International Journal of Current Advanced Research
ISSN: O: 2319-6475, ISSN: P: 2319-6505, Impact Factor: SJIF: 5.995
Available Online at www.journalijcar.org
Volume 7; Issue 3(H); March 2018; Page No. 10944-10948
DOI: http://dx.doi.org/10.24327/ijcar.2018.10948.1880

Review Article

HEALTHCARE COLLABORATIONS AMONG SAARC COUNTRIES: CHALLENGES AND PROSPECTS

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A R T I C L E I N F O

Article History:

Received 16th December, 2017
Received in revised form 20th January, 2018 Accepted 4th February, 2018
Published online 28th March, 2018

Key words:

Healthcare sector, Underdeveloped world, Collaboration among SAARC countries

A B S T R A C T

The regional organisations like SAARC can play an important role in boosting the healthcare sector in India and neighbouring countries. Health is a productivity enhancer and increase physical and mental capacities. In the underdeveloped world healthcare is considered more as a burden on state exchequer than growth enabler. There is a great scope of innovation and entrepreneurship in this sector which has to be identified and tapped by these countries. In its history of creation of more than three decades, SAARC countries are still at the nascent stage of co-operation and collaboration. The paper reviews the health status among SAARC countries, level of cooperation in healthcare sector and identifies prospective areas for further co-operation and collaboration among these countries so that these countries can put synergistic efforts together to improve their healthcare systems and provide better healthcare and better quality of life to their citizens.

INTRODUCTION

Economic theory has sufficient evidence to prove that 'Health drives wealth of a Nation'. There is a strong correlation between the state of health and productivity of a nation's workforce. Investment in health is a must for a country if it wants to build a strong foundation for economic success and prosperity. Health is also a productivity enhancer as it increases the physical capacities, such as endurance, strength and mental capacity involving reasoning ability and cognitive functioning. In underdeveloped countries like India, healthcare is considered more as a burden on state exchequer than growth enabler. This mindset needs to be changed because the sector has the ability to propel GDP growth if given due focus. A robust healthcare system drives GDP growth in the presence of adequate investments and a conducive environment (FICCI, 2015). The demand for healthcare services in expected to increase manifold due to rise in ageing population and growing disease burden. This calls for a greater number of healthcare practitioners and skilled workers, thereby creating more direct and indirect job opportunities. Smart investment in healthcare sector can also bring the coveted foreign exchange through medical tourism. In addition to all this, there is a great scope of innovation and entrepreneurship in this sector which can be instrumental in driving economy's growth. However, this sector has not developed to its full extent in the underdeveloped countries like India which has led to the vicious cycle of GDP loss and healthcare burden as adversities of diseases have the capacity to snowball into fiscal drags. India should therefore put up a synergistic effort along with the neighbouring developing countries to improve healthcare system. In this context, the regional organisations like SAARC can play an important role in boosting this sector through meaningful collaborations in this field.

This paper aims to identify the synergies in health facilities and implement identified best practices to provide better health and better quality of life to the citizens of SAARC countries. Experiences of the different countries of the region regarding health issues and facilities have been discussed and implications for collaborations have been brought out. The discussion in the paper has been divided into four sections. Section I brings out the health status among SAARC countries, section II is devoted to existing position of co-operation, section III concentrates on prospective areas of co-operation in healthcare and section IV sums up the discussion.

India constitutes over 70 percent of the area and population among the SAARC nations which comprise of Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan and Sri Lanka. It is one of the most populated regions of the world and accounts for 22 percent of the world's population and 3 percent of world's area with 33 percent births annually, about 37 percent of annual global child mortality (CM) and second highest maternal mortality ratio (MMR). The countries of this region face similar health issues and challenges. In spite of having common health problems and being affected by the same kind of natural calamities and epidemics, these countries have not attempted for a common minimum program to

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overcome the same and they continue to be a guinea pig for MNCs. The health indicators reflect commonality in terms of population growth, mortality rate and in input to health in terms of expenditure especially among nations bordering India. There are various approaches towards common problems and a strategic approach within SAARC countries is to share, learn and implement various innovations and practices, which could help in generating a more effective pathway for providing better health facilities for the inhabitants of this region.

Trends in Health and Morbidity Indicators in SAARC Region

The performance of South Asian Countries regarding health indicators like maternal mortality, child survival, prevalence of fatal diseases like Malaria, tuberculosis and other health problems is far worse than other regions of the world (Govt. of India, 2015). Table 1 shows global maternal mortality by region.

Table 1 Trends in Global Maternal Mortality by Region

(Per lakh of population)

Region	1990	2000	2013
South Asia (SA)	550	370	190
Europe and Central Asia (ECA)	61	44	28
Latin America and the Caribbean (LAC)	150	110	87
Middle East and North Africa (MENA)	160	110	78
East Asia and Pacific (EAP)	170	130	75
Sub Saharan Africa	990	830	510

Source: Trends in Maternal Mortality: 1990 to 2013 – WHO, UNICEF, UNFPA and The World Bank Estimates, 2014

The table shows that the maternal mortality in South Asian region is quite high as compared to other regions. Only the countries of Sub Saharan Africa have maternal mortality more than this region.

An important indicator for measuring progress of women is the maternal mortality ratio-which is a strong indicator of the attention that is paid to the healthcare for women. Across the region around a quarter of a million women die each year as a result of events as natural as pregnancy and childbirth and many are left disabled or chronically ill.

Table 2 brings cut the status of child and maternal health in SAARC countries in terms of different indicators.

Table 2 shows the deplorable condition of child and maternal health in almost all the SAARC countries, with Afghanistan performing the worst in these indicators. Infant mortality and under 5 mortality is quite high among all the SAARC nations except Maldives and Sri Lanka. Immunization coverage in India and Afghanistan when compared with other SAARC nations is leading to high morbidity and mortality from immunization preventable diseases. Maternal mortality ratio is also very high in all SAARC nations except Maldives and Sri Lanka.

Malaria and Tuberculosis are the two age old diseases and all the SAARC countries have been struggling with them since a long time. Different programmes were made and implemented by the respective governments for the control of these diseases. Table 3 shows that while Maldives and Sri Lanka have been successful in eradicating Malaria, Afghanistan, Bangladesh, India and Nepal still have high prevalence of this disease. There is widespread prevalence and subsequent deaths on account of Tuberculosis in the SAARC nations. South Asian countries have extent of TB incidence worse than the countries of Sub Saharan Africa. While Afghanistan, Maldives and Bhutan have registered accelerated progress towards reduction of TB incidence, Bangladesh, India, Nepal and Pakistan have recorded stagnant ratio of TB incidence. With the development of new and more effective interventions like DOTS greater strides may be made in the fight against TB in the coming years.

Healthcare infrastructure is of utmost importance for any country as it enables it to deliver quality healthcare series. It improves the efficiency, effectiveness, safety, access and patient-centered care. Inadequacies in health system infrastructure may limit the access and contribute to the poor quality of care and outcome, particularly among vulnerable population groups. Table 4 shows the abysmal status of healthcare infrastructure in SAARC countries. The total number of healthcare professionals and hospitals fall short for addressing the enormous demand in these countries. The inadequate healthcare facilities and less spending in healthcare sector has limited the universal access to the healthcare.

Table 2 Child and Maternal Health in SAARC Countries

Description/Country	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Infant Mortality (per 1000 live births)	134	29 (2015)	30.0 (2013)	42 (2012)	9 (2012)	46 (2011)	66 (2015)	8.2 (2013)
Under five Mortality (per 1000 live births)	199	36 (2015)	37.3 (2013)	52 (2012)	11 (2012)	54 (2011)	18.7 (2015)	10.0 (2013)
Underweight Children under five years (%)	39.3 (2004)	45 (2010)	12.7 (2010)	43 (2005-06)	30.4 (2001)	28.8 (2011)	81 (2012)	17.0 (2013)
Children under 1 immunized against measles (%)	76	84 (2014)	97.2 (2013)	74.1 (2009)	99 (2012)	88 (2011)	84 (2015)	99.5 (2015)
DPT3 immunization (%)	83	N.A	97 (2012)	55.3 (2005-06)	99.5 (2012)	91.3 (2011)	88 (2015)	99.0 (2015)
Maternal mortality ratio (per 100000 live births)	1400 (2008)	181 (2015)	86.0 (2013)	178 (2012)	13 (2012)	229 (2010)	260 (2011)	22.0 (2010)
Antenatal care coverage at least four visits (%)	NA	31.2 (2014)	81.7 (2013)	47.9 (2005-06)	85	50.1 (2011)	28 (2007)	93.0 (2007)
Birth attended by skilled health personnel	24 (2008)	42.1 (2014)	89 (2014)	83.4 (2012)	96 (2012)	36 (2011)	58 (2015)	99.0 (2007)

Source: *SAARC in Figures 2016*, Central Bureau of Statistics, Kathmandu, Nepal, August 2016

Health Ministers (November 14-15, 2003, New Delhi) stressed upon the need to co-operate on health issues amongst

Table 3 Prevalence of Malaria and Tuberculosis in SAARC Countries

Description/Country	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Malaria per lakh population	238 (2015)	281 (2014)	6.1 (2013)	106 (2012)	0 (2012)	450 (2009)	40 (2011)	0.24 (2014)
Tuberculosis prevalence rate per lakh population	340 (2015)	79.4 (2010)	1.5 (2011)	249 (2012)	30 (2012)	238 (2011)	NA	NA
Tuberculosis incidence rate per lakh population	189 (2009)	227 (2014)	225 (2013)	181 (2012)	39 (2010)	163 (2009)	230 (2011)	44.5 (2015)
Tuberculosis detection rate under DOTS (%)	48 (2009)	43 (2010)	85 (2012)	59 (2011)	45 (2012)	90 (2011)	91 (2012-13)	68.4 (2015)

Source: *SAARC in Figures 2016*, Central Bureau of Statistics, Kathmandu, Nepal, August 2016

Table 4 Healthcare and Resources Indicators in SAARC Countries

Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
3 (2015)	4 (2014)	3.3 (2014)	13.5 (2011)	16 (2010)	4.7 (2011)	10 (2005)	8.5 (2014)
5 (2015)	8 (2014)	18 (2012)	5.7 (2011)	23 (2009)	NA	6 (2015)	38.6 (2014)
7.4 (2009)	0.7 (2014)	2.4 (2014-15)	1.4 (2012-13)	8 (2009)	1.1 (2011)	0.42 (2015)	10.6 (2015)

Source: *SAARC in Figures 2016*, Central Bureau of Statistics, Kathmandu, Nepal, August 2016

Co-operation in the Field of Health among SAARC Nations

Health and population activities were one of the original five areas of co-operation identified by SAARC member countries. The primary focus of the Technical Committee set up in 1984 was on maternal and child health, primary healthcare, disabled and handicapped persons, control and combating major diseases in the region such as malaria, leprosy, tuberculosis, diarrhea, rabies and AIDS.

Important health issues have been at the centre of SAARC social agenda. Stress has been laid on greater inter-country co-operation amongst the member states to enable them to make a frontal attack on communicable and non-communicable diseases afflicting the region (Singh and Singh, 2009). Networking arrangements for training, research and eradication of malaria and regional approach for combating major diseases in the region have been undertaken. A directory of training programmes in six priority areas, i.e. malaria, tuberculosis, leprosy, diarrheal diseases, human rabies and maternal and child health have been prepared and subjects relating to health have been circulated among the member countries. Member countries have also identified centres such as the National Institute of Malaria Training and Research, Lahore to act as focal points on the different diseases. The SAARC tuberculosis centre, established in Kathmandu in 1992, is playing an important role in the prevention and control of tuberculosis in the SAARC region by coordinating the efforts of the National TB Control Programmes of the member countries.

SAARC Health Ministerial Meetings

The SAARC Health Ministers have been meeting from time to time to discuss both the emergent and long run issues relating to the countries.

Emergency meeting of SAARC Health Ministers was held in Maldives in April 2003 in the wake of widespread threats brought about by the emergence of the severe Acute Respiratory Syndrome (SARS). The First Meeting of SAARC SAARC member countries, not only in the field of traditional system of medicine but also on the whole gamut of health issues confronting the region, strengthening the mechanism for surveillance, reporting, diagnosis and management by exchange of expertise and sharing of infrastructural facilities among SAARC Member States. A common regional strategy to combat HIV/AIDS, TB and other deadly communicable diseases was emphasised and setting up of SAARC Surveillance Centre and a Rapid Deployment Health Response System was also recommended.

Second Meeting of SAARC Health Ministers was held on July 16, 2005 in Islamabad and led to the adoption of Islamabad Declaration. In this meeting, the countries resolved to work together developing regional policies and programmes as well as effective partnerships in order to check the illegal trade in drugs and medicines.

The Third Meeting (April 25-26, 2005 Dhaka) launched the SAARC Regional Strategy on HIV/AIDS. The Technical Committee on Health and Population Activities was set up to hold deliberations on the issue of reproductive health with a view of advancing effective regional co-operation, prepare guidelines for a regional initiative on basic healthcare services, nutrition, safe water and sanitation particularly in rural areas. The health ministers also adopted Dhaka Declaration- A Better Health Profile for South Asia.

The Fourth Meeting (Male 10-12 April 2012) welcomed the launch of SAARC Regional Strategy for prevention and control of communicable diseases. It urged the member countries to focus on the speedy implementation of regional projects that bring about the tangible gains for the people of the region.

In the Fifth Meeting of SAARC Health Ministers (New Delhi, 08 April, 2015) the HIV/AIDS Progress Report (2004-2014) was launched. The meeting discussed the Draft Delhi Declaration on Public Health Challenges.

From the above discussion it is clear that the meeting of SAARC Health Ministers provides policy guidelines to the Technical Committee on Health and Ministers provides policy guidelines to the Technical Committee on Health and Population to carry out a number of regional initiatives to promote and protect the health of the population in the region. SAARC health related initiatives have mostly focused on HIV/AIDS, tuberculosis, communicable, pandemic preparedness etc. SAARC has identified different centres to act as focal points on selected diseases. SAARC Tuberculosis and HIV/AIDS Centre (STC) has played an important role in the prevention and control of tuberculosis. It was renamed as

SAARC Tuberculosis and HIV/AIDS centre in 2005 and now takes the added responsibility of co-ordinating and implementing regional activities related to HIV/AIDS.

Since 2010, SAARC has been coordinating the Highly Pathogenic Emerging Diseases HPED Programme in South Asian region funded by the European Union through FAO, OIE and WHO. The objective of the HPED programme is to improve epidemic and pandemic preparedness in the region. SAARC Development Fund also implemented a regional project on 'Strengthening Maternal and Child Health Immunization' (June 2009-Dec. 2013) with a total budget of US$15 million.

Prospective Areas of Further Co-operation and Collaborations among SAARC Countries

In its history of creation of more than three decades, SAARC countries have held of only five health ministerial meeting, which shows that the collaborations and cooperation of these countries in this area is in its nascent stage (Kundra and Srivastava, 2006), even when the potential is immense and the gains enormous.

Following are the areas where there is need for further collaboration and co-operation among SAARC countries:

1. **Information sharing:** The countries should make the database on burden and trend of communicable diseases of public health importance available for universal access. There should be more co-operation for improving the reporting, validity and quality of data, early identification of outbreaks and feedback for adequate response.
2. **Quarterly meetings:** Quarterly meeting could be held at local levels to share the data of affected areas with specific diseases. Mechanisms may be developed at the local level for information exchange and coordinating and control activities.
3. **Synchronized interventions:** The preventive and curative interventions should be synchronized to have optimum synergistic effects e.g. the Indoor Residual Spraying should be synchronized so that the effective vector control can be achieved on both the sides of the borders. Similarly IEC campaigns can also be synchronized.
4. **Intensified monitoring:** To develop future drug and insecticide policy, there should be intensified monitoring of drug resistance or insecticide resistance among all the bordering countries.
5. **Mobilizing regional expertise for public health:** Ayurveda is a system of medicine with its historical roots in the Indian subcontinent. Modernized practices derived from Ayurveda tradition are a type of complementary or alternative medicine. The SAARC countries must collaborate in encouraging Ayurveda by opening more Ayurvedic universities and colleges. This can save these countries from the import of costly medicines from the western world. Alongwith this, an institute should come up for the study of traditional medical practices of all the SAARC countries.
6. **Established network of laboratory facilities:** SAARC countries should come together to establish a widespread network of high standard laboratory facilities which are lacking in most of these countries. The recognized laboratories should be allowed to establish their satellite centres in the neighbouring countries.
7. **Human resource development in the field of health:** With the growing demand for health facilities in SAARC countries, acute shortage of healthcare professionals is felt in these countries. The demand for doctors, dental surgeons, auxiliary nurses, midwives, lady health visitors and pharmacists has outpaced its supply. Thus these countries need to increase the number of the medical institutions and also the quality of education. In this context it is recommended that the existing government and private institutes in India should be exhorted to obtain the world class accreditations for which they have all the potential and then there should be exchange of information, students and MOUs among these countries. Indian must reserve some seats for the students from the SAARC countries in its medical colleges and universities. Satellite centres of premier institutes should be opened in other SAARC nations.
8. **Medical tourism:** Lack of quality healthcare infrastructure and skilled manpower deficit in the SAARC countries have strengthened India's position as a sought after destination for medical tourism (FICCI, 2015). Physical proximity and similarity in culture, food and language make India a convenient option. For these reasons, SAARC countries have formed a dominant piece in the medical tourist pie. Regional co-operation treaties between India and these countries can further strengthen India's position (Govt. of India, 2014). Medical treatment offered to tourists in India enables them to save around 30 to 70 percent of their costs. The government needs to increase efficiencies in terms of visa, airport documentation and co-ordination among various agencies to boost this sector.
9. **Research and Development:** SAARC countries are today facing the dual burden of communicable and non-communicable diseases, giving rise to a new pool of patients. In addition to this, the increasing and ageing population also needs to be taken care of (Helpage, 2015). This calls for SAARC countries to be the epicentre of innovation in the healthcare sector as it will have a positive domino effect on the health and wealth of these countries.

The above discussion shows that the SAARC countries have a huge potential for co-operation and collaborations in the field of health and medicine but the region has not been able to tap its potential due to the following problems:

a. There are still a lot of barriers to travelling freely between the countries of the region due to lack of connectivity and transportation, Geopolitics has taken over geo-economics in most cases and even when the countries concerned know the clear economic gains they are reluctant to let down the barriers.
b. Regional co-operation has taken a back seat in the midst of two acrimonious neighbours-India and Pakistan. The SAARC meeting which was supposed to be held in Islamabad on November 15-16, 2016 was postponed indefinitely because India withdraw from it, protesting against Pakistan's hand in the Uri terrorist attack. These kind of developments hinder the pace of co-operation and development in South Asian Region.

No meaningful progress can be made in the environment of mutual distrust and enmity. India and Pakistan should try to resolve their bilateral issues so that the SAARC countries make meaningful progress, especially in healthcare collaborations.

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How to cite this article:

Navjot Kaur (2018) 'Healthcare Collaborations Among Saarc Countries: Challenges And Prospects', *International Journal of Current Advanced Research,* 07(3), pp. 10944-10948. DOI: http://dx.doi.org/10.24327/ijcar.2018.10948.1880

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