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Health System Issues, Challenges, and Options: Reflections on urban India at the turn of the 20th Century

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Abstract
The success, issues and challenges that India face is always important not only for the Asian sub-continent, but also for the entire humanity as its home to around one fifth of global population. The paper tries to reflect on Indian health services in terms of issues related to financing, provision with an emphasis on urban India. The urban India stands much better than its rural counterpart, but leaves a lot to be desired. Failure of Indian policy makers in understanding the dangers of leaving it to the mercy of free market is emphasized. Public spending on health care is also disproportionately higher in urban areas. However, fast rise of private sector has compounded the problem of access to health care for the urban poor and mediflation is a harsh reality in urban medical services affecting both rich and poor.

Keywords: Health system; health financing; health care provisioning; health equity; urban India.

Introduction

Background: India's health system has been running through rough weather for quite some time and at this moment, calls for radical progressive transformation, if it is to offer a good deal of welfare to its population. Soon after Independence, the national planners committed themselves to develop the country and its people through a socialist framework and health had to be an obvious component in it. The post-independent plans and policies on health care were much influenced by visionaries like Bhore whose committee on Health and Development in India made primary care approach the bedrock of Indian health care system, and the public sector was visualized keeping these ideals in mind. The committee laid down the principle that access to primary care is a basic right and ability to pay or any other socio-economic considerations should not be barriers in accessing care. The country has made tremendous progress in health outcomes in terms of increased life expectancy at birth, reduced IMR, MMR and death rates, etc. However, the achievements are not so significant once we look through a comparative lens. The perceived needs and demands have been undergoing tremendous changes while the resources needed to finance them are greater than ever before. The rate of progress is such that almost every day another new drug or treatment, or a further advance in medicine and health technology, is announced (WHO 2000). For a state that promised universal health care through the public health care delivery system, India has allocated only a meager fraction of the public resources for health care. The country's health system evolved with ambitious plans; however, the resources were no adequate enough to fulfill even the minimum commitments made in the initial plans. The more worrying aspect has been that, rather than heavily increasing the public health resources, it came down substantially in successive plans. It has already been mentioned that it is high time health care assumed priority in the agenda of policy makers which should be reflected through substantially increased allocation for health care sector, monitoring the performance of the public and private health care providers, the changes in the different access and utilization of care by the different socio-economic groups.

The present paper is an attempt at understanding the Indian health care system better which

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had travelled a lot, but failed to make significant achievements. Some of the issues related to financing, provision etc are reflected with an emphasis on urban India.

Issues and Challenges

Soon after the nation achieved Independence from the British Empire, the country's policy makers especially Jawaharlal Nehru had ambitious plans for the development of the country's future which was much evidenced in his speeches in the Constituent Assembly and in his revelations to the public. He acknowledged health care as a major component in 'eradicating poverty, inequities and diseases. The Indian National Congress was fully in favour of providing free care to all the populations by the state (Narayana 1983). Each Five-Year Plan reiterated the government's intention to provide quality health care at the lowest possible cost and a community centered health care. Though each plan and committee regretted or criticized the inability of the government in providing care to all, there was hardly any attempt to understand the factors for the failure (*Ibid*). Rather than having a proper plan on health care, what we had were adhoc committees and some guidelines which were not clear on their objectives. Some for the other factors responsible for the failure of the Indian health services were

1. Health care was a state subject as per the Constitution and an absence of a strong national policy emphasizing the importance of health care led to differential importance attached to health care in many states and was reflected in varying allocation of health care finances in different states leading to wide inequities in the distribution of public health care. The initial conditions of many states were very poor in terms of health outcomes and declining health care system worsened the situation further.
2. The development strategy of the national government was heavy-industrialization oriented, which demanded huge number of resources which might have reduced the allocation for health care. The First Plan gave 3.3 percent of the Plan resources to health care and unfortunately, it had never gone up from the initial mar and now, is hovering around one percent of the Plan funds (Government of India, 2002). Rather than increasing the distributional equity among the population, it has increased inequity due to less employment elasticity of the production
3. The state has never attempted fully to intervene in the private health services not only the hospital sector, but also in the other critical inputs sectors like pharmaceutical industry, medical equipment industry etc.
4. The Human resource policy including medical education, role of media in the post –Independent India needs a critical review in enhancing the role of state inn providing the kind of services the population wanted. For example, a review of articles on health in a national daily by Jean Dreze and Amartya Sen (2000) reveals that health care issues were highly unrepresented in the new writings. All these point to the general feeling that health care is getting individualized with health of an individual as a private responsibility with less role for any social organization, which is generally not a desirable trend for the health of the population. With this brief introductory discussion on Indian health services, we may move forward to the country's current practical issues in health scenario.

The Indian healthcare scenario is often dubbed as pro rich and pro urban as majority of the health care delivery institutions, both public and private are concentrated in the urban area. The burden of health care in India is inversely related to economic status of the household and the poorer households are found to be victims of inefficient health care system (Gumber, 1997). It has eaten into their already thin household budget though out-of-pocket payments made for treatment as well as through inability to earn during the period of illness. India with its highest levels of private financing of health care especially through out-of-pocket expenses worsens the inequity in access to health care seeking. While private household out-of-pocket expenses form more than 80 percent of the total health expenditure in the country, the role of government expenditure is limited to less than 17 which is one of the lowest in the world. The role of private health insurance is 0.16 percent of the population and confined mostly to urban areas. The private health insurance does not have a solid ground in Indian health scenario because of the low size of the market primarily contributed by low market size, inadequate coverage, high premiums, lower awareness etc. The share of social insurance is very limited with another two percent population mainly through Central Government Health Scheme (CGHS) and the Employees State Health Insurance Scheme (ESIS). Studies reveal that repressiveness is the highest for out-of-pocket payment and it is hardly possible to make an impact on poverty reduction without addressing the ill health financing issues. Indi's health care system, in the present look, essentially a market-based one where diagnoses and drugs are treated much like any other commodity (Dreze and Sen 2000). A brief look at the international health system reveals that India's health care delivery system is the most privatized one with minimum collective responsibility, and it is important to note that even the so-called capitalist industrialized countries have heavy state involvement in the functioning of their health services. The public involvement has to be very high in the country specially to combat communicable diseases where private sector is hardly interested due to what is called "market failure' in economics literature.

Further, one of the grave problems in the present health care arena is its failure to control communicable diseases, despite the availability of cost-effective and relatively simple technologies. These pre-transition communicable and infectious diseases, whose treatment and prevention have a very high degree of positive externality still constitute more than half of the disease burden (as measured by DALYs) in the country. When the country started implementing measures to reduce mortality and enhance life expectancy at birth etc, the challenges thrown up by the ongoing health transition has important implications for the public heath structure and population health in the country. The three important constituents of the transition –demographic, epidemiological, and social changes-possess the capacity to change the outcomes of health actions, changes the requirements of the system, raise the financial burden of treatment, and increase pressure on the health system to deliver satisfying care to

the clients. Ageing is the inevitable outcome of demographic transition with the share of elderly constituting are increasingly proportion level. The epidemiological changes bring in more of the so-called Group-II diseases whose treatment and management are costly and need long term care. Social transition regarding the quality of care, which further contributes to the rising expectation of the population regarding the methodology of treatment especially through enhanced quality increases the cost geometrically. The changes in demographic pattern have a great implication on cost of medical care in the sense that the elderly does exhibit a higher stock of morbidity. For example, few studies reveal that the large level in health care expenditure across households is explained by the number of elderly members in the family (Narayana 2001). The exorbitant costs of treating non-communicable diseases including cardio-vascular diseases, diabetes, neoplasm, neurological disorders etc further strain the system and make huge devastation on the population. The fresh challenges including HIV/AIDS, resurgence of diseases which were earlier thought to have been eradicated, drug resistance to some diseases etc add to the woes of the health sector in the country.

Urban Health System: Health and health conditions in urban areas are different from the average Indian scenario. With regard to the urban health outcomes, health care problems are more often a consequence of factors outside health care including issues of decent housing, poor sanitation, noise and air pollution, unsafe drinking water etc. A majority of the urban poor work in the informal sector, characterized by self-employed and low paid workers, not having any fixed employer-employee relationship and is of any statutory, social security measures. In addition, the presence of risk factors such as pollution, unhygienic environment etc coupled with poverty make the urban poor more vulnerable to diseases. High rate of growth of urban population and consequent increase in population residing in slums has led to over straining of infrastructure and deterioration in public health (Gupta and Mitra 2002). The urban slums which form around 22% of the total urban population is characterized by poor living conditions, absence of proper water and sanitation facilities making urban poor vulnerable to a host of diseases (Dilip and Duggal 2004). So, any strategy designed to influence the urban health outcomes may have to incorporate these non-biomedical factors into consideration. There exist wide disparities between and within the poor especially in terms of caste and gender. Social exclusion and lack of voice for poor increases their vulnerability to ill-health and violence. As a result, the urban poor carry higher risks of sexually transmitted infections HIV/AIDS and poor reproductive health. The workers in the informal sector do not get any health care benefits as insurance coverage in India is heavily skewed in the favour of upper and urban middle class, and the employees working in the organized sector. Sudden illness episodes, especially those that my call for hospitalization result in heavy losses in their daily earnings. Despite better physical access to health care, the higher average cost for accessing health services makes the urban poor community as disadvantaged as their rural counterparts. A very large number of people cannot even afford to access the “fire”. Government services and heavily depend on poor quality services provided by local unqualified practitioners. Despite a significant reliance on public health facilities, the poor households tend to spend nearly one fifth of their income on treatment. In the absence of any formal risk pooling mechanisms, high out of pocket expenditure coupled with inability to earn during the period of illness, drive many poor families into perpetual indebtedness. So diseases are a critical factor in explaining poverty of the urban poor.

It is often believed that the publicity provided health services are free of charge. However, especially in recent times, almost all the state governments introduced or increased the level of user charges manifold making even public health care costly. The patients seeking care from public are charged explicitly and implicitly. The direct charges mainly take the form of user charges and other charges. As per estimates by Krishnan (2000), in the rural sector, less than 3 percent in Haryana and Punjab and about 7 percent in Uttar Pradesh get free treatment as in-patients in hospital. Even fewer numbers receive such free treatment in the urban sector in these states. The numbers receiving free treatment in urban sector are smaller than those in the rural sector in all states. Of the rural patients, 70 and 54 percent receive free treatment in Jammu and Kashmir and Tamil Nadu respectively. This proportion is 46% for Orissa and Rajasthan and 34% for West Bengal.

In states like Andhra Pradesh (12.2), Gujarat (15.97), Karnataka (16.78), Kerala (15.08) and Maharashtra (16.71), this varies between 12 and 17 percent. In the urban sector, 47% in Tamil Nadu and between 6 and 12% in Gujarat, Karnataka, Kerala and Maharashtra receive free treatment. Besides, the patients attending public hospitals may have to incur large amount of indirect costs including the amount spend on medicines and other services which are to be purchased from private sector, bribes for hospital staff, and other inefficiency costs. Since a large number of patients utilizing care in health services in the urban India are from rural areas, they may have to spend on transportation charges, lodging and associated expenses making health care seeking a costly event. Since the cost of treatment in public sector indirectly influences the cost of treatment in private sector, the increased user charges in public hospitals might also be a reason for increasing health expenditure in private hospitals.

Statistics clearly show that the bed-population ratio is higher in urban areas than in rural areas and that there has not been any significant decline in these disparities over time (Duggal et al 1995). This regional imbalance is present in both governments run public sector and in the private sector. Further the public spending on health care is also disproportionately higher in urban areas. Although the urban populations have better access to health care facilities than their rural counterparts there is widespread inequalities between the poor and rich even while the proportion of those living in poverty appears to be declining. The density of providers in urban areas is much higher than rural areas. The urban healthcare service delivery system in India consists of medical colleges, middle-level government hospitals, maternity homes, dispensaries, ESI-run hospitals and dispensaries, and many private practitioners and private hospitals of varying size and variety. Though urban areas are comparatively much better than rural areas in terms of health indicators, survey-based information shows wide inequalities in accessing services within the urban context. The urban health services are devoid of primary health care

workers and the health care system is primarily curative in nature. (Jay Satia et al 1999). NSSO survey reveals a very high utilization rate of private sector for both inpatient and outpatient care in urban areas. (NSSO 1998). According to the survey, those seeking outpatient care services from public sector were 20 per cent in urban areas and for inpatient care services it was 43 per cent (Table 1 & 2). Although most of the people utilize private practitioners for minor illnesses, they depend on public facilities for acute illnesses requiring hospitalization and maternal care (Yesudian 1999). A recent study on the pattern of utilization of municipal health services in Mumbai have shown that cutting across all socio-economic groups, a good majority of households from all such groups used the private sector for minor and chronic ailments. The multiplicity of agencies rendering government health facilities, absence of proper coordination and inefficiency are the important reasons for low utilization of public health facilities. The other factors responsible for the low utilization of the urban health centres are inconvenient timings, long waiting times; non-availability of medicines and the feeling that the services provided by private practitioners and the teaching hospital are better. Some micro-level studies add empirical support to the national survey. For example, in places like Mumbai, the municipal corporation has not been able to expand its medical infrastructure adequately to cover the suburbs, which ultimately led to the growth of the private sector (Yesudian 1994) which burdens the higher-level facilities leading to breakdown of public health services. Private practitioners are in the vicinity and they offer quick cure and provide personalized treatment (Baru 1998). Existing heavily dualistic model is one where the rich have the ability to extend their life, while the poor are not only denied an extension of their life, but even a bare survival. This situation runs contrary to the well-adopted saying of Bevan that 'rich and poor are treated alike, that poverty is not a disability, and wealth is not an advantage'.

Table 1: Public-Private Sector Utilisation for Outpatient Care: All-India (Percentage distribution)

	Rural		Urban	
	1986-87	1995-96	1986-87	1995-96
Share of Public Sector	25.6	19.0	27.2	19.0
Share of Private Sector	74.5	80.0	72.9	81.0
Private hospitals	15.2	12.0	16.2	16.0
Private doctors	53.0	55.0	51.8	55.0
Private Practitioners				
Others	5.2	10.0	2.9	7.0
Total	100.1	99.0	100.0	100.0

Sources: Gita Sen et al 2002, NSSO 1992, Statements 13R and 13U, pp 67-68 Statement 2R and 2U, pp 53-54, NSSO 1998, Table 4.10, p.22, Table 4.16.p.28.

Table 2: Public-Private Sector Use for Impatient Care: All-India (Percentage distribution).

	Rural		Urban	
	1986-87	1995-96	1986-87	1995-96
Share of Public Sector	59.7	45.2	60.3	43.1
Share of Private Sector	40.3	54.7	39.7	56.9
Others	1.7	0.8	1.2	0.6
Total	100.1	99.0	100.0	100.0

Sources: NSSO 1992, Statements 13R and 13U, pp 67-68, Statement 2R and 2U, pp 53-54, NSSO 1998, Table 4.16,p 28.

The general increase in the health care demand couple with inability of the public hospitals to provide adequate medical facilities accelerated the growth of the private health sector in India. The demand- supply gap for public health care delivery is large and, on the rise, and this gap is increasingly being filled by private health care institutions. The general increase in the income levels and the corporatisation of care in urban areas has led to commodification of health care, access to which is determined by ability to pay for the service. The urban health care industry is booming, with a host of private hospitals offering state-of-the-art services for the rich and the middle class. The availability of medical technologies has brought significant increase in the demand for use of advanced technology. The changes in the disease pattern due to epidemiological transition, easy availability of financial resources and easing of important restrictions has contributed significantly to the rapid influx of medical technology. Private provision brings in a great number of fresh problems including non-involvement in prevention of diseases, over-charging, induced demand, absence of a genuine quality assurance mechanism, etc. The private sector is so heterogeneous that it ranges from large corporate hospitals to small five-bed nursing homes and solo practitioners with questionable qualifications, practitioners who have medical degrees in indigenous medical systems, but also practice modern medicine and diagnostic centres offering numerous services. Various studies have identified that a vast majority of private health care providers in urban areas do not follow any norms either with regard to the use of physical infrastructure (space per bed, provision of certain utilities, etc) or the structural aspects of care (medical and paramedical personnel employed, services offered etc). The important problems cited by these studies are lack of physical standards, inadequate spacing of hospitals (a majority of nursing homes are substandard, most of them being housed in tiny flatlets), absence of trained human personnel especially qualified nurses, maternity homes without labour rooms, poorly lit and dirty wards and beds, absence of records of notifiable diseases, births and deaths etc (Nandaraj and Duggal 1997). This has also led to medically

unjustified use of technology and the existence of a complex network of arrangements between the physicians in the government sector and the private hospitals as well as local diagnostic centres. These types of mural arrangements have a definite bearing on the cost of care since most payments are made out of pocket on a fee-for service basis. The complexity of actors, their actions, the structure and conduct of the business make it extremely difficult to frame policies on regulating the private health services. Even in areas where private provision seems to be theoretically harmless, issues arising of inequality in information between the agent (provider) and the principal (patient), uncertainty in incidence and outcomes of treatment etc usually works against the consumer. In such chaotic markets the user/consumer is helpless and competition by itself is a poor efficiency- enhancing device especially when consumer is unable to judge the level of quality (Dreze and Sen 2002). Whether the state can effectively take up is a priceless question.

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