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Ayushman Bharat and the Trivialisation of Healthcare

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New Nagu-Magu Ambulance services vans parked at Freedom Park during the launch of National Urban Health Mission (NUHM) in Bengaluru on January 20, 2014. File Photo: K. Murali Kumar.

'Healthcare', in the modern world, is conveniently, but wrongly, conflated with 'medicare' and is, consequently, increasingly being designed to maximise the need for elaborate - often unnecessary - diagnostic 'tests', nudging patients towards newer and more expensive interventions even when cheaper options exist, and exponentially increasing the consumption of medicines. The purpose of healthcare, ideally, should be to create and maintain conditions under which one can lead a healthy life without having to depend on

doctors and hospitals and consuming medicines. In this commentary on the state of healthcare in India, *Amitabha Pande, retired Indian Administrative Service officer****, points out how the latest government intervention distorts the role of the state and channels public funds into private profits. He also suggests three significant shifts in focus that would enable the Indian state to re-prioritise its policies in its pursuit to provide universal health and medical care.***

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The conflation of 'healthcare' with 'medicare' has been one of the more dangerously perverse developments of contemporary society everywhere. Under perfect conditions, if one kept good health one should only occasionally need medical care, if at all. The purpose of healthcare should ideally be to create and maintain conditions under which one can lead a healthy life without having to depend on doctors and hospitals and consuming medicines. The health of a society has to be measured by the extent to which this ideal can be achieved and not by the extent to which more people become dependent on medicare.

We seem to have turned this simple logic upside down. With 'healthcare' becoming a mega business and synonymous with 'medicare', we have, literally, 'insured' that we have more and more people needing more and more expensive treatment not just to sustain the 'demand' for medicare but to stimulate and increase it. The reality is diabolical. Medicare systems are now designed to maximise the need for elaborate (and often unnecessary) diagnostic 'tests' which require more and more technological sophistication at ever increasing costs, prolonging the duration of hospitalisation or pushing for a faster turnover, nudging patients towards newer and more expensive interventions even when cheaper options exist, and exponentially increasing the consumption of medicines. This is not a conspiracy, it is the logic of a market-driven industry.

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One of the most radical social critics of the last century, Ivan Illych, presented a compelling thesis in 1974 called *Limits to Medicine: Medical Nemesis - the expropriation of health*. He argued that modern medicine posed a major threat to health the world over. Despite its extreme polemical character Illych's argument, prescient when it was made, has become even more relevant 45 years later. This is how he begins his thesis:

> **'Within the last decade medical professional practice has become a major threat to health. Depression, infection, disability, dysfunction, and other specific latrogenic diseases [those caused as a result of diagnostic and therapeutic procedures undertaken on a patient] now cause more suffering than all accidents from traffic or industry. Beyond this, medical practice sponsors sickness by the reinforcement of a morbid society which not only industrially preserves its defectives but breeds the therapist's client in a cybernetic way. Finally, the so-called health-professions have an indirect sickening power—a structurally health-denying effect..... By transforming pain, illness, and death from a personal challenge into a technical problem, medical practice expropriates the potential of people to deal with their human condition in an autonomous way and becomes the source of a new kind of un-health.'**[1]

Even if one ignores the Luddite undercurrents of his argument, there is no denying that the three kinds of latrogenesis that he highlighted are a frightening part of our daily lives. Clinical latrogenesis which is the injury done to patients by ineffective, toxic and unsafe treatments; social latrogenesis, which results from the medicalisation of life as more and more of life's problems are seen as amenable to medical intervention; and, cultural latrogenesis which involves the destruction of traditional ways of dealing with illnesses.[2]

The fallacy behind Ayushman Bharat

Health is one sector of 'human development' where commercialisation or 'marketisation' presents a very complex problem, much more so than in the case of education. In education, commercialisation creates certain inequities, but the net expansion of demand for learning, for books and knowledge products, for new tools and technologies is a positive outcome. In health, on the other hand, commercialisation means that the growth of the industry is dependent on growth in sickness and disease and because we have all unquestioningly accepted the conflation of healthcare with medicare we have come to believe that consuming more medicare improves our health. This is fallacious.

Prime Minister Modi's Ayushman Bharat initiative has to be seen in the context of this fallacy. Since its launch in September last year, the scheme has had its share of

adulation, especially on account of the breathtaking scale of its coverage, as well as of criticism. Though a cheerleading media have welcomed it as 'historic' and 'game changing', critics continue to be sceptical.

Much of the criticism has focussed on insufficient budgetary allocations, poor delivery infrastructure and/or the difficulties in implementation. While it is pertinent, this line of criticism is easily countered as it is primarily a question of marshalling and channeling financial resources which, if there is a will, are not beyond the Government's means.

More insightful criticism has underscored the apprehension that such a unilateral focus on medicare represents a decisive shift in priorities - from primary health care to tertiary and a diversion of public investment from public healthcare infrastructure to assuring more profits for private medicare.

The focus on medicare represents a diversion of public investment from public healthcare to profits for private medicare

Among other critics, Jean Dreze[3] believes that the pitiful public investment in strengthening the primary healthcare infrastructure while pushing insurance coverage actually trivialises India's quest for Universal Health Care at a time when many countries including Brazil, Mexico, Thailand and Sri Lanka (and, of course, China) have already achieved or are close to achieving that goal.

Clamouring to move up the business value chain

This is a problem, however, which has less to do with Government's lopsided priorities than with everyone wanting to move up the medicare business value chain — practitioners as well as consumers. On the supply side, a doctor who does not become a specialist (and then a super specialist) is considered a failure and unless forced by circumstances is most unlikely to serve as a General Practitioner in a Primary Centre. To find good doctors to man such centres is becoming increasingly difficult both because no one who is any good wants to remain at the bottom of an unremunerative, bureaucratically managed career and because on the demand side, there are few takers for the sub-basic services offered by a PHC.

Free insurance cover of the kind envisaged under Ayushman Bharat, will certainly accentuate the trend towards super speciality care even if treatment is available at

primary or secondary levels. No one wants to settle for a lower end product when a higher one is available and becomes affordable through insurance. When health becomes more a business than a public service, the push towards services (whether public or private) offering more revenue and higher margins is inevitable.

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Insurance adds to the purchasing power for these services and expands the market for 'medicare' massively. One of the features of medicare infrastructure growth in India in the last few decades has been the disproportionate growth of tertiary services compared to primary and secondary, and of the private sector in comparison to public. Many see this as cause for alarm in the belief that despite their poor management, hospitals in the public sector are primarily driven by considerations of selfless service and people's welfare and those in the 'private sector' by the pursuit of greed.

This uncritical assumption overlooks two things. First, that unlike the OECD countries where the welfare dimension of the state is of considerable political significance, the dominant feature of the Indian state is its 'rent-seeking' character, and all social and economic interventions, undertaken by the state, open up and expand opportunities for rent seeking, cronyism and corruption. So the dominance of the profit motive in the private sector is simply substituted by the rent seeking motive in the public sector.

Unlike OECD welfare states, the Indian state's dominant feature is its rent-seeking character in all public interventions.

Second, that the medicare business is driven primarily by big pharma, bio-technology giants, medical equipment manufacturers, technology providers and commercial R&D, not by hospitals. Hospitals are, in a sense, the retail end of the business and it matters little whether the retailer is state owned or private because both push the same product.

In fact, as a retailer, a Government hospital is inefficient, wasteful, callous and, in real terms, if you factor in the cost of infrastructure creation at market prices, probably costlier than private. In a remarkable volume of essays edited by Samiran Nundy, Keshav Desiraju and Sanjay Nagral[4] the anatomy of corruption in healthcare in India has been laid bare in great detail. A careful reading confirms that corruption in healthcare has a structural basis and extends to the sector as a whole, and that increased commodification and marketisation of medical care is the principal reason that makes people's health a consideration secondary to the growth of the medical industry. The 'nemesis' that Illych referred to is now a part of the new normal.

The importance of externalities

The problem lies, therefore, not in the binary of public versus private treatment centres, but in the way public policy priorities get distorted by seeing health in 'medicalised' terms, as an exclusive sector of policy independent of the physical and social environment we live in. We forget that the water we drink, the air we breathe, the food we eat, the civic infrastructure we have and the environmental conditions in which we live, the education we get - all have a direct bearing on our health. In a situation where these conditions continue to deteriorate rapidly and where even in affluent areas the degradation is alarming, checking this degradation has to precede and take priority over expanding access to expensive treatment.

Food, civic infrastructure, environmental conditions and education - all have a direct bearing on our health.

A telling example is that of Gorakhpur in Uttar Pradesh where year on year over 600 infants are lost to encephalitis and scrub typhus. The recurrence of the disease is directly related to degraded civic conditions. A concentrated effort to ensure appropriate sanitation infrastructure, waste management, clean water supply and sewerage and drainage example, can have a dramatic impact on reducing the incidence of disease. But this is barely ever given any attention and instead high priority is given to setting up a super speciality, advanced research and treatment centre which will perversely need the disease to persist in order to justify the heavy investment in its establishment. On the other hand, the environmental degradation

responsible for the morbidity in the first place will continue unchecked. The perfect vicious cycle.

Reconceptualising development and healthcare

The political justification for such a lopsided understanding of health priorities lies in our definition of 'development'. Despite availability of evidence of the development model as followed in India – seen for example in the refusal to curb tobacco production and consumption, or worsening air pollution as a result of irrational urbanisation – as being largely responsible for the increase in the burden of non-communicable diseases, yet little is done to stop this self destructive cycle.

What is the answer? The solution to the above set of contradictory situations lies in bringing about three significant shifts in focus:

- First, is the need to view 'health' in terms of its inter-relatedness with other relevant environmental, social and economic factors so that policies, strategies, interventions reflect the multi-sectorality and the complex, interdependent nature of health and well being.
- Second, is the need to view health within the context of the community behaviour, cultural perceptions and environment.
- And the third is to situate the governance structures of health and its social determinants within the community, that then must own, control and manage the well being of its members – be it health, education, sanitation, security or welfare.

The Gandhian dream of self-sufficient, networked community governments – Panchayats – is often dismissed as utopian and impractical. The contrary is true. Community institutions have many distinct advantages in looking after their own habitat and the health and welfare of their members. Interventions can be context specific and based on intimate knowledge of one another; they will rely on mutual cooperation rather than on a bureaucracy or the dictates of the 'market'; they will be able to have a more holistic and a less 'medicalised' approach to health and they will be able to work out the most appropriate cost recovery methods for whatever facilities and services they provide.

Experience shows that people, including the poor, are willing to pay, if they have trust in the system and believe that service levels will be satisfactory. Tests and procedures can be cross-subsidised or covered through innovative insurance

arrangements. And for some basic, routine ones, the community can itself negotiate reasonable prices.

For the revival of the all-purpose General Practitioner

A devolved and decentralised community-centred approach also makes it possible to revive the institution of a dedicated all-purpose General Practitioner (GP) equipped with basic diagnostic facilities and qualified staff. Many different kinds of arrangements are possible. For example, the Panchayat / Local Government owning the facility can employ the GP and the staff or it can lease space and have a service level contract or simply outsource the entire operation on mutually advantageous financial terms. The important thing is that the choice must be exercised by the community with full decision-making powers so that the service provider(s) know clearly who they are accountable to.

At the policy level, it is essential on the one hand to establish an innovative regulatory framework under which community institutions function without any loss of autonomy but at the same time conform to strictly enforced quality standards; and, on the other, making financial assistance conditional to achieving key performance indicators – reduced morbidity, infant mortality, incidence of chronic infections alongside improved nutrition and so on, measured against certain preset benchmarks. ICT tools make it possible to capture community-specific data to implement a community-specific human development index, linked to financial incentives.

It is essential to establish an innovative regulatory framework under which community institutions function.

Much of this is doable and requires modest budgetary support. It requires a simple change of focus and as Ritu Priya of the Centre of Social Medicine and Community health has suggested elsewhere[5] it needs getting out of unhealthy silos in our own thinking processes. But changing mindsets is even more difficult than changing systems. And there's the rub.

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[All URLs were last accessed on January 18, 2019]

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