POLICY BRIEF

HEALTH CARE IN DELHI*

Universal coverage is being increasingly considered as the holy grail of health policy worldwide, and is regarded as the ultimate goal for health systems aiming at equity and promoting responsiveness. Universal health coverage (UHC), with its roots dating back to the 'Health for All' declaration of Alma-Ata way back in 1978, repositions health as a basic, undeniable human right - an entitlement which is obligatory for the state to provide to all citizens irrespective of income, social groups, localities or social class. In India, the health policy discourse in recent years have also veered towards the notions of universal coverage; the draft 12th Plan document on health devotes a fair length to emphasize the virtues of universal coverage, drawing on comparative international experiences, and puts forward the recommendations of a High-Level Expert Group constituted by the Planning Commission to review and suggest the modalities of moving towards universal coverage (Planning Commission 2013). It is thus, natural that health policy and systems research in India is waking up to assess performances and impact of health programmes and interventions viewed with the UHC lens. However, comprehensive reviews of the roadmap towards universal coverage have been rare.

1. HEALTH SYSTEM CHALLENGES IN DELHI

Delhi, apart from being the national capital territory (NCT), is an interesting case for health policy and systems review. The cosmopolitan fabric of the city-state presents a microcosm of the growing India of today and thus, an ideal setting for experimenting new ideas and reforms to improve service delivery and match people's aspirations and

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expectations. A largely urban city-state, the health system in Delhi is beset with a number of pressing challenges.

Firstly, while the state government is responsible for planning and executing delivery of health services within the NCT, its clientele, comprising the entire national capital region (NCR) and contagious districts in the neighbouring states, actually surpasses manifold the domiciled population.

Secondly, the existing laws and regulations often lead to overlapping actions by multiple agencies regarding public health aspects: the precise roles and responsibilities of the different agencies, viz. the state government, the three Urban Local Bodies (Delhi Metropolitan Corporation, New Delhi Municipal Corporation, and the Delhi Cantonment Board), and the Delhi Development Authority are often ambiguous and lead to blind-spots in programmatic actions.

Thirdly, the social determinants of health – mostly living conditions and access to basic amenities – continues to be grossly inadequate for certain disadvantaged localities and populations such as the *jhuggi-jhopdi* (JJ) clusters, slums, unauthorized colonies and other low-income settlements in high-density localities. The consequent risks for public health and poor health behaviours are significant.

Fourthly, in terms of the common summary measures of population health Delhi presents a mixed bag of achievements and shortcomings. Although, having the lowest death rates and one of the best life expectancy levels in the country, infant mortality rate (IMR) continues to be high at 28 infant deaths per 1000 live births according to the latest available estimates from the Sample Registration System (RGI 2012). A bulk of deaths in infancy is during the neonatal period and of avoidable causes such as infections. Institutional deliveries, presently at 84 per cent[1], is yet to be universal; with much better availability of health facilities, it suggests persistence of socioeconomic inequalities in the access barriers – poor awareness, knowledge and lack of hygiene disproportionately affecting the poor benefiting from these services. Besides, as mentioned earlier Delhi has to bear with a steady influx of healthcare seekers from neighbouring states/region. A significant proportion of these 'external demand' are sick newborns and infants, often at critical conditions, brought to the large government

hospitals located at the city, and this leaves little chances for life-saving interventions to be effective. Following usual norms of civil registration system, such deaths of 'out-born' infants get registered on Delhi's account, inflating the mortality indicators, but with little scope for any intervening action by the state's health system on these cases.

Fifthly, the burden of disease scenario in Delhi, as evident from hospital-based disease surveillance system reaffirms the well-set 'double-burden': non-communicable diseases account for nearly a third of all ailments in Delhi, and half the deaths[2]. While certain diseases such as pneumonia are on the wane, cancers, diabetes, chronic heart diseases and respiratory problems are on a steady rise.

Lastly, in spite of having an impressive network of health facilities, public delivery of health services are severely affected by lack of adequate health workforce – even including specialists and other health professionals normally not available for general practice, less than four health care providers are available for every 10000 population in the state. About 40 per cent of the sanctioned positions of medical officers remain vacant and about 20 per cent of paramedical positions[3]. Notably, recent household surveys have indicated a growing reliance on the public health facilities – a recent Public Perception Survey found nearly 60 per cent of the households visiting a public health facility during the latest episode of service-need (Mazumdar and Mazumdar 2013). Among the low-income households, the reliance is near-universal. It is clearly a tough challenge to manage the huge demand at the primary and secondary levels: often a dispensary witnesses a General-Duty Medical Officer (GDMO) treating more than 600 patients in the span of about six hours. The most direct fallout, apart from overcrowding and occasional scuffles, is the quality of services. In the survey cited above, the two aspects on which the public facilities were rated as 'highly unsatisfactory; included the interpersonal dimensions of 'behaviour of the provider' and 'proper examination' (ibid).

2. POLICY OPTIONS ON THE ROAD TO UNIVERSAL COVERAGE

With its typical mix of service needs and expectations, the state government has been making quite a few sincere initiatives to manage these multi-faceted challenges and has to its credit a few remarkable achievements. The budgetary outlay on health in Delhi – at

about 10 per cent in 2012-13 according to a recent RBI publication (RBI 2013) – is the highest in the country. Schemes aimed at reaching out to the underserved and vulnerable segments such as the JJ clusters – the Mobile Health Scheme currently serves more than 430 localities and treats an average of two million mostly poor patients annually – is an important step towards ensuring equity in service delivery. Delhi perhaps is credited with being one of the pioneers in providing generic (as well as branded formulations) for free in all public health facilities, based on a strong system of stringent quality checks, real-time stock updation and rational drug use. In spite of pressing problems and almost perennial disputes regarding availability of land between different government agencies, there has been almost a two-fold increase in the number of beds and clinics in Delhi over the last 15 years[4]. Lastly, while there are alleged claims of the private hospitals flouting the requirement through fudged-up records, nearly 650 free-beds are available in 44 private hospitals (including some of the best corporate hospital chains such as the Apollo Hospitals, Max Hospitals etc.) in Delhi for poor patients residing anywhere in the country.

2.1 Focus on Emerging Challenges

However, the road to universal coverage, beset with the challenges outlined above is still a long way to traverse. While the proliferation in the availability of heath service options makes 'unmet need' a less-pressing concern, certain typical services for new, emerging health conditions may be in short supply. Examples include provisions for specialized geriatric care (including mental health), and the 'silent epidemic' of chronic diseases. Notably, in her latest budget speech, the Chief Minister Mrs Sheila Dikshit, recognized such emerging risks and insisted in shifting focus from a predominantly curative care-oriented system to a more holistic health system. As increasingly accepted globally, lifestyle modifications such as workplace wellness interventions, tobacco cessation clinics etc. are the most cost-effective solutions to manage chronic diseases and its risks, which, as recent studies indicate, exert a disproportionate toll on the poor (Vellakkal et al 2013). Such integrated preventive strategies and interventions, with routine community-based screening, needs to be an integral part of the health system. Lifestyle education campaigns needs to be vigorously pursued and in partnership with civil society organizations such as the Residents' Welfare Associations (RWAs).

2.2 Restructuring Health Workforce through Dedicated Cadres

The Delhi Human Development Report 2013 has proposed a radical facelift to the existing manpower policies to meet up the crisis of health workforce, in a spirit similar to that made in the High-Level Expert Group (HLEG) Report. This includes creation of a dedicated cadre of Public Health Technical Officers (PHTOs) with an intensive six-semester training program on basic epidemiology, public health, social and preventive medicine, pharmacology and health management. The PHTO cadre will have the responsibility as health facility managers, and incentivized to build individual primary health centres and clinics as *Wellness Centres*. The manpower solution needs to be matched up with innovative, need-based service reorganization solutions. These can include, identifying 'high-volume' centres based on some ratio (e.g. a threshold of 200 patients/6 hour shifts), and use alternative options to manage the excess patients e.g. contracting-in services of local general practitioners (GPs) for certain days on standard incentive schedules; starting 'evening clinics' in these centres, with the added facility of having specialists rotating between clinics in the same district on the designated days; special day-long weekend clinics can be run, with a compensatory week-day off for the manpower involved. In the true spirit of a *cafeteria-approach*, these arrangements can extend a wider array of service delivery options, and help significantly in improving the quality dimensions by facilitating a more relaxed physician-patient interaction.

2.3 Towards Health Coverage as an Entitlement– the Universal Health Entitlement Card

The central aspect of universal coverage is concerned with financial risk-protection. Here, as in other aspects of service provisioning in Delhi, it is apparently a multiplicity of options, often cancelling out each other and leaving gaps in the safety-net required to be extended. The flagship national health insurance scheme – the Rashtriya Swasthya Bima Yojana (RSBY) – is a poor performer in Delhi, partly due to weak convergent action between the labour and health departments. The latter, is reluctant to push the RSBY scheme, and argues in support of its own illness assistance funds (the Delhi Arogya Kosh

and Delhi Arogya Nidhi[5]), and specific equity-oriented measures such as the provision of free beds in private specialty hospitals mentioned above. Though novel, and fine in spirit, the coverage of both the illness assistance funds remains awfully inadequate. The DHDR 2013 proposes the introduction of a *Universal Health Entitlement Card* (UHEC) with the operational aspect and logistics similar to the existing RSBY modalities of Smart Cards. The UHEC will be 'prepaid' biometric cards, with credits in-built and varying according to the socioeconomic classification of the household. The UHEC can be debited at all public health facilities and designated Points-of-Care (POC) to avail a pre-identified package of basic health services, similar to that mooted in the 12th Plan (Planning Commission, *op. cit.*). This basic package – which we term as the *Common Standard Health Entitlement Package* (CSHEP) will include treatment for common ailments in clinics (basically, broad-basing the RSBY to cover outpatient clinic consultations, as done already in a few states on a pilot basis), child care and maternal health conditions, screening for chronic diseases and emergency critical care, and accidents/injury/trauma cases. The optimal package of services can be decided based on need and reported health conditions. Similar to the RSBY, a standard schedule of charges will be determined for each service/consultation. Households can pre-purchase credits for the UHEC at designated outlets, and can actually 'save' for unforeseen health contingencies. Provisions can be made for individuals to avail extra credits for their respective UHECs by participating in wellness programmes or lifestyle modification interventions, or for offering voluntary health services work in the neighbourhood. While the details and modalities of the UHEC can be only finalized after rigorous, randomized tests, it well-embodies the spirit of UHC, and puts forth for the government an option to consider adopting.

3. CONCLUSION

The road to universal coverage for a growing metropolitan region like Delhi is mired with challenges aplenty, but a good network of health care infrastructure and strong fiscal support to the expansionary approach of the public health sector provides an ideal setting to fast-track the progress towards making the health system more inclusive, equitable and responsive. It requires continued efforts in strengthening the service delivery systems, particularly addressing shortfalls in manpower and reaching out

aggressively to the underserved, vulnerable pockets. Greater receptiveness to evidence-based research from the ground, and partnerships between the policy-makers, the academia and civil-society groups to test out innovative mechanisms, similar to the ones mooted in the Report, should form a core basis of priority-setting and concurrent evaluation of progress towards the goals of universal coverage.

Endnotes

1 Communication from the Directorate of Family Welfare, Department of Health and Family Welfare, Government of National Capital Territory of Delhi.

2 For detailed break-up of burden of diseases and cause of death statistics in Delhi, see Chapter 4 on Health and Healthcare, *Delhi Human Development Report 2013*.

3 Official communication from the Department of Health and Family Welfare, GNCTD, dated August 13, 2013.

4 *Ibid*

5 These schemes are designed to provide cash assistance to patients from the economically weaker sections (and having the relevant entitlement cards) for treatments involving high financial costs. The Delhi Arogya Kosh is specifically aimed at supporting dialysis related expenses, in government and empanelled private hospitals.

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