Speaking for Myself

Do we care? India's public healthcare: A viewpoint from the bottom of the pyramid

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Do we care? India's health system is the title of a recent publication by a former secretary to the Ministry of Health and Family Welfare.[1] I have not read the book. The blurb says it is an 'insider's view' of healthcare in India and that it suggests 3 solutions to the problems of India's public health: (i) increase in health budget/spending; (ii) greater use of technology; and (iii) improved leadership and governance. I worked in India's healthcare system for 30 years but only at a lower level. I wish to put it across how we, who are low down in the hierarchy, view the problem.

The book cover notes declare that statistics speak louder than critics. I was in charge of a small hospital for *beedi* workers, under the Labour Welfare Organization (LWO) Bengaluru region, of the Ministry of Labour for some years. When I tried to compare the data on *beedi* workers from the hospital's register with various other departments that were concerned with the *beedi* industry, I found that:

i. *Beedi* companies never kept any list of workers because it was the contractors who were employing the workers, nor they had addresses of the contractors. Several contractors who were dead for more than 10 years were still issuing identity cards!
ii. The excise department, which collects the excise duty on tobacco, did not have the complete list of *beedi* companies in the area.
iii. The provident fund department, responsible for ensuring provident fund facilities for eligible *beedi* workers, did not have any data on *beedi* workers. As per my hospital register, hardly 2% of workers who were continuously on our registers for years had provident fund accounts.
iv. Our own LWO, which received applications from *beedi* workers' children for scholarships, compiled the number of applications but not the number of workers.

I was in charge of another hospital for mine workers under the same ministry earlier. The hospital and an administrative unit under the ministry located nearby were required to send a dozen reports; some of them (such as vehicle maintenance reports) identical for both, some monthly, and some quarterly—to the office of the welfare commissioner, which in turn sent them to the Ministry of Labour. While holding temporary charge of the administrative unit, a quarterly report was put up to me in the month of May. When asked for the reason for the delay, the clerk said they always sent the 'quarterly report' once in 4 months since the inception of the office 10 years earlier! No one even noticed for 10 years that only 3 reports were coming in a year instead of 4! Statistics do speak loudly but do not tell the whole truth.

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Lack of resources, trained personnel, technology and political will, and corruption are some of the ills of India's healthcare identified by experts. I shall restrict my comments to only a few points with which I was familiar while in service.

Lack of resources

Despite the complaint of low budget allocation,[1–3] much of the allocated budget is surrendered each year. Foreigners, who do not wear the 'Indian bureaucrat's goggles', have commented on the same point.[4] The reason is not far to seek. Although money is allocated, decision on spending is not delegated. Purchase of any modern equipment is to be approved at Delhi and approvals take years together to come. A proposal I made for the purchase of a haematology system for the hospital in Mysore received a reply nearly 1 year later asking whether the same work could not be done with a flame photometer which was lying unused somewhere in Orissa (now Odisha). A still more hilarious example was of a request I made for a new chair to replace a broken one in the mine workers' hospital. I was asked by a bureaucrat in the regional office at Bengaluru to find out where some chairs were transferred 10 years earlier from a defunct industrial workshop run by the attached office.

Even as we talk of meagre investment in health, the mine workers' hospital is now closed, the empty buildings vying for attention with the Hampi ruin nearby and the *beedi* workers' hospital and many of the dispensaries remain grossly underutilized.

Shortage of workforce

Raman Kumar has produced detailed district-wise data to show that even in Bihar, there are more applications from doctors for appointment in each district than available vacancies.[5] It is also worth examining how well the services of AYUSH doctors employed in the name of promoting indigenous medical systems are utilized. If they do not have enough work, they may be used in several other ways—preventive health work, immunization, for example. The students admitted to the government nursing schools may be asked to sign a bond for 3 years' government service after passing.

Use of technology

Technology does help but technology is only as good as the people who use it. Almost every clerk in the office of LWO Bengaluru had a computer. The office receives patient's disease statistics from nearly 40 dispensaries and 2 hospitals under it, spread over Kerala and Karnataka every month but never compiled the data. My observation of the data sent from the 2 hospitals I was in charge indicated that respiratory illnesses—especially chronic bronchitis—and fractures and dislocations are common illnesses

among iron ore workers, and diabetes and hypertension were the most common among *beedi* workers. Surprisingly, diabetes and hypertension were almost absent among mine workers.

Leadership and governance

I do not know whom the 'We' in the title of the book refers to. It is common to blame the politicians. But the 'We' should include the bureaucrats who actually run the ministries. The delusions of self-importance, control and power some of the bureaucrats have are to be seen to be believed. 'I have six doctors under my control' (words of a welfare administrator), 'Don't go to that section; they don't have any powers' (words of a section officer) and 'Don't quote any examples; I don't have the time' (words of an IAS officer) are some of the quotes I can give as examples of these attitudes. Health administration is team work. Doctors have to spell out what they need in simpler terms to bureaucrats. Bureaucrats have to translate the issues to the language of accounting and finances. It requires mutual respect and coordination, not competition for power.

The way forward

Space does not permit to spell out my concepts in detail. Briefly, the steps I propose are as follows:

1. Corruption is much less in Central health services than the state ones. Doctors, like any other employees, need promotional avenues, delegation of responsibilities and at least token recognition for the good work done. Although the present time-bound promotional system in Central health services cannot be reversed, it may be possible to convert at least a few posts into 'functional promotion' posts––with greater responsibilities and better incentives. Doctors need basic training in the establishment and accounts rules of the government. At least a few of them can be posted to each state as nodal officers to coordinate and monitor the implementation of various Central health schemes. They may be able to establish better rapport with the state health service officers than medical officers of WHO employed for polio eradication used to do.
2. Expand the network of existing LWO dispensaries, which are mostly in rural areas to deliver primary care to specified groups of people such as retired Central government employees who are away from the Central Government Health Services (CGHS) dispensaries, farm labourers and domestic workers. These dispensaries should concentrate on providing only the drugs in the National/WHO Essential Drug List to cut down the costs.
3. The contours of the universal health insurance scheme that is being implemented now are not clear but dispensaries under both these schemes can be used to scrutinize referrals to specialists as general practitioners do in the National Health Service (NHS) in the UK.[6]
4. Negotiate with private tertiary care hospitals and obtain much lower rates for hospitalization and various medico-surgical procedures. The increase in volume with the implementation of universal healthcare is likely to compensate the hospitals for lower rates.
5. Full privatization will not work well in a society such as ours where the awareness of consumers is low. Without an alternative for the public to fall back on, they will be exploited. There is enough evidence to show that in low- and middle-income countries, the private sector healthcare performs better when there is a strong public sector.[7]

Bureaucrats who run the ministries have to realize that the way to get more work done is by careful selection of personnel to key posts, delegation of adequate powers to them and recognition of good work done. There was news earlier of building an All India Institute of Medical Sciences (AIIMS) in each state. The original AIIMS reached where it is today because of careful selection of personnel and real autonomy. But do we care to learn from examples?

Conflicts of interest. None declared

REFERENCES

1 Sujatha Rao K. *Do we care? India's health system*. Delhi:Oxford University Press; 2017.
2 Patel V, Parikh R, Nandraj S, Balasubramaniam P, Narayan K, Paul VK, *et al*. Assuring health coverage for all in India. *Lancet* 2015;**386:**2422–35.
3 Debroy B, Kumar A. The road to universal health coverage in India. *Lancet* 2015; **386:**e56–7.
4 Berman P. India's health: More practical solutions needed. *Lancet* 2015;**386:**e58–9.
5 Kumar R. The leadership crisis of medical profession in India: Ongoing impact on the health system. *J Family Med Prim Care* 2015;**4:**159–61.
6 Reid TR. *The healing of America: A global quest for better, cheaper and fairer health care*. New York:Penguin Books; 2010.
7 Morgan R, Ensor T, Waters H. Performance of private sector health care: Implications for universal health coverage. *Lancet* 2016;**388:**606–12.