Network of Asia-Pacific Schools and Institutes of Public Administration and Governance (NAPSIPAG) Annual Conference 2005
Beijing, PRC, 5-7 December 2005

Theme: The Role of Public Administration in Building a Harmonious Society

Workshop on Health Care for the Poor in Asia

Health Care for the Poor in India with Special Reference to Punjab State

B.S. GHUMAN*
AKSHAT MEHTA**
* Professor and Chairman, Department of Public Administration, Panjab University, Chandigarh-160014, India
**Research Fellow, Department of Public Administration, Panjab University, Chandigarh-160014, India
Health Care for the Poor in India with Special Reference to Punjab State

B.S. GHUMAN*  
AKSHAT MEHTA**

Quality of human resources plays a strategic role in the economic and social development of a nation. Quality of human resources in turn, largely depends upon the quality of education and health services. The literature on market failure suggests that health, as also education is a 'merit good', which if left to the individuals, is normally under-consumed. It is more so in the case of poor, who have meager resources. Another feature of merit good is its positive externalities. That means the benefits of merit goods do not confine only to the individuals, who pay for it; society/community at large also reap its benefits. Health care being a merit good, literature points out that private market may result in restricted access. The government’s active role either in the form of direct provision of health care services or regulation of the supply of health care by the private sector is essential for ensuring equitable access particularly to the poor (Walsh, 1997). In India, the health care services are marred by class inequalities, denial of opportunities to disadvantaged groups, low accessibility to lower strata and rampant corruption. The same trend is noticeable in Punjab also (Government of Punjab, 2004). This necessitates active role of government in the provision of health services, particularly to the poor.

At present mainly three policy initiatives are in progress for health care for the poor. These include: (i) Exemptions to the poor from users fee in government hospitals; (ii) Provision of free of cost treatment to poor (subject to a proportion of total patients) in private super-speciality hospitals; and (iii) Health insurance schemes for the poor.

The objective of this paper is to examine health care for the poor in India with special reference to Punjab State.

The paper is organized into three sections. In Section I, methodology adopted in the paper has been described. Major findings of the study, covering resource allocation to health sectors, inequity in health care services and specifically progress on account of health care for the poor have been reported in Section II. Conclusions and Policy implications have been documented in Section III.

I  
METHODOLOGY

The study has used both primary and secondary data. The secondary data have been collected from reports of Ministry of Health and Family Welfare; Government of India; National Planning Commission; Punjab Health Department; Punjab Health Systems Corporation (PHSC); Government and Private hospitals located in Punjab; Economic and Statistical Organisation Punjab; Punjab Urban Development Authority (PUDA); Punjab State Planning Board; and literature (Deogaonkar, 2004; EPOS Health Consultants; Gupta and Datta, 2003; Gupta, 2002; Mahal, 2000; Multinational Monitor, 2000; and PUCL Bulletin, 2000).

* Professor and Chairman, Department of Public Administration, Panjab University, Chandigarh-160014, India. E-mail: ghumanbs@pu.ac.in; ghumanbs@hotmail.com

** Research Fellow, Department of Public Administration, Panjab University, Chandigarh-160014, India. E-mail: akshat_humane@yahoo.co.in
Primary data have been collected with the help of a structured questionnaire. The questionnaire is divided into five sections. The sections include general information about the respondents; awareness about the below poverty line document, popularly known as yellow card; yellow card usage at government and private hospitals; satisfaction level with health care services and health insurance. The questionnaire before finalisation was pre tested. The final questionnaire was administered to 100 respondents. The respondents were mainly residents of Mundi Kharar village in Kharar development block of Ropar district in Punjab. All the respondents were Scheduled Caste, which are the lowest strata of the society. In Punjab, as also in rest of the country, majority of the poor belong to Scheduled Caste population. Observation was also used as a method of data collection to supplement the information collected through questionnaire. Data have been analysed by employing simple techniques such as percentages and averages.

II

(i) Resource Allocation to Health Sector and Inequity in Health services:

Indian economy has been experiencing a rate of growth in the vicinity of 5 percent since mid-eighties barring a few years of economic crisis. The fruits of economic growth, however, have not percolated to social sector. Health sector – a major constituent of social sector – instead of gaining has suffered on account of allocation of funds – during the high profile economic growth phase of the economy. For example, the public expenditure on health as a percentage of total government expenditure was 3.12 per cent during the first year (1992-93) of economic liberalization and it declined to 2.99 per cent in 2003-04 (See Table 1). The combined expenditure on health as a percentage of gross domestic product (GDP) follows the same trend. Table 1 shows that the combined expenditure on health as percentage of GDP was 1.01 per cent in 1992-93 and it came down to 0.99 per cent in 2003-04.

Table 1
Public expenditures on health, disaggregated

<table>
<thead>
<tr>
<th>Year</th>
<th>As % of Total Government Expenditure</th>
<th>As % of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>States</td>
<td>Centre</td>
</tr>
<tr>
<td>1992-93</td>
<td>4.96</td>
<td>1.31</td>
</tr>
<tr>
<td>1993-94</td>
<td>5.16</td>
<td>1.49</td>
</tr>
<tr>
<td>1994-95</td>
<td>4.85</td>
<td>1.62</td>
</tr>
<tr>
<td>1995-96</td>
<td>4.98</td>
<td>1.78</td>
</tr>
<tr>
<td>1996-97</td>
<td>4.85</td>
<td>1.50</td>
</tr>
<tr>
<td>1997-98</td>
<td>4.94</td>
<td>1.55</td>
</tr>
<tr>
<td>1998-99</td>
<td>4.98</td>
<td>1.58</td>
</tr>
<tr>
<td>1999-2000</td>
<td>4.80</td>
<td>1.75</td>
</tr>
<tr>
<td>2000-2001</td>
<td>4.65</td>
<td>1.87</td>
</tr>
<tr>
<td>2001-2002</td>
<td>4.41</td>
<td>1.99</td>
</tr>
<tr>
<td>2002-03</td>
<td>4.27</td>
<td>1.67</td>
</tr>
<tr>
<td>2003-04</td>
<td>4.12</td>
<td>1.69</td>
</tr>
</tbody>
</table>


It is not only that the investment of public funds has been declining in the health sector; the benefits of public health services have mainly been accruing to better off strata of the society. The combination of declining public funds for health sector and the accentuation of inequalities in health care services has been hitting hard the marginalized and socially dis-advantaged...
population (Government of India, 2002). According to one estimate the Infant Mortality rate among the poorest 20 percent of the society is 2.5 times higher than that of its counterpart (i.e. the richest 20 percent of the society (Deogaonkar, 2004). Mahal, et.al. (2000) in their study have also found bias in favour of rich in public policy. According to them the poorest 20 per cent of the total population received about 10 per cent of the total net public subsidy. In contrast, the richest 20 per cent population garnered around 30 per cent of total net public subsidy (Planning Commission, 2005). The mushrooming of private sector hospitals has further widened the disparities between the urban and rural areas as well as among various strata of the society. The Hindu in its editorial stated, “International studies have shown nearly 80 per cent of patients in India resorting to private caregivers for major and minor ailments — despite the existence of a public health system of a sort. Such patronage and steadily increasing demand have resulted in a significant expansion of private hospital bed capacity, although this is concentrated largely in urban India and remains unaffordable to the overwhelming majority of the people. The strong growth of private healthcare has understandably led to the demand for a system of oversight in the interests of equity, credibility, and professional accountability” (The Hindu, April 5, 2005).

The case of Punjab state is not different from the national scene. Punjab state is one of the richest states of the Indian Union. The state has experienced a highest growth rate (around 5 percent) among Indian states for about 30 years. In the recent past the rate of growth of the state economy has started decelerating. In spite of being the richest state in terms of economic development, the state lags behind on account of social development, particularly in the area of health. According to Human Development Report 2004, Punjab, public investment in health is very low. Primary health care is the major sufferer of lack of investment and thus pushing people particularly poor towards expensive and unregulated private sector (Government of Punjab, 2004). The state budget allocates meager resources to both primary and secondary health care sectors. A quick look at Table 2 indicates that budgetary allocation to health services constitutes around 4 per cent of the state’s total expenditure. The total expenditure on medical and public health is only 0.79 per cent of the state income, which is below the national average (0.99 %).

Table 2
Expenditure on Medicine and Public Health by Government of Punjab

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Expenditure (Rs. Crores)</th>
<th>Expenditure on Medical &amp; Public Health (Rs. Crores)</th>
<th>Net State Domestic Product (NSDP) (Rs. Crores)</th>
<th>Expenditure on Medical &amp; Public Health as % age of the Total Expenditure</th>
<th>Expenditure on Medical &amp; Public Health as % age of NSDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-04 (Actual)</td>
<td>15701.92</td>
<td>556.70</td>
<td>69840.82</td>
<td>3.54</td>
<td>0.79</td>
</tr>
<tr>
<td>2004-05 (Revised)</td>
<td>19220.07</td>
<td>704.77</td>
<td>N.A.</td>
<td>3.66</td>
<td>-</td>
</tr>
</tbody>
</table>


(ii) Exemption From User Fee in Government Hospitals:

The Punjab Government, since the onset of economic liberalization, privatization and globalization, in the beginning of 1990s, introduced two drastic reforms in health policy of the state. First, the government of Punjab set up the Punjab Health Systems Corporation (PHSC) in October, 1995 under the World Bank sponsored India-State Health Systems Development
Project-II. More than 150 health care institutions run by the government were transferred to PHSC. With a view to mobilize resources the earlier practice of free services was replaced by the users fee from all patients barring few categories of patients including people below poverty line.

The second policy decision is the opening of health care services in a big way to the private corporate sector. Under this policy, the private sector hospitals have been getting land and other infrastructural facilities at subsidized rates and are expected to provide free of cost treatment facility to the yellow card holders (i.e., people below poverty line), up to 10% of the outdoor patients and 5% of the in-door patients. These hospitals on yearly basis have to provide the details of yellow cardholder patients to the Punjab Urban Development Authority (PUDA)- an organization, which has allotted land to these hospitals on subsidized rate.

In case of government hospitals, the poor under the new policy, as stated earlier are exempted from user charges. However, outcome is far away from the rhetoric.

Results based on primary data show that only negligible proportion of people below poverty line avail exemptions from the user charges in government hospitals. Table 3 shows that the percentage of yellow cardholders treated free of cost constitutes only 0.4 per cent of the total patients treated in the out patient department of civil hospital Kharar in Punjab in 2002-03, which further declined to negligible proportion (i.e. 0.008 per cent) in the year 2004-05. In district hospital Ropar also, out of the total 1, 48, 300 patients only 4 patients were yellow cardholders during the year 2004-05.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Yellow Card Holders Treated</th>
<th>Total Patients Treated</th>
<th>% age of Yellow Card Holders to the Total Patients Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2002 to September 2003</td>
<td>321</td>
<td>80109</td>
<td>0.4%</td>
</tr>
<tr>
<td>September 2003 to September 2004</td>
<td>18</td>
<td>78107</td>
<td>0.02%</td>
</tr>
<tr>
<td>September 2004 to September 2005</td>
<td>7</td>
<td>79553</td>
<td>0.008%</td>
</tr>
</tbody>
</table>

Source: Health Management Information System, Civil Hospital, Kharar, Punjab

According to the field survey, mainly two factors, viz. ignorance among the poor for the free treatment, and complex and cumbersome procedure for getting and renewing of the yellow cards are constraining the access of the poor to public health care services.

Around 58 per cent of the respondents, had a yellow card in their name at a point of time. The field survey reveals that 75 per cent of the respondents were not aware that a yellow cardholder gets user-fee exemption in the government hospitals. As many as 43 per cent of the respondents faced renewal problem and 32 per cent of the respondents said that they had encountered bureaucratic/procedural problems while obtaining the yellow card. The overwhelming majority, i.e., 84 per cent of the respondents were illiterate, which has further compounded the problem as 37 per cent of the respondents were not even aware about the procedure for getting a yellow card prepared and 31 per cent did not even apply to get one. While
applying for a yellow card, 77 per cent respondents had loan benefits in their mind and only 7 per cent were aware of its health benefits.

Of those who were aware about the user fee benefits of yellow card in government hospitals, only 8 per cent availed this facility and the respondents named x-ray, medicines and treatment as the facilities, which were made available to them at concessional rate or free of cost. The out of pocket expenses even after availing the benefits of yellow card were quite high and averaged around Rs. 500 per case.

It is interesting to note that getting health care benefits on the basis of yellow cards is not free from hurdles. For example, about 10 per cent of the respondents faced difficulties in getting yellow card benefits in government hospitals. The problems listed by them included, non-cooperative staff, repeated visits, long waiting lists, insensitivity and being told to pay for the services availed.

Lack of adequate health services provided by the government compels the poor to mainly depend upon their own resources for health care. On an average a poor household spends Rs. 428/- per month on health care, which constitutes about 25 per cent of mean household income (Rs. 1730) of the poor families. Among poor families elderly members are the main sufferers due to the lack of resources for health care. The survey reveals that 100 per cent of the respondents opined that old people had to sacrifice because of the low levels of their income. Children followed by young get preference in health care expenditure. Interestingly among the poor, there is no gender bias so far as getting the medical treatment for family members is concerned.

The poor in Punjab in the absence of adequate opportunities provided by the government for health care largely depend upon the unorganized private sector (Gupta, 2002). About 90 per cent of the respondents prefer private hospitals mainly, due to proper attention and saving of time and immediate relief. Saving of time is the major consideration as poor have high opportunity cost in the form of wage loss. The private sector in the state is dominated by quacks. The survey reveals that 89 per cent of the respondents used the services of quacks, traditionally known as dais for the purpose of birth of the child and only when these dais can’t handle a case or complications develop, the patients are taken to the government hospitals. Dais/quacks are preferred on account of cost, accessibility and proximity considerations. According to a recent report three children died while two more children and one man were taken seriously ill within minutes of swallowing medicines provided for different ailments by the quacks in Ludhiana are not uncommon in Punjab (The Hindustan Times. a., 2005).

(iii) Private Super Speciality Hospitals and Poor:

The second policy decision, as mentioned earlier is the opening of health care services in a big way to the private sector.

The benefits of this policy decision have also not percolated down to the poor. In one of the very prestigious private hospitals, not even a single poor patient has availed free treatment against the targets of 10 per cent for the outdoor patients and 5 per cent for the indoor patients. Punjab Urban Development Authority (PUDA) so far has not received the list of poor patients from any of the private hospitals in the state. The elite orientation of the management, lack of awareness among the poor for free treatment in private hospitals, and ineffective regulatory mechanisms are the major stumbling blocks in the way of the poor for getting free treatment from private hospitals.

The results thrown up by the field survey reveal that 99 per cent of the respondents had not even heard that yellow cardholders were eligible for user-fee benefits at private super speciality hospitals. The respondents stated that they were not only unaware of any such facility
but, it was simply beyond their imagination to even think that any one in private sector could offer services free of cost as profit was their sole motive. Only one per cent of the respondents, who approached a private sector super speciality hospital reported of non-supportive nature of the staff owing to their profit orientation and commented that such hospitals don’t pay attention to the poor patients.

Absence of free treatment of poor by the super-speciality private hospitals is not unique to Punjab. Two Public Interest Litigations (PILs), one each in Delhi High Court and Bombay High Court have been filed against corporate hospitals for not providing free treatment to the poor. According to the PIL in Delhi High Court, Delhi development authority (DDA) has provided land on concessional rate to 12 private hospitals. In case of Bombay the number of such hospitals is 70. None of these hospitals provides free treatment to the deserving poor (Thomas, 2005; and The Tribune, 1999). The cases for providing free treatment to the non-poor under poor categories, however, are reported (The Tribune, 1999). A recent study conducted by the Planning Commission also says that the bulk of private health care units in India are run by the doctors and doctor-entrepreneurs and remain unregulated either in terms of facility of competence, standards or quality and accountability of practice. Also as a follow up to the National Health Policy 2002, private hospitals were given concessional lands, customs exemption and liberal tax benefits/concessions against a commitment to reserve beds for poor patients for free treatments. But unfortunately, as no procedure exists to monitor this and the disclosure systems are far from transparent, redressal of patient grievances is poor (Neogi, 2005). Adenwalla (2005), while making similar observations said, “The administrators in most private sector hospitals and medical colleges are essentially businessmen. They have reduced medical care to the level of an industry. The poor man, unless he is willing to incur enormous debts, is unceremoniously elbowed out of these institutions” (also see Praveenlal et.al. 2005). The Prime Minister of India, while recently inaugurating, a multi-speciality hospital in the private sector in Punjab, reiterated that the benefits of these institutions must reach the poor (The Hindustan Times, b., 2005).

(iv) Health Insurance and Poor:

Health insurance is another means to improve the access of the poor to health care services. Prime Minister of India has also underlined the role of health insurance for improving the access of poor to health care services (Hindustan Times, 2005). In India, both the public sector insurance companies and NGOs/community based organisations have floated a host of insurance schemes for the poor. Two prominent schemes introduced by the public insurance companies are Jan Arogya and Universal Health Insurance Scheme. The NGOs have offered around 26 insurance schemes for the poor. The health insurance schemes have also not succeeded in achieving their objective, i.e. helping the poor during the ailments. For example, Bennett et al. 1998, while reviewing the community based insurance schemes opined that most of these schemes suffer from poor design and management and fail to reach the poorest of the poor. Their membership is not widely spread over the poor population and in addition these schemes need extensive financial support (WHO, 2004). In Punjab the position is very grim on account of health insurance for the poor. The insurance companies have not launched any comprehensive awareness and marketing strategies for these schemes and thus the poor fail to take their advantage. For example, the field survey shows that none of the respondents had even heard about health insurance policies for the poor, as nobody told them and the illiterate background also restrict poor's access to health insurance policies. Though most of the respondents showed keen interest in this scheme, but, they were not aware as to which agency to contact or what to do.
In India, social sector in general and health sector in particular has been the looser on account of resource allocation during post-liberalisation and globalisation phase. During the first year (1992-93) of liberalisation, the combined expenditure of central and state governments on health was 1.01 per cent of the GDP, which declined to 0.99 per cent in the year 2003-04. The similar trend was noticeable in case of Punjab state. The poorer strata of society have suffered more due to meager resource allocation to health sector.

In Punjab, health policy has witnessed two major reforms during the post-liberalisation phase. First, the government of Punjab set up the Punjab Health Systems Corporation (PHSC) in October, 1995 under the World Bank sponsored India-State Health Systems Development Project-II. More than 150 health care institutions run by the government were transferred to PHSC. Aiming to raise resources the earlier practice of free services was replaced by the users fee from all patients barring few categories of patients including people below poverty line. Second policy decision is the opening of health care services in a big way to the private sector. Under this policy, the private sector hospitals have been getting land and other infrastructural facilities at subsidized rates and are expected to provide free of cost treatment facility to the Below Poverty Line (BPL) family document holders.

The empirical evidence gathered from both secondary and primary sources and data suggests that the benefits promised to the poor in the form of free treatment in government hospitals after the setting up of Punjab Health systems Corporation, have not really reached the target groups. Mainly two factors, namely, ignorance among the poor for free treatment, and complex and cumbersome procedure for getting and renewing of the yellow cards are constraining the access of the poor to public health care services.

The poor in the absence of adequate access to government hospitals mainly depend upon the unorganized private sector hospitals for health care. These hospitals are dominated by untrained doctors/quacks. The dependency of the poor on private hospitals takes away around one fourth of their income.

The benefits of super speciality hospitals have not reached the poor at all. Factors such as elite orientation of the management, lack of awareness among the poor for free treatment and ineffective regulatory mechanisms are the major stumbling blocks.

The government and NGOs have announced many health insurance policies for the poor. The outcome again is unsatisfactory. Poor design and management of the policies, lack of wider coverage and inadequacy of funds explain unsatisfactory progress of insurance policies for the poor.

Based on its analysis, the study suggests the following for improving the access of the poor to health care services in India in general and Punjab in particular.

First, the national and state governments should allocate more resources to health care and achieve the target of 6 per cent as set by the National Health Policy - 2002. Further, within health sector progressively allocation to primary health care should increase, as the poor are the major beneficiaries of primary health care services.

Secondly, the government and NGOs should launch a campaign for making the poor aware about the exemption of user charges in government hospitals and super-speciality private hospitals. The government should make it mandatory to both public and private hospitals to
display prominently in their premises, the information regarding exemptions of user charges to the poor.

Thirdly, the procedure for getting and renewing the below poverty line document (i.e. yellow card) should be made simple, transparent and time bound. In the light of decentralization initiatives (i.e. the 73rd and 74th Constitutional Amendments) aiming to empower rural and urban local elected bodies, the authority to issue yellow cards should be transferred to local governments.

Fourthly, the government should make it mandatory for super-speciality hospitals to meet their targets meant for poor patients. The hospitals should regularly submit the data regarding poor patients to Punjab Urban Development Authority, failing which; heavy penalty should be imposed upon them.

Fifthly, the poor should be widely informed through local elected bodies and civil society organizations about the health insurance policies for them. In their design, management and implementation, the participation of the poor should be solicited.

Sixthly, a more vigilant, transparent and regulatory regime is all the more necessary for making the delivery of health care services pro-poor. The information about the regulatory authorities, particularly about the nodal officer’s name and phone number should be displayed in each hospital, so that the poor patients can easily contact the officer in case of denial of service by the hospital.

REFERENCES


EPOS Health Consultants (2004), State Health Systems Development Project II - Punjab, New Delhi.


Gupta, I.; Datta, A (2003), "Inequities in health and health care in India: can the poor hope for a respite?", Institute of Economic Growth, Delhi University.


The Hindustan Times. a., "Quack’s medicine kills 3", Ludhiana, September 21st, 2005.


Thomas, Shibu (2005), “No Free Treatment for Poor at Charity Hospitals in City”, Mid-day, February 24, 2005.


BIOGRAPHICAL SKETCH OF THE AUTHORS

B.S. Ghuman is Professor and Chairman, Department of Public Administration, Panjab University, Chandigarh, India. He is the author of about 50 papers and one book. His current research interests are economic administration, public enterprise management including privatization, governance, policy studies, poverty and sustainable development. He is on the Editorial Boards of the Social Sciences Research Journal, The Asia Pacific Journal of Public Administration and Consultant, Political Economy Journal of India. He is on the Board of Directors, FACT (A Government of India Undertaking). He is also Director of two international projects and Co-ordinator, the Canadian Studies Centre.

Akshat Mehta is a Junior Research Fellow in the Department of Public Administration, Panjab University, Chandigarh, India. He is pursuing his Ph.D. on Telecom Regulatory Authority of India.