INDIA'S 'NEW DEAL' MOMENT

Written by ***Vedant Patil***

3rd Year LLB, ILS Law College, Pune

"Healthcare is a human right, not a privilege!" the booming voice of Bernie Sanders, during the Democratic primaries in USA, now slowly fades into obscurity. And half a world away, India must introspect its existing healthcare infrastructure, as the steadily increasing number of Covid19 positive patients makes it the third worst affected country in the world. The reasons behind this must be understood in their entirety before addressing them. The unemployment numbers across the country have risen up. This, coupled with the pre-existing recessionary trends in the economy could plunge the nation in severe economic depression. As India slowly opens up after a strict 70 day lockdown, the government must embark upon a massive multi-sectoral investment program to kick start economic activity. Taking lessons from the Great Depression of 1929 and the current state of healthcare infrastructure in India, this could prove to be our 'New Deal' moment.

INTRODUCTION

The healthcare system in India rests on 3 key pillars: the government with its policies and schemes, the doctors and medical infrastructure, and the pharmaceutical industry. As the Covid19 situation across the country worsens and the pharmaceutical research strives to find a cure, it will be helpful to take a look at the remaining two pillars in the meantime. Paving the way for a 'New Deal' in the healthcare sector essentially requires the convergence of political will and a complementary upgrade of the medical infrastructure.

HEALTHCARE AND THE INDIAN CONSTITUTION

A study of the constitutional assembly debates reveals the importance of healthcare in the minds of the constituent assembly members. Prior documents to supplement a constitutional right to public healthcare can be found in the Nehru Report (1928), Karachi Resolution (1931) and the Draft Constitution of the Republic of India (Socialist Party, 1948).[i]

Presently, the subject of 'Healthcare' finds itself under Article 47, among the Directive Principles of State Police and Schedule VII State List, entry no. 6 'Public health and sanitation; hospitals and dispensaries'. This gives complete autonomy to the states to decide upon the healthcare facilities to be made available to the people therein as well as make allocations in the state budget and formulate different programs for the promotion of health among its residents. This has disadvantages of its own. States tend to prioritize policies and sectors according to their political agenda, and at times, that of certain vested interests, eventually resulting in non-uniform quality of healthcare facilities across different states.

Interestingly, this problem was discussed at length during the Constitutional Assembly Debates and a member of the committee HV Kamath had expressed a need to move Public Health to the State List. He argued that owing to the then abysmal condition of public health in India, the Central Government should have more than a mere recommendatory role in the development of healthcare facilities in the country.[ii]

The Supreme Court thus, has played a crucial role in expanding the fundamental right under Article 21, whereby every person is ensured a right to life which can be denied to him only through a procedure established by law. It has recognized the Right to access public healthcare as a fundamental right of every person. Most importantly, to ensure this right is available to every person, the Supreme Court also ruled that the State cannot excuse itself from the same, citing inadequate financial resources.[iii]

POOR STATE OF PUBLIC HEALTH

Despite the aforementioned constitutional obligations, the states have repeatedly failed to provide access to quality public healthcare to people. This can be understood from various dimensions.

The World Health Organization recommends ideally 1 doctor for every 1,000 people in a country. In India, the ratio stands at 1:1,445[iv]. The Medical Council of India states the figure of active doctors in India to be 1,050,000. Basic calculations show that India falls short of this ideal ratio by around 400,000 doctors. Another estimate also states that India has a shortage of nearly 20 lakh nurses and even more supporting staff.[v]

Another important parameter of relevance here is the number of beds available in public hospitals. A study by Princeton academicians estimates the figure to be 1,899,228 for a total of 69,256 hospitals across India (Public + Private).[vi] As the number of private hospitals (43,487) is roughly twice that of public hospitals (25,778), the beds follow this proportion as well. During the Covid19 pandemic, private hospitals across the country were shut for a long period, shifting the burden of incoming patients on public hospitals. Despite private hospitals accounting for 62 per cent of the total hospital beds along with ICU beds and almost 56 per cent of the ventilators, they are handling only around ten per cent of the workload and are reportedly denying treatments to the poor.[vii]

States like Maharashtra have taken control of 80 per cent beds in private hospitals until 31st August, 2020 to ease this burden. Public hospitals, as a result, have to keep functioning, with inadequate staff and funding, risking the lives of its staff[viiiix] in the process, while private hospitals have the luxury to stay shut and refuse intake of patients when a crisis situation, like a pandemic, arises.

Given the above factors, India, also falls behind on the parameters of access and quality of healthcare. This was evident in the Healthcare Access and Quality Index (HAQ) published by the Lancet Journal, where India ranked 145th out of 195 countries. Neighboring countries like China (48), Sri Lanka (71), Bangladesh (132) and Bhutan (134) have performed better than India.[x]

BUDGETARY ALLOCATIONS

Healthcare being a state subject, it is expected from the states that they direct their efforts towards the development of this sector. The union government, announces schemes, but leaves it to the discretion of the states for their implementation. Thus, the states prioritizing different sectors, according to their income levels, at the cost of healthcare expenditure, have resulted in disparities among states in delivering quality healthcare.

Expenditure on public health in India has remained at 1.3% of its GDP till now. The National Health Policy 2017 aims to increase it to a mere 2.5% by 2025[xi]. The global average expenditures by developing economies is 5% of GDP, showing the lack of interest by the government towards developing a welfare state in terms of healthcare expendires.

AYUSHMAN BHARAT SCHEME

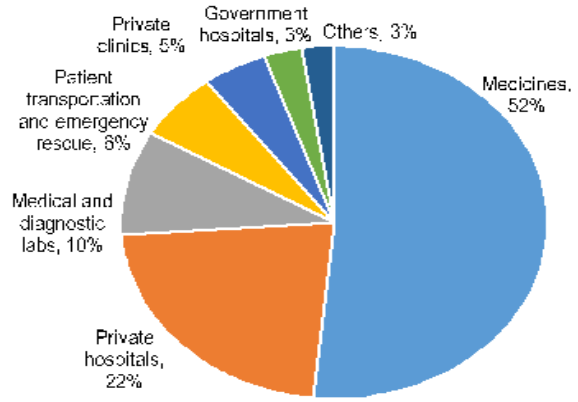
Giving effect to the National Health Policy (2017), the government launched the flagship Ayushman Bharat yojana, part of the Pradhan Mantri Jan Aarogya Yojana (PM JAY). It aims to provide health insurance to over ten crore families, with nearly fifty crore beneficiaries, who belong to the poor and vulnerable sections of the society. Under this scheme, secondary and tertiary hospitalization costs up to Rs. 5 lakh per family are reimbursed to the holders of Ayushman Bharat card.

The allocations since 2018, have been cut down, from Rs. 6,556 Crores to Rs.6,429 Crores for 2020-21.[xii]

A study on the share of expenditures shows that 52 % of total health expenditure is incurred on medicines. This forms the major chunk of out-of-pocket expenditure, followed by private hospitals (22%)[xiii]. The focus of the scheme is on secondary and tertiary hospitalization expenses. Thus, it leaves out this major expenditure borne by the patients. This shows the misplaced priorities of the government on healthcare schemes.

To help curtail these expenses, the government has also launched Pradhan Mantri Jan Aushadhi yojana, which aims to cut expenditure on medicines by increasing access to generic medicines. The success of this scheme can be doubted, as some routinely prescribed medicines have been priced higher than its market alternatives.[xiv]

Figure 3: Major heads for which out of pocket expenditure is made



Source: Household Health Expenditures in India (2013-14), December 2016, Ministry of Health and Family Welfare; PRS.

OVER-RELIANCE ON PRIVATE HEALTHCARE

Nearly 70 per cent of the healthcare services in India are provided by private players. This is partly evident from the fact that the contribution of private hospitals and beds is approximately 2/3rd of the total.[xv] The reasons behind this preference towards private over public healthcare facilities are due to multiple factors. Lack of sufficient hospitals and beds, inadequate investment by the government, inferior quality of diagnosis and care by doctors, absence of specialization among them, have chipped away at the efficiency of the public hospitals. Prior to the pandemic, government hospitals have been perceived by the majority of India's population as a mainstay for the poor people due to the affordability of services. Thus, the lower middle class and above are willing to shell out excess charges for private healthcare services. Addressing this simple demand-supply problem in healthcare, a large number of doctors prefer working at private hospitals or set up personal clinics.

It becomes evident in emergency situations like the current pandemic that public hospitals are severely under-staffed and overburdened by the daily influx of new positive coronavirus cases.

EXCLUSIONARY NATURE OF PRIVATE SECTOR

The very existence of the private sector is defined by its profit making nature. Healthcare is no exception to it. As this leads to unaffordable prices in a competitive market, the government has to step in. This, along with the popularity and excess reliance on private healthcare by majority of the Indians is why the government launched the Ayushman Bharat scheme. However, during unforeseen circumstances like the Covid19 pandemic, many private hospitals had shut their doors[xvi] to the public. There have been several cases where private hospitals were found charging the patients in excess for Covid related treatments[xvii][xviii].

Instances of even non-Covid19 patients being turned away[xix] raise serious ethical questions about ethical practices by private healthcare. From the patient's side, claims made under this scheme have seen a drastic fall during the pandemic, when it would be reasonable to expect the exact opposite.[xx]

It must also be noted that out of 43,487 private hospitals, less than 20,000 have been empanelled[xxi] under the Ayushman Bharat scheme for beneficiaries, while all public hospitals

have been empanelled by default. Denial of service or any other malpractice by the private hospitals[xxii] merely leads to their de-empanelment[xxiii]. This seems to be quite convenient outcome for hospitals, as they have adequate footfall of patients anyway. The focus of disciplinary actions imposed on hospitals should in some way address appropriate relief to the patients.

The issues grappling Indian Healthcare ecosystem are multi-dimensional. Fixing this problem holistically must be the target, as cherry-picking issues for giving a temporary solution cannot be afforded in the long-term.

WHERE DO WE GO FROM HERE?

Right to Affordable and Accessible Healthcare as a Fundamental Right

As evident from above, the government seems to be lacking a genuine effort to transform the healthcare sector to make it a truly comprehensive and inclusive system for Indians. The starting point to overhauling this should be a constitutional amendment through which Article 47 would be moved to Article 21B whereby, Right to Affordable and Accessible Public Healthcare would become a fundamental right.

The Indian Constitution has provisions regarding health under articles 38, 39 (e) (f), 42 and 47. In Vincent Panikulangara vs. Union of India, the Supreme Court of India on the right to health care observed: "Maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends the building of the society of which the Constitution makers envisaged. Attending to public health in our opinion, therefore is of high priority-perhaps the one at the top".[xxiv]

Despite these precedents, Indian healthcare infrastructure remains woefully inadequate to serve its populace. Thus, recognizing affordable and accessible healthcare as a fundamental right would not only show a serious intent by the government to act on this but also empower the citizens to question the government on its performance and strengthen civil rights to keep the healthcare system functioning at its optimum levels.

Additionally, the subject of 'Public health and sanitation; hospitals and dispensaries' which is currently placed under States list, should be moved under Concurrent list. This will ensure

that the Centre has adequate powers to frame legislations and policies for healthcare, and not remain entirely dependent on the whims of the state legislature. If a national level regulatory mechanism is to be developed and implemented for monitoring the quality of services in hospitals, this amendment is a pre-requisite. This will also facilitate the creation of a national level medical service on the lines of Indian Medical Service of the British era, which will help formulate healthcare policies and oversee their implementation across the country.

Although the Supreme Court had recognized the right to healthcare as an expanded definition of right to life, provisions for the same have remained under the directive principles. India lacks a rights based approach to healthcare and instead, has chosen the development model. A rights based approach will ensure higher spending by the State instead of making cursory provisions and waiting for the private sector to build up on its own. As seen above, if the State infrastructure on such an important issue is inadequate, in situations like the Covid19 pandemic, the nation suffers as an entire system is caught off-guard.

Reassessing Ayushman Bharat

Taking a hard look at the loopholes in the Ayushman Bharat scheme, the government must make substantial changes in the scheme. The coronavirus pandemic has showed the apathy of the private hospitals as well as the inability of government hospitals to handle situations of this magnitude. The current scheme tries to cater to 10 crore families and provide them with insurance which can be availed in only two out of every three hospitals in India, where all the public hospitals and less than half of the private hospitals are empanelled.

As the current expenditure on healthcare is at 1.3% with a target of spending 2.5% of GDP by 2025, which is far below the ideal expenditure level (5-6%). Therefore, a good starting point would be around 3% and eventually raising it to 6-7% over time. The funding for this can be arrived at by changing the tax structure and bringing more people and businesses under the taxation ambit. Focused approach through CSR financing can be availed for organizations already investing in the sector.

The emerging and aspiring middle class of India equates a model healthcare arrangement with large private hospitals. This pushes the public healthcare apparatus in a state of neglect. Public

healthcare system cannot be treated as residual care whose need is felt only during crisis situations. The differences between private and public healthcare facilities should be ironed out eventually, in terms of cost of service, wait times and other logistics.

Also, reduction in out-of-pocket expenditure by patients must be seriously addressed by increasing access to generic medicine and making regulatory provisions for doctors, in order to curb the liaison with the pharmaceutical industry. Both sides of the equation must be addressed judiciously: the affordability of quality healthcare and the ability of people to pay for it.

Reliance on private insurance should not leave the poor and vulnerable distressed as settling insurance claims can prove to be a tedious task in itself. Currently, high costs are being shelled out by patients without insurance cover in private hospitals. This has created a virtual binary of one healthcare system catering to the rich and another to the poor. Ideally, the Ayushman Bharat scheme must cover every Indian's healthcare expenses. Therefore, we need a single healthcare system involving both private hospitals as well as the public ones but serves all at affordable prices. Thus, the ultimate goal of a comprehensive healthcare scheme must be achieving Universal Health Coverage for all Indians, as it will complement the Right to Affordable and Accessible Healthcare.

Terms of engagement with the Private Healthcare Sector

Private healthcare has been popular among Indians due to its high quality and efficiency. As private hospitals have established their presence across the country, it would be wiser for the government to develop a better partnership with them. Public healthcare facilities have been marred by poor quality of treatment, hygiene and lack of interest by the government in raising the funding for these hospitals for better provision of infrastructure, logistics and manpower. A recent report by Niti Aayog 'Model Concession Agreement for Setting up Medical Colleges under the Public Private Partnership'[xxv] attempts to address this issue. This model arrangement suggests linking private medical colleges with district hospitals, while adopting international best practices.

A valid criticism from public health experts has been that this step merely hands over share of public healthcare facilities to private players. It would further lead to increase in healthcare costs, which undercuts the whole idea of making healthcare more affordable and accessible for

the disadvantaged. Instead, the focus of public private partnerships in healthcare should be on expanding the existing healthcare infrastructure i.e. building more government hospitals, providing more beds, ICUs and ventilators therein; by bringing the patient to doctor and patient to bed ratios to the WHO recommended number. This expanded facility then, can be shared with the private healthcare sector, whereby its best practices and expertise can be made available for treatments hitherto available exclusively in private hospitals.

Additionally, a strong regulatory mechanism must be developed for the private sector, to ensure that patients are not charged in excess and the quality of healthcare is uniform across the hospitals. As the government sought help from private hospitals during the pandemic for bed sharing, such engagements must be promoted further to harness the private healthcare for public welfare. We also need independent bodies to monitor the costing and auditing of healthcare facilities to ensure fair pricing of services, ironing out the disparities between private and public healthcare expenditures by the patients.

Massive boost to economy and employment numbers

During the nationwide lockdown, as India's economy was brought to a grinding halt and millions of people rendered jobless, it was observed that the stock markets only suffered initial losses and then recovered quickly.[xxvi] This shows a clear disconnect between the financial markets and the ground realities, which can no further be taken as a credible indicator of the nation's economic health. As scientists have predicted a second wave of coronavirus after the first wave recedes, it would be wiser on part of the government to increase its capacity of patient intake and show the people where its priorities lie.

Healthcare being a perennial need of the society, serves as the ideal sector to develop long term employment opportunities. It cannot be emphasized enough the need for skill development in Indian workforce to create sustainable jobs in the manufacturing and service industry. India's unemployment figures were at 8 per cent[xxvii] before the pandemic struck. During the nationwide lockdown, these numbers had peaked at 24 per cent.[xxviii] Although, since the economy has slowly opened up, these figures have shown a steady decline, there is still a sense of caution among the public, which is evident from the slow movement of goods in the market.

The healthcare sector meanwhile, needs an additional 4 lakh doctors, if the WHO ratio of 1:1000 doctors is to be achieved in this decade. This requires new medical colleges which can

be semi-private or autonomous. Along with doctors, India also needs staff of nurses and paramedics, which is estimated to be around 20 lakh short currently. Addressing these demands of medical colleges, hospital staff, manufacturing ancillary equipment (hospital beds, ventilators, etc.) will help create millions of jobs in a hitherto untapped sector. The government must also raise its capital expenditure by constructing more hospitals for secondary and tertiary care without undermining the need for Primary Healthcare Centers in the rural areas.

When the domestic needs are addressed sufficiently, India can also open its doors to the world outside as a specialized medical tourism industry. With the current number of internationally accredited hospitals for medical tourism at mere 38[xxix], India has an enormous potential for expansion in this sector.

The association between poor health and poverty is well known. The converse is equally true. A strong economy and healthy work force go hand in hand as well. By expanding access to affordable healthcare, in the short run, India will be able to eradicate many of the diseases that require specialized treatments. With this, India stands to boost the productivity of its workforce in the long run.

CONCLUSION

Hence, we can see that healthcare infrastructure in India has been suffering at multiple levels since the very beginning. Ensuring that Universal Healthcare becomes a fundamental Right in letter and spirit might cost the government a disproportionate amount of capital and revenue expenditures in the short run, but it has massive long term socio-economic gains for the nation. Hence, the covid19 setback, having exposed the existing shortcomings of our system, should serve as a fillip to overhaul the healthcare infrastructure. As unemployment numbers rise and Indians search for quality jobs in the post-covid world, battling economic slowdown, India has a 'New Deal' moment to grab.

REFERENCES

[i]Vineeth Krishna E, *Public Health in Indian Constitutional History*, CADIndia (June 21, 2018) https://www.constitutionofindia.net/blogs/public_health_in_indian_constitutional_history

[ii]Kruthika R, *Public Health and Federalism*, CADIndia (Apr. 24, 2020) https://www.constitutionofindia.net/blogs/public_health_and_federalism
[iii] Paschim Banga Khet Mazdoorsamiti vs State Of West Bengal & Anr 1996 SCC (4) 37, JT 1996 (6) 43
[iv]Raman Kumar and Ranbir Pal, *India Achieves WHO recommended doctor population ratio*, NCBI (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6259525/

[v]Nishikant Dubey, *India must give more room to private sector,* IE (May 29, 2020) https://indianexpress.com/article/opinion/columns/india-coronavirus-cases-lockdown-covid-19-6432056/

[vi]Geetanjali Kapoor ET AL, *State-wise estimates of Current Hospital Beds, ICU Beds and Ventilators*, CDDEP (Apr. 21, 2020) https://cddep.org/publications/covid-19-in-india-state-wise-estimates-of-current-hospital-beds-icu-beds-and-ventilators/
[vii]Christophe Jaffrelot, Utsav Shah, *India needs to urgently step into the domain of healthcare,* IE (June 9, 2020)https://indianexpress.com/article/opinion/columns/coronavirus-epidemic-healthcare-system-public-hospitals-6449264/

[viii] Ashlin Mathew, *Delhi Hospitals turn COVID19 zones*, National Herald (June 5, 2020) https://www.nationalheraldindia.com/india/delhi-hospitals-turn-covid-19-zones-479-medical-staff-test-positive-at-aiims-81-at-ram-manohar-lohia-83-at-lok-nayak-hospital
[ix] Afshan Yasmeen, *Hospitals hit as staff test positive,* The Hindu (June 20, 2020) https://www.thehindu.com/news/national/karnataka/hospitals-hit-as-staff-test-positive/article31878976.ece
[x] Nancy Fullman ET AL,*Measuring Performance on Healthcare Access and Quality Index*, THELANCET (May 23, 2018) https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30994-2/fulltext
[xi]*National Health Policy 2017*, MoHFW, Health Finance 2.4.3.1 Pg.3 https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf
[xii]*Outlay on Major Schemes*, INDIABUDGET Entry no.30 https://www.indiabudget.gov.in/doc/Budget_at_Glance/bag7.pdf
[xiii] http://www.mohfw.nic.in/sites/default/files/38300411751489562625.pdf
[xiv]Kanchan Mukherjee, *A Cost Analysis of the Jan Aushadhi Scheme*, IJHPM, 2017 Vol.6 Issue 5 Pg. 253-256 https://www.ijhpm.com/article_3309_f58423d94c4a8858cc768987c764341e.pdf
[xv] Ibid 6
[xvi]Sruthisagar yamunan, *Fear of Covid-19 spread makes private hospitals turn away patients*, SCROLL.IN (Apr. 23, 2020) https://scroll.in/article/959727/fear-of-covid-19-spread-makes-private-hospitals-turn-away-patients-or-charge-them-higher-bills
[xvii]Pooja Biraia Jaiswal, *How Mumbai's private hospitals are fleecing COVID-19 patients*, THEWEEK (June 09, 2020) https://www.theweek.in/news/india/2020/06/09/how-mumbai-private-hospitals-are-fleecing-covid-19-patients.html
[xviii]K.Shiva Shankar, *20-lakh bill for 23-day coronavirus treatment*, THEHINDU (June 09, 2020) https://www.thehindu.com/news/cities/Hyderabad/20-lakh-bill-for-23-day-coronavirus-treatment/article31790684.ece

[xix]Anil Bhatnagar, *Noida:Pregnant woman turned away by 8 hospitals*, IE (June 07, 2020) https://indianexpress.com/article/cities/noida-pregnant-woman-dies-family-says-turned-away-by-8-hospitals-in-12-hours-6446459/

[xx]Leroy Leo, *Ayushman Bharat claims slump as much as 78% in May during lockdown*, LIVEMINT (June 05, 2020) https://www.livemint.com/politics/policy/ayushman-bharat-claims-slump-as-much-as-78-in-may-during-lockdown-11591367671207.html

[xxi] Shailender Kumar Hooda, *Decoding Ayushman Bharat*, EPW, Vol. 55 Issue 25 (June 20, 2020) https://www.epw.in/journal/2020/25/special-articles/decoding-ayushman-bharat.html
[xxii] Milan Sharma, Centre removes 97 hospitals from govt panel over fraud claims, INDIATODAY (Sept. 17, 2019) https://www.indiatoday.in/india/story/india-today-impact-ayushman-bharat-hospitals-fraud-harsh-vardhan-1600148-2019-09-17
[xxiii] *Guidelines on Process f empanelment of hospitals*, PM-JAY Pg.15-16 *https://pmjay.gov.in/sites/default/files/2019-04/NHA_Guidelines_on_Process_of_Empanelment_for_Hospital_Revised_0.pdf*
[xxiv] Vincent Panikulangara vs. Union of India. AIR 1987 SC 990. p. 995

[xxv]*PPP In Medical Education*, NITI AAYOG (Dec. 2019) https://niti.gov.in/sites/default/files/2019-12/ModelConcessionAgreement-forSetting-upMedical-Colleges-under-Public-private-Partnership-Draft-for-Comments.pdf
[xxvi]Anand Adhikari, *Stock markets defy coronavirus economic slowdown*, BUSINESS TODAY (June 6, 2020) https://www.businesstoday.in/opinion/perspective/stock-markets-defy-coronavirus-economic-slowdown-are-bourses-behaving-like-casino/story/406154.html
[xxvii] https://unemploymentinindia.cmie.com/
[xxviii] Ibid.
[xxix] Dr.Shankar Narang, *Need for more accredited hospitals to boost medical tourism*, PHARMABIZ (June 5, 2019) http://www.pharmabiz.com/NewsDetails.aspx?aid=116160&sid=9