The public-private gap in health care

The recent controversy about transparency in the working of the cadaver transplant programme in Tamil Nadu has provided an opportunity to revisit the vexed question of medical rationing in India.

It is a hard reality that not all medical interventions are available to every citizen who may need it. The gap between what is technologically possible and what government hospitals generally provide widened appreciably after the technological leaps in medical care began, starting in the 1980s.

The NITI Aayog's document, 'Three Year Action Agenda, 2017-18 to 2019-20', has a section on health care. One of the recommendations is for the government to prioritise preventive care rather than provide curative care. The document also advises the government to pay attention to stewardship of the health sector in its entirety rather than focussing on provision of health care. Therefore, the system of private health care for those who can afford it and government care for those who cannot will continue in the foreseeable future.

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Every government since Independence has stated egalitarianism as its goal in health care. The policies, however, have not matched the statements. Many interventions, especially those which are very expensive, continue to be provided only to those who can pay for them. This is medical rationing of the covert kind. Token provision of these interventions in a few government hospitals is merely an attempt by governments to appear fair.

The new Ayushman Bharat health scheme to provide secondary and tertiary care to those who are socio-economically deprived has a cap of 5 lakh per family per year. It is quite obvious that many interventions cannot be accessed for this amount, certainly not human organ transplants.

Transplanting a human organ is not a single event, but a life-long process. The actual act of transplantation itself needs expensive infrastructure and trained human resources. For the continuing success of the transplanted organ, expensive medication is needed. It is a sad truth that in India, out-of-pocket expenses for medical care are about 70% of all medical expenditure, and this particular intervention is only going to be available to those who can pay.

Health care in India is obviously not egalitarian, but is it at least equitable? The evidence suggests otherwise. Governments have been giving subsidies to private players, especially to corporate hospitals. The repeated boast that India can offer advanced interventions at a fraction of the costs in the West does not take into account the cost of the subsidies that makes this possible. Since it is all taxpayers' money, it is a clear case of taking from the poor to give to the rich. In an illuminating article, "Investing in health", in the *Economic and Political Weekly* (November 11, 2017), Indira Chakravarthi and others pointed out that private hospital chains in India have entered every segment of medical care, including primary and secondary care and diagnostics. Most have large investors from abroad and some are effectively controlled by foreign investors. In short, taxpayers' money is being used to ensure profits for foreigners.

Successive governments have been increasingly dependent on the private sector to deliver health care. The Ayushman Bharat scheme is a further step in this process. The benefit to patients is questionable but private players will see a large jump in profits. It will further institutionalise medical rationing by explicitly denying certain interventions — a "negative list" presumably of procedures which will not be covered, which is not yet in the public domain.

Besides being inequitable, medical rationing has other detrimental effects. One is a distrust of the public in government hospitals. The poor expect to get from them what the rich get in private hospitals. With present policies, this is simply not possible. Without a clearly defined mandate, morale among medical personnel in public hospitals is low. The perception that doctors in the private sector are much better than those in the public sector has a severe debilitating effect on the professional image of medical personnel in public hospitals. Attempts by doctors to provide these high technology interventions in public hospitals is bound to fail without continuing commitment from policymakers; it is quite clear from policy documents, which doctors and the public do not read, that such commitment will not be forthcoming.

Our hearts tell us that every possible medical intervention should be available to every citizen. Our minds tell us that the government is not committed to this. The only pressure group which can ensure at least equitable medical care is the electorate. Until such time as it demands this from governments, we will continue to witness the tragic drama of two levels of medical care in India.

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