

1st HM Patel Memorial Lecture

Healthcare and Governance

by

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I. Introduction

The greatest challenge before India today is combating mass poverty and making lives of ordinary people bearable. If dignity is denied to an Indian in 2005 AD, and people are forced to be hungry even as food grains are rotting in warehouses, then that is unacceptable. If in 21st century, poor Indians suffer in monsoon from torrents of rain for want of shelter over their heads, or shiver in cold, then that is a disgrace to our republic.

If rights of the poor are trampled upon without reparation, and justice is delayed and denied, and poverty is therefore perpetuated, that is an unbearable shame in a democracy. If a child born in this land of ours has no access to health care, and suffers needlessly from preventable illness, that is clearly a negation of our democratic ideals, and perversion of our humane Constitution. If the children are denied basic education of reasonable quality, and if their minds are stunted on account of the non-fulfillment of their potential, and their latent talents nipped in the bud, then the political and governance system should be assailed without hesitation.

Sadly, all these and more are true about our country and its governance. Thanks to our misplaced priorities and irrational policies, the governments, over the years, have failed to do what they ought to, and have always taken upon themselves tasks, which are not theirs. The results are waste of public money, perpetuation of poverty, uncontrolled population, ubiquitous corruption, ecological degradation and failed policies.

Most economists across the world generally agree that India can grow faster if only certain impediments to prosperity are removed.

The economic reform process of India started in 1991, has yielded good dividends and helped the growth rate to rise. Consumer goods are now better and cheaper, and people have a greater choice on offer. Investment has gone up, and exports have boomed for a decade. The percentage of poor people is showing decline, and population is reaching replacement levels in the South and the West. Removal of foreign exchange controls has led to increase in reserves. India has witnessed a revolution in telecom and information sectors. Many new enterprises such as BPO's have sprung up, and helped the young people find lucrative jobs. Most people are actually better off today than they were a decade ago. In that sense the reform process has yielded good results.

And yet, if you look around, most Indians express a great unease and the country's true potential remains unfulfilled even today. The current 5 - 6% growth rate is widely regarded as unsatisfactory. Impressive as it is by global standards, our growth rate is insufficient to make a significant dent in poverty, or to absorb the millions of youngsters joining the workforce. Fiscal deficits stubbornly remain at the 10% GDP level. Government continues to be wasteful, inefficient and corrupt.

How is such a paradox possible? How can we do better, and feel worse at the same time?

In truth though the reform years did accomplish an important task by breaching the dam of controls, licenses and permits, and allowing our productive potential and entrepreneurial

energy to flow; the reservoir of growth has been stymied as there are no fresh in-flows of reforms and more importantly no inclusive, all-pervasive changes. That is why our growth rate is tapering off, and our excitement is slowly giving way to forebodings.

Politically it has been observed that since the 1980's, there is really no serious ideological contention, notwithstanding a few make-believe arguments and politics of populism to garner votes. Generally, there is a broad agreement on key areas of state intervention to promote growth with equity. Despite this impressive political consensus on the goals, no government is able to ensure outcomes. The resultant gulf between promise and fulfillment is at the heart of the volatility in voter behaviour, and the persistent anti-establishment verdicts.

And in many ways the 2004 Lok Sabha election verdict was an expression of this discontent by the poor and dispossessed. But it is understood that the verdicts are not against economic reform; they are for a more inclusive growth process that meets the aspirations and basic needs of the underprivileged.

Ideologues see growth and equity as incompatible. But history has shown and taught us the invaluable lesson that growth and equity are durable only when they reinforce each other. Education, healthcare, infrastructure, natural resources development and institutions of rule of law and good governance - all these promote both growth and equity. Unfortunately, low priority is accorded to public spending in key sectors such as Education and Health in India vis-a-vis other major countries (Table 1). In fact, there are sectors in which with minimal investments, we have the ability to

promote maximum public good. And, healthcare is clearly one such sector. Although our knowledge and skill in this field can match the best in the world, our health indicators are very poor.

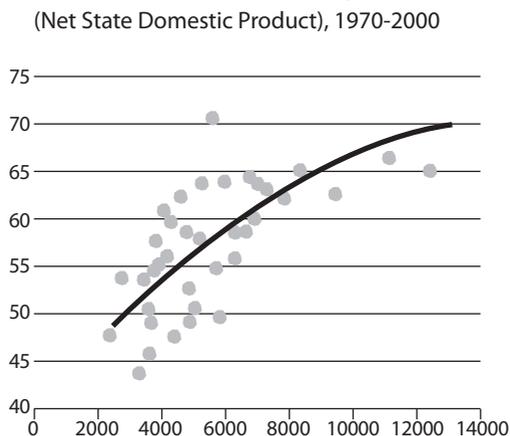
Table 1: Priorities in Public Expenditure (PE)

Country	PE on Education as % of GDP	PE on Health as % of GDP
United Kingdom	4.5	5.9
Germany	4.6	8.0
United States	4.8	5.8
OECD	5.2	8.1
India	3.2	0.9

Economic Growth and Health

That economic prosperity and the state of health of a community go together is a self-evident proposition (Box 1). As global prosperity improved after the Second World War, there has been significant improvement in health indicators. Between 1960 and 1995, life expectancy in poor countries rose by a remarkable 22 yearsⁱ (Economist: Dec 20, 2001). Infant Mortality Rate in poor countries, which was around 150 per 1000 live births, fell to 40 on an average. The reasons are not far to seek. With economic growth, there are higher investments in basic infrastructure. As access to safe drinking water and sanitation improves, most of the water-borne diseases disappear. With education come health awareness and skills to combat disease. And as more resources are devoted to public health, there is better immunization coverage, and greater access to primary and secondary healthcare. Much of health improvement witnessed in India too followed the same pattern.

Figure I
Life expectancy at birth (LEB) and per capita NSDP
(Net State Domestic Product), 1970-2000



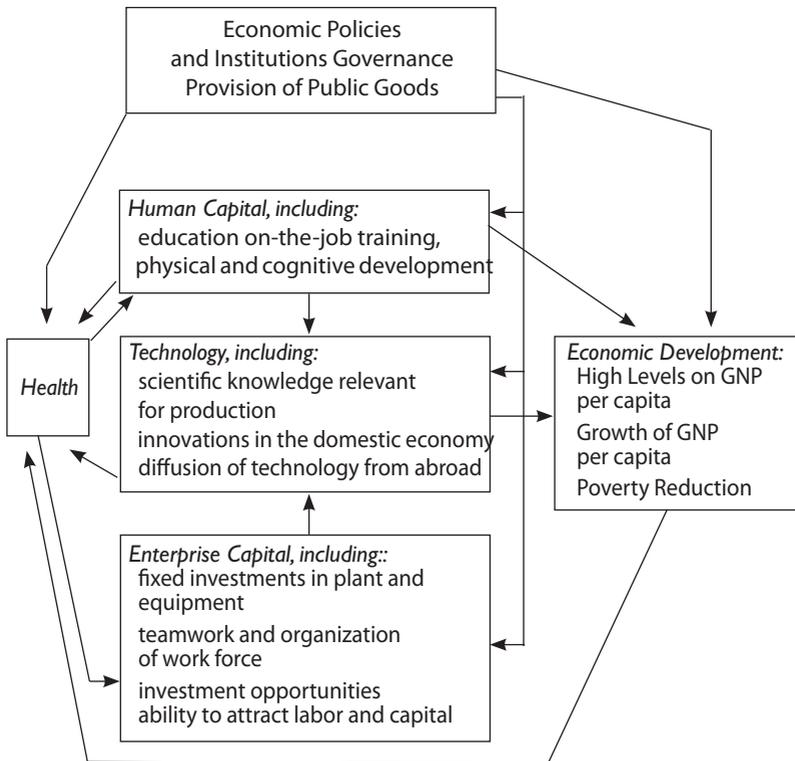
Source: report of the national commission on macroeconomics and health

At the level of the individual and family, the impact of poor health on economic well-being is even more pronounced. Sickness forces poor families to sell their precious, and often productive, assets to pay for medical care. Poor families in India spend 7 to 8 percent of their annual household income on healthcareⁱⁱ (Charu C Garg: 1998). World Bank studies show that hospitalized Indians spend 60 percent of their total annual expenditure on medical care, and a large share of this comes from borrowed funds. Sickness is thus one of the biggest contributors to impoverishment and indebtedness. When infant mortality is high, parents tend to have more children as they do not expect all children to survive. The resultant population growth, and consequent pressures on scarce resources and limited opportunities are only too evident in India to need elaboration. Education of a child is a low priority in a large family, perpetuating the low skills-poverty-sickness cycle. Epidemics and endemic infections

discourage tourism and free movement of people, leading to economic isolation. The prevalence of dengue fever and chloroquin-resistant malaria in Eastern India, and fear of AIDS, yellow fever, malaria, kala azar and leishmaniasis in many African countries have significantly curbed economic activity and trade. According to Economistⁱⁱⁱ, by one estimate, malarial countries would be twice as prosperous today if the disease had never existed!

Figure 2: Health as an Input into Economic Development

Figure 1. HEALTH AS AN INPUT INTO ECONOMIC DEVELOPMENT



Source: *Macroeconomics and Health: Investing Health for Economic Development*, Report of The Commission on Macro Economics and Health, World Health Organization, 2001. p.26

The Commission on Macroeconomics and Health^{iv}, chaired by Jeffrey Sachs in its report has succinctly summed up the interrelation between health and economic development:

“Because disease weighs so heavily on economic development, investing in health is an important component of an overall development strategy. This is especially true in poor countries where the burden of disease is very high. But investments in health work best as part of a sound over-all development strategy. Economic growth requires not only healthy individuals but also education, and other complementary investments, an appropriate division of labor between the public and private sectors, well-functioning markets, good governance, and institutional arrangements that foster technological advance. Private sector-led growth in the business sector must be complemented by an active role of government in several areas: ensuring core investments in health and education, guaranteeing the rule of law, protecting the physical environment, and working in cooperation with the private sector to foster scientific and technological advance. We are not claiming that investments in health can solve development problems, but rather that investments in health should be a central part of an overall development and poverty reduction strategy.”

As the figure shows, economic output is a function of policies and institutions (economic policies, governance, and supply of public goods) on the one hand, and factor inputs (human capital, technology, and enterprise capital) on the other. “Good policies determine economic performance

for any given level of capital and technology, and also the pace at which capital and technology accumulate. Health has its most important economic effects on human capital and on enterprise capital through a variety of pathways, some obvious and others subtler. Health itself is affected by the prevailing policies and institutions, the level of human capital (since education, for example, promotes health), the level of technology in the society, especially in the health sector itself, and on the very growth in income and poverty reduction that better health engenders,^v

II. India's Impressive Record since Independence

India recorded significant achievements in health sector over the past 56 years. Life expectancy, which stood at 32 years in 1947, has doubled. Infant mortality rate, which was 146 per 1000 live births in 1951, is now under 70. Many deadly infections are now better controlled. Smallpox has been eradicated, and polio is close to being eliminated. There has been impressive expansion of health infrastructure and manpower. As the National Health Policy - 2002^{vi} notes:

“Government initiatives in the public sector have recorded some noteworthy successes over time. Smallpox and Guinea Worm Disease have been eradicated from the country; Polio is on the verge of being eradicated; Leprosy, Kala Azar and Filariasis can be expected to be eliminated in the foreseeable future. There has been a substantial drop in the Total Fertility Rate and Infant Mortality Rate. The success of the initiatives taken in the public health field are reflected in the progressive improvement of many demographic/epidemiological infrastructural indicators over time.”

Table 2: Achievements through the Years - 1951-2000

Indicator	1951	1981	2000
Demographic Changes			
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
IMR	146	110	70 (99 SRS)
Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no. of cases)	>44,887	Eradicated	
Guinea worm (no. of cases)		>39,792	ERADICATED
Polio		29709	265
Infrastructure			
SC/PHC/CHC	725	57,363'	1,63,18 (99-RHS)
Dispensaries & Hospitals (all)	9209	23,555	43,322 (95-96-CBHI)
Beds (Pvt & Public)	117,198	569,495	8,70,161 (95-96-CBHI)
Doctors (Allopathy)	61,800	2,68,700	5,03,900 (98-99-MCI)
Nursing Personnel	18,054	1,43,887	7,37,000 (99-INC)

Source: National Health Policy - 2002

As the National Health Policy notes, this improvement in health indicators is the outcome of specific health initiatives as well as other complementary initiatives in the developmental sector. One of the happy features of healthcare in modern world is that mankind is getting ever closer to full potential in terms of health, quality of life and life span. Most of preventable disease and avoidable suffering can now be eliminated or controlled. Health technologies can be transplanted with

relative ease even on otherwise underdeveloped societies. Most effective health interventions are relatively inexpensive and can be widely applied to large masses of people. Modern communications revolution too makes it easy to generate demand for better health, and disseminate information on healthy practices. The real challenge is one of creating and sustaining viable, effective and responsive health delivery system.

India enjoys a somewhat privileged position among developing countries. We have impressive technical capabilities and manpower availability compared to most poor countries. We have over half a million trained allopathic physicians. While the doctor, population ratio of around 1:2000 (UNDP HDI report 2002) is well below the norm for advanced countries, there is evidence to suggest that for our level of economic development and affordability, we have more physicians than we can gainfully employ. A World Health Organization (WHO) technical report on migration of physicians and nurses (1979) established a relationship between GDP per capita and the physician coverage available to the community. In other words, the number of modern doctors trained by expensive western methods that the society can gainfully employ depends not on the availability of doctors or the real needs of the population in terms of prevalence of morbidity and mortality, but on the stage of economic development. Based on a projection of available data (1970), it was concluded that India could sustain only 6 physicians per 100,000 population at that time. India had 21 physicians per 100,000 population then; today India has about 50 physicians per 100,000 population; while there is no data on how many of them are gainfully employed,

it is certain that we have more than adequate number of physicians for our current economic status. The comparisons with rich countries and norms which suggest that we need a physician for every 500 population or so are somewhat unrealistic, as they have not taken into account the socio-economic realities. In fact Sri Lanka, which is ranked 89 (as opposed to India's 124th rank) in HDI, and whose health indicators are far superior to ours in many respects, has only 36 physicians per 100,000 population!

Similarly, India has impressive health research capability. But its expenditure on health research in both public and private sectors in 1998-99 (NHP-2002) was a paltry Rs 1150 crores, which constitutes only 1.5 % of total health expenditure. Even NHP-2002 goals are modest, the targets for public expenditure on health research being pegged at 1 % of total health expenditure in 2005, and 2 % in 2010. However the basic infrastructure, manpower and capability exist for quality research.

Yet another advantage is the impressive pharmaceutical industry in India which makes us largely self reliant in drug production. While there are obvious problems of adjustment on account of protection of intellectual property rights under the new world trade agreement, our industry has the resilience, skills and capability to serve our needs at reasonable costs.

Finally, the diagnostic and therapeutic skills of Indian medical manpower are second to none. Excellent hospital infrastructure is coming up. The cost of sophisticated medical and surgical interventions in India is only a fraction of that in

the developed countries, while our safety and success rates are comparable with the best in the world.

These are impressive achievements for an otherwise poor country with relatively low level of human development. We need to build on these strengths and capabilities while devising and implementing effective strategies for ensuring a healthy future.

Despite these formidable advantages, our health care suffers from great deficiencies.

III. Serious Deficiencies

India is ranked very low in terms of Human Development Index (124th) and health status (112th). Though a signatory to the Health For All by 2000 declaration at Alma Ata and the Millennium Development Goals, India has a high birth rate (26.1) and infant mortality rate (70). We still have unsatisfactory rates of immunization (Tuberculosis: 68 %; Measles: 50 %; DPT: 70 %), and only about a third of our children are fully protected against common preventable diseases. Malaria is endemic in all of India, and is probably the largest cause of fever and morbidity. Tuberculosis remains a major challenge with the largest number of cases in the world. AIDS is spreading rapidly, with 0.8 percent of all adults between 15 and 49 infected by HIV. The easily preventable Rheumatic Heart Disease is widely prevalent, with about 5 cases for every 1000 school children. About 10 million Indians suffer from preventable blindness. Nearly 70 percent Indians do not have access to safe, hygienic toilets. While several major states have achieved impressive performance in population control, vast tracts of India still witness a high

population growth rate, plunging millions into poverty.

The malaise affecting our health care system is threefold:

Accessibility:

First, most people do not have proper access to health care of acceptable standards. According to the report on Millennial Survey of India's Public Services conducted by Public Affairs Centre, Bangalore, only 40 percent of Indians have access to a government health care provider within one kilometer. While we do have a large number of trained physicians and impressive infrastructure, most doctors and hospitals are concentrated in urban areas. Public health facilities are largely inadequate in most major states, with only Kerala and Tamil Nadu achieving impressive levels of health care. Public health expenditure accounts for only 0.9 percent of GDP in India. According to National Health Policy - 2002 document, the union budgetary allocation for health over the period 1990-99 has been stagnant at 1.3 percent of the total budget. During the same period, the fiscal pressures led to a reduction of the states' public health expenditure from 7 percent to 5.5 percent. The current annual per capita public health expenditure in India is around Rs 200, of which 15 percent comes from the union, and the rest from the states. Even this low level of public expenditure is highly skewed and largely unproductive in terms of outcomes. Most public health expenditure is tied up in salaries, leaving few resources for essential drugs, supplies, and operations and maintenance. 97 percent of all public health expenditure goes towards consumption, leaving only 3 percent in capital expenditure. 60 percent of all expenditure goes in wages and salaries, and only 35 percent for material and supplies, drugs and transport.

Out of the limited public health budget, curative services including hospitals and dispensaries, insurance schemes, and medical education and training account for 60 percent, leaving only 26 percent for public health and family welfare, and 14 percent for administration and miscellaneous services (Charu C Garg^{vii}). This low level of public expenditure, inadequate infrastructure and skewed priorities have limited access to health care delivery for the bulk of our people.

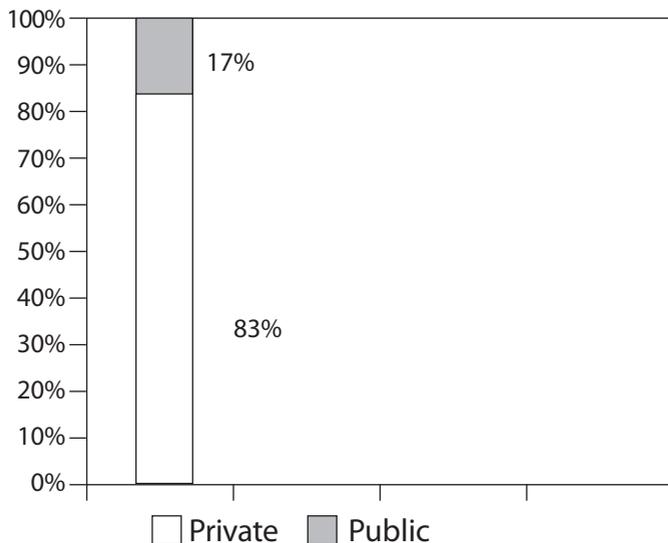
Affordability:

The second major problem afflicting our health delivery is its unaffordability for the bulk of our people. The bulk of India's health expenditure is in private sector, accounting for 83 percent. About 90 percent of this expenditure is out-of-pocket. This declining public spending on health places India in the bottom 20 percent of the countries. More significantly, the high reliance on private, out-of-pocket programs in health in India impose a disproportionate burden on the poor. As a result, the poorest 20 percent Indians have more than double the mortality rates, malnutrition and fertility of the richest quintile. (The World Bank, 2001^{viii}). As nearly all the private spending is out-of-pocket, the poor are vulnerable to health risk. The poor generally avoid hospitalization because of their inability to pay and lack of risk pooling. Hospitalization frequently means financial disaster. As the World Bank report "India Raising the Sights: Better Health System for India's Poor^{ix}" shows, only 10 percent of Indians have some form of insurance, and most of this is inadequate. Hospitalized Indians spend about 58 % of their total annual expenditure on health care. For the poor, this proportion may be much higher. More than 40 percent of those hospitalized are

forced to borrow money or sell assets to cover expenses. At least a quarter of hospitalized Indians fall below poverty line because of hospital expenses. The poor depend heavily on private sector for out patient care, which accounts for 81 percent. The share of private sector in inpatient-care has been on the rise, and is currently close to 60 percent. All these facts make health care increasingly unaffordable, particularly for the poor. As preventive and primary care are relegated to the background, and as curative services are ever more sophisticated and expensive, the cost of health care is increasingly unaffordable to most of the poor.

Figure 3

- Total Health Expenditure of India 5.2% GDP
- Comparable countries:
 - Cambodia
 - Burma
 - Afghanistan
 - Georgia



Accountability:

The third major problem afflicting the health sector is the lack of accountability. Both the public sector and private sector are increasingly unaccountable to stake-holders and the community. Corruption, poor quality of services, medical malpraxis, overbilling, careless treatment causing serious damage, defensive medicine, excessive investigations - all these have become endemic in India. The millennial survey results show that only 14 percent of the people express satisfaction at the quality of services. Even the inadequate public services are largely unavailable to people as corruption is rampant. People are forced to pay hefty bribes for a variety of services including for admission, medical certificates, surgeries, deliveries, emergency services and even post mortems. Corruption is also rampant in the form of unauthorized private practice or running of private hospitals or pharmacies owned by spouses, relatives or business partners. Referral to private hospitals, procurement of drugs, equipment and furniture, and civil works -all invite corruption. As the Lok Ayukta in Karnataka established, administrative tasks like recruitment, postings, transfers, promotions, sanctioning of leave and medical reimbursement involve enormous extortion of money. Corruption is rampant even in medical education - ranging from sanctioning of new colleges, allocation of seats and admissions, to recruitment of teaching staff, examinations and registration at medical council.

Recent expansion of private sector and huge investment in curative services and sophisticated equipment resulted in corrupt practices in private practice too. Payment of consideration to touts who get hospital patients,

and doctors who refer patients has become a common practice. Commissions to doctors who prescribe expensive investigations and procedures which are often unnecessary is another form of unethical practice and corruption. Needless hospitalization, overbilling and expensive procedures have become endemic in private sector.

As government facilities are inadequate, reliance on private hospitals for curative services has become quite common, particularly in public enterprises, and insurance-based health services in public or private sector. With expansion of health insurance coverage and risk pooling, this is a rapidly growing form of corruption. Recent media reports of fraudulent claims by several Hyderabad hospitals from Central Government Health Scheme (CGHS) are an example of such fraud. According to audit reports, several private hospitals showed fictitious patients whose names were drawn from CGHS rolls; expensive investigations like MRI were supposedly carried out several times a day (four times on one patient on a single day); abnormally large doses of costly drugs (some times fatal doses) were shown to have been administered - and all these were billed to CGHS. Such patently fraudulent claims were promptly settled by corrupt and incompetent officials without even minimal verification. Such collusion robbed the exchequer of several crores of rupees in one city alone. Thanks to such practices, billing skyrocketed four to five times the normal within one year. The rates charged to CGHS were often several times those charged to other patients.

All these indicate the need for effective steps to curb corruption in health care, and to improve access to the poor, and evolve mechanisms of reducing cost of services.

Clearly, public expenditure on health care should increase significantly. More importantly, most public expenditure should be directed towards preventive and primary health care. We need to evolve mechanisms for risk-pooling, so that most health care interventions are affordable to the poor and middle classes. Most of all, mechanisms must be evolved for enforcing accountability in health sector.

IV. Improving the Healthcare Sector in India

I. Resource Allocation and Service Delivery

Firstly: there is a case for greater allocations to prevent avoidable suffering. India's allocation for public health is indeed pitiful - 0.9% of GDP. Shamefully, our public health expenditure at 17% of total health expenditure is comparable to that of failed societies like Cambodia, Burma, Afghanistan and Georgia.

Country	GDP per capita (in PPP terms - \$)	Health Expenditure per capita ranking (in \$ terms)	Health Level Ranking (DALE)
Low Income Countries			
Sri Lanka	3530	138	76
Indonesia	3043	154	103
Pakistan	1928	142	124
Egypt	3635	115	115
India	2358	133	134
Middle Income Countries			
Russian	8377	75	91
South Africa	9401	57	160
Brazil	7625	54	111
OECD Countries			
United States	34142	1	24
France	24223	4	3
Germany	25103	3	22
Japan	26755	13	1
United	23509	26	14
Sources: The World Health Report - 2000 and UNDP Human Development Report - 2002 (UNDP)			

Table 3. GDP Per-capita, Health Expenditure DALE Rankings

However, more allocations do not always guarantee better outcomes. Bad policies, poor delivery systems and absence of accountability are playing havoc. The need is to focus on better delivery and to direct resources sensibly to ensure maximization of public good.

Let me tell you what happened some months ago in AP over the issue of childhood heart disease. Hundreds of paediatric cardiac patients were paraded on the streets seeking surgical treatment, and one of them died in front of the television cameras. The well-meaning media and activists were focusing on the human drama and pathos and pressurizing the government to make allocations.

Now let us look at our health infrastructure and need for allocations to meet this challenge. In the entire country, a total of 42,000 heart surgeries take place every year. A typical surgery costs Rs 100,000. 90% of the surgeries are for coronary artery disease, and not even 10% of the surgeries are for congenital or rheumatic heart diseases. Now these two diseases, Congenital (CHD) and rheumatic heart diseases (RHD) are the two major forms of heart disease afflicting the young. On an average, eight children out of 1000 are born with CHD. And the commonest causes of CHD are fully preventable maternal infections during pregnancy, consanguineous marriages, and childbearing by women above 30 years of age. All these are completely avoidable - by MMR vaccination, marriage counseling, and public education on risks of marrying relatives and late childbearing. And yet, annually about 200,000 children are born with CHD in India. The case of RHD is even more pathetic. It is caused by a simple streptococcal sore throat, a common childhood

infection, between the ages of 5 and 15. While sore throat is gone in a couple of days, the child may develop Rheumatic fever, resulting in RHD. Even most educated middle-class parents are unaware of this. RHD is fully preventable, and all it needs is immediate treatment of strep throat in children with simple, relatively inexpensive, antibiotics. And yet, over 150,000 children get RHD every year. There are probably 5 to 10 million Indians suffering from CHD and RHD.

If today's government is willing to make allocations to surgically treat all cases of CHD and RHD - it will have to allocate Rs 50,000 crores to just take care of the existing patients - and at the current rate it will take over a 1000 years! It would cost Rs 4000 crores to just take care of the 350,000 new patients who are added each year. Even after all that expense and effort, about half the patients cannot be helped much and the life span of the rest is prolonged for limited periods.

And meanwhile human misery keeps mounting as more unborn, and young children are afflicted by these preventable diseases.

Clearly, misplaced compassion and political grandstanding are no substitutes to sensible policy when it comes to promoting human welfare. Poliomyelitis paralysed 500,000 children every year not too long ago. Polio vaccines have been invented by Salk, and later Sabin decades ago, and Salk was honoured by the Indian government with Nehru Award long ago. Yet millions of children fell prey to polio because of senseless public policies, and the misplaced compassion of the many activists to spend money on calipers for polio victims did

not improve the situation. At last, the government and civil society got their act together, and over the past five years, through a remarkable campaign of public-private partnership, Polio has been almost eradicated.

What we need is a similar campaign of mass immunization (MMR), public education (consanguineous marriages, late pregnancies and strepthroat), and immediate treatment of strepthroat in all children in 5 - 15 age group. Such a programme costs no more than Rs.100 crores per annum for the whole country. We should still help the unfortunate victims of CHD and RHD with available resources, but the priority is clearly to prevent millions from being victims tomorrow.

One ailment - childhood heart disease - thus offers invaluable lessons in management, allocations, delivery and accountability of our health sector. Academics and policy analysts need to climb down from their ivory towers, and internalise these lessons. We are lucky to live in an age when most problems have simple, effective, relatively low-cost, high-impact solutions.

2. Mechanisms for Improving Accountability

Five steps are essential in promoting accountability. First, community ownership and local control are critical. If the health care facility is managed by a local government, people understand the link between taxes paid and services delivered. As authority at local level is fused with accountability, it becomes easy to enforce minimum standards of care. Transparency will be improved, and there will be better allocation of resources. At present, in PHCs in some major

states, while the cost of wages is Rs 20 lakh per annum or more, the cost of drugs and supplies is a paltry Rs 70,000 per annum! About 50 % of the vacancies in health sector at primary level are left unfilled; and where personnel are posted, they are rarely available to the people. These maladies are a direct consequence of over centralization, and can be effectively curbed by local control and decentralization.

Second, effective steps must be taken to punish the corrupt swiftly and severely in order to serve as an example. Only when bad behaviour is penalized quickly and good behaviour is rewarded can corruption be curbed. Public education, transparency and exemplary punitive action - all are important in this respect.

Third, improved procedures in procurement of goods and health services, and standardization of procedures, protocols and costs are essential to enforce probity in health delivery. In the absence of rigorous procedures and standardization there are no verifiable means of detection of corruption and malpractices. Many countries adopt standardization and benchmarking as means of improving standards of delivery. For instance, there are rigorous standards applicable to National Health Service delivery in Britain; and people are aware of time frames involved, and there is strict supervision of costs.

Fourth, innovative procedures should be evolved to effectively curb corruption, and involve the public and whistle blowers in the fight against corruption. For instance, the US adopts two procedures in tandem to great effect. Many public agencies adopt a simple rule in procurement: the contractor must supply goods and services at the most favourable terms to the

government -i.e. the price cannot be higher than that charged to any private customer. In conjunction with that, there is an innovative law called the "False Claims Act" applicable in the US to detect fraud and penalize the wrongdoers. Under this law, any person can unearth fraud or false claims, and file a suit on behalf of the US government against those who have falsely claimed federal funds for any procurement of goods, works or services. Such a whistleblower is called a 'relator' and the false Claims Act litigation by such relators is called Qui Tarn litigation. Persons who file successful Qui Tarn suits can recover 15-25 % of any settlement or judgment reached in a case if government intervenes in the action, or up to 30 % if they pursue it on their own. The courts usually order three times the loss or damage sustained as recoveries. Thus private citizens have an enormous incentive to detect false claims and corruption and file suits. Consequently a huge industry of unearthing false claims has sprung up, and hundreds of Qui Tarn suits have been filed, resulting in \$ 6 billion recovered. In addition, \$ 4 billion was recovered in government initiated claims.

Finally, we need to strengthen procedures to enforce ethics and standards in medical profession. The internal regulatory mechanisms have by and large failed in India. Physicians, like other professionals, tend to take a lenient view of the misdeeds of their peers. As people are often uninformed and helpless, professionals form powerful pressure groups and laws are violated with impunity. Consumer Protection Act has to some extent provided relief to victims of medical malpraxis. But better regulation of professional ethics in the long-term interests of medical profession, greater transparency, vigilant

civil society groups, and consumer awareness are critical for better health delivery.

3. Low-cost High Impact Solutions

In order to ensure maximum results with prudent expenditure, the following five measures have to be implemented expeditiously.

(i) Raising an Army of Community Health Volunteers

The experience of several pioneering and successful healthcare initiatives clearly establishes the need for bridging the gap between the formal health institutions and the people. This can be achieved through efficient functioning of community health volunteers. There will be a female Village Health Worker (VHW) on an average for every 1000 population. The VHWs shall be selected by the community from among the educated women from the village. A million VHWs are needed for India. The habitation will be the unit for VHW. Each habitat, even with population less than 1000, will have a VHW. In larger villages, the population served by a VHW may be more than 1000. On an average, it is expected that there will be one VHW per 1000 populations. There will be Urban Health Workers (UHW) in urban areas inhabited by low-income and poor populations. The VHWs / UHWs shall be given a three-month training programme. Estimated cost will be Rs 6000/ trainee - training of all VHWs / UHWs may be spread over three years. Several non-profits - Voluntary Health Association of India (VHAI), Jana Swastha Abhiyan (JSA), Foundation for Research in Community Health (FRCH), Comprehensive Rural Health Care Project, Jamhked (CRHP), Tribhuvandas Foundation, many other charitable foundations, healthcare providers, and government should work in

partnership in this training and capacity building programme. This training will be imparted at the district and sub-district level, and monitored by the Panchayats, with technical support from the 30 - 50 bedded Community Health Centre covering the area. VHWs will be purely voluntary workers who are paid an honorarium of, say Rs 1000/month (1200 crores per year). The budget can be allocated by the union government and states on cost sharing basis (50:50). The amount will be kept at the disposal of village Panchayat; the selection of VHW, and payment of honorarium will be determined by the panchayat. If the VHW's functions are integrated with the ICDS / Anganwadi worker, the honorarium will be in addition to the benefits that they are receiving under universalization of ICDS programme. VHWs will primarily focus on preventive care, health education, immunization, maternal and child care, home delivery of babies, family planning services, and early diagnosis and control of major preventable illnesses. VHWs/UHWs may also be provided performance-linked additional incentives based on immunization, institutional deliveries when required, referral of patients to PHC or Community Health Centre etc. The VHWs will pay special attention to counseling and prevention of female foeticide and gender violence

(ii) Strengthening the Primary Health Care Delivery System

As has been pointed out the health infrastructure seems impressive. But, in reality there are many lacunae. And there are more deficiencies in poorer and poorly served states. For instance, while there is a surplus of physicians in PHCs overall, in 8 states there is a shortage of 1779 doctors. 1186

PHCs are without a physician. There is a shortage of about 6,500 Female MPWs (4.8%), and 81,000 male MPWs (58%). There is also shortage of Male Health Assistants (25000), lab technicians (5221 - 23%) and pharmacists (2102 - 9.2%). More important, even when the staff is in place, the supplies of drugs and consumables is inadequate.

A massive national effort is therefore required to fill these gaps and make our primary health care delivery institutions at PHC and sub centre level effective. While health is a state subject, the poorer states are also poorly served by public health institutions. Given the fiscal constraints facing most states, union assistance is required to overcome the deficiencies in primary health care. However, the formula of sharing the burden between the union and states can vary, based on a combination of per capita income of the state, health indicators like infant mortality rate, and demographic indicators like birth rate, and fertility rate. These allocations will have to be in addition to the current level of expenditure by the union and states. Also, first, the government commitments of allocations in health sector under the Tenth five-year plan must be honoured. Subject to these provisos, the following measures are to be taken:

- Enlisting the services of 80, 600 Male MPWs, mostly in the poor states with the highest disease burden (with Union financing)
- Provisioning of 35 drugs listed in the Essential Drugs List (EDL) to all PHCs will substantially improve the usage the PHCs
- Intensification and integration of ongoing communicable disease control programmes

- With increasing urbanization, we have to strengthen the urban primary health care delivery too. A large number of health workers and other personnel need to be financed.
- As the prosperity levels rise and health indicators improve, there is an increasing burden of non-communicable diseases such as diabetes, hypertension and respiratory ailments. Therefore a new programme needs to be initiated for control of NCDs.
- The facilities at PHCs need to be upgraded in order to provide 24-hour delivery services, and care of the newborns.
- Poor sterilization and reuse of injection needles are common causes of spread of infections, including intractable hospital infections and HIV virus. Therefore introduction of auto-destruct syringes for routine immunization is necessary

(iii) National Mission for Sanitation

It is well recognized that safe drinking water and sanitation are two vital requirements for good health. Governments have been paying serious attention to drinking water problem, and 88 percent of Indians have access to improved water sources. Drinking water supply is an intensely political issue, and parties and governments are responding to people's urges. Several schemes and programmes are being implemented to provide safe drinking water in rural and urban areas. But the condition of sanitation is appalling. Only 31 percent people have access to a safe, hygienic toilet. 69 percent of Indians are forced to defecate in public, with grievous consequences to health, hygiene and human dignity. No serious efforts

are made to combat this problem, which causes severe inconvenience particularly to women, children, the aged and the disabled.

The cost of a modern, scientifically designed, hygienic toilet is no more than Rs 3000. Sulabh International and many other organizations demonstrated the efficacy of low-cost household toilets. The problem is one of ignorance, habit, poverty and at the local level, unavailability of the material to build the toilet. Habits change with time and persuasion, and people always prefer better lifestyles. Ignorance can be overcome by a massive public education campaign. Government needs to come forward with a programme for a toilet for every household. Once materials are mass-produced and available at low cost in the market with government initiative, most people can afford to build toilets at their own expense. All it requires is a short-term national campaign to promote hygiene and sanitation.

(iv) Taluk / Block Level Referral Hospitals for Curative Care

Even though the primary healthcare centers (PHCs) are originally designed to deliver both preventive and curative healthcare services, over the years they have failed largely on both fronts. As a result, the feeling of increasing number of people is that PHCs are not there to serve the people, and are there only as an extended arm of government. There are three principal reasons for this:

- Non-availability of the staff
- PHCs are not equipped to deliver curative services.
- The facilities and location of the PHC in most cases are

not conducive for it to act as a referral center. The natural tendency of people seeking curative care is to go to a more central location, and not to a more remote location.

The preventive health care system will be trusted by the people only when the hospital system supporting it is accessible and effective. Therefore it is essential to strengthen existing institutions and create new institutions to serve as credible and effective referral centers to offer curative services. The referral centers must be designed based on the following guidelines:

- One 30-50 bed referral hospital for every 100,000 population with a full complement of staff and infrastructure including one Civil Surgeon, 3 or 4 Civil Assistant Surgeons, a dentist, 7 or 8 staff nurses and two paramedical personnel.
- This hospital should be controlled by the local government (district panchayat or town/city government) and District Health Board. The staff should be recruited, appointed and controlled by the District Health Board and financial provisioning for the hospital should be made by the Board, with full assistance from state and union governments in the form of grants.

While redesigning the primary and curative institutions, the following broad principles should be adhered to:

- 80 % of all cases can be handled by the VHW, ANM or PHC through prevention. About 15 % of patients need to go to a referral center and 5 % to the tertiary level.
- Out of the total public healthcare budget, at least 50 %

should be for preventive care, and no more than 35 % for referral care and 15% for tertiary care.

- The preventive care budget should be supplemented by additional funds to meet cost of drugs for common ailments such as Malaria, Diarrhea, TB, Leprosy etc.
- Functional classification of diseases and jurisdiction among different service providers will be adhered to, not according to medical pathology, but according to the varying levels of knowledge, skills and facilities needed for diagnosis, management and care.

We need to remember that when the PHCs were conceived, the communication and transport network were very weak in this country. Though there is a lot more to be done to improve communication/transport networks, the current situation is far better than in 1950's and 1960's. The experience of the past few decades demonstrates that the location of PHC has been determined by various extraneous factors such as political compulsions and availability of free land. Further, people tend to visit closest neighboring towns, semi urban and urban centers as they provide choice in terms of medical shops, transport facilities, lodges and food joints. If we factor all these and the success of several health care projects, establishment of referral centers would clearly ensure better delivery of health services

(v) Risk-Pooling and Hospital Care Financing

Apart from a few high income persons, insurance coverage in general is available to only organized sector employees. The publicly managed CGHS and ESIS institutions covering health risks are well-known for their sloth, incompetence, inadequacy and corruption. The total number of persons covered under

all the different risk-pooling schemes would be of the order of 100 million (21.1 million families). However, any credible national insurance programme, even with modest and limited risk coverage will cost about Rs. 10,000 crores per annum.

The total per capita expenditure on public health care now is only about Rs. 200. At a time when the public health system and preventive care are in disarray, a national health insurance will end up subsidizing private hospitals and drive investment into curative medicine, sophisticated diagnostics, and heroic interventions. This will further diminish resources for preventive and public health, and lead to escalation of demand for high cost curative medicine, in the fond hope that more hospitals will ensure better health.

The UPA government has made a commitment to introduce a national health insurance scheme for the benefit of poor families. But is a national health insurance the solution?

Advancing technology has skyrocketed hospital costs. With increased private investments in expensive equipment and facilities, there is ever increasing temptation to subject every patient to a plethora of largely unnecessary and costly investigations. Many hospitals are billing huge amounts for heroic interventions in cases of terminal illness! A national health insurance will merely transfer these costs to the public exchequer, without commensurate improvement in health-care.

Experience of many health insurance projects run by civil society initiatives and non-profit foundations indicates that the average actuarial costs even for a modest health insurance coverage will be about Rs. 200 per capita per annum. A national scheme

involves coverage of about 300 million poor people with full government subsidy, and another 400 million lower middle-class people with 50% subsidy. The cost to the exchequer will be around Rs. 10,000 crore per annum for any credible national insurance programme, even with modest and limited risk coverage. When the current public health expenditure is only Rs. 20,000 crores, a 50% escalation only for health insurance is unrealistic and unsustainable. Such shift in expenditure will actually result in subsidizing private hospitals and drive investment into curative medicine.

What is worse, such diversion of expenditure will further diminish resources for preventive and public health. Most of the disease burden is a consequence of failure of primary care. The need of the hour is clearly to strengthen preventive and public health systems in order to give best value for the money spent, reduce disease burden and promote the health status of the community. Excessive reliance on health insurance as a means of health-care delivery is neither prudent, nor cost-effective. Health insurance will only address the symptoms of failure of public health, without reducing the disease burden. This failure of preventive health will only escalate costs of curative medicine, in the fond hope that more hospitals will ensure better health

Many advanced countries witnessed spiraling health-care costs on account of accent on hospital care and insurance-based medicine. Insurance usually involves adverse selection of beneficiaries, as those who are likely to benefit from hospital care are more likely to join it. There is also the moral hazard problem of two kinds - poor hospital care once the population is enrolled in the risk-pooling mechanism, and over consumption of medical services by the richer and better-informed sections. As a result, in OECD

countries, health-care costs are growing much faster than GDP. The total health-care costs in rich countries are estimated at an astronomical \$3 trillion. Let us not repeat the mistakes of other countries.

Disease spectrum is indeed changing slowly even in India with enhanced prosperity, better preventive care and longer life-spans. India should therefore move towards risk-pooling options to reduce the burden of hospital costs on individual patients. But we need to hasten slowly. Our first priority should be improvement of public health delivery system. That is where the least investment yields the best returns. Meanwhile, the government can encourage the innovative schemes taken up by credible institutions like SEWA in Ahmedabad or Tribhuvandas Foundation in Gujarat. Subsidies to such schemes are necessary, and a national health insurance can be contemplated in the coming decades based on a review of their experiences. Premature steps towards national insurance will only strengthen private sector hospital care and subsidize it at the cost of public sector, which is already floundering.

However, the mounting cost of hospital care, increasing out-of-pocket expenditure for hospitalization, and their catastrophic impact on personal and family finances demand an innovative and flexible risk-pooling mechanism to provide a security net for the poor and low income groups. Where necessary, we must be able to involve private providers also, but with strict control of costs and standards of care. But the primary goal should be to strengthen public health system, even as families are protected from financial ruin in case of sickness. Such risk-pooling mechanism should meet the following tests:

- Linking risk-pooling with strengthening of public health care providers.
- Recognize the magnitude and importance of small, low-cost private providers as a national resource, and integrate them in health care system when necessary and feasible.
- Ensuring decentralized, local control and flexibility.
- Create incentives and risk-reward system to promote quality health service delivery.
- Raise resources innovatively and make the programme sustainable.
- Promote greater accountability and cost control in curative services.
- Ensure choice to patients among multiple service providers.
- Encourage competition among health care providers
- Ensure access and quality of service to those with no influence or voice.
- Focus must be on optimal care for all at low cost, and not ideal care for a few at exorbitant cost.

Given these objectives the following model substantially meets most of the above requirements cost.

- An amount of Rs 150 per capita will be raised every year for risk-pooling of hospital care costs as follows:
 - Rs 50. per capita will come from the union government o Rs 50 per capita will come from the state government
 - Rs 80 per capita will be raised as a local tax collected by the local government along with property tax and

other local taxes. This tax will be levied and collected only from above-poverty line people. Assuming that 40% of people are exempted on account of poverty, the final realization will be Rs 50 per capita. Alternatively, Rs 50 per capita can be raised from all those above poverty line, and the balance will be reimbursed by the union and state.

A total of Rs 15000 crores will thus be raised annually. This hospital care fund will be disaggregated for every district on population basis. The amount will be kept at the disposal of the District Health Board (DHB) constituted in each district, or for every 3 million population. For instance, for a DHB serving 3 million people, Rs 27 crores will be allotted. While public hospitals are built at government cost, no other maintenance budget will be allotted to them except through the District Health Fund (DHF). Every patient will have a choice to approach any one of the public hospitals within the area of DHB, in case of sickness. All primary health care services will be provided by PHCs, sub-centres and VHWs / UHWs free of cost, for which separate budget allocations are made. CHCs will be the first referral hospitals. Only when CHCs cannot deal with a patient on account of need for highly specialized services can patients be referred to the district and teaching hospitals. All these hospitals will be funded only by way of reimbursement of costs for services rendered. Both salary costs and maintenance costs will be recovered only by way of services. The DHB will manage the DHF. Funds credited to DHF shall be non-lapsable. Reimbursements will be based on standard costs decided by experts periodically. There will be flexibility to suit local conditions. For instance,

a cataract surgery costs may be reimbursed at Rs.600 to Rs.1000. Standards of care and protocols will be prescribed. If the local public hospitals are not able to handle the case-load, the patients can go to approved non-profit hospitals or private doctors and small nursing homes. Private providers too will be reimbursed in the same manner as public hospitals. The discretion of involving private providers will be exercised by the DHB depending on local requirements. There will be appropriate accreditation procedures for all such private providers intending to participate in the hospital care programme. Such a risk-pooling mechanism as outlined above meets all the tests for a viable, sustainable and effective curative care system.

V. Politics, Service Delivery and Healthcare

The challenges before India

A bit of wisdom, sensible policies, well-directed and modest allocations, and effective delivery systems can accomplish a great deal to promote growth and human happiness. A bit of wisdom is also need to alter the nature of contemporary political discourse. In mature democracies not a day passes without public attention being focused on health and education policies or the State of those services. Most elections are fought on education and healthcare issues. In India much of our political process is divorced from real issues of life and death, and empowerment. Health and education are relegated to the background, and politics has been reduced to a game of private power for personal aggrandizement. In the ultimate sense quality healthcare and citizen-centred democracy go together. The struggle for better health, the

fight for accountable democracy, the quest for people's sovereignty and the urge for best value for public money spent are all inseparable. We have the strength and resilience as a society; our workers have skills and enterprise; and our people have good sense and ambition. We are privileged to live in the 21st century, when most human predicaments have practical solutions, and avoidable suffering can be prevented as never before. We have the cumulative experience in our own country and throughout the world to guide us. If we internalize those lessons and strive to build and sustain a viable healthcare system, we will surely attain a State of health and happiness in keeping with our full potential.

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Dr Jayaprakash Narayan

Dr Jayaprakash Narayan is a physician by training, a public servant by choice, and a democrat by conviction. He joined the Indian Administrative Service in 1980 in the aftermath of Emergency and the failure of the Janata Experiment. During his nearly 17 years of distinguished public service in various capacities, he acquired a formidable reputation in the State of Andhra Pradesh. Rehabilitation of 8000 youth from displaced families of Visakhapatnam Steel Plant, designing the reconstruction of drainage and irrigation network in Krishna and Godavari deltas, strengthening the credit cooperatives and making them independent of government control, and several major policy initiatives including empowerment of parents in schools, speedy justice through rural courts, economic reform and restructuring of Andhra Pradesh, developing the Infocity in Hyderabad, and empowerment of local governments and stake holders are among his outstanding accomplishments in Andhra Pradesh. Among other things, he served as Secretary to both Governor and Chief Minister.

Dr. Narayan's experience in government fully convinced him that what India needs today is not merely periodic change of players, but a fundamental change in the rules of the game. In order to translate his vision into practical reality, he resigned from the Indian Administration Service (LAS) in 1996, and worked with like-minded colleagues for the formation of Lok Satta.

Lok Satta emerged as India's leading civil society initiative and people's movement for wide-ranging governance and political reforms. The movement is driving the electoral

and governance reform agenda of the country with several notable successes to its credit. Recently, Lok Satta launched a national platform called VOTEINDIA in partnership with several organizations to spearhead the campaign for political reforms. Dr Narayan is the National Coordinator of LOK SATTA and VOTEINDIA movements.

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