Chapter 6

Findings, Conclusions, Suggestions, and Recommendations

6.1 Findings and Conclusions
A. General Findings about the Respondents and their Accessibility of Health Services
B. Reasons for Availing the Services of Private Clinics or Charitable Hospitals during Prolonged Minor Illness
C. Reasons for Not Availing the Services of Government Hospitals during Prolonged Minor Illness
D. Reasons for Availing the Services of Government Hospitals during Major Illness and Feedback on their Services
E. Reasons for Not Availing 10% Quota for Economically Backward Classes in Private Hospitals during Major Illness
F. Expenditure Pattern of Urban Poor towards Healthcare Sector
G. Gender Disparities in Health Services Accessibility

6.2 Suggestions and Recommendations
A. Suggestions for Making Health Care Services Available to All
B. Suggestions for Making Health Care Services Accessible to All
C. Suggestions for Making Health Care Services Affordable for All
D. Administrative Reforms
E. Quality Initiatives in Health Sector
F. Human Resource Development Initiatives in Public Hospitals

6.3 Suggestions for Patients’ Benefits and Rights
6.1 Findings and Conclusions:

With private sector omnipresent across urban and rural India, it continues to be preferred compared to the public sector. In a study conducted in the city of Mumbai, reasons for preference of private sector facility included proximity, quality of care and convenient timing. The only factor that compelled poor population to access to public health services was ‘Affordability’. Secondary data analysis has indicated that the strength of the private sector includes accessibility and availability of medical care services compared to the public sector, which has for long focused only on affordability. Though, affordability is a critical factor, it is non-congruence with the other two parameters which influence health seeking behaviour. This has promulgated the growth of private sector.

A. General Findings about the Respondents and their Accessibility of Health Services:

(1) Frequency of Visit to Doctor or Hospitals: It was revealed in field survey that frequency of visit to the doctor/hospital was once in every 15 days in case of 14% of the respondents while 66% of them reported to visit a doctor/hospital at least once in a month. Thus, 80% of the respondents fell sick frequently. In slums open drains, lack of adequate sewerage, lack of civic amenities, unsafe drinking water and overall poor living conditions, combined with a high concentration of people are very common which lead to greater incidence of communicable diseases. These respondents living in slums held poor levels of hygiene, cleanliness and sanitation. Therefore they are prone to communicable diseases. It was observed that many of them survived on daily wages and therefore, it was not possible for them to afford good quality food. This was also one of the reasons for high incidence of health problems due to poor immunity among these people.

(2) Considerations for Selecting a Dispensary or Hospital for Treatment: The cost factor was found to be the most important factor in case of 99% respondents while selecting a doctor/hospital as most of them were daily wage earners. The second most important criterion rated by 70% of the respondents was the distance that they had to travel in order to access a doctor/hospital. As a result preference for private clinics or charitable dispensaries in vicinity was stronger over public hospitals for minor illnesses as they could be accessed without incurring any additional cost on commuting. In case of 41% of the respondents, time factor was the reason in choosing a dispensary or a hospital. They relied on the services of local doctors and private clinics due to convenient timings of these clinics and quick treatment. In the absence of basic amenities of life, quality of services becomes a least important factor while availing any service including health services. This is clearly reflected in the poor responses (26%) to quality of services while availing health services.
(3) **Tendency to Avoid Treatment on Falling Sick:** In case of 83% of the respondents there was a common tendency to avoid treatment on falling sick for several reasons, major among them being loss of subsistence. In case of minor illness like cold, flu, cough, fever, headache, etc., these respondents treated themselves by consuming some antibiotics prescribed by a local chemist or by following any home remedy and thus waited for 2-3 days for self-recovery. Since most of them were employed in unorganised sector and survived on daily wages, it was not possible for them to visit doctor during working hours and therefore many times they avoid visiting a doctor or hospital. Some of them also mentioned financial problems to be one of the reasons for delay in seeking medical treatment on time. Thus, urban slum dwellers delayed treatment of their illnesses mainly to avoid their absence of duty which may cause loss of pay for them.

(4) **Primary Source of Treatment on Falling Sick:** The field survey revealed that 15% of the respondents relied on home remedies, 27% of the respondents mainly relied on the medicines prescribed by the local chemist while 41% of the respondents consulted local quacks for treatment on falling sick. Thus 83% of the respondents preferred to treat minor sickness in conventional way, i.e. either through home remedy or by consuming medicines recommended by local chemist or local quacks. It was also noticed during the field survey that local doctors, who are not qualified allopath, are very popular among poor masses as their fees ranges between Rs.10 and Rs. 30 and they are located at the closer proximity. Only 17% of the respondents reported that they visited qualified doctors in private dispensaries or charitable dispensaries or government hospitals on falling sick. Thus, majority of poor population visit government hospital as a measure of last resort only when all these conventional treatments become ineffective.

### B. Reasons for Availing the Services of Private Clinics or Charitable Hospitals during Prolonged Minor Illness:

(1) **Source of Treatment during Prolonged Illness (Minor):** It was revealed in the field survey that 83% of the respondents approached a qualified doctor only on being ill for long period. In case of prolonged minor sickness, 11% of the respondents preferred a government hospital for treatment, 67% of them visited private clinics while 22% approached a charitable dispensary. Thus most of the respondents preferred availing treatment from private practitioners and charitable dispensaries over public hospitals for minor ailments. They attributed unavailability of medicines, distant location and inconvenient timings of government hospitals to be the main reasons for their preference over private clinics. Charitable dispensaries were found to be the most popular in the areas where their services were available.
(2) Reasons for Availing Services of Private Clinics during Prolonged Minor Illness: The major reasons for choosing private clinics are the convenient location being in the close proximity (78% of the respondents opined) and convenient service timings as they are open until late in evening (89% respondents opined) which makes it possible for them to approach these clinics after they return back from work in the evening. Some of the private dispensaries were reported to be open till late in night (up to as late as 12 o’clock). On the other hand, the OPD timings in many government hospitals are in the morning, generally from 9.00 am to 1.00 pm which is very inconvenient for the respondents as it falls during their duty hours. There were also complaints of doctors reporting late for their duties. Thus, easy accessibility and convenient timings were found to be the most important reasons for most of the slum dwellers preferring services of private and charitable clinics over government hospitals. According to 67% of the respondents private clinics were economical in comparison to government hospitals. According to them, the opportunity cost of accessing government hospitals in terms of money spent on commuting, buying outside medicines and loss of work day due to long waiting period in government hospitals is very high. All these factors make cost of accessing government hospitals very high for a common man. Private dispensaries in slum were reported to charge Rs. 30 to Rs. 40 for one time treatment with convenient timings and location. These dispensaries were found to be more popular among them as they could save their workday due to convenient timings and low cost of treatment which involved no transport cost.

(3) Average Time for Accessing the Services of Private Clinics during Minor Illness: All the respondents reported that waiting time at private clinics and charitable clinics is less than 1 hour as against an average of 2-3 hours in public hospital. It was also revealed that average waiting time at private clinics is not more than 15 minutes unless there is huge rush of patients. Most of them reported of getting services of doctor within 30 minutes. Respondents also reported that these doctors report on time and give advance notice in case of their absence. Again every locality has private clinic and therefore patients need not to waste time in travelling.

C. Reasons for Not Availing the Services of Government Hospitals during Prolonged Minor Illness:

(1) Awareness about Free Medical Services in Government Hospitals: Result of the field survey revealed that all 300 respondents had knowledge about the availability of free services in all government hospitals – state managed as well as municipality. In government hospitals, patients visiting out-patient department are required to pay a nominal charge of Rs. 10 for registration or a
case paper. All consultancy services and medicines are provided free of charge, subject to their availability. However, most of them complained that the nominal fee paid by them was the prescription charge as they were often asked to buy medicines from the private chemist due to unavailability of medicines in the public hospitals.

(2) Reasons for Not Availing Free Medical Services of the Government Hospitals during Prolonged Minor Illness: Though, the services in government hospitals are provided at a negligible cost of Rs. 10, most of the prospective beneficiaries refrain from availing these services due to poor accessibility to Government hospitals and long waiting hours. The field survey revealed that 77% of the respondents avoided public hospitals due to inconvenient location and lack of easy accessibility and 73% of them avoided these services due to long waiting period that caused loss of their subsistence wage. According to these respondents, time and cost wasted in commuting to these hospitals during rush hours and long queues in out-patient department of public hospitals result in long waiting time and loss of a day’s subsistence for these people. Therefore, many of them are reluctant to access these services. According to 48% of the respondents, the out-patient department in public hospitals operate during fixed hours, i.e. usually it is open from 10 am to 1 pm and in some hospitals in afternoon from 2 p.m. to 4 p.m., whereas private clinics open in the evening at 6.00 p.m. and operate till late in night. Thus, patients can avail services of these clinics conveniently after returning back home from their work. Thus, fixed and inconvenient timings of the government hospitals are also one of the reasons why prospective beneficiaries of free medical services of government hospitals are reluctant to actually use them. It was also reported that unavailability of adequate medicines and diagnostic facilities also compelled them to approach private and charitable hospitals. Field survey revealed that 41% of the respondents complained that it is costly to access government hospitals as they were very often referred to private agencies for many essential diagnostic facilities that are very expensive. They were also forced to buy medicines very often from the private chemist as they are not available in government hospitals. During all the three visits to the same public hospital in a year, researcher found that the in-patients complained of paying for X-ray services to the private diagnostic agencies due to unavailability of X-ray services in this hospital due to technical fault in the machines. This hospital reported to be having only two X-ray machines and that too in non-working condition during all the three visits in a year.

(3) High Commuting Cost as a Constraint in Accessing the Services of Government Hospitals: Accessibility/location plays a very important role in the utilisation of public health care facilities. Due to inconvenient locations and poor accessibility, patients have to explore alternative sources for availing
these facilities. Majority of the respondents (93%) have attributed high cost of commuting to one of the most important reasons for them preferring private and charitable clinics over public hospitals. According to them, due to lack of adequate number of primary public health care centres in their vicinity, they have to spend a huge amount on commuting in order to gain accessibility to public hospitals. Thus, they preferred the services of local doctors to save huge travelling expenses as well as to save their time in travelling long distances.

(4) Average Cost Spent on Commuting to Government Hospitals: It was revealed in the field survey that 8% of the respondents spend Rs. 20–Rs. 30 on transport to reach government hospital from the place of their residences, 22% spent between Rs. 30–Rs. 40 while 70% of them had to spend more than Rs. 40 on transport to reach government hospital. Uneven geographical distribution of primary health centres and public hospitals compels them to use the services if private doctors and hospitals. Thus, these respondents are deprived of free medical services provided by these centres due to high cost of commuting.

(5) Long waiting Time as a Constraint in Accessing the Services of Government Hospitals: Most of the respondents prefer to take medicine from local chemist or in case of prolonged illness prefer to visit a private clinic in the locality. It was revealed in the survey that 96% of the respondents have attributed long waiting time at government hospitals to be one of the major reasons for their preference for private hospital. According to these respondents, there is heavy rush of patients in out-patient departments of the government hospitals, resulting in long queues and waiting time. The situation becomes worse due to late reporting by doctors and sometimes due their absence on duty without any notice. As stated earlier, most of these slum dwellers do not have fixed source of income and they survive on daily wages. If they waste their time in waiting in government hospitals for long time, they are doubly suppressed. On one hand, they have to wait for long time in queue and on the other hand they lose their subsistence.

(6) Average Time Lost in Waiting in Government Hospitals: Each government hospital has a specific quota, after which they stop issuing case papers. Thus, patients have to report to hospital early in the morning to avail case paper. Due to this waiting time at government hospitals becomes exceptionally long. On an average a person is required to wait for 2-3 hours for getting treatment at government hospitals. Field survey report revealed that 40% of the respondents had to wait for more than 3 hours to get treatment for common problems like fever, cough and cold and like. Again, they have to report to hospital early in the morning to get themselves registered and avail case paper. In addition to that the time wasted in commuting from the place of residence to hospital and back to home may
take away one full day, not only of the patient but also of the one who accompanies him.

D. Reasons for Availing the Services of Government Hospitals during Major Illness and Feedback on their Services:

(1) **Source of Treatment during Major Illness:** While selecting a hospital for treating major illnesses, affordability criteria was the topmost priority of the patients. It was observed that urban slum dwellers (96%) generally preferred public hospitals for treating their major illnesses. According to them, though, private hospitals are equipped with advanced testing and evaluation instruments and also provided quality service, it was beyond their means to afford the huge bills of private hospital as the cost of availing services of private hospitals is many times higher than a public hospital (government hospitals have introduced user-charges for in-house patients). Thus, it can be concluded that though most of the urban slum dwellers preferred private clinics for out-patient care whereas Government hospitals were preferred by them for inpatient care due to financial constraints. Per day charges in the private hospitals was reported to be beyond their budget.

(2) **Accessing Government Hospitals during Major Illness:** It was found that majority of the respondents (93%) have got themselves or any of their family members admitted to a hospital for treatment of any major illness. Slums are characterised by open drains, lack of adequate sewerage, lack of civic facilities and overall poor living conditions, combined with a high concentration of people. All these conditions are likely to favour a greater incidence of communicable diseases in these areas. This is further ratified by 93% of the respondents reporting that either they themselves or someone in their acquaintances had undergone hospitalisation in government hospitals. This question was asked in order to seek their responses on quality of services in government hospitals.

(3) **Immediate Hospitalisation in Emergency in Government Hospitals:** Timely hospitalisation is necessary for saving a valuable life. While assessing the facilities and quality of services of government hospitals, it was also necessary to assess the promptness of government hospitals in providing these services. 62% of the respondents reported that they could avail immediate hospitalisation during emergency. However, they also reported that there is always a space crunch in these hospitals and many times they were made to adjust on extra beds adjusted on floors between two beds.

(4) **Feedback on Testing and Evaluation facilities in Government Hospitals:** Although 63% of the respondents reported that they could get hospitalisation on emergency basis in government hospitals, 72% of them reported that
government hospitals lacked adequate infrastructure and evaluation and testing facilities. It was reported that X-ray machines and ECG facilities are often out-of-order. Many advanced testing facilities are not available in these hospitals and therefore, poor patients have to shell out huge money on getting these tests done from private hospitals and clinics. When inquired reason for such breakdowns, the hospital staff reported that there is heavy pressure of patients on these machines and therefore, they are used round the clock. They also reported that most of these machines are purchased through government rate contracts who generally supply substandard machines and instruments and there is no maintenance contract for these machines. For efficient functioning, these machines need regular upkeeping and maintenance. Under these circumstances, they have to recommend their patients to private hospitals and clinics for testing and evaluation.

(5) Feedback on Standards of Cleanliness, Food, Sanitation and Hygiene in Government Hospitals: Most of the respondents (62%) found the standards of cleanliness, food, sanitation and hygiene in Government hospitals to be satisfactory but not at par with the hygiene and cleanliness standards maintained by private hospitals. While government hospitals are charitable institutions and in many cases refrain from adopting “scientific cleaning practices” as it comes at a price, the private set ups claim a handsome price for both treatment and the clean factors. But on the whole respondents were found to be satisfied with the standards of cleanliness and sanitation maintained by the government hospitals. However, the level of satisfaction rated by some middle class and semi-literate in-patients was poor. On the basis of their report researcher confirmed the fact that hospital wards were not clean up to the required standard. It was also observed that Bedspreads and pillow covers were not washed regularly. Medical equipments were used without sterilisation. There was no proper waste disposable system. It was also observed that the in-patients needed awareness and orientation to maintain cleanliness and hygiene in the hospital.

(6) Feedback on Services of Doctors in Government Hospitals: More than half the respondents (57%) who visited a Government hospital for treatment found the quality of services of doctors and their approach towards patients to be above average with 17% of the respondents rating it to be excellent and 40% rating it to be good. Field report shows that patients are generally satisfied with the quality of services of government doctors and in many cases people have complaints against other staff and absence of infrastructural facilities in hospitals. However, 15% of the respondents were dissatisfied with the services of doctors in Government hospitals. According to these respondents, accessibility of a doctor is a vital factor, especially in case of emergency. But, field survey revealed that doctors were not accessible during emergency.
(7) **Feedback on Services of Nurses and Administrative Staff in Government Hospitals:** Services of nurses and administrative staff in Government hospitals are found to be satisfactory by 70% of the respondents. However, as compared to the quality of doctors in government hospital, 22% of the respondents rated the quality of services of nurses and administrative staff to be poor. It was reported that the nurses and administrative staff in government hospitals behave arrogantly and are insensitive and unsympathetic to the needs of patients.

(8) **Feedback on Overall Services in Government Hospitals vis-a-vis Private and Charitable Hospitals:** Empirical evidences show that the failure of public sector is one of the prime reasons for growth of the private sector in India. In the present study, majority of the respondents (76%) have rated the services provided by public hospitals to be poor as compared to private and Trust run hospitals. The reasons for this are:

- Despite free of cost and subsidised treatment in government hospitals, long waiting time, long distance, inadequate infrastructure, irresponsible behaviour of staff (sometimes), comparatively poor standards of cleanliness and hygiene are some of the factors that contribute to the dissatisfaction of patients and preference for treatment in private hospitals.
- On the other hand, proximity to place of residence, quality of sanitation and hygiene, polite behaviour of staff, quick services and convenient timings collectively contribute to high level of satisfaction among people with the services of private hospitals and dispensaries.

Those respondents who rated services of the government hospitals to be better cited a reason that these hospitals handle critical cases in more responsible ways than private hospitals. In order to defend their point of view, they cited a number of cases of failure and mismanagement in private hospitals as well.

**E. Reasons for Not Availing 10% Quota for Economically Backward Classes in Private Hospitals during Major Illness:**

(1) **Awareness about 10% quota (either completely free or at concessional rate) for economically disadvantaged groups in private hospitals:** As per the Government policy, it is mandatory for each private hospital in the state to reserve 10% of total intake capacity for BPL families. However, most of the prospective beneficiaries (85%) lack awareness about such scheme. It was also observed during the field survey that some of the respondents who approached private hospitals during emergency for admission under this scheme were denied admission on the ground of non-availability of beds. The hospital administration reported that most of this quota is allotted to their own employees and their relatives as it becomes difficult for them to admit slum dwellers in their hospitals. Administrative staff and doctors in some private
hospitals revealed that they avoided admitting poor patients to maintain their standard. Admission of slum dwellers and BPL patients may spoil the image of their hospital and their standard.

(2) Availing Free Hospitalisation in Private Hospitals under the Quota Reserved for Economically Disadvantaged Groups: It was revealed that out of 46 respondents who were aware of the quota for economically backward groups in private hospitals, only 15% of the respondents reported of having availed the benefit of free hospitalisation in private hospitals under quota reserved for them. If we calculate the percentage of beneficiaries who availed benefit of free hospitalisation under quota reserved for economically backward people in private hospitals with reference to total respondent population, the actual beneficiaries are only 2% (7/300). The issue was probed in detail through personal interview and discussions to find out the reasons for poor accessibility to this ambitious scheme of the Government of Maharashtra. The following factors came to light why slum dwellers could not access quota reserved for economically backward groups in private hospitals:

- The main reason for this was the lack of adequate information and awareness among poor masses about such scheme. 85% of the respondents reported that they were not aware of such quota reserved for them in private hospital.
- The other reason that was cited for poor response to 10% quota for economically disadvantageous groups was that private hospitals were not keen on admitting slum dwellers in their hospitals. They try to avoid them in all possible ways and allot this quota to their own employees and their acquaintances.
- Some of them were found to be reluctant to use such quota as they said that it requires a number of documents and paperwork which many of them are not well versed with. Even poor masses refused to rely on such quota in private hospitals, especially when there is an emergency of hospitalisation.

F. Expenditure Pattern of Urban Poor towards Healthcare Sector:

(1) Average Monthly Family Spending on Medical Bills: It was revealed in the field survey that each family spent on an average 5-10% of their monthly income on availing routine medical treatment. The sample selected for the present study has an average income range of Rs. 5000-10000 per month. It was disclosed in the field survey that on an average at least one person per family is ill for an average period of 15 days during a month. Thus, significant amount of money is spent on the medical expenses.

(2) Entitlement for Medical Leave: A majority of respondents worked in unorganised sector and some of them were daily wage earners. Therefore, they
were not entitled to any sick leave or medical allowances. The same has been reflected in the responses of 94% of the respondents who reported of not getting any sick leave from their jobs. In India major proportion of labour is employed with unorganised sector which does not provide the facility of medical leave to the employees. For them leave from job means loss of subsistence for that particular day. Thus, many of them avoided treatment and were forced to work even thought they were sick.

(3) **Number of Man-days Lost Monthly due to Illness:** The field survey revealed that 22% of the respondents stayed at home (lose subsistence) for about 1-2 days in a month due to illness, 42% for 3-4 days, 25% for 4-5 days and 11% remained absent from their work for more than 5 days every month due to illness. The above data clearly indicates that the incidences of sickness are high among slum dwellers in urban areas and consequently the number of man-days lost is equally high. This loss cannot be viewed as a loss at the individual level but it is a national loss. Each man day loss due to sickness has its impact on productivity and ultimately on GDP.

(4) **Avoiding Treatment to Prevent Loss of Subsistence:** It was revealed in the survey that 67% of the respondents avoided treatment of their illness to prevent loss of subsistence. One of the crucial impacts of staying sick for any person working on daily wage basis is the wages he/she has to forego while being sick. Since, most of the respondents in this study were employed in day-to-day basis; the incidence of lost wages was quite high for such people. Therefore, 67% of the total respondents avoided treatment in order to prevent the loss of wages.

(5) **Awareness about Health Insurance and Those Having Health Insurance:** The responses of the respondents indicated that 74% of the respondents were not aware about medical insurance. Medical insurance is an essential requirement, at least for people living in urban areas due to high exposure to disease producing factors such as urbanisation, industrialisation, pollution, overcrowding, poor standards of health and hygiene, fast moving life, and like. Although medical insurance is a necessity in today’s fast moving urban life, none among the respondents who were interviewed for the present survey was medically insured. The penetration of health insurance in India has been low. It is estimated that only about 3% to 5% of Indians are covered by health insurance. In terms of the market share, the size of the commercial insurance is barely 1% of the total health spending in the country.

(6) **Awareness about the Rashtriya Swasthya Bima Yojana (RSBY) of the Government of India for BPL Families:** The Ministry of Labour and Employment, Government of India launched the Rashtriya Swasthya Bima Yojana to provide health insurance coverage for Below Poverty Line (BPL)
families. Beneficiaries under RSBY are entitled to hospitalisation coverage up to Rs. 30,000/- for most of the diseases that require hospitalisation. Coverage extends to five members of the family, which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding. In the survey, none of the respondents was aware of this scheme. Therefore, the Government should undertake a mass drive to inform and encourage BPL families to enrol for the scheme.

(7) **High Health Expenditure Pushing Poor into Debt Trap:** Major proportion of medical expenses is borne through Out-of-pocket spending in India both in case of out-patient or in-patient care. It was revealed in the field survey that people often borrowed money for financing expenses of prolonged sickness, especially when they are admitted to hospitals for treatment. According the field survey, 71% of the respondents have reported of borrowing money to finance medical expenses of themselves or of their family members. Though, most of the respondents preferred Government hospitals in case of major illnesses, but due to lack of required facilities, they are compelled to get various tests done from private clinics. In addition to that the cost of medicines is equally high. Also lack of regulations and standard protocols for health care lead to a wide range of irregularities like unnecessary prescriptions, procedures and diagnostic tests, unnecessary surgeries, cross practice and other forms of malpractice. All these have financial consequences for the user in terms of increased costs of healthcare. In the absence of adequate provision for healthcare, these poor masses have no other option but to borrow from private source or dispose of their assets or belongings. These borrowings lead to large scale indebtedness and further poverty of masses.

(8) **Incidences of Borrowing for Meeting Health Expenditure:** The field survey established that 6% of respondents had borrowed up to Rs. 5000 for meeting medical expenses of their family during last five years, 37% had borrowed Rs. 5000-10,000, 13% had borrowed Rs. 10,000-20,000 and 44% had borrowed above Rs. 20,000 during last five years for paying medical bills. It is a common notion that sickness involves expenditure that needs financing. Expenditures can range from insignificant amounts to very expensive ranges depending on the disease and kind of treatment sought. This suggests that the cost of hospitalisation as well as other medical expenses is quite high and which is beyond the limits of any average slum dweller who lives hand to mouth to meet these expenses. All the respondents have reported of borrowing money from non-banking sources with 53% of them borrowing from private moneylenders who are generally exploitative. Absence of formal employment make them 'non-bankable'. Thus in addition to subsidised health services, poor
also need easy access to credit on liberal terms at a concessional rate of interest as and when they need it for meeting medical expenses.

(9) Poor Government Expenditure on Health Sector – A Major Cause of Distress for Poor: It can be concluded from the study that high medical expenses are responsible for pushing poor population in a debt trap which is supported by 93% of the respondents. Health care is a matter of accessibility and more so of affordability. Spending in India’s health sector totals $32 billion, but only 15 percent of this comes from the government sector. The bulk of all money spent on medicine in India goes to private doctors and hospitals, which is encouraged by government policy. Barely 5 percent of Indians have insurance coverage, so the vast majority of this private medical expenditure is paid out-of-pocket.

(10) User-fee in Government Hospitals – A major Deterrent: Hospitals that receive subsidies from the Government are required to provide free of cost or subsidised treatment to those earning less than Rs. 50000 a year. In reality, free of cost treatment is rarely available to the patients who fall under this category. Field survey of some hospitals revealed that the patients had to comply with complex formalities such as to get Income certificates from the District collector, recommendations from the local MLAs or MPs which again involves cost and time. In many trust and private hospitals (10% quota for poor) this facility is already claimed by their own employees. Also, since 2001, public hospitals have introduced “user fees” to recover costs from all inpatients except those who can prove that they are below the poverty line. In addition to a fee for a case paper documenting a first visit, user charges are levied for all procedures, from X-rays to surgeries. While these charges are subsidized, they are a lot of money for the class of patients visiting public hospitals. E.G. Single X-ray costs Rs.30 in public hospitals that is unaffordable for a poor patient. User fees cover between 0.67 percent and 10.67 percent of the real costs of most procedures, dissuading many from seeking essential care.

G. Gender Disparities in Health Services Accessibility:

(1) Secondary Status of Women in Indian Society: Women from infant stage to their old age get an unfair deal in matters of health. They are conditioned through generations to place themselves last within the family itself; though they put in the most labour without any financial gain. As such their health concerns also get a very low priority. The sex-ratio in India speaks volumes about the importance given to women in this country. If a man and a woman have the same problem requiring expensive treatment, it is invariably the man who gets the first attention, often the only one to get the attention. It is not just the poor who for want of resources and with the inherent preference for a boy
are guilty of bias, even in well-do families parents tend to spend more on the health of the boys than the girls. It is the attitude which is responsible for ignoring the health of the women in India.

(2) **Poor Share of Women in Health Expenditure:** The National Sample Survey Organization (NSSO) data reveals that in the rural areas the money spent per illness episode for outpatient care was Rs. 151 and Rs. 137 respectively for male and female. The respective amounts for urban areas were Rs. 187 and Rs. 164. Gender variation is expenditure spent for in-patient care is also reported. In the survey, 20% of the male respondents and 63% of the female respondents reported that women are given secondary treatment in availing medical services.

**Cost-Benefit Analysis of Visit to Private Clinics and Government Hospitals during Minor Illness:**

(A) **Time Consumption in Accessing Private Clinics and Government Hospitals:**

Table No. 6.1

| Table Indicating Comparison of Time Required in Accessing Healthcare Services of Private Clinics and Government Hospitals in case of Minor Illness |
|:--:|:--:|:--:|:--:|
| Sr. No. | Average Time Taken to Access Healthcare Services in case of Minor Illness |
| | Private Clinic | Government Hospital |
| 1. Commuting* | 8 min. | 25 min. |
| 2. Waiting* | 12 min. | 90 min. |
| Total | 20 min. | 115 min. |

*Average time.

Source: Field data.

It is evident from the field survey that time factor has been the major cause for preference of private clinics/doctors over public hospitals/primary health centres. The time wasted in waiting in queue and commuting results into wage and workday loss for a patient as well as for a person who accompanies the patient. The above table indicates the comparison of average time taken to access healthcare services of private clinics and government hospitals. It can be seen in the above table that the average time spent by the respondents in private clinics is only 20 minutes while it is almost two hours (115 minutes) in the case of government hospitals. Thus, the time wasted in approaching for the services of government hospitals is around 6 times higher than that of the time taken to approach private hospitals. Commuting time to public hospital is three times higher than the private hospital. Thus, it is time consuming to access government hospitals for minor illness and this adds to the monetary loss of the patient and the family member who accompanies the patient to the hospital. Long waiting period also results in frustration and fatigue which also may prolong the recovery period of a patient. Further, long waiting time in a government hospital surrounded by a big crowd and unclean surroundings may further aggravate one’s illness.
(B) Cost Consideration in Accessing Private Clinics and Government Hospitals:

Table No. 6.2

Table Indicating Comparison of Cost Involved in Accessing Healthcare Services of Private Clinics and Government Hospitals in case of Minor Illness

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Average Cost Involved in Accessing Healthcare Services in case of Minor Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private Clinic</td>
</tr>
<tr>
<td>1.</td>
<td>Commuting*</td>
</tr>
<tr>
<td>2.</td>
<td>Doctor’s Fees*</td>
</tr>
<tr>
<td>3.</td>
<td>Opportunity Cost**</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

*Average cost.

**Opportunity cost is the cost of any activity measured in terms of the value of the next best alternative foregone. It is the loss of subsistence involved in accessing healthcare services.

Source: Field data.

The above table clearly indicates that the cost of accessing government hospital for minor illness is at least five times the cost involved in accessing private clinics in local areas. The field survey data shown in the above table reveals that average cost of commuting to government hospital is 25 times higher than the cost of commuting to private hospital. Similarly if one approaches the government hospital doctor’s fee is Zero and in private hospital it is 30 times higher as compared to public hospital. However, if we compare the opportunity cost of availing public health services, it is 125 times higher than the private health services. In short, if one avails the private health services, he/she may not lose or may lose lesser workdays or wages as compared to the services of public hospital. Visit to public hospital may increase the frequency of patient’s visit and further add to the commuting and opportunity cost because a patient suffers physical exertion while commuting to the public hospital and waiting for a longer period of time. As a result, he/she loses more workdays and wages as compared to his/her visit to private hospital.
6.2 Suggestions and Recommendations:

In India health has received low priority in the central and state budgets and it is one of the lowest in the world (i.e. less than 1.1% of GDP). The budgeting for the healthcare infrastructure is relatively much lower for the magnitude of population which is shooting up at the terrific pace. The crying need of the hour is to improve the health infrastructure to take stock of the local needs and to ensure adequate presence of healthcare manpower.

Need for Credible Public Health Infrastructure:

There are many reasons for advocating a large public sector in health.

1. It is less expensive than private health care.
2. It is often much more equitous, both geographically and socially.
3. It is an opportunity for rational drug use and use of standard treatment protocols.
4. It helps to keep the balance right between preventive, promotive and curative care.
5. It insulates the poor against market led promotion of drugs and diagnostics.
6. It allows the state an opportunity to face up to unfair markets for drugs, diagnostics and other health services.
7. It allows a greater possibility for convergent action, given the wide diversity of determinants of health – water, sanitation, women’s empowerment, education, nutrition, social and gender inequalities, cultural practices, etc.

It can be concluded from the responses of the respondents and their analysis that Availability, Accessibility and Affordability should be the three important pillar of any health policy.

1. Availability: Indian health policies had always been rural centric. Although, there has been greater influx of people from rural areas to urban areas and steady rise in urban population and consequently health problems, the Central Government has mainly concentrated on development of health care facilities in rural areas. Urban health care have been left at the mercy of the State Governments and Local Self Governments. Most of the health budget of these bodies is used for payment of huge salaries to the staff employed in these hospitals without much improvement in healthcare facilities. Total urban population has increased manifold during last two decades, but public health facilities are more or less same. Mumbai has four tertiary hospitals (which are also medical colleges), 76 general hospitals, 176 health posts and 235 dispensaries. Despite this infrastructure, primary health care facilities are not easily accessible to slum dwellers and other marginal sections of society. There is a need for stronger grassroots level healthcare infrastructure. In the absence of this, the financially weaker sections of society postpone seeking medical facilities until serious symptoms develop that hamper their ability to earn a
livelihood. Also, the institution of the general practitioner is slowly dwindling creating pressure points for the OPD facilities in hospitals.

(2) **Accessibility:** More often than not, health services fail those who need them most – the poor. Although Mumbai has a vast network of government hospitals, dispensaries and health posts, they are no adequate enough to serve huge population of the mega city. As per the statistics released by the health department of MCGM, about 21,200 out-patients are treated every day at MCGM hospitals. Being public institutions, they cannot refuse anyone. According to the data published by the Public Health Department, MCGM in 2008, a public hospital with an average of 500 beds receives a minimum of 1,500 patients. Thus, inadequacy of health care facilities is one of the reasons why many slum dwellers do not access government hospitals. The second reason is the distance they have to travel in order to access free or concessional services of the government hospitals. In metro like Mumbai, private transport is very costly (Rs. 11 for a minimum distance of 1.6 km in rickshaw and Rs. 16 for a minimum distance of 1.6 km in taxi). A patient has no option than to use private transport for travelling to and fro. Therefore, slum dwellers avoid treatment of minor illness in public hospitals as the cost of commuting to public hospitals comes to more than the fees charged by the private medical practitioners.

Most of the slum dwellers are daily wage earners and therefore, are compelled to work even if they are sick. They cannot afford to lose their daily subsistence for accessing the services of public hospitals as these hospitals operate only during specific hours. They visit private doctors who are available during morning time before they go to work or in the evening after they return back home. Some of the doctors in these localities were reported to work till mid-night. All these factors are responsible for poor accessibility of public health care services in urban areas like Mumbai.

It is suggested that most basically of all, services must exist in the places where poor people live. Many countries have already recognised that they need to expand health services in poor communities, for example, through outreach services. What is needed is a reallocation of resources to favour peripheral areas over urban ones and basic health care over tertiary care.

(3) **Affordability:** Health services must also be affordable. Poor people already pay a lot, both in terms of fees and for the indirect costs of health care, including unofficial ‘fees’ (corruption), transport, medicines and loss of income. There are many cases where free services do not benefit the poor people, for e.g., corruption results in free medicines being sold and doctors diverting patients to private practice.
The government has introduced user fee in government and hospitals. Although this fee is negligible in comparison to private dispensaries and hospitals, the cost of accessing the services of government hospitals is very high for the following reasons.

- Cost of travelling to and from residence to hospital and back.
- Opportunity cost of accessing free services of public hospitals in terms of loss of subsistence due to their operation during working hours.
- Opportunity cost of accessing free services of public hospitals in terms of loss of subsistence due to long waiting time at the public hospitals.

The utmost priority is the architectural correction in the basic healthcare delivery system to ensure efficient, affordable and accessible healthcare services to the poor population especially those residing in slums and particularly women and children. Against this background the researcher has made the following suggestions for achieving ‘3 As’ of health care system, viz., Availability, Accessibility and Affordability.

A. Suggestions for Making Health Care Services Available to All:

(1) **Redesigning the Structure of Public Health Services in Mumbai**: The structure of public health services in city like Mumbai is faulty. The structure of public health services should be redesigned keeping in mind the local population and their needs. Mumbai is a unique metropolitan not only in India but in the world, with huge population, expanding city limits and slums and slum population.

Considering the responses of the respondents and unique features of the city, the researcher proposes the following three-tier structure for public health services in the city of Mumbai:

- **Primary health centres** should deal with routine problems like fever, cold, cough, pain, infections, etc. One primary health centre for a population of 10000 people recommended. The total population of the city as per 2011 Census stood at 12478447 persons. Thus, total number of primary health centres required is approximately 1250. A person on falling sick must approach a primary health centre first for diagnosis and treatment.

- **Secondary health centres** should be specialized hospitals dealing with issues such as family welfare and child and maternal care, HIV/AIDS patients, TB patients, etc. One secondary health centre for a population of 50000 people recommended. Considering the total population of the city, the number of secondary health centres required is approximately 250. Secondary health centres should deal only with specific problems as specified above.

- **Tertiary health centres** should be multi-speciality hospitals dealing with critical cases only on the recommendations of the primary and secondary health centres. There are 70 big and small hospitals in Mumbai which are run by different government agencies such as MCGM, State Government, Railways, etc. The administration of these hospitals should be merged under a single administrative body to avoid duplications.
There should be uniformity in the basic structure and services such as sanitation, electricity, waiting room and laboratories. Equipment, transportation, laboratory facilities and medical supplies for urban health facilities need to be standardized, and their availability ensured.

(2) **Infrastructure at Different Tiers of Healthcare Structure for Mumbai City:**

The researcher recommends the following facilities at different tiers of health structure recommended for the city:

<table>
<thead>
<tr>
<th>Healthcare Tier</th>
<th>Operating Time</th>
<th>Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health centres:</td>
<td>(9.00 am to 3.00 pm and 4.00 pm to 10.00 pm)</td>
<td>2 doctors + 2 nurses + 2 helpers during each shifts</td>
</tr>
<tr>
<td>(Two Shifts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary health centres:</td>
<td>24 X 7</td>
<td>As required</td>
</tr>
<tr>
<td>Tertiary health centres:</td>
<td>24 X 7</td>
<td>As required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthcare Tier</th>
<th>Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health centres:</td>
<td>Facilities for diagnosis of common illness and adequate stock of medicines for the same</td>
</tr>
<tr>
<td>Secondary health centres:</td>
<td>Facilities for maternal health and child care and facilities for diagnosis and treatment of specific diseases such as TB, HIV, etc.</td>
</tr>
<tr>
<td>Tertiary health centres:</td>
<td>Facilities for treatment of all types of diseases and well-equipped operation theatre.</td>
</tr>
</tbody>
</table>

The government should enter into tie up with private pathologies and test centres to undertake routine to all types of high cost tests. The private sector should provide these tests to government clinics and hospitals at concessional rates as per certain pre-determined agreement. The government may charge negligible charges for these tests to above BPL families and provide these tests free of costs to BPL families.

(3) **Strengthening Primary Health Care Services:** Primary healthcare is considered to be the backbone of the healthcare system. Empirical studies have shown that health care services provided through primary healthcare infrastructure help maximise quality and coverage to all strata of society. However, in Mumbai, though we have a strong secondary and tertiary healthcare infrastructure, the primary healthcare facilities are inadequate. The immediate effect of this is that there is heavy burden on secondary and tertiary health care infrastructure and consequently the poor and the disadvantaged not being adequately provided for. Therefore, there is a strong and immediate need for strengthening primary health centres in the city of Mumbai.

In 2006, the MCGM managed 352 primary health centres of which 176 were health posts, 150 were dispensaries and 26 were maternity homes located within the slums.

(4) **Performance Guarantee and Maintenance Contract:** It was observed during the field survey that a number of medical equipments and facilities in public
hospitals, although very hi-tech, do not function well or are out-of-order due to poor maintenance. There are two reasons for it:

- Supply of poor quality equipments under government approved rate contracts.
- Poor maintenance of these equipments due to absence of maintenance contract.

The problem can be remedied by giving authority to individual health centres at each level to source their own requirements from private sources through open bidding. The tender notice must demand a minimum performance guarantee for these equipments and should also make maintenance contract with the suppliers.

(5) **Filling up Vacancies in the Government Hospitals:** The shortage of personnel – either because of under-staffing or because of rampant absenteeism among the support staff including nursing staff gravely affects the quality of services in the public hospitals. There are two reasons for this:

- Understaffing due to a number of posts in government hospitals lying vacant.
- Filling up vacant posts by appointing temporary staff, who do not won loyalty to their work.
- Widespread absenteeism at all levels from Class I to Class IV employees add to the problem of understaffing.

The problem can be remedied by:

- Decentralising appointments of staff at secondary and primary levels to tertiary level.
- Appointments for the tertiary tier to be made by the Mumbai Public Health Department (MPHD).
- Attendance in hospitals to be monitored centrally through bio-metrics and aligning salary calculation with entries in it.
- Setting a target of one month for fresh appointment as soon as a vacancy at any tier of the health services is created.
- Keeping a data base of job-seekers ready to fill up vacancy as and when it arises.

(6) **Partnership with the Non-government Organisations (NGOs):** The Non-governmental Organizations are critical to the government’s endeavours of ‘Health for All’. Such partnership has been a great success in establishing the rights of households to health care in certain rural areas. Under the Mother NGO programme of the Rural Health Mission, 215 MNGOs covering nearly 300 districts have been appointed. Their services are being utilised under the RCH-II programme.

- In the first stage, the Government of Maharashtra should make use of a number of NGOs who are doing yeomen’s service in the field of health care in slum areas for providing primary health services to slum dwellers. The
Government can provide these NGOs with subsidised premises, medicines, finance and trained staff for provisioning of primary health care in slum areas.

- In the second stage, NGOs can be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalised sections or in underserved areas and aspects, working together with community organizations and local government, and contributing to monitoring the right to health care and service guarantees from the public health institutions.

(7) **Not Only Encouragement but Popularizing and Making People to Use the Indian Medical Systems:** The country has a large stock of health manpower comprising of private practitioners in various systems, *for example*, Ayurveda, Unani, Homeopathy, Yoga, Naturopathy, etc. This resource has not so far been adequately utilised. In March 1995, the Department of Indian Systems of Medicine and Homoeopathy (ISM&H) was created and re-named as Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) in November, 2003 with a view to providing focused attention to development of Education and Research in Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy systems. However, the practical applications of these systems are limited. If these systems are popularized and people are rightly encouraged to use these systems for their benefits, the huge burden of patients on allopathic system of medicine will reduce considerably. Therefore, the government should make planned efforts to dovetail the functioning of the practitioners of these various systems and integrate their services, at the appropriate levels, within specified areas of responsibility and functioning, in the over-all health care delivery system, especially in regard to the preventive, primitive and public health objectives.

(8) **Prevention rather than Cure:** Most of the budget of the state government and local government is spent on providing curative services rather than preventive services. If the same budget is spent on preventive treatment then huge sum of money wasted in treating diseases can be saved. The hygiene and sanitation conditions in slums are very poor which causes a number of diseases such as cough, cold, common fever, malaria, tuberculosis, etc. among slum dwellers. Another major cause of illness is the poor nutrition which also reduces their immunity. Again, a number of slum dwellers avoid visiting doctors immediately on falling sick due to high fees, waste of time and loss of subsistence. This makes the condition of a patient worse. If these factors are taken care of, the number of patients in public hospitals can be reduced greatly. The researcher has made two suggestions in this regard:

- Improve sanitation and hygiene conditions in slums.
- Create awareness about various diseases.
- Provide immediate relief to patients on falling sick.
B. Suggestions for Making Health Care Services Accessible to All:

The Accessibility of health care services in Mumbai is mainly constrained by lack of adequate infrastructure, distant locations and fixed operating timings. The researcher has made the following suggestions for making health care services in the city of Mumbai accessible to all.

1. **Restructuring of Health Infrastructure on the Basis of Need rather than Existence:** In past few years, there has been tremendous change in the composition and distribution of population of the Mumbai city. However, the number and location of public health centres in the city have remained more or less same. Population in some areas has reduced (South Mumbai), while in some other areas it has increased (North Mumbai), similarly slums have readied in some areas while in some other areas number of slum dwellers has increased. Considering this, there is an urgent need for revamping and relocation of the public health care infrastructure in the city as per the plan discussed in the point A-1.

2. **Looking beyond Notified Slums to find Urban Poor:** It has been observed that the local bodies and state governments only focus on notified slums in urban areas while framing health care policies for poor population. It is suggested that a proper approach needs to be adopted to develop city level urban health plans which are responsive to the urban context. Comprehensive planning is critical to ensure that unlisted and invisible urban poor clusters or slums (which are also the neediest) are reached. The official slum lists should be updated regularly to include all slum dwellers, notified as well as non-notified, irrespective of their origin and background. Public health service administrators need to be sensitized that legality/notification related issues do not come in the way of reaching out to a family or cluster with basic health services as mandated in the Indian Constitution. Since, urban poor populations are highly mobile and diverse, an in-built flexibility will enable urban health services ensure that such population are included.

3. **Health for ‘All’ at the Doorstep of Needy of Population:** Among the three tiers of health care system, the primary health care centres should be located as close as possible to the needy population. The government should provide health services to people without any discrimination of race, religion, region of origin, caste and community. It was revealed in the field survey that most of the population do not access public clinics and hospitals due to their distant locations. The cost of travelling to such places is much higher than the one-time fees charged by local doctors. Therefore, most slum dwellers avoid accessing the services of public hospitals and clinics during minor illness. Therefore, the primary health services should be provided to people in the periphery of 2-3 km of distance and where it is not possible to provide such services, 24X7 mobile health services will greatly reduce dependence of poor population on private clinics.
(4) **Mobile Health Vans:** Inaccessibility due to geographical constraints is not an issue in the city like Mumbai which is well connected with all types of transportation facilities. However, mobile health vans, equipped with the basic diagnosis facilities and a doctor and a nurse, can go a long way in reducing the predicament of poor people. The concept of doctor-on-call can certainly help people to access public health facilities as and when required. Each secondary health centre should maintain at least one mobile health van while tertiary health centre should maintain at least two mobile health vans. There is no need to appoint additional staff for these vans. The doctor on duty should immediately attend the patient in the geographical territory allotted to the mobile van. There should be a centralised arrangement for receiving calls and informing the health van in the vicinity to attend to a patient.

(5) **Point of Care Testing Facilities (POCT):** Point-of-care testing (POCT) is defined as medical testing at or near the site of patient care. The main objective of POCT is to conduct the test conveniently and immediately for the patient. There are a number of POCT instruments which are transportable, portable, and handheld instruments. These instruments give immediate results, are convenient and cost-effective and do not require much maintenance. POCT instruments are available for some of the common tests such as blood glucose testing, blood gas and electrolytes analysis, rapid coagulation testing, rapid cardiac markers diagnostics, drugs of abuse screening, and so on. Some of the common POCT devices are blood glucose meter, nerve conduction study device and test kits such as CRP, HBA1C, Homocystein and HIV salivary assay. Use of such devices can reduce expenses on testing and evaluation facilities and can also help in quick diagnosis of diseases.

C. **Suggestions for Making Health Care Services Affordable for All:**

The Affordability of health care services not only in the city of Mumbai but in most of the metropolitan cities is a major issue. The researcher has made the following suggestions for making health care services affordable for masses in the urban cities like Mumbai:

(1) **Health Cess and Tax Incentives for Investments and Contributions to Public Health:** The Government should consider levying Health Cess in the budget in order to meet public expenditure on health sector. The Government should also provide tax rebate and tax incentives to individuals and corporate for making investments and contributions to the public health sector. This will give boost to investment in public health sector.

(2) **Affordability of Healthcare Service during Minor Illness:** The fees of private medical practitioners in the city of Mumbai vary from Rs. 30 to Rs. 150 per visit for one time prescription. A patient is required to visit a minimum of 2-3 times to a doctor for complete cure from common problems like common cold, cough,
fever, aches and pains, etc. Thus, on an average if one person falls ill, he or she has to spend a minimum of Rs. 300 for treatment. If on an average each person in a family of 4 members fall sick once in a month, the total family bill comes to Rs. 1200, which is considerably high for middle and lower income groups.

To solve this problem, the government should ensure that people access Primary Health Centres of the government. For this,:

- Primary Health centres should be located as close to the people as possible as suggested in A-1.
- Primary Health centres should provide free and quality services to people from 9.00 am to 10.00 pm.

The problem of affordability of health services during minor illness can automatically be solved by providing free and quality services in primary health centres in vicinity of people.

(3) Affordability of Healthcare Service during Major Illness: Medical expense during major illness is a major factor that pushes many families into debt trap and poverty. The cost of hospitalisation and subsequent follow up is huge. Middle class and lower middle class families cannot afford to get in-patient services of private hospitals and therefore, most of them depend on public sector hospitals for treatment. Some have to borrow money in order to meet hospitalisation expenses. The government hospitals have failed to cater to the increasing pressure of patients due to the problem of understaffing and limited infrastructure. On the other hand, some private hospitals and clinics have excess capacity. This dichotomy in health care services in the city of Mumbai can be resolved through effective public-private partnership. There a number of other means of providing in-patient services to the needy population. Some of them are health insurance, information helpline, tie-up with charitable hospitals and charitable institutions, etc.

(4) Financing of Mumbai Public Health Department (MPHD): The activities of MPHID should be financed by different government agencies in proportion to the number of beds in each hospitals owned by them. Deficiencies, if any, can be met through user charges which should be charged on the basis of paying capacity. BPL families should be provided all facilities free of charge. The burden of subsidies given to BPL families should be borne by the Central government and the respective state governments in certain pre-determined ratio. The Central government should levy health cess, on the lines of education cess, to meet increasing demand for development of health infrastructure of international repute. Measures should be taken to increase state funding and revenue potential of Urban Local Bodies (ULBs) and to provide cross subsidisation and regulation of the private sector. There must be an attempt to ensure prompt release of funds as well as delegation of monetary powers. Cashless insurance service should be provided by all accredited private/public hospitals.
Involvement of Individuals, Charitable Trusts, Professional Bodies and Corporates: In a huge country like India with a creditable high income and middle income groups who consider charity for social cause a religious duty, the government can certainly look up to them to fill up financial gaps in the health sector. Rich philanthropists, individual donations, donations from corporate and professional bodies may be the crucial requirement in areas to make the PPP initiative effective in delivering health care.

- Social clubs like Rotary Club and Lion’s Club have played a significant role in immunization campaigns, Pulse Polio campaign and other health care services. Since these clubs have a nationwide network, their involvement ensures better coverage. They also bring in their expertise and resources to the health care services.
- Under the CSR initiatives, the corporate sector has taken active part in advocacy efforts, funding NGOs for innovative interventions, introducing new schemes for the promotion of reproductive and child health services particularly family planning services for population in and around their locations.
- A number of professional associations such as Indian Medical Association, Gynaecologists federation, nurses associations etc. have played a significant role in promoting new programmes such as Vande Mataram Scheme, Gaon Chalo project and immunization programme particularly pulse polio.

Though in some states mechanisms and provisions are present for utilizing these private donations for improving local health situation, many other states lack these systems. Efforts have to be made to create simple and transparent institutional mechanisms to encourage donations to contribute to the growth and improvement in reproductive and child health services in their area.

Filling Information Gap through Medical Helpline: A number of provisions such as quota in private hospitals, free facilities in charitable hospitals, medical aid given by charitable institutions, etc. are not known to poor population. This information gap should be filled by creating a 24 X 7 helpline for providing information like, availability of beds in hospitals, facilities in different government hospitals, availability of quota for BPL families in private hospitals, details of charitable hospitals and their services and medical aid provided by various private trusts, religious trust and corporates. This information will go a long way in reducing the financial burden and predicaments of poor and needy population.

Health Insurance for BPL Families: The Ministry of Labour and Employment, Government of India has launched the Rashtriya Swasthya Bima Yojana (RSBY) on 1st April 2008 to provide health insurance coverage for Below Poverty Line (BPL) families. Beneficiaries under RSBY are entitled to hospitalisation coverage...
up to Rs. 30,000/- for most of the diseases that require hospitalisation. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding. As per the data published by the Department of Labour, Government of Maharashtra, as on 29th February 2012, total 27,987,800 smart cards were issued and 3,251,995 cases of hospitalisation were reported under the said scheme. However, the awareness among people about the scheme is very low. In the survey, none of the respondents was aware of this scheme. Therefore, the Government should undertake a mass drive to inform and encourage BPL families to enrol for the scheme.

(8) **Universal Health Insurance Scheme:** The Planning Commission has accorded a top priority to healthcare sector is the twelfth Five Year plan (2012-2017). In the 2012-2017 Plan, the Indian government aims to increase the spending on the healthcare from current 1% of the GDP to 2.5% of the GDP. This is paving the way for recognition of the “Right to Health” as a fundamental right. The Government should extend the Rashtriya Swasthya Bima Yojana (RSBY) to all individuals in the economy in order to make it more inclusive and recognise the basic right of people to good health. In order to achieve this, the government should lay down different layers of premium for different categories of beneficiaries based on their paying capacity. For example, the BPL families may be provided health insurance free of cost while the individuals in middle income groups and higher income groups can be charged higher rate of premium. All individuals registered under the scheme should be issued smart cards which should be valid in all government as well as private hospitals.

**D. Administrative Reforms:**

(1) **Demarcation of the Fields of Services of Primary, Secondary and Tertiary Health Care Infrastructure:** The public health facilities have a fairly extensive infrastructure from the primary to the tertiary levels in Mumbai.

- At the primary level there are 176 health posts, 150 dispensaries and 26 maternity homes located within the slums.
- Secondary level includes peripheral hospitals that offer delivery services, and other specialised treatments.
- The final tertiary level comprises of services of the medical colleges and hospitals which not only offer specialised services but also super specialty services.

Among these, the tertiary level health care system has more pressure both in terms of in-patient as well as out-patient services. What needs to be done is that the services of these levels should be clearly demarcated so as to avoid too much pressure on one level and too less on the other. It is recommended that there
should be extensive functional network of Primary Health Care Centres which should only look after routine problems like fever, cough, cold, body pain and like. The secondary level centres should provide only specialized services like delivery services, child care, etc. and the tertiary level hospitals should deal with only major and complicated health problems such as heart diseases, renal failure, etc.

(2) **Establishment of a Mumbai Public Health Department (MPHD):** An independent department dealing exclusively with public health in Mumbai city should be established to take over the administration all government hospitals, hitherto looked after by different agencies like municipality, state governments, railways, etc. However, the ownership of these hospitals should be vested with their owning bodies. This will bring about greater efficiency and transparency in the functioning of public clinics and hospitals. It will also avoid duplication of work and functions. The functions of such department would be to frame policies and programmes for efficient functioning of primary, secondary and tertiary health centres in Mumbai.

(3) **Building Co-ordination among Public and Private Urban Health Stakeholders:** There are multiple urban health stakeholders including Health and Family Welfare Department, ICDS, ULBs, DUDA, NGOs, CBOs, donor agencies, professional bodies (IMA, IAP), formal and informal private practitioners, corporate sector, charitable organizations, employee state insurance and local resources such as schools. These stakeholders operate in isolation with little coordination. They can benefit greatly by sharing resources, information and expertise and avoiding duplication of efforts. This co-ordination can be brought about by the Mumbai Public Health department (MPHD) by creating a data base of various stakeholders and securing their active participation in policy formulation and jointly evolving plans for their implementation without duplication and wastage of resources.

**E. Quality Initiatives in Health Sector:**

(1) **Establishment of a Healthcare Assessment Cell within the Mumbai Public Health Department (MPHD):** A Healthcare Assessment Cell should be established within the Mumbai Public Health Department for continuous evaluation and assessment of public healthcare system in the city of Mumbai. Some of the basic functions of the Cell are:

- Continuous assessment of the supply of the requisite health care services in the city in relation to the demand for the same.
- Locating deficiencies in the public health services in the city and making recommendations to the MPHD for meeting those deficiencies.
- Registering the complaints of the people and assessing the quality of public health care services.
• Making recommendations for improvement in the public health services through public-private partnership.
• Supervising the public health care service at all three levels – primary, secondary and tertiary levels.

(2) Improving the Quality of Health Services in Public Hospitals: As well as being accessible and affordable, health services must be of decent quality. This means not only offering a good standard of care, but also reducing waiting times, making medicines available and treating patients with respect. In order to improve the reach and quality of health services, there is a need to:
• To provide motivational training to health providers (ANMs, MOs, Supervisors) to be more sensitive towards the disadvantaged.
• To coordinate effectively with slum based community health volunteers and with slum level CBOs;
• To develop a delivery system that is responsive to the needs of slum dwellers and facilitates them to avail services;
• To regularize outreach services in slums;
• To provide health card to every urban child to ensure basic health services.

(3) Adopting International Standards in Health Sector: With increasing internationalisation and integration of the Indian economy with the global world, the Indian planners should also work on integrating Indian health sector with international standards such as number of hospitals beds per 1000 population or number of doctors/nurses per 1000 population to measure the level of healthcare infrastructure/services in a particular region or country as a whole.

India should not only accept norms such as 4 hospital beds per 1000 population or 2 doctors per 1000 population as minimum targets, but should also focus beyond on how to achieve these benchmarks. The modus operandi of this should be worked out by a committee consisting of the representatives from the Central, States and the Local Government. The move towards international standards in health sector should be closely monitored through effective regulation and accreditation system, which should be voluntary for private hospitals and mandatory for public hospitals.

(4) Compulsory Accreditation of Public and Private Hospitals: The MPHD should create an independent agency for accreditation of private and public sector hospitals in the city of Mumbai. Typically, accreditation systems are structured to provide an objective measurement of quality of infrastructure, focusing more on patient care and access to healthcare. Such accreditation processes are essential to ensure quality of system and become important when a city such as Mumbai wants to meet international benchmarks.

Accreditation will make both the private and public hospitals more responsible and transparent in their operations and approach. While grading private hospitals
more weightage should be given to their contribution to society in terms of provision of health care for poor segment and special categories such as backward classes, minorities, women and children and clinical research and observance of ethical standards. Accreditation of public hospitals should be based on their effectiveness in dealing with health problems of poor population, standards of cleanliness, attendance in government hospitals, maintenance of equipments and testing facilities, filling up of posts in the government hospitals, number of patients’ complaints and their resolution, etc. These steps will go a long way in improving health care standards in the government hospitals.

(5) **Health Sector Data Base and Management Information System:** An Information Cell should be set up under the auspice of MPHDI for collection of data and information about health sector in Mumbai City. Some of the suggested functions of the Cell are:

- The Cell should undertake mapping of the city to locate vulnerable population.
- It should detail the existing health facilities and identify gaps between the demand for and supply of health care facilities in the city.
- It should also collect data about proliferation of various diseases and existing facilities to treat these diseases.
- It should undertake a social assessment in notified and non-notified slums to assess health status, needs, utilisation behaviours and vulnerability.
- It should also collect data on aggregated health indicators by type of city, type of slum and subgroups of the population.
- The Cell should liberally finance research endeavours on urban health sector by private agencies and academicians.

F. **Human Resource Development Initiatives in Public Hospitals**:

(1) **Improving Staff Attitude and Approach towards Poor and Neglected Class:** Along with quality of services, it is also important to improve staff attitudes towards poor people and their treatment. *For example,* by promoting listening skills, instilling in staff the idea that poor people have a right to health care and to be treated with dignity. The hospitals authorities should install a system to monitor staff behaviour and channels through which poor people can complain and get feedback. Implementation of all these strategies must take into account the specific and special needs of women, in particular, and sub-groups of the poor such as indigenous people. Indigenous people are typically discriminated against by health staff, who may not understand their culture or even their language. Women may be reluctant to seek care from male doctors.

Equally, strategies to improve health services are much more likely to be successful if poor people are involved. Processes to decentralize the management of health services – underway in many countries – provide an excellent opportunity for this. Policies such as co-management and community-based
monitoring of health services can greatly improve their effectiveness, as well as their responsiveness to poor people’s needs.

(2) **Incentives for Working in Slum Areas:** Most of the doctors and nurses avoid working in slums under unhygienic and poor sanitation and environmental conditions. This is a problem often neglected by health policy. Therefore, the health policy must make provisions for imparting periodic sensitivity training for the staff in public hospitals in order to sensitise them towards the health needs of slum dwellers. Mere training will not suffice; they should also be given special allowances and incentives for working in slums. Continuous efforts should be made to improve staff capabilities and working conditions in the public hospitals. Co-management of health services with local communities can also provide incentives to shift the behaviour of health care providers.

**6.3 Suggestions for Patients’ Benefits and Rights:**

(1) Community participation by involving students, senior citizens, retired medical practitioners and retired nurses to control and manage the provisioning of healthcare services in urban slums and rural areas will be an effective solution in creating awareness. This will also reduce neglect of treatment by the poor due to lack of awareness or ignorance about health.

(2) The role of media through programmes on ‘Right to Healthcare’ in regional languages in the form of documentary films, advertisements, etc. will be effective in creating awareness among poor. Programmes on healthcare and information about healthcare services will enable better utilization of healthcare services by poor and underprivileged class of society.

(3) Poor living conditions coupled with poor sanitation and poor hygienic conditions breed communicable and non-communicable diseases resulting in high infant, child and maternal mortality rates. The general cleanliness drive both in slums and rural areas through community participation should be promoted.

(4) Researcher found an absence of adequate toilet facilities and general cleanliness in the municipal hospitals. There is also absence of waste disposable system even in reputed municipal hospitals. It is suggested that cleaning jobs should be assigned to private agencies. An action plan for planning and implementing various programmes related to health, hygiene, nutrition, sanitation, drinking water etc. should be drawn.

(5) The shortage of medical equipment and non-functioning due to poor maintenance also needs to be addressed. None of the hospitals surveyed had adequate number of X-ray machines, ECG, Oxygen cylinders, sterilizers, urine test kits, pathological test kits etc. It was observed that even for routine tests, the patients in these hospitals were sent to private testing centres. Hence it is essential to identify the various requirements at each level on
priority basis. It is also suggested that each public hospital should set up maintenance and repair department to ensure the availability of diagnostic services available without any disruption.

(6) The non-availability of medicine and materials at the public health centers is forcing patients to spend money on medicines, bandages, injection syringes, vaccination, vitamin tablet etc. This is leading to high out of pocket expenditures defeating the objective of providing accessible healthcare services to vulnerable sections of the population and pushing the households below the poverty line. The Government should look into the matter and ensure regular and adequate supply of medicines and monitor the same. Third Party machinery appointed by the government for stock maintenance can also be effective solution to this problem.

(7) Hospital officials also reported that the funds received by the government hospitals are insufficient as significant amount of money is spent on telephone and electricity bills, maintenance and purchase of facilities, maintenance of hospital premises etc. Hence, there is a need to restructure the budgetary allocations. It is also necessary to monitor the proportion of fund utilized under different heads.

(8) Hospital officials also revealed shortage and absenteeism of doctors, nurses and technicians that affects the delivery of health services in government hospitals is causing long waiting period resulting in overcrowd and dissatisfaction among service users.

(9) The Right to Information is an important tool in the hands of public to ensure quality services in government hospitals. The public at large can demand information on issues such as dearth of staff in hospitals, poor quality of services, unclean and unhygienic environment in public hospitals and sometimes irresponsible behavior of some doctors and nurses, under the Right to Information Act and popularize such information through media coverage. This will go a long way in creating awareness in the society about their Right to Health.

(10) Media has been raising the issue of ‘Right of Public to Health’ since long. The Government had set a goal of ‘Health for All’ by 2000. Although, the Government has taken some piece-meal steps in this direction and some progress has definitely been made, a concrete move with a will to make ‘Health – a Right’ is missing. Media should make collective efforts to put forth the voice of people to bureaucrats and politicians to make Health a fundamental right.

(11) There are a number of NGOs in India working in the field of public health. These NGOs should put collective pressure on the government to take positive steps in ensuring Health for All.

Deficit in health and education services are most pronounced in India. Building strong civil society is essential to encourage better governance and greater
attention to the needs of under privileged population. Due to lack of awareness among poor about their right to health, people appear to be satisfied with the existing facilities. During elections their demands are limited to free food grains, jobs, water supply, electricity etc. Education and healthcare are not in the list of their basic needs. Healthcare like water is also a survival good. Awareness programmes on Right to Health will enable the poor to make collective claims for healthcare and this will improve the utilization and availability of healthcare. As a result government in the democratic set up can be punished or rewarded by the people through elections for its failure and success in addressing these problems.