# Suppressing the Symptoms or Treating the Malady?

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Maharashtra, which recently witnessed several attacks on front line doctors, has comparatively very low levels of per capita public health spending, shortfalls in health facilities, and major shortages of specialist public doctors. Dialogue mechanisms should be developed based on community monitoring, while existing legal provisions for grievance redressal need implementation. Doctor–patient communication must improve, and the serious ailments afflicting public health services in Maharashtra must be addressed to move beyond superficial solutions.

Maharashtra has witnessed a spate of attacks by attendants of patients on front line doctors in public hospitals across the state in March 2017. This precipitated a major strike by over 4,000 resident doctors, which was supported by the 40,000-strong Indian Medical Association (IMA) in the state. The Bombay High Court intervened based on a public interest litigation that had been filed against the strike, and ordered the resident doctors to resume work. With the government having given an assurance that 1,100 additional security guards will be appointed in public hospitals across the state, the strike was withdrawn after nearly five days of turmoil.

What was notable in this process was that all major parties involved—the doctors' associations, the government, and the court—treated these attacks purely as a security issue. The chief justice of the high court termed the attacks as "madness," perhaps implying that there could be no understandable rationale for people to be moved to such violent action. It appeared as if the growing popular dissatisfaction with the availability and quality of services being provided in major public hospitals across Maharashtra had nothing to do with the violence that had erupted in certain public hospitals of the state. This seemed like a situation where a cauldron of water had been allowed to simmer on a flame, and yet when the pot boiled over, this was sought to be controlled by putting a lid on the vessel, rather than by putting out the fire.

## Not Just about Law and Order

All would agree that such attacks on front line doctors, who are often overworked and provide health services in difficult conditions, are completely inappropriate and unjustified. However, the question is, how can such situations be definitively prevented? Is the appointment of a few security guards in each hospital department the complete solution to this problem? (The state has around 130 larger public hospitals, not counting municipal hospitals; 1,100 additional guards would mean an average of about eight more guards per hospital.) Or are there deeper health system issues that must also be addressed? The Jan Arogya Abhiyan, a state-level coalition of civil society organisations working in the health sector, organised a press conference in Mumbai on 22 March 2017 during the strike period, with the participation of health activists and certain organisers of junior doctors and nurses (Iyer 2017). Here, the need to prevent violence, with a focus on addressing such underlying health system issues was strongly underscored, summarised by the slogan: "Don't target the doctors, target the system."

An accompanying concern is that when doctors go on strike, the Essential Services Maintenance Act, 1968 is invoked with the argument that unlike, say, factory workers, doctors are not allowed to strike since they perform an essential public service. The chief justice is reported to have mentioned during the hearing that "if doctors go on strike like factory men, then they are unfit to be doctors." Besides the implied slur on factory workers, there is a deeper question that arises here. When doctors are on strike, healthcare is declared an "essential service," but does the state accord the same level of priority to these "essential" health services while allocating resources and human power?

## Public Health Expenditure

Despite being a state with relatively high per capita income (fifth highest among major Indian states), Maharashtra, spending ₹831 per capita, figures towards the bottom when states are ranked by per capita public health expenditure (Figure 1, p 14).

It can be seen that per capita health spending in Maharashtra is below the national average (₹963), and is barely around half of the amounts for Rajasthan (₹1,584) and Kerala (₹1,650), which have

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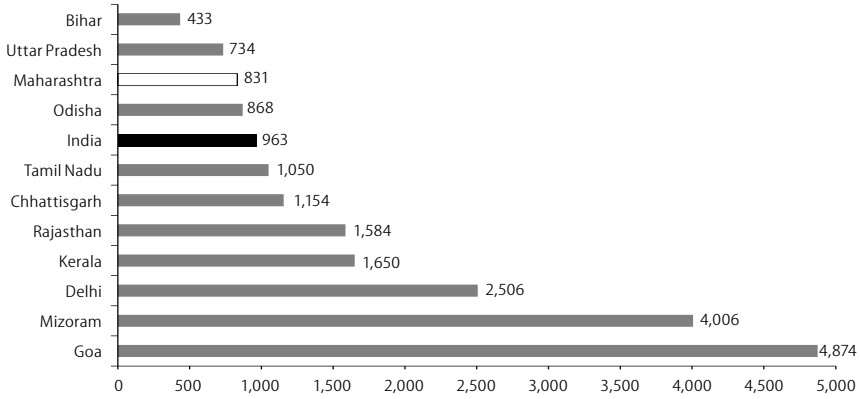
**Figure 1: Per Capita Public Health Spending 2015–16** (in ₹)




Source: Calculations based on data in MoHFW (2016); population projections based on 2011 Census.

lower per capita incomes as compared to Maharashtra. Neighbouring Goa is in a separate league in this regard (₹4,874), and even though it is a much smaller and richer state, its per capita public health spending is six times higher than Maharashtra's, giving some idea of the desirable levels of expenditure required to ensure adequate health services.

What is equally a matter of serious concern is that public health expenditure by Maharashtra has been declining as a proportion of the gross state domestic product (GSDP), declining from 1% in 1985–86 to 0.49% in 2017–18, and placing Maharashtra behind most states in the country. Even during the current financial year, allocations for public health and medical education have been cut down by 4.4% compared to the revised budget estimates for 2016–17.[1] Do these pathetic levels of public health spending reflect the high priority that must be accorded to this so-called essential service?

## Shortfall of Services

Public health services in Maharashtra were relatively performing well until the mid-1980s. However, given the subsequent crunch on financial resources, as well as declining political priority and the privatisation of healthcare, it is not surprising that there are now serious shortfalls in providing health services at various levels, forming the backdrop to rising public dissatisfaction. As per the most recent official data available (MoHFW 2015: Table 11), there is a shortfall of 22% in the number of sub-centres, 18% in the number of primary health centres, and 35% in the number of community health centres (rural hospitals). Compared to 550 rural hospitals that are required to serve the population (estimated at 2011 levels), only 360 are in place, which naturally would force a greater number of patients to seek care in higher level hospitals, placing significant strain on them.

Further, there are serious shortages of specialist doctors in the public hospitals that are functioning. Compared to 1,440 specialist doctors required in rural hospitals across the state, only 578 are in position, indicating a shortfall of nearly 60% in this critical cadre of doctors who are essential for treating complicated and emergency conditions (MoHFW 2015: Table 28). It is, perhaps, but expected that out of the 360 rural hospitals in Maharashtra, only 127 (35%) currently meet Indian Public Health Standards (MoHFW 2015: Table 37B). Shortages of medical staff plague district hospitals also, which have a 24% shortfall of doctors (MoHFW 2015: Table 69). It should be noted that massive, unregulated proliferation of the private medical sector has contributed to this situation, since even specialist doctors graduating from public medical colleges are pulled away by the magnet of private hospitals. With 50 medical colleges, Maharashtra leads the country just behind Karnataka. Yet, after churning out so many doctors, if over half of the required posts for specialist doctors remain vacant year after year, should this not be regarded as a larger policy failure?

What is even more serious is that certain district-level hospitals (such as in Akola, Latur and Nanded) are running with hardly any specialist doctors, while almost all posts of Class 1 specialist doctors are vacant in the medical college-associated hospitals in these districts. In many district hospitals, even the appointed senior doctors are often reported as "missing in action" since they are busy in their private practices. It is an open secret that in many district hospitals, after the morning outpatient department hours, specialists are unavailable, leaving the running of the hospital to junior doctors. It is in such settings that services for critical patients might not be available in a timely manner, leading to the front line doctors being exposed to socially explosive situations.

## Guidance and Redressal

Another important factor that contributes to the breakdown of communication and trust in the context of public hospitals is the lack of effective patient guidance and redressal systems. Patients and relatives from rural areas, who travel long distances to the district hospital located in an unfamiliar setting, require systematic information and support, which are often lacking. When complaints do arise, which is inevitable, effective mechanisms need to be in place to deal with these as promptly as possible, while ensuring accountability of the service providers.

Here, the experience of Community Based Monitoring and Planning (CBMP) of Health Services, a process being implemented since 2007 as a component of the National Health Mission in 30 blocks across 14 districts of Maharashtra,[2] provides a number of positive examples about how such dialogue and grievance redressal could be developed as part of accountability mechanisms. In each CBMP block, facilitators and coordinators belonging to nodal civil society organisations have been given the responsibility for promoting community action, and frequently receive calls from patients requiring support in rural and sub-district hospitals. These activists, who are aware of healthcare provisions, dialogue with the relevant health officials and doctors to ensure that required services are made available, while also guiding the patient in negotiating the health facility. Since major grievances are also periodically discussed in multi-stakeholder monitoring and planning committees at block

and district levels, and during annual *jan samvads* (public dialogues), this process ensures that health providers are held accountable, while attempts are made to address health service-related structural issues through local problem-solving and decentralised planning.

It may be relevant to explore how similar dialogue, accountability and grievance redressal mechanisms might be developed in the context of larger public health facilities like district and medical college hospitals, which seem to be the epicentre of the recent violent incidents in Maharashtra, reflecting the complete breakdown of trust and communication between people and healthcare providers. Provision for help desks in larger hospitals run by local civil society groups, and widely publicised and accessible grievance redressal forums could be steps in this direction. Such mechanisms would, of course, not be substitutes for much-needed health budget, human-power and service-related improvements, but could complement these to ensure that mandated services become more accessible, and conflicts are minimised through dialogue for problem-solving in various situations.

## Prevention of Violence

In this context, some of the legal dimensions also deserve attention. Resident doctors (who fall in a grey zone, somewhere between students, workers and professionals) are not paid a salary, but rather get a stipend that is not indexed to inflation. Hence, the Maharashtra Association of Resident Doctors (MARD) goes on strike almost every year, demanding a rise in the stipend for resident doctors, and after some negotiations with the government, generally based on certain raise in stipends, the strike is withdrawn after a few days. What is relevant here is that, during these strikes by junior doctors, besides the perennial demand for increase in stipends, the demand for protection against attacks has also emerged since 2006. It is notable that such attacks have been growing in the case of private hospitals also, with serious dissatisfaction relating to medical care among patients and relatives, even though the causes for dissatisfaction in public and private hospitals are likely to be qualitatively different.

Given this background, on demand from the IMA Maharashtra State, the Maharashtra government enacted the Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act in 2010.[3] According to this act, violence against doctors, medical staff and medical establishments is a non-bailable offence, which can attract imprisonment of up to three years, and a fine of up to ₹50,000. Further, in case of damage to property, any offender would have to pay as compensation twice the amount of loss caused to the property.

Though sound in principle, in practice it seems that these legal forms of protection have not worked very well. In fact, the need for stringent implementation of this act was repeatedly invoked during the recent doctors' strike. Yet, it is a moot question as to whether a mob of angry relatives and attendants of a patient, who acutely perceive some serious grievance in a hospital, perhaps following the death of a near one, would reflect on the provisions of such an act and then quietly go home, without their grievance (real or otherwise) being addressed. Here, we might get a clue as to the reasons for the ineffectiveness of this act until now, from the final functional clause in the act itself. This clause seems to have been inserted as an afterthought, and is not generally mentioned by public votaries for the act belonging to medical associations. As per available information, this section has effectively not been implemented in the last seven years since the act came into force. Implicitly admitting that patients might have some genuine grievances in hospitals, which need to be addressed through participatory mechanisms, Section 7 of the said act states:

> (1) The State Government shall, by notification in the *Official Gazette*, establish the Authority for the area as may be specified in such notification, *to hear grievances of victims of medical negligence or mismanagement and to aid and advise such victims for taking recourse to an appropriate forum for suitable relief.*
> (2) The Authority shall consist of experts one each from the field of medical, law, consumer movement and health management. (emphasis added)

We are led to speculate as to why this section of the statute has never been publicised by the government and has not been implemented so far. What might have been the impact, if over the last seven years this clause had been implemented with full sincerity and political will in public and private hospitals across the state? With the creation of multistakeholder authorities in every area to guide people with complaints, with prompt guidance available to address grievances, could some of the attacks by disgruntled elements have been averted? Could a significant number of people's genuine grievances related to hospitals been resolved? While such questions cannot be answered definitively, there is no doubt that until now this law seems to have been interpreted selectively even by the government, and a crucial provision to support patients and healthcare users has been ignored. Instead of bridging it, the gap between hospitals and people has been allowed to further widen, with tragic consequences that we are witnessing today.

## Doctor–Patient Relationship

Another aspect that emerges, besides unavailability of required care and adverse health outcomes in some cases, is the frequent lack of empathetic and sensitive communication by doctors. There is no doubt that junior doctors are often overworked, stretched for time, and have multiple responsibilities to handle. But, especially in critical cases, rude or callous behaviour by doctors can become the last straw that might break the bounds of patience of a group attending to the patient, who may have even witnessed the death of a family member. Perhaps, fewer armed guards might suffice if doctors are regularly oriented in communication skills and management of crisis situations in a sensitive manner. Once again, this would not substitute the need for adequate health system resources, structural improvements and upgradation of healthcare services, but definitely needs to be kept in mind as a supplementary measure of some importance.

Finally, at a social level, there seems to be a general decline in levels of tolerance and a greater tendency to indulge in group violence, which is manifesting

in many forms. It is ironic that with the dismantling of the welfare state through neo-liberal policies, one of the most visible symbols of welfare, namely, public hospitals, are emerging as targets. There is no doubt that the wide spectrum of social organisations, movements and political parties in Maharashtra must, on the one hand, strongly appeal to people to desist from attacking doctors and healthcare staff and, on the other hand, start actively demanding and working for health system improvements and changes.

To conclude, these unfortunate attacks on doctors are not just a law and order problem, rather they should be treated as "wake up calls," symptoms of a deep health system malaise, embedded in an increasingly troubled social milieu. Government and society must squarely recognise and address the serious ailment afflicting public health services in Maharashtra today. The provision of security guards can, at best, partially suppress the symptoms. For a definitive cure, we must tackle the roots of this systemic problem.

## NOTES

1 Maharashtra state budget figures for 2016–17 and 2017–18 available at https://beams.mahakosh.gov.in.

2 See, http://www.cbmpmaharashtra.org/.

3 See, http://www.lawsofindia.org/pdf/maharashtra/2010/2010MH11.pdf.

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