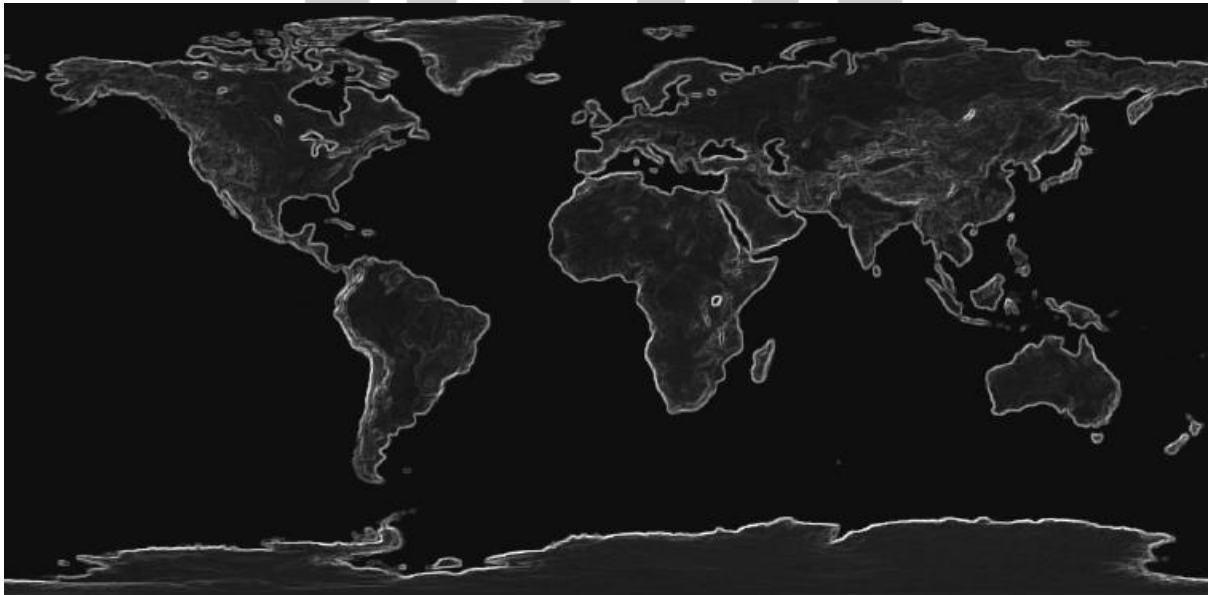




THE ELEPHANT IN THE WAITING ROOM: THE DIRECTION OF INDIAN HEALTHCARE POST-COVID

*India's healthcare model faces a massive problem-solution gap, and it is
expensive.*

Veritas et Aequitas



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Healthcare has always been a neglected industry in the context of politics. This is especially true in developing nations like India, where the growing middle class rarely make it a voting issue, resulting in under-criticised healthcare policies and its eventual invisibilisation. The pandemic, however, has been a nasty jolt back to reality – countries famed for their medical systems, such as Italy or the U.K. are struggling to cope with the repercussions of COVID-19. Almost every healthcare provider and pharmaceutical company are suffocating under the pressure of delivering care in a system that was never tested this way. The resilience of healthcare industries isn't merely contingent on the number of physicians and personnel available in a region, but also upon the nature of the network of healthcare and how it restructures in response to a shock.

As countries have finally begun to recoup and minimise their rates of infection, the foremost question in the minds of policy-makers is how the health industry is going to change, or will it? There are two scenarios that can arise: One, a return to how life was before the virus, once deaths and rates of spread rapidly decrease. This would mean lockdown measures being lifted, and heads of state shift the narrative to re-opening economies and coping with unemployment and recession. Upcoming elections will be won on the promise of recovery and addressing the deep hurts in society. Perhaps there would be calls for change in the medical services, but they won't come to the limelight as people focus on getting back to work. Two, we might witness gradual changes focused around preventing such a dire collapse of healthcare systems in the future. Society acknowledges the importance of preparedness, diagnostics, and logistics in response to a health shock. There may be a higher investment into infrastructure and testing capacities, with or without state support. Alternatively, such changes may be drastic as well, with heavy and robust calls to ramp up health spending, increased airport security and scrutiny, and radical restructuring of health infrastructure.

While the second scenario is largely unlikely, I attempt to look at where such changes might be likely in India, if they ever occur.

Role of private entities

Ever since liberalisation in India in the 1990s, the government neglect of healthcare has fostered the private sector's role instead. This is evident in the image of India that is cast as a leading destination for medical tourism, despite having extremely high rates of infant mortality or negligible service quality for the poor. That kind of inequality points towards the domination of healthcare by private players, who award quality services to those who can afford it.

Since the pandemic reared its ugly head, leaders, and heads of private hospitals have been clamouring for state support as their cash flows came to a trickle with a 50-70 percent drop in revenue in the last 10 days of March. Actions recommended by the Federation of Indian Chambers of Commerce and Industry include liquidity infusion in the form of debt waivers and short term interest-free loans, tax reliefs and exemptions, and waivers of renewals of licenses.

However, other industries have responded to the government's call for private aid to combat the pandemic. Anheuser-Busch InBev, which sells Budweiser and Haywards, is in production for 15 lakh basic medical equipment and face masks. Reliance Industries took charge of churning out 1 lakh masks and agreed to provide free fuel to emergency vehicles carrying patients. Maruti Suzuki pledged the production of ventilators, masks, and PPE to state governments. Such decisions were likely not made out of pure humanitarian interest alone – it plays into their CSR quotas, and allows the



companies to repurpose their factories to keep up production during low demand, while also retaining their workforce.

Such enthusiasm for public good seems to have escaped private hospitals, who account for about 62% of total beds available and nearly 56% of ventilators, yet only took up 10% of the workload while also denying free or low-cost treatment to the poor. This is especially true in Bihar where, according to a CDDEP/Princeton study, private entities have twice as many beds as state hospitals, but have withdrawn almost fully from providing services. This forced the state of Bihar to demand the private sector to re-open and aid the efforts. The scene is in sharp contrast to Kerala's response, showing that where central coordination fails, decentralised authority works. However, this withdrawal isn't unique to the era of COVID-19. Private hospitals in Delhi received land for subsidized rates or for free, conditional on them providing services for unskilled workers. Instead, they fought this condition in the High Court and were subsequently exempted from having to cater to the poor.

Both the sudden involvement of private companies in manufacturing equipment and the withdrawal of private hospitals from the frontlines show the need to revisit public-private partnerships in healthcare models of developing countries. This need is largely due to India's insistence on imitating the free-market structure of American healthcare, despite having drastically different requirements. The U.S. itself did not have plans in place to deal with the surge in medical demand and is yet to address gaps in planning and personnel. As a consequence, Trump finds himself in the midst of a huge stress test. On the other hand, Thailand borrowed its healthcare model from the U.K, with tweaks to suit its population needs. It provides universal healthcare through government schemes, only incorporating private players when necessary to complement the goals. As a reward, the country has reported no new cases as of writing this article.

India would do well if it reflects on its own performance, and re-evaluates the strategic role of private providers in modern healthcare.

Pricing and payment structures

In 2018, Narendra Modi unveiled the Pradhan Mantri Jan Arogya Yojana, an insurance scheme dubbed as 'Modicare'. It had the ambition of being the largest healthcare programme, in a similar fashion to other Modi-fied initiatives. PM-JAY's aim is to reduce the costs of hospitalisation by providing household insurance, but in practice, it hasn't achieved this. This is because it is modeled around U.S. insurance policies, along with the previous Rashtriya Swasthya Bima Yojana (RSBY). Both of these models are expensive with extremely inefficient outcomes. PM-JAY is entirely funded by taxpayers' money with the centre and states sharing their burden at 60:40.

How are they inefficient? Firstly, most poor families in India suffer heavily due to rising out-patient costs as opposed to in-patient hospitalisation. Most impoverishment is due to the smaller but more frequent payments for outpatient services. Paying for health pushed 60 million Indians below the poverty line in 2010. PM-JAY does not cover outpatient care, primary care, or high-level tertiary care. Local or state schemes step in for these shortcomings instead.

Secondly, in the current fee-for-service payment model in India, costs are open-ended since each service is paid for independently. This grants private entities a great deal of flexibility in their provision of services, along with reduced accountability. Most insurance claims were found to have gone to private hospitals. Such hospitals have boldly hiked the insurance premiums of the government schemes by as much as three and a half times.



This increases the likelihood of hospitals overcharging COVID-19 patients, referring them to other private clinics, or recommending bogus procedures. In suburban and rural centres, this leads to large-scale corrupt practices such as the refusal of free treatments or consultations, prescribing unnecessary drugs, or hiking costs by adding-on charges for supplementary procedures that could have been avoided. India saw private doctors needlessly remove the uterus of several hundreds of women, as Reuters found. Such procedures are often the most profitable as they are expensive and require hospitalisation, which is covered by government insurance at the expense of taxpayers.

There is a repetition of the same now, with many decrying the high billings charged by hospitals that do manage to take in COVID patients. Sushma Anupam, deputy general manager of New India Assurance Co. Ltd. quoted to media that a PPE kit worn by a doctor who visits many patients in the hospital is billed individually to all these patients.

In the post-COVID era, we can expect private hospitals to hike consulting and treatment fees owing to their increased burden of costs in the present wave of the virus. This would only worsen the ability of the poorest to access medical care, even at the most basic level, while imposing higher costs on India's middle class. Regulatory changes must address the dire need for universal coverage, along with implementing transparent billing models based on packages of services, say, instead of charging individual components. It seems radical to propose, but this can be made possible with the use of data collection and software systems that can estimate medical costs based on standard guidelines.

Data, artificial intelligence, and diagnostics

Diagnostics is an integral part of healthcare but has received minimal attention. Hospitals and states spend minimally on testing and diagnostics, even though studies have found that about 70% of medical decisions are based on these tests.

Where private players have failed in other areas of healthcare, they could perhaps be prompted to develop and disseminate the use of technology in improving healthcare access. Hospitals could leverage the large amounts of data they gather to streamline and co-ordinate clinical attention to patients – maintaining records of co-morbidities, improving diagnosis, and prescriptions. For instance, In the midst of the pandemic, many hospitals have resorted to online consultations to replace the poor availability of point-of-contact testing kits. 'Telemedicine' is becoming increasingly popular but remains largely informal.

Big data and A.I. can be harnessed in several ways. In the realms of detection, Swedish public health authorities tracked a virus spreading in 2014 using Websök, an internet-based surveillance system using search engine data. However, there has been no mention of using a similar mechanism in the midst of this much larger crisis of health. Taiwan, which was hit hardest in the 2003 SARS outbreak, set up a robust disaster management system. They quickly combined infected patients' past 14-day travel history with their identification data and used mobile tracking. The Entry Quarantine System notified hospitals, clinics, and dispensaries of patients' travel histories.

In Kerala, railway employees have been using a Microsoft app called 'Kaizala', that enables them to search for the nearest hospitals, diagnostic centres or emergency care units. They can book appointments, share lab reports with their doctors directly, and save them in the 'Me Chat'. Feedback features are also a part of the app.

In order for these methods to sustain beyond the pandemic, states need to establish clear guidelines for confidentiality requirements, and legal responsibilities for those that utilise online services. If codified, there is enormous potential for digitization to improve the entire supply chain management



of healthcare providers, and could further enhance oversight and accountability. It would become much harder for doctors to take advantage of information that patients do not have awareness about. It may also reduce the costs of dispersing healthcare to rural regions. India can capitalize on this potential by doing what Singapore or Taiwan did – implementing rapid response systems, setting up clear data use laws, and integrating it with regional needs. After all, isn't "digital India" a dream for the many that elected Modi?

Such types of solutions are contingent on the legal limitations of each country's data protection and use laws, which means that in the future we may see how barriers to free-use can be relevant in discussions about healthcare. Scalability is also important because there is no use in developing technologies that cannot reach those who most need it. Companies can be subsidized to not only create but also enable the production and dissemination of A.I. driven solutions.

In conclusion, the Indian government has little room for large, ambitious goals post-COVID, but it could begin by having concrete and realistic healthcare models that borrow from better influences than American-style market solutions.

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