism of Indian leaders as the country opens to the global economy. Many predict economic growth rates of 7-9% in the coming decade. The engine will be India's world competitiveness in human services -- the so-called "IT," "BT," and "PT" revolution, respectively in information, biological, and pharmacological technologies. The hype about high-tech is so infectious that the Indian Prime Minister while visiting the country's leading IT company in Bangalore (the day after an important Chinese visitor) reportedly called InfoSys "India's new Taj Mahal!"

This hype would worry Krishnan, because he was primarily concerned about social equity. Some caution would be appropriate, as described by Chandrasekhar, because the breadth and depth of these high-tech developments are confined to a very small pocket of Indians, threatening to widen rather than bridge India's deep divides. He would also not aspire for health equality, which is impossible because of people's differing physical endowments, behaviors, and lifestyles. Health equity is based on "fairness," a moral notion of what is right and socially just. The goal of health equity is that each person should be able to realize her or his full health potential.

Globalization presents both threats and opportunities for health equity. I am told that Kerala recently had three distinguished speakers on globalization -- the Nobel Laureate Amartya Sen, the Indo-British industrialist Suraj Paul, and the World Bank Vice-President Vinod Thomas. For me, globalization may be defined as the global movement of ideas, people, money, goods, and services -- driven by private markets and facilitated by a revolution in science and technology. Globalization results in a compression of time and distance -- the phenomenon of "anytime, anywhere." Inter-connectedness means that distant events can exert an impact in far away places. Global movement is not new to Kerala with its long history of international trade and migration. What characterizes our times is the speed and intensity of these connections.

The role of the private market propelled by globalization is under active debate in Kerala. Some believe that Kerala had been experiencing slow growth, economic stagnation, and unemployment. Others report that Kerala's economic performance in the 1990s was among the top half of Indian states. A dilemma is the appropriate balance and

compatibility between collective societal stability versus entrepreneurial individualism. These debates are also manifested in the health sector. Private health care is growing rapidly in Kerala. Among Indian states, Kerala has the second highest level of private care, commanding two-thirds of services offered. Yet, experiences around the world, especially in the United States, have demonstrated that private markets can be neither fully equitable nor highly efficient in health care.

In harnessing modern medical technology, Kerala is arguably the most advanced state in India. This causes both upstream and downstream challenges for health equity. Upstream research and development is biased towards cures for diseases of the rich driven by profit imperatives. That is why India is being flooded with new products for lifestyle-linked diseases, like lowering cholesterol, treating diabetes, and even enhancing sexual performance with three local brands of Viagra. Neglected by commercial research are technologies against the "orphaned" diseases of the poor, like tuberculosis and common infectious diseases. Downstream, India has witnessed an explosion of "super-hospitals" and "super-specialties." Large for-profit hospital chains like Escorts are proliferating; Apollo recently entered into a strategic alliance with a Singapore-based multi-national firm. Neglected by these commercial ventures are the equity-enhancing challenges of universal access, service quality, provider responsiveness, and affordability. Compared to other states, Kerala has been able to bring an equity lens to these downstream priorities, but the upstream challenges are global in scope.

Kerala's Global Connections

Two aspects of contemporary Kerala, I believe, offer hope for advancing health equity in a globalizing world. These are Kerala's people and the State's innovation in governance. India is increasingly confident that its people are world class, as demonstrated by the success of the writer Arunadutti Roy, the economist Amartya Sen, the IT billionaire Narayana Murthy, and the Indian winners of this year's Ms Universe and Ms World contests. India has top-flight human talents in a competitive global knowledge-based economy. Investment and growth are projected for software, IT enabling, and backroom services. Among Indian states, Kerala is well ahead in human capital formation. Its people are universally literate, well-educated, and hardworking.

Another dimension of Kerala's human asset base is the diaspora. In today's global economy, the "brain drain" may also be a "brain gain." Migrating Keralites exploit opportunity and send back remittances. These two-way flows strengthen Kerala's global connections. Long-standing out-migration from Kerala had earlier targeted work opportunities in the Indian army, neighboring states, and the demand for teachers and nurses. International migration to the Middle-East accelerated after the oil price shock in the 1970s. In the past decade, skilled Keralan technicians are being attracted to high-tech jobs in Bangalore and Hyderabad. Many of the 1.2 million non-resident Indians (NRIs) in the United States are from Kerala.

Globalization is producing huge inequalities, concentrating wealth and exacerbating mass poverty. The 130 million people of neighboring Pakistan produce a GDP of US$ 60 billion which is the same as the estimated annual income of some two million Pakistani overseas. India's GDP of US$ 400 billion is nearly matched by the estimated asset wealth of some 20 million NRIs. Economic remittances make up about two-thirds of India's foreign exchange earnings. This economic dis-equilibrium may

generate social or philanthropic flows back to India. Obviously, these flows based on extreme wealth along-side impoverishment cannot solve India's poverty challenge. Philanthropic remittances can only be an interim ameliorative approach. Ultimately, the only sustainable solution to poverty is for the poor to generate their own wealth.

Kerala is also innovating in local governance. Over the past decade, the State has decentralized power to local Panchayats. Facilitated by constitutional amendments, 40% of Kerala's state budget is now transferred directly to local Panchayats in support of more than 20 key functions following the principles of subsidiarity, devolution of decision-making, and local capacity building. Health and education are central components of decentralization. Devolution has been not just technical and financial, but it is also backed by mass social mobilization. Community participation has followed the approach of Kerala's pioneering people's science movement and mass literacy campaigns.

Kerala's decentralization underscores a critical gap linking local and global governance. Ironically, while Kerala's Panchayats are empowered by decentralization, national governments and global institutions are being overwhelmed by transnational flows. The crisis of global institutions is reflected by social protests last fall at the World Trade Organization meeting in Seattle and at the recent World Economic Forum in Davos. These protests mix multiple concerns -- global equity, "Americanization," and environmental and labor standards. The concerns appear to focus less on global flows per se and more on the fairness of the ground rules for global engagement, which are perceived to be detrimental to the poor in developing countries.

Will decentralization accelerate Kerala's progress in an era of globalization? Or will global forces overwhelm local initiatives? One problem of globalization, in my opinion, is not global connectivity but rather the lack of democratic governance to ensure fairness in global engagement. Global decision-making is excessively concentrated among only a few power centers. These biases fuel a sense of powerlessness among world citizens who feel unable to control global decisions that shape their destiny.

Conclusion

Kerala captured the world's imagination for its success in health and development. What lessons will Kerala offer for the future? How will Kerala's people, both residential and non-resident, exploit the opportunities of globalization? How will Kerala's decentralization perform in the face of changing global governance? How will Kerala and India balance entering the competitive global economy while improving global systems of governance?

Kerala's people may show that its human talent, skills, and enterprise can compete in the global economy. Kerala's experiment in local governance may demonstrate that decentralization can help democratize decision-making at both the local and global levels. Yet, Kerala's future must be navigated in a world lacking in genuinely democratic institutions. Without the democratization of health, global health equity built on consensus and shared values will be difficult and people will continue to feel unable to shape their health future.

Krishnan was visionary about these challenges. When India began economic liberalization in 1991, he did not oppose the expansion of private markets in India per se.

Rather, he became a passionate defender of public provisioning to protect the poor. He advocated for maintaining India's public food distribution system; indeed, he was a founder of the Food Corporation of India. In our UN-Harvard-Government project on health and development, Krishnan created partnerships among the actors and linked them to young social scientists throughout India. True to his values, his last paper on the crippling cost of family health crises moved him to propose the introduction of catastrophic hospital insurance for the poor. These intellectual contributions were based on Krishnan's understanding of Kerala's history of participatory democracy, tolerance among groups, and pluralism of ideas. Krishnan passed away confident about the resilience of Keralan society increasingly connected to a rapidly changing world.

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