Inequities in Health Services in Mumbai

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First allow me to apologize. I am not a community medicine expert. I am a surgeon, a teacher, an administrator and essentially a professional who has spent all his time in hospital management of the sick. Secondly, due to prolonged period of convalescence after prostate trouble, I could not devote adequate time to study the subject in full details. However, I will try to do my best within these limitations.

MCGM (Municipal Corporation of Greater Mumbai) is a very rich corporation. Its annual budget exceeds that of many states like Kerala, Goa, Chhattisgarh, Jharkhand, etc. It is probably the only Municipal Corporation in Asia to run - not one-three medical colleges; and a fourth one is in the offing. It is also one of the rare government bodies which spend a very high amount on health and medical education -- at one time nearly 15% of its revenue expenditure but now it has dwindled to about 8% or so. In absolute terms, the MCGM has presented a budget for the year 2015-16 wherein its income is Rs. 33,000 crores and expenditure is Rs 31,000 crores. Out of this expenditure, it has allotted Rs. 2,552 crores for health and medical education for the total population of 13 million people. The percentage works out to be nearly 8%. It has allotted a little more than Rs.600 crores for Primary health, Rs. 744 crores for its peripheral hospitals, another Rs 108 crores for TB (Rs 100 cr) and Acworth Municipal Hospital for Leprosy (Rs 08 cr) Hospital. However it is spending a whopping Rs. 1,100 crores for its 3 medical colleges and their hospitals plus 1 dental college. These are tertiary care hospitals and, no doubt, some of the best medical centers in India offering CT scans, endoscopy, laparoscopy, angiography, angioplasty, open heart surgery, neurosurgery paediatric surgery, ICUs, nephrology, dialysis, kidney transplants, all sorts of emergency services and what not!

The Mumbai Municipal Corporation has a network of health services and, despite all its deficiencies, it has one of the best health services in the country - probably exceeded only by Tamil Nadu State. The network consists of primary health services consisting of 174 dispensaries, 168 outreach Health posts, 15 RCH health posts, and 30 maternity homes. Secondary health services comprise of 18 peripheral hospitals plus 5 specialty hospitals, namely, one ophthalmic, two ENT, one TB and one leprosy hospital, besides one large Infectious Diseases Hospital, namely the Kasturba Hospital. Tertiary care, as mentioned above, is offered by 3 major teaching hospitals which also offer complete secondary care too. The public sector is ably assisted by State Government hospitals like J.J. hospital (a teaching hospital) and other 4 secondary hospitals. There are many other state and central health services and their hospitals which cater to specific groups: their own workers. Two Railway Hospitals, a Naval Hospital, CGHS, BARC (atomic energy), ESIS hospitals, Port Trust Hospital, etc. These, however, are not available for the general public. Yet, the health care needs of the Mumbai population are hardly satisfied and private sector has expanded like never before. Earlier, till the year 2000, it was the small hospitals/Nursing Homes which rapidly increased in number, especially in suburban areas. This was because, as is seen in the map, public sector hospitals were concentrated in the island city till 1980. It was during Municipal Commissioner V.B. Deshmukh's time that peripheral hospitals were established in suburban areas, the number rose to 16 (and now to 18). The total population at that time (in seventies) was around 52 lakhs. But in this century, tertiary care hospitals are growing very rapidly in the private sector, due to high expectations of the people from modern technology and its affordability among the increasing percentage of Mumbaiites. At least 30% are now covered by insurance or re-imbursement by their employers. They do not feel the pinch of steep rise in the cost of health care but the rest of the population suffers heavily as the cost of management rises for them, too. Private sector in Mumbai comprises of around 1500 hospitals - mostly small or big Nursing Homes - but now at least a dozen major tertiary hospitals with all modern high tech facilities have sprouted in various regions of the city.

The total number of beds available are:

Municipal 12000: 28%, Government 8000: 22% and Private 21000: 50% .

The total of 40,000 beds or more fall too short for the population of 13 million, with a ratio of 1 to 3000 when the most minimum ratio should be 1 to 1000. (These are old figures about 12 years back and differ widely from what Dr. Jotkar, Dy.Director, Health Services, Maharashtra, reported in 2005 According to him Mumbai had 203 beds per lakh population, that is,

2 beds per 1000.

It is strange and highly regrettable that we do not have any authentic data as to the number of (allopathic) doctors in Maharashtra and especially in Mumbai. MMC is stuck with the figure of 80,000 doctors since the year 2002. But, if we consider that 16,000

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Nursing Homes Inadequacies	
Physical Standards - not met	6% Have adequate space
Unskilled Human Power	38% maintain records
Poor Sanitation & Waste Mgmt.	36% in residential building
Irrational/Unethical Practices	64 % having less than 15 beds.
Poor Record keeping	24% having less than 25 beds.
No monitoring & Accountability.	Only 12% have more than 25 beds.

Source: Jotkar, D.H.S., 2005

students that pass MBBS every year in Maharashtra alone, the number ought to reach 1. 5 lakhs by now. Mumbai has 10% of the total population but doctors are more concentrated in Mumbai than elsewhere. Presuming that just 15% of the doctors practice in Mumbai – it must be more – it still means that there are more than 22,000 doctors in Mumbai – a ratio of 1 doctor per 600 people. It could well be 1 to 500 - almost the same as for U.K. Thus, Mumbai has enough budgetary provisions, the corporation is spending 8% of its budget on health. There is a good network of health care centers and public sector caters to 50% of the city population, there are more than enough doctors and almost all facilities that a developed nation has. One should expect that health care indices of Mumbai should be very good at par with the developed nations. NO. IT IS NOT SO.

There is a gross disparity in availability of health services and the health indices are very poor in slum and peripheral areas. The life expectancy at birth is around 64 years for India, 67 or 68 for Maharashtra but for a Mumbaikar it is a dismal 57 years. Tuberculosis is increasing and there is near 100% increase in deaths due to TB. The incidence of malaria is also on the increase and in both diseases, resistant strains are causing a serious threat. Extremely resistant TB accounts for nearly 10% of the total cases. There are probably 2.5 lakh patients of TB in the city. The Infant Mortality Rate (IMR) is around 40/10000 but it is deceptive. It was found that IMR was as high as 55 to 60 in some slum areas and inaccessible peripheral localities. Luckily population has stopped growing, family planning and reduced influx of migrants assisting to curb the population growth. Immunization is 90 to 95 % successful. But 45.5% of children and 37.4% of women are anaemic – the percentage rises to 76% and 42% respectively for the slum areas. More than 50% children under the age of 3 years are underweight, 49% are stunted and 21% are wasted. Though HIV/AIDS was under control, the withdrawal of assistance by Bill Gates foundation js resulting in shortage or non-availability of drugs and there is a lurking fear that AIDS may re-appear. The teaching hospitals are over-crowded – OPD attendance being around 32 lakhs in a year. KEM Hospital claims to see 4,000 to 5,000 OPD cases every day; the figure for LTMMC (Sion) being 2,500 or so. Sion Hospital conducts 16,000 to 17,000 deliveries every year – a child is born every half an hour. How can one do justice to these patients? Same is true of peripheral hospitals. But mostly they are under-utilised. There is dearth of full-time specialists and honorary specialists avoid taking responsibility due to "lack of modern facilities." Similarly, primary centers are more concerned about government programs like immunization, MCH, DOTS, etc., but early primary care is hardly administered there. The result is people are forced to attend private clinics and nursing homes despite financial difficulties. The growing middle class is squeezed to pay high price in private hospitals only because of the mad rush and confusion at public hospitals. The total outcome is very poor health service for the large majority of the people except those who can afford – the organized section of the society.

And I have not touched upon the burden of non-communicable, life-style diseases. Cardiac diseases take the highest toll of even the young population. About 10% of the adults are likely to be having diabetes. And the poorer sections of the society are equally vulnerable to these illnesses. The biggest killer is trauma. Assaults and accidents bring nearly 4 to 5 thousand patients per month to Sion Hospital alone with mortality of 20% or more. Majority of emergencies of all sorts are managed in public hospitals in Mumbai - private hospitals have hardly any emergency service worth the name except for cardiac emergencies. Thus, there is a great burden of modern diseases on the public hospitals which they cannot handle efficiently.

Why are these inequities, insufficiencies? The main reason is unregulated system. There is NO SYSTEM. Anybody can attend any clinic or hospital. Even tertiary care is given to the patient who goes there – not to the patients who need them. Any medical officer can refuse to treat a patient quoting one reason or the other – usually lack of facility and sometimes lack of assistants. If we look at the duties for health service personnel (see Table 1) it will be realized that administering primary and secondary care is but one of the multiple functions and is being given the least importance. Even if a case was seen and then referred to a hospital for further care, there is no preference given to such a patient. He/she is just one among the crowd and may not be seen at all by the relevant specialty. On the other hand most people seek direct consultations at the teaching

hospitals, thereby increasing the work-load there unnecessarily. It is believed that at least 30% of the cases could have been treated at primary centers; while referred patients from private doctors also directly approach the specialists and are USALLY seen with priority. Thus public dispensaries are reduced to zero significance, the medical officers become least interested, Primary centers are least utilized. THERE IS NO SCOPE FOR EXPANDING PRIMARY CARE. Yet, primary care must expand. I had suggested a three pronged plan: a) that there should be a primary care center for every 20,000 population as shown in the design. It will run round the clock, served by about 4 doctors in each of the morning and evening shifts and helped by a physio-therapist, and a psychological counselor, Only simple investigations (not costing more than Rs 500) will be allowed and only simple medications (not costing more than Rs 250 per daily dose) will be prescribed. The patients will have to be referred to the hospital if more is needed and in the hospital these patients will be seen with priority at specified time of OPD. THEY WILL RIGHTLY BE TREATED FREE OF CHARGE (or nominal charge as of to-day). ANY OTHER PATIENT ATTENDING DIRECTLY WILL BE SEEN AT A DIFFERENT TIMING AND WILL BE CHARGED FEES (at least 25% of the market price) Such a duel system of charging will ensure that the poor are properly treated, and the barely affording middle class will also be looked after but with reasonable charges that will bring revenue to the public sector for further expansion About 20 to 25% beds will have to be reserved for the latter group in the hospital. b) MBBS doctors who do not secure a post-graduate seat, should be specially trained for the role of primary physician. The medical world is moving fast towards high technology. That affects the teaching pattern as well and the medical student is taught recent advances in medical technology. Thus, he becomes totally incompetent to practice medicine with more observation and less investigations and cheap but effective medicines or surgical procedures. These graduates should be offered a two year course in general practice wherein they will work partly in primary centers and spend part of the time in hospitals rotating through various departments. At the primary centers, they are allowed to prescribe only simple investigations and cheap effective medications as stated earlier. In two years time they will develop immense confidence to treat the patients "under adverse circumstances". and c) the advanced technology needs to be de-glamorized. It is extremely sad to see the social activists strongly supporting the demand for more and more new modern equipment "to improve the health service." MODERN FACILITIES CANNOT REDUCE COSTS. THEY IMPROVE SERVICES ONLY SELECTIVELY. De-glamorizing is a difficult task so I leave that discussion here.

Table 1: Duties of the Directorate of Health Services

Registration of births and deaths and maintenance of statistics
- Regulation of places for disposal of dead
- Maternity and child welfare and family welfare services, school health services
- Control of communicable diseases
- Food sanitation and prevention of adulteration of food
- Control of trades likely to pose a health hazard
- Insect and pest control
- Impounding stray cattle, immunisation and licensing of dogs
- Regulation of private nursing homes
- Medical relief through hospitals
- Issuance of international health certificates for travelling abroad
- Ambulance and hearse services
- Treatment of contagious diseases

The biggest hindrance to the scheme above is Consumer Protection Act made applicable to the medical profession. Almost 100% of the doctors are unwilling to take any risks, lest they are sued or punished – or even assaulted by the mob. The Act does not protect patients from negligent management by doctors, it is punishment to patients who now pay through their nose to get paltry treatment – it destroys the faith between the doctor and the patient and is mainly responsible for self-protecting practices of the present generation. Unfortunately, most NGOs and most activists strongly believe that such "punitive" action is necessary. Not all but more socially oriented doctors will definitely work better for their patients – if only this law is repealed.

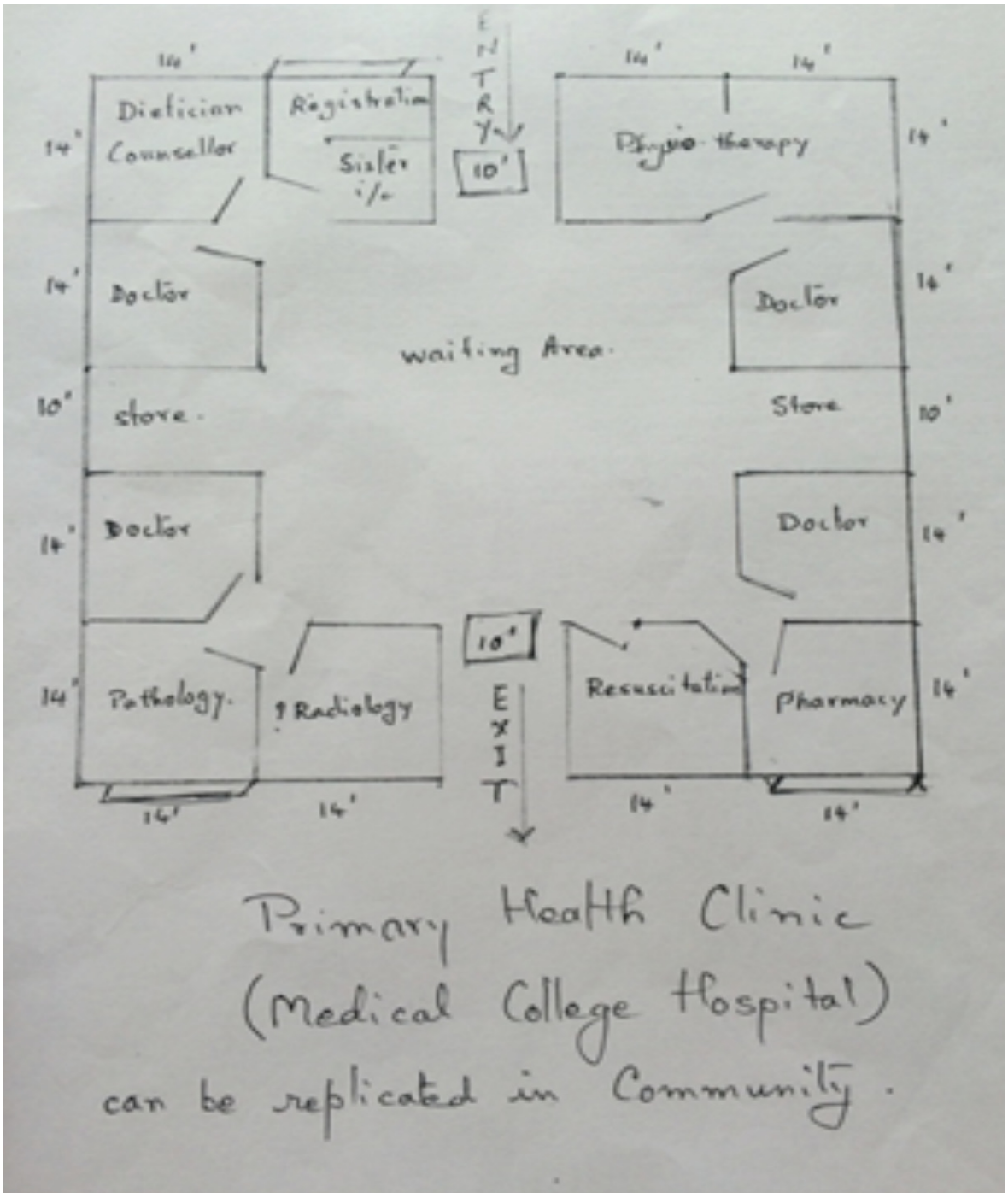
The city needs more beds. Lack of space and money are the biggest obstacles. The present small hospitals and nursing homes are managed most wastefully – the manpower and equipment are not used even to 30% extent. The report of Mr. Jatkar reported on the condition of nursing homes in Mumbai and it is an eye-opener. The problem could be solved by PPP – public-private participation. Government/ Municipal Corporation could build the suitable hospitals for joint practice and community primary centers as shown: a community primary center and a 30 bed hospital for Joint Practice per 20,000 to 25,000 population and give it on rental basis to groups of doctors with specified controls on pattern of charges. The charges would be quite affordable in these centers. The development plan for the city should have mandatory provision for such centers and hospitals. Universal Health Coverage is ideal but cannot be achieved till every citizen is made to

IDEAL GROUP HOSPITAL (private or public)

SERVICE	RUNNING COST	RETURNS	REMARKS
O.P.D. & Day Care	Low	Very High	
Wards	Moderate	Moderate	
Diagnostics	High	Very High	
O.T.	High	High	If fully utilised
PHARMACY	Moderate/ Low	High	Rapid Turnover
Emergency	Moderate	High	
I.C.U.	Very High	Low	But essential

pay a certain percentage of his salary/income for health services. In my opinion, UHC THROUGH TAXATION MONEY IS A MYTH.

Lastly, we must become cost conscious. Anything can be done with money but money is not easy to get. Social activists must propose and struggle for facilities within the financial capacity of the community or the State. They can certainly point out the discriminations and unjust practices in the management but must advocate facilities within the



capacity of the community. Politicians take advantage of the very demand of the people and dump costly modern technology on our heads – not much relief but extra-ordinarily high costs.

If proof were necessary, Mumbai is a startling example to prove that the best health can be provided not by hospitals and modernity, it is by simple other means such as hygiene, de-congestion, clean water and nutritious food, along with a pollution free atmosphere and a stress-free peaceful society. The contribution of the state towards primary health care and at least 50% of the health expenditure helps a lot. Bhutan has 2 doctors per 10,000 people but is declared a happy and healthy country, Thailand has 3.5 doctors but a good system and they live upto 72 years; so also Sri Lanka 5.3 doctors but has a life expectancy of 72-73 years. It is difficult to show a city with more pollution and more stress than Mumbai (Delhi excluded) and all medical advances and numbers of doctors do not help.