Hospitals, out-of-pocket and out of reach

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India’s healthcare is affordable, we’re told now and then, even through development statistics tell a different story. Less than 10% people in India have some form of health insurance. Hospitalisations account for about 58% of an average Indian’s total annual expenditure. Over 40% people borrow heavily or sell assets to cover hospitalisation expenses, which forces 39 million people into poverty each year, shows World Bank data.

The explanation for the “affordable” tag, as usual, lies in the fine print. India’s healthcare is affordable only when compared to dollar and Euro-economies. So we, in India, are supposed to consider ourselves lucky, but the way, we have to pay $12,000 for kidney dialysis per year compared to $66,750 in the US. Unfortunately, people in India earn in rupees — which has been going through tumultuous times lately — and pay hospital bills in rupees. For an average middle-class family in the US, $12,000/year may not be too much, but in India, it means ₹ 7.36 lakh/year, which puts it out of reach for most people. More so when you consider the organ-donation scarcity that’s made transplants rare and forces people to go for treatments such as dialysis indefinitely.

It’s not just transplants that cost money, even a toothache can leave you poorer. For most people who are not a part of the organised sector, almost all Medicare is out of pocket and out of reach. The situation is likely to stay this way unless the Central and state governments — and the not just private hospitals seeking overseas patients — think innovatively to bring down costs.

Or hospital care will be of reach for many more. Like the rest of the world, India is facing a demographic transition, with people aged 60 and above projected to exceed children below five years in 2050, people over 60 years will increase from 76.6 million (7.4% of the total population in 2005) to 35 million (60.3%) of the 58 million in 2050. By 2050, people over 60 years will increase from 76.6 million (7.4% of the total population in 2005) to 35 million (60.3%) of the 58 million in 2050.

Almost all of them will need high-end care, and here’s why. Increasing life-spans mean more non-communicable diseases — such as heart disease, stroke, cancers and diabetes — which have already replaced infections such as tuberculosis, pneumonia, and malaria as the leading killers. Lifestyle diseases accounted for 5.2 million (50.5%) of the 10.3 million deaths in India in 2005, compared to 35 million (60.3%) of the 58 million deaths worldwide, shows data from the World Health Organisation (WHO). Treatment will not only cost money, but will also create a need for skilled doctors and nurses. India is already facing an acute shortage of doctors and specialists, especially in villages and remote areas. There are 6.5 physicians per 10,000 population in India, reports the WHO’s World Health Statistics report 2013. Sweden has 39 physicians/10,000, population.

India has 0.9 beds/1,000 population, which is far below the global average of 2.9 beds/1,000 population. Public sector hospitals are so overburdened that people have to sometimes wait days just for a consultation. New Delhi’s All India Institute of Medical Sciences, for example, treated 20.49 lakh people in the out-patient department (OPD) and did 1.14 lakh surgeries in 2010-11.

What’s needed is increased public health investment through increased public spending, improved management and public-private partnerships in both the insurance and healthcare delivery sectors. The Planning Commission’s proposal to raise total public health expenditure to 2.5% of GDP by the end of the Twelfth Plan is a start. Existing duplication between health programmes at operational levels must go. For example, several flagship schemes, such as Janani Suraksha Yojna (JSY), Janani Shishu Suraksha Karyakram (JSSK) and Indira Gandhi Matritva Sahyog Yojna (IGMSY), focus on the same beneficiaries: pregnant and lactating mothers. JSY aims to bring down the maternal mortality by promoting institutional deliveries. JSSK entitles all pregnant women free deliveries in public hospitals, and IGMSY provides conditional cash transfer scheme for them.

Lastly, partnerships that have worked should be scaled up. An example is Karnataka’s Yeshaswini Health Insurance Scheme — which was started in partnership with Narayana Hrudayalaya’s Devi Shetty in 2003 for people to get treated at a medical centre of their choice — has become more or less self-funding in less than a decade. The money raised from premiums is around ₹ 60 crore, with the state
government providing an annual contribution (Rs 45 crore for the current year). In the past year, nearly 30 lakh farmers had enrolled for health insurance.

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Globalization has come down heavily on India and countries like India. Global age has started various cost comparison between developed economies. Because it is easier for the political leaders to bring this comparison before the people and pat their back. That they are maintaining much lower cost in comparison with other countries. And that people should start paying for social obligations, to be maintained by the government. Whereas facts are totally different. In a country like India where BPL line is Rs 26 & Rs 32, where more than 80% population needs support to fight hunger. How these costs can be compared. Should income structure not be considered, before applying these standards.

To counter these fooling efforts of the political class a strong Consumer movement is required. Which may bring all these abnormalities before the consumer of the country. And make the consumers understand that how these so called well wishers of the poor are eating in to the revenue paid by them, for their welfare works, by way of indirect tax.(National Secretary, AKHL BHRATIYA GRAHAK PANCHAYAT)