Making Healthcare a Public Good

India's governments must realise that healthcare is a public good and is the state's responsibility.

Ravi Duggal writes:

The vice chairman of the NITI Aayog, Rajiv Kumar, was recently quoted as saying that "Modicare" will expand private healthcare markets and stimulate the growth of the private health sector, especially in tier 3 and 4 towns, which will make healthcare affordable. This statement is most unfortunate because, in the health sector, markets do not work the way they presumably work for other commodities or services. Healthcare in the marketplace works through supply-induced demand. It is the providers who decide the character and quantum of supply for the healthcare demands made. Since there is an acute asymmetry of information, patients succumb to what the healthcare provider forces upon them: the battery of diagnostic tests, the range of medicines prescribed, and various procedures and interventions.

The Food and Drug Administration (FDA) in Maharashtra investigated well-known private hospitals for malpractices like reuse of medical devices such as catheters, which in the first place were charged to the original patient at two to three times the maximum retail price. These kinds of practices not only unnecessarily inflate patients' bills, but also amount to cheating, and put them at risk of infection for which they may need further treatment. This means increased out-of-pocket spending for patients, and increased earnings and profits for providers.

Malpractice has infected the healthcare sector across the board: from cut-practice to unnecessary referrals, needless diagnostic tests and drug prescriptions for paybacks, gifts and travel subsidies from the pharma industry, unnecessary surgeries and procedures, organ transplant rackets, overcharging patients, insurance fraud, etc. The list of malpractices is growing alongside the private healthcare sector.

The Indian Medical Association (IMA) has resisted bringing in the Clinical Establishment Act that seeks to regulate healthcare provisioning and medical practice. The IMA has especially opposed any regulation of price in the sector. In stark contrast, an association of doctors in Canada told their government that the periodic increase in their salaries should not be done because they felt doctors are already overpaid for the work they do.

The difference in healthcare practices we see between Canada, and for that matter many other countries across the world, and India is largely due to effective regulation of healthcare, and the adherence to the ethics of medical practice. In India, the IMA functions more like a guild than a professional association. They have historically opposed any form of regulation and price control, have never taken any action against peers who indulge in malpractice, and have ignored the need to build ethics in medical practice. As a consequence, the political economy of healthcare in India has become highly commercialised and profit-oriented.

The National Health Policy 2017, and Union Budget 2018–19's announcement of the National Health Protection Scheme under the Ayushman Bharat programme clearly indicate the direction in which the Narendra Modi government wants to drive health policy. It is unfortunate that the Ministry of Health and Family Welfare has lost control over decision-making for healthcare to the NITI Aayog, whose recommendations only promote the private healthcare market, the use of insurance as a mode of financing healthcare, and the privatisation of public healthcare, among others.

The world over, countries that provide good quality healthcare with equitable access to their populations have effectively regulated health systems under a public mandate, which is financed through taxes and social insurance payments. They do not segment their populations based on income and employment for determining eligibility to receive health benefits, and have developed a strong culture of ethics in practice amongst healthcare providers. And, above all, these countries do not leave healthcare to the whims of the market, but ensure that healthcare remains a public good and the state's responsibility.

It is time to ask tough questions about the direction of healthcare policy in India. Why do our public servants (bureaucrats) and parliamentarians have Central Government Health Scheme (CGHS) benefits (most of it today is provided via the private sector)? In 2015, this scheme cost the state exchequer a whopping ₹6,300 per CGHS beneficiary annually, nearly six times the ₹1,100 that the government allocates per capita to the general public. It is time to change this equation. Governments talk of universal access to healthcare, but their policies and actions translate into a segmented and selective approach, leading to large-scale deprivation and widening inequities in access to healthcare.

If this is to change, healthcare has to be detached from the marketplace and developed as a public good. This is the direction in which countries are moving the world over, and there is no reason why India should be any different. In fact, Mizoram, Sikkim, Goa, Puducherry, and the Andaman and Nicobar Islands are on this track, committing over ₹4,000 per capita to healthcare in their budgets. They do so because the private sector has no significant presence in these states. They have a robust primary healthcare system and good health outcomes. If the government wants an Ayushman Bharat, then it should learn from global best practice and these states, and strive to make healthcare a public good that is free from the clutches of the market.

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