SAVE PUBLIC HEALTH CARE CAMPAIGN

Mumbai is the largest city in India with over 120 lakh people. Despite its massive wealth, endowed with the best human and industrial resources and being the commercial/financial capital of the country, more than half its population lives in conditions of misery. Where health care is concerned, again Mumbai is very well endowed with the best health humanpower and facilities being available in the city. Yet the vast majority of people find it difficult to access these services because of the rising costs and user charges of health care services in both the private and public health sectors.

Mumbai's public health services are second to none in the country. They are reasonably well organised and structured but over the years its functioning has deteriorated considerably due to sheer neglect and indifference on part of the health administration. The public health infrastructure of Mumbai has not grown sufficiently to cater to the growing population and demand and hence availability of various services in the public domain is becoming an increasing problem.

For instance, investment in new infrastructure slowed down in the eighties and has virtually stopped in the nineties. The focus too of investment has changed (in the nineties the World Bank supported IPP –V created a new infrastructure of Health Posts and post-partum centres which focused primarily on family planning services) making public health services selective and target oriented instead of being integrated and comprehensive. Availability of medicines in the dispensaries and hospitals have become sparse, both due to rising costs of drugs as well as inadequate allocations in the budgets for medicines thus shifting the burden onto patients. Diagnostic tests too are being prescribed to be done outside public institutions thereby further burdening out of pocket expenses of patients. User charges have gradually been introduced in public hospitals for various services and these are now being hiked to virtually market levels. Many non-medical services in hospitals have been privatised or out-sourced and now we are witnessing handing over of public institutions to the private sector.

Such trends in public health care provision in the context of the already adverse scenario due to consequences of globalisation are only further harming the health of the people, especially the poor and the lower middle classes. If these trends are not rolled back we will be staring in the face of disaster.

Health and health care are globally acknowledged as fundamental human rights. Article 12 of the International Covenant on Economic, Social and Cultural Rights emphasises **the right to the highest attainable standard of health.** "Health is both a fundamental human right in itself and an indispensable precondition for the exercise of other human rights. Every human being is entitled to the enjoyment of healthy living conditions indispensable for living a life in dignity. The attainment of an adequate standard of health may be pursued by complementary and non-exclusive approaches: On the one hand by means of policies, programmes and strategies but also specific legal instruments developed by the World Health Organisation, and on the other hand by recognising the right to health as a legally enforceable fundamental human right."

Also Article 25 (1) of the Universal Declaration of Human Rights affirms that "everyone has a right to a standard of living adequate for the health of himself and his family, including food, clothing, housing, and medical care and necessary social services...". Thus it is time that health as a human right gets recognised and established and for this state agencies and public institutions have a critical role to play.

The **Save Public Health Care (SPHC) Campaign** asserts the right to health and health care and demands from the state government and the Brihan-Mumbai Municipal Corporation (BMC) this right on behalf of the citizens of Mumbai and Maharashtra. We demand that:

- All user charges for services in dispensaries and hospitals be removed and instead voluntary payments through donations, services etc.. promoted and encouraged
- All dispensaries must be strengthened by raising its medicine and maintenance budgets and the BMC must honour its own commitment of one dispensary per 50,000 population
- Referral systems must be put in place to rationalise hospital services and strengthen dispensary-hospital linkages
- Budgetary allocations for non-salary components like medicines, equipment, diagnostic materials, linen, maintenance, medical records and information systems, etc.. must be substantially increased to improve efficiency, efficacy and patient satisfaction
- Instead of user charges the BMC must look at other innovative ways of raising resources where the payments are in direct proportion to earnings and wealth, for example health cess on private vehicles, health cess on polluting industries, and health tax on health degrading products like cigarettes, guthka, panmasala, alcohol, and levying a health tax (like profession tax) on the organised sector employees and employers…
- All initiatives of privatisation must be rolled back and instead the private sector must be regulated and organised under a system of public-private mix so that private health services also become part of the public domain

ANNEXURE

Table 1: A Health Infrastructure Profile of Mumbai and Maharashtra *c2000*

	MUMBAI			Rest of MAHARASHTRA	
	BMC	GOVT.	Private@	Public	Private@
Hospitals & Nursing Homes	51	29	1416*	532	2583
Per 100,000 persons	0.44	0.25	12.31	0.63	3.10
Hospital and NH Beds	11,700	9,000	23,202*	70852	20700
Per 100,000 persons	101.74	78.26	201.76	84.85	24.79
Dispensaries and Clinics	185	50	20,000	831	7312
Per 100,000 persons	1.61	0.43	173.91	0.99	8.76
Health Posts and PHCs	176	--	--	1752	--
Per 100,000 persons	1.53			only phc 3.07	
Utilisation (*in lakhs*) OPDs	135	27	650	670	2680
Inpatients	14	8	15	26	21
Bed-days per inpatient	3.5	4.1	5.6	5.7	6.5
Expenditure (Rs. Crores)	500	220	2500	1100	4480
Per Capita (Rupees)	435	191	2170	132	536

Source: Maharashtra Govt. and BMC Annual Reports and Budgets
*CEHAT survey and BMC records; for private beds the data was available only from about half the number of hospitals so the actual number of beds will be even higher
@ private sector data estimates based on micro studies and NSS 52nd Round
Maharashtra public health facility data from Health Information India 1997
Population base used for calculations is 115 lakhs for Mumbai and 835 for rest of Maharashtra

It is evident from the above table that the private health sector overshadows public health services in numbers, atleast in OPD care. In inpatient care still about 57% of the cases are treated in public institutions. In Mumbai the BMC is the main public provider of health services. The state government services for the general public in Mumbai is confined to the JJ Group of Hospitals, St George, Cama and GT (the one the government wants to privatise) which together have about 3000 beds. The rest of the government facilities (central and state) in Mumbai are for specific population groups like railway employees, ESIS insured employees, defense services employees, government employees, Port Trust employees, Atomic Energy employees etc.. In terms of cost of health care over four-fifths is estimated to be borne out-of-pocket of households. Overall in Maharashtra too the private health sector is quite dominant and public health quite inadequate.

Table 2: Growth of BMC Health Services 1974-1998

	1974	1979	1985	1989	1994	1998
Teaching Hospitals	3	3	3	3	3	3
❑ Expd.Rs. Lakhs				4172	7792	17500
General Hospitals	7	11	13	13	15	15
❑ Beds	1328	2362	2851	3294		4000
❑ Inpatients	523169	963129	945990	790579		1000000
❑ Per bed inptnts.	394	408	332	240		250
❑ OPDs (lakhs)		56	34	50		35
❑ Expnd.Rs.lakhs	167	651	1362	2094		6470
❑ Exp. Per bed Rs	12575	27561	47773	63570		161750
Special Hospitals	5	5	5	5	5	5
Maternity Homes	27	25	28	25	25	27
Dispensaries	107	148	148	150	159	185
❑ Cases (lakhs)	123.32	158.88	40.94	39.73		40.00
❑ Cases per disp.	115252	107351	27662	26487		21622
❑ Expnd.Rs.lakhs			294.73	338.09		1350.00
❑ Exp.Per case Rs			7.20	8.51		33.75
Health Posts					176	176

Source: Annual Reports of Executive Health Officer upto 1989; Know Your Wards, respective years; BMC Budget A, Part II, various years.

Table 2 gives a profile over a period of time and it reveals interesting facts. It shows that growth of health care facilities was rapid in the seventies, slowed down in the eighties and has remained stagnant in the nineties. What adds to the intrigue is that during the eighties the utilisation of the health care facilities both OPD and inpatient began to decline not only as a ratio but even in actual numbers. The worst declines are seen in dispensary utilisation where the per dispensary cases attended in a year declined from over 115,000 per year in 1974 to a mere 21,622 in 1998, that is from an average daily attendance of 436 to a mere 82. This shows that public health facilities got transformed from being overcrowded to underutilised. The data available does not indicate the reasons but anecdotal accounts, visits to facilities and survey data show that public health facilities are increasingly underprovided in terms of medicines, diagnostic materials, maintenance costs etc., while salaries have increased keeping pace with inflation. Thus the increased budgets are partly due to inflationary costs and partly due to increased salary levels but service provisions have declined drastically reducing efficiency, efficacy and availability. To make this situation worse user charges have been introduced.

Table 3: HEALTH CARE PROFILE OF MUMBAI CITY - 1998

	BMC	Govt.	Private*	Total	Population per unit
1. Hospitals, Maternity & Nursing Homes	51 (3.4)	29 (2.0)	1416 (94.6)	1496 (100)	7350
2. Hospital Beds	11700 (27)	9000 (20)	23202 (53)	43902 (100)	250
3. Dispensaries and Clinics	185 (0.91)	50 (0.25)	20000 (98.84)	20235 (100)	545
4. Expenditure Rs. Crores	380.8 (12.5)	160.0 (5.3)	2500 (82.2)	3040.80 (100)	Rs. 2765 percapita

Source: Same as Table 1. Figures in parentheses are percentages across sectors

Table 3 data is similar to Table 1 but with percent distribution across sectors and population ratios for all health care facilities. This table only highlights that the overall health infrastructure is more than adequate but since most of it is in the private sector which operates without any regulation whatsoever its affordability becomes a major concern. There is an urgent need to regulate the private health sector and the best would be to bring it under a public-private mix which is the best solution for providing universal access to health care and assure people the right to health and health care. This is the experience of all countries which provide universal access to their citizens.

Table 4: BMC Health Services, 1998

	Number	Beds	OPD In Lakhs	Inpatient In Lakhs	Expenditure Rs. Crores
Teaching Hospitals and Medical Colleges	3	4500	20	10	175.0
Special Hospitals	5	2200			11.0
General Hospitals	15	4000	35	10	64.7
Maternity Homes	27	1000	6.2 anc/pnc	3.6	17.3
Postpartum centres	30				1.4
Dispensaries	185		40		13.5
Health Posts	176		7.9 immun. 26 home visits		14.8

Source: Same as table 1

Table 5: Use Statistics of BMC Dispensaries – 1970 to 1998

Year	Dispensaries	Attendance in Dispensaries
1970		9,293,632
1971	80	10,007,699
1973		10,931,769
1974	107	12,328,833
1976		14,699,258
1977	128	14,187,783
1978		15,402,417
1979	148	15,888,269
1981		17,560,508
1982	154	10,505,263
1983		5,107,962
1984	150	4,386,452
1985	148	4,094,726
1986	149	4,395,712
1987	150	4,557,141
1989	150	3,973,972
1994	159	
1998	185	4,000,000

Source: Annual Reports of the Executive Health Officer upto 1989; other years BMC records

As mentioned earlier BMC is the major provider of health care in the public domain and hence the focus has to be on the BMC to pressurise it to strengthen its services, improve the quality, assure adequate availability of supplies and resources, rationalise its structure and functioning, invest more resources, and ofcourse raise further resources through means other than user charges or any charges at the point of provision of care. The current hike in charges is given in Table below:

Table 6: Recent Introduction/Hike in User Charges in BMC Hospitals

Procedure/Activity	Existing Charges in Rupees	Revised Charges in Rupees
Cardiac Catheterisation	1200	2500 (108)
EMG	75	150 (100)
Paying Bed	100	200 (100)
Paying Ward	50	100 (100)
Superspecialty Operation	Nil	5000 (infinity)
Specialty Operation	300	1000 (233)
Minor Operation	150	400 (167)
X-Ray	60	60 (0)
Pathology	60	60 (0)
ECG	60	60 (0)
EEG	150	250 (67)
CT Scan	1000	1200 (20)
Ultrasonography	50	100 (100)
Bed charges-Emergency ward	100 per day	100 (0)
Delivery Charges	250	500 (100)
Radiotherapy	750 per course	1500 (100)
ICU	100 per day	200 (100)
New OPD Case Paper	Free	10 per 14 days (infinity)
Follow up cases OPD/14 days	Free	10 (infinity)
Stress Test	Free	500 (infinity)
Barium Test/IVP	Free	200 (infinity)
Colour Doppler	Free	500 (infinity)
Hormone assay/organ scans	90	150 (67)

This draft note and compilation of data for SPHC Campaign has been done from the CEHAT database and information centre by **Ravi Duggal**.

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