Health for All – Issues of Access and Corruption

by

Dr Jayaprakash Narayan

FOUNDATION FOR DEMOCRATIC REFORMS/LOK SATTA

401 Nirmal Towers, Dwarakapuri Colony

Punjagutta, Hyderabad – 500 082

Tel: 91 40 23350778/23350790; Fax: 91 40 23350783

Email: loksatta@satyam.net.in ; url: www.loksatta.org

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

India is ranked very low in terms of Human Development Index (124th), and health status (112th). However, we enjoy a somewhat privileged position among developing countries in terms of capabilities and potential. We have impressive technical capabilities and manpower availability compared to most poor countries. We have over half a million trained allopathic physicians. While the doctor, population ratio of around 1:2000 is well below the norm for advanced countries, evidence suggests that for our level of economic development and affordability, we have more physicians than we can gainfully employ. The comparisons with such countries and norms which suggest that we need a physician for every 500 population or so are somewhat unrealistic, as they have not taken into account the socio-economic realities. In fact Sri Lanka, which is ranked 89 in Human Development Index (compared to India's 124th rank), and whose health indicators are far superior to ours in many respects, has only 36 physicians per 100,000 population (compared to 50 in India)!

True, our health manpower structure is skewed - there are fewer nurses and paramedics than necessary. But the nation has the capacity to set right such imbalances and train the required skilled workers with indigenous resources. We also have significant research capability to address our own health problems. There is an impressive and growing hospital infrastructure with high level of capability for sophisticated medical interventions. The cost of many diagnostic, therapeutic and surgical procedures is only a fraction of that in advanced countries. The pharmaceutical industry is mature and sophisticated, and has the capacity to produce drugs to meet our requirements at relatively affordable costs.

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

The malaise affecting our health care system is threefold. First, most people do not have proper access to health care of acceptable standards. According to the report on Millennial Survey of India's Public Services conducted by Public Affairs Centre, Bangalore, only 40 percent of

Indians have access to a government health care provider within 1 kilometre. While we do have a large number of trained physicians and impressive infrastructure, most doctors and hospitals are concentrated in urban areas. Public health facilities are largely inadequate in most major states, with only Kerala and Tamilnadu achieving impressive levels of health care. Public health expenditure accounts for only 0.9 percent of GDP in India. According to National Health Policy – 2002 document, the union budgetary allocation for health over the period 1990-99 has been stagnant at 1.3 percent of the total budget. During the same period, the fiscal pressures led to a reduction of the states' public health expenditure from 7 percent to 5.5 percent. The current annual per capita public health expenditure in India is around Rs 200, of which 15 percent comes from the union, and the rest from the states. Even this low level of public expenditure is highly skewed and largely unproductive in terms of outcomes. Most public health expenditure is tied up in salaries, leaving few resources for essential drugs, supplies, and operations and maintenance. 97 percent of all public health expenditure goes towards consumption, leaving only 3 percent in capital expenditure. 60 percent of all expenditure goes in wages and salaries, and only 35 percent for material and supplies, drugs and transport. Out of the limited public health budget, curative services including hospitals and dispensaries, insurance schemes, and medical education and training account for 60 percent, leaving only 26 percent for public health and family welfare, and 14 percent for administration and miscellaneous services (Charu C Garg[ii]). This low level of public expenditure, inadequate infrastructure and skewed priorities have limited access to health care delivery for the bulk of our people.

The second major problem afflicting our health delivery is its unaffordability for the bulk of our people. The bulk of India's health expenditure is in private sector, accounting for 83 percent. About 90 percent of this expenditure is out-of-pocket. This declining public spending on health places India in the bottom 20 percent of the countries. More significantly, the high reliance on private, out-of-pocket programs in health in India impose a disproportionate burden on the poor. As a result, the poorest 20 percent Indians have more than double the mortality rates, malnutrition and fertility of the richest quintile. (The World Bank, 2001[iii]). As nearly all the private spending is out-of-pocket, the poor are vulnerable to health risk. The poor generally avoid hospitalization because of their inability to pay and lack of risk pooling. Hospitalization frequently means financial disaster. As the World Bank report " India Raising the Sights: Better Health System for India's Poor[iv]" shows, only 10 percent of Indians have some form of insurance, and most of this is inadequate. Hospitalized Indians spend about 58 % of their total annual expenditure on health care. For the poor, this proportion may be much higher. More than 40 percent of those hospitalized are forced to borrow money or sell assets to cover expenses. At least a quarter of hospitalized Indians fall below poverty line because of hospital expenses. The poor depend heavily on private sector for out patient care, which accounts for 81 percent. The share of private sector in inpatient-care has been on the rise, and is currently close to 60 percent. All these facts make health care increasingly unaffordable, particularly for the poor. As preventive and primary care are relegated to the background, and as curative services are ever more sophisticated and expensive, the cost of health care is increasingly unaffordable to most of the poor.

The third major problem afflicting the health sector is the lack of accountability. Both the public sector and private sector are increasingly unaccountable to stake-holders and the community. Corruption, poor quality of services, medical malpraxis, overbilling, careless treatment causing

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

Recent expansion of private sector and huge investment in curative services and sophisticated equipment resulted in corrupt practices in private practice too. Payment of consideration to touts who get hospital patients, and doctors who refer patients has become a common practice. Commissions to doctors who prescribe expensive investigations and procedures which are often unnecessary is another form of unethical practice and corruption. Needless hospitalization, overbilling and expensive procedures have become endemic in private sector.

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

All these indicate the need for effective steps to curb corruption in health care, and to improve access to the poor, and evolve mechanisms of reducing cost of services. Clearly, public expenditure on health care should increase significantly. More importantly, most public expenditure should be directed towards preventive and primary health care. We need to evolve mechanisms for risk-pooling, so that most health care interventions are affordable to the poor and middle classes. Most of all, mechanisms must be evolved for enforcing accountability in health sector.

Five steps are essential in promoting accountability. First, community ownership and local control are critical. If the health care facility is managed by a local government, people

understand the link between taxes paid and services delivered. As authority at local level is fused with accountability, it becomes easy to enforce minimum standards of care. Transparency will be improved, and there will be better allocation of resources. At present, in PHCs in some major states, while the cost of wages is Rs 20 lakh per annum or more, the cost of drugs and supplies is a paltry Rs 70,000 per annum! About 50 % of the vacancies in health sector at primary level are left unfilled; and where personnel are posted, they are rarely available to the people. These maladies are a direct consequence of overcentralization, and can be effectively curbed by local control and decentralization.

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

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

Fourth, innovative procedures should be evolved to effectively curb corruption, and involve the public and whistle blowers in the fight against corruption. For instance, the US adopts two procedures in tandem to great effect. Many public agencies adopt a simple rule in procurement: the contractor must supply goods and services at the most favourable terms to the government – i.e. the price cannot be higher than that charged to any private customer. In conjunction with that, there is an innovative law called the “False Claims Act” applicable in the US to detect fraud and penalize the wrongdoers. Under this law, any person can unearth fraud or false claims, and file a suit on behalf of the US against those who have falsely claimed federal funds for any procurement of goods, works or services. Such a whistleblower is called a ‘relator’ and the false Claims Act litigation by such relators is called Qui Tam litigation. Persons who file successful Qui Tam suits can recover 15-25 % of any settlement or judgment reached in a case if government intervenes in the action, or upto 30 % if they pursue it on their own. The courts usually order three times the loss or damage sustained as recoveries. Thus private citizens have an enormous incentive to detect false claims and corruption and file suits. Consequently a huge industry of unearthing false claims has sprung up, and hundreds of Qui Tam suits have been filed, resulting in $ 6 billion recovered. In addition, $ 4 billion was recovered in government initiated claims.

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

profession, greater transparency, vigilant civil society groups, and consumer awareness are critical for better health delivery.

In a society increasingly conscious of health, and in an age of rapid advances in medical care, health care costs are bound to increase. Effective mechanisms need to be evolved not only to improve access and make quality care affordable; but also to curb corruption and minimize costs. Countless Indians are subjected to avoidable suffering because of the callous neglect of our governance system in respect of health care. It is time we adopted the successful best practices in our country and elsewhere, to make low-cost, high quality health care accessible to all citizens.

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[i] This article draws heavily from the author's paper " Ensuring a Healthy Future for India" slated for publication in IPN journal.

[ii] Charu.C Garg, *Equity of Health Sector Financing and Delivery,* Boston (MA): Harvard School of Public Health; 1998, p.15

[iii] The World Bank, *India Raising the Sights: Better Health System for India's Poor, Overview*, Washington (DC): World Bank; 2001

[iv] The World Bank, *India Raising the Sights: Better Health System for India's Poor, Overview*, Washington (DC): World Bank; 2001