Overcoming the divide

On the eve of Independence, the founding principles of health care for India were established through the Bhore Committee. Here, health care was envisaged as comprehensive, universal and free at the point of delivery, based on a government-led service, and to be paid from tax-funded revenues. These policies, which were adopted from the National Health Service (NHS), a major social reform in the U.K. following the Second World War, have stood the test of time and remain a source of pride for the U.K. But for India, it is an embarrassment that this health model has declined because of chaotic, mismanaged, unregulated and discriminatory policies and the priorities of successive governments.

This has created a second system (supposedly more efficient) in the form of the urban private sector, which is responsible for most health care in India. The private sector over-medicalises: over-promises, over-investigates, over-treats and overcharges to meet management targets, creating needless fear and paranoia. There has been a paradigm shift from a ‘service’ to a fee-for-service model of health care. Medicine has changed from ‘doctor-patient-treatment’ to ‘customer-provider-delivery’. All this disorganisation has led to a trust deficit between patient and doctor.

The decline of a universal, social health system has led to the cost of treatment becoming astronomical. Health care in India is changing from a conservative, clinical, affordable, accountable, patient-centric British model to a more investigative, aggressive, expensive, commercial and insurance-driven American system, without the safety mechanisms of either. India still faces many communicable diseases (malaria, dengue and tuberculosis) which require a robust public health system. Along with non-communicable diseases (diabetes, heart disease and cancer) also on the rise, this is a double burden.

This mismatch is further compounded with only 4% of GDP allocated to health. India has one of the highest (86%) out-of-pocket (private) expenditures on health care in the world. With little or no health insurance, this leads to approximately 40 million people falling below the poverty line every year. Let’s draw an analogy with the organised, Western health system (public and private care), taking the example of any international university. There are two kinds of fees — one for national students and usually a slightly higher one for international students, which is akin to treatment costs in a hospital where there are higher private fees. At the end of the course, all students are awarded the same degree much like patients who get the same level of care in a public or private hospital in the West. Private care in the West exists to streamline routine services and possibly reduce waiting times.

In an ideal world we would want an egalitarian health-care model. However, misuse of private health care at the patient’s expense leads to a breakdown of the whole model. Compare it to transport, where there are buses and taxis, representing public and private health care, respectively. The drivers are akin to doctors. Someone decides to pay a bit more and take a taxi, creating room for more people on the bus. It sounds reasonable. But if more people take taxis than buses (it is like private health care overtaking public health care), then all the roads will become clogged, the bus services will not be looked after, and the whole infrastructure will be destabilisesd. A doctor too decides to pay more attention to private care as it is more rewarding. Everyone is under the perception that private care is better .Then people can only hope to either take a taxi or walk. A balance between the two health systems is required, where there is no compromise made on the quality of care delivered.

This random and shambolic state of health care in India has made the expectations of the patients and relatives, unrealistic and unreasonable. This has created hype, fear, paranoia, a false sense of security and is responsible for breaking the ‘sacred patient- doctor’ relationship. Expensive

treatments and interventions with marginal benefits should be realistically considered to treat frail, futile, terminal patients and relatives should be explained the outcomes. It is for the society to decide the ceiling of treatment. We need to strengthen our public health-care system based on the pillars of trust, accountability and efficiency. A balance needs to be made between public and private health care. This balance will only be restored by the mutual respect and belief between a doctor and patient.

Raghav Bhargava is at the School of Medicine, Cardiff University, U.K.

At around 2 a.m. on May 17 morning, a grievously sick Mohammed Salih, a 28-year-old architect from Kerala’s Perambra town, was rushed by his family to

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