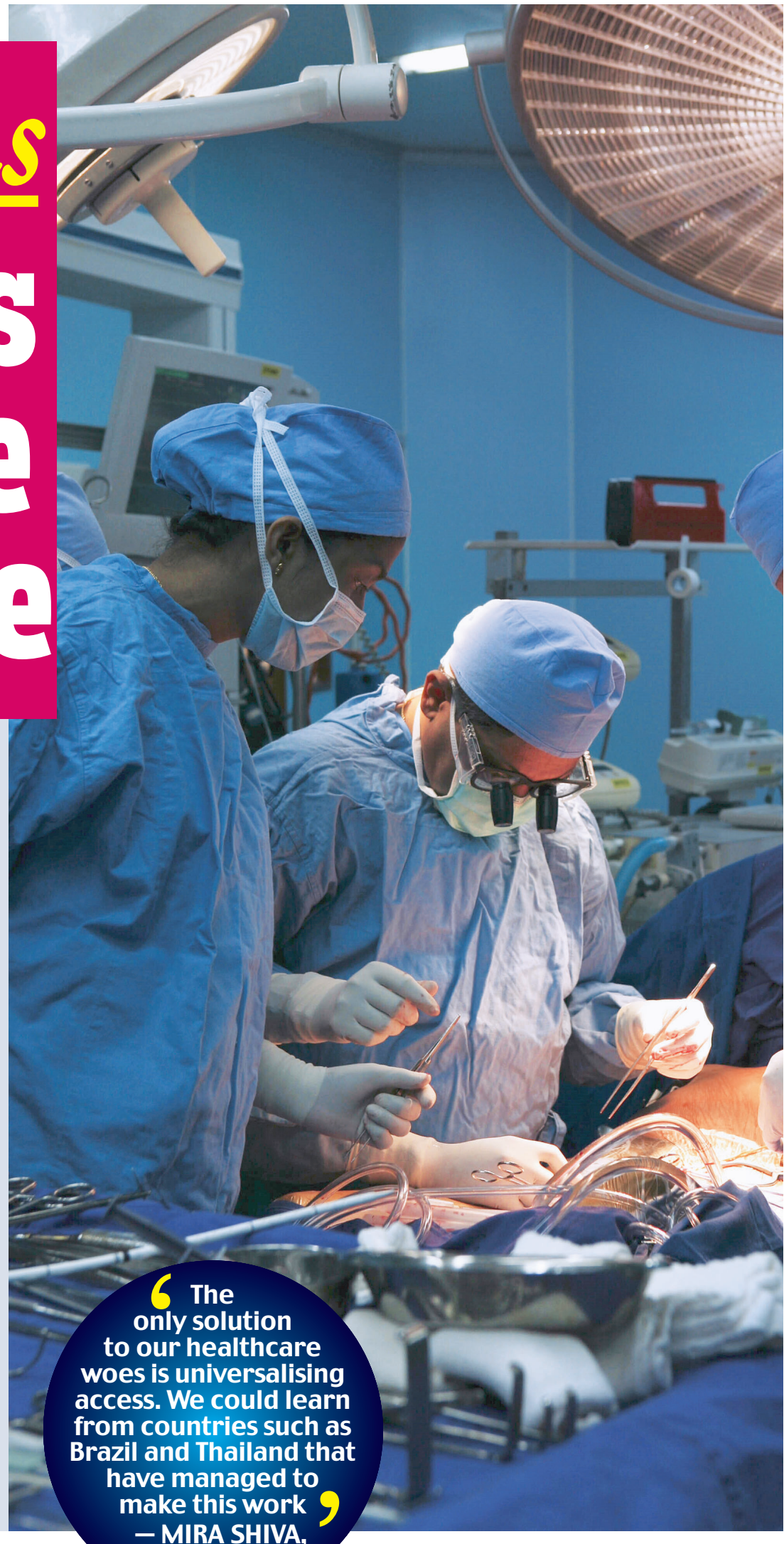
NEWS & ANALYSIS

Prescriptions for India's healthcare nightmare



Barefoot doctors or super speciaists, cash-free healthcare or private providers charging fat fees, a focus on lifestyle diseases or malaria and TB, obesity or malnutrition, primary care or top-class medical tourism — our health system is constantly confronting these contradictory choices. *The Lancet*, the leading medical journal, has proposed a blueprint for reform. DINESH C. SHARMA examines the various policy options.

1.82% of the GDP is how much the Chinese spend on healthcare; India spends less than **1%**

2 years is the length of time the National Health Bill has been gathering dust

15.8 doctors per **10,000** people reflects the poor state of healthcare in Chhattisgarh

> **'The only solution to our healthcare woes is universalising access. We could learn from countries such as Brazil and Thailand that have managed to make this work'**
> **— MIRA SHIVA,** Initiative for Health & Equity in Society

Raise public spending

One of the foremost cures to the sick health system is to administer it a heavy dose of steroids in the form of higher state funding. Despite being a welfare state, the Indian government's health expenditure as a percentage of GDP is among the lowest in the world. After an increase between 1950-51 and 1985-86, the government's health spending has virtually stagnated at just below one per cent of the GDP, which is among the lowest in the region.

The Chinese government, for instance, spends 1.82 per cent of its GDP on health. There are huge disparities among states. Although the average per person state funding comes to Rs 268, it is just Rs 93 per person in Bihar. In some states, staff salaries account for a large chunk.

"The amount and the composition of health expenditure affect both the efficiency and effectiveness of health spending," point put experts writing in *The Lancet* special issue. They feel taxation is the only viable option to generate additional resources in order to achieve the goal of increasing health spending to 3 per cent and then to 6 per cent of the GDP. However, increased spending would have to be accompanied by steps to improve performance, accountability and efficiency of the system as well as laws to regulate quality and the price of healthcare and drugs.

Cut out-of-pocket expenses

India may be witnessing scorching rates of economic growth, but 39 million Indians slip below poverty line every year just on account of healthcare costs. Since government spending on health is low, private spending — also known as out of pocket expenditure — is very high. Nearly 80 per cent of the expenditure on health is from private sources.

The bulk of it is incurred on outpatient treatment and not for hospital care. Drugs account for as much as 72 per cent of the total OOP. One major way to reduce private spending, therefore, would be to promote generic drugs through low-cost pharmacies all over the country. A handful of such stores — under the banner of Jan Aushadhi — exist where drugs are being sold for a fifth of the branded versions.

But vested interests are not allowing this network to grow. Some states like Tamil Nadu have streamlined procedures for procuring drugs for the state system, which has helped bring down costs. In addition, promotion of rational drug policies would help eliminate costly irrational combinations from the market. Once public spending on health goes up, along with improvements in access and quality, experts feel the OOP would automatically come down.

New education order

The lack of health workers in villages and the unwillingness of urban-educated doctors to go to rural areas is often cited as the main reason for the poor state of health in rural areas. India currently has 2.2 million health workers, including 7 lakh allopathic and 2 lakh practitioners of other systems like Ayurveda and homoeopathy.

For every population of 10,000, the country has 8 healthcare workers, 3.8 allopathic doctors, 2.4 nurses and nurse-midwives. Not only is this much below international standards, but health workers are also unevenly distributed across the country. Kerala, for example, has 38.4 allopathic doctors for every 10,000 persons, while Chhattisgarh has just 15.8.

Overall, the number of health workers per 10,000 in urban areas is 42 compared to 11.8 in rural areas. The solution is opening more medical and nursing colleges — at the right places. Every district in Tamil Nadu, for example, has a government medical college attached to the district hospital (UP has just seven government medical colleges). This attracts local youths to medicine and most of them stay back in their own district.

"India has to move away from the idea that only allopathic doctors should deliver primary health services," note researchers writing in *The Lancet*. A new cadre of trained non-allopathic practitioners and health workers can do the job in rural areas, while allopathic doctors can be used more optimally at subdistrict and district levels.

Universal insurance

In addition to increasing state funding of health and reducing out of pocket expenses, it is necessary to have a universal insurance protection scheme. The currently available schemes cover only hospital admission, exclude several illnesses and are prohibitively costly for the poor. The focus is entirely on tertiary care. Some state-funded schemes such as the Rashtriya Swasthya Bima Yojana exist but are inadequate and insufficient. Indian experts writing in *The Lancet* have proposed a single-payer system in which "the government would collect and pool revenues to purchase healthcare services for the entire population from the public and private sectors".

Such an insurance scheme, it is argued, can be supported by public financing from tax revenues, mandatory insurance for all private employers and income –indexed compulsory personal insurance payments.

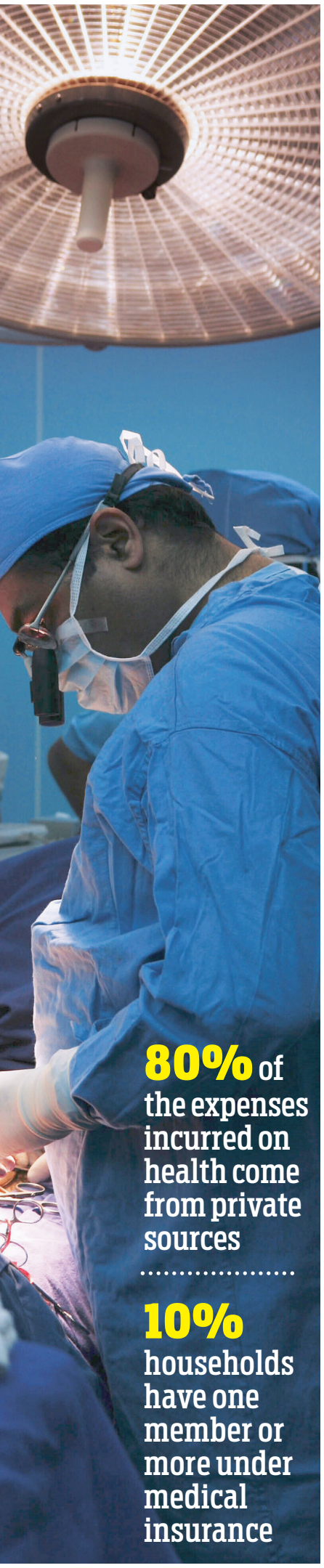
This could make healthcare at the point of care cash-free and accessible to all. "If well managed, countries with single-payer system have been able to deal with delays and shortages. They have been better able to manage competition, contain and decrease costs, negotiate reduced prices with private providers," researchers note.

International literati home in on Jaipur **Page 26**

Why Butterfly's creator is upset with Pakistan **Page 28**

THE CHANGEMAKERS

These doctors have shown that quality health care can be affordable and reach those left untouched by state support



80% of the expenses incurred on health come from private sources

10% households have one member or more under medical insurance

Regular pvt doctors

Pumping money into a sick health system without a proper regulatory framework for both medical education and the healthcare industry could prove to be counterproductive.

The present regulatory mechanisms in the form of the Medical Council of India and state medical councils controlled by lobbies of doctors have proved to be ineffective. The regulation of pricing and standards of private care has effectively been stalled for years by vested interests.

Certain public health standards have been specified in the National Rural Health Mission but there is no mechanism to ensure compliance. If a national health system and insurance plan — as suggested by experts — have to be implemented right, the process has to start with an authority being set up to monitor the standards of private practitioners.

ABHAY & RANI BANG

Saving babies in backward Gadchiroli

The doctor couple — trained in public health in the US — has successfully shown that the best way to practice medicine in rural India is to provide 'demand driven healthcare' by asking people what they want. Since they launched their Society for Education, Action and Research in Community Health (Search) in Gadchiroli near Nagpur two decades ago, the infant mortality has dramatically come down from 121 live births per 1,000 in 1988 to 30 per thousand in 2003.

ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

Dedicated band of barefoot doctors

No health system can be effective if it does not have an efficient system of delivery at the grassroots level. Despite its shortcomings, the introduction of ASHAs as part of the National Rural Health Mission has helped in ensuring healthcare delivery in rural areas. The new band of barefoot doctors is chosen from their own villages so as to overcome the problem of 'absentee' health workers. ASHAs are engaged in ensuring increased use and accountability of state-run health services.

DEVI SHETTY

High-profile surgeon and low-cost health pioneer

A responsible private sector can deliver low-cost yet quality care to the poor even in areas like heart disease. Narayana Hrudayalaya — a multi-specialty hospital set up by Dr Shetty 2001 — has proved this. The hospital works on the concept of assembly line heart surgery, which aims at reducing the cost of surgery a great deal. Shetty has also pioneered Yashasvini scheme, a comprehensive health insurance scheme, in collaboration with the Karnataka government.

H. SUDARSHAN

Leader in tribal healthcare

Karuna Trust, floated by Dr Sudarshan has demonstrated that it is possible to provide quality care through state-owned primary health centres (PHC). In tribal areas of Karnataka, his work has resulted in bringing down incidence of leprosy from 17 per 1,000 people to less than 0.3. Also, a form of epilepsy prevalent there has been completely controlled. Now the trust is running PHCs in five states, addressing health delivery gaps through innovations like telemedicine, health insurance and in tegration of mental health in primary care.

K. SRINATH REDDY

Raising an army of health activists

As head of the Public Health Foundation of India (PHFI), Dr Reddy has been engaged in training an army of public health professionals and addressing gaps in the healthcare system. The ideas originating from the foundation have influenced health policy making. The voluntary agencies set up by him are engaged in promoting tobacco control, cardiovascular health and chronic disease prevention among the youth and school children. This has helped translate research results into action.