

# **HEALTH CARE IN BANGALORE CITY**

*Need for a participatory, comprehensive  
health plan*

**DRAFT REPORT – NOT TO BE QUOTED**

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## **INTRODUCTION**

Bangalore is the second fastest growing major metropolis in India and a hub for IT and other industries, defense organizations, colleges and research institutions. The growth in population has been due to in-migration from across India and the expansion of the city limits. In 2007, the Bruhat Bengaluru Mahanagara Palike (BBMP) was formed by merging 100 wards of the erstwhile Bangalore Mahanagara Palike (BMP) with 7 City Municipal Councils (CMCs), one Town Municipal Council (Kengeri) and 111 villages. BBMP now consists of 198 wards and a population of nearly 10 million.

## **HEALTH CARE IN INDIA – SOME PERSPECTIVES**

From the time of independence, the Indian state committed itself to providing health services to its people. Various committees laid out blueprints for infrastructure, staff, services etc. A major milestone was the signing of the Alma Ata Declaration in 1978, which committed the signatories (178 nations, including India) to providing Health for All by 2000. The Alma Ata Declaration also laid out a vision for **comprehensive primary health care**, which addresses the main problems in the community, providing preventive, promotive, curative and rehabilitative services close to home. Comprehensive primary health care is linked to secondary and tertiary care through referral systems and addresses the social determinants of health through inter-sectoral linkages with other social programmes. These principles were incorporated in the National Health Policy passed in 1983.

In the 1990s, the liberalization and privatization policies adopted by the Indian state resulted in its retreat from the principles of Health For All and the adoption of selective rather than comprehensive health care. Emphasis was placed on certain 'target' areas, such as maternal and child health, and interventions were driven by the goal of reducing indices such as IMR and MMR. Emphasis was placed on vertical programmes, which prevented an overall strengthening of the health system. The result has been that diseases such as TB, which require a comprehensive approach, have not been controlled. Another stark example is **malnutrition** and its persistence, which also requires a comprehensive approach involving multiple ministries

and policies. Studies, including a recent survey conducted in Karnataka (JAAK, RFC & SPJ, 2011) show the strong links between malnutrition and water and sanitation, nutrition and livelihoods.

Of significant concern is the increase in out-of-pocket expenditure. Private spending on health in India is among the highest in the world and according to the WHO, every year an alarming **3.2% of India's population fall below the poverty line** due to health-care costs.

The awareness of falling health standards and the need for strengthening public health system led to the launch of the National Rural Health Mission (NRHM) in 2005 by the Government of India. NRHM has re-packaged health budgets for rural areas in a way that health systems could be strengthened (although the budgeted percentage of GDP for public health is still too low) and incorporated community participation through ASHAs, Arogya Raksha Samitis (ARS) etc. While it has had its successes and failures, it has shown that through government attention and community involvement, the health system can be improved.

A similar scheme for urban areas, the National Urban Health Mission (NUHM) has not yet been launched. In parallel, however, the Planning Commission has been deliberating on providing Universal Access to Health Care (UAHC) in the 12<sup>th</sup> Plan. Discussions are also ongoing about Free Medicines for All and commitments are being made to increase spending on health to 2.5% of GDP by the end of the 12<sup>th</sup> Plan. However, these consultations seem to be paving the way for increased presence of private insurance and more Public-Private-Partnerships (PPP), all of which have a 'user pays' approach. It is hoped that people-friendly initiatives will be approved to ensure affordable and accessible health care for all of India's population.

## **HEALTH SERVICES IN BANGALORE**

The health-care scenario in Bangalore city is a mix of plenty and scarcity. A number of government bodies and schemes provide health services. In infrastructure terms, if all primary health facilities maintained by different government bodies were combined, there are likely to be enough centres to

meet the primary care needs of the population.

The city is also host to autonomous institutions with high caliber medical professionals, such as National Institute of Mental Health and Neuroscience (NIMHANS) and the Jayadeva Institute of Cardiology. Further, like in other urban areas, a huge private sector caters to the health needs of the population. Bangalore is a hub for medical tourism, with super-specialty hospitals boasting state-of-the-art treatment facilities.

On the other hand, the communities that particularly need public health services, such as the urban poor and working classes, are unable to access them due to the shortage of medical staff, lack of medicines and diagnostic services, high levels of corruption and the low sensitivity towards their needs. They end up using the private sector, which is an expensive option, or postpone essential health care – an even more expensive option for which the individual, family and society pay a price. There have been cases of women **delivering babies at home** or in auto-rickshaws as they were turned away at Maternity Homes and did not have time to reach a secondary or tertiary institution, or the resources to get there. Tertiary care is expensive even in government hospitals due to bed charges, medicines and other expenses. The result is high levels of indebtedness and health indicators among the urban poor that are almost as bad as the rural poor.

### ***Government Service Providers***

Public health services in Bangalore are provided by a number of local, state and national bodies. BBMP provides primary health care in the 134 wards of the old BMP. In the new BBMP areas, primary health care continues to be provided by the Health and Family Welfare (H&FW) Directorate. Secondary health care is provided through BBMP Referral Hospitals and Taluk and District Hospitals operated by the H&FW Directorate.

The Medical Education department administers teaching hospitals such as Vani Vilas and Bowring hospitals, which provide secondary and tertiary care. Autonomous institutions such as NIMHANS and Indira Gandhi Institute of Child Health provide specialized care and operate independently. State-sponsored insurance schemes, Rashtriya Swasthya Bima Yojana (RSBY) etc.

provide coverage for hospitalization and tertiary care for specific communities such as farmers, domestic workers and BPL families. In addition, the Employee State Insurance Corporation (ESIC) has its own hospitals and services (at primary, secondary and tertiary levels) as do the Railways, Defense and the Central Government Health Scheme (CGHS). The roles and lacunae of some of these service providers in Bangalore are as follows:

### **I. BBMP Hospitals**

The 74<sup>th</sup> amendment, passed in 1993, gave urban local bodies the responsibility for providing health services. At that point, there was already some health infrastructure in Bangalore. This was enhanced with funding from various sources including the World Bank.

Currently, BBMP provides health services in the 134 wards that were part of the old BMP. These include 6 Referral Hospitals, 24 Maternity Homes (MHs), 29 Urban Health Centres (UHCs), 19 Urban Family Welfare Centres (UFWCs) run by BBMP, 18 UFWCs run by NGOs and 17 Dispensaries. Additionally, outreach work is carried out by Link Workers. These services are utilized by the community, especially for reproductive and child health – nearly 50,000 antenatal cases are examined every year in Maternity Homes alone and about half of these women deliver in these institutions. However, there are significant lacunae in BBMP services, some of which are detailed below:

1. **Standards:** A public health system should have standards that must be met to address the needs of the community. These include defining the health infrastructure, equipment and staff required per unit of population, detailed list of services available, referral mechanisms etc. Under the auspices of NRHM, Indian Public Health Standards (IPHS) have been defined for rural areas. BBMP does not have equivalent health standards for the centres under its administration. The available guidelines are very brief. Further, no Health Charter has been developed. This leads to widely varying understanding of their roles by health personnel and an overall lack of clarity in the system.
2. **Splintered and incomplete services:** At the primary level, four

different facilities - UHCs, UFWCs, MHs and Dispensaries - provide services, but combined, they do not add up to comprehensive health care. Some wards are assigned dispensaries, which only provide outreach through Link Workers. The residents of these wards have to travel to other wards for all other services and cannot be assured of follow-up at their homes, which should be the rationale for the Link Worker programme.

3. **Staff shortages:** Due to severe staff shortages, many of the BBMP services are not available or are limited. The vacancies in Medical Officer positions are well known, but positions for nursing staff, ANMs, lab technicians etc. are also not filled.
4. **Corruption:** Bribes are demanded at every stage, even for seeing one's baby after delivery.
5. **Lack of diagnostics:** Basic diagnostic tests and ultrasound are only available at 1 Maternity Home and a few Referral Hospitals. At the rest, patients are referred to private diagnostic labs.
6. **Lack of medicines:** Most medicines are not available at the hospitals. For e.g., even Iron and Folic acid tablets are not provided and patients have been asked to purchase them from private pharmacies.
7. **Public participation:** Boards of Visitors provide oversight for RHs and MHs, make spending decisions and provide grievance redressal. However, these have not been reconstituted after the 2010 BBMP elections. Further, these Boards do not have representation from the users of the hospital and therefore do not ensure full public participation.

## **II. Health & Family Welfare Directorate Hospitals**

The H&FW Directorate administers 38 PHCs, plus 22 PHCs set up by the IPP/RCH-II program and 2 CHCs, mostly in the outer wards of BBMP. It also operates Taluk Hospitals in K. R. Puram and Yelahanka, District Hospitals in Malleswaram (K.C. General) and Jayanagar and some specialty hospitals such as the T.B. Hospital. Some of the issues that need to be looked into are as follows:

1. The areas where the Directorate provides services have seen rapid

urbanization and population growth, but the services have not increased. For example, K. R. Puram's population is above 2,00,000 but has only 1 PHC and the Taluk hospital.

2. Staff shortages also plague the system and the number of ANMs is not sufficient for the community's needs.

### **III. ESI Hospitals**

Under the Employee State Insurance Act, all persons employed in non-seasonal power using factories employing 10 or more persons and non-power using factories employing 20 or more persons and earning up to Rs. 15,000 p.m. are eligible to receive benefits through the ESI scheme. These benefits include full medical coverage for the employee and his/her family, paid maternity leave, sickness benefit, vocational and physical rehabilitation, unemployment allowance and more. In Bangalore urban district, there are 48 dispensaries, a diagnostic centre in Basavanagudi and hospitals in Rajajinagar and Indiranagar. For superspecialty care, the ESI Corporation has tie-ups with advanced medical institutions such as Jayadeva.

ESI is a well-funded scheme with regular employee and employer contributions. It has generous benefits for leave, reimbursements for medicines etc. and well-staffed dispensaries. The services are well-utilized, for example the Kengeri dispensary sees 100-150 patients per day. Certain structural and procedural issues, however, create barriers to effective usage of the services:

1. Many dispensaries are open only during working hours, making it difficult for employees to access them without taking leave from their workplace
2. Dispensaries do not provide comprehensive primary health care services. For example:
  - All deliveries are conducted at the 2 ESI hospitals in Rajajinagar and Indiranagar. Even antenatal checkups require patients from all over Bangalore city (and neighbouring areas) to travel to the ESI Diagnostic centre in Basavanagudi for tests and then back to their neighbourhood dispensaries for follow-up.

- Dog and snake bite cases are referred to the ESI hospital
  - Family planning services, immunization, health education, HIV/AIDS counseling etc. are not available at all dispensaries (some have/had tie-ups with NGOs for specific services)
3. An ambulance is available at the ESI hospital, but none are available at the dispensaries, therefore most patients end up arranging for their own transport.
  4. Referral to the ESI hospital involves waiting at the dispensary and obtaining a referral form. This form is only valid for that day and the process has to be repeated in case the patient cannot travel to the hospital by the end of the day.

#### **IV. Tertiary care**

In Bangalore, tertiary care is provided through a number of government hospitals run by the Medical Education department, ESIS and CGHS. Autonomous institutions such as NIMHANS also provide specialized care.

Many of the low-income communities in Bangalore and neighbouring areas use the services of hospitals such as Vani Vilas and K. C. General. Often, this is for services that should be available at the primary level, such as normal deliveries. The overall costs for the patients are significantly higher. A study in Kanakapura (Belaku Trust, 2007-10) showed that the median out-of-pocket expenses for normal deliveries was about Rs. 1200 in PHCs and more than Rs. 5000 in other government hospitals (most of which are in Bangalore). Further, there is no formal referral system and subsequent follow-up with the primary care institutions.

Tertiary care institutions are often overcrowded and turn away patients in dire need of care. There have been cases of huge fees demanded upon admission and at discharge (or for releasing the body at death).

In recent years, various insurance schemes such as Arogyasri and Rashtriya Swasthya Bima Yojana (RSBY) have been introduced, which provide coverage for treatment in private super-specialty hospitals. Insurance coverage has increased from 75 million people covered (roughly about 16 million family beneficiaries) in 2007, to an estimated 302 million people in 2010, about

one-fourth of the population. Most of these schemes are new and patients are still being enrolled. But initial studies have shown problems with enrolment and reimbursements. The families covered are often not aware of the benefits, for e.g., that the card covers up to 5 members of the family, and thus do not make full use of them. Further, for major hospitalization, the cover of Rs. 30,000 provided through RSBY has been found to be insufficient. Finally, there is little provision for grievance redressal or public participation in these schemes.

### ***Special needs***

People with special needs are particularly vulnerable and require attention. Their needs are not sufficiently met by government services. Some examples:

- No screening of newborns for physical or mental disabilities, hearing problems etc. is provided. Early detection is crucial for early intervention, which is more effective than later treatment (and often less expensive in monetary and social terms).
- Basic rehabilitation services such as physiotherapy are not available at primary or secondary level hospitals.
- Special services for malnourished children, such as nutritional advice that takes family circumstances into account, are not available.
- There are no mental health services at the primary or most secondary level facilities. Therefore, conditions such as depression often go untreated in the community. Severe conditions are treated at NIMHANS, K. C. General, Victoria and Bowring Hospitals, but even these services are insufficient. Medications for diseases such as schizophrenia are very expensive and the free medicine programmes for poor patients do not stock enough medicines to meet demands.

### ***Social determinants of health***

Good health is not just determined by access to health-care services but also by adequate provision of food and water, good livelihoods, living space etc. This requires coordination between health services and programmes such as ICDS, water and sanitation, solid-waste management etc.

The lack of coordination is clearly seen in the case of malnutrition. A recent survey conducted in Bangalore (along with 10 other districts in Karnataka) showed that most anganwadis are not visited by health officials. This means that severely malnourished children cannot be tracked on an ongoing basis, which is absolutely necessary to improve their condition. Referrals to Balasanjeevini, a program that provides tertiary care to children of BPL families, are done without any kind of support. Since the program only reimburses expenses and does not provide cashless services, the costs are exorbitant for families. The Balasanjeevini programme is being run by the Women and Child Department, but the Health Department must take on some responsibility as well.

### ***Summary***

The barriers faced by Bangalore's population in accessing public health care services can be summarized as follows:

1. **Insufficient primary health care:** Primary health care centres do not provide comprehensive primary health care, are understaffed and under-equipped and are often too far from home. This results in the neglect of essential health care needs, increased out-of-pocket spending and over-reliance on tertiary care centres.
2. **Lack of referral system:** The absence of a functional referral system (except in the ESI system) means that patients are not provided support when they travel from a primary care centre to a secondary or tertiary care centre. There is also no follow-up unless the patient revisits the secondary or tertiary centre.
3. **Insufficient public participation:** While some mechanisms for public participation exist, they do not incorporate participation from the actual users of health services and have insufficient grievance redressal mechanisms. There are no mechanisms for system-wide public participation in addition to that at individual institutions.
4. **Coordination between departments:** Co-ordination between the various departments providing health services and with other departments such as Women and Child Welfare, Water, Sanitation etc. is

minimal. The result is that patients have to navigate the bureaucracies of multiple departments and often have no one to turn to for resolving their problems.

## **NEED FOR CITY-WIDE PLANNING**

A Bangalore city-wide plan was last formulated at the start of the World Bank funded IPP-VIII project, which was operational from 1993 to 2002 and focused on the 8.51 lakh population living in 525 slums. Its goals were to improve health and family welfare services in this population and to reduce infant, child and maternal mortality levels and fertility rates. For this, it adopted strategies to expand the existing system by constructing new facilities and upgrading old ones, forming partnerships with NGOs for service delivery, training and communication etc. Many of the plans developed during that time, such as establishing new UHCs in slum areas and converting maternity homes to Upgraded Urban Health Centres, were subsequently not implemented due to unavailability of land and other reasons. Once the program was completed in 2002, BBMP did not provide sufficient funding and some established programmes were cut. Further, the IPP-VIII focus on maternal and child health led to planning for selective rather than comprehensive primary health care. Finally, tertiary care needs were not addressed in this planning process.

Bangalore's population has since doubled and its needs have increased. While NRHM has been introduced in rural areas, with a comprehensive approach to the health system, a similar scheme has not been introduced in urban areas. The schemes that have been launched in Bangalore in recent years, such as insurance schemes, focus on hospitalization and tertiary care. Bangalore's health services continue to be fragmented, with unequal distribution of resources and little communication between the various services. A participatory and comprehensive plan would allow for the best use of available resources to address these gaps and to improve existing services. Most importantly, it would rationalize coverage and increase accessibility, especially if done through a participatory process.

## **A PARTICIPATORY, COMPREHENSIVE HEALTH PLAN**

In conclusion, the key characteristics a participatory comprehensive plan should have are:

- A Public Health focus to health services in Bangalore, with analysis of population density and needs and rationalized services to meet these needs.
- Commitments to provide comprehensive rather than selective primary health care.
- Involvement of all relevant departments and agencies providing health services in Bangalore, with roles and responsibilities assigned to each.
- Standards for health services which are uniform, define required manpower, infrastructure, equipment, medicine etc. at every level and a Health Charter that outlines the services provided, grievance redressal mechanisms and the rights and responsibilities of citizens.
- A blueprint for an effective referral system that links primary, secondary and tertiary care and provides support to patients.
- Joint monitoring by all concerned departments and agencies and provision for public participation at all levels of the health system.
- Inclusion of services that are needed in the community and not currently addressed, such as mental health.

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## APPENDIX

### 1. Severely malnourished children

Activists from three networks, Janaarogya Andolana Karnataka, (JAAK), Right to Food Campaign Karnataka (RFC-K) and Samaajika Parivartana Janaandolana (SPJ) undertook a rapid survey in the communities they work with in 13 districts in the first two weeks of November 2011. The survey was undertaken to understand access of severely malnourished children to health and child care services, understand these families' experience of seeking care and seek their suggestions for improving the same. Some findings from the survey of 62 families in Bangalore city:

- More than 75% of the families belonged to SC/ST communities
- 18 out of the 62 children had a disability such as cerebral palsy or mental retardation
- Only 37% of mothers had taken their children to a UHC/UFWC/MH/PHC and most reported that they did not receive the required care
  - 41 percent said that the doctor does not do tapasane (examination) or give any treatment.
  - 28 percent said doctor has not been available whenever they have visited in the past and therefore have stopped going
  - 28 percent said that they do not receive good advice or medicine, only referrals
- Families had spent a huge amount of money for treating their malnourished children in the private sector. **Families of children without disability had on an average spent Rs. 4,931 (ranging from Rs.400 to Rs.20000) and those with disability had spent Rs.1,20,635 (ranging from Rs.800 to Rs.5,00,000).** Given that nearly all the families were dependent on daily wages for their living it was not surprising that they had all taken a loan at high rates of interest to pay for their children's treatment.

Experiences of those who went to the government health centre only reinforced the reasons why people avoided them in the first place:

*They said my child is weak and wrote out a prescription and asked me to get it from the WCD department. But the medical shop was closed. - Bangalore,*

Housewife

Even when doctors gave advice they were not interested to see if the family can afford it or how one can ensure best nutrition in limited resources:

*Doctor was there. He examined the child and said child is very weak. He asked me to give milk, fruits, vegetables, eggs and meat. He gave prescription to buy tonic outside. I don't have money to buy the tonic or to give all the food he listed.*

- Bangalore, Vendor

In fact in one instance in Bangalore the activists intervened and put in a word to the doctor at the local health centre before he examined the child:

*I had gone to the health centre thrice but could not meet the doctor. Today the doctor examined only after madam came with me to the hospital and spoke to him that he should pay attention because the child is severely malnourished.*

---- Bangalore, Domestic help

### **Suggestions and recommendations**

Mothers had several practical suggestions for both health as well as WCD departments.

- An important suggestion was that **doctor should make monthly visits to the anganwadi, examine the children, provide treatment and follow-up till the time the children are normal and well.**
- Mothers also emphasized the fact that they should not be made to run around for treatment of their children. They reported being tired of being referred from one place to the other which had caused inordinate delay in initiating treatment and also cost them several days of lost wages. **So they suggested that immediate treatment be initiated and completed in the anganwadi itself.**
- **Mothers felt that staff in Health Centres and anganwadis should be respectful, provide support and understanding and listen to their issues and problems and respond accordingly.**
- Finally, they felt that advice given by health and anganwadi staff should not be restricted to just 'give this' or 'give that'. It should focus on actually showing mothers recipes to feed, how to feed and practical suggestions keeping their situation in mind. Therefore home visits by Link Worker and anganwadi worker to provide individualized advice was important, they felt.

- **Safe drinking water also featured on the mothers' list of preventing malnutrition**

## **2. Some staffing data collected from BBMP**

i. UHCs and UFWCs: ANMs: Total sanctioned = 135, Working = 46, Vacant = 89

ii. Referral Hospital example: Banashankari

<b>S. no.</b>	<b>Post</b>	<b>Sanctioned positions</b>	<b>Working</b>	<b>Vacant</b>
1	Superintendent	1	1	-
2	Anaesthetist	1	-	1
3	OB-Gyn	3	-	3
4	Assistant Surgeon	1	1	-
5	Staff nurse	5	2	3
6	ANM	4	1	3
7	Senior Health Assistant	2	2	-
8	Junior Health Assistant	2		2
9	Pourakarmika	3	2	1
10	Ayah	2	1	1
11	Jawan	2	1	1
12	Peon	2	2	-
13	Dhobi	1	-	1
	<b>TOTAL</b>	<b>29</b>	<b>13</b>	<b>16</b>