# Fixing healthcare

Can two knowledgeable and well-meaning people appear adversarial? That depends on where they are coming from. If you are coming from the side of efficiency within the limits of a system, there will be one recipe. If there is an urge to visualise a system as serving much more than efficiency, to include affordability and equity as well, the response will be different. This is why Sujatha Rao and Amitabh Kant differ in their articles, 'A strange hybrid' (IE, August 11) and 'A healthy partnership' (IE, August 19). Each calls the other's stand ideological. Is more of the same better for a broken system or is a complete overhaul worthwhile?

No one will deny that India's health system requires fixing. Increasing the budget to 3 per cent of GDP will be a welcome step but may not be the only one that is required. More money within the current clientist system will be akin to flushing it down the drain. How we revamp the existing ecosystem to deliver better service is the issue. Some feel with just an increase in outlay, many problems will sort themselves out. The other view is that the ecosystem can't be changed, so why not have a private system coexist within the government system? Maybe the competition will improve the service delivery in the public system or maybe the more efficient system will gobble up the defunct one.

Is the broken system that we see to be accepted and should we work only modestly towards small, incremental improvements? Is a 35 per cent shortfall of doctors an insurmountable problem? Anyone entering a government medical college can be made to sign a contract to serve the government sector for 15 years with attendant provisions for study leave, research leave, annual training and short-term courses. Otherwise, they may be mandated to pay the market value of the course to the government - to the tune of Rs 50 lakh for a five-year programme. After appointment, is it impossible to control absenteeism? It is, provided the government forsakes its ambivalence. Technology will be of great help here.

Health services in government hospitals are quasi-public goods or merit goods. But a poor person will not get medicine if the budget is low or if large numbers of the well-heeled are given free medicine or diagnostic tests. A diminishing budget hits the poor first. Private hospitals facilitate profit-maximisation with impunity. In government hospitals, failure takes place because of a lack of accountability, absenteeism, trade unionism and underfunding. While public goods have the chronic free rider-problem, private health service routinely excludes a large poor population, overcharges and reduces many to penury. Private healthcare is often without regulation and even tenuous attempts at implementing the Clinical Establishment Act have not been made.

Amitabh Kant makes a succinct point with regard to abandoning patients to negotiate the maze of the government hospital where the bargaining powers of the patient vis-à-vis the provider are at their lowest. But in government institutions, politics trumps merit. The more politically clued in one is, the more one is likely to survive and prosper. Adhering to one's calling as a doctor will likely lead to hitting a wall. How do we make the ecosystem change? The political ethos which prevails today can be reversed by fencing it with local management control, with a scorecard for each department and employee. NITI Aayog will do well to work out this architecture and model contracts as they are best placed to design the nuts and bolts of this transformative work.

It was Alan Greenspan who said the absence of evidence is not evidence of absence. Merely because an evaluation of the efficiency of private care has not been done, it does not mean its efficacy for a large section of the poor is not questionable. It is unregulated and non-transparent in a different manner from the public system. There is a different maze to be negotiated here. The poor or not-so-rich handle it by selling property. Coming from the National Human Rights Commission, I can vouch that there are complaints galore of private sector hospitals denying

health rights, prescribing unnecessary tests and medicines and keeping patients in ICU longer to charge more.

What is our track record in handling PPPs with the private sector? The devil lies in the small print. Our government system finds it difficult to draft an agreement without a consultant. This consultant carries the typical dilemma of a third-party negotiator - whether to protect the client, to join the second party or to advance her own agenda. When there is a difference in interpretation, the case inevitably lands up in the court of law where delay is the norm and private sector is most likely to win. Collaboration between a predatory private sector and an inept government sector ends up with an asymmetrical alliance which works against the poor.

More than 60 per cent of the population cannot afford private healthcare. When the elite moved away from the government health system, its decline was exacerbated. Efficiency is a must for public health systems but co-existing with private players in the same premises is not the best solution. Private players will be tempted to shift the expenditure to the budget book of the state, shooting from the shoulder of the poor. In a twin-system of healthcare from the same premises, the real pricing, both formal and informal, will go up because of the misbehaviour of market forces and functionaries. The inexorable march to profit-making will eclipse other systemic issues. Whenever you start with design flaws you get both egregious intended and unintended consequences where the poor suffer. The Niti Aayog will do well to design a public health system around a new architecture with attendant rules and contracts for transforming the ecosystem rather than trying to pluck the low hanging fruits.

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