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HEALING PEOPLE, PART I

India on less than $30 a Year

Sandhya Srinivasan

MUMBAI, India—Shanta had a good life for a working class woman in Mumbai. Her husband Manoj was a watchman in a factory compound in a western suburb, and they lived in a room with running water, free electricity, even firewood for cooking. She commuted to work, an hour each way, into south Mumbai, where she cleaned three households. But in 2007, Manoj suffered a stroke, and though they went to a municipal hospital for treatment, they spent thousands of rupees (hundreds of dollars) on prescriptions. Shanta became the sole earner and they continued to spend on local healers. Then, Shanta was hospitalized for a severe bout of falciparum malaria (a virulent strain of the mosquito-borne disease, once limited to northeastern India, but now common in Mumbai). Recently, Manoj fell and broke a hip and required surgery, which cost $426 for subsidized treatment at a municipal hospital. To put that number in perspective, the monthly per capita income for 80 percent of the urban population is less than $42. In Shanta's case, the cost of her husband's hip surgery was four months' wages.

As medical costs rise, hospitalization can send a family to the local money lender, running up debts at exorbitant interest rates. Treatment for a single illness can push them to the brink. During one of her health crises, Shanta borrowed $213 at a 60 percent annual interest rate—money she paid back with a loan from one of her employers. India's annual health care expenditure per capita is $21, an amount the government believes is sufficient for all health care services. However, barely 15 percent of this money comes from federal finances, so people must pay for most health care out of pocket. When a country spends just 1 percent of its GDP on health, as India does, there is an intimate link between its health expenditure and the insecurity of its poor. The uncertainties of wages, housing and nutrition are critical factors that can mean the difference between survival and destitution. More than 450 million people (nearly half the population of India) live below the poverty line and make less than $1.25 per day. Trapped between expensive private services and an inaccessible (and still pricey) public sector, the poor can either seek medical treatment and risk pauperization, or go without.

No Alternatives

Health care is a matter of affordability and accessibility. Spending in India's health sector totals $32 billion, but only 15 percent of this comes from government public health services. The bulk of all money spent

on medicine in India goes to private doctors and hospitals, which is encouraged by government policy. Barely 5 percent of Indians have insurance coverage, so the vast majority of this private medical expenditure is paid out of pocket. Hospitals that do receive subsidies from the government are required to provide free or inexpensive treatment to those earning less than $1,066 a year. In reality, these subsidies are rarely available to those who need it most. Indeed, some of the major hospitals have been asked to provide evidence of their reduced-rate treatments, or to explain why they have not fulfilled their legal obligation to provide free or heavily-subsidized care.

When Shanta's husband Manoj broke his hip, they had to find a way to get him to the nearest hospital, an expensive private facility. It was just across the railway tracks from their slum, but the road journey even to the other side of the tracks cost $5. "There they told me they could treat my husband but that it would cost more than we could possibly afford," Shanta says. The nearest government health center didn't have the equipment or the staff to treat him—and they live barely 90 minutes from the heart of India's commercial capital. Eventually the family decided to bring Manoj to a municipal hospital in central Mumbai, but when an ambulance couldn't be found he had to travel for two hours by autorickshaw. It cost them $21, about 20 percent of Shanta's monthly income.

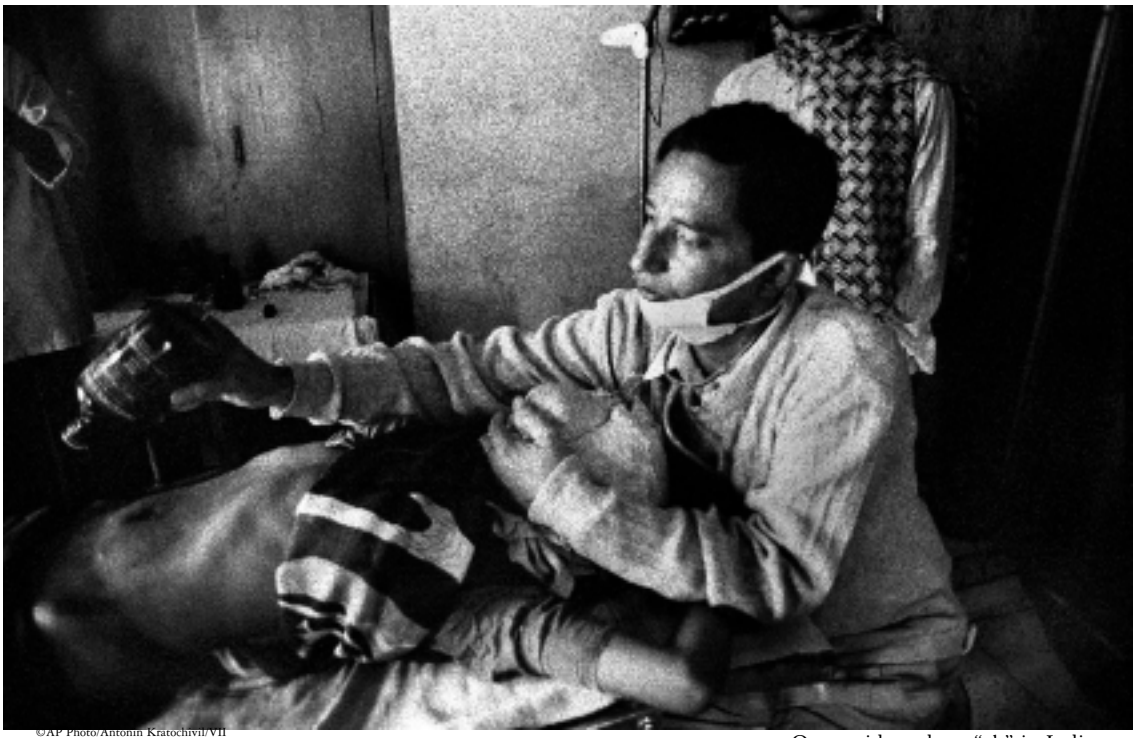
The municipal hospital was an institution of last resort, and they were greeted with a host of documents to fill out before Manoj could be considered for subsidized treatment. They had to have an income certificate and ration card from the local district office—though most poor Indians don't have such formal documents. Often, to get a government official to certify income, you must pay a bribe.

Packed and Violent

In a Mumbai suburb, in a municipal hospital, the corridor of the outpatient department is packed and steaming. A fight breaks out. The ward attendant keeps watch over some two dozen patients and their relatives as they push and shove, trying to crowd around the harried doctor. Bellowing threats, he manages to keep most of them in order, at a distance from the doctor's cubicle. The seated patients are uncomfortable and antsy; the standing ones are even worse off. A queue has formed on a bench along the wall and occasionally someone sneaks ahead, provoking cries of outrage from the others. An angry young woman shouts at the attendant for turning a blind eye when someone breaks the line. Later, he snaps at a woman who shows him a doctor's note with the word "urgent" scribbled at the top. "This is a municipal hospital," the attendant barks. "Urgent only means today, not this very minute."

The doctor in charge is surrounded by patients. She tries to concentrate on the person sitting in front while others vie for her attention. Public hospitals are primarily run by medical students completing residency requirements under the supervision of their instructors. Overworked staff must manage without basic amenities. Residents may be forced to use all their persuasive skills just to get a patient an urgent sonogram. One recounts gaming the system to obtain essential drugs and equipment. Sometimes they are unsuccessful. Inevitably they face outrage from a frustrated public.

The wards may be packed, the walls grimy, the paint peeling off the furniture and the stretchers battered—but public hospitals like this one are the only option for proper medical treatment for the poor in Mumbai and across much of India. The long waits mean that a simple outpatient visit requires missing a day's work, losing a day's earnings. The vast majority of the popula-



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Open wide and say "ah" in India.

tion has no job benefits and no job security, so each hospital visit is all the more costly and risky. In-patient care in public hospitals is even more taxing—requiring the constant presence of a patient's relatives to feed the patient and help in nursing care and, most importantly, to be on standby to rush out and purchase urgently required medicine that is not available in the hospital.

Since 2001, public hospitals have introduced "user fees" to recover costs from all inpatients except those who can prove that they are below the poverty line. In addition to a fee for a case paper documenting a first visit, user charges are levied for all procedures, from X-rays to surgeries. While these charges are subsidized, they are a lot of money for the class of patients visiting public hospitals. User fees recover between 0.67 percent and 10.67 percent of the real costs of most procedures, deterring many from seeking essential care. Others may not be able to pay the daily charges once they arrive. There are reports of patients sneaking out of the hospital during visiting hours.

The artificial hip Manoj needed for his surgery cost $277. The social worker reduced the charge to $214. "The social worker asked me how much money I earn and how many sons I have, and then wrote something on the paper," Shanta says. Her employer paid the money. "We schedule the operation only after the money is paid to the company that sells the implant," says one of the surgeons. If the surgery is done without payment, the hospital could be stuck with a bill. Public hospitals are meant to provide drugs and surgical materials free of charge, but many of the drugs and materials are not in stock. On the morning of Manoj's operation, Shanta was sent to the pharmacy across from the hospital's main gate to buy a list of items that came to $43. Shanta even had to buy the sutures required to sew her husband back up.

Middle Class Troubles, Too

Just 5 percent of all Indians are covered by any sort of private medical insurance, and even this is largely limited to hospital expenses. In the case of non-communicable diseases like diabetes, those who do get treatment often struggle to find the cheapest options. Families are often the first source of financial support. Diabetes affects some 32 million Indians, and insulin is expensive. One study of the medical expenses related to diabetics found that Indians with diabetes in rural areas can spend up to 25 percent of their annual income on treatment —for urban poor this rose to 34 percent.

Like insulin, cancer drugs are not covered by price controls, which means six months of chemotherapy can cost between $640 and $6,400. There are some 400,000 women in India living with breast cancer, with about 120,000 to 150,000 new cases each year. Hormonal therapy costs $533 to $3,837, and targeted therapies up to $2,558 a month. As a result of such high costs, barely 10 percent of those who need treatment receive it. In April 2008, the Cancer Patients Aid Association launched a campaign calling on the government to persuade drug companies to lower their prices for cancer drugs.

So what does health care mean at $21 per capita per year? It means that India has some hospital services equal to or surpassing those in many developed countries. Medical tourism is an industry recognized by the government, and hospitals are filled with people from the United States, Britain and other countries seeking procedures from cardiac surgery to dental implants at a fraction of the price back home. But for the vast majority of Indians, affordable and accessible health care is still but a distant dream. ●