

## On Contemporary Issues in Indian Health Sector

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### Abstract

This paper dwells upon a few contemporary issues in India's healthcare sector, pointing out some weak links which call for strengthening them. There are public sector health providers and so also private sector players. One could also see a few Public-Private Partnership (PPP) models which are relatively of recent origin. The issues are categorized as anomalies, policies and actions, data base of patients, innovative ideas and new developments. Yashaswini-the Government of Karnataka scheme is mentioned as an illustration. The paper ends with summary of discussion as pointers to further research.

**Key Words & Phrases:** *Big data; database; E-pharma; Healthcare; Innovation; Quality regulator.*

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### The Study: A Brief

No one denies that quality healthcare must be provided at affordable cost. But when it comes to practice, both these aspects suffer. This is particularly so in the Indian set up. The ethical issues are often overlooked and sidelined. In India, healthcare is provided by public and private healthcare providers separately and sometimes in conjunction (PPP models). The present paper focuses on the Indian health sector and dwells at length upon the noted anomalies, policy changes and actions needed, database of patients as a multipurpose tool, innovative changes and some new developments. The Yeshaswini scheme of Karnataka Government is outlined as a PPP model. Some relevant discussion is provided at the end.

### 2. Anomalies in Indian Health Sector

A few existing anomalies in the Indian health sector are pointed out below.

#### 2.1 *Highest Inequality in Access to Health Services*

The gulf between the well-placed and the deprived seems to be the highest when it comes to access to health facilities. In fact a recent study in Bengaluru City (July 2015) which covered 468 households from 25 city wards (Total population 16.84 lakhs) and was conducted by The Centre for Infrastructure and Urban Planning found that most inequality was seen in matters related to health.

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Economists consider 30% inequality as normal in society and are seen in perceptions related to economy. But in the area of health this is more than 50%. Thus there is a need to develop proper healthcare system which can be ideally met by PPP (Public-Private Partnership) models. An example provided by the Yeshasvini Scheme of the Karnataka Government. The respondents from all wards preferred PPP - type governance where Government intervention is needed to regulate and monitor private institutions.

## **2.2 Need for Fair Insurance Policy for the Elders**

The elderly are denied affordable health insurance policies (in India), when it is they who need it the most. It is ironic that most health insurance in India is offered to younger people who, very often, will not need it in their working years. The elderly are generally not provided just because they are more likely to make claims. How such profit-motive serve society if something so vital does is denied to those who are at risk of being hospitalized or needing care? The best solution would be to bring many more people compulsorily into the ambit of health insurance and pay small premiums during their entire working lives! And how, would this benefit the young? We should remember it is only a matter of time before they too will grow old. Insurance works on the basic principle that the insured pays not just for self, but for all other members in the system that is insured.

## **2.3 Geriatric Healthcare Only in its Infancy**

India lacks trained medical professionals to provide geriatric care to its elders. The problem is particularly acute in Karnataka State. For example, as of now, it has no colleges that offer courses in geriatrics either at the undergraduate or post graduate levels. The only course available is a Post Graduate Diploma in Geriatric Medicine offered by Indira Gandhi National Open University. As a result, senior citizens have no access to specialized care in hospitals, except by psychiatrists, general physicians, who attend to geriatric patients too and may then refer them to specialist doctors. Affordability is the greatest worry as almost all the available professionals are scattered in corporate hospitals.

Acknowledging this aspect, the theme of International Day of Older Persons (Oct. 01) is sustainability and age

inclusiveness in the urban environment. The population of senior citizens in India has gone up from 57 million in 1991 to 90 million in 2011 and is projected to touch 340 million by the year 2050.

## **2.4 Family Doctors: A Dying Breed**

The good-old clan of family physicians is gradually becoming extinct, which is a worry some trend. There are several instances of such cases. The family doctors are forced to shut their doors either because of stiff competition from multi specialty hospitals or because they graduate into specialists. The federation of Family Physicians' Association of India (FFPAI) is understandably worried. It has decided to take this as a challenge to make the general practitioners' post attractive. The idea is to ensure that family doctors who would have started practice after MBBS degree are abreast of the latest medical knowledge.

A robust advertisement campaign by the hospitals and increased dependability of the people on the internet has made the hospitals popular. Going through a family physician is advantageous as he/she knows the entire health history of the patient. This is critically important as it is the basis for further treatment. Cost-wise too this system is economical. Also if a person has multiple ailments and if he sees multiple specialists, the treatment will only be compartmentalized. It is helpful if a family doctor does the overall examination and refers him/her to a specialist. The general practitioner is the first point of contact in developed countries. This is generally perceived as a more efficient and wholesome system.

## **2.5 Poor Cancer Patients rely on Inexpensive Medicines, Risk of Relapse**

Breakthroughs in cancer drugs have done little for poor patients diagnosed with cancer: A recent study (2011-13) that they still use the drugs available at cheaper rates and risk a relapse. This is the finding of the Bengaluru based study on breast cancer patients. It focused on the effects of economic disparity in treating cancer. This pioneering study quantifies the effect of inadequate financial resources on the outcome of cancer treatment.

## **3. Policies and Actions**

Some relevant points having policy implications and calling for action are elaborated next.

### 3.1 Improved Maternal Care, Need of the Hour

In 1990, the United Nations created eight Millennium Development Goals (MDGs) to encourage countries to reach critical development targets. One of them is improvement of maternal health which specifically states that all countries should attempt to reduce the burden of maternal deaths by three-quarters between 1990 and 2015.

The Government's flagship public health program, the National Health Mission (NHM) has maternal health as a core focus area. It has attempted to increase access and to improve health systems to deliver quality service.

Today many private sector maternity hospital and clinics are working with the government to implement these PPP schemes, so that pregnant women at all socio-economic levels can get quality maternal care. But there is an urgent need to do more. Some of the priorities are as follows:

- a) Increased access to affordable maternal health care in urban areas;
- b) Awareness generation and attitude change through extended mass media campaigns;
- c) Health education on pregnancy, childbirth and safe motherhood for adolescents at schools;
- d) Improved quality of services to bring down infant and maternal mortality rate and those children survive beyond age five;
- e) Increased accountability of health service providers for the loss of every mother and child in child birth through regular death audits;
- f) Health infrastructure improvements through private-public partnerships;
- g) Increased fellowships and training in obstetrics and gynecology for doctors in rural areas; and
- h) Early and effective screening processes to identify high risk mothers and babies to prevent mortality and improved referral mechanisms to deal with such cases.

### 3.2 Regulator Needed to End Unethical Practices in Healthcare

"The medical establishment has become a threat to health" wrote Ivan Illich in his 1975 book Limits to

Medicine. Going by recent events, Illich's stentant criticism of Western Medical Establishments is also pertinent to healthcare in India.

A doctor-patient relation is built on trust. Despite being recognized as a consumer-seller relation under law, patients lack the information needed to choose the best decision in their own interest. Unlike buying a cell phone, where buyers know what features they want, in healthcare such decisions have to be made placing trust in the doctor's technical knowledge and skill. But what if there is a conflict of interest between a healthcare decision that is in the interest of the patient and an incentive to the doctor, as is often the case? Will a doctor resist a few supplementary thousand rupees for referring a patient for an MRI scan? Will he refuse an all expenses paid foreign trip or a sought after gift for his clinic in exchange for increasing medicine prescriptions? Should we as a society allow healthcare to be delivered under such a perverse system, which is unethical to the profession and averse to the patient. Irrespective of doctors indulge in unethical practice, an impartial regulatory system is needed.

### 3.3 Quality Healthcare with Public Funds

Six practical steps in this context are listed below:

#### *Tax-payer financed services*

1. The government could issue a clarion call for Universal Health Insurance (UHI). This will free the current out-of pocket spending on health and channel funds toward far more productive uses. Patients often get now very expensive treatment or over-treatment of poor quality. UHI should prevent large expenses for the poor.
2. A rapid scale-up the introduction of new vaccines against diarrhea and pneumonia among children. Novel delivery model must be tested and scaled to deliver vaccines to every doorstep.
3. The most feasible priority will be to reduce smoking, which kills about one million Indians a year. All cigarettes must be taxed on their tobacco content and not length.
4. Preventing Vascular Deaths

In order to tackle adult vascular deaths-the leading cause of deaths in the country (over a million per

year), low-cost generic risk pills that combine aspirin with a statin drug to reduce cholesterol and lower blood pressure may be introduced.

#### 5. Controlling Malaria

Specific measures need to be taken to prevent a big resurgence of malaria. This included considering a proper use of combination drugs, to be made widely available in rural areas

#### 6. A major effort should be made to improve health reporting. This could be achieved through a new central hub which will track and report on development and progress.

These six steps correspond to priority areas and will ensure maximum returns for a given level of investment and result in big strides in healthcare improvement.

### **3.4 Healthcare to India's Remote Tribes**

The tribal community lags behind the national average on several vital public health indicators with women and children being most vulnerable. Research has shown that 75% of India's tribal population defecates in the open and 33% does not have access to clean source of drinking water. Insanitary conditions, ignorance, lack of health education and poor access to healthcare facilities are the main factors for the poor health of tribal.

Posts of doctors and paramedical in Primary Health Centers (PHCs) are often vacant. Additionally, the non-availability of essential drugs and equipment, inadequate infrastructure, difficult terrain and constraints of distance and time and lack of transport and communication facilities further hinder healthcare delivery. Tribal's' right to good healthcare must be addressed using modern technology and innovative approaches and, most importantly, by involving the community in developing solutions to its healthcare problems.

### **3.5 The Right Prescription**

Universal healthcare offers a solution by extending access to healthcare as widely as possible and providing quality care through minimum standards. Soviet Union implemented it in 1937 with the UK following nearly a decade later. Most nations have funded it through general taxation, supplementing it by special levies

and private payments. Compulsory insurance utilizing common risk compensation pools and a choice of insurance funds have helped reduce inequality and increase access.

Public-private partnerships or build-operate-transfer operations and maintenance contracting schemes can utilize private capital for provisioning healthcare services. With our growing population, the need for treatment of non-communicable and life-style diseases will increase, particularly in Tier 2 and Tier 3 cities. Affordable healthcare programs under PPP model will offer significant margins for private players, while helping to address talent resourcing and under-utilization issues.

Insurance coverage is also abysmal in India, with just about 25% of the population covered while a target should be around 75%. Access with low out of pocket spending can be achieved through an expansion of healthcare insurance with the government playing a guarantor's role. Universal healthcare requires cheaper drugs. Capping drug prices has become controversial. But pharmacy firms are coming under pressure to lower drug prices across the world. Drug providers should take a price cut and benefit from India's healthcare expansion. Public interest can also be private interest, in greater volumes.

### **3.6 Act Tough Against Tobacco**

Tobacco is one of the four major risk factors for non-communicable diseases. Its products are smoked, inhaled, chewed and sucked in different forms, all seriously damaging health. Despite the hazards of tobacco, there is an increasing trend of initiating tobacco among the young and women globally.

The impact of tobacco much beyond health, increased expenditure on healthcare, deaths and diseases cause productivity loss, affects the quality of life and family harmony and has economic cost to the society. There is a close association between poverty and tobacco. Tobacco use is more prevalent among the socio-economically vulnerable groups.

All countries are implementing measures against tobacco, but these are highly inadequate calling for stronger measures. Also importantly countries have to

support cross-border control of tobacco related trade. Heavy smoking and alcohol use cause distinctive changes in human DNA, leading to an accelerated premature ageing.

#### 4. Multipurpose Database of Patients

A good database of the patients has several utility aspects and is a national priority. A computerized database with basic information on persons having major diseases will be useful in more than one way: A ready and reliable brief history on disease (getting over lack of memory of the patients in this regard), treatment received, disease status etc. We propose a 12-digit unique ID Number and the basic information to be compiled by the (first) hospital, with easy access to other hospitals subsequently. This felt need by the hospitals and akin to Customer ID of the bank customers. A format for the purpose is also suggested which may be finalized after a pretest.

##### 4.1 Database on Patients having Major Diseases

[Suggested format]

12 digit code [To be assigned by a nodal agency in order to ensure continuity and avoid duplication]

*Two digits for state\city, two for disease type, one for sex MF, seven for patient file No.*

1. Name: .....
- Blood Group: .....
2. Sex, Date of birth, Educational qualification, Profession
3. Address: Phone No.
4. (a) Major Health Problems (up to 2)  
(b) Surgical \ Nonsurgical
5. (a) Since the Year \ Month  
(b) Main Treatment (s)
6. Names of Hospital (s), with City & Contact Phone
7. Current Status of Disease
8. Major Source of Income
9. Total Expenses up to Now  
(a) Doctor's Charges  
(b) Cost of Medicine

(c) Hospital Charges

(d) Others

10. Rank (1 to 5) the extent of co-operation received from the patient, 5 being excellent.
11. Other Relevant Information
12. Aadhar No. of Patient

##### 4.2 The ICD-10 Codes in US

The US hospitals and doctors have to use these codes, w.e.f. Oct 01, 2015, which cover everything from Parrot bites to getting sucked into a jet engine. In this list, there are 70,000 ways to get sick, hurt or mortally injured and the US has made it official. These codes have been made mandatory to bill government programs and private insurers in the country's healthcare system. The codes cover a vast gamut of possibilities and are exhaustive as well as extensive. The list has, however, some absurd excuses such as Z. 63.1 'Problems in relationship with in laws' or V 91.07 XA ' Burn due to water skis on fire'. These codes will help identify ways to manage all kinds of conditions, from heart disease to roller skating injuries.

#### 5. Innovative Ideas

Innovative moves are needed to revolutionize Indian Health services. Some current thoughts in this regard are mentioned below.

##### 5.1 Innovation: A Must for Quality Healthcare

'The drug manufacturers most adopt world class manufacturing practices and operate in ethical manner' was the unanimous conclusion of a recent (Jan, 2015) meeting of government, regulators, captains of the pharmaceutical industry, pharmacy associations and healthcare professionals from across the country. The theme was 'Make, Develop and Innovate in India'. The consensus was for a collaborative approach that will ensure patient's access to innovative medicines while supporting the government's goals of bringing growth to India through research, innovations and manufacturing. Access to healthcare extends beyond the cost of medicine, to the proximity, quality and functionality of the infrastructure that supports that access. Creating a healthy India requires balancing the need for innovation with the necessity for more affordable medicines.

Quality is another big concern. Patients need to be assured that their medicines conform to prescribed standards. The healthcare industry has a collective responsibility towards all patients and must guarantee that we deliver 'responsible healthcare'. Any long-term solution to India's healthcare challenges will require a holistic approach and a critical evaluation of the existing systems.

### **5.2 Inclusive Ecosystem for Mental Health**

It is now time to assign resources to government's progressive mental health policy and initiate programs that promote social inclusion, participation and mobility. The long term needs of persons with mental health issues may be better served by an inclusive ecosystem, like a new house which provides newer opportunities and greater personal meaning. This housing intervention and a related sense of ontological security may contribute significantly to the patient's rediscovery of identity and introduce a new credence to life. The process of social mixing demonstrated by occasional transactions at shops, joint celebration of festivals, visits to places of worship etc. can be very helpful in the healing process.

According to the World Health Organization's (WHO) Mental Health Atlas 2011, 38 percent of people living in mental hospitals are estimated to have stayed there for a year or more. Long term care for persons with persistent forms of illness, if restricted to extended stays in hospitals or traditional rehabilitation homes can be spiritless and lacking in vitality. Institution alienation is not and cannot be the answer. A feasible supplementary system is to have a mechanism to bridge the treatment gap by promoting access to clinical and social care. The needs of vulnerable groups and challenges around institutional and long term have been identified as key areas of focus. Much of the work here sits at the intersection of social welfare and healthcare.

### **5.3 Free Medicines can Transform Disease Management**

It is a well-established fact that a truly innovative intervention in disease control expands the reach of the public health programs, improves patient satisfaction and health outcomes, reduces patient

costs and engages all stakeholders, especially the private sector. Yet, few such innovations appear, and when they do, they are often over-looked because current health programs are either too well-established or relatively inflexible. A case in point is a simple but trans-formative innovation being implemented in Mehsana, a town in Gujarat. With a part-rural and part-urban population, this town is implementing India's first pilot for universal free tuberculosis (TB) drugs-an idea that could transform TB treatment and management in India. If successful, it could transform disease control altogether. TB constitutes one of the biggest health crises for India. It kills over 750 Indians every day and causes economic losses of \$ 23.7 billion annually. Despite an extensive national program, a large percentage of patients continue to seek care in India's vast private sector, where they believe they will get better care. Unfortunately, this is not always true. There is wide spread use of inaccurate diagnostics and inappropriate treatment, pushing patients and their families into poverty.

The program offers no financial incentive to the doctor and offers only a small overheads charge to the pharmacists. However, in the end, the program provides a win-win situation for all: the chemist acts as a referral point, the patient gets the right diagnosis and free drugs, and the private physician retains his or her patients. This innovation in Mehsana can possibly transform public-private partnerships and thereby the way the public health programs are run. An innovation of this nature if scaled up nationally could address several of the existing challenges.

## **6. New Developments**

Three new developments in health sector are dwelt upon next.

### **a) Post-operative Cardiac Care Simulator**

Researchers at the Indian Institute of Science have developed a post-operative cardiac critical care simulator for training nurses. This is said to be the first of its kind to be manufactured in India. This is expected to change the way nurses are trained in this job, without actually coming face-to-face with such patients. This platform is a game changer for two reasons: A very basic imported simulator would cost Rs.1 crore, while

the one developed by the Institute would cost about 15 lakhs. With the nurse training model being far simpler than the one being also used to train doctors the cost-benefit could be quite significant.

### **b) E-Pharmacy: A Contested Development**

Early in the year 2015, about 20 websites including Amazon, Flipkart started soliciting orders for online sale of drugs. More than 45 drugs were listed on one portal alone. Sale of new drugs has stirred any controversy as that of medicines. With the law yet to be updated to govern online pharmacy, several e-tailers jumped on to the pharmacy bandwagon. This has led to a large outcry from the All India Organization of Chemists and druggists. Meanwhile, the Government has set up a panel to go into the entire gamut of issues.

At present, producers are allowed to sell drugs only to licensed dealer, registered doctors and hospitals. Retailers are licensed only if they have adequately equipped premises for storage of temperature-sensitive medicines and have qualified on-site pharmacists to dispense drugs against prescriptions by registered medical practitioners.

Several key issues are involved in E-Pharmacy context. How would a website located, say in Mumbai check if (a) the scanned copy, even if obtained, is genuine and not tampered, (b) medical council registration corresponds to the place of residence of the patient and (c) how would the original prescription be endorsed as required by law for suppliers made so that additional stocks are not obtained on the strength of the same prescription, more so in the case of psychotropic drugs such as anti-anxiety and anti-depressant which are not only misused for recreational purpose but can be fatal in overdose. In short, e-commerce in retail trade of medicine in India is fraught with unacceptable risks to patients and with no benefits to the nation. This activity, if at all to be permitted, calls for large scale changes in the laws and rules. It is an issue of life and death.

### **c) Value of Big Data in Public Health**

The global burden of disease sets a compass and foundations work with governments with emphasis driven in part by what nations, governments and the United Nations want.

The procedures developed should maximize the chances for health and minimize the chances of side effects. This is in real life seeing what precision medicine could look like. This is an area calling for reliable investigations on precision medicine in public health. For instance Bill and Milinda Gates Foundation have been focusing on Ebola and on the ways it spread. Using big data to understand the conditions that made it spread is precisely what is needed for epidemic prevention. The available technical expertise should be used for the people who need it most, who are among the poorest in the world. It needs to be culturally competent and affordable. The derived technological solutions should be available to the poorest of the poor.

### **7. Karnataka PPP model (Yeshasvini Scheme)**

A large population segment (particularly rural) is given very little financial security against healthcare expenditure. Thus the poor cannot afford good healthcare; if they do, the attempt become expensive and they get impoverished. Yeshasvini, Rashtriya Swasthya Bima Yojana (RSBY) and the Vajpayee Arogyasri in the context of Karnataka state are the major schemes being implemented. In this setting, Yeshasvini Co-operative Farmers' Health Care Scheme (YCFHCS) assumes special significance due to its novelty. If implemented efficiently, it can result in a success story.

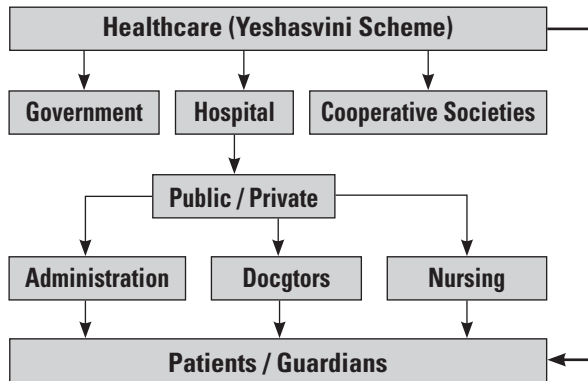
Healthcare in India has undergone a lot of change in recent years. With the launch of Yeshasvini scheme, it is expected to reach large masses in the rural & urban areas. This initiative by the State Government of Karnataka is creating awareness among the masses.

YESHASVINI, a unique Cooperative HealthCare Scheme launched for the first time in the world, is meant for farmers who are members of the Cooperative Societies. Its aim is to ensure good health for farmer cooperators of Karnataka.

The Government of Karnataka has introduced this scheme with a view for greater reach (particularly for BPL families) with respect to healthcare, including surgical treatments. This is positioned as a public-private model, with selected hospitals (e.g. Narayana Hrudayalaya, Bangalore) authorized to provide the services. The beneficiaries have to register (paying a nominal fee) under the scheme. It has been expressed

that the awareness among the people about existence of this scheme is low, coming in the way of success of the scheme. It is of relevance to examine the quantitative and qualitative aspects of the scheme in order to enhance its effectiveness. A total of 823 surgical services in 496 identified hospitals in the state are available under the scheme including medical emergencies like snake bite, drowning and accidents in agricultural work stations.

**Yeshasvini Scheme Model:**



**Source:** Author

The Yeshasvini Scheme was launched on 01/06/2003 and the progress of the scheme during the past 11 years is shown below:

**Reach of Yeshasvini Scheme**

Year	Members Enrolled (lakhs)	Members Contribution (Crores)	Govt. Contribution (Crores)	No. of Free OPD availed	No. of Surgeries availed	Surgery Amount Reimbursed to Hospitals (Crores)
2003-04	16.01	9.49	4.50	35814	9047	10.65
2004-05	21.05	12.87	3.57	50174	15236	18.47
2005-06	14.73	16.94	11.00	52892	19677	26.16
2006-07	18.54	21.56	19.85	206977	39602	38.51
2007-08	23.18	27.75	25.00	155572	60668	54.09
2008-09	30.47	36.10	30.00	191109	75053	61.03
2009-10	30.69	41.36	30.00	134534	66796	55.08
2010-11	30.47	41.68	30.00	157480	73963	57.23
2011-12	30.70	45.08	30.00	116690	77619	60.09
2012-13	30.36	58.88	35.00	110842	80401	74.12
2013-14 (31.12.2013)	34.50	49.21	3254.14	99656	62067	58.88

**Source:** Author

**8. Discussion**

The Indian health sector lags far behind in several respects with reference to the UN set minimum standards. Though there is no denying of the need for quality healthcare at reasonable costs, the contemporary Indian health sector scenario is disappointing and it presents several anomalies, be it in maternal care or care for the elderly. The progress in control of health hazards like use of tobacco is meager. The ethical standards on the ground are low. All this calls for basic policy changes and relevant strict actions. Some innovative changes too are in order for a breakthrough. There is a need for developing a multipurpose database of the patients at the State and at National level. The paper highlights all these ground realities along with discussion of a PPP model (Yeshasvini scheme) of the Karnataka Government. Suitable suggestions are included all along the narrative.

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