

SHORT ARTICLE

The State of Healthcare Facilities in the Field of Cardiovascular Diseases: Reflections from a Public Cardiac Hospital, Uttar Pradesh

Arti Singh

Academic Associate, School of Social Sciences, Indira Gandhi National Open University, New Delhi

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Corresponding Author

Arti Singh, School of Social Sciences, Indira Gandhi National Open University, New Delhi-110068, India.
E Mail ID: meet.aartisingh@gmail.com



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Abstract

Background: Literature suggest that majority of Indians belonging to lower socio-economic status (SES) are dependent on public health sector but still there is higher rate of deaths among them due to cardiac diseases. **Objective:** The aims of this paper are twofold: (i) To depict the ground realities of a public cardiac hospital, and (ii) To identify the key challenges for the effective policy implementation and control of CVD. **Method:** Using direct field based observation, experiences and field notes. **Result and Conclusion:** India's public healthcare sector for cardiac patients suffers from problem of accessibility and affordability. Further, prevalence of prohibited practices makes things worse for the poor patients.

Keywords

Cardiovascular diseases; India; Public Healthcare Sector; Cardiac Hospitals and field observation.

Introduction

With the attribution of a quarter of deaths annually to CVD(1), it has been assigned as the number one killer of Indians. In 2015 alone, 2.1 million Indians died of cardiovascular diseases. Of these, 0.9 million deaths occurred between the age group of 30-69 years(2). In a systematic review, it has been concluded that in contrast to western countries, in India CVD is still more prevalent among higher Socioeconomic Status (SES) strata but the burden of its mortality lies among lower SES strata(3). In India, a majority of patients from economically weaker section prefer public sector hospitals(4) and higher rate of cardiac deaths among them have been attributed to the presence of disparities in treatment facilities and its related factors(5). These studies suggest that available facilities and healthcare policies with respect to public healthcare sector are not conducive enough in curbing the prevalence of CVD among the vulnerable section (lower SES) of India. Even though India is going through an epidemiological transition(6), non-communicable diseases are not getting due importance in health policies. The focus is still on acute and infectious diseases(7). In the view of this epidemiological transition, many researchers

have suggested a need to re-orient the healthcare policies and programs towards non-communicable diseases such as CVD, cancer, diabetes, etc.(7)

The discussed public cardiac hospital is located in the city of Kanpur. It was the only State Government run cardiac hospital of Uttar Pradesh; India's third largest and most populated state. This viewpoint is based on the interviews, observations, and experiences of the author gained during her fieldwork for Ph.D. dissertation. Based on experiences gained during her fieldwork, this paper present the views of the author on the problems prevailed in public cardiac hospitals.

This viewpoint has been discussed in the context of the problems of accessibility, affordability, and prevalence of prohibited practices.

Problem of Accessibility

Many studies have reported that in India, healthcare facilities are more skewed towards urban population(8,9). This unequal distribution of healthcare facilities leads to the problem of accessibility for the semi-urban and rural population. Discussing the problems in reaching to the hospital (studied site), a patient reported that, "The day I have to come here for my checkup, I start my journey at 5:00 a.m. from home so that I will reach here before 8 a.m.

as registration starts at 8:00 a.m." Another patient, who also came there for his regular check-ups, mentioned that he took a bus at 6:00 a.m. Both patients were suffering from Myocardial Infarction (MI) and live in the suburban areas of Kanpur city, Uttar Pradesh, India. This is just a glimpse of the struggle faced by people living in the villages and suburban areas to get regular check-ups for their disease. To get medical advice and treatment, some patients reported coming from places as far as 200 km. Several factors were attributed by the patients for coming from such a long distance. Some of the frequently reported factors were: absence of any specialized cardiac hospital, limited facilities in the hospitals back home and availability of subsidized treatment in the Government hospital.

Accessibility for better healthcare becomes more challenging for the patients and their family members as government ambulance service does not function properly. Respondents reported that even in the situation of emergency they had to travel to hospitals either using public transport or rented private vehicles. A small fraction of patients had their own vehicle, but majority of them were dependent on public transport. It was noticed that even though many government ambulances were parked outside the hospital premises, none of the respondents had ever used the ambulance service. Upon enquiring the reason for this, they responded that they do not have any trust in government ambulance service and many of them reported that they did not know how to contact the ambulance service. Interestingly, it was also noticed that many of these ambulances were in unused condition. Another study has also reported that there is a lack of good ambulance service in India(5).

Problem of Affordability

Many patients reported that they had either taken loans or borrowed money for their treatment. In one such case, the mother of a 43 years old male patient told that they are farmers by occupation and her only son had heart failure five months ago. Initially they took her son to a private clinic in Kanpur. They even sold a small piece of land to get their son operated. However, the surgery resulted in some complications later. "As we were left with very less money and could not get treatment in private clinic, we decided to come here." Similar accounts were shared by other respondents also. Such responses indicate the problem of Out-of-Pocket-Payments (OPP). In India, OPP is a major healthcare issue. In a report, Government of India also estimated that in India, approximately 70% healthcare expenditures were out of pocket(10).

To deal with the problem of OPP the Government has introduced many health insurance schemes for economically weaker sections like National Health Insurance Programme, Rashtriya Arogya Nidhi (RAN) and Health Minister's Discretionary Grants (HMDG). When inquired about awareness regarding these programs, very

few respondents reported having any knowledge. Further, those who reported being aware of the programs, had no idea of availing the facilities offered by the programs. The problem with these Government health insurance programs does not end here. Some patients were also found to be misusing these facilities. In one such case, a patient who was not Below Poverty Line (BPL) reported that he had managed a BPL card in his name to get cheaper treatment. Based on these observations on affordability issue, following can be concluded: (i) irrespective of socio-economic class, private healthcare sector is the first choice for majority of people which leads to OPP especially among weaker economic sections, (ii) there is a lack of awareness among people about government health insurance programs for weaker economic section and, (iii) misuse of these health insurance programs is also prevalent. Barik and Thorat (2015) have also suggested that irrespective of their inability to pay the bills of private healthcare facilities, a majority of the Indians prefer it over public healthcare sector.

Prevalence of the Prohibited Practices

In the year 2017, Indian Prime Minister announced that Government would bring law to prohibit doctors from prescribing brand names of drugs in order to stop unethical nexus between drug companies and doctors. During fieldwork in the present hospital, it was also observed that many medical representatives used to wait in OPD to meet doctors, indicating the presence of this unethical nexus. The most startling observation was the claims of patients that there is no Government-owned medical store in the studied hospital. Interestingly, a medical store was present in the hospital premises. When inquired, patients identified it as a 'private medical store,' but the presence of a private pharmacological center in the premises of a government hospital is not legal. When the author inquired the staffs of pharmacological store in question, they recognized themselves as private. The study site is the only government-run cardiac hospital and absence of government-owned medical store indicates issues and corruptions at multiple levels in the administrative system.

The issue of prohibited practices was not limited to the drug store. According to Government norms a doctor employed in the public hospital is prohibited from doing any private practice (Magotha, 1998). However, many patients reported that they regularly visit private clinics of the doctors. Patients also mentioned that sometimes they see their doctors in their private clinics and once in a while they come to here (in the studied hospital). This situation is not atypical to this hospital, and it characterizes the illegal practices prevalent among most of the doctors of Government hospitals. In India, there is no comprehensive policy available over the question of allowing private practice by the doctors of public sector(11). A debate is still going around the corridor among intellectuals over it.

On one hand, allowing doctors to work privately can only hamper the already weak public health sector and will lead to an increased percentage of OPP. Whereas, on the other hand, it can be argued that services of cardiologists after their assigned working hours should be applauded and considered as an additional service for the already burdened Indian healthcare sector. The ratio of heart patients and trained cardiologists is severely skewed in India and, choosing a middle path to tackle this situation should be one of the most important priorities of the Government.

Summary and Recommendation

Based on field observations and experiences, author highlights the condition of a State government-owned cardiac hospital in Kanpur, Uttar Pradesh, India and explains what's wrong with India's public cardiac hospitals that lead to higher cardiac deaths among lower SES patients.

Based on observation, following can be recommended for policy consideration:

To deal with the issue of accessibility, government can built a small healthcare unit in every Primary Health Center. These units can provide the facility of regular CVD check-ups and free generic medicines to cardiac patients living in remote and rural areas. Ambulance services play crucial role in providing timely treatment. As observed, the state of ambulance services is handicapping and non-functional, it is therefore essential to strengthen it especially in rural areas where public transportation facilities are already in poor state. Based on observations two steps can be suggested; there is a need to increase the number of ambulance vans targeting rural and semi-rural areas and, as many cardiac patients were not even aware about the existence of government ambulance service there is a need to popularize its service and helpline number among them.

In recent times, government has implemented many commendable insurance schemes to ensure affordability of costly healthcare treatment to poor section. However, ground realities are different as majority of the targeted population are unaware of these health insurance schemes. Concrete steps are needed to ensure the awareness among common people about available government health insurance schemes. The government

should establish compulsory pharmaceutical stores in every public cardiac hospital as well as enforce regulatory framework for any illegal activity for ensuring availability of free and cheaper generic drugs for poor CVD patients. Further, there is dire need to come up with a uniform code of conduct for doctors practicing in public sector over the issue of private practice.

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