Health and Heath care in BRIC Cities: Ideas for Collaborative Research

Professor Victor G. Rodwin

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About the Speaker
Victor G. Rodwin is Professor of Health Policy and Management at the Robert F. Wagner Graduate School of Public Service, New York University (NYU), and co-director (with Michael K. Gusmano) of the World Cities Project (WCP), a joint-venture of Wagner/NYU, the Hastings Centre, and the Robert N. Butler Centre on Aging, Columbia University. WCP studies population health and aging, and health care systems, among megacities worldwide.

Abstract
The largest cities in the wealthy nations all face an unprecedented challenge: how to meet the needs of a population that lives longer, has a declining birth rate, is generally healthier, but also increasingly beset by the rise of chronic illness. The World Cities Project (WCP) has produced two books and numerous articles based on comparisons among, and within five of the world's most dynamic cities: New York, Paris, London, Tokyo and Hong Kong. These cities are centres of economic growth and finance, culture and media, sophisticated transportation systems and innovations of all kinds. They are renowned for their centres of excellence in medical care, top-ranking medical schools, institutes of bio-medical research, and public health infrastructure. Likewise, they attract some of the wealthiest, as well as the poorest populations of their nations, which forces their health care systems to confront the challenge of confronting glaring inequalities and redesigning their health care systems.

The presentation and discussion

Prof. Rodwin gave a brief overview of his work on BRIC countries with a focus on cities. He drew insights from the contrasting experiences of the BRIC countries with the health sector. The history and politics of each of these countries are important. Brazil has developed a more public centric health and health care system in place unlike Russia and India that have a privatised health care system. India performs the worst in its population health indicators and the government health spending among the BRIC countries.

Prof. Rodwin gave several propositions on developing a comparative framework for health and health care systems in BRIC countries:

He gave comparisons in terms of population health where he compared three indicators – life expectancy, infant mortality rate and maternal mortality rate; based on total health expenditure and out-of-pocket expenditure across the BRIC countries. India performed the worst here. He spoke of widening socio-economic status in all countries except Brazil that has resulted in health inequalities within countries.

To compare health care system performances he proposes to look at amenable mortality, that is, deaths that are preventable and therefore, captures the consequences of poor access to disease prevention, primary care, as well as specialty services.

The idea proposed by Prof. Rodwin was to do a megacities project of BRIC nations. This would include the megacities that exist in these nations and given the similar challenges, he suggested three areas – study IMR across neighbourhoods within these cities; look at access to specialty care that save lives and access to primary care, that is, physicians at the primary level of care. He opened the session for more ideas from the scholars.

The discussions brought back the importance of social determinants of health and the role of state in health service systems. There is a minimum basic need that must be fulfilled even before one thinks of talking about specialised care services and one had to cross that threshold, assumption that private sector will play an important role.

Fair amount of mobilisation has happened in India around public health issues. There is a public health movement in India and there are lessons that have been learnt from Brazil. There has been active engagement by scholars with health reforms and the global political economy. The outcome of these reforms cannot be ignored. One has to engage politically and also for generating evidence because evidence has become important in today's world. We need to look at medical care as we all know it is important but one needs to understand the role of the private sector especially the corporates moving to urban cities. Technology too is one of the main driving factors that link to the private sector. Health care has become a business model as in the Unites States. There could be lessons drawn from the US model. One would therefore need to document how our commercial/ corporate sector is doing?

If one looks at urban cities it is assumed that there exists a situation without any historical basis. One has to look at why a city has a particular structure in terms of the way the population is divided, the rise of slums, the inequalities, access to public services. If you look at big cities like Delhi and Mumbai they are largely dominated by private sector or big corporates. If we want to convert the debate into a normative one and see what ought to happen then there is no other way but to look at the political economy of what is happening.

Regarding data availability for urban cities in India, there is a major influx of population coming from rural areas to district hospitals so that data is not of urban population. Even though there might be residential addresses available scholars would not have access to it. There is also no clear division between rural and peri-urban areas and there are multiple agencies providing care in urban cities that makes the picture very complex. One could get data to a certain level but getting unit data is tough as the government does not make it public or give access to scholars who would want to use this data.

There are certain assumptions that the larger debate on public health centres on. For example that India is moving from infectious diseases to non-communicable diseases and the use of methods like DALYS (Disability Adjusted Life Years) that are biased instrument and do not look at under-nutrition that underlines most of these diseases and calculates it in a way that distorts the picture. So if we bring in preventive and primary care for non-communicable diseases we are once again leaving those people who are still waiting to get basic services. Almost 65% of Indians live without food

security and the intended calories. If we are looking at IMR data we need to be aware that it is closely linked to environmental health and under-nutrition. Looking at simply amenable mortality and access to specialised care is jumping the issue as the basic services are still not in place. If one goes to the fringes of Delhi, it is shelter, livelihood, food and education that are far more important. This is the concept of health for many. Working for welfare is, therefore, crucial.

BRIC is important to study and this is the kind of data that needs to be shown to policy makers. Policy makers are too blinded by the growth oriented model of development and the truth is hidden. So it is not that we do not have data in the country, there are huge amounts of national data but researchers do not have access. Urbanisation is important but it is being told that everything will be urbanised. Urban studies are crucial because majority are migrants who are coming from rural and are marginalised. If as a researcher I say that I should do with whatever is available then I am closing my eyes to the bigger questions. Work in public health and urban research has to relate to the bigger questions. For example in the context of BRIC one would like to see what was in Brazil that made them realise that blind privatisation does not help and had to relook at the strategy. How did they build their basic care systems and how did they convince their policy makers? There needs to be further discussion on how to take this comparative project forward.