Lucknow In a daze, a poor couple bring their sick child to a government hospital, holding up a drip bottle. For many like them, private hospitals are out of reach.

Care at government hospitals is poor.

The Doctor Only Knows Economics

This could be the UPA’s worst cut to its beloved aam admi. Healthcare has virtually been handed over to privateers.

LOLA NAYAR, AMBA BATRA BAKSHI

Not For Those Who Need It Most

Gv't seems to have abandoned healthcare to the private sector

Diagnosing An Ailing Republic

- 70 per cent of India still lives in the villages, where only two per cent of qualified allopathic doctors are available
- Due to lack of access to medical care, rural India relies on homoeopathy, Ayurveda, nature cure, and village doctors
- While the world trend is to move towards public health systems, India is moving in the opposite direction: 80 per cent of healthcare is now in private sector
- India faces a shortage of 65 lakh allied health workers. This is apart from the nurse-doctor shortage.
- According to World Health Statistics, 2011, the density of doctors in India is 6 for a population of 10,000, while that of nurses and midwives is 13 per 10,000
- India has a doctor: population ratio of 0.5:1000 in comparison to 0.3 in Thailand, 0.4 in Sri Lanka, 1.6 in China, 5.4 in the UK, and 5.5 in the United States of America
- Fifty-six per cent of all newborn deaths occur in five states: UP, Rajasthan, Orissa, MP and Andhra Pradesh
- Forty-nine per cent of pregnant women still do not have three ante-natal visits to a doctor during pregnancy
- An estimated 60,000 to 100,000 child deaths occur annually due to measles, a treatable disease
- Uttar Pradesh, the most populated state in the country, does not have a single speciality hospital for cancer
The top three causes of death in India are malaria, tuberculosis and diarrhea, all treatable.

The WHO ranked India's public healthcare system 112th on a roster of 190 countries.

Post-independence India's most noteworthy achievement in the public health arena has been the eradication of polio and smallpox.

**Affair of the states**

- **Best Public Health** Kerala, Tamil Nadu, Maharashtra, West Bengal
- **Worst Public Health** Rajasthan, Bihar, Uttar Pradesh, Madhya Pradesh, Orissa

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India is taking firm steps to a certain health disaster. All of 80 per cent of healthcare is now privatised and caters to a minuscule, privileged section. The metros are better off; they have at least a few excellent public health facilities, crowded though they might be. Tier II and III towns mostly have no public healthcare to speak of. As the government sector retreats, the private booms. In villages, if you are poor and sick, no one really cares, even if the government pretends to. You go to the untrained village "doctor"; you pray, you get better perhaps; all too often, you die of something curable. "India is the only country in the world that's trying to have a health transition on the basis of a private healthcare that does not exist," Amartya Sen said recently in Calcutta. "It doesn't happen anywhere else in the world. We have an out-of-the-pocket system, occasionally supplemented by government hospitals, but the whole trend in the world is towards public health systems. Even the US has come partly under the so-called Obamacare."

Sadly, even the few initiatives the Indian state takes are badly implemented. Hear the story of Suresh, 45, who lost his younger sister to cancer, eight months ago. He's a guard at the guesthouse of a pharmaceutical company in Mumbai and could not afford her treatment, so he sold some ancestral farmland in Gujarat. That money covered but a few months of bills from a private hospital. He then turned to a government hospital, but it didn't have cancer care. It didn't help in any way for Suresh that he worked for a pharmaceutical company: his job didn't come with medical benefits. "We brought her back home, hoping that if we saved on the hospital bills, we would be able to buy her medication. Finally, the money I had was too little to provide her basic help. Maybe if I had been able to buy her medicines, she would have been alive today."

But the state could have ensured that Suresh's sister lived had he been able to utilise the ambitious health insurance scheme announced in Maharashtra in 1997. The Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) is on paper supposed to provide for 972 surgeries, therapies or procedures, along with 121 follow-up packages in 30 specialised categories. It provides each family coverage of up to Rs 1.5 lakh in hospitalisation charges at empanelled hospitals. It even allows for treatment at private hospitals. But poor implementation has ensured Suresh and hundreds of families like his do not know of such a scheme. This is true of other schemes across the country too.

Meanwhile, health statistics are terrifying. More than 40,000 people die every year of mosquito-borne diseases, which are easily preventable; a maternity death takes place every 10 minutes; every year, 1.8 million children (below 5 years of age) die of preventable diseases. "We are the only country in the world with such a huge percentage of privatised healthcare. Recent estimates suggest that approximately 39 million people are being pushed into poverty because of high out-of-pocket expenses on healthcare. In 1993-94, the figure was 26 million people," says Dr Shakhtivel Selvaraj, a health economist.

So the state's pretence of reaching out to the poor is really quite a farce. Consider what's been happening between the Planning Commission and health ministry. In November, the battle between then health minister Ghulam Nabi Azad and the Planning Commission...
came to light: Azad had pressed for increased spending on the public sector while the commission was intent on increasing private participation. This was a telling comment on the priorities of the UPA government. But with the 2014 elections in view, the government would like to present “health reforms” as a political tool. A framework for “universal health for all” is expected by April this year.

According to the draft of the 12th Plan, the government will increase spending on health from 1.2 per cent of the GDP to 1.9 per cent, with greater emphasis on public-private partnership. While the expert group asked for scaling up public funding from the current 1.2 per cent of GDP to roughly 2.5 per cent by the 12th Plan-end (2017-18) and to roughly 3 per cent by the 13th Plan-end (2023-24), the government only relented a bit—enough to give it room to announce more populous aam amin schemes. D. Raja of the CPI believes that “through PPP (public-private-partnership), floated in the 12th Plan, the government is working as facilitator for private sector”, something that goes against the constitutional mandate of a welfare state. Former health secretary Sujata Rao says the state “cannot co-opt the private sector to provide healthcare for which government is paying money without framing stringent rules and norms.” More than 70 per cent of expenditure on health in the past five years has come from households. In its nine years in power, the UPA has overseen the shrinking of the public sector and the boom in the private. All the while, it has paid lip service to aam amin causes—even as it pushes people from the margins into the wilderness. In those five years, the well-to-do have obtained better healthcare than ever before. Both the Congress and the BJP have said in their party manifestos that they want to make India a “health tourism” destination. That has already happened. Would the UPA, champion of the aam amin’s interests, pat itself on the back for that? Meanwhile, most private facilities ignore a Supreme Court directive to reserve a certain percentage of their beds and treatment for the poor because they were given land at concessional rates.

Barely 100 km from the national capital, the Kosi Kalan district of Uttar Pradesh, near Mathura, presents a pathetic picture of community health care. Four months ago, the primary health centre, which caters to more than 50,000 patients with two trained nurses and two doctors, was upgraded into a community health centre with a new building. However, doctors haven’t been posted at the new centre. Says Rajkumar, a doctor at the primary health centre, “We got the new building about four months ago. We are waiting for administrative sanctions.”

Gurgaon Subedar Gupta (right) has spent about Rs 30,000 at private hospitals for his wife’s treatment in one month. He feels the hospitals have made her undergo unnecessary tests.

It’s a familiar tale of rural India. But what is also significant is that in the post-liberalisation era, the government health sector has virtually vanished from Tier II and III urban centres. Subedar Gupta, 32-year-old commercial vehicle driver from Gurgaon, has discovered that the government sector is an empty shell. It’s the private sector that has fleeced him. His wife Chanda Devi has been complaining of severe bodyache, itching and weakness for the last five years and no one knows why. Gupta spent about Rs 30,000 last month at private hospitals. He is now broke. “They ask us for same tests—blood test, X-rays and ecg. She is continuously on medicines. They are sucking all the money out of us.”

Millions of Indians living in small towns go through the same agony—not knowing where to turn to in the absence of a good health system. Because of that, thousands travel to Delhi’s overburdened AIIMS and Safdarjung Hospital, which are staffed with excellent doctors. The rest just pay for a private system designed to extract the maximum from each patient. “Public health is a big question in small cities. They have government hospitals, which are not well-equipped—in terms of infrastructure or adequate numbers of doctors and other staff. There is also a shortage of woman doctors,” says Dr Rajesh Shukla, a consultant in Tier II and Tier III towns, the public healthcare system is non-existent. Even
who has evaluated ICDS programmes in rural areas and studied medical care in small towns.

A large number of swanky hospitals and clinics have come up in urban India. But that does not ensure good care. There is also the issue of all this being loaded in favour of a profit-seeking system. Take the Rashtriya Swastha Bima Yojna, a government-supported health insurance scheme that rides on the private sector to provide medical care and surgical procedures at predetermined rates. Experts point to the dangers of induced demand and the prescription of unnecessary procedures to claim insurance benefits. Besides, the technology at private centres is often used to fleece patients rather than help them.

Dr Subhash Salunke, former director-general of health services, Goa, and currently director of the Public Health Federation of India, says the private sector is very scattered and unregulated, leading to lot of malpractices. This could have been checked to some extent had rules of the Clinical Establishment Act, 2010, been framed and implemented. Two years after the legislation was passed by Parliament, it hasn't been implemented. The problem lies with the "stiff resistance from the private sector to the laying down of guidelines".

The health sector is also crippled by a shortage of doctors and nurses (see graphic). So when the government says it is serious about training more doctors and nurses, by setting up six new AIIMSes, it makes for sound planning. But politics quickly shows up: one of the AIIMSes is planned in Sonia Gandhi's constituency, Rae Bareli. Many doctors trained in excellent government medical colleges swiftly move to the private sector; they are even reluctant to take up rural jobs or postings. "Of the 1,400 doctors appointed after a proper selection process, only 900 joined the service," disclosed a spokesman of the Uttar Pradesh health directorate. Because of the shortage of doctors in government hospitals, the National Rural Health Mission (NRHM) had started to recruit those trained in the Ayurvedic, Unani, Siddha and homoeopathic streams, but the process was stalled by a Rs 5,000 crore scam.

So the poor continue to suffer. In a general ward of Krishnanagar Hospital in Nandia District, West Bengal, members of a patient's family say that not a single doctor checked their ward for 24 hours after he was admitted with a cerebral condition. The doctor assigned to the hospital, who was in his chambers some 10 km away, had this to say when tracked down by Outlook, "I'm the only doctor for close to 500 patients. Is it possible for me to visit each and every patient? You have to understand my constraints. There is very little monetary incentive for doctors working in the rural areas. These are punishment postings. No one wants to come here. They want to work with rich patients and earn big money."

As he spoke, there were close to 100 patients waiting in the visiting room to see him. They were all from the villages and small towns in Nandia district. Krishnanagar Hospital is the main district hospital and patients from all over Nadia are referred to this hospital. In Uttar Pradesh, modern private health services have yet to reach beyond a dozen key cities. The rest of the state has to depend on these 12 cities, a handful of which have facilities for tertiary care. Some facilities are available only in Lucknow, where the government has concentrated all the healthcare while the rest of the sprawling state—75 districts—goes without even secondary care. According to the NRHM's fourth common review mission report, of the 515 community health centres in Uttar Pradesh, 308 were below norms laid down in the Indian Public Health Standards.

Even in states that are economically better off, such as Andhra Pradesh, it is an abject tale. Right from Seetampeta in north Srikakulam district to Utnoor in Adilabad, the public healthcare system is in a shambles. Adivasis simply have no access to potable drinking water and succumb easily to totally preventable diseases. If it's gastroenteritis in Adilabad, it's malaria in Paderu Agency of Visakhapatnam district. Anti-larval spraying operations are late and haphazard. Community health workers are badly
Andhra’s Rajiv Aarogyasri scheme, a brainchild of YSR, sounds perfect on paper. Only, the rich end up misusing it.

Trained. Human rights teams which visit these areas say the medicines provided are sometimes past the expiry date. “Deaths due to malaria are sought to be passed off as due to other diseases like cancer, heart stroke, old age or TB,” says V.S. Krishna of the Human Rights Foundation. Once touted as a model state for implementation of health insurance, Andhra Pradesh today faces a problem where the scheme is being misused by the rich. A qualified doctor himself, the late YSR, former chief minister of Andhra Pradesh, launched the Rajiv Aarogyasri Scheme in 2006, providing medical cover of up to Rs 2 lakh for bpl families. Since corporate hospitals handle a bulk of the procedures, the scheme is misused. Says a cardiac surgeon at a leading Hyderabad hospital, “The rich come and seek heart procedures under Aarogyasri, casually whipping out white cards meant for bpl families. There are no checks.”

The ailments of the poor often have nothing to do with the agendas of rich and powerful pharma companies. Are there lessons India can learn from the world? Experts say that the US has one of the worst public healthcare systems in the developed world. But in most countries, in Latin America or Europe, universal healthcare been achieved through governments. In Asia, Sri Lanka and Thailand can teach India some lessons on the health front. So India may be a powerful nation simply by dint of its size and market. But it is also a ‘sick’ nation, where there’s no help for the poor when they fall sick. It’s a country where a poor man can die on the pavement outside a gleaming state-of-the-art hospital with the best medical technology in the world.

By Amba Batra Bakshi & Lola Nayar with Sharat Pradhan, Madhavi Tata, Dola Mitra, Panini Anand, Chandrani Banerjee, Prarthna Gahilote and Prachi Pinglay-Plumber

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