People Power

The Great Debate: Allocations Vs Delivery

The new UPA government has made commitments to enhance allocations for agriculture, employment guarantee, education, health-care and many other sectors. Given the precarious condition of our public finance, a great debate is raging about the wisdom of allocations *vs* focusing on better delivery of services.

Let's take health-care. India's allocation for public health is indeed pitiful – 0.9% of GDP. Shamefully, our public health expenditure at 17% of total health expenditure is comparable to that of failed societies like Cambodia, Burma, Afghanistan and Georgia. Clearly, there is a case for greater allocations to prevent avoidable suffering.

However, more allocations do not always guarantee better outcomes. Bad policies, poor delivery systems and absence of accountability are playing havoc. The need is to focus on delivery and direct resources sensibly to ensure maximization of public good. Otherwise, more money leads to greater waste and corruption.

Recent events unfolding in Andhra Pradesh over the issue of childhood heart disease dramatically illustrated this. Hundreds of paediatric cardiac patients were paraded on the streets seeking surgical treatment, and one of them died in front of television cameras. The well-meaning media and activists are focusing on the human drama and pathos and pressurizing the government to make allocations. Hospitals are hard-put to cope with the patient-load. In all this, the real issues are ignored to the detriment of the poor. As a sage said, " God, I will deal with my enemies on my own; but save me from my friends!"

It would be worthwhile to examine the issues of public policy, delivery and accountability in relation to childhood heart disease and health-care. Sometimes deeper understanding of micro-issues can give us greater insights about the management of the economy and resource allocation than debates in ivory towers.

A few facts first. Congenital (CHD) and rheumatic heart diseases (RHD) are the two major forms of heart disease afflicting the young. On an average, eight children out of 1000 are born with CHD. And the commonest causes of CHD are fully preventable maternal infections during pregnancy, consanguineous marriages, and childbearing by women above 30 years of age. All these are completely avoidable – by MMR vaccination, marriage counseling, and public education on risks of marrying relatives and late childbearing. And yet, annually about 200,000 children are born with CHD in India. The case of RHD is even more pathetic. It is caused by a simple streptococcal sore throat, a common childhood infection, between the ages of 5 and 15. While sore throat is gone in a couple of days, the child may develop Rheumatic fever, resulting in RHD. Even most educated middle-class parents are unaware of this. RHD is fully preventable, and all it needs is immediate treatment of strepthroat in children with simple, relatively inexpensive, antibiotics. And yet, over 150,000 children get RHD every year. There are probably 5 to 10 million Indians suffering from CHD and RHD.

Now let us look at our health infrastructure and need for allocations to meet this challenge after the disease strikes children. In the entire country, a total of 42,000 heart surgeries take place. A typical surgery costs Rs 100,000. 90% of the surgeries are for coronary artery

disease, and not even 10% on CHD and RHD. If today's government is willing to make allocations to surgically treat all cases of CHD and RHD – it will have to allocate Rs 50,000 crores to just take care of the existing patients – and at the current rate it will take over a 1000 years! It would cost Rs 4000 crores to just take care of the 350,000 new patients who are added each year. Even after all that expense and effort, about half the patients cannot be helped much and the life span of the rest is prolonged for limited periods. And meanwhile human misery keeps mounting as more unborn, and young children are afflicted by these preventable diseases.

Clearly, misplaced compassion and political grandstanding are no substitutes to sensible policy when it comes to promoting human welfare. Poliomyelitis paralysed 500,000 children every year not too long ago. Polio vaccines have been invented by Salk, and later Sabin decades ago, and Salk was honoured by the Indian government with Nehru Award long ago. Yet millions of children fell prey to polio because of senseless public policies, and the misplaced compassion of the many activists to spend money on calipers for polio victims did not improve the situation. At last, the government and civil society got their act together, and over the past five years, through a remarkable campaign of public-private partnership, Polio has been almost eradicated. What we need is a similar campaign of mass immunization (MMR), public education (consanguineous marriages, late pregnancies and strepthroat), and immediate treatment of strepthroat in all children in 5 – 15 age group. Such a programme costs no more than Rs.100 crores per annum for the whole country. We should still help the unfortunate victims of CHD and RHD with available resources, but the priority is clearly to prevent millions from being victims tomorrow.

Next, we need the delivery system to spread health education, administer vaccines and early treatment. Mass media must be deployed on a grand scale in a creative manner to inform every family. And an army of million health volunteers needs to be raised at a low cost (about Rs. 600 crores per annum) to be the interface between the community and primary health centres, and they will address all the health needs, not merely heart disease. The remarkable results of the Comprehensive Rural Healthcare Project in Jamkhed (Maharashtra) pioneered by Dr Raj Arole covering a population of 500,000, and many other similar successful pilot efforts establish the efficacy of community health workers. Finally, we need these health workers to be owned by, and fully accountable to, the community. There are simple mechanisms to ensure such ownership and accountability.

One ailment – the childhood heart disease – thus offers invaluable lessons in management, allocations, delivery and accountability of our health sector. Academics and policy analysts need to climb down from their ivory towers, and internalise these lessons. We are lucky to live in an age when most problems have simple, effective, relatively low-cost, high-impact solutions. Very few of our problems are intractable. A bit of wisdom, sensible policies, well-directed and modest allocations, and effective delivery systems can accomplish a great deal to promote growth and human happiness.

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