What ails India’s public healthcare?

The current state of India’s healthcare is like a scene from Shakespeare’s *Hamlet* where Marcellus famously says, “something is rotten in the State of Denmark”, to which Horacio’s replies “then we should let God take care of it”. Both the rotten state and the apathetic and unimaginative response are symptomatic of the disease that ails India’s healthcare system.

All at once India’s healthcare suffers from quality, quantity, footprint, access and affordability issues. Any one or two of these alone would bewitch most countries—suffering all of them simultaneously is proving to be near fatal.

First, the quantity problem. The World Health Organization estimates that India spent about $267 per capita on health care in PPP adjusted terms in 2014—China spent three times that amount, Brazil five times, European nations 10 times and the US 20 times. In aggregate, India spends only about 1.5% of gross domestic product (GDP) on public healthcare. Most countries spend two or more times that number. This allocation is a fundamental problem that impacts infrastructure, supply of critical equipment and consumables (including syringes, oxygen, etc.), the number of hospitals and the retained staff of doctors, specialists, nurses and assistants.

Second, the quality issue. India suffers from an acute shortage of secondary and tertiary hospitals, a significant shortfall in specialists and specialized equipment, and a rigid regulatory framework combined with corrupt enforcement. All of this leads to appalling quality for the medical system in the country. Add to this a hopelessly inadequate feeder system from preventive health to primary care to secondary and tertiary referral and you have the makings of system that is so completely broken that it may not be fixable without a zero-base approach.

The NITI Aayog has taken the bold step of proposing a complete “repeal and replace” of the Medical Council of India (MCI) which is currently in charge of medical education and medical professionals in the country. It has come to this pass because according to a recent Brookings report the MCI has been a bribe-taking organization for accreditation of medical colleges. It has also used its authority to require that doctors without specialized degrees cannot perform the most routine of procedures like caesarean section or ultrasounds.

Combine this with an acute shortage of post-graduate seats for medical education and you have an absurd situation where MBBS doctors are not allowed to legally treat many of the leading causes of death in India.

Access and affordability issues add to a rather poor prognosis for the health system. Primary health centres (PHC) in villages are supposed to feed medical cases that require treatment to specialist hospitals in districts and further on to state-level specialist hospitals. PHCs are not present in many villages (about 1 for every 20 villages), and where present so severely undermanned that the “access” system is broken at the first mile. This lack of footprint impacts not only the filtering of patients but also deeply impacts prevention and early detection. A prevention and early detection system is a must if costs of the whole system for the country are to be contained.

The government has been taking some steps—such as increasing the number of drugs under price control. With an increasing footprint for equipment and drugs under price control it is only a matter of time before procedures and protocols also fall under this umbrella. While price control appears to be a solution in the short-term it is rarely a good solution in the long-term because it keeps professional profit motivated players out and encourages participants to cheat and creates incentives for the well-to-do to use illegal methods to get around it. While framework adjustments

like requiring the prescription of generics (India is the generics capital of the world after all) make sense, outright price control of the type now mandated for stents is poor policy.

The three biggest problems to address are 1) the acute shortage of medical professionals, 2) the hopelessly inadequate medical filtering and referral system and 3) who will pay and how they will pay for medical access.

The National Eligibility cum Entrance Test (NEET) combined with a new medical commission is meant to address the first issue but the proposal from NITI Aayog does not go far enough in viewing the medical system in a holistic sense and addressing the entire chain from education and prevention to secondary and tertiary medical care.

There are four basic models of payment for healthcare: the Beveridge model that is modelled on the general tax payer payment system of the British National Health Service, the Bismarck Model of socially funded insurance schemes, a nationally funded health insurance system and an out of pocket model. While there are elements of three of the four systems present in India (except national health insurance), the coverage is extremely limited.

Much work needs to be done to figure out a combination of these methods to address the needs of a heterogeneous India that caters to the urban and rural populations, rich and poor and formal and informal workers.

The diagnosis is clear—the system is broken. The policy doctors seem to be as apathetic and unimaginative as the real ones. The prognosis is not good.

P.S. “Health is the real wealth of a nation”, said Mahatma Gandhi.

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