INFOCHANGE

agenda

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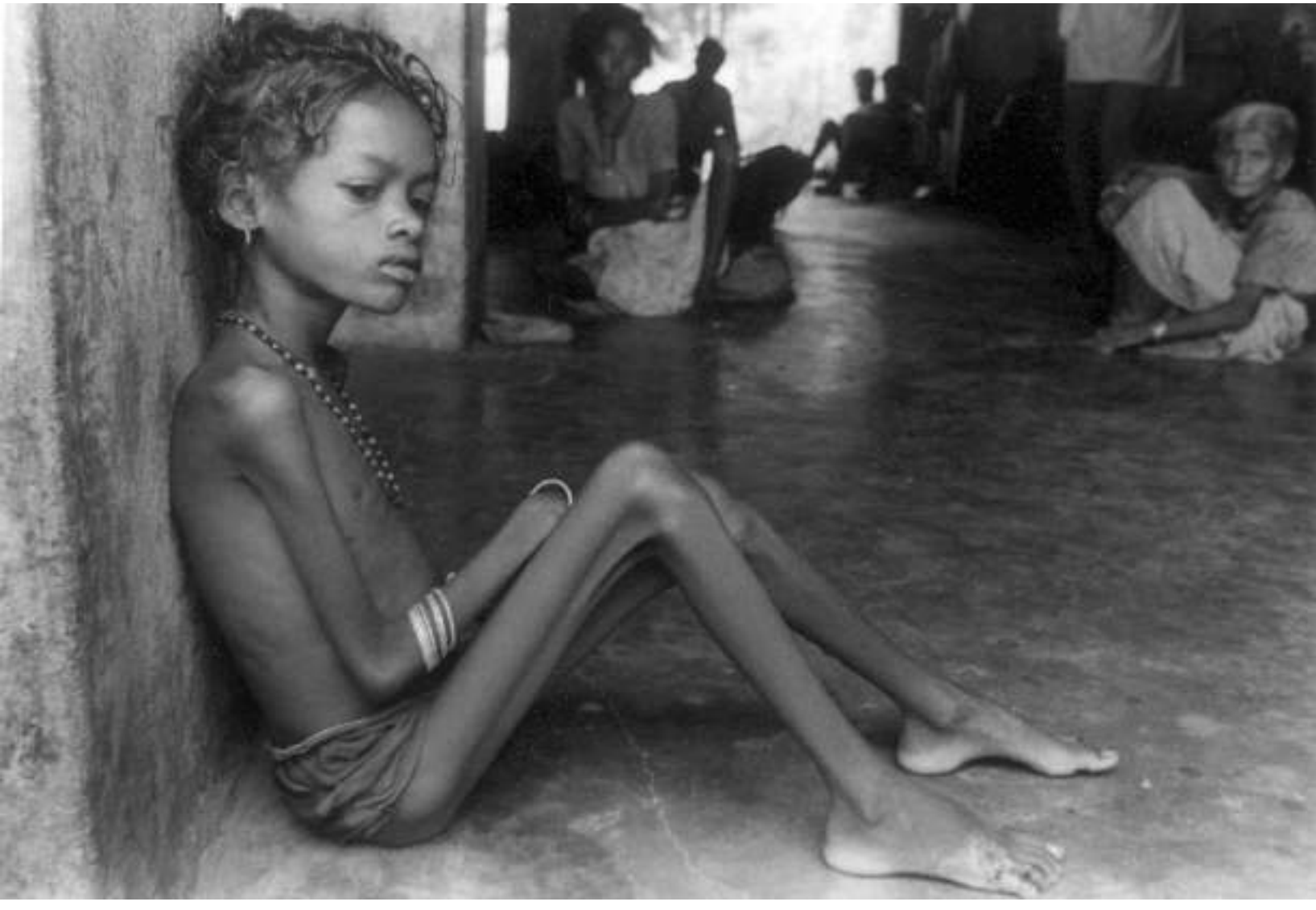
ACCESS DENIED

The cost of healthcare is spiralling
Government spending on healthcare is shrinking
The impact on the poor is catastrophic:
They are being wiped out in their struggle to access healthcare



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Contents

This issue has been guest-edited by Sandhya Srinivasan

Cover photograph by Sudhrak Olwe

A matter of life and death

The majority of illnesses Indians suffer are linked to poverty and poor living conditions. Children fall ill because they are not vaccinated. Patients die because the health centre is too far away or because life-saving drugs are not available. Surely it's an injustice that people must accept illness and death because they cannot get even basic treatment?

SANDHYA SRINIVASAN

WE READ THE SAME NEWS year after year. Tribal children die in a measles epidemic they fall ill because they were not vaccinated, become severely ill because they're malnourished, and die because the health centre is too far away. Health centres are empty of life-saving drugs. Families are bankrupted as they pay for medicines to save their loved ones. Hospital patients are held hostage till they pay the bill. And hospital staff are attacked by angry patients and relatives.

Such numbing reports need to be put in perspective.

Poverty and ill-health: The majority of illnesses Indians suffer — such as tuberculosis, respiratory infections, malaria and diarrhoeas — are linked to poverty and poor living conditions. Nearly half of all children under the age of five are undernourished. It is estimated that some 200,000 children die from malnutrition-related causes every year in Maharashtra alone. Nearly half of all Indian women are anaemic. Some 100,000 Indian women die each year from complications of pregnancy, including bleeding to death because they could not get treated. Around 500,000 people die every year from tuberculosis, a curable disease for which free treatment is supposed to be available through the government.

These deaths are preventable through adequate nutrition, clean water and sanitation, effective immunisation and an accessible health service to provide prompt treatment. The right to earn, to eat, to live decently, to healthcare — they're all linked. A government's duty includes enabling its people to exercise these rights. And indeed, governments do this job in developed countries like the US, the UK and Canada, as also in poor countries like Cuba and Sri Lanka. But in India a government commitment to healthcare, as articulated in various committee reports, has never really been fully asserted, and has become even more limited in recent years. Surely it's an injustice that people must accept illness and death because they cannot get even basic treatment?

This issue of *Infochange Agenda* contains a collection of articles by researchers, activists and journalists, giving readers an idea of trends in healthcare and the consequences, especially for the poor, and possible ways forward.

The opening articles provide a picture of the situation of most Indians today. A sketch of a shrinking public health system is followed by reports from around the country, and testimonies from public hearings of the Jan Swasthya Abhiyan (JSA) illustrating the predicament of the poor.

How did we arrive at this state of affairs? An overview of trends in healthcare financing indicates that India's high healthcare expenditures are borne by individuals, not governments. Should we then be surprised that we also have some of the worst health outcomes in the region? A report on farmers' suicides is a stark illustration of summarised studies on the 'medical poverty trap'. A history of government policy describes the role played by international funding organisations in healthcare in India. A bird's eye view of the international scene suggests that people's health is affected not just by the country's wealth and how much money it spends, but also by *how* the money is used. Other articles examine the growth of the private sector, access to essential drugs, mental healthcare, and the special problems of women's access to healthcare.

What is the way forward? One thing is clear: healthcare is not distributed equitably when it is treated as a commodity in the marketplace. Competition does not keep prices down. The very poor will just get wiped out in their efforts to obtain healthcare. Various models have demonstrated that communities can be mobilised to provide effective healthcare that is neither expensive nor technologically complex. However, these should not absolve the government of its responsibility. The effort must be to make the government work.

The Jan Swasthya Abhiyan is the Indian circle of the People's Health Movement, a worldwide health movement which directs attention to the social determinants of health, and calls for government provision of comprehensive primary healthcare. Co-convenor Thelma Narayan notes that the JSA is a platform for organisations representing various political as well as non-political perspectives. JSA activities have ranged from public hearings to interventions in policy at the state and national level. One such intervention took place before the recently launched National Rural Health Mission meant to integrate vertical health programmes and reach healthcare services to the village level.

B Ekbal, convenor of the JSA, argues in an interview that the problems are not just about money, but how it is spent. The decentralisation experiment in Kerala looked at whether people's involvement could change the way the healthcare system functioned, without an increase in funds.

While these readings may not provide a complete picture, we hope that they provoke some debate and discussion.

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Public health infrastructure: What we need and what we have

We need 7,415 community health centres per 100,000 population. We have less than half the number. Worse, at the healthcare facilities we do have, the basic staff is not in place. Only 38% of our primary health centres have all the required medical personnel. With the public health infrastructure in such a shambles, how can the poor count on government health centres?

SANDHYA SRINIVASAN

HOW CAN INDIA'S POOR count on government health centres when the infrastructure is in such a shambles? Dr Alpana Sagar, from the Centre of Social Medicine and Community Health in JNU, Delhi, asked this question at a meeting in Mumbai recently.

Dr Sagar presented data showing that after 1991 the government stopped planning for any significant growth in rural healthcare infrastructure. Figures on infrastructure development since the First Five-Year Plan (1951-56) indicate a drastic slowing down from the Eighth Plan (1992-1997) onwards (see table).

Establishment of infrastructure in India since First Five-Year Plan

Plan number	Plan period	Community health centres	Primary health centres	Sub-centres
First	1951-56		725	
Second	1956-61		2,565	
Third	1961-66		4,631	
Fourth	1969-74		5,283	33,509
Fifth	1974-79	214	5,484	47,112
Sixth	1980-85	761	9,115	84,376
Seventh	1985-90	1,910	18,671	130,165
Eighth	1992-97	2,633	22,149	136,258
Ninth	1997-2002	3,043	22,842	137,311

According to the government's formula, we're supposed to have one sub-centre for every 5,000 people (3,000 in hilly areas), one primary health centre for every 30,000 people (20,000 in hilly areas) and one community health centre for every 120,000 people (80,000 in hilly areas). Dr Sagar used the government's formula to calculate the number and staffing at healthcare facilities in rural areas where about three-fourths of India's 1.027 billion population live.

We are far short of this requirement. The worst-off are community health centres. If we should have one for every 100,000 rural population, we need at least 7,415 CHCs, but we have *less than half of what we should have.*

In the 3,043 CHCs that we *do* have, only 440 have a paediatrician, only 704 have a physician, only 780 have a gynaecologist and 781 a surgeon. So not only is the infrastructure inadequate, we don't even have the staff to use the existing infrastructure. We need 76,622 midwife nurses (one per PHC and seven per CHC). We have planned only for 44,143 and only 27,336 — barely half the requirement — are in place.

In the case of other rural healthcare personnel too there are similar and dramatic differences between what we *need,* what is *allocated,* and what is *actually in place*: we have only 71,053 male multipurpose workers compared to the 13,73,311 planned and the 148,303 needed; 137,407 auxiliary nurse midwives compared to the 160,153 planned and 173,020 needed; 19,927 male health assistants compared to the 22,842 planned and the 24,717 needed; 19,855 lady health visitors compared to the 22,842 planned and the 24,717 needed; 21,118 pharmacists compared to the 25,885 planned and the 32,132 needed; and 13,262 lab technicians compared to the 25,885 planned and the 32,132 needed.[1]

Rural health services infrastructure 2000-2001

Service	Existing	Required
PHCs		
1 per 20,000-30,000	22,842	24,717
Sub-centres		
1 per 3,000-5,000	137,311	148,303
Community health centres		
1 per 100,000	3,043	7,415

These figures give only a broad picture of the problem. They cannot tell us, for example, about whether the facilities are appropriately located. According to the NCAER, in nearly 20% of cases rural households travelled more than 10 km for treatment. In Meghalaya, in 54.56% of rural illness cases and in Orissa in 33.47% of rural illness cases, patients travelled more than 10 km. Even when patients do get to the health centre there is no guarantee that the staff will be present. According to a survey by the Jan Swasthya Abhiyan, only 38% of all PHCs have all the critical staff. A survey by the International Institute of Population Sciences found that only 69% of PHCs have at least one bed, and only 20% have a telephone.

The National Health Policy 2002 aims to increase usage of public health facilities from the current level of less than 20% to more than 75% by 2010. How realistic is this goal?

Kerala: The last bastion begins to fall

Kerala's striking health indices are partly attributed to a healthcare infrastructure developed by a government committed to healthcare. For example, in 1955-56, the state's revenue expenditure on health was 8.48% of total revenue expenditure, compared to the all-states average of 4.36%, and it has pretty much stayed that way. In 1994-95, the state's revenue expenditure on health was 7.44% of total revenue expenditure, compared to the all-states average of 2.63%. Even

with fiscal crises since the 1980s, the state's per capita public expenditure on health remained higher than the all-states average. As a result, in the 1980s Kerala had an adequate network of well-staffed health facilities, though access was limited in some districts of the state, according to public health researcher V Raman Kutty.

Starting in the 1980s, there was an overall drop in the rate of growth in government health expenditure forced by the pressures of a fiscal crisis. According to Dr Raman Kutty, it would have been difficult to cut back on salaries so revenue expenditure — for salaries rather than medical supplies — increased at the cost of capital expenditure for new infrastructure.[2]

This was accentuated after 1991. In a study of the impact of macroeconomic adjustment policies on access to healthcare,[3] Dr D Narayana of the Centre for Development Studies, Thiruvananthapuram, notes that between 1981-82 and 1997-98, the state's expenditure on medical and public health services, as a proportion of total expenditure, declined from 9.62% to 6.98%. Revenue expenditure on medical and public health services, as a proportion of total revenue expenditure, went from 9.74% to 8.7%. Capital expenditure on medical and public health services, as a percentage of total capital expenditure, plunged from 9.61% to 1.57%.

People relied increasingly on private services as the state's public services deteriorated in quality. Sixty per cent of people in rural areas avoided the government's primary health centres, citing lack of medicines and long distances.[4]

As Dr Joy Elamon of the Kerala Health Studies Research Centre, Thiruvananthapuram put it: "They used to say that if a PHC in Kerala was unmanned, a crowd would gather to demand that the doctor turn up. That's apparently no longer true."

The growth of the private sector

Health economists like Dr Rama Baru from the Centre of Social Medicine and Community Health, Jawaharlal Nehru University (JNU), New Delhi, link the growth of the private sector to the deterioration of public services.

Dr Baru notes that starting in the late-1970s, private nursing homes began growing in number, mostly in urban areas and in agriculturally prosperous states — essentially wherever there was a market for their services. So nursing homes and hospitals started coming up in states like Kerala, Andhra Pradesh, Maharashtra, Punjab, Gujarat and Tamil Nadu. The trend was accentuated in the 1980s as a result of government policy. Not only did cutbacks as far back as the 1980s affect the quality of government services, but government doctors were more often found doing the more lucrative private practice. Meanwhile, the medical education system had created an army of doctors. And in the absence of regulation, the private sector was an attractive option, with the potential for unnecessary procedures, tests, kickbacks for referrals, and so on.

Indeed, a study in Ahmednagar, Maharashtra,[5] found six private providers (registered and otherwise) for every 2,000 people in urban areas, but only one for every 2,000 people in rural areas — naturally, the doctors went where the market was. Similarly, a study on urban and rural Nashik district[6] in Maharashtra

Sudharak Olwe

found that fairly inaccessible but prosperous villages had good dispensaries. The private sector is the major source of curative services in urban as well as rural areas. Remote villages were served almost solely by visiting 'quacks'. Slum settlements within the city were totally dependent on private services for treatment.

The setting up of the first corporate hospital in Chennai in 1983 marked a qualitative shift in the growth of the private sector, hitherto dominated by single-owner nursing homes. Another concurrent trend has been the import of medical equipment for stand-alone diagnostic centres as well as corporate hospitals. This high technology pushed up the cost of medical care. Dr Rama Baru quotes a study in Hyderabad that found hysterectomies cost between Rs 14,000 and 23,000 in corporate hospitals compared to Rs 4,000-6,000 in nursing homes; C-sections cost Rs 10,000-12,000 compared to Rs 6,000 at nursing homes.[7]

The government actively supported the growth of the private sector, notes Dr K V Narayana from the Centre for Economic and Social Studies, Hyderabad. Customs duty for medical equipment was halved in the 1980s, when liberalisation actually started. Various other taxes were waived and land was given free if hospitals treated 10% of their in-patients and 40% of their outpatients free of charge.

The private sector outstrips the public

Thus by the 1990s, public hospitals were losing their place as the primary providers of in-patient care, writes Dr K V Narayana.[8] He notes that between 1986-87 and 1995-96, the private sector's share of in-patient care grew in every state in the country except rural Orissa where it went from 11.9% to 9.4%. In 1995-96, 54.6% of in-patient rural healthcare and 56.9% of urban healthcare was in the private sector. In Andhra Pradesh, 77.5% of rural healthcare and 63.8% of urban care was in the private sector.

In outpatient care, the private sector grew in every state. All-India, 81% of outpatient rural care was in the private sector; 82.6% in urban areas. The exceptions were rural Andhra Pradesh and urban Assam and Bihar. As much as 95.3% of care in rural Uttar Pradesh — a poor state with some of the worst health indices in the country — was in the private sector.

In 1992-93, 57.3% of institutional deliveries in India were in the public sector, and 42.7% in the private sector. By 1998-99, 49.5% of deliveries were in private hospitals, 48.4% in public hospitals and 2.1 in voluntary sector hospitals.

Finally, is the growth of private hospitals reducing the pressure on public services? No, Dr Narayana answers. Public hospital administrators must fight for funds; many senior specialists have left for corporate hospitals where they'll be paid much more, and public hospitals have become 'dumping grounds' for unwanted cases.

Public hospitals in poor states

According to a survey in the early-1990s by the National Council for Applied Economic Research,[9] people were more likely to go to government doctors in Himachal Pradesh, Jammu and Kashmir, Orissa, Rajasthan and Pondicherry. In general, says economist T N Krishnan, public hospitals are more important in backward states — even if they are grossly inadequate, with barely 40 hospital beds per 100,000 population in states like Uttar Pradesh and Orissa where up to 80% of in-patients are treated at public hospitals. The reason: “High levels of poverty and low incomes presumably restrict the demand for private healthcare,” he writes.[10]

Further, though 55-60% of people get admitted to general wards (up to 95% in backward states), only about 20% get free treatment — less than 3% in Haryana and Punjab and about 7% in Uttar Pradesh). Presenting an analysis of NSS data Dr Krishnan notes that the cost of care at both private and public hospitals is higher in more affluent states and lower in backward ones.

Even in public hospitals, the burden of treatment will depend on a number of factors — cost of treatment, type of illness, various sources of finance, effect on the family income, etc. Dr Krishnan calculates that for the bottom 10% income class, “while (the ratio of treatment cost to the annual per capita expenditure) is below 30% in Kerala, Tamil Nadu and West Bengal, the burden of treatment in government hospitals in the rural sector varies between 100 and 230% in Bihar, Assam, Punjab, Rajasthan, Haryana and Uttar Pradesh”. The burden of private care for the same group “exceeds 100% in all states except Assam, West Bengal, Kerala and Tamil Nadu, implying thereby that it would have entailed either incurring debts to pay for treatment or decline in the overall consumption levels of the household.” The burden of public care is much less for urban people — except in Uttar Pradesh where it is 350%.

In other words, the burden of treatment will worsen poverty. There is a direct link between access to healthcare and poverty. Dr Krishnan notes that this picture should signal that privatisation of healthcare would be suicidal. The priority must be to provide access to universal healthcare in public services.

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Healthcare denied

Children dying of snakebite for want of anti-venom vaccine at the public hospital; women in labour turned away from community health centres.... These horrifying case studies, recorded at public hearings in different states in 2004 by the Jan Swasthya Abhiyan and by *InfoChange Agenda* correspondents, illustrate the extent to which citizens are denied the basic human right to effective healthcare

UTTAR PRADESH

Raj Kumari, resident of Rampur Dullah village, district Devria, Uttar Pradesh, had tuberculosis of the bone. She had a persistent complaint of vomiting and headache but could not get diagnosed or treated at the district hospital. She had to approach a private hospital in Gorakhpur, where she was diagnosed with TB. She incurred an expense of Rs 12,000 in the private sector.

Type of denial

No diagnostic and treatment facilities at the district hospital.

Consequence

Heavy financial loss and delay in diagnosis of the illness.

Nazir Khan of village Kamalpur, Datawali post, district Meerut, took his child to the district hospital for a leg injury. After some delay the doctor referred Khan to a private clinic for an X-ray of the leg. He spent Rs 60, and took the X-ray back to the doctor. He was sent away and asked to buy expensive medicines from the market. A few cheaper medicines were provided by the hospital. Since sepsis set in, Khan had to take his child to a private nursing home where he was told that the child was seriously ill. The child is still required to go to the private nursing home for treatment. Rs 25,000 has already been spent on this episode. Now Khan has no money left for treatment.

Type of denial

Absence of basic facilities (X-ray) and medicines to treat minor injuries at the district hospital.

Consequences

Worsening state of injury and high cost of treatment incurred in the private sector.

Prahlad Prasad of Kuiya Kanchanpur, district Maharajganj, was suffering from a chronic illness (probably TB). He first approached the PHC. With no signs of improvement in his condition he went to Gorakhpur where he was advised an X-ray. Here he was diagnosed with TB. Since he was not satisfied with the services at the district hospital, he went to West Champaran, Bihar. He has spent around Rs 16,000 and is heavily in debt. He had to sell his ox, mortgage his land, and take loans from relatives. There is only a 50% improvement in his condition and he has to continue medication for one more year.

Type of denial

Absence of basic facilities and medicines at the PHC and district hospital. No early diagnosis of TB, resulting in delay in treatment.

Consequences

Deteriorating health condition and high cost of treatment incurred at private nursing homes, resulting in indebtedness.

Sudharak Olwe

Nankai went to the community health centre (CHC) in Mohanlalganj, Lucknow, for her first delivery. Her mother was asked for Rs 5,000. She arranged the money. After some hours they were asked for Rs 10,000 more. Her mother expressed her inability to pay. They were thrown out of the doctor's room. Nankai delivered a stillborn baby at the gates of the CHC. She had to be admitted to the Dufferin hospital and still has a two-and-a-half-inch tear.

Type of denial

Denial of service, extortion, humiliation.

Consequences

Stillbirth, infection, financial loss.

NEW DELHI

Mangal Singh and his wife Mohini Devi had been working in the stone crushing and quarrying mines of Lal Kuan for the past 20 years. Both of them are suffering from silicosis. They went to the Nehru Nagar Chest Hospital for a check-up where both were diagnosed as TB patients and prescribed medicines. Mohini Devi's condition was fast deteriorating. She was taken to Safdarjung Hospital where she was immediately admitted. But due to the delay in treatment, she died the following day. At present, Mangal Singh visits Lala Ram Swarup Chest Hospital for his routine check-ups.

Gulab Devi, another worker in the Lal Kuan mines, complained about a wrong diagnosis of TB at the Nehru Nagar Chest Hospital. The medicines for tuberculosis she has been taking for a long time have caused damage to her kidneys and liver.

Type of denial

No infrastructure and facilities for diagnosis and treatment of silicosis; no compensation to mine workers.

Consequences

Chronic and fatal disease, high costs.

MAHARASHTRA

At one of the Narmada Bachao Andolan's (NBA) Jeevan Shala schools in Nandurbar district, northern Maharashtra, a girl student was bitten by a snake. The resident teacher hurriedly took her to the rural hospital. The incidence of snakebite in this area is very high, especially in the monsoons. However, there was no snake anti-venom available at the hospital, and the girl died. Activists from the NBA tried to persuade the hospital authorities to make anti-venom available immediately so that similar cases would not recur. Unfortunately, the drug remained unavailable at the hospital for more than a fortnight. During this period, two more girls died of snakebite.

Type of denial

Non-availability of essential medicines at the rural hospital, although incidence of snakebite in this area is very high.

Consequences

Completely avoidable deaths of three girl students studying at Jeevan Shalas.

One-year-old Pinty Bhanwar was taken to Vashila PHC in Thane district of coastal Maharashtra with acute breathing problems and swelling around the eyes. Although she was taken to the PHC during working hours, the doctor on duty was not present. The compounder at the PHC gave her some local application for the eyes. Pinty's parents waited for the doctor to come for around four hours; finally they decided to shift her to the adjacent Nandgaon PHC. The doctor at this PHC gave her an injection and tablets, assured her parents that everything would be all right within a few hours, and left the place. In spite of repeated requests, nobody at the PHC bothered to tell them what was wrong with their daughter, nor was the child admitted in the PHC. The parents had to keep the patient at a nearby relative's house. The child died the same day.

Type of denial

No doctor was available at the first PHC; the patient was not admitted at the second PHC. The doctor left the PHC, abandoning the patient.

Consequences

Death of the child.

Anouk van der Stam, 2004, courtesy of Photoshare

Safdarjung Hospital, New Delhi

Sudharak Olwe

Nanhe Singh of Sheikhpura village near Bulandshahr in Uttar Pradesh has cancer of the pharynx for which he has been undergoing radiation therapy at Safdarjung Hospital. A marginal farmer with just four bighas of land, Nanhe visits the hospital for sessions of radiation therapy. There is no facility for cancer treatment anywhere near his town.

Nanhe has no one in Delhi to stay with and cannot afford private lodging. He wasn't lucky enough to get a bed at the hospital dharamshala and therefore spends his nights under a tree on the grounds of the hospital in the biting 4-5 degrees Celsius Delhi winter. "I came prepared," he says, patting his sack stuffed with a quilt.

Didn't someone accompany him to Delhi? "I make do with Rs 15 or so everyday for food, which I eat at the dhaba outside the hospital. An attendant will mean more expenses. We cannot afford it," says Nanhe. Both his sons are farm labourers and their earnings of Rs 50 a day (each) provide for the large family. They get work only in the harvest season.

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Abdul's is a harrowing tale of neglect. A fruit vendor at Nizamuddin Station in Delhi, Abdul was travelling home to Bharaich on the Kalinga Utkal Express on November 12, 2004. He lost his balance and only saved himself from falling off the train by hanging onto a railing. In the process he hit his legs against a girder and fractured both lower limbs. It was around 2 pm.

At the next station, Abdul was taken off the train and carried to the general hospital in Palwal, a small Haryana town. "I was in terrible pain and couldn't move my legs. At the hospital, they supported my limbs with wooden strips/bandages and gave me an injection, perhaps a painkiller, which didn't have much effect," he recalls.

The Palwal general hospital was not equipped to handle a fracture of that nature. It was suggested that the next best option would be to move him to the government hospital in Faridabad. An ambulance had to be arranged. "The hospital attendants reached into my pocket, in the presence of the doctor, and removed Rs 250. They claimed it was towards ambulance charges," he says.

By the time Abdul reached the government-run BK Hospital in Faridabad, it was around 10 pm. There was no one to attend to him and he insists no doctor even examined him. He lay there unattended for a long time; then he started howling for water and attention. After much deliberation by hospital staff it was decided that there was little they could do for him and that he should be shifted to Safdarjung Hospital in Delhi.

Again the question of hiring an ambulance came up. Charges would be Rs 350, he was told. Abdul had no money on him but promised he would borrow from relatives and pay up as soon as he reached Delhi. The hospital would have none of it and he was forced to plead with private ambulance operators, who subsequently extracted Rs 650 from him.

It was past midnight when he reached Safdarjung Hospital and medical attention, a full 10 hours after the accident. Abdul was operated on, on November 14; he stayed on till the 29th. He then went back to his village and returned to the hospital on December 17 as advised.

But the hospital refused to admit him. Instead, they banished him to the dharamshala. "My condition has only worsened after coming here. I am made to go around in circles to dress my wounds. Infection has set in and, worse, the antibiotic drug (cefuroxine) prescribed to control the infection is not issued to me. The supply is erratic, forcing me to buy it from the market," says Abdul.

He brandishes the day's newspaper as he goes on about the appalling neglect and indignity he has had to suffer. The newspaper carries a news item about the organised racket unearthed at Safdarjung's sister hospital, the All India Institute of Medical Sciences (AIIMS). Three employees of the hospital, including the chief pharmacist, have been arrested for siphoning off life-saving hospital drugs worth lakhs to private dispensaries!

Abdul is worried. "Will I ever recover? Can I walk again?" he asks. He has been told to vacate the dharamshala by the end of the month. He has no clue what he will do then.

— Naren Karunakaran

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Uttara Rupchand Dakhane, 25, resident of Ghati, Kurkheda taluka, Gadchiroli district, registered herself at the Kurkheda PHC for ante-natal care in mid-2003. On August 5, 2003, she developed labour pains and was taken to Rural Hospital, Kurkheda. Medical officers were present at the hospital. Rupchand Dakhane asked the nurse to admit the patient in labour. The nurse told him to first get the patient registered. Once the patient was in the labour room, the nurse came and put the patient in position for delivery and left the room. Dakhane asked to meet another medical officer. This MO had a look at the patient and warned her husband that since the mother was very weak, this could be a complicated delivery and dangerous to her life. Despite this, the MO did not visit the labour room again. Finally the delivery took place without medical assistance. When the patient's husband reported the delivery to the nurse, she came and cut the cord. She did not ensure that the baby cried. The baby cried only when the dai (local midwife) cleaned her, nearly half-an-hour after the birth. After four-five months, the parents realised there was a problem with the child and took her to a child specialist in Nagpur. He diagnosed mental retardation due to negligence at the time of birth.

Type of denial

Negligence on the part of doctors and nurse. Denial of essential care to the newborn.

Consequences

Lifelong mental retardation.

Kusum Mali was taken to the Osmanabad Civil Hospital in Marathwada, Maharashtra, with complaints of a high fever and numbness in the extremities. She was diagnosed with typhoid (without a laboratory test) and treatment was started. Since her condition deteriorated, she was taken to a private hospital where she was diagnosed with a much more serious illness, GB Syndrome. Since her family could not afford to treat her at the private hospital, she was again shifted to the Civil Hospital. Her condition deteriorated further and she had acute respiratory problems. She was in urgent need of a respirator, which was not available at Civil Hospital. It was not available even at the main hospital in neighbouring Solapur district. Her relatives had to rent a respirator from a private hospital at Rs 1,500 per day. Precious time was lost during this exercise. Relatives were also frequently asked to buy medicines from outside. This resulted in severe financial loss; relatives had to sell ornaments and borrow from the moneylender. But the delay in treatment irreversibly damaged the patient's health. She died.

Type of denial

Essential equipment (respirator) not available at the district (civil) hospital level. Failure to diagnose a life-threatening ailment.

Consequences

Death of patient. Catastrophic financial loss to the family.

Calcutta Medical College and Hospital

The Kolkata newspapers regularly carry stories of babies being found in garbage bins, of seriously ill patients dying because the electricity went off in the intensive care unit for hours on end. While there have been arguments that such stories are motivated and based on careless research, to visit a public hospital in this city is to witness despair.

In the weary crowd at the HIV department of the Calcutta Medical College and Hospital, a premier government institution, Shanti Yadav's piercing, kohl-rimmed eyes stand out. "For the last four years my husband has been very sick, in and out of hospitals. I have spent thousands of rupees to save him. Hospitals, medicines, tests, hospitals. Now I am reduced to being a servant in people's homes to take care of my daughter. If it weren't for her I would have gone mad." Shanti, 32, keeps a watchful eye on her husband Kamal who is barely able to sit up on the bench because of his incessant wheezing.

The Calcutta Medical College in central Kolkata is the oldest in South East Asia, built in 1835. It is a teaching hospital; its maternity ward, Eden Hospital, was once one of the best and had the highest number of deliveries. Its maternity management was cited by doctors all over the country as the "Eden Hospital protocol".

Four years ago, Kamal, a taxi driver, fell ill with high fever and nausea. He was admitted for tests to a well-known private hospital run by a religious trust. Shanti was confident about the hospital because she had delivered her daughter there. After 10 days and numerous tests Kamal was released undiagnosed. He was re-admitted to the same hospital after a few months when he almost collapsed; this time the doctors diagnosed tuberculosis and jaundice and began treatment.

For a few months, Kamal felt better and resumed driving his taxi for a few hours every day. By then Shanti had sold off her jewellery and brass utensils to pay Rs 70,000 for her husband's hospitalisation, medical tests and medicines, besides the household expenses.

A year ago, Kamal became very sick. This time Shanti's brother, also a taxi driver, told Kamal to visit Medical College's HIV department. He knew about the disease because his friend's illness had gone undetected for years till the blood test proved him positive. Tests proved that Kamal had full-blown AIDS.

Today, Shanti works as a maid in three houses and earns Rs 1,200 a month. She brings her husband to the hospital each time his condition worsens, or to consult a doctor for his fever and diarrhoea. She is grateful that the doctors finally succeeded in diagnosing her husband's illness and that she had to spend only Rs 1,000 for his medical tests. But she is disgusted at the behaviour of the staff. "They are unhelpful and rude. I wonder if they are human beings at all."

— Rajashri Dasgupta

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Waiting for a lifeline

At Mumbai's JJ Hospital, 1,000 HIV-positive people are amongst the 4,000 nationwide who are accessing the government's free anti-retroviral therapy (ART) programme. Sixty children in the hospital's paediatric ward are waiting for a lifeline. There are around 250,000 other patients in India urgently in need of ARVs, who can neither access the programme nor afford to buy the medicines for themselves

SHABNAM MINWALLA

JUST FOUR MONTHS AGO, the story of Shaila Tule's life seemed to be hurtling towards a tragic end. Her husband had been diagnosed with AIDS in 2002 and had walked into the sea soon after, leaving Shaila with three children and an HIV-positive test report. As her health deteriorated, the gaunt 31-year-old seemed to be succumbing to weakness and despair.

Hope tiptoed into her Colaba shanty in Mumbai last October, however, when Shaila returned from a check-up at JJ Hospital with a box of tablets. Two months later, she felt strong enough to get out of bed; and today she is able to cook, fill water and actually dream of a future with her young children.

Shaila is one of a number of people with HIV/AIDS in the country who have regained their weight, courage and smiles. For, a 10-month-old government programme providing free anti-retroviral therapy (ART) has yanked over 4,000 people back from the precipice — possibly bringing down their viral loads by as much as 99%, and literally giving them a new lease on life. "Our centre is already giving free drugs to more than 1,000 people and the number is going up rapidly because we have a big supply at the moment," says Dr Alka Deshpande, head of the department of medicine at JJ Hospital, one of the 25 centres appointed to dispense free drugs in the country. "It's believed that ART can increase the lifespan by 10 to 15 years."

The good news then is that the potent three-drug therapy can transform an unforgiving, fatal disease into a chronic but stable condition. The bad news is that a majority of Indians who urgently need the therapy are still unable to access it. After all, barring a fortunate few — government employees who are reimbursed for these pricey drugs, and those who have managed to navigate the crowded OPDs and mind-boggling paperwork to avail of the free drugs programme — most patients have to fork out anything between Rs 2,000 and Rs 7,000 a month. In a country where the per capita income per month is around Rs 2,000, most people simply cannot afford it.

Inevitably, desperate patients throng the dismal waiting area of the HIV/AIDS clinic at JJ Hospital. The Shindes from Hingoli — an infected couple and their son — visit Mumbai for a check-up every six months. "Between us we spend almost Rs 5,000 a month on treatment; then there are the frequent blood tests which cost another Rs 500," says 37-year-old Ramesh Shinde, whose bloodshot eyes and defeated expression betray the tremendous strain he is under. "I am a labourer in a shop and make about Rs 1,500 a month," he says.

How do they manage to pay for the medicines? "We make adjustments from here and there. But I wonder how long we will manage."

Next in the crawling queue is Ayesha Bibi, a burkha-clad woman from Kurla. "My son and daughter-in-law tested HIV-positive three years ago," she says. "They get free drugs for TB and have been told to buy medicine for HIV from outside. But how can they? We just don't have the money."

These certainly aren't isolated cases. Dr Shashank Joshi, who treats many people with HIV/AIDS, estimates a dropout rate of at least 50% because of lack of funds. Then there are those undergoing sub-optimal treatment — either because their doctor doesn't know any better, or because they themselves discard one of the three drugs or skip a few days every week to save money.

The good news is that the potent three-drug therapy can transform an unforgiving, fatal disease into a chronic but stable condition. The bad news is that most Indians are still unable to access it

Given that India is estimated to have 5.1 million people with HIV — of whom approximately 250,000 urgently require anti-retroviral therapy — the scope of the tragedy is huge. Drugs manufacturer Cipla estimates that less than 20,000 Indians are undergoing optimal therapy at the moment, which raises terrifying questions about the fate of all those other shadowy figures — HIV-positive pregnant women who, without ART, will almost inevitably transmit the disease to their infants; HIV-positive children who will never see adulthood; and people with full-blown AIDS for whom access to the drugs is literally a matter of life and death.

NGOs and activists in the area of HIV/AIDS have been quick to lay the responsibility at the door of the government — and have

criticised the fact that the free ART programme has a short-term target of just 100,000 patients. But, detractors point out that there is no reason why a government that is unable to offer free cardiac surgery or cancer treatment must foot the medical bill for people with HIV/AIDS — especially because it involves lifelong commitment. "Patients have to take these drugs for the rest of their lives," says Dr Deshpande. "It could become a huge financial burden for our public health system."

On paper at least the free drugs programme gives priority to patients who fall into three categories: pregnant women who are found to be HIV-positive when they access government-run ante-natal clinics; children under the age of 15; and adults with symptomatic AIDS who are referred to the programme by public hospitals.

The need for public healthcare in the urban jungle

Surely public healthcare would be more accessible in the commercial capital of the country? Not really. In 1996, Sonya Gill and others interviewed OPD users in Mumbai's KEM Hospital, a tertiary care centre in the middle of the city. They found that 54% came from the urban unorganised sector. Over two-thirds had earlier gone to a private doctor but shifted because the treatment didn't work, or it became too costly. Why didn't they go to the urban health centre? Because there was just one municipal dispensary for a population of 50,000 — compared to a private practitioner for less than 2,000 people in the ward where the hospital was located. The dispensary could hardly match the coverage of the private sector or consider itself the main provider of first-level care.

Dharavi is a large settlement in the centre of Mumbai. Renu Garg found that residents of Dharavi rarely used the urban health centre. They went to private doctors for minor problems or the public tertiary hospital for major illnesses. When researchers interviewed patients in that tertiary hospital they found:

- 3.2% were not provided beds, 19.5% were not provided linen, and 16.3% were not given hospital clothing. 21.1% of linen and 27.6% of hospital clothes had never been changed.
- 68.1% had to buy medicines from outside pharmacies. One out of three had to get tests done outside.
- Still, overall patient satisfaction was high. Only the poor come to public hospitals, many of them after being exploited and neglected at private hospitals.

Researchers T R Dilip and Ravi Duggal surveyed inhabitants of a densely populated ward in Greater Mumbai with a predominantly lower middle class population. They found that financial reasons forced 30% of those surveyed to travel to another ward for public sector in-patient care. Fifteen per cent went outside for outpatient public care. Apparently for this group, the cost and inconvenience of travel was less than the cost of a private hospital. Though the majority of households used the private sector for outpatient care, and slightly fewer for in-patient care, a substantial percentage of households said they'd rather go to the public sector if it were available in the locality.

The reality is much more muddled. It's apparent that educated patients and those who are shepherded by NGOs stand a better chance of cutting through the bureaucratic and medical tangle. Also, while women are supposed to be given priority, a majority of beneficiaries at the moment are men — purportedly because their illness is more advanced.

Shockingly, the paediatric prescription has not yet been procured by the government, which means that children under 12 cannot be treated. Around 60 HIV-positive children are waiting for a lifeline in the paediatric wards of JJ Hospital itself. Moreover the particular drugs procured by the government, when given in tandem with TB medication, can cause immense toxicity. Which means that treating people with full-blown AIDS can be incredibly complicated and has to be approached very slowly.

Identifying the most needy patients and giving them free drugs is only the first challenge. The need for rigorous counselling is apparent — many patients waiting for check-ups don't even know the difference between TB treatment and ART; almost none know what their blood test reports indicate. So, while the National AIDS Control Organisation claims its ART centres have "achieved an adherence rate of 96.1% among people who have been placed on treatment," not everybody is convinced. "We are dealing with people who have little predictability in their lives — no steady job, no regular diet, no regular income," says a social worker in the Tardeo slums. "It's difficult enough to make them take an eight-day course of antibiotics on schedule. So how can you talk of lifetime compliance — especially in relation to drugs which have to be consumed at a precise 12-hour interval and are bound to have side-effects?" Dr Joshi adds: "It's a farce. This programme will eventually propagate a drug-resistant strain."

While India's overstretched health system is finding it difficult to meet even its present modest targets, countries like Brazil are talking about taking ART to all those who test positive for HIV. "It may make sense from a humanitarian point of view, but will only make sense from a public-policy point of view if it reduces the rate of HIV transmission — and the jury is still out on that one," says the head of a big city NGO that works in the area of HIV prevention and counselling. "In fact, the AIDS prevention community is worried because in certain pockets — like the gay community in the US — easy access to ART has increased risky behaviour."

These debates mean little to J L Jadhav, however. The 55-year-old man who runs a *paan-bidi* shop in Belgaum is one of the lucky few to have made the grade and started free ART two months ago. Although he has to make the journey to Mumbai once a month and is experiencing a slew of uncomfortable side-effects, Jadhav is not complaining. Instead he says quietly: "I feel I have been given a second chance. I hope others get one too."

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Nagaland has 500 doctors for 2 million people

Patients from Nagaland often travel to Assam for medical attention. Meghalaya has set up permanent accommodation in Vellore, Tamil Nadu, for patients travelling there for treatment. A severe shortage of medical personnel and facilities is the major problem in the northeast

RAHUL GOSWAMI

• When TW, a teacher in the northern district of Mon in Nagaland, needed treatment for an infected leg she painfully made the trip from her village to the district headquarters, and from there bore a seven-hour bus ride over a road that's a little better than a bullock-cart track to the town of Sonari in Assam. Like many who need medical attention and care in the remote district, she has no confidence in the government hospital and would rather undergo the hardship of travelling to the next state in order to be treated.

• VA, a senior member of a village council in Nagaland's Kohima district, was left with little option but to travel first to Dimapur, and then to Guwahati, to seek treatment for a kidney ailment. Although the state capital Kohima is a little over an hour away by road from his village, VA's condition could be diagnosed only outside the state. Through 2004, at great cost to his family, he has had to be treated far away from his home village.

• Two years ago PS, who runs a small grocery shop in Shillong, Meghalaya, was advised a CT scan of the head. She was told this could be done only at a private hospital in Guwahati, which is three-and-a-half hours by road. The scan cost her about Rs 1,500 and she was able to pay for it only by borrowing money from friends and family. Yet she counts herself more fortunate than other people she knows who have been forced to sell their assets to pay for medical diagnosis and treatment.

The major problems of the health sector in the northeast are severe shortages of personnel and facilities. The northeastern states have a combined population of around 39 million (about 3.7% of the country's total population). In Arunachal Pradesh, Manipur, Meghalaya, Mizoram and Nagaland, scheduled tribes comprise about two-thirds of the population. The number of indigenous communities in this patchwork of states is probably as great as the number of dialects, but it is generally reckoned that there are over 200.

Examples such as those cited above help explain why the Nagaland state government has been running up a bill of around Rs 20 crore a year as reimbursements for those from the state who are forced to seek medical treatment outside it. "The lack of adequate specialty services means people have to go outside the state to seek healthcare. Laboratories and other associated ancillary diagnostic facilities are at a premium — few and outdated. There is only one CT scan machine in the whole state, at a private hospital in Kohima. Patients requiring high-end investigations and immunology are sent to Mumbai, Kolkata and Guwahati," says the Nagaland State Human Development Report 2004, the state's first.

In Meghalaya, the dependence on external medical diagnosis and healthcare is even more pronounced. Late in 2004, the Meghalaya state government announced, with some fanfare, the inauguration of a 'Meghalaya House' in Vellore, Tamil Nadu, to "provide accommodation to Meghalaya people going for treatment at the Christian Medical College" there. Reportedly, the state government has so far paid Rs 65,00,000 to the Tamil Nadu Housing Board for the 10 houses purchased solely to accommodate those from the state who travel to Vellore — this is a high-traffic route — seeking medical diagnosis and healthcare.

The wrangling between the state governments of Meghalaya and Assam and the central government over the planned "super-specialty" hospital — the North East Indira Gandhi Regional Institute for Medical Sciences (NEIGRIMS) — has not helped. The institute was originally approved by the central government in May 1986 and would have then cost Rs 72 crore if completed on schedule in March 1999. In February 2001 the project was re-opened with a new deadline of March 2005 and

Manipur has the lowest infant mortality rate in India

"Even in 1981, Manipur had the distinction of having the lowest infant mortality rate in the country, even lower than Kerala. Both Kerala and Manipur have better availability and a more equitable distribution of health services in comparison to the rest of the country. What is striking is that, unlike Kerala, the level of female literacy in Manipur is not significantly high, it is in fact around the national average. Women's empowerment brought about by its unique socio-cultural context, and not so much by female literacy, explains the impressive health attainments of the state. Greater women's freedom; increased political consciousness and participation facilitated, in part, by the matrilineal structure of the society; higher levels of maternal advancement; stronger social organisations and, perhaps, overall system of entitlement protection and relative equality reinforce each other to lower the infant mortality rate in Manipur. Work participation rates for women in Manipur, in different categories of work, are much better than the national average as per Census 1981 and 1991. In Manipur, the mean age of women at marriage, 23.3 years in 1981, is even higher than in Kerala."

— National Human Development Report 2001

a project cost of Rs 422 crore. The 500-bed NEIGRIMS is now being monitored by the ministry of statistics and programme implementation and is expected to be completed in May 2005.

While the government in Shillong is understandably upbeat about the regional institute being set up there, Assam's government has been voluble in its disappointment at the Guwahati Medical College not yet being "upgraded" to the status of an All India Institute of Medical Science, and has tended to view the nascent institute in Shillong as having diverted much-needed funds and central attention away from the state.

Although the condition of health infrastructure in the northeast region ranges from basic to abysmal — the Guwahati Medical College does not have a fully equipped emergency ward — such one-upmanship does little to provide desperately needed regional solutions. If the college at Guwahati needs to be upgraded, a popular argument in Assam points out, what about the Assam Medical College in Dibrugarh, which at one time was reputed to be the premier medical education institution and hospital in the entire region? Students at the Dibrugarh college have been led to agitate at the lack of facilities in their institute, which has the potential of attending to the healthcare needs of Arunachal Pradesh, the northern districts of Nagaland, and of course the upper Assam region — the tea and oil belt of the northeast.

Yet Assam's own Human Development Report of 2003 had cautioned: "People do not necessarily visit the facilities, even if they are available. While this may be due to a variety of reasons — credibility loss, poor care and attention, amount of time taken, absence of medicines and sometimes absence of doctors — it has important policy implications." It is indeed the absence of enough doctors and trained medical personnel that drags down health indicators all across the region.

Nagaland has less than 500 doctors, including 98 specialists, to serve a population of 2 million. The indications are that Naga students want to enter medicine, but with no institute for medical education in the state Nagaland exports a human resource it simply cannot afford to. Meghalaya is short of at least 100 doctors, which the state government has said "severely affects" healthcare in rural areas of the state, with most primary health centres and community health centres insufficiently staffed, complained state Health Minister Sayeedullah Nongrum. Manipur's Health and Family Welfare Minister Laishram Nandakumar has pointed out in the state assembly that the state is short of around 160 doctors (including 120 specialists) and that there are only 150 doctors in the state health department who are very thinly deployed over 420 public health sub-centres, 72 public health centres and 16 community health centres.

There are a host of plans and initiatives aimed at improving health services in the northeast. The region's nodal development agency, the North Eastern Council, is supporting a tele-medicine network for the northeast in association with the Indian Space Research Organisation. Tele-medicine facilities are planned for all the medical colleges in the region: the Guwahati Medical College and Hospital, Silchar Medical College, Assam Medical College and the Regional Institute of Medical Sciences in Imphal. Simultaneously, a North East Health Care Mission is likely to be launched this year, with an act establishing the mission to be brought before parliament soon. Under this, Rs 88 crore a year will be used to take healthcare to every village. Finally, a region-wide health insurance programme is being promoted.

Without the healthcare basics being addressed, however, and urgently, such programmes are only likely to widen the disparities within medical care in the region.

Nagaland's communitisation of health experiment

The Nagaland Communitisation of Public Institutions and Services Act, 2002, was designed to take advantage of the traditional social capital of Naga communities for the state's development. In the health sector, it means turning over the management and maintenance of health institutions to the community. All primary healthcare institutions have been transferred to village communities.

Under communitisation, each village has a village health committee whose responsibility it is to manage, coordinate and monitor its health services. Expenditure on health is routed through these committees, which are responsible for buying medicines, paying salaries, maintaining accounts, planning expenses and focusing on public health issues. The committee consists of members from key stakeholder groups like the village council and village development board, but the participation of women in such societies remains extremely low and, as a result, women's health concerns have tended to be inadequately represented — their views on sanitation for example are dealt with cosmetically by organising 'village cleanliness drives' but without addressing the very conspicuous attitudinal and infrastructural difficulties that exist.

The Nagaland State Human Development Report 2004, the state's first, observes that, "the quality of existing infrastructure needs to be improved", that there are not enough health personnel and specialists which "restricts the coverage of health services in rural areas", and, finally, that "the chasm between reality and vision is enormous". While the report has been generous in praising Nagaland's communitisation experiment (which includes education, power, roads, forest management and other aspects of community development), little has been said about the abysmal condition of the state's delivery mechanisms.

When essential medicines are not available, when they cannot be stored as required because of lack of equipment, when medicines available in the market are suspected to be fake and secure channels of distribution of essential drugs are not protected there is little the village health communities can do to ensure that their families, clanspeople and neighbours have access to basic and reliable healthcare.

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Ill and impoverished: The medical poverty trap

Sickness in households that do not have the capacity to pay for medical expenses can have catastrophic consequences. A survey of households dragged into poverty showed that 85% of 134 households in two districts of Gujarat and 74% of 335 households in three districts of Andhra Pradesh said that health expenses were the main reason for their economic decline

ADITI IYER

IDEALLY, ACCESS TO MEDICAL TREATMENT should not depend upon an individual's ability to pay. But this is increasingly the case in countries that cannot assure universal healthcare access to its citizens, especially the poor. Such countries have highly privatised health systems, as in the US, or they have publicly funded health systems that charge formal or informal fees which patients have to bear, as in China. Or they have both systems in place, as in India.

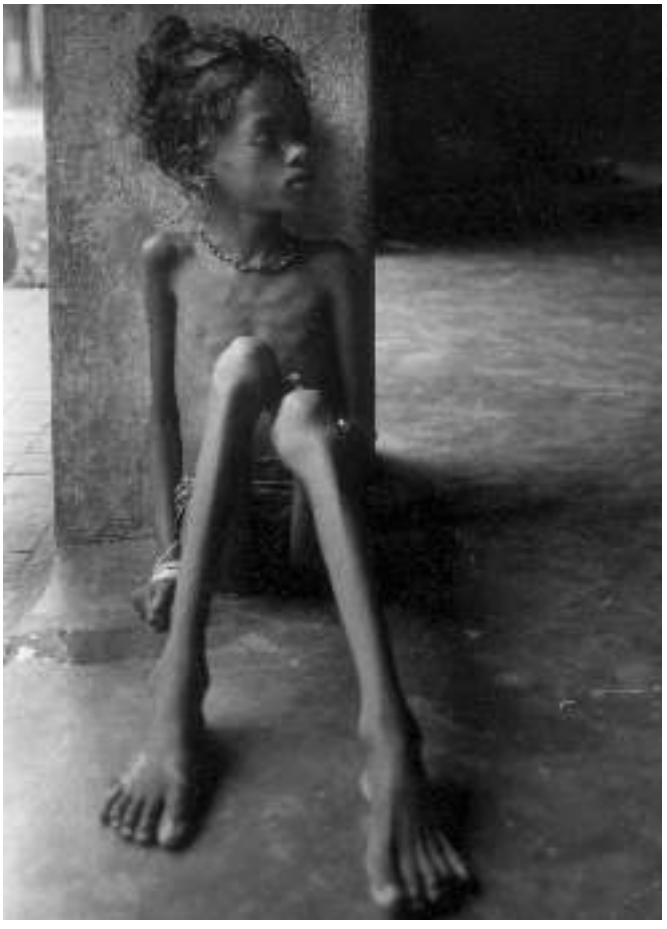
When households do not have the capacity to meet medical expenditure from their own resources, trouble sets in, sometimes with devastating consequences for patients and their families. What follows is a grim set of realities: denial of treatment, incomplete treatment, or treatment at the cost of financial and social wellbeing. Households curtail spending on food, children are pulled out of school and/or forced to work, adults are pushed into labour, people are made to work longer and harder than usual, care-givers are stretched to breaking point… It is no wonder then that such payments are called 'catastrophic', or leading to impoverishment.

A recent analysis of survey data from 59 countries concluded that a significant proportion of households face catastrophic payments for out-of-pocket health expenses. These include countries like Ukraine (affecting 4.39% of households), Argentina (6.02%), Colombia (6.26%), Azerbaijan (7.15%), Cambodia (5.02%), Brazil (10.27%) and Vietnam (10.45%). These countries have been liberalising their economies by reducing state controls while supporting greater privatisation.

Although the study did not include the US in this group of vulnerable nations, the situation is equally grim for uninsured families there (see box). In other words, this phenomenon is not limited to the so-called 'developing' world; disadvantaged populations in the 'developed' world are equally at risk. The study described above concluded that catastrophic payments were a particular problem in countries that had a large proportion of poor and/or uninsured families, and a large proportion of sick persons seeking and paying for treatment (Xu and others, 2003). In such situations, access to healthcare becomes a double-edged sword. Not having it amounts to a denial of one's rights, but having it under these conditions is detrimental to the wellbeing of the household. Public health specialists reviewing this phenomenon call it the 'medical poverty trap' (Whitehead and others, 2001).

Whatever the terminology, it is obvious that sickness and the attendant medical expenditure can destabilise and drag households into poverty or increase the vulnerability of those already poor.

This phenomenon is increasingly evident in India, and it's not surprising. After all, we have a large set of private and government health providers who have to be paid directly; we have high levels of poverty and inequality; and financial risk protection mechanisms are mainly limited to private health insurance which only the middle class and rich can afford. It is no wonder then that a recent World Bank document assessing the health sector in India estimated that direct out-of-pocket payments could push 2.2% of all healthcare users, and a fourth of all hospitalised patients, into poverty in a year (Peters and others, 2002). Such estimates were based on National Sample Survey (NSS) data during the mid-1990s. Although these percentages may seem small, they translate into substantial



Sudharak Olwe

numbers. Besides, these estimates do not take into account sick persons who ignore their symptoms, and those who do not seek treatment despite being sick.

Research conducted by an academic based at Duke University, Anirudh Krishna, and his colleagues, clearly documents that medical expenses are one of the three major reasons why households fall into poverty in states like Rajasthan (Krishna 2003), Gujarat (Krishna and others, 2003) and Andhra Pradesh (Krishna and others, 2004). (The other two reasons are marriage and death expenses, and high-interest private loans -– to meet these expenses.)

Working with local understandings of poverty, researchers mapped the movement of households from poverty to economic stability (and vice versa) over 25 years with representatives from the community. They found that even as some households overcame poverty over the previous generation, others had become impoverished over the same period for entirely different sets of reasons. They then verified the information gathered through this participatory exercise by interviewing samples of households. They visited 12 villages in Rajsamand and Udaipur districts in Rajasthan, and inquired why 109 households had fallen into poverty. They found that poverty was not brought about by a single factor but by a combination of reasons and circumstances. In 55% of the cases, poor health and high healthcare-related expenditure were the principal reasons for falling into poverty. In a study of 20 villages in Vadodara and Panchmahals districts in Gujarat, ill health and healthcare expenses were mentioned by 85% of 134 households as the main reasons for impoverishment. They visited 36 villages in Nalgonda, Khammam and East Godavari districts in Andhra Pradesh. Of the 335 households that had fallen into poverty, 74% mentioned ill health and healthcare expenses as the main reasons for their economic decline.

Why have we landed in this situation? Three aspects of economic and health sector reforms since the 1990s may have played a role.

First, steep increases in drug prices following systematic deregulation of pharmaceutical production and price control have sent up the overall cost of healthcare. Second, stagnating financial investments in government-run health institutions have resulted in them being devalued and degraded. Moreover, they are no longer an inexpensive and good alternative to the private sector, as user fees are legitimately charged at hospitals, and doctors and paramedical workers treating patients at clinics or in communities levy informal fees. Moreover, health centres are so poorly stocked with medicines that patients have no option but to buy them from private medical shops.

Third, the policy of increasing unregulated privatisation of the healthcare sector through special concessions to private hospitals, or through the indiscriminate encouragement of public-private partnerships, has not enabled better access for those without the means.

These changes resulted in worsening the inequities in healthcare access between women and men in different economic classes. Analysis of the NSS surveys of health utilisation and expenditure during the mid-1980s and mid-1990s by our research team at the Indian Institute of Management-Bangalore (Sen and others, 2002) revealed that:

• Until the mid-1980s, public hospitals were still the dominant providers of in-patient care, especially for the poor, even though patients went to the private sector for outpatient care. However, by the mid-1990s, there was clear evidence that the private sector had become dominant in terms of both in-patient and outpatient care, even in poorer states like Rajasthan, Orissa, Madhya Pradesh and Assam. Of those who were hospitalised in the mid-1990s, around 55% went to private sector institutions,

Illness and medical bills cause half of all bankruptcies in the US

Illness and medical bills caused half (50.4%) of the 1,458,000 personal bankruptcies in 2001, according to a study published by the journal *Health Affairs*. The study estimates that medical bankruptcies affect about 2 million Americans annually — counting debtors and their dependants, including about 700,000 children.

More than three-quarters were insured at the start of the bankrupting illness. However, 38% had lost coverage at least temporarily by the time they filed for bankruptcy.

Most of the people who filed for medical bankruptcy were middle class; 56% owned a home and the same number had attended college. In many cases, illness forced breadwinners to take time off work — losing income and job-based health insurance precisely when their families needed it most. Families in bankruptcy suffered many privations — 30% had a utility cut-off and 61% went without needed medical care.

The research, carried out jointly by researchers at Harvard Law School and Harvard Medical School, is the first in-depth study of the medical causes of bankruptcy. With the cooperation of bankruptcy judges in five federal districts (in California, Illinois, Pennsylvania, Tennessee and Texas), they administered questionnaires to bankruptcy filers and reviewed their records.

Dr David Himmelstein, lead author of the study and associate professor of medicine at Harvard, commented: "Unless you're Bill Gates you're just one serious illness away from bankruptcy. Most of the medically bankrupt were average Americans who happened to get sick."

Today's health insurance policies — with high deductibles, co-pays, and many exclusions — offer little protection during a serious illness. Uncovered medical bills averaged $ 13,460 for those with private insurance at the start of their illness. People with cancer had average medical debts of $ 35,878.

"The paradox is that the costliest health system in the world performs so poorly. We waste one-third of every healthcare dollar on insurance bureaucracy and profits while 2 million people go bankrupt annually and we leave 45 million uninsured," said Dr Quentin Young, national coordinator of Physicians for a National Health Programme. "With national health insurance ('Medicare for All'), we could provide comprehensive, lifelong coverage to all Americans for the same amount we are spending now and end the cruelty of ruining families financially when they get sick."

compared to 40% in the mid-1980s. Moreover, the average cost of all care had significantly gone up, the sharpest increases evident in private outpatient care and public sector in-patient care. For the poor, this was a double whammy, as private out-patient care was not that much more expensive than public care earlier, and public in-patient care used to be much less costly than private care.

• The divide between rich and poor had grown. Already in 1986-87, the poor were less likely to get treated for their illnesses than the rich, and this was worse among women than men. When the poor did get treatment, they tended to spend less on both outpatient and in-patient care. In the 1990s, healthcare had clearly become difficult for poor people to access. This is borne out by the growing weight of financial constraints among the reasons given to explain untreated illnesses.

• Women were worse off than men overall during the 1980s and 1990s. But by the mid-1990s, the inequalities between men had increased in terms of untreated sickness and their use of hospitals. This relative worsening of access for poor men, even though they continued to be better off in absolute terms than poor women, may imply that poor households were now really stretched to breaking point in terms of access and affordability of health services.

After this, our team decided to understand the issue of healthcare access and ability to pay in Koppal, a drought-prone area and one of the poorest agrarian districts in northern Karnataka.

In this context, unqualified medical practitioners (also called RMPs) are the most popular providers of medical care in villages and small towns. Qualified private practitioners are mainly located at the taluka headquarters or in larger towns. Some government doctors at PHCs provide medical care too, but those with very busy clinics charge fees as private doctors would. Although some government hospitals are better equipped than private nursing homes, they are understaffed and incapable to dealing with emergencies. Drugs are inadequate and are reportedly of poor quality, at government health institutions. And there is no blood bank in the entire district.

Our interview-based study covered almost 2,000 households in 56 villages in this district. We found a huge burden of morbidity — more than 80% of households had at least one sick member during the reference period.

We also found that most households were unable to meet the growing demand for healthcare. Access of individuals to healthcare depended on the family's income (where it came from — regular wages, self-employment or casual wages) and the individual's access to this income (determined by sex, age, seniority, etc). Men who were unable to seek treatment were mainly constrained by economic barriers. Women experienced economic barriers too, but because of their relatively poor status had poorer access to economic resources within and outside the household. Instead, they were mainly held back by gender-biased norms resulting in an absurdly high level of self-censorship and lack of acknowledgement of their health problems. It was common to hear women say that they did not seek treatment because their sickness was "not serious". And this, despite the fact that more than half of them had illnesses that impaired their daily functioning. Women were 'normalising' their health conditions to such a degree that they did not even recognise their sickness. Healthcare access was a particular problem for women, especially lower-caste and poorer women. In their case, gender only compounded the disadvantages linked to their caste and class status. As a result, SC/ST women who lived in households that depended on casual wage labour had the poorest access to healthcare compared to SC/ST men and all other women.

In this situation, both public and private health providers will have to be more sensitive and responsive to people's needs. Not only does it call for a change in individual attitudes, but also a larger commitment on the part of the government to put in place all of the things that would result in better healthcare access for its citizens, especially the poor. Indeed, the government needs to respond urgently to a growing crisis whose dimensions are too grim to bear. It must commit more of its public funds to supporting and building health systems without the usual excuse of lack of funds, which speaks more of lack of political will. Even poor countries in Africa like Mozambique spend more on the health sector than India does. When a government spends just 0.9% of its GDP on healthcare, it means that PHCs will be empty of drugs, equipment broken, health workers absent, etc. Given this, people have no choice but to spend five times more in the private sector. Anirudh Krishna notes that any anti-poverty policy must consist of two parts: one set of policies to help households escape poverty (poverty alleviation) and another to prevent households from descending into poverty (poverty avoidance). Social insurance is an example of how poverty can be avoided in rural and urban areas among the poor and also among middle class families that find it equally hard to withstand the catastrophic consequences of galloping medical expenses.

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Anatomy of a health disaster

Janreddy's family survived crop failure. But debts of Rs 300,000 to cover health costs have nearly destroyed them. Loans taken to cover health costs have been a major contributor to the debt-suicide cycle in Andhra Pradesh

P SAINATH

JANREDDY SAT WRACKED WITH PAIN, a picture of ill health. "Why isn't this man on his way to hospital," we asked the neighbours crowding around his bed. "Well," they said nervously, "we just brought him home from one. He was there for days. This family has already lost all its money on hospitals."

Janreddy died hours after we met him. His daughter-in-law, who became a bonded labourer to keep the family afloat, will remain one till debts of Rs 500,000 are paid off. Over Rs 300,000 of that was incurred on medical costs. His wife, who donated one kidney to her son — both of his had collapsed — does any work she can find. The son, Narsi Reddy, confined to the house, has to drink only the purest water in a place where there is none. His medicines cost around Rs 1,000 a month.

The huge medical bills of this family of six were incurred despite the son getting free operations at the Osmania Government Hospital in Hyderabad. They had first gone to private hospitals for check-ups, a biopsy and other tasks. As the costs mounted they sold off land and cattle to meet them. That Narsi Reddy had sunk four borewells didn't help. All of them failed. Crisis on their four-acre farm in Chelliagudam village of Nalgonda district saw Janreddy's health also cave in. "They might just have survived the crop failure," say the neighbours, "but their medical costs destroyed them."

Health spending is amongst the fastest growing components of rural family debt. More so in Andhra Pradesh. For years, the state boosted the private sector in health, promoted corporate hospitals and pioneered the 'user fees' system in government ones.

"The Chandrababu Naidu government dismantled the public health system," says M Geyanand, a leading doctor from Anantapur district. Dr Geyanand is also state president of the Jana Vignyana Vedika (JVV), a body that aims to promote popular science and the scientific temper. "Ninety per cent of patients who go to public hospitals are poor. When that system fails them, they turn to private ones at a huge price. Health costs often count for as much as 20-25% of the total expenditures of such households. And a single medical emergency can ruin them."

A common thread running through the farmers' suicides plaguing the state has been very high medical spending. Just five households affected by such deaths had health costs totalling around Rs 400,000. All of them farming families who held between half-an-acre and three acres of land (some of that mortgaged). Janreddy's family has not seen a suicide. But it fits this profile rather well.

As do countless other poor households. Even last year, we ran into a farmer who had attempted suicide in the Nallamada mandal of Anantapur district. His friends managed to get him to a hospital just in time. The rescued farmer abused his saviours. The reason: The four-day stay and treatment in hospital cost Rs 45,000. "I tried to commit suicide because I could not pay debts of Rs 150,000," he said bitterly. "Now I owe even more."

"There is a link between the suicides and the crisis of health in Andhra," says Dr Geyanand. "The collapse of the public health system is crucial. In any poor village, you can see people dying of diseases that should not kill them. Malaria is just one example. For years now, all their support systems have been slashed. The costs are so high, they run out of money halfway through treatment. Those who fall ill are selling land, gold, cattle and other assets to pay medical bills. They also take loans they can never repay."

In G Edavalli village in the same district, the local rural medical practitioner sold all his land to pay his own treatment costs of Rs 400,000 at a corporate hospital in Hyderabad.

In the years these dramas unfolded, public hospitals were starved of funds, medicines and drugs. Given Rs 600 crore by the World Bank for public health, the Naidu government spent this mostly on buildings. Very few doctors or nurses were recruited. Naidu also authored a government 'tie-up' with corporate bodies. Under this, employees of the state went to corporate, not public hospitals. The government reimbursed their costs. This meant a windfall for those hospitals. It also meant many scams in the shape of inflated reimbursement bills. Meanwhile, health institutions in the public sphere suffered.

"The introduction of 'user fees' made health even less accessible to the poor," says a senior IAS officer. The fees have since been withdrawn by the new state government. Also dumped was an idea of handing over some super-specialty departments of public hospitals to 'private management'. That is, to corporate hospitals.

The damage, though, has been done. The medical costs of those who preferred death to debt still plague the living. We pass Janreddy's wife at the bus stand, looking for any 'coolie work' she can find. There are, after all, bills to be paid.

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The out-of-pocket burden of healthcare

There is clear evidence that public financing is critical for good healthcare and health outcomes in any country. Yet in India, only 15% of the Rs 1,500 billion healthcare sector is publicly financed. Investment and expenditure in the public health sector is shrinking. As a result, the public health system is on the brink of collapse, and there's been a 30% decline in the use of public healthcare facilities

RAVI DUGGAL

BETWEEN 1987 AND 1996, there was a shocking 30% decline in the use of public healthcare facilities in both rural and urban areas. Over this decade, utilisation of private health services, especially in the hospital sector, increased substantially, out-of-pocket spending on healthcare galloped, and indebtedness due to healthcare affected nearly half the users of healthcare facilities. A comparison of utilisation and health expenditure data across the 42nd (1987) and 52nd (1996) Rounds of the NSS showed up these alarming trends. As a consequence of the declining use of public healthcare facilities, the 52nd Round showed higher levels of untreated morbidity, especially amongst poorer groups. The 2002 National Health Policy unashamedly acknowledges that the public healthcare system is grossly short of its defined requirements, that functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continue to be unacceptably high, and resource allocations generally insufficient.[1]

Why did this happen? The inadequate commitment of public resources to healthcare was mainly responsible for poor health outcomes in India.

The cost of seeking treatment even at public hospitals had increased five-fold (simultaneously, the cost of treatment in private hospitals increased nearly seven-fold), though the purchasing power of the poorer classes had not changed in any substantial way.

These trends are closely linked to a wide spectrum of changes in the economy since the mid-1980s, which have led to the privatisation of services, deregulation of drug prices, increased reliance on market mechanisms to address welfare needs, and a weakening of public health systems.

As a result of structural adjustment programmes, investment and expenditure in the public health sector has been declining. This privatisation policy, which mandates the introduction and/or increase of user charges at public health facilities, has taken the public health system to the brink of collapse. With greater dependence on the market for healthcare, access had become more difficult for an increasing number of people.

Public financing is critical

Public financing of healthcare is critical in both developed and developing economies. A political economy based largely on private health financing can create adversities for health not only for poorer sections of society but also the middle classes. In most developed countries, where healthcare access is near-universal, public financing, which accounts for around 80% of all health expenditure, whether through state revenues and/or social insurance, has been the critical component in realising universal access with equity.[2,3] In contrast, in most developing countries the reverse is true — 70-80% of health expenditure is met by individuals from their private resources.[4]

India lost the opportunity to implement a national healthcare system immediately after Independence through the Bhore Committee[5] recommendations. The country made very poor investments in the public health sector over the years. But the mid-1970s saw major investment, especially in rural India, via the Minimum Needs Programme. The Fifth to Seventh Plan period was the 'golden era' of public health sector performance in India, when public investment and expenditure in healthcare peaked and health outcomes witnessed substantial improvement, first in the developed states and then in the underdeveloped ones.

But the economic crisis of 1991 and the economic reforms posited by the Structural Adjustment Programme (SAP) pushed by the World Bank upset the achievements of the public health sector in this golden era. Resource commitments to public health declined in the 1990s, especially in the developed states. Improvements in health outcomes slowed down, and the rural-urban gap widened. Public healthcare facilities were incapacitated because of insufficient inputs. This has been caused by the compression of public spending in the health sector as well as allocative inefficiencies caused by unprecedented increases in salaries as a consequence of the implementation of the Fifth Pay Commission (1996-1998). Non-salary components have shrunk considerably as budget increases do not factor in allocative efficiencies for the effective running of the public health system.

When we relate health outcomes with expenditure we see that in comparison to similarly developed countries India's performance is the worst despite the fact that we have one of the highest total health expenditures amongst these countries (see the table below).

This poor performance is largely because, in India, spending is mostly out-of-pocket as the public resources committed are very low. In a scenario of poverty, such a mechanism of financing will never show up good health outcomes because when the poor and not-so-poor have to pay their health expenses they forego other basic needs or, worse still, get indebted. National surveys show that loans for healthcare is the number one reason why families, especially the poor, are trapped into indebtedness.[6] This is clear evidence that public financing is

Health outcomes in relation to health expenditure patterns					
	Total health expenditure as % of GDP	Public health expenditure as % of total	U-5 mortality	Life expectancy Male	Female
India	5	17	95	59.6	61.2
China	2.7	24.9	43	68.1	71.3
Sri Lanka	3	45.4	19	65.8	73.4
Malaysia	2.4	57.6	14	67.6	69.9
South Korea	6.7	37.8	14	69.2	76.3

Source: Changing the Indian Health System — Draft Report, ICRIER, 2001

critical for good healthcare and health outcomes.

Only 15% of the Rs 1,500 billion healthcare sector is publicly financed

The total value of the health sector in India today is over Rs 1,500 billion, or US$ 34 billion. This works out to about Rs 1,500 per capita, which is 6% of GDP. Of this, 15% is publicly financed, 4% is from social insurance, 1% from private insurance (Mediclaim policies, 85% to public sector insurance companies) and the remaining 80% from the pockets of patients as user fees (85% of which goes to the private sector). (See table below.) Two-thirds of users are purely out-of-pocket users and 70% of them are poor. The tragedy is that in India, as elsewhere, those who have the capacity to buy healthcare from the market most often get healthcare without having to pay for it directly, and those who are below the poverty line or living at subsistence levels are forced to make direct payments, often with a heavy burden of debt. National data reveals that 50% of the bottom quintile sold assets or took loans to access hospital care. Thus, loans and sale of assets are estimated to contribute substantially towards financing healthcare. This further underlines the need for insurance and social security.

Financing healthcare in India (2003)		
	Estimated users in millions	Expenditure (Rs in billions)
Public sector	250@	252 (17)*
Of which social insurance	*55*	*30 (2)*
Private sector	780@	1,250 (83)**
Of which social insurance	*30*	*24 (1.6)*
Private insurance	*11*	*11.5 (0.8)*
Out-of-pocket	*739*	*1,214.5 (80)*
Total	1,030	1,552 (100)

@ Estimates based on National Sample Survey 52nd Round, and Labour Year Book
** Finance accounts of central and state governments, and Labour Year Book*
*** Private final consumption expenditure from national accounts statistics*
Figures in parentheses are percentages

About 80% of public financing of healthcare comes from state government budgets, 12% from the Union government and 8% from local governments. Of the total public health budget today, about 10% is externally financed in contrast to around 1% prior to the structural adjustment loan from the World Bank and loans from other agencies. Private financing is mostly out-of-pocket, with a large proportion, especially for hospitalisation, coming not from current incomes but from savings, debt and sale of assets. Insurance contributions, whether for social insurance schemes or as private insurance premiums, constitute a very small proportion.

Trends in public health expenditure

Public investment in the social sector in India has been cause for concern. The attempt at a mixed economy that marries socialism and capitalism has not worked for either system. In retrospect, the large public sector economy failed to realise both economic and social goals. On the contrary, it helped the accumulation of private capital. The Indian bourgeoisie and the state did not have the vision to promote a welfare state. From the First Plan onwards the health sector has received inadequate resources and these resources largely benefited the small urban-industrial economy.

It is evident that the state has, over the years, committed a mere 3% of public resources for the health sector and this has invariably been less than 1% of GDP. As a consequence, healthcare has been an out-of-pocket burden on households. Of the total health expenditure in India, the public sector contributes around one-fifth and this has remained more or less constant over the years, with a declining trend in the last decade. This level of state investment in health is not adequate to ensure universal and equitable healthcare access.

The post-SAP period saw a declining trend in public resources being committed to the health sector, and the stagnation in health outcomes is largely a consequence of this. Graph 1 and Table 2 show the trends in public health spending from 1976 to 2001 and it is evident from this that in the 1980s public health expenditure as a percentage of GDP as well as a proportion of total government spending peaked and then began to decline. Worse, the proportion of capital expenditure was halved during the '90s as compared to the '80s; this meant that new investment in public health had almost ceased. This was the period of private sector expansion in the health sector (post-SAP, even private health expenditure showed a decline, but in the latter half of the '90s it began climbing again and rapidly). (See Table 1 and Table 5 at the end of the article.)

While overall public health investment and expenditure have been low and inadequate to meet the healthcare needs of the population at large, there are hierarchies within this health spending. The most obvious hierarchy is the rural-urban dichotomy in public health investment and expenditure. Rural areas across the country have public health services that largely focus on preventive and promotive aspects. Thus, immunisation of children and pregnant women, ante-natal care, surveillance of selected diseases and family planning services constitute the key focus of the primary healthcare system provided for rural India. The component for ambulatory curative services is grossly inadequate under the primary healthcare system. In contrast, the focus in urban healthcare is largely curative, with dispensaries and hospitals taking away most of the health resources. Since India lacks a national health accounting system, disaggregation of public spending across rural and urban areas, for the country as a whole, is difficult to compile. However, we have done this exercise for Maharashtra state to estimate rural-urban differentials in the allocation of resources (Table 3 at the end of the article).

The rural-urban distribution of resources at one level favours urban health facilities with over 60% of allocations for urban areas where 40% of the population resides. But, more important, at another level the service mix of healthcare in the two regions differs significantly. Rural areas get only half the resources urban areas get on a per capita basis, and within this low allocation only 4% is for medical care and a little over 1% for capital expenditure (Table 3). The rest is on the preventive and promotive programmes referred to earlier.

In contrast, in urban areas, resource distribution shows a good mix of curative, preventive and promotive services, with curative services comprising nearly half the urban health budget. While this data is from Maharashtra, in other states the rural-urban disparity should not be very different; in fact the allocation of resources to rural areas in the under-developed states is likely to be less.

While rural-urban differential health expenditures are not available in the national health accounts, we do have data on expenditures across major health programmes. Table 4 shows that until the beginning of the 1990s the proportion across programmes maintained an astonishing consistency. What we see since then is a decline in the proportion of expenditure on hospitals and dispensaries, capital expenditure and disease programmes. One programme that has gained substantially is mother and child health (MCH), now called reproductive and child health (RCH) together with the family planning programme, because of an increased focus on ante-natal care and child immunisation. Capital expenditures have taken a real beating (see Table 2) and as a result there have been virtually no new investments in the public domain during the 1990s and subsequently. However, the decline under the budget head 'hospitals and dispensaries' and 'disease programmes' may not be actually so. In the finance accounts there have been changes in reporting in which external budgetary support is shown under a separate head, and since such resources have come largely to the hospital sector (health sector reform projects of the World Bank, European Union, etc) and to disease programmes like AIDS and tuberculosis, there is perhaps no real decline under these two heads. So the astonishing consistency seems to continue, perhaps reflecting that there is very little drive for change in the method of public health spending.

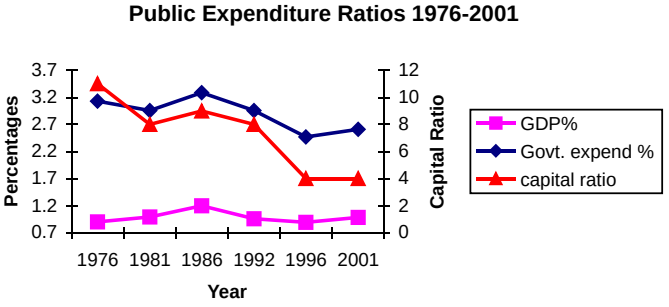
Further, when we look across states the declining trend in public health expenditure during the 1990s is almost universal (Table 6). The collapse is taking place across the length and breadth of the country and this is a very serious concern. Yet, one sees increased proportions being allocated in the central government's budget: this is also a matter of concern because most of this increase is due to external funding for vertical health projects like the health sector reform projects of the World Bank and EU, RCH projects of various bilateral and multilateral donors, HIV/AIDS funding, etc.

Another concern vis-à-vis public health budgets is that of allocative efficiency of resources. In the 1990s, budgets shrank, yet salaries (post-1996) increased substantially and this upset the availability of resources for non-salary components in most states and added salt to the wounds of the ailing public health system. It is only in the last few years that the ratio of salary to non-salary is returning to pre-1996 levels.

To sum up then, it seems clear that the collapse of the public health system during the last decade is linked to falling levels of public health investment and declining public health expenditure. In a situation of continuing poverty, this can only lead to increased adversities in health outcomes.

This is an abridged version of a paper titled 'Public Health Expenditures, Investment and Financing Under the Shadow of a Growing Private Sector' by Ravi Duggal, published by CEHAT in Review of Healthcare in India. *Ravi Duggal is the coordinator of CEHAT and his areas of research interest include health policy, systems and financing, reproductive health and health and human rights*

Graph 1



Source: 1. Up to 1986 — combined finance and revenue accounts, respective years, GOI, New Delhi; 2. 1992-2001 — finance accounts of states and Union government, respective years; and RBI — finances of the state governments, respective years, RBI, Mumbai; 3. GDP and population data — national accounts statistics, CSO, 2003

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Table 1: Pattern of investment and expenditure on health and family welfare (Rs in billions) and selected health outcomes

	Public health investment and expenditure						Private health		Total health		Health outcomes	
Plan period	Health & FW plan expen-diture	Health & FW as % of plan	Health & FW expen-diture plan + non plan	% of health & FW of total govt expen-diture	% of health & FW of GDP	% of plan H&FW expen-diture	Private health expen-diture	Private health as % of GDP	Total health expen-diture	Public as % of total health	IMR at end of plan period	Life expec-tancy during plan period
First Plan (Actuals) (1951-56)	0.65	3.33	2.27	3.74	0.44	28.63	7.5	1.46	9.77	23.2	148	37
Second Plan (Actuals) (1956-61)	1.46	3.12	3.93	3.52	0.56	37.15	13.2	1.88	17.13	22.9	138	44
Third Plan (Actuals) (1961-66)	2.51	2.92	6.68	2.65	0.62	37.57	26.89	2.53	33.57	19.9		
Annual Plans (Actuals) (1966-69)	2.11	3.18	6.84	2.80	0.69	30.85	26.92	2.71	33.76	20.3	129	51
Fourth Plan (Actuals) (1969-74)	6.14	3.89	19.91	3.35	0.84	30.84	67.02	2.83	86.93	22.9	129	
Fifth Plan (Actuals) (1974-79)	12.53	3.18	34.33	2.86	0.81	36.50	148.21	3.52	182.54		120	52
Annual Plan (1979-80)	3.84	3.30	11.29	3.19	1.04	34.01	45.85	4.21	57.14	19.8	114	52
Sixth Plan (Actuals) (1980-85)	34.12	3.12	95.72	3.15	1.10	35.64	354.64	4.06	450.36	21.3	96	55
Seventh Plan (Actuals) (1985-90)	68.09	3.11					556.05	3.35			80	58
Annual Plans (1990-91), (1991-92)	37.71	3.06	109.95	2.94	0.99	34.30	307.63	2.80	417.58	26.3	79	59
Eighth Plan (Actuals) (1992-97)	141.10	2.9	434.34	2.52	0.93	32.49	1352.23	2.88	1786.57	24.3	71	61
Ninth Plan (Anticipated expenditure) (1997-2002)	299.96	3.19	847.69	2.65	0.97	35.38	3054.24	3.49	3901.93	21.7	66	65
Tenth Plan (Draft outlay) 2002-2007	589.20	3.86	1785.00	2.50	1.0	33.0	7500.00	4.28	9285.00	19.2	60	67

Source for plan data: 1. 'Indian Planning Experience — A Statistical Profile', Planning Commission, GOI, New Delhi, 2000; 2. Ninth Five-Year Plan, Planning Commission, GOI, New Delhi, 1998; 3. Draft Tenth Five-Year Plan, www.planningcommission.nic.in/; for total public health expenditure (ministries of health and family welfare: 1. Upto 1986 — combined finance and revenue accounts, respective years, GOI, New Delhi; 2. 1987-2002— finance accounts of states and Union government, respective years; and RBI — finances of the state governments, respective years, RBI, Mumbai; for private health expenditures and GDP data — national accounts statistics, CSO, 2003; for health outcomes — Registrar General of India, respective years. Projections estimated by author

Table 2: Total public health expenditure (revenue + capital) trends 1975-2003 and selected ratios

	Total public health expenditure (rupees in billions)	% of GDP	% of total government expenditure	Per capita (rupees)	Capital as ratio to revenue expenditure
1975-76	6.78	0.90	3.13	11.16	0.11
1980-81	12.86	0.99	2.96	18.94	0.08
1985-86	29.66	1.19	3.29	39.28	0.09
1991-92	56.40	0.96	2.96	65.89	0.08
1992-93	64.64	0.74	2.71	74.13	0.04
1993-94	76.81	0.98	2.89	86.21	0.04
1994-95	85.65	0.93	2.33	94.33	0.05
1995-96	96.01	0.89	2.47	103.57	0.04
1996-97	109.35	0.88	2.43	115.96	0.04
1997-98	127.21	0.92	2.50	132.65	0.05
1998-99	151.13	0.94	2.66	155.01	0.04
1999-00	172.16	0.96	2.61	173.72	0.05
2000-01	186.13	0.98	2.69	182.66	0.04
2001-02 RE	211.06	1.02	2.72	203.53	0.05
2002-03 BE	219.59	1.00	2.60	208.54	0.05

Source: 1. Upto 1986 — combined finance and revenue accounts, respective years, GOI, New Delhi; 2. 1987–2003 — finance accounts of states and Union government, respective years; RBI — finances of the state governments, respective years, RBI, Mumbai; 3. GDP and population data — national accounts statistics, CSO, 2003

Table 3: Maharashtra 2000-01 public health expenditure (Rs in millions)			
Type of expenditure	Rural	Urban	Combined
Medical care*	259.55 (4.09)	7,457.24 (74.59)	7,716.79 (47.22)
Public health	4,514.34 (71.15)	1,947.33 (19.48)	6,461.67 (39.54)
Family planning	677.57 (10.68)	61.70 (0.62)	739.27 (4.52)
MCH	136.91 (2.15)	58.68 (0.58)	195.59 (1.20)
Other FW	672.34 (10.60)	167.77 (1.68)	840.11 (5.14)
Capital	84.41 (1.33)	305.04 (3.05)	389.45 (2.38)
Total	6,345.12 (100.00)	9,997.76 (100.00)	16,342.88 (100.00)
Percent to combined	38.82	61.18	100.00
Per capita	113.85	243.73	168.92

** Includes teaching hospitals, medical education and ESIS; figures in parentheses are column percentages*

Note: In addition, urban areas have municipal health expenditures, which can be substantial in bigger cities; for instance, Mumbai city alone has a municipal health budget equivalent to the entire medical care budget of Maharashtra state

Table 4: Disaggregation of national public health expenditure by major programmes								
Year	1950-51	1960-61	1970-71	1980-81	1985-86	1990-91	1994-95	2000-01
A: Amount in million rupees								
Revenue expenditure on health	218.55	1,076.82	3,351.18	1,1888.12	2,7153.91	5,1031.67	8,1740.53	1,78900.0
Disease programmes	23.73	280.51	456.86	1.540.33	3.174.14	5.537.20	8.537.43	1.4062.94
Hospitals and dispensaries	96.15	427.92	1,249.59	5,147.53	1,0270.37	1,5372.22	2,1574.44	3,9273.97
ESIS, CGHS	—	29.00	152.00	1,001.00	—	2,698.47	4,280.23	8,392.38
Medical education, training and research	10.91	60.31	239.60	1,077.90	2,353.92	5,706.57	9,555.48	1,9190.85
Family welfare excluding MCH*	—	—	—	1,359.09	4,735.69	7,927.97	1,2679.49	2,4153.80
MCH services*	—	—	—	60.38	136.14	465.29	1,486.48	4,948.52
Health administration	30.62	119.65	671.90	583.99	1,285.00	2,298.98	3,706.05	9,390.75
Capital expenditure on health*	—	—	—	969.00	2,507.22	2,513.87	3,909.47	7,632.40
B: Percentage distribution								
Total expenditure on health	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Disease programmes	10.86	26.05	13.63	12.96	11.69	10.85	10.44	7.86
Hospitals and dispensaries	43.99	39.74	37.29	43.30	37.82	30.12	26.39	21.95
ESIS, CGHS	—	2.69	4.54	8.42	—	5.29	5.24	4.69
Medical education training and research	4.99	5.60	7.15	9.07	8.67	11.18	11.69	10.73
Family welfare*	—	—	—	11.43	17.44	15.53	15.51	13.50
MCH services*	—	—	—	0.51	0.50	0.91	1.82	2.77
Health administration	14.01	11.11	20.05	4.91	4.73	4.51	4.53	5.25
Capital expenditure on health*	—	—	—	7.54	8.45	4.69	4.56	4.09

Note: The sub-heads do not add up to the total as some sub-heads like public health training, health statistics, health transport, public health laboratories, etc, are not included here. Percentages for all programmes are a proportion of total revenue health expenditure, except for capital which is a proportion of total health expenditure

** (i) Family welfare and MCH from 1950-51 to 1970-71 included in medical and public health account heads (ii) Capital expenditure on health is shown separately only from the '70s, prior to which it was under the ministry of works*

Source: Upto 1985-86 is combined finance and revenue accounts, Comptroller and Auditor General of India, respective years. Other years — finance accounts, respective states

Note: From the mid-'90s, external funding for hospital sector reforms and for select disease programmes has increased sharply and these are recorded under separate budgetary heads and hence the decline we see in the budget head 'hospitals and dispensaries' and 'disease programmes' may not be really so

Table 5: Private health expenditure trends			
Year	Private health expenditure (Rs in billions)	% of GDP	% of total health expenditure
1975-76	24.66	3.26	78.43
1980-81	52.84	4.06	80.43
1985-86	90.54	3.61	75.32
1991-92	160.65	2.73	74.01
1992-93	175.57	2.61	73.09
1993-94	195.43	2.50	71.78
1994-95	278.59	3.04	76.48
1995-96	329.23	3.07	77.42
1996-97	373.41	3.00	77.35
1997-98	458.99	3.30	78.30
1998-99	653.40	4.04	81.21
1999-2000	835.17	4.76	82.91
2000-01	981.68	5.18	84.06
2001-02*	1100.00	5.32	83.90
2002-03*	1250.00	5.60	85.06

** Estimates by author*

Source: CSO-GOI national accounts statistics, 2003

Table 5: Revenue expenditure on health: Union government and states

Year	1950-51	1960-61	1970-71	1980-81	1985-86	1990-91	1994-95	1999-2000	2000-01
A: Amount in million rupees									
Major states									
Union government	19.97	267.80	284.35	1,022.18	2,561.51	5,523.53	8,189.19	1,7219.15	2,5864.76
Andhra Pradesh	—	75.57	259.39	876.22	1,837.60	3,268.04	5,601.91	1,0940.18	1,2860.91
Assam	6.29	30.42	74.93	232.60	647.08	1,103.10	1,921.47	3,070.24	3,461.82
Bihar	16.47	65.27	162.53	544.11	1,235.89	2,713.33	4,128.06	1,0162.00	9,964.30
Gujarat	—	31.88	213.87	641.99	1,480.69	2,510.76	4,131.96	9,131.27	8,937.52
Haryana	—	—	75.58	238.17	597.82	819.28	1,427.65	2,839.31	2,909.09
Jammu and Kashmir	—	10.40	46.29	196.74	420.23	756.28	1,569.14	3,352.51	3,610.48
Karnataka	0.46	46.36	159.53	603.49	1,385.49	2,430.15	4,577.49	8,682.94	9,035.63
Kerala	—	44.49	150.11	570.92	1,133.97	2,127.69	3,432.39	6,880.37	6,738.91
Madhya Pradesh	7.01	55.62	197.04	687.85	1,500.99	2,745.52	4,473.32	8,365.20	8,319.90
Maharashtra	4.59	90.68	385.33	1,252.05	2,694.69	4,774.24	7,580.35	1,3547.7	1,5953.42
Orissa	6.97	25.90	107.59	408.74	739.01	1,350.29	2,157.21	4,256.70	4,331.06
Punjab	7.83	42.11	98.31	387.11	842.18	1,662.89	2,261.66	5,445.62	6,375.88
Rajasthan	—	44.98	212.21	569.01	1,225.32	2,506.66	4,608.69	8,580.30	8,775.99
Tamil Nadu	41.89	83.12	278.50	882.32	1,885.52	3,790.06	6,100.09	1,1414.77	1,1604.94
Uttar Pradesh	30.02	74.01	281.12	1,116.18	3,712.27	6,214.30	8,981.31	1,2702.00	1,4102.20
West Bengal	37.17	88.18	266.91	1,096.08	2,015.23	4,330.13	5,262.32	1,2274.95	1,3766.15
Other states									
Arunachal Pradesh	—	—	—	42.07	82.91	170.62	280.94	539.60	536.10
Goa, Daman and Diu	—	—	19.51	53.58	118.87	238.38	362.76	765.88	823.64
Mizoram	—	—	—	37.90	89.30	149.18	257.83	536.90	538.50
Pondicherry	—	—	10.95	35.02	83.61	181.88	281.42	731.51	804.16
Himachal Pradesh	—	—	39.88	154.63	324.40	667.33	1,163.70	2,478.20	2,630.60
Manipur	—	—	10.89	53.63	95.90	188.20	284.13	753.40	663.70
Meghalaya	—	—	10.65	66.56	124.93	207.62	304.18	636.80	705.10
Nagaland	—	—	17.82	55.92	158.73	245.92	323.41	626.30	764.36
Sikkim	—	—	—	12.79	37.47	79.31	144.10	336.51	317.30
Tripura	—	—	13.79	44.19	122.30	277.09	358.31	711.30	827.34
Delhi	—	—	—	—	—	—	1,573.51	3,913.60	4,392.40
Chhattisgarh	—	—	—	—	—	—	—	—	771.20
Jharkhand	—	—	—	—	—	—	—	—	—
Uttaranchal	—	—	—	—	—	—	—	—	3 4 2 . 2 0
All India	218.55	1076.82	3351.18	11888.12	27153.91	51031.68	81738.50	150733.21	178189.04
B: As percentage of total government revenue expenditure									
Major states									
Union government	0.47	2.53	0.58	0.48	0.52	0.54	0.46	0.50	0.75
Andhra Pradesh	—	8.89	8.74	7.55	6.61	5.94	5.89	6.06	5.57
Assam	6.74	7.51	6.20	6.51	6.75	5.81	5.87	5.25	5.39
Bihar	6.32	9.02	6.53	5.72	5.68	5.48	5.46	6.30	6.95
Gujarat	—	6.22	9.75	7.11	7.51	5.80	5.48	5.21	4.05
Haryana	—	—	8.09	5.94	7.00	4.24	*	4.08	4.05
Jammu and Kashmir	—	8.58	6.68	7.35	7.61	6.06	6.21	5.54	5.45
Karnataka	0.35	5.83	6.32	6.74	6.60	6.12	6.30	5.70	5.42
Kerala	—	9.67	9.16	8.55	7.85	7.53	6.77	5.95	5.67
Madhya Pradesh	2.48	8.42	9.66	6.77	6.69	5.78	5.73	5.18	5.55
Maharashtra	6.22	7.60	8.38	6.53	5.97	5.45	5.12	4.59	4.27
Orissa	5.80	7.29	7.69	7.47	7.38	5.40	5.35	5.03	4.90
Punjab	3.80	7.12	7.22	7.04	7.24	5.54	3.74	5.34	5.44
Rajasthan	—	9.89	9.64	8.28	8.11	7.20	6.83	6.39	5.84
Tamil Nadu	7.05	9.12	8.66	7.66	7.70	6.72	6.33	5.51	5.34
Uttar Pradesh	5.79	5.13	6.79	6.50	9.75	6.52	5.83	4.42	4.54
West Bengal	9.89	9.48	8.80	9.83	8.92	8.44	6.90	6.30	6.23
Other states									
Arunachal Pradesh	—	—	—	6.86	5.85	6.61	6.41	6.57	5.90
Goa, Daman and Diu	—	—	15.01	10.29	8.22	8.65	7.60	5.33	4.82
Mizoram	—	—	—	7.03	6.80	4.91	5.56	6.00	5.27
Pondicherry	—	—	13.96	10.60	9.11	8.91	7.84	8.65	8.75
Himachal Pradesh	—	—	6.39	8.24	7.89	7.40	7.21	6.48	6.01
Manipur	—	—	7.17	7.68	6.15	5.60	5.59	5.55	5.87
Meghalaya	—	—	11.04	11.12	9.20	6.68	6.66	6.11	6.53
Nagaland	—	—	7.24	6.11	6.96	5.85	5.53	5.31	5.92
Sikkim	—	—	—	4.17	4.83	6.19	2.74	2.23	4.16
Tripura	—	—	7.91	5.07	6.53	5.57	*	4.87	4.77
Delhi	—	—	—	—	—	—	—	11.11	11.88
Chhattisgarh	—	—	—	—	—	—	—	—	4.78
Jharkhand	—	—	—	—	—	—	—	—	—
Uttaranchal	—	—	—	—	—	—	—	—	3.75
All India	2.69	5.13	3.84	3.29	3.29	3.02	2.67	2.97	3.13

*Note: — = Not applicable; * = Not available*

Source: Upto 1985-86 — combined finance and revenue, Accounts Comptroller and Auditor General of India, GOI, respective years; other years — finance accounts, respective states, respective years; RBI — finances of the state governments, respective years

User fees: The cost of cost recovery

Since 1991, user fees have been introduced in government hospitals despite evidence that they do not really help cost recovery and only end up placing a further burden on the poor

SANDHYA SRINIVASAN

USER FEES — for various services within a healthcare facility — are an integral part of post-1991 health system restructuring packages, though 'cost recovery mechanisms' in government hospitals existed in some states before 1991. The rationale: money for public healthcare must be raised from somewhere; we already know that people are willing to pay for healthcare, and payments will reduce 'frivolous' use of the healthcare system.

Many health activists and networks like the Jan Swasthya Abhiyan (JSA) oppose user fees and other cost recovery mechanisms. Their reasoning:

User fees do not raise much money. For example, a review paper by Ramesh Bhat ('Public Private Partnerships in Health Sector: Issues and Prospects', Indian Institute of Management, Ahmedabad, 1999) notes that "the option of meeting this expenditure through user fees has been tried out by various state governments. However, this could not provide a solution since the receipts were less than the expenditure. In 1992-1993 the average hospital receipts were 1.4% of the total hospital expenditure." Elsewhere, when user charges were recovered as part of health restructuring programmes, Zambia and Kenya recovered about 3% of costs. Ghana raised between 5% and 12% of expenditure.

Cost Recovery and Health Expenditure by States, 1996

India / States	Total Exp. (Rs. Lakhs)	Total User Fees (Rs. Lakhs)	Cost Recovery Ratio
Andhra Pradesh	47897.97	734.93	1.53
Bihar	22130.44	229.75	1.03
Gujarat	33564.11	438.14	1.31
Haryana	11957.45	1136.67	9.51
Himachal Pradesh	11621.46	78.40	**0.67**
Karnataka	42614.04	1180.41	2.77
Kerala	31226.29	4952.00	**15.86**
Madhya Pradesh	36218.31	577.91	1.60
Maharashtra	45892.85	2126.99	4.63
North East	25695.49	386.37	1.50
Orissa	19893.68	183.71	0.96
Punjab	17693.15	1808.04	**10.67**
Rajasthan	43861.48	397.92	**0.92**
Tamil Nadu	55983.65	1238.33	2.21
Uttar Pradesh	84308.17	2726.22	3.23
West Bengal	50801.52	1063.42	2.09

Source: India: Raising the Sights – Better Health Systems for India's Poor, World Bank, 2001 (19)

Means testing (to give fee waivers for the very poor) doesn't work. A 2002 report by INSAAF International, 'World Bank Funded Health Care: A Death Certificate for the Poor', reported instances of patients in Punjab being thrown out of public hospitals because they didn't have the money. After user fees were imposed in hospitals of the Punjab Health Systems Corporation, from October 1995, the poorest were entitled to exemptions based on government-issued yellow cards. But in Bhatinda, a city of 270,000 people, no exemption cards had been issued since 1996 and only 44 yellow cards were renewed since 1998. Not a single exemption was granted between July and December 2000 at the Bhatinda referral hospital. Only one in 150 city slum women had even heard about yellow cards. The researchers reported a 20% reduction in bed occupancy and a 20-40% reduction in outpatient cases.

User charges can be at significant cost to users. "Ten years ago, ICU charges were free and many medications were available. Today an angiography costs Rs 6,500 — almost the same as some small private hospitals in Mumbai. People are still charged Rs 65,000 for stents at municipal hospitals though the prices have come down in the market," says a doctor. How do people manage? "Some take loans, some manage grants from the chief minister's fund, some don't get the treatment done." There have been reports of patients slipping out of government hospitals during visiting hours because they could not pay their bills. There has also been the absurd situation of poor patients being kept in the hospital till they pay their bills — with the bill increasing each passing day.

Many surveys have found that user fees further reduce access to healthcare. Public facilities are used mostly by those who do not have a choice. There are no comprehensive studies in India on whether user fees reduce demand for healthcare. But many small studies in other countries say exactly this:

- OPD visits went down by 52% in Kenya, 30% in Papua New Guinea, 53.4% in Dar Es Salaam, Tanzania, 50% in Ghana.
- In China, user charges, introduced in the 1980s and implemented even in the TB control programme, are held responsible for the poor quality of TB programmes.

Health organisations testify to the ill-effects of user fees

- The international health relief organisation Medicins Sans Frontieres (MSF) reported that governments often insisted on user fees even within MSF-funded projects. MSF tried to improve cost recovery systems, ensure rational care-seeking, implement more effective waiver systems and make better use of collected revenues. But it found repeatedly that clinic attendance dropped after user fees were imposed and went up when they were removed.
- In 2004, MSF decided that it could no longer accept or allow exclusion within its projects -– whether in crisis and conflict or in stable situations. Its position is that healthcare should be free at the point of delivery.

• "In a context of deficit health budgets and pressure from international agencies such as the International Monetary Fund and the World Bank to restrain public spending, health services are doomed to focus on making ends meet instead of responding to the needs of the ill …Cost recovery policies need to be changed so that lives are not sacrificed for the sake of macroeconomic theory."

The money does not go where it should. Health researcher Ravi Duggal notes that user fees introduced in Kerala were withdrawn as the money remained unspent because of disputes between local authorisation committees and politicians. In Maharashtra, user fees were increased in 2000 but the money is not used, apparently because of bureaucratic problems. The system remains starved of essential drugs and equipment.

Healthcare is a right. Access to primary education and healthcare is a right that should not be conditional on the ability to pay. All people already pay for these services -– through taxes of one kind or the other. User fees shift the burden onto the poor and deflect attention away from the fact that more money should be spent on the public healthcare system.

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What doctors think about charging fees in public hospitals

More than 1.5 million people visit the OPDs of the King Edward Memorial Hospital, Mumbai, each year. Starting in the late-1980s, the hospital instituted user charges for OPD papers, various tests and procedures. User charges were increased in the 1990s and applied to a broader range of services.

"Public hospitals were set up for the very, very poor who cannot go anywhere else," says Dr Sunil K Pandya, who retired in 1998 as head of the department of neurosurgery at KEM Hospital. "When I joined in 1967 not only were there no fees but every in-patient would have clean bedsheets and towels. You can't even imagine this today." While expensive tests and some consumables such as heart valves used to be charged in Dr Pandya's time, the social worker would raise the money if needed. "Today every operation is charged — this is not justified." Dr Pandya remembers routine shortages of drugs and other necessities, starting in December till the end of the financial year, "because the budget would always be 25-30% less than needed".

Eighty per cent of the revenue earned at KEM (amounting to about 10% of its annual budget) is from the radiology department. Dr Ravi Ramakanthan, head of the department of radiology, finds the process an administrative nightmare.

"We are supposed to do 20% of scans free. The decision is made by the medical social worker, but in emergency cases the assistant medical officer, who has no training in this, decides. Are we deciding correctly and uniformly? And we can't stop after the 20% quota is over — each case has to be decided on merit." Charges include the cost of consumables, but the department sometimes runs out of contrast dye, for example. In such cases Dr Ramakanthan tells the patient to buy the dye from outside and waives all charges.

Rates for basic tests are on the website. The department does other therapeutic procedures for which the charges cannot be fixed. "This can range from Rs 5,000 to Rs 3 lakh." For such large amounts, which cannot be waived, 'non-affording' patients are sent to the social worker who writes letters to charitable trusts and raises about 80% of the money needed. In an emergency the cost can be underwritten by the dean and money taken from the hospital poor box, which collects donations to pay for poor patients' care.

Do doctors find that some patients must return without the necessary treatment? Do they worry about how patients raise money at short notice? "We have to be thick-skinned, we just can't take that on," says Dr Ramakanthan.

"Today's patients are willing to pay if you explain the need to them, and it's still much, much cheaper than in the private sector," says Dr Avinash Supe, professor and head of the department of surgical gastroenterology at KEM Hospital. While basic drugs are stocked in the hospital, some expensive less-used medicines will have to be bought from the market as will, for example, the special mesh for hernia operations. An endoscopy costs Rs 150 at KEM, compared to at least Rs 1,500 outside.

Do doctors see patients go without care because they cannot afford it? Rarely, says Dr Supe. The hospital social worker will apply to charitable trusts or get money from the hospital poor box. Or patients will borrow the money from somewhere.

"The biggest problem is when patients get transferred from a private set-up where they have already spent all their money. This happens very often — I must have five such patients in my ward at any given time."

"I think it's outrageous," says Dr Armida Fernandez, neonatologist and former dean of LTMG Hospital, Sion, Mumbai. Many of the hospital's patients come from the slums of Dharavi next door. "They cannot possibly afford Rs 300 per day in the neonatal ICU — and they're also paying for many drugs unavailable at the hospital." Dr Fernandez remembers many times when families just could not pay the expenses of treatment. This would either prolong hospital stay and the bill while someone tried to raise the money, or the family would just pack up and leave discreetly during visiting hours. "And then the administrators would be required to file police cases for non-payment." Sneha, an NGO working with women and children in Dharavi, next to LTMG Hospital, found that many women were forced to undergo home deliveries — increasing the risk both to the mother and the child — because of the hospital policy of charging for a third delivery.

The big squeeze

What does a liberalised economic policy have to do with public health? Everything. With the World Bank and IMF calling for market-based pricing of welfare services, including healthcare, the introduction of user fees and greater private sector participation, health expenditure in India has declined from an already low 1.3% of GDP in 1990 to 0.9% in 1999

AMIT SEN GUPTA

PUBLIC HEALTH POLICIES are largely determined by the overall goals of economic and social development pursued by a country. Such goals are crucial in determining the kind of support that is provided by the government in enhancing public health outcomes. Over the last two decades, economic policies across the globe have been informed by the new liberal paradigm which advocates that governments should play a much smaller role in welfare sectors like health, education and food security. Such policies have, to a large extent, been influenced by institutions such as the World Bank and the IMF, which have argued that services, including welfare services, should move towards what they call "market-based pricing".

Asem Ansari/ICDDRB, 1979, courtesy of Photoshare

Along with this, the World Bank, IMF and World Trade Organisation have facilitated what is now known as globalisation.

Globalisation has essentially meant providing increased access to local markets by global players like MNCs, and allowing for the free flow of goods and services across borders. Unfortunately globalisation as we see it today does not, at the same time, allow free flow of labour and knowledge, thereby tilting the terms at which globalisation is taking place in favour of developed countries.

There is, however, a clear contradiction between the principal tenets of public health and neo-liberal economic theory. The former posits that public health is a "public good", that is, its benefits cannot be individually appropriated or computed but have to be seen in the context of benefits that accrue to the public. Thus public health outcomes are shared, and their accumulation leads to better living conditions. Such goods never mechanically translate into visible economic determinants, namely, income levels or rates of economic growth. Kerala, for example, has one of the lowest per capita incomes in the country, but its public health parameters rival those in many developed countries. The infant mortality rate in Kerala is less than a third that of any other large state in the country. But neo-liberal economic policies are loath to even acknowledge such benefits. Kerala's development is linked to wide-ranging reforms in the agrarian sector in the '50s and land reforms that abolished absolute poverty in the state to a very large extent. This, in turn, has led to the state making large strides in the area of literacy and education. Kerala's example shows that a more egalitarian sharing of resources is the first prerequisite of better public health outcomes.

As discussed earlier, the World Bank has been a key player in formulating overall guidelines for economic and social development across the globe. In the health sector the issues were sharply focused upon for the first time in 1987 by a World Bank document titled 'Financing Health Services in Developing Countries'.[1] The document recommended that developing countries should:

- Increase amounts paid by patients for public health facilities.
- Develop private health insurance mechanisms.
- Expand the participation of the private sector.
- Decentralise government healthcare services (a euphemism for rolling back government responsibility and passing on the

burden to local communities).

By the '80s the World Bank's intervention in various developmental issues was being lapped up by pliant country governments. As a result, its prescriptions on health too were made part of public policy in many developing countries, including India. These recommendations were further 'fine-tuned' and reiterated by the Bank's World Development Report, 1993 titled 'Investing in Health'.

The World Health Organisation (WHO), long a silent spectator to the process whereby the Bank had usurped its functions, attempted to make amends by setting up a Commission on Macroeconomics and Health.[2] What we have before us is an unabashed attempt by the WHO to speak the language of the Bank. The report in its introduction says: "With globalisation on trial as never before, the world must succeed in achieving its solemn commitments to reduce poverty and improve health." In other words, poverty reduction and health improvement are goals that need to be achieved in order to rescue globalisation from the dock!

We need to go back to the notion that public health is a public good, its benefits shared by everybody

The report starts from the premise that health can be broken down to a few 'magic bullets' appropriately delivered at a target. It is a premise that is the exact opposite of the essential principles of public health.

Health sector reforms in India

India embarked on its present path of economic liberalisation, on instructions from the World Bank and the IMF, relatively late (liberalised economic policies had been initiated in Latin America and Africa a decade earlier), in 1991. The immediate fallout was a savage cut in budgetary support to the health sector.[3] The cuts were severe in the first two years of the reform process, followed by some restoration in the following years.

As a result of this rolling back of government support to healthcare the first major casualty in infrastructure development has been the rural health sector. We are now seeing this as a major contributory factor to the disruption of the rural primary healthcare system. As a percentage of GDP, health expenditure in India (already one of the lowest in the world) has declined from 1.3% in 1990 to 0.9% in 1999. While central budgetary allocation has remained stagnant at 1.3% of total outlay, the budgetary allocation to health in state budgets (which account for over 70% of the total healthcare expenditure of the country) has dropped in this period from 7.0% to 5.5%.[4] This is a direct consequence of the squeeze imposed on the finances of the states by economic liberalisation policies.

This is not to suggest that optimal use was made of public health expenditure in the country before the reforms process. Much of the blame for what is today being called the "resurgence of communicable diseases" lies in strategies adopted well before the reforms programme in the country. These strategies relied on various centrally-administered programmes (vertical programmes) for disease control and prevention. With no integration at the level of delivery, the programmes were insensitive to local conditions, unresponsive to local needs, highly bureaucratised and inefficient. Local populations were indifferent and, in some cases, hostile to such programmes, resulting in fair measure to the very poor utilisation of government health facilities in many areas.

Oblivious to these trends the government has geared itself towards showcasing the "market orientation" of healthcare policies. Investment in the private hospital sector was very low in the 1970s, but since then it has grown at an exponential rate. This was fuelled by a slowing down of investment by the state and simultaneous incentives given to the private sector in the form of soft loans, subsidies and tax exemptions. In recent years new medical technologies have further added to the impetus, with increasing participation from the corporate sector. This, coupled with the impending entry of insurance multinationals, has cleared the way for the Indian healthcare sector being taken over by forces that control the global 'market' for healthcare. In the process, the health needs of an overwhelming majority of Indians are being increasingly ignored.

National Health Policy 2002

The National Health Policy[4] announced by the government in 2002 is a continuation of the trends indicated earlier. A perusal of the new policy throws up many fundamental concerns. The policy admits that public health investment has been "comparatively low" and recommends a welcome increase in public health expenditure from the present 0.9% of GDP to 2.0% in 2010. However, the quantum suggested is too little and comes very late. It falls far short of the 5% of GDP that has been a long standing demand of the health movement and recommended by the WHO decades ago. Moreover, the draft projects that public expenditure in 2010 will be 33% of total health expenditure — up from the present 17%. But even 33% is lower than the average of any region in the world today — India would continue to be one of the most privatised health systems in the world even in 2010!

Numerous formulations in the policy, in various forms, clear the way for even greater privatisation of the healthcare system. The policy says: "The NHP will...suggest policy instruments for implementation of public health programmes through individuals and institutions of civil society." This constitutes a veiled attempt to clear the way for sub-contracting public health to NGOs. The policy proposes to employ user fees in public hospitals, with the usual sugar coating of user fees being introduced for those who can pay. The global experience of user fees at any level shows that they serve only one purpose — to drive out the poor and the indigent.

New directions in policy

Since the National Health Policy 2002 was announced there has

been a change of government in the country. Hopes of a change in direction were stoked by some positive declarations of intent in the Common Minimum Programme (CMP) of the newly-installed UPA government. It stated, for example: "The UPA government will raise public spending on health to at least 2-3% of GDP over the next five years with focus on primary healthcare." The CMP also underlined its commitment to focus on primary healthcare. It said: "The UPA government will take all steps to ensure availability of life-saving drugs at reasonable prices." However, the hopes raised by such positive statements have been belied in the ensuing months.

The first budget by the UPA government provided no additional budgetary support for healthcare, thereby rendering meaningless its commitment to increasing public spending on health. There have been no concrete moves to impose price controls in order to bring down spiralling drug prices.

The government's commitment to primary healthcare is now being sought to be implemented through the new Rural Health Mission. However, a reading of initial drafts of the mission raise a number of disturbing concerns. The scheme proposes to hand over large parts of the public health system to private providers and NGOs. It lays emphasis on the need to levy user fees in order to maintain the infrastructure. It is not committed to strengthening the public health infrastructure, but instead proposes to fill gaps in the infrastructure through private sector participation. An impression is being created that the non-functioning of the public health system is a legitimate reason for resorting to privatisation of the structure (http://mohfw.nic.in/NHRM.ppt).

No medicines for the poor

The Trade Related Intellectual Property Rights (TRIPS) agreement designed to introduce uniform laws providing patent protection, signed in 1995 as part of the WTO agreement, was the most bitterly fought during GATT negotiations. Laws that provide strong patent protection limit the ability of developing countries to enhance their S&T capabilities and retard dissemination of knowledge. Before the TRIPS agreement, many countries like India had domestic laws that did not favour strong patent protection — Indian domestic laws since 1970 didn't allow medicines to be patented.

These arguments were, however, systematically subverted during the GATT negotiations, leading to the signing of the TRIPS agreement. The TRIPS agreement required countries like India to change over to a strong patent protection regime by 2005. A regime that would no longer allow countries to continue with domestic laws that enabled domestic companies to manufacture new drugs invented elsewhere, at prices that were anything between 1/20th and 1/100th of global prices.

In order to comply with the TRIPS agreement, the Indian Patent Act has been amended thrice — in 1999 and 2002, and recently through the promulgation of an ordinance.[5] Unfortunately, the previous amendment and the recent Patents Ordinance have failed to even use the flexibility available in the TRIPS agreement. The TRIPS agreement was bad for developing countries to start with, but the Indian government is making it worse by not even using the possibilities available in the agreement and the clarification issued in the Doha Declaration of 2001.

Two significant areas where Indian law goes beyond what is required even under TRIPS relate to compulsory licensing and pre-grant opposition. The former (compulsory licensing) is an instrument under TRIPS by which governments can allow domestic manufacturers to manufacture patented products within three years of their introduction. In the Indian law this provision is still weak and cumbersome. Pre-grant opposition is an instrument by which patent applications can be challenged — and a strong provision would help limit the number of patents granted. The new Patents Ordinance seeks to drastically dilute this provision. What is disturbing is that these provisions in the Indian law are unnecessary for us to comply with the obligations laid down by the TRIPS agreement. In other words, when asked to bend the government is willing to kneel!

As a consequence, over a period of time Indian companies will lose the opportunity to develop processes for patent-protected drugs in the country and India will become dependent on MNCs for technology to produce new drugs. Votaries of the new Patents Act argue that old drugs will not be affected by this act. While this is true, it must be understood that the rate of obsolescence of old drugs is extremely fast today. Further, technological dependence on MNCs is the proverbial thin end of the wedge that will be used by MNCs to establish their dominance over the Indian drug market once again (a position they lost after the mid-'70s). Today Indian companies are the largest suppliers of low-cost drugs to developing countries — an estimated 60% of drugs to treat HIV/AIDS come from India. The new ordinance will make this impossible, thereby threatening the lives of hundreds of thousands — not only in India but also across the globe.

Rescuing public healthcare

If public healthcare is to be rescued and is to chart a course based on the actual health needs of the people, it is crucial that policymaking on health is de-linked from neo-liberal economic policies. Specifically, we would require greatly enhanced spending on healthcare and acceptance that the government has a duty to provide comprehensive healthcare services. We need to go back to the notion that public health is a public good, its benefits shared by everybody. We as a nation need to understand that investment in health is money well spent -– this has been the experience of all developed countries.

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Less than 1% of our health budget is spent on mental health

Mental health disorders account for nearly a sixth of all health-related disorders. Yet we have just 0.4 psychiatrists and 0.02 psychologists per 100,000 people, and 0.25 mental health beds per 10,000 population. If access to mental healthcare is to be improved, mental healthcare must be provided at the community and primary level

SOUMITRA PATHARE

MENTAL DISORDERS are grossly underestimated by the community and health system in India and across the world. It is estimated that in 2000, mental disorders accounted for 12.3% of disability adjusted life years (DALY) and 31% of years lived with disability. Projections suggest that the health burden due to mental disorders will increase to 15% of DALY by 2020 (Murray and Lopez 1996). Thus mental disorders account for nearly a sixth of all health-related disability.

Despite this, most countries devote 1% or less of their health budgets to mental health services. India spends just 0.83% of its total health budget on mental health (WHO 2001a).

India has a high rate of suicides — 89,000 persons committed suicide in 1995, increasing to 96,000 in 1997 and 104,000 in 1998, which is a 25% increase over the previous year (WHO 2001b). Hidden in the data on mental health morbidity are two points of particular importance for India:

- The burden of mental disorders is highest among young adults aged 15-44 years, which is the most economically productive section of the community.
- It is projected that developing countries such as India will see the most substantial increases in the burden of mental disorders in the next two decades.

Many people are still unaware that there are effective treatments for many mental disorders. For example, nearly 50-60% of persons with depression will recover with treatment in three to eight months; with schizophrenia, a combination of regular medication, family education and support can cut the relapse rate from 50% to 10%. There is also sufficient evidence to show that adequate prevention and treatment of mental disorders can reduce suicide rates, whether such interventions are directed at individuals, families, schools or other sections of the general community (WHO 2001c).

In spite of the high burden of mental disorders and the fact that a significant portion of this burden can be reduced by primary and secondary prevention, most people in India do not have access to mental healthcare due to inadequate facilities and lack of human resources. India has 0.25 mental health beds per 10,000 population. Of these, the vast majority (0.20) are in mental hospitals and occupied by long-stay patients and therefore not really accessible to the general population. There is also a paucity of mental health professionals. India has 0.4 psychiatrists, 0.04 psychiatric nurses, 0.02 psychologists and 0.02 social workers per 100,000 population. To illustrate the level of under-provision, Indonesia, a low-income-group country from the Asian region, has 0.4 beds per 10,000 population and 0.21 psychiatrists, 0.9 psychiatric nurses, 0.3 psychologists and 1.5 social workers per 100,000 population (WHO 2001a).

India has a community mental health programme that consists of integrating basic mental healthcare into general healthcare services by training primary healthcare personnel in mental healthcare, providing adequate neuropsychiatric drugs in primary care settings, supervising primary healthcare staff and establishing a psychiatric unit at the district level. The programme is being implemented in 22 districts in the country and covers around 40 million people, which is approximately 5% of the population. This programme will be extended to 100 districts over the next five years but will still only cover 150 million people, or approximately 15% of the country's population.

Thus, the key priority for mental health in India is addressing the accessibility issue. Policy interventions are needed to increase the level of access of the entire population to appropriate and quality mental health services.

How can access be improved?

First it must be acknowledged that improving access requires additional financial resources. There is an absolute as well as relative (to other health sectors) under-provision of financial resources for mental health that needs to be urgently corrected. Within the health budget it is imperative that allocation to mental health be increased, taking into account the burden of mental health problems.

It is difficult to know the exact break-up of spending, as India does not have a separate mental health budget. However, details of mental health spending are available for one Indian state, Gujarat. In Gujarat, the total allocation towards mental health works out to Rs 82 million out of a total health budget of Rs 8,562 million. Of this Rs 82 million, Rs 37 million is spent on mental hospitals, Rs 34 million on medical colleges (presumably departments of psychiatry in medical colleges) and Rs 5 million on district hospitals (Mission Report, 2003). It appears that Rs 2.15 million under 'central sponsored schemes' is the only outlay on a community programme. About 67% of total expenditure is on salaries; 20% on medicines and supplies.

Many countries spend much more on mental healthcare as a percentage of total health spending. For example, Malaysia spends 1.5% of its total health budget, China 2.35%, South Africa 2.7%, Australia 6.5% and New Zealand 11% (WHO 2001a).

Integrating mental health with primary care

Integrating mental health services into primary care is the only viable strategy for quickly increasing access to mental healthcare. Services provided through primary care also have higher acceptability within the community. There is less stigma associated with seeking help from primary healthcare centres because these centres provide both physical and mental healthcare. Community-based primary care services are also less likely to result in human rights violations for persons with mental disorders. Most such violations have occurred in institutions.

For integration to succeed it is important that primary care staff have the appropriate training and skills in providing mental healthcare. Primary care staff are already overburdened with multiple healthcare programmes. If they are to take on additional mental health work, the number of primary healthcare staff will have to be increased. Adequate support and supervision of primary care staff by mental health professionals is essential.

Availability of psychotropic drugs at the primary level

Psychotropic drugs provide an essential first line of treatment for mental disorders as they can reduce symptoms, shorten the course of mental disorders and prevent relapses. Psychotropic drugs should be included in the essential drugs lists so as to improve their availability at the primary care level. Legislative and policy changes may be necessary because only psychiatrists are authorised to prescribe many psychotropic drugs. If primary care integration has to work, primary care health professionals should be allowed to prescribe and access psychotropic drugs.

The indicative costs of drug treatment for mental illness is quite low compared to many other chronic medical conditions. For example, the indicative drug cost of treatment for schizophrenia is Rs 1,380 for three years; for bipolar disorder it is Rs 6,000 for three years and for depression it is Rs 1,300 for one year. These costs are based on retail pricing of drugs — bulk purchases by organisations are likely to cost at least 30% less. There are also many low-cost providers of psychotropic medications who can provide these medicines still cheaper.

Increasing the number of mental health professionals

Increasing the number of mental health professionals is another area that needs urgent attention. Along with an absolute increase in the number of mental health professionals, the ratios of various mental health professionals should be balanced. India has a top-heavy and skewed distribution of mental health professionals, with nearly 10 times as many psychiatrists as psychiatric nurses, and nearly 20 times as many psychiatrists as psychologists and social workers. In most countries the ratios are the reverse, with 10-15 times as many psychologists, psychiatric nurses and social workers as psychiatrists. Unfortunately, there is no professional body that has overall training responsibility for mental health professionals. Professional psychiatric training is controlled by agencies dealing with medical education and training such as the Medical Council of India, National Academy of Medical Sciences and the like, while nursing education and training is the responsibility of the Nursing Council, and psychology and social work training the responsibility of university departments of psychology and social work. Many psychologists and social workers do not get any hands-on clinical training, as their courses are almost entirely classroom-based. There is a need for closer collaboration and co-operation between the various agencies involved in training different mental health professionals. For example, psychologists and social workers need clinical training in working with patients with mental illness — this can only be done in medical departments of psychiatry, which historically have only been involved in training medical professionals. It is important that university departments of clinical psychology and departments of psychiatry work together to train all mental health professionals.

Inter-sectoral collaboration

Inter-sectoral collaboration provides another opportunity for improving access to mental healthcare. Inter-sectoral collaboration includes collaboration within the health sector and outside the health sector, as well as collaboration between the private sector, NGO sector and public sector. For example, there are many general practitioners in the private sector who can provide community-based care, with adequate training and supervision. Psychiatry departments in public sector medical schools could collaborate with these general practitioners to provide training and supervision and thus exponentially increase access to mental healthcare.

Within the health sector, collaboration with other health programmes such as those addressing HIV/AIDS and maternal and child health provides the opportunity to improve access, especially to vulnerable sections of society. Many NGOs have community-based programmes, and effective collaboration between the mental health sector and the NGO sector could help improve access to mental healthcare. For example women's mental health issues, including depression, could become part of a wider programme addressing domestic violence. Masum, an NGO working with rural women in Maharashtra, has decided to integrate mental health issues in all its programmes. Its staff (120 of them) will be trained to detect clinical depression in the community. All staff will be trained to assess the risk of suicide. A smaller proportion of the staff (approximately 20) will be trained in specific psychotherapeutic methods and a basic understanding of psychotropic drugs. This is backed by a general physician prescribing medicines if necessary. They also have access to a psychiatrist who is mainly involved in training and supervision and will see only the most seriously ill persons. This way, most of the clinical work is done by community-based staff within the community and the medical professionals are only utilised for serious problems where medication or admission to hospital may be necessary.

Community participation and awareness

It is essential to involve communities, families and users in developing and delivering mental health services. This leads to the development of services that address people's perceived needs and are therefore better utilised by them. Community participation also has the added advantage of tackling the stigma and discrimination associated with mental disorders.

Increasing public awareness about the burden of mental disorders and the availability of quality treatment is essential to reduce barriers to treatment due to inadequate knowledge about mental health services. The media can play a role in highlighting the availability of effective and safe treatments for mental illness. It can stop using negative language when referring to people with mental illness (for example the use of words such as "crazy," "mad," "lunatic") and also spread information on the symptoms of common mental disorders. Public health departments also have a responsibility to disseminate information on the identification of common mental disorders and the availability of help at the primary care level. Many people who are aware of their own mental illness will not seek help because they fear they will have to approach a mental hospital and also fear the stigma of having a mental illness. It is important to assure them confidentiality and availability of mental healthcare at the primary level.

Mental health policies

Finally, it is important that we develop mental health policies, programmes and legislation to increase access to mental healthcare and promote respect for the human rights of persons with mental disorders. India's mental health law is very inadequate and in many instances acts as a barrier to accessing mental health services. We need a modern mental health law that gives priority to protecting the rights of persons with mental disorders, promotes development of community-based care and improves access to mental healthcare. The legislation in India does not promote community-based mental healthcare and widespread access to mental health services. There is no specific law requiring the creation of community-based services in the Mental Health Act, or incorporating mental healthcare into primary healthcare. There is no explicit legislation requiring the informed consent — oral or written — of a patient for medical treatment upon admission under voluntary or involuntary circumstances. There are no safeguards or review mechanisms for involuntary treatment of patients, regardless of how they were admitted into a psychiatric facility. And, lastly, Indian penal laws still regard attempted suicide as a criminal act. Thus patients who have attempted suicide are liable for prosecution. Thus we have a peculiar situation here — the state will not provide medical help for what is clearly an act arising out of mental illness, but is eager to prosecute vulnerable people who need help.

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If Sri Lanka can, why can't we?

In Sri Lanka, the public sector caters to 60% of the country's health needs

SHABNAM MINWALLA

TO WHAT EXTENT is the government of a country responsible for providing healthcare? What should be the role of the private sector? Is a healthy population achieved merely by spending huge sums of money on the healthcare system? How, for example, does Costa Rica, which spends just $ 562 on the health of each of its citizens, obtain results that rival the US, which spends almost $ 5,000 per citizen? What hope is there for India, where the per capita expenditure is a measly $ 80?

International experiences with healthcare throw up more questions than answers.

The healthcare systems of most countries today seem to be in flux. As part of its cost-cutting drive, the British government has been pruning the National Health Service and encouraging privatisation. Canada's much-touted Medicare programme too is inching towards privatisation — pushed along by spiralling costs and the realisation that consumers tend to abuse services that are completely free. At the other end of the spectrum is the American system that is virtually run by mammoth, profit-oriented companies and throws up great material for a horror film.

Here are a few healthcare models — across the financial, political and geographical spectrum — which give a sense of the international experience with healthcare. Compare them with the statistics for India, below:

India

Per capita health expenditure: $ 80 in 2004

Public healthcare as percentage of GDP: 0.9

Private healthcare as percentage of GDP: 4.2

Health indicators: Life expectancy: 63.7 years; under-five mortality: 93 per 1,000

Sri Lanka

Per capita health expenditure: $ 122

Public healthcare as percentage of GDP: 1.8

Private healthcare as percentage of GDP: 1.9

Health indicators: Life expectancy: 72.5 years; under-five mortality: 19 per 1,000

In Sri Lanka, the public sector caters to 60% of the country's health needs, and meets 95% of the demand for in-patient care. Interestingly, the public healthcare system offers both ayurvedic and allopathic treatment and drugs. Though a countrywide

network of health facilities has been developed to provide free healthcare, relatively underserved geographical areas and population groups still exist. In the past, the government allocated considerable resources to medical infrastructure such as hospitals, but the prolonged ethnic conflict has shifted public spending from social projects to defence and greatly undermined the country's health sector.

Realising that an inflow of funds was necessary, the Sri Lankan government tapped the World Bank for assistance and is now involved in a number of joint projects to tackle problems like malaria and malnutrition. The government has also encouraged the private sector to play an increasingly important role in the provision of healthcare, by offering various incentives. Government doctors were allowed to engage in private practice in the late-1970s, which led to a rapid expansion of the private sector. Financial incentives were offered to investors to establish modern hospitals.

United States

Per capita health expenditure: $ 4,887

Public healthcare as percentage of GDP: 6.2

Private healthcare as percentage of GDP: 7.7

Health indicators: Life expectancy: 77 years; under-five mortality: 8 per 1,000

The United States spends much more per capita than any other country in the world. But perhaps because health is treated like any other commodity — soap or shoes — this investment yields handsome profits for a few corporations but indifferent healthcare for helpless consumers.

Indeed, there are many reasons why callous and profit-motivated health maintenance organisations (HMOs) are as detested as tobacco firms in the US today. Millions of Americans are denied treatment even as 300,000 beds remain empty in hospitals across the country. As insurance premiums spiral, more than 43 million people have been forced to remain uninsured and are unable to access care when they need it. Even those who have insurance coverage find that after years of paying the premium, when they finally need to avail of services only a fraction of the cost may be covered. A study found that of the 1 million Americans who filed for bankruptcy in 1999, nearly half were pushed over the edge by their medical bills.

The mighty HMOs function according to formula — rewarding doctors who incur minimum treatment costs and penalising those who prescribe multiple tests and expensive treatment. Huge administrative departments work overtime to find excuses for why patients' costs should not be covered. And, in the constant rush for profit, patients' needs are routinely neglected — often with tragic consequences.

Canada

Per capita health expenditure: $ 2,792 in 2004

Public healthcare as percentage of GDP: 6.8

Private healthcare as percentage of GDP: 2.8

Health indicators: Life expectancy: 79.3 years; under-five mortality: 7 per 1,000

Canada's problems are dramatically different from those of its next-door neighbour. For over 30 years Canada has taken pride in its universal programme, which is founded on the belief that every citizen should have equal access to quality healthcare. But, skyrocketing costs and plummeting satisfaction levels forecast a dire future for Canadian Medicare.

Part of the problem is that in a free-care system there is no personal accountability. So people access services even when they don't really need them, leading to excessive queuing. It can take 25 weeks to get an appointment with an ophthalmologist, almost 21 weeks to receive orthopaedic care, over 16 weeks to see a neurosurgeon, and nearly 12 weeks for a gynaecological examination. Doctors and nurses are overloaded and there is a very high turnover. Moreover, there is the widespread feeling that low-income groups and minorities are less able to access quality services. This is compounded by the fact that the poorer sections are unable to afford supplemental private insurance.

The situation is becoming critical because costs are climbing rapidly for the Medicare system — and in individual provinces, where most of the administration is done, 30% of annual provincial budgets are allocated to healthcare. At the moment, the perturbed Canadian government is examining a range of solutions — a degree of privatisation, extracting payment for services, and a fundamental restructuring of the system — to help Medicare hold its own against the growing private sector.

United Kingdom

Per capita health expenditure: $ 1,989

Public healthcare as percentage of GDP: 6.2

Private healthcare as percentage of GDP: 1.4

Health indicators: Life expectancy: 78.1; under-five mortality: 7 per 1,000

The United Kingdom's National Health Service (NHS) was born in 1948 and was the first free healthcare system available on the basis of citizenship rather than payment of fees or insurance premiums. For decades it was a model to be emulated, but the last 25 years have seen a series of measures that have curbed its scope and efficiency. Public expenditure on health in the UK has been slashed, and the system is undeniably cash-starved. New management techniques have ensured that financial figures and management professionals influence decision-making, rather than the needs of patients and health professionals. A large number of services — including laboratory, catering and diagnostics — are now being outsourced. Certain areas of medicine, like dentistry and ophthalmology, are now outside the ambit of the NHS.

Today the NHS is chronically impoverished and short-staffed. The queues for services are enormous, and more and more consumers feel compelled to turn to the private sector in an emergency.

Spain

Per capita health expenditure: $ 1,607

Public healthcare as percentage of GDP: 5.4

Private healthcare as percentage of GDP: 2.2

Health indicators: Life expectancy: 79.2 years; under-five mortality: 6 per 1,000

Spain is another example of how politics determines whether an unemployed or low-income individual will be able to afford a bypass operation or cancer treatment. The popular and efficient Spanish National Health Service (NHS) was set up in 1986 by the socialist government, and offered universal coverage, free primary healthcare and active prevention and promotion programmes. Studies reveal that 80% of the Spanish population would rather be admitted to a public hospital if ill.

When the conservative Partido Popular gained power in 1996, however, there was a gradual dismantling of the healthcare system. This has resulted in the curtailing of services offered by the NHS, privatisation of services like laboratories, high-tech diagnostics and even patient care in certain hospitals, and an increased role for private insurance companies. There is, however, strong and active opposition to this gradual conversion of a basic right into merchandise, which is bound to result in unequal care and even a drop in overall standards.

Costa Rica

Per capita health expenditure: $ 562

Public healthcare as percentage of GDP: 4.9

Private healthcare as percentage of GDP: 2.3

Health indicators: Life expectancy: 78 years; under-five mortality: 11 per 1,000

Thanks to its commitment to health and social reform, Costa Rica has the best health outcomes of any country in Latin America. The publicly-funded, comprehensive healthcare system is considered one of the world's most successful universal systems — and has brought this middle-wealth country's health indicators in line with those of OECD countries. 'Universality' in the Costa Rican system means that 100% of the population is given comprehensive public health insurance and has equal access to services. Workers contribute 15% of their salary to this health insurance, but even those who are unemployed can access services in a variety of ways. One reason for the success of this system is the large contingent of mid-level workers who, while much cheaper than doctors, effectively extend health programmes to rural areas.

Thirty per cent of the population used the private sector in 2001, partly because of long waiting lists which could extend up to three months. Mixed medicine, in which a patient will pay for a private consultation with the physician of his choice, and insurance will pay for the diagnostic services and drugs, is becoming increasingly popular. On the whole, however, studies reveal that 70% of the population is very satisfied with the public health system in this country.

Malaysia

Per capita health expenditure: $ 345

Public healthcare as percentage of GDP: 2.1

Private healthcare as percentage of GDP: 1.8

Health indicators: Life expectancy: 73 years; under-five mortality: 8 per 1,000

The Malaysian healthcare system has won international recognition from the World Health Organisation and other health agencies. Government health services in particular, financed by taxes and other public revenues, have achieved impressive coverage. People in rural areas have recourse to an extensive network of government health centres and *klinik desa* with referral backup, while urban residents have access to government as well as private hospitals and clinics. More than 90% of the population lives within five kilometres of a primary healthcare facility — leading to health indices almost on a par with those of richer industrialised nations.

Today, however, the cash-strapped public system is facing trouble — an exodus of senior, experienced staff to the remunerative private sector, chronic understaffing and low morale. Although the government is spending a modest 2.1% of GDP on healthcare, it claims it cannot afford the burden any longer. It is therefore in favour of "corporatising and privatising" the public health system and adopting a variation of the American managed-care model. Although it has promised that the privatisation of public hospitals in Malaysia will be undertaken alongside a public health insurance scheme, the private insurance lobby seems to be working overtime to block this.

Cuba

Per capita health expenditure: $ 229

Public healthcare as percentage of GDP: 6.2

Private healthcare as percentage of GDP: 1.0

Health indicators: Life expectancy: 76.7 years; under-five mortality rate: 9 per 1,000

The Cuban National System of Health was established in the 1960s, based on the belief that access to health services is a basic human right. By 1989, all Cubans had access to free health services and Cuba witnessed a dramatic improvement in life expectancy and a fall in infant mortality.

The '90s were, however, difficult years for Cuba. The Soviet Union and Eastern Bloc were big markets for Cuban products, and with their demise the Cuban economy encountered severe problems. These were compounded by prolonged economic sanctions against Cuba. Nevertheless, the Cuban government decided to continue supporting the health system and to retain its universal, free-of-charge character.

Today, however, the health system is in urgent need of resources, medical equipment and drugs. Health experts foresee the need for a complete overhaul.

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Women suffer more, get treated less

Morbidity amongst women is higher than amongst men. But women are less likely to access healthcare for several reasons: they cannot afford treatment, they can't get time off work, they have little status within the family, and they're intimidated by a public healthcare system that does not cater to the needs of the illiterate

NEHA MADHIWALLA

LACK OF RESOURCES fundamentally changes the way illness is viewed. While for the average middle class person sickness is a period where one can legitimately expect care, concern and opportunity for rest, for the poor, illness constitutes a crisis, especially if it affects those who provide for the family.

Within the Indian family structure, which is based on filial obligations, able-bodied adults are the last to receive healthcare because they are obliged to keep working and earning as long as they can. Women, whose work is seen as less important and less strenuous, receive even less attention. Medical treatment means taking time off work, admitting to yourself and the family that you cannot work, getting others to look after you. It means that instead of providing, you have to be provided for. All of these are conditions that adults in poor families cannot accept.

Specifically for women, whose status and authority derive from their contribution to the family, accepting the above would be extremely difficult; it would make them vulnerable within the family.

Poverty also implicitly means that levels of education are low, lower still among women. In the rural setting, where public life is premised on the assumption that people cannot read and write, health functionaries are expected to reach out to and 'compensate' for people's illiteracy. But in the city, where literacy is taken for granted, people are expected to function in a literate, 'educated' way. This puts migrant women, who have never had any education, at a big disadvantage. Not being able to read, travel alone, communicate effectively with doctors, nurses, etc, limits women's mobility and increases their dependence on others to access primary healthcare services.

Poor urban women are often invisibly employed. They work as home-based workers or part-time casual workers, with no documented employment. Such work is very un-remunerative and affords no sense of a collective, because they never come

Sudharak Olwe

into contact with each other.

This is the background against which we must understand what happens when women seek healthcare. When such women seek services in the public sector they face problems at every level. Firstly, these relate to poverty. Not being able to afford healthcare is still one of the primary reasons for not seeking treatment. The costs of healthcare may be direct — in the form of doctors' fees, hospital charges, medicines, tests and so on. Then there are the indirect costs, such as the cost of transportation. Moreover, most government centres are crowded, extremely bureaucratic and rigid. So one has to spend the whole day, even several days, to get simple tests done or get medicines. For the poor, who have no paid leave, this is a big indirect cost. For women, who either have no leave (from housework and childcare) or get paid only when they work (as in home-based work), it becomes very difficult to take so much time off. Inevitably, they go to the public hospital only when they become so sick that they cannot work in any case.

These pressures inevitably push the poor to the private sector, where the costs may be a little higher but the timings, terms of payment and location of services are more convenient. The private sector is also very varied and has all kinds of practitioners — ranging from completely unqualified quacks to specialists. The lower-end practitioners are the ones who cater to the large proportion of the poor's health needs, for obvious reasons. For women, who must make do with as little as possible, these quacks seem the ideal solution. Therefore it is not uncommon for people to drift from one quack to another, then to general practitioners before finally ending up at the government hospital as the problem worsens. This is one of the reasons why health problems become chronic and needlessly long-term. The more time is wasted on incomplete cures or neglect, the more difficult the problem becomes to treat.

A classic example of this would be uterine prolapse. This problem affects a large number of women, mainly after delivery. As time passes, the prolapse becomes worse. Women find it distressing because it causes incontinence, problems during future deliveries as well as frequent infections. Invariably, women ignore the problem initially out of embarrassment. A large majority of practitioners in slums are men who will not do vaginal examinations. Even if they are women, there is no privacy in which to do an internal examination. So women are given tonics and antibiotics (if they complain of vaginal discharge). After several years, they may land up at a government hospital, when the problem has become quite severe. At this point they may be told that there is no alternative to surgery (to remove the uterus), and they return because they are unable to afford the cost of surgery or because they are daunted by the idea of possible danger and disruption to their daily lives.

Thus, clearly, the problem of access to healthcare for poor urban women is rooted in poverty, but not explained entirely by poverty. While making free healthcare available to all would solve many women's problems, there will be other hurdles to cross. Changing power relations in the family, making social support available (childcare, housekeeping, nursing), creating opportunities for women to come together, interact, learn from each other and form a sense of community, gainful and satisfying work that allows women to develop confidence and self-reliance, and, finally, a healthcare system which treats them seriously, with respect and sympathy are all important elements in improving women's access to healthcare.

45% of illness episodes among women go untreated

Two studies suggest that women have less access to healthcare than men do, though they may need it more

Sunil Nandraj, Neha Madhiwalla, Roopashri Sinha and Amar Jesani interviewed 3,581 women in 1,193 urban and rural households in Maharashtra. Nashik district was selected for its 'average' development index and substantial tribal population (CEHAT 1999).

• Women reported a higher morbidity than men did (506 per 1,000 women vs 307/1,000 men reported illness within the given reference period). Their illnesses tended to be chronic and linked to their work, childbearing and contraception. • Yet, women's utilisation of healthcare was relatively low — they did not seek formal or informal treatment for 45% of the illness episodes they reported. In 40% of these episodes, the reason for not seeking treatment was that it cost too much. • Women were more likely to use home remedies and informal services. • Certain types of illnesses, such as aches/pains, injury and weakness, were mostly treated in the informal sector. Long-term illnesses were not treated as frequently as short-term infectious illnesses. • Women did use public health services, but this was mostly restricted to contraception. • More than 12% of women's illness episodes were not treated at all, because health facilities were not accessible or adequate. • In general, women from deprived groups — women from remote villages, scheduled castes and urban minority communities — did not receive healthcare for a large proportion of their illnesses.

The same researchers did a similar study in Mumbai (CEHAT, Mumbai, 1998). Women in 430 households in slums, chawls and an apartment block in the city were interviewed in detail. Some findings:

• Again, women reported much higher morbidity than men did, with health problems linked to their household work. But men were more likely to receive treatment. • The average private per capita expenditure on healthcare was Rs 415.68 per year. In contrast, the state government spent Rs 250 per person in Mumbai; the national per capita public expenditure was Rs 90. • In both slum and non-slum areas, households spent less on women's health — Rs 148.56 per illness episode for men and boys, and Rs 78.59 per illness episode for women and girls. • More than 32% of illness episodes were not treated. Almost two in five reproductive illnesses were not treated, apparently because women did not have access to female doctors or other health services. • Fifty-seven per cent of pregnant women who used some type of health facility went to the private sector; only 32% utilised public facilities. • Twenty per cent of deliveries were conducted at home. Forty-three pregnant women did not utilise any healthcare facilities.

Work two years and maybe you can afford to get treated for TB

There is a gross under-supply of drugs at public health facilities, forcing patients to buy overpriced drugs from the profit-driven private sector. For many poor Indians, getting sick and buying medicines is a sure route to further impoverishment. A labourer earning Rs 60 a day will have to work more than two years to afford treatment for multi-drug-resistant tuberculosis

S SRINIVASAN

THE SITUATION WITH THE INDIAN DRUGS INDUSTRY is a bit like the situation of our overflowing food stocks in godowns and starving masses. At a time when the world is singing hosannas to the might of the Indian drugs industry, drugs are overpriced and unaffordable for patients. For many Indians, getting sick and buying medicines is a sure route to impoverishment or further impoverishment.

Poor drug availability in the public sector

The Indian drugs industry has grown rapidly, especially after the Indian Patents Act 1970, with annual domestic sales estimated at between Rs 250-300 billion. But a very small proportion of all drugs in India is consumed in the public sector, which caters primarily to the poor and middle class.

A decade ago, a study in Satara district, Maharashtra, by Phadke et al showed that all drug needs for primary-level care could be met at Rs 100 per capita (in 1991) if rationally and equitably used. But for this, drug supply to PHCs would have to be doubled. Instead, the Maharashtra government's health expenditure declined from 1% of the State Domestic Product in 1985-86 to 0.6% in 2002-03.

Deepak Turbhekar

The Satara study found that drug supply to the public sector in Satara district was a mere Rs 5.6 million compared to drug sales of Rs 213 million in the private sector. Things have worsened since the 1990s, as expenses on public health as a proportion of government expenses have declined.

The Municipal Corporation of Greater Mumbai (MCGM) is probably the richest corporation in India. A recent drug monitoring exercise at one of its secondary hospitals found 34 of 60 drugs prescribed for patients at the gynaecology outpatient clinic were not available.[1] These included antibiotics, vaginal pessaries, antispasmodics, anti-inflammatory drugs, hormone-based drugs, neuro-regulators and drugs used to treat infertility. The most common reason given was that it was "not on the MCGM schedule". A comparison of drugs listed in the Essential Drugs List (EDL) and the MCGM drugs schedule found that 140 of the 264 drugs listed in the EDL were not on the MCGM schedule.

Accessibility in the private sector

Given such a gross under-supply of drugs at public health facilities, most of the drugs available in India are through the market. This privatised drug accessibility is quite problematic in view of high levels of poverty and unrestricted profiteering by the drugs industry, combined with a lot of wastage of patients' money on account of irrational fixed-dose combinations and wastage on 'promotional' expenses (huge expenses on promotional activities are necessary for the private sector but merely add to the patient's cost).

Irrational drug combinations

Less than 400 of the 1,500 drugs mentioned in standard medical textbooks are essential drugs (as defined by the WHO). Of these 400, only about 40 are considered rational fixed-dose combinations (such as iron-folic acid, oral rehydration salts and co-trimoxazole [brand Septran]). More than 60% of our top-selling 300 drugs, as per ORG figures, are irrational or unnecessary and do not find a place in the National Essential Medicines List, NEML 2003.

Brands and pricing

Paracetamol for reducing pain and fever can cost as little as 13 paise per tablet to produce.[2] When sold under a brand name it can cost four to fives times more. The price of the brand has apparently no relation with the cost of production. For example,

amlodipine is a drug for high blood pressure. The most expensive brand costs almost nine times as much as the cheapest brand of the same drug. Similar examples abound in other drugs. A 1998 study in the *Indian Journal of Pharmacology* on the prices of 84 drugs for cardiovascular diseases in the Indian market found that price differences ranged from 2.8% to 3,406%.

Worse, the same company may price the same drug under different brand names at different prices, sometimes 'positioned' for different market segments. For example, cefuroxime tablets are manufactured by GSK under the brand names Ceftum and Supacef, at Rs 80.91 and 63.01 respectively for 125 mg tablets. Since consumers are not aware that these different brands contain the same medicines — anyway it is the doctor who prescribes — they do not know that they have been cheated. In 1975, the Hathi Committee recommended the abolition of brand names, but this was not implemented. Thanks to the higher prices of branded drugs, many poor people are effectively denied access to even life-saving drugs. Poor access to health services adds to the misery.

De-control of drug prices

Consumer resistance is among the lowest in healthcare, as it is not the patient who decides which medicines to buy. Besides, patients are ready to pay excessively to get relief. Indeed, there is no other situation akin to the purchase of drugs by a patient where:[3]

- The consumer may have no knowledge about the goods he/she is purchasing.
- The goods can be purchased only on the written recommendation of a third party (who may charge heavily for doing so).
- The goods are purchased in a situation of such distress.
- The result of non-purchase of the goods may be death or disability.
- Expensive gifts and heavy discounts are offered to those recommending and stocking a particular drug, and none offered to those who purchase them.
- A particular company making a particular product can have exclusive rights over marketing and manufacture for a period of 20 years.

Drug prices need to be controlled to protect the interests of vulnerable groups, which would be the majority in India. Instead, the number of drugs under price control has gone down from 347 in 1979 to 74 in 2004. And the criteria for drugs to be under price control produces enormous anomalies (see 'Theatre of the absurd'), as the criteria are based on market share and so-called prevalence of competition rather than the essentiality of the drug for the diseases obtaining in India.

Twelve out of 16 West European countries control the prices of drugs directly. Even the report of the Government of India's

Table 1: Antibiotic brand leaders, market share and price behaviour: A brief overview

Drug product	Market turnover of product in Rs (crores)	Brand name of product leader (s)	Market share of product leader (in %)	Product leader is price leader?	Remarks
Cefataxime injection	122.02	Taxim	63%	Yes	
Ceftrioxone injection	136.01	Monocef	35%	No	Price leader is Becef
Cefuroxime tablets	12.82	Ceftum	38%	Yes	
Cephalexin capsules	171.26	Phexin Sporidex	69%	No No	Price leader Ceff is 10% costlier
Amoxycillin capsules	212.45	Mox Novamox	47%	Yes Yes	
Amikacin sulphate injection	69.12	Mikacin Amicin	68%	No No	
Chloramphenicol capsules	41.31	Chlormycetin Enteromycetin Paraxin Kemicetine	86%	Yes Yes Yes Yes	Chloromycetin is the *costliest*
Ampicillin + Cloxacillin capsules	109.05	Megapen Ampoxin	78%	No No	
Ciprofloxacin capsules	272.35	Cifran Ciplox Ciprobid Alcipro	56%	Yes Yes Yes Yes	Four brands dominate the market; the product is costly; but still would not be in price control as per PP 2002. Currently in price control
Doxycycline capsules	63.35	Microdox Doxy - 1	46%	Yes Yes	
Roxithromycin capsules	97.60	Roxid	49%	Yes	
Erythromycin tablets	95.41	Althrocin Erythrocin	84%	Yes No	
Azithromycin	62.71	Azithral	30%	Yes	
Norfloxacin tablets	53.09	Norflox	61%	Yes	
Gentamycin	38.08	Genticyn	33%	Yes	

All data as per ORG-AC Nielsen Retail Audit, Oct 2003

Table 2 : A comparison of tender rates and retail market rates

Drug name	Name of firm	Tender rate (Rs)	Unit	Manufacturer	Retail market price (Rs)	Over-price index Col (6)/(3)	Tender rate as % of retail market price (Rs)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Albendazole tab IP 400 mg	Cadila Pharmaceuticals P Ltd	22.60	10 x 10 tablets	Torrent	1,190	52.65	1.89
Bisacodyl tab IP 5 mg	Lark Laboratories (I) Ltd	16.50	10 x 10 tablets	German Remedies	717	43.45	2.30
Alprazolam tab IP 0.5 mg	Bal Pharma Ltd	3.50	10 x 10 tablets	Sun Pharma	141.5	40.43	2.47
Diazepam tab IP 5 mg	Pharmafabricon/ LOCOST	3.05	10 x 10 tablets	Ranbaxy	92.5	30.33	6.26
Folic acid and ferrous tab NFI	Aurochem India P Ltd	5.89	10 x 10 tablets	Smith Kline	148.5	25.21	3.97
Amylodipine tab 2.5 mg	Lark Laboratories (I) Ltd	9.10	10 x 10 tablets	Lyka	148.5	16.32	6.13

Drug Price Control Review Committee 1999 noted that:
…in most other countries, the regulation of drug prices is considered necessary to contain public expenditure due to government's role in funding social health and insurance schemes that cover hospital and outpatient drugs. The price regulations are used as an instrument to keep their health budgets within reasonable limits. In these countries, a substantial proportion of the population is covered through health insurance and public health schemes…As opposed to this, a substantial proportion of the population in India are market-dependent and have to meet all their expenses out of their own pocket on this account, making price regulation of pharmaceutical products in the market unavoidable.

Nevertheless, the government planned to "lessen the rigours of price control" in its Pharmaceutical Policy 2002. That would have reduced the number of drugs under price control to less than 30.

Competition does not always lead to lower prices

The premise for removing price controls is that competition will lower prices. The invisible hand of the market is expected to take care of any imbalance. Government criteria for control/de-control talk of free market conditions below a certain market share and above a certain number of producers. But these criteria always end up decontrolling vital drugs and retaining some relatively unimportant ones in the price control basket (see 'Theatre of the absurd').

In reality there is no free market in the pharmaceutical industry and in the health and hospital services sectors. The end user, namely the patient, has no choice. The doctor/prescriber makes the choice and the consumer has no easy way of evaluating the doctor's advice.

Competition in the drugs industry is weak and imperfect. This is illustrated in Table 1. Some antibiotics and antibacterials showed[4] that the brand leader is often the price leader. That is, the top-selling brand is often also higher priced; most often it is the highest priced. With true competition and a free market, the brand leader should also be the cheapest. This suggests that competition does not always bring down prices in the pharmaceutical retail market, even when there are many players. Once a company is sure that the sensibilities of the consumer can be played with, the same drugs are priced to attract the high-end consumer. Competition might work with an efficient regulatory agency with teeth that responds to market signals with alacrity.

Overpricing

The prices of drugs quoted in stiffly contested tenders can serve as benchmarks for the lowest possible prices — as no manufacturer will supply drugs at a loss and these prices would be very near actual production costs. Therefore, a comparison of tender rates with retail market prices would give a clear understanding of the extent of overpricing, or value added, or post-manufacturing margins. A comparison of the tender prices quoted for the well-regulated, quality-conscious and transparent Tamil Nadu Medical Services Corporation (TNMSC) shows estimated overpricing, or post-manufacturing mark-up, to the extent of 5,000%[5] (see Table 2: A comparison of tender rates and retail market rates). Or, the government tender price is 2-3% of the retail market price! Surely this absurd situation does not occur in any other industry in the world.

Huge margins for traders

Another prevailing phenomenon is the huge trade margin for pharmaceutical distributors and retailers. These come from the competition between big and small companies to capture the 'branded-generic market', and prices can range from two to 15 times as much in a given sample. Irrational drugs and tonics and syrups — even rational generic drugs — often enjoy 500-1,000% trade margins. The situation in small towns and talukas and in states with relatively weak drug administrations is alarming. Drug manufacturers are at the mercy of retail pharmacists (at last count more than 250,000 all over India). So manufacturers induce both doctors and retail pharmacists to push sales.

What is the implication of this profiteering for a labourer who earns Rs 60 a day? How much will he have to work to be cured? Anurag Bhargava, in LOCOST's *Impoverishing the Poor,* has worked this out for 10 common illnesses. It comes to two

Theatre of the absurd

Drugs in price control and those out of it

In the list of drugs *out* of price control:
- Oral rehydration salts for diarrhoea
- All anti-cancer drugs
- INH, ethambutol pyrazinamide for TB
- Primaquine, quinine, artemesin for malaria
- All drugs for HIV/AIDS
- Dapsone, clofazimine for leprosy
- Diethylcarbamazine citrate for filariasis
- Atenolol, enalparil, hydrochlorthiazide, amlodipine for hypertension
- Glyceryl nitrate, isosorbide nitrate, beta blockers and calcium channel blockers for coronary artery disease
- Vaccines of every kind including cell-culture-derived rabies vaccine
- Antitetanus serum
- Antidiptheria antitoxin
- Anti-D immunoglobulin
- Phenytoin, carbamazepine, valproic acid (anticonvulsants)

The list of 74 drugs *in* price control includes:
- Hazardous drugs like analgin, phenylbutazone
- An outdated drug like sulphadimidine
- Non-essential wonders like Vitamin E, diosmine, pantothonate and panthenols and becampacillin

days for a sore throat, more than two months for anaemia, more than two years for multi-drug-resistant tuberculosis, and one month just for diabetes treatment. These are all common illnesses for poor Indians, and the government does not provide free drugs for any of these.

Substandard quality

Access to substandard drugs is no access at all. The government-appointed Mashelkar Committee (2002-03) examined various estimates and concluded: "Only 17 states have drug testing and even among these laboratories, only about seven have the capacity to test all classes of drugs. On an average, about 36,000 samples are tested annually, both in the central and state drug testing laboratories. The number is, however, inadequate as compared to the number of batches of thousands of formulations manufactured in the country…Samples of less than 1% of the batches of drugs manufactured in the country are exposed to scrutiny by the government drug testing laboratories."

The recommendations of the Mashelkar Committee, if implemented, would help curb spurious, substandard drugs. It called for totally overhauling the drug control administration and for centralised regulation similar to that of the US FDA. (Currently, health and pharmaceuticals come under the concurrent list of the Constitution, to be looked at by both the Centre and the states.) However, the committee lost the opportunity to recommend putting pricing policy and health-related drugs policy under a single authority. It also did not address the problems of profiteering and of irrational drugs. Are not irrational drugs a variety of spurious drugs?

Conclusion

The prices of medicines need to be regulated. They are regulated even in the 'free market' countries of the West. But price regulation by itself will not improve access. We need functioning health services and a system where all levels of healthcare are accessible to people in all parts of the country. The number, kind and quality of medicines sold in India also need to be regulated. After all, it is a matter of life and death for us all.

Acknowledgements

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The advent of patent raj

The third amendment to the Indian Patents Act, recently passed by Parliament, is likely to adversely affect the availability, accessibility and affordability of medicines — three important components of people's right to health

AMMU JOSEPH

THE FATE OF MILLIONS OF PEOPLE in India, as well as Africa and other parts of Asia, hangs in the balance after the Indian Parliament passed the Patent (Amendment) Bill 2005 on March 23. The new law, which ironically received the President's assent on World Health Day (April 7), introduces product patents in the country, as required under the global agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). It upholds the rights of drug patent holders at the expense of generic drug manufacturers and prevents domestic drug companies from producing versions of branded drugs by using a different process, as permissible under the process patent regime that had prevailed so far.

The controversial legislation continues to be vociferously opposed by health advocates both in India and overseas. The final bill, as passed, incorporates 15 changes proposed by local civil society organisations and the country's left parties to curb potential abuse by multinational drugs companies. However, critics claim that the law fails to take advantage of the flexibility available within TRIPS that permits governments to promote "access to medicines for all". They also point out that it is replete with technical loopholes, some of them due to the ambiguous terms used in a number of clauses.

According to public interest groups working on health issues, India is in the process of trading away its sovereign right to protect public health, as well as the rights of people here and elsewhere who need access to low-cost and good quality generic medicines. Unfortunately, they point out, governments tend to view patents as a narrow trade issue concerning the often conflicting claims and interests of local and global pharmaceutical companies rather than as the broader issue concerning public health that it actually is.

Health advocates believe that the prices of drugs required for the treatment of many common diseases could shoot up as a result of the new law. Such a development would potentially affect the large numbers of people suffering from a wide range of illnesses, including life-threatening and chronic conditions such as diabetes and hypoglycaemia, hypertension and coronary heart disease, asthma and respiratory tract infections, schizophrenia and depression, arthritis and spondylitis, urinary tract infection, HIV infection, and various forms of cancer.

This is because the relatively low-cost, locally manufactured generic drugs that have thus far been available to patients here may have to be withdrawn from the market when the patent applications pending for several medicines used in the treatment of these and other ailments are granted, as they are likely to be under the new legislation.

The repercussions will be felt in other parts of the world too, because India plays a unique role in global access to medicines as the world's chief exporter of cheap generic drugs — primarily to poor nations in Africa and Asia that have no pharmaceutical capability of their own.

The controversial third amendment to the Indian Patents Act, 1970, relates to India's obligations under the TRIPS agreement, adopted in 1994 as one of a package of agreements that member states of the World Trade Organisation (WTO) must adhere to. Under the agreement, developing countries like India were obliged to introduce patent protection for pharmaceutical and agro-chemical products by January 1, 2005.

The Indian patent law had already been amended twice — in 1999 and 2002 — to comply with TRIPS. Thanks to earlier amendments, the term of patent protection had been extended from seven to 20 years, and exclusive marketing rights (EMR) were available for drugs and agro-chemicals, allowing manufacturers a monopoly over products even before their patent applications were approved.

The primary purpose of the new law is to introduce product patents, as required by TRIPS, in the fields of food, chemicals and pharmaceuticals. Till now, Indian law had provided patent protection for processes -– rather than products — in the pharmaceutical and food sectors. A process patent gives the owner exclusive right over the manufacturing process, not the product itself. In other words, anyone can make and sell a particular product as long as they use a different process to produce it. On the other hand, a product patent prevents others from manufacturing, selling, distributing or importing the patented product — even versions produced through different processes — without the authorisation of the patent holder.

Thanks to the flexibility and competition allowed by the process patent regime, not only has the Indian pharmaceutical industry grown at a phenomenal rate, but the prices of medicines in the country have been among the lowest in the world (even though certain recent developments in drug policy have already driven the cost of several drugs up to unprecedented levels). With the introduction of a product patent regime, patent owners will be able to monopolise the market for 20 years and, in the absence of competition, get away with exorbitant prices. It is expected that both accessibility and affordability of drugs will be reduced as a result, with high prices putting many medicines out of the reach of the majority of Indians.

Health activists allege that the new law does not use the minimal flexibility available within TRIPS, especially in the context of the 2001 Doha Declaration on Public Health. Despite several ambiguities and deficiencies, the latter does state that the agreement should be interpreted and implemented in the light of WTO member countries' right to protect public health and promote access to medicines for all.

The new act will permit Indian companies that are already producing generic versions to continue producing them — but only if a "significant" investment has been made and after a "reasonable" royalty has been paid. Critics point out that such vague terminology can be interpreted to benefit patent holders at the expense of producers of generic drugs and, ultimately, the consumer. Recalling the notorious case in South Africa some years ago, when the country's courts had to intervene to prevent Glaxo Smith Kline from holding out for a royalty of 25% for a drug used in the treatment of HIV/AIDS, they suggest that the royalty rate needs to be fixed at a realistic percentage, based on the norm of 4%. Meanwhile, the lack of clarity may lead local manufacturers of cheaper medicines to stop making affordable medicines in order to avoid the risk of a lawsuit or the burden of excessive royalties.

The Affordable Medicines and Treatment Campaign (AMTC), a coalition of civil society organisations, patients' groups, healthcare providers and concerned individuals working towards the sustained accessibility and affordability of medicines and treatment in India, cites the case of a drug used in the treatment of patients suffering from chronic myeloid leukaemia (CML) as an example of what can happen when monopolies are allowed in the pharmaceutical sector.

The generic version of the drug has been available to CML patients in India at Rs 9,000-12,000 per month. Then the government granted EMR to Novartis AG for its version of the drug, Gleevec, as a transitional arrangement while its product patent application is pending. If the EMR is enforced, generic versions of the drug will have to be withdrawn from the market. As a result, the overwhelming majority of Indians suffering from CML will have to do without the life-saving medicine because the price of Gleevec is astronomical, at Rs 120,000 per month. The one ray of hope is that both the pharmaceutical industry and civil society groups in India have challenged the granting of EMR on Gleevec in the Supreme Court.

One of the arguments put forward to suggest that product patents will not push the cost of medicines up is that "drugs used for common ailments are already in the generic category, having gone off patents years ago". This is misleading because new and better drugs required for the effective treatment of many illnesses are constantly being produced and ought to be accessible to all.

At present, locally manufactured versions of even new drugs are available in India at a fraction of their cost in most other parts of the world. Take the example of atypical anti-psychotic drugs used in the treatment of schizophrenia, a common, serious and lifelong mental illness. Since there has so far been little price difference between old and new drugs in this category, and since the prices of locally produced brands are far lower than those of multinational companies, even public hospitals such as the National Institute for Mental Health and Neuro Sciences (NIMHANS) in Bangalore have been prescribing indigenous versions of the newer drugs, which have fewer side-effects and ensure better quality of life. If the patent application currently pending for one of these drugs — Olanzapine — is successful, cheaper local versions of it will no longer be available to patients here. Other drugs in this category will soon follow suit.

The financial implications of sharp increases in the cost of medicines are particularly serious in the Indian context since patients here, and their families, have to shoulder the entire burden of medical expenses, including purchase of drugs, in the absence of an effective public health system and universal, let alone public, health insurance.

Health advocates also point out that the new legislation may provide a loophole for pharmaceutical companies to keep products patented in perpetuity by allowing grant of patents for existing drugs for which a "new use" has been found — even though there is no obligation under TRIPS to issue patents for different uses and/or dosages of known medicines. Although the new act includes a clarification on the definition of "new use," some opponents believe that the language is too vague to prevent misuse.

They are concerned that this provision can be manipulated to extend patent protection to drugs beyond the 20-year period — also known as "evergreening" — for less than valid reasons. For example, a minor enhancement to an existing medicine for heart disease could lead to a new patent being granted and what is essentially the same medicine being protected for a further 20 years. Similarly, where a new purpose is found for an existing medicine, a patent could be granted for the new use, keeping the old drug protected for another two decades.

A study showing that only 35% of the 1,035 new drugs approved by the US drug regulatory authority during 1989-2000 contain a new chemical entity suggests that this is not an imaginary threat. The fact that only 274 new chemical entities received marketing approvals from the US FDA between 1995-2003 suggests that many patent applications concern products that involve frivolous or marginal changes.

Significantly, TRIPS does not require patents on such products to be protected. According to health advocates, even the official

committee that looked into the regulation of the pharmaceutical sector, headed by Dr R A Mashelkar, had recommended in 2003 that patents be given only to new chemical molecules or entities, so as to limit the number of patent protected drugs.

Another related issue flagged by health advocates concerns the provision for "pre-grant opposition," an important mechanism that enables civil society to block frivolous patents. According to health activists, with more than 8,000 patent applications for pharmaceutical products currently pending in the mailbox (a majority filed by foreign corporations and individuals), public scrutiny is essential to ensure that only necessary, useful drugs are granted patents. The draft bill infamously proposed to do away with the procedure. While the new law has restored the opportunity for any member of the public to oppose an application for patent before it is granted, the effectiveness of this process will obviously depend on citizens' access to information on mailbox applications, which is not guaranteed.

Health activists are also critical of the act's provisions relating to compulsory licences, an important mechanism within TRIPS that allows countries to get around patent monopolies under certain specified circumstances, especially at times when the supply of the medicine by the patent owner does not meet the demand for it, or when the drug is too highly priced to be accessible to those who need it. According to them, under the new law, compulsory licences are likely to be unduly delayed, with applications coming up for consideration only three-and-a-half years after a patent is granted. What this means is that life-saving medicines which the patent owner will not make available or will supply only at an unaffordable price will not be accessible to consumers in India for at least 3.5 years, which is the earliest any other manufacturer can request permission to produce and sell the medicine at a lower cost.

One of the important uses of compulsory licences is to enable the export of affordable drugs to countries with non-existent or insufficient manufacturing capacity in the pharmaceutical sector. The TRIPS general council had permitted the grant of compulsory licences for export purposes through a decision taken on August 30, 2004.

The new act has improved on the draft bill, which had placed certain restrictions on such export to developing or "least developed" countries. However, opponents argue that lack of clarity within the law could potentially delay the supply of new drugs that another country may urgently require.

The significance of compulsory licence becomes clear in the context of treatment for people living with HIV/AIDS (PLHA). As recently as four years ago, millions of PLHA across the world, and in India, could not afford the cost of treatment with anti-retroviral (ARV) drugs, known to prolong the lives of HIV-positive people. At that time prices ranged between US$ 10,000 and 12,000 (approximately Rs 450,000-540,000) per person per annum. Prices began falling when Indian manufacturers introduced generic versions of ARV drugs until, by 2003, the annual cost per person had come down to US$ 140 (about Rs 6,300). Such a dramatic decrease was possible because of India's process patent regime. Under the new regime, not only are prices of existing medicines likely to go up but the new drugs that HIV, by its very nature, necessitates may well be inaccessible to millions of patients across the world.

The conclusions of a working paper by the US-based National Bureau of Economic Research (NBER) on the effects of extending intellectual property rights protection to developing countries, based on a case study of the Indian pharmaceuticals market — focussing specifically on a particular type of antibiotic — is also worth noting here. The authors suggest that the introduction of product patents, leading to the withdrawal of currently available domestic drugs from the market, will cost both the economy and the consumer dearly, especially in the absence of compulsory licensing and/or price regulation.

Clearly, compulsory licences are critical for the promotion of public health now that a product patent regime is in place. Yet, according to opponents of the act, it does little to strengthen this mechanism and ensure that it can be used at least to the extent envisaged in the Doha Declaration. This seems particularly unwise in view of the fact that both governments and pharmaceutical companies in industrialised countries (which currently hold 97% of the world's patents) have in the past used legal action, political pressure and economic sanctions to oppose measures like compulsory licences in order to protect their profits.

Health advocates believe that the new Patent (Amendment) Act, 2005 will impact drug prices sooner rather than later. According to them, many local manufacturers who are currently making cheaper versions of key medicines for common ailments such as asthma, diabetes, hypertension, high cholesterol and other heart diseases, and bacterial or viral infections, including HIV/AIDS, are likely to stop production on account of the new law. Even if some manufacturers are able and willing to continue producing such medicines, prices are likely to rise to compensate for what will have to be paid as royalty to patent owners.

Health activists point to a number of legal documents, both international and national, including the International Covenant on Economic Social and Cultural Rights and India's Protection of Human Rights Act, 1993, to argue that the country must not trade away its right, and duty, to protect and promote public health through this bill. A number of other landmark documents relating to health, including international ones such as the 1978 Alma Ata Declaration and the 2000 People's Charter for Health, as well as domestic ones like the 1946 report of the Health Survey and Development Committee headed by Sir Joseph Bhore, and the 1983 National Health Policy, recognise the provision of essential drugs at affordable cost as a key ingredient of a humane and just health policy. The question is if and how the new law upholds the fundamental human right to health.

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75% prefer the private sector

In the absence of a robust state-funded health infrastructure providing free care, citizens have no option but to seek out private facilities. As a result, we have a burgeoning private healthcare sector, unregulated and often exploitative

G ANANTHA-KRISHNAN

A SINGLE EPISODE of major illness is enough to eat away the life-savings of most individuals in India. In fact, there is data to suggest that such illnesses push several families below the poverty line. The World Bank reported in 2002 that irrespective of income class, one episode of hospitalisation is estimated to account for 58% of per capita annual expenditure, pushing 2.2% of the population below the poverty line. Even more disconcerting is the fact that 40% of those hospitalised had to borrow money or sell off assets. During 1986-96, the number of people who could not access healthcare because of financial reasons doubled over the baseline.[1]

This obviously suggests a greater role for the public sector in healthcare. Yet, several studies have recorded the growing role of the *private* sector in the provision of healthcare in India. In a study of World Bank projects operating in India, Kamran Abbasi makes it clear that lack of funding in the public healthcare sector translates into inadequate quality of service, which forces "the poor to turn towards the private sector, which in turn exploits clients by using expensive inappropriate technologies and overprescribing".[2]

Writing on the role of private practitioners in tuberculosis control, Mukund Uplekar et al note in *The Lancet* that 80% of households prefer to use private sector treatment in India for minor illnesses, and 75% of households prefer to go to the private sector for major illnesses.[3] An examination of healthcare access patterns for the population leads to the startling revelation that the vast majority of people have been forced to rely on private facilities because there is an absence of state-funded alternatives.

According to figures from the National Sample Survey Organisation for 1998, quoted in a study by V R Muraleedharan and Sunil Nandraj,[4] there was a 7% increase in the number of outpatients patronising rural private sector facilities, from 74% in 1986-87 to 81% in 1995-96. In urban areas, this rise was about 8%, from 72% to 80% during the same period. In the case of in-patients, the rise was sharper, from 40% to 56% in the case of rural and 40% to 57% in urban areas.

A snapshot of the private healthcare sector in India emerging from the study by Muraleedharan and Nandraj[5] shows that in absolute terms, the size of the health infrastructure is significant, but its distribution is lopsided and urban-centric. There is one qualified doctor for 802 people and one hospital for 11,744 people, besides one bed for 693 people. But there are serious imbalances in the distribution of these facilities. In Tamil Nadu, at least 70% of 37,733 allopathic physicians are in the private sector while 10,000 are in government service. There are nearly 10,000 doctors in and around Chennai. Therefore, the ratio of doctors to population changes from 1:800 for Chennai to 1:1,590 for the state average.

The National Council for Applied Economic Research reported in 1992 that a study of household surveys showed over 55% of illness episodes being cared for by private facilities, and 33% to 39% by the public sector. PHCs and sub-centres catered to only 8.2% of cases in rural areas.

Why do so many patients seek private doctors?

In some settings, private practitioners are perceived as providing better care because they include injections as part of every

Sudharak Olwe

All about quacks: The cost and quality of care in the private sector

In 1989, researchers R Duggal and S Amin interviewed 500 households in Jalgaon taluka, Maharashtra. They found that private services were used more than three-fourths of the time — more often in rural areas. The poorest people used the public sector most. Numerous other studies have confirmed the dominance of the private sector and the reasons for this dominance: government health services entailed longer travel and waiting periods, arrogant behaviour of doctors and non-availability of medicines. Almost all private expenditure is 'out-of-pocket', and not covered by insurance of any kind.

This kind of expenditure on healthcare in the private sector can have devastating consequences on poor households. In Kerala, a sample of rural households first surveyed in 1987 was followed up in 1996 for health and socio-economic status. Even accounting for an annual inflation rate of 10%, per capita healthcare spending had increased by 517% — with the increase being higher for the poor than for the rich. "Even granting a certain degree of under-reporting of incomes, this is a very high figure and undoubtedly is a major contributing factor to debt and further impoverishment among those on the lower rungs of the social ladder."[1]

In 2001, D Narayana conducted a survey on the effects of macroeconomic policies and health sector reforms on access to the health sector. Kerala was one of the states surveyed. He found that in Kerala, the extensive healthcare infrastructure ensured that very few are deprived of care. However, he also found that 9.08% of the population surveyed in Kerala reported spending more than 100% of their annual income on healthcare — implying that they had had to sell assets for healthcare.[2]

Researchers V R Muraleedharan and Saradha Suresh tracked 1,273 pregnant women in 61 slums in Dindugal, Tamil Nadu, over 16 months. They found that 33% of deliveries took place in private hospitals; 55% in municipal maternity homes or hospitals; and about 10% at home. The cost of deliveries at home and in the municipal home averaged Rs 295 and Rs 238 respectively. They cost more than twice as much in a government general hospital. A C-section cost Rs 8,774 in a private hospital, compared to Rs 2,410 in a general hospital. The researchers noted that a considerable number of women from high poverty-risk groups had chosen private facilities for delivery and had spent as much as Rs 15,000 on a C-section.[3]

S Nandraj visited 24 private nursing homes and hospitals in Mumbai.[4] Some findings:

- Less than a third had qualified nurses.
- 50% were poorly maintained, even dilapidated.
- 66.7% did not have a generator.
- Most were congested, with narrow passages and entrances.
- 77% of nursing homes with an operation theatre did not have a sterilisation room.
- 77% did not have scrubbing rooms.

In a similar study in rural Maharashtra, S Nandraj and R Duggal surveyed 53 private providers and 49 hospitals in two talukas.[5] Some findings:

- One-fourth of providers were unqualified — the poorer taluka had almost five times as many unqualified providers. 40% were allopaths (8.3% in the poorer taluka) and 52.5% from Indian systems (75% in the poorer taluka). But 94% practised allopathy.
- Only 55% of providers had the appropriate registration. Only 38% maintained any records.
- Essential equipment and instruments such as thermometers, sterilisers, examination table, weighing machine, sheets, towels and washbasin were lacking. In one taluka, only 36.4% had a thermometer, and only 9.1% had any sutures or ligatures.
- Not one of the 49 hospitals surveyed was registered. 29% were run by non-allopaths. There were only three qualified nurses in the entire sample.
- Only 18% of hospitals had the minimum facilities for pathology tests. Only one quarter of the hospitals had uninterrupted power supply, and not a single hospital had an ambulance. 39% of hospitals functioned without a full-time doctor or visiting consultant. Fourteen hospitals did not have any nurses. Only 10% of hospitals had an ECG monitor, 65% a steriliser, and 56% an oxygen cylinder.

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treatment, and are willing to make house visits, which are convenient. In contrast, government services are not popular because of long waiting periods, the arrogant attitude of staff and non-availability of medicines.[6]

In the absence of a robust state-funded health infrastructure providing free care, citizens must seek out private facilities. Based on a study of weaknesses in the tuberculosis control programme, *The Lancet* reported that among 22 countries with the highest prevalence of TB, private health expenditure as a percentage of the total was among the highest in India, at 87%. The number of patients incurring 'out-of-pocket' expenditure as a percentage of total spending was also unconscionably high at 84.6%.[7]

Acknowledging the rise in patronage of private healthcare in many poor nations, the *British Medical Journal* traced the phenomenon to greater flexibility of access, shorter waiting time, greater confidentiality, and sensitivity to user needs.[8] However, there cannot be an unreserved commendation of any measure to expand the private sphere without an overarching concern for a state-funded care system. The debate on the debilitating impact of a policy that is guided by private care imperatives has dominated proposals to revamp the National Health Service (NHS) in the United Kingdom, with suggestions that the discourse on expansion is actually driven by a desire to pave the way for the entry of private care-providers from the United States and elsewhere. Thus, tax funds would indirectly lead to an expansion of the private healthcare sector at the cost of the public system.

This issue is of particular concern to India, as the private sector has not met its obligations of providing free care to a particular percentage of poor patients as required by law. Citing this little-known and poorly-enforced provision, Members of Parliament Ram Kripal Yadav and Daroga Prasad Saroj wanted to know, in the Lok Sabha, the steps taken by the Centre to ensure that private hospitals provide 30% of their patients free treatment. Union Minister of State for Health and Family Welfare Panabaka Lakshmi replied on July 21, 2004: "Health being a state subject, it is for the respective state governments to formulate conditions and norms for setting up of private hospitals… (and) with regard to the treatment of poor patients and also to ensure that the conditions and norms are followed by private hospitals."

The issue becomes clearer in the answer of Health Minister A R Antulay to a question in the Rajya Sabha in 1995. The minister said: "The 4th Joint Conference of Council of Health and Family Welfare held in October 1995 also recommended that the private sector which benefits from concessions should provide a minimum of 30% beds and 40% outpatient/diagnostic services free for treatment of the poor. In the past, private hospitals/nursing homes were allowed to import medical equipment at concessional rates of duty subject to the condition that a certain percentage of free treatment would be provided in OPD/IPD to poor patients. The state governments are required to check whether these conditions are being met by private hospitals/nursing homes."[9]

Regulation and the lack of it

There is a complex set of factors that have rendered regulation of medical care practically meaningless in India. Muraleedharan and Nandraj report that the major problems include lack of monitoring by statutory bodies, outdated and inadequate legislation, and inability of the government to enforce even the available regulatory laws.

One of the earliest laws in force is the Delhi Nursing Homes Registration Act 1953, which requires that all private nursing homes satisfy a set of criteria and register themselves. However, a survey reported in 1994 found that there were 1,600 unregistered nursing homes functioning in the national capital, despite the law, indicating that it was not being enforced even in the city where national laws are made.[10]

On the question of costs associated with private care, V R Muraleedharan points out that there is inadequate information on in-patient care to come up with a sound analysis on whether the costs are justified. The lack of sustained data collection was confirmed by the then minister of state for health and family welfare, in answer to a question in Parliament: "Health being a state subject, the details of hospitals run by state governments in the country are not maintained centrally."

There is thus considerable evidence to conclude that the poor are unable to access quality healthcare in India due to inequities prevailing within the system. Health insurance, either taken individually or provided as group cover, is helping some sections, though this remains a minority phenomenon in the overall scheme. The imperatives for policy therefore are to bring about greater budgetary expenditure on public health, institute monitoring mechanisms involving transparent and professionally audited procedures both in the public and private sectors, and ensure that the private sector, which has a legal commitment to share its facilities with the poor, is compelled to do so.

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NRHM: New hope for the rural poor

The mission provides for a health activist in each village, a village health plan prepared by a local team headed by a panchayat representative, strengthening of rural hospitals for effective curative care and accountability to the community

ABHIJIT DAS

THERE ARE STARK DISPARITIES in the healthcare services available to rural and urban Indians. While world-class five-star hospitals have sprung up in various cities across the country, encouraging the new growth industry of medical tourism, facilities in rural India languish. A countrywide study conducted a few years ago (RCH Facility Survey 1st round) found that less than 50% of primary health centres (PHCs) had a labour room or a laboratory, and less than 20% had a telephone. Less than a third of these centres stocked iron and folic acid, a very cheap but essential drug.

Rural healthcare service delivery is thus severely compromised. Despite major advances in medical science, people continue to die in large numbers from preventable illnesses like tuberculosis, gastroenteritis and malaria. Five lakh succumb to tuberculosis alone. Emergency services for delivery complications are unavailable outside cities, and, as a result, maternal death rates in the northern states rival those of sub-Saharan African countries. India accounts for a fourth of all maternal deaths worldwide, and the numbers are increasing. Uttar Pradesh, with its huge population base and very poor health system, contributes a large proportion to the overall preventable mortality and morbidity in the country. But its healthcare delivery system is preoccupied with the pulse polio campaign and with chasing family planning targets (see box).

If it delivers on its promises, the recently launched National Rural Health Mission (NRHM) could change the face of rural healthcare in India. On January 4, 2005, the cabinet approved the formation of this mission which aims to improve the access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

Sudharak Olwe

The mission seeks to integrate different vertical health programmes, decentralise healthcare service delivery at the village level and improve intersectoral action. It is an articulation of the commitment of the government to raise public spending on health from 0.9% of GDP to 2-3% of GDP, over the next five years. The NRHM is expected to substantially reduce maternal and infant mortality and communicable diseases within the next four years. It is focussed on 18 states that have weak public health indicators, including the seven northeastern states, and 11 states in north and eastern India.

Key components of the mission include the provision of a health activist in each village; a village health plan prepared through a local team headed by the panchayat representative; strengthening of rural hospitals for effective curative care and accountability to the community; and integration of vertical health and family welfare programmes. The mission proposes a village health plan, to be drawn up by members of the community in partnership with the auxiliary nurse midwife (ANM) and anganwadi worker. It also makes provision for employing nearly 300,000 rural women health workers who will provide frontline healthcare to the community. These health workers will not only offer simple remedies such as the oral rehydration mix but will also motivate families to adopt clean drinking water practices, sanitation and safe pregnancy and delivery.

The provision of curative services at the peripheral level is an area of weakness in present government healthcare service delivery. There is an acute shortage of medical officers. The NRHM proposes to strengthen curative services from the village up. There will be two people at each sub-centre (auxiliary nurse midwives or health workers) and PHC (medical officers), so that one person is available for curative services. Community health centres (CHCs) are to be strengthened as rural hospitals so that emergency surgery and hospitalisation are possible round the clock. This requires operationalising 3,215 existing CHCs (30-50 beds) as 24-hour first referral units.

Protocol and standards for curative services will be codified into the Indian public health standards to ensure quality of care. Stakeholders' committees (Rogi Kalyan Samitis) will be promoted for hospital management so that the health facilities are accountable to the community.

40,000 women die in childbirth every year in UP

Uttar Pradesh's shocking statistics on maternal and child health bring the state of public healthcare in rural India into sharp focus.

Healthwatch UP/Bihar and KRITI Resource Centre, Lucknow, report some shocking statistics on maternal and infant health in the state of Uttar Pradesh:

• Total population of Uttar Pradesh: 16.6 crore (2001 census) • Crude birth rate in Uttar Pradesh: 32.9 per 1,000 population (e-Census India, Issue 13, August 2002) • Infant mortality rate in Uttar Pradesh: 85.1 per 1,000 live births (e-Census India, Issue 13, August 2002) • Neonatal mortality rate in Uttar Pradesh: 51.4 per 1,000 live births (NFHS 2-1998-99) • Maternal mortality rate: 707 per 100,000 live births (Sample Registration System 1998) • All recommended types of ante-natal care: 4.4% (NFHS 2-1998-99) • Birth attended by skilled attendant: 22.4% (NFHS 2-1998-99) • Delivery at a medical institution: 15.5% (NFHS 2-1998-99) • Post-natal care: 7.2% (NFHS 2-1998-99)

These statistics reveal that around 54,00,000 children are born in Uttar Pradesh each year. Of these, 450,000 infants die before they are one year old, and 275,000 infants die before the age of one month. The rate of infant mortality in Uttar Pradesh is among the highest in the country.

Nearly 40,000 women lose their lives giving birth, each year. The rate of maternal mortality in Uttar Pradesh is the highest in the country and roughly one out of every 15 maternal deaths worldwide takes place in Uttar Pradesh.

Of the more than 54,00,000 pregnant women, only 225,000 receive the full check-up and care that they require during pregnancy. Over 40,00,000 women deliver without any skilled attendant present, and over 45,00,000 deliver at home. Of the women who deliver at home, 42,00,000 are not visited by a health worker even two months after childbirth.

Conditions at government health centres and hospitals

The Government of India conducted a survey to understand the status of government healthcare facilities in 2000. The report on Uttar Pradesh mentions:

• Total number of PHCs surveyed: 486. Of these 486 PHCs only 10 had a working telephone, 418 did not have a working vehicle. A medical officer was not present at 107 PHCs. Female health staff was not complete in 442 PHCs; male staff was incomplete in 403 places. As far as equipment is concerned, 342 PHCs did not have labour room equipment; 418 places did not have normal delivery kits; and 467 places did not have emergency delivery kits/drugs.

• Of a total number of 34 first referral units surveyed (FRUs are hospitals like community health centres and district hospitals where facilities for Caesarean operations should be available), 16 FRUs did not have a working vehicle, 24 FRUs did not have a telephone. Eighteen FRUs had an obstetrician posted, but only two places had an anaesthetist. Anaesthesia equipment was available in 16 places, but emergency labour drugs were only available in six places. Oxygen cylinders were available in 19 places.

The National Rural Health Mission is a bold proposition aimed at changing the way healthcare services are prioritised and delivered in India. But while it is true that the moribund government healthcare services need bold measures to revitalise them, there is also a sense of *déjà vu*. Many new health-related programmes have been initiated over the years, and others re-organised, but the results have always lagged far behind the projections. And, the more things change the more they tend to remain the same. Take, for example, the family welfare programme — the most active health-related initiative in the country. In the last decade, this programme has seen a whole slew of new initiatives, but it seems to be delivered the same way it was a long time ago. Not so long ago, family planning targets were given to ANMs and anganwadi workers and even the district magistrate's work was judged by the number of cases obtained from his/her district. Then, the target-free approach was announced and there was a general sigh of relief. However, the situation now seems to have reverted to the earlier state. Reports from Uttar Pradesh, Madhya Pradesh and Rajasthan indicate that not only are targets in place once again, but there are inducements like gun licences for getting sterilisation cases.

Hopefully the National Rural Health Mission will be different and will deliver on a significant number of its promises. However there are still many unanswered questions and unresolved issues. The idea of a village health worker is not new. There was an earlier scheme where a village health worker (VHW), was paid Rs 50, in the late-'70s. The ASHA (the reincarnated VHW) will not be paid a fixed honorarium and is expected instead to earn a living from performance-linked incentives. A similar experiment of the Jan Swasthya Rakshak, currently operating in Madhya Pradesh, has not brought about much improvement in healthcare indices. Some authorities note that it has, instead, led to the creation of a new rural political cadre as well as a new class of informal private practitioners. There is also concern that instead of becoming a community activist, this person may end up as an auxiliary to the ANM.

The most important hurdle will be getting different states to take ownership of the entire process. Health is a state subject in India and most of the financial outlay (upto 85% of government spending) is made by the state governments.

The poor in India have always lived in hope; the National Rural Health Mission has become a new hope for them. It will take a concerted effort between the state and central governments, a partnership between the government and the non-government sector, a common commitment to standards by providers and managers, and faith in the people's ability to make plans and monitor them for this hope not to be betrayed.

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'You can't blame liberalisation for all our woes'

It's convenient to externalise the enemy, says national convenor of the Jan Swasthya Abhiyan, B Ekbal, but it's the lack of political commitment and glaring deficiencies in the system that are really responsible for the mess the public health sector is in. In this interview, Dr Ekbal discusses the JSA campaign and the decline in Kerala's model healthcare system

ARCHNA DEVRAJ

FRESH FROM THE PARTIAL VICTORY scored by the Left Front parties over the controversial Patents (Amendment) Bill, against which the Jan Swasthya Abhiyan (JSA) lobbied extensively with MPs and health policymakers, JSA national convenor B Ekbal, however, asserts that the "battle is far from over" and adds that close monitoring will be essential to safeguard the hard-won concessions.

An informal alliance of 21 networks working on public health-related issues in different parts of the country, the JSA was formed as a follow-up to the first People's Health Assembly in Savar, Bangladesh, in December 2000 and the National People's Health Assembly held in Kolkata prior to that.

The Savar conclave witnessed the coming together of thousands of civil society organisations and people's movements from various countries, to draw up an action plan to pressure governments around the globe to implement the 1970 Alma Ata pledge of 'Health for All by 2000'.

Talking to InfoChange Agenda, Dr Ekbal details the campaigns taken up by the JSA, during the past four years, at the national, state and grassroots level to further the alliance's goals. He also talks of the decline in the healthcare system in his native Kerala, once lauded as a model for public healthcare systems in the country.

How did a neurosurgeon like you get involved in public health and access to healthcare? How did you get involved with the Jan Swasthya Abhiyan?

After finishing my medical studies in 1970 I got actively involved with the Kerala Sastra Sahitya Parishad (KSSP), which was taking up health-related issues apart from other social concerns relating to education, the environment, etc. I was also closely interacting with the Medico Friends Circle (MFC), which had then taken up a nationwide campaign against the selling of banned drugs in India. So, my interest in public health issues goes back some 25-30 years. As an activist of the People's Science Movement, I also got the opportunity to interact with several national and international organisations working on issues of right to healthcare.

The Jan Swasthya Abhiyan was founded in India as part of the Global People's Health Movement, following the first People's Health Assembly at Savar in 2000. Before heading for the Savar assembly, national networks and NGOs had come together in Kolkata to organise the National Health Assembly, which declared the major goals of the Indian people's health movement in the form of an Indian People's Health Charter.

What have the JSA's activities been? What do you see as its achievements? At the micro-level, in terms of specific programmes, and at the national level, in terms of policy, would you say that it is making a difference?

I feel the JSA's campaigns are definitely beginning to have an impact, both at the national and state levels. At the policy-level, our foremost concern is to address the healthcare issue from a rights perspective. In this we have got very crucial support from the National Human Rights Commission (NHRC). The national-level public hearing *(jan sunwai)* on the right to healthcare, organised in Delhi in December 2004, clearly recognised our demand for the right to healthcare to be included in the chapter on fundamental rights of the Indian Constitution. The national public hearing, which was held following a series of regional public hearings in different parts of the country, also demanded the enactment of a Public Health Act by the central and state governments.

Several structural anomalies in the public healthcare system, exposed in the personal testimonies of those who participated in the *jan sunwais*, are also being followed up in various states, notably Karnataka and Tamil Nadu. We have also prepared a format to hold *jan sunwais* right down to the panchayat, taluka, district and state level, in all the states.

Close monitoring of the public healthcare system, with the active participation of the state human rights commissions, people's representatives, bureaucrats and public health activists, will make the system more responsive. For instance, in Karnataka, during the regional public hearing, we found that some three or four primary healthcare centres (PHCs) were located close to each other in one particular district, forcing people from other parts of the district to travel long distances to avail of their services. Some of the PHCs have since been relocated.

In Kerala also, we hope to start the state-level *jan sunwai* from June-July. The purpose of these public hearings is not to find fault but to rectify structural anomalies in the public healthcare system, such as lack of adequate medicines and other infrastructural facilities like blood banks and investigative facilities at government hospitals, which force people to turn to private sector hospitals.

In Kerala, the JSA took up the Patents (Amendment) Bill in a big way, initiating a debate, briefing MPs on the technical details, and collecting over 300,000 signatures. I can confidently say that the JSA played a small role in the Left parties' success in

wresting major concessions from the government in the Patents (Amendment) Bill.

Though the JSA's ultimate goal is to see that TRIPS is taken out of the WTO, for the time being we have to accept the reality of product patents becoming the norm, instead of the earlier process patent. However, given the present political situation, the left parties have been able to wrest substantial gains from the government, including reducing the number of drugs to be patented, compulsory licensing and the exclusion of a clause preventing the export of cheap Indian drugs to other developing countries.

What are some of the JSA's future activities? What do you see as the big problems ahead?

The follow-up of public hearings will remain an important focus area. The national working group of the JSA, which will meet in Kolkata in April, will examine the Rural Health Mission announced by the Government of India. Also in Kolkata on April 16-17, the JSA is organising a seminar on the Indian pharmaceutical industry. Apart from the patents rules, several other issues facing the industry, including the status of public sector companies and price control mechanisms, will be discussed.

Some of the other campaigns taken up by JSA constituents include those relating to children and gender issues, geriatric problems and the changing demographic profile, mental health, and HIV/AIDS.

Also, an appraisal of the General Agreement of Trade in Services and its impact on health, education and other sectors and the public health impact of new technologies like biotechnology and reproductive technologies will be initiated shortly.

Which are the participating organisations in the JSA? The JSA is an example of collaboration between political organisations and NGOs, and even religious organisations, some of which have in the past been distrustful of each other. How did this collaboration come about?

Groups working on public health issues, ranging from the extreme left to those professing Gandhian ideology and faith-based organisations, have been in touch with each other for a number of years. They have discussed major issues at length with each other in an effort to arrive at some sort of clarity on them, if not consensus, on such organisational platforms like the Medico Friends Circle, All India Drug Action Network and National Campaign Committee on Drug Policy. Starting with 18 networks, the JSA has grown to an informal alliance of 21 networks. All these networks work in a decentralised manner, taking up issues jointly at the national level as well as

individually at the local level.

The People's Health Charter, adopted after the Kolkata meet, is a consensus document. Thus, there is some degree of unanimity, a common bandwidth, among the groups constituting the JSA.

Also, there have been major changes in the world and the country in the past 10 years. In the face of imperialist globalisation and other threats facing the country, it is important for these groups to face these challenges unitedly. There are several factors binding these groups together. There is no time to quarrel. There are larger issues, stronger enemies that we have to fight together.

Kerala was once seen as an ideal healthcare system, with an extensive network of government health services and high health indicators. Have there been any changes in healthcare access in Kerala since 1991? What has been the effect of neo-liberal policies at the national level? There are studies, including those by the KSSP, indicating that healthcare costs have shot up in Kerala, with the private sector playing a greater role than before. What has led to this situation?

It is true that there has been a definite decline in the Kerala public healthcare system. However, I trace the decline not to 1991 but prior to that, to the early-1980s. The chief cause for this has been a lowering of political commitment to healthcare issues. There has been no proper planning at the policy level. Even where funds are available in the government sector, there is no proper utilisation. The government is spending more money on building super-specialty hospitals than concentrating on the primary and secondary health tiers.

A study done by the KSSP as early as 1986 indicated that the public healthcare system in Kerala was on the decline. Disturbing trends had surfaced, mainly on account of the neglect of the primary and secondary healthcare sectors. New infectious diseases like Japanese encephalitis, leptospirosis and dengue fever have surfaced, and malaria has returned. Rising consumerism, resulting in changes in food habits, has also led to an increase in lifestyle-related diseases such as diabetes and hypertension.

The changing demographic profile, with an increasingly ageing population, has given rise to another set of geriatric health issues. Studies show that the suicide rate in Kerala is three times the national average. This indicates the weak mental make-up of the people, unable to cope with stress and other social problems.

The KSSP study also highlighted that a majority of the population was turning to private sector hospitals for treatment. Even among the poorest, nearly 40% relied on the private sector, which, in Kerala's case, is totally unregulated. Lack of investigative facilities and drugs also forces those going to government hospitals for treatment to turn to the private sector for these services.

Another study, taking the 1986-1996 sample period, showed that people's healthcare expenditure had gone up five times.

As for the impact of the neo-liberal policies of 1991, I think that they have had only a minimal impact on the total health scenario so far. The major issues are the result of internal factors. It is convenient to externalise the enemy and to blame globalisation or liberalisation. The fact of the matter is that there are glaring deficiencies in the system itself, which are not being addressed. To blame liberalisation for all our woes is a cliché now. It is actually lack of political commitment that has largely brought about a decline in the public healthcare system in Kerala. However, in the near future, because of changes in the Patent Act in India drug prices are likely to increase. This will affect the people of Kerala more than those in other states because more than 90% of people in Kerala access modern medical treatment. Also, the introduction of user fees at public hospitals as part of the liberalisation agenda will definitely lead to the internal privatisation of public health institutions.

The difference that political will can make to the system is made evident by the major policy initiative introduced by the Left Front government in Kerala in 1996, under the People's Campaign for Decentralisation. Under this, 35% of the plan budget was allocated to local bodies for all their activities. Of this, 40% could be used for social services sectors like health and education.

This led to a dramatic improvement in the facilities available at some PHCs and taluka hospitals. Surveys showed an especially excellent improvement in some of the more backward districts like Malappuram, Idukki and Wayanad, where the incidence of infectious diseases could be controlled. In a few places, private hospitals had to be closed down as people found government sector facilities to be on a par with them.

According to a rough estimate, one could say that nearly 40% of panchayats are performing well in service delivery, following the people's decentralisation campaign. However, with the coming of the UDF government four years ago, the tempo has again slowed down. Funds have not been released on time. New rules have been put in place to curtail the transfer of funds to local bodies. The Planning Board, which was playing an active role in the decentralisation campaign, has been distanced from the process.

The UDF government has also allowed self-financing medical colleges to come up. Students who pay Rs 25,00,000-30,00,000 to get into private colleges are hardly bothered about ethical issues or the doctor-patient relationship. They see medicine only as a source of making money.

However, all hope is not lost. The decentralisation process has been set in motion and it cannot be dismantled. A change of government in the state could revive the stalled process.

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