Making Healthcare a Public Good

Ravi Duggal[1]

"Modicare will expand private healthcare markets and stimulate the growth of the private health sector especially in tier 2 and 3 towns which will make healthcare affordable"[2]asserts Rajiv Kumar, Vice Chairman of NITI Aayog.This statement is most unfortunate because in the health sector markets do not work like the way they work for other day to day commodities or services. Healthcare in the marketplace works through supply induced demand. The providers decide the character and quantum of supply for the healthcare demands made. So when a patient visits a doctor or hospital it is the latter who decide what care or treatment would be provided and since there is huge asymmetry of information the patients succumb to what the healthcare provider forces upon them – the battery of diagnostic tests, range of medicines prescribed, procedures and interventions.

Similarly when patients visit private hospitals they are subject to various kinds of malpractice and exploitation. The FDA in Maharashtra investigated well known private hospitals recently for malpractices like reuse of medical devices like catheters, which in the first place were overcharged by 2 to 3 times the MRP to the original patient[3]. This unnecessarily inflates the patient's bill but also amounts to cheating when it is reused and charged again to the next patient, putting the latter at risk of infection for which s/he may need further treatment.This means increased out of pocket burden for patients and increased earnings and profits for providers.

What the FDA has revealed is not an isolated practice. The revelations are only tip of the iceberg. Malpractice of a wide range has infected medical practice across the board[4]. From cut-practice to unnecessary referrals, needless diagnostic tests and drug prescriptions for paybacks, gifts and travel subsidies from pharma industry, unnecessary surgeries and procedures, transplant rackets, overcharging patients, frauds under insurance etc. The list is endless and growing along with the growth of the private health sector. And the media is increasingly exposing this[5].

Further there is also the resistance of the Indian Medical Association to bringing in the Clinical Establishment Act for regulation[6] of healthcare provisioning and medical practice, and especially opposing any regulation of price for healthcare provisioning. In sharp contrast an association of doctors in Canada have told their government that the periodic increase in

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[1] Independent Researcher and Consultant.

[2] https://www.livemint.com/Politics/Aw6b1LV0uPZxsJ7z63FjUK/Modicare-will-expand-private-healthcare-market-NITI-Aayog-V.html

[3] https://www.hindustantimes.com/mumbai-news/hospitals-in-maharashtra-reused-1-306-catheters-charged-patients-77-of-mrp-says-fda/story-Vq1edOVndlWy35mDaMu8DO.html

[4] https://thediplomat.com/2016/08/dealing-wth-the-growing-threat-of-medical-malpractice-in-india/

[5] https://www.businessinsider.in/Scary-real-incidents-show-how-unethical-Indian-doctors-have-become-But-these-Doctors-tell-you-just-how-to-figure-fake-from-real/articleshow/52223528.cms

[6] http://www.tribuneindia.com/news/haryana/clinical-establishment-act-anti-doctor-ima/513388.html

their salaries[7] should not be done because doctors are already over paid 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 in India is largely due to effective regulation of healthcare and ethics in medical practice. In India there is an almost complete absence of regulation of the health sector and lack of ethics in medical practice. 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 resulting political economy of healthcare in India becomes highly commercialised and profit oriented.

Further the government is also a party to this increasing commercialisation of healthcare. The 2017 National Health Policy and the 2018-19 budget announcement of the National Health Protection Scheme under Ayushman Bharat are clear markers of which direction the government wants to drive the 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[8] which keeps interjecting with statements and suggestions to expand private health markets, use insurance as a mode of financing healthcare, promote privatization of healthcare etc.

Global experience is clearly contrary. Countries which provide good quality healthcare with equitable access to its population have effectively regulated health systems under a public mandate which is publicly financed from taxes and social insurance payments, do not segment their populations based on income and employment to receive health benefits and have developed a strong culture of ethics in practice amongst its providers. And above all these countries do not leave healthcare to the whims of the market but assure that healthcare remains a public good.

So, the recent discussions on healthcare in the media are welcome and one hopes this would lead to politicization of healthcare into an issue which gets centre-staged in election battles and finds resonance in the parliament and state assemblies. It's time to ask hard questions on healthcare in India as that is the only way that the general public will be able to access improved and equitable healthcare. Why do our public servants (bureaucrats) and Parliamentarians get CGHS benefits (and most of it today via the private sector) which cost the state exchequer in 2015 a whopping Rs 6300 per CGHS beneficiary annually in sharp contrast to the general public for whom the governments in the same year allocated a mere Rs. 1100 per capita[9]?

It's time to change this equation. Governments talk of universal access to healthcare but their policies and actions translate into a segmented and selective approach and leads to

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[7] https://www.theguardian.com/world/2018/mar/09/canada-doctors-protest-pay-cuts

[8] https://scroll.in/pulse/844272/niti-aayog-and-health-ministry-prepare-model-contract-for-privatising-urban-health-care

[9] https://timesofindia.indiatimes.com/india/government-spends-just-rs-1100-per-year-on-your-health/articleshow/61898331.cms

huge deprivation and inequities in access to healthcare. If this must change then healthcare has to be detached from the marketplace and developed as a public good. This is the direction countries are moving to the world over and no reason why India should be different. In fact, there are already some states like Mizoram, Sikkim, Goa, Puducherry, Andamans etc. who are on that track committing over Rs. 4000 per capita on healthcare in their budgets[10] and they do so because there is no significant private sector in those states and have a robust primary healthcare system and good health outcomes. If the government wants Ayushman Bharat then it should learn from these states and other global experiences like Thailand, Mexico, Venezuela, South Korea etc.and strive to make healthcare a public good and free it from the clutches of the market. Instead we are moving away from national or state run (tax based) healthcare system to an increasingly insurance financed or market based healthcare system following the USA model without the appropriate regulatory framework in place.

The 2015 health policy draft was a robust one pitching for a tax based strong primary healthcare system that would move towards universal access but in 2017 the NITI Aayog diluted this policy to move towards a stronger private sector or market based health policy that would increasingly use insurance as a financing mechanism.Insurance is not the way to go. It promotes segmentation and inequity, it is selective, it will not support you in your old age when you don't work and can no longer afford the increasing premiums, experience from states across the country give enough evidence of failure of insurance - despite insurance OOPs have increased in these very states as revealed by NSSO surveys[11].Leaving it to the market or private sector will not help in realizing health for all. We need to strengthen the public health system which faces the following deficits that we need to resolve:

- Deficit of demand based planning (Program Implementation Plans, District Planning Committees, Gram Panchayat Development Plans etc..) - need to strengthen bottom up planning and involving various stakeholders at the local level to develop plans and budgets for the public health system as per their needs and demands
- Deficit of investment and expenditures - inadequate infrastructure and human resources in place, expenditure of only 1.1% of GDP is grossly inadequate; need to learn from Railways, Armed forces, CGHS and ESIS and afew states like Mizoram, Goa, Puducherry etc. in development of a strong public health system which at today's prices requires between Rs. 3500 to Rs. 4000 per capita in contrast to the current Rs. 1500 per capita. Need to use well accepted benchmarks like WHO norms, Indian Public Health Standards etc.
- Deficit of Governance and implementation - the top down decision making cannot work in a sector like health which is highly local oriented. Decision making and management has to be left to the local institutions and governance and not a top down bureaucratic mechanism.
- Deficit of accountability and legislative oversight - our legislators don't call to account the executive and this leads to neglect and failure of public service delivery being implemented effectively; community oversight through Community Based

[10] http://www.dnaindia.com/analysis/column-in-crying-need-of-critical-care-2487811
[11] NSSO, 2015:*NSS 71st Round–2014,* New Delhi, Government of India.

Monitoring and Planning needs to be implemented across the board - the Maharashtra model in 14 districts has shown how CBMP can help reclaim the public health system

- Deficit of political will and executive commitment - healthcare is not politicised enough
- Deficit in policy -Healthcare system driven by markets - moving from healthcare as a public good to a commodity; health as a public good has to be reclaimed

Instead of dealing with the above deficits the government recently launched Ayushman Bharat which has two components of Prime Minister Jan AarogyaYojana (hospitalisation cover for bottom 45% population) and the health and wellness centres to consolidate primary healthcare; the former has been initiated to support insurance and private health sector but the latter which should form the foundation for the former has been ignored and no significant budget allocation has been made.

The recently launched Ayushman Bharat component of PMJAY by the incumbent government is an attempt to appease the bottom half of the population withaccess to hospitalization benefits but it has failed before it could take off because of its flawed design. The PMJAY is a hospitalization only cover for the bottom 50% of the population and it is being framed within the insurance model. Both the Union government through RSBY and many state governments through its state specific schemes have gone down that road and have seen more failures than success. Despite huge investments by states in such schemes the out-of-pocket burden of households has not reduced as revealed by the 71st Round of NSSO. Ignoring this history the union government still opted for such a model led by the wisdom of the NITI Aayog – a model that does not benefit the patient but the insurance company and the private hospital. Such a model has not worked anywhere else in the World so why will it work in India. Further the second and more critical axis of Ayushman Bharat – the health and wellness centres – which were to strengthen primary healthcare at the sub centre level has been completely side-lined and no significant budgetary allocations have been made for it.

Why this will not work is because it is selective and targeted and uses a flawed financial model. It leaves out the rest 50% population, it ignores primary healthcare which is the foundation for any UHC approach and above all it fails to bring in the minimum resources needed – atleast 2.5% of GDP or Rs. 3600 per capita.

Public finance for healthcare in India is one of the lowest in the World, even lower than most least-developed countries. For 2018-19 health ministries committed Rs. 191060 crores or Rs 1470 per capita or a mere 1.02% of GDP[12]. The Centre's contribution net of grants to states and UTs was only 11% (27% including grants disbursed). If we net the CGHS from the above then the budget for the general population comes down to Rs 1448 per capita. Ofcourse there is wide variation across states with quite afew states spending more than the national average. In Arunachal it is Rs 6706 per capita, in Sikkim it is Rs.5575 per capita,

[12] RBI, 2018: State Finance – A Study of Budgets 2017-18 and 2018-19, RBI, Mumbai, 2018; Ministry of Finance, 2018: Expenditure Budget Vol. SBE 42, Dept of Health and Family Welfare, GoI, New Delhi

in Mizoram Rs 4304 per capita, in Goa Rs 2536 per capita and at the bottom we have West Bengal at Rs 806 per capita, UP Rs 892 per capita, Bihar Rs. 898 per capita and Maharashtra at Rs. 975 per capita[13]. The states which spend above the national average are also on the average better performers in healthcare outcomes and have more robust public healthcare delivery.

The challenges across the country differ due to different levels of development of the public and private health sectors in the states. Let's illustrate this comparing a good performer lik Mizoram and a poor performer like Bihar. Mizoram, a small and hilly state, already has an excellent primary healthcare system functioning with one primary health centre (PHC) per 9,000 population (Bihar has one per 52,000) and one community health centre (CHC) per 50,000 population (Bihar has one per 6,00,000). And, since Mizoram has virtually no private health sector, the demand-side pressures are huge and, hence, the public health system delivers (in Bihar only 14% of outpatient care and 42% of hospitalization is in public facilities). Each PHC in Mizoram has 2 to 3 doctors on campus available around the clock, with 15–20 beds which are more or less fully occupied and 95% of deliveries happen in public institutions (in Bihar, there is one doctor per 28,391 population and one hospital bed per 8,645 persons). So, Mizoram has indeed realized the Bhore Committee dream. The problem in Mizoram is that there are very few specialists available and, hence, higher levels of care become problematic; the CHCs, however, are run by MBBS doctors who have received some additional training. Mizoram does not have a medical college, but it does have reservations in other state medical colleges. While the state cannot provide tertiary care, it has a budget to send people elsewhere to seek such care. And, Mizoram does this with 2.7% of its net state domestic product (NSDP) or Rs 4,300 per capita and has the best health outcomes in India. In some sense, Mizoram is like Sri Lanka – a statist model. There are a few other states in India which can do a Mizoram because they too do not have a significant private health sector, but to do that they have to demonstrate the political will of Mizoram.

Even though extremely successful, Mizoram cannot be the national model because the reality across most other states, including Bihar, is very different. It is the reality of an entrenched private health sector, including a wide variety of quacks, which is both unethical and unregulated. The private health sector has to be reined in and this can only happen with a strong political will which declares healthcare to be a public good and which takes on the private sector to get organized under public mandate. Under the NRHM sporadic efforts towards this end have been undertaken in the name of public–private partnerships (PPPs) like Chiranjeevi in Gujarat, Yeshasvani in Karnataka, ArogyaRakshak in Andhra Pradesh, Rajiv Gandhi Hospital in Raichur (Government of Karnataka and Apollo Hospitals), JeevandayiAarogyaYojana in Maharashtra, RashtriyaSwasthyaBimaYojana (RSBY) across the country, etc. They may have achieved limited success, but then healthcare systems cannot be built by segmentation into programmes and one-off initiatives like PPPs. There have to be serious efforts at building a comprehensive healthcare system and it goes without saying that, given India's political economy of healthcare, the private sector will have to be a

[13] Ravi Duggal, 2018: Health Budgets 2017-18, Mfc bulletin No.379, July 2018

significant partner in this process. So, states have to think beyond the Chiranjeevis and Yeshasvanis and learn from the recent experiences of Thailand, Mexico, and Brazil to invest in an organized healthcare system, and, with a booming economy, resources will not be a constraint.

So, the challenge for the New Health Policy is not replacing the NHM with Ayushman Bharat as another flagship programme, but in implementing effective restructuring of the healthcare system in the country through strong regulatory mechanisms, both for the public and private sectors, education of professionals in ethics of practice, pushing the politicians for creating a strong political will to make healthcare a public good as well as generate and commit adequate resources to realize universal access. The restructuring of the healthcare system and its financing strategy, given the price advantage of India and economies of scale it offers, will actually reduce nearly by half the healthcare spending in the country and reduce substantially the financial burden on households for accessing healthcare. Calculations I have done show that, for universal access to healthcare across India, we need less than 3% of the gross domestic product (GDP) or Rs 3,500 (at 2015 prices), provided we show the political will to shift healthcare from the domain of the market to the category of a public good. This will indeed do a lot of public good!

rduggal57@gmail.com / 27th Dec 2018