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THE HEALTHCARE GAP

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As epidemiologists tend to consider that the peak of the COVID-19 epidemic may not come before July, the question of the resilience of the Indian health system becomes more pressing, especially in cities like Mumbai, Delhi and Ahmedabad. The limitations of the country's public health system are well-known. India's public hospitals have only 7,13,986 beds, including 35,699 in intensive care units and 17,850 ventilators, according to a recent study by the Center for Disease Dynamics, Economics & Policy (India) and Princeton University. Why does it matter? Not only because the country has already registered 1,24,981 active cases, but also because these figures are a reflection of the lack of interest of the government of India, for decades, in developing a welfare state.

The general perception behind the inadequate provision and availability of healthcare services is attributed to the country's developing nation status. However, India lags behind its BRICS peers on the health and quality index (HAQ index). As per the National Health Profile 2018, India's public health spending is less than 1 per cent of the country's GDP, which is lower than some of its neighbours, countries such as Bhutan (2.5 per cent), Sri Lanka (1.6 per cent) and Nepal (1.1 per cent). In fact, according to the World Health Organisation, India finishes second from the bottom amongst the 10 countries of its region for its percentage spending of GDP on public health. Maldives spends 9.4 per cent of its GDP to claim the top spot in the list, followed by Thailand (2.9 per cent).

Similar trends for India are observed on indicators like hospital beds per 1,000 people. As per the OECD data available for 2017, India reportedly has only 0.53 beds available per 1,000 people as against 0.87 in Bangladesh, 2.11 in Chile, 1.38 in Mexico, 4.34 in China and 8.05 in Russia. The numbers have not changed in the last four years of available data, showing India's stagnant allocation to the public health care budget.

The subnational HAQ differences in India are of critical importance. While the best performing states, Kerala and Goa, scored more than 60 points, the worst performing states of Uttar Pradesh and Assam scored less than 40 points. Further, the gap between these highest and lowest scores increased from a 23.4 point difference in 1990 to a 30.8 point difference in 2016. Upon comparing state populations with the number of available beds, Kerala with a population of only 3.5 crore (2018) has over 22,300 available beds in public hospitals/government medical colleges. Whereas, bigger states like Gujarat and Maharashtra with populations of over 6.82 crore and 12.22 crore (2018) respectively, have only 16,375 and 6,970 beds respectively. These differences across states also speak for the differing capacities to contain the virus at a subnational level wherein Kerala has emerged as a successful model.

One of the obvious reasons why public healthcare has not been a priority for successive governments of India lies in the fact that India's middle class did not need it. The CDDEP/Princeton study shows that the private hospitals have 11,85,242 beds, 59,262 ICU beds and 29,631 ventilators. Currently in India, most of the COVID-19 treatment is being done in public facilities but as the epidemic progresses, it will be critical to expand the outreach of healthcare services by involving the private sector as an equal partner and stakeholder. Despite private hospitals accounting for 62 per cent of the total hospital beds as well as ICU beds and almost 56 per cent of the ventilators, they are handling only around 10 per cent of the workload and are reportedly denying treatments to the poor. This is seen in Bihar, which has witnessed an almost complete withdrawal of the private health sector and has nearly twice the bed capacity of public facilities. In states where private hospitals have not opened their doors to the poor to

enhance and supplement the governments' efforts to ensure public health, the governments in question have taken control of some of them. As the Modi government has invoked the National Disaster Management Act of 2005, authorities are empowered to take over the management of private institutions.

Maharashtra is a case in point: It has taken control of 80 per cent of all private hospitals' beds in the state till August 31. For the patients of these beds, rates have been capped at Rs 4,000 in the case of simple ward and isolation beds, Rs 7,500 per day for ICU beds without ventilator and Rs 9,000 for those with ventilator. Will other states follow? For the moment, the Delhi government has asked 117 private hospitals to allocate 20 per cent of beds for coronavirus patients. And how will the private hospitals be compensated? One way to do it, for the governments (Union and state), would be to pay crores of dues they owe to private hospitals for treating patients under the Central Government Health Scheme (CGHS) and the Ex-servicemen Contributory Health Scheme (ECHS).

Similar policies should apply to testing, a key priority, as India continues to test less than it should in a post-lockdown scenario where testing is one of the most obvious ways to flatten the curve. Here, the Supreme Court, after ruling on April 8 that private labs should conduct free testing, modified its decision five days later to fix the rate of one of the most dependable tests at Rs 4,500 — which is costlier than in Bangladesh, and which allows private labs to make some important profits, it seems. Anyway, why should this issue be the business of the Supreme Court and not part of the crisis management by the state?

The state is staging a comeback everywhere in the world in the context of the COVID-19 crisis. In India, one of the domains where it has to step in is public health. A debate on the lack of investments in public health is bound to take place in the country after the dust has settled. But the return of the state does not necessary mean more centralisation. Some state governments are doing a better job than the Centre today and the most effective ones are the most decentralised ones — see Kerala.

It does not mean that civil society has no role to play either: In fact, the situation would be much worse if NGOs and private foundations (using CSR money sometimes) did not play such a huge part at the grassroots level. But the most effective interventions seem to take place when there is a high degree of coordination with the state apparatus.

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