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Healthcare in India: Towards an Agenda for Change

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Covid-19 has shown that we must abandon unscientific medical practices, integrate what is useful in traditional medicine into a modern system, intelligently plan our health workforce and move towards a medical care delivery system financed by taxes.

The terrible disaster that has befallen India in the last year-and-a-half, with the Covid-19 pandemic sweeping through the country and exposing its skeletal health infrastructure, should lead to reflection and plans to remedy the situation.

In 1946, on the eve of independence, the Joseph Bhore Committee (the Health Survey and Development Committee), which had been set up in October 1943, submitted its report. It envisaged a healthcare delivery system to cover the entire population, paid for through taxes, with primary health centres at the base, and a network of taluk, district, and medical college hospitals in a pyramid above them. Although the bare framework of this system was put into place in the years after independence, the vision of the Bhore document was never fully realised. The reasons for this are multiple and I will not attempt an analysis here. However, a fundamental question that still haunts us is the scientific basis of the health system that we want to follow.

Modern medicine and 'alternate systems'

A part of the struggles worldwide against colonialism were attempts to establish the position of indigenous cultures. Newly independent countries tried to reclaim their indigenous heritage, which had been pushed into a subordinate position under colonialism. The phrase "the soul of a nation long suppressed finds utterance" in the famous *Tryst with destiny* speech delivered by Jawaharlal Nehru captures this desire to re-establish the position of the people of India as equal citizens of a new world order.

In medical care, this project to deconstruct colonialism resulted in a championing of so-called 'Indian knowledge systems'. Thus, whatever their ideological orientation, whether to the right or to the left, many intellectuals and activists rallied to the side of traditional systems of medicine in India, the largest of which are Ayurveda, Siddha, and Unani. This conflation of the scientific method with colonialism and the resulting confusion in the minds of the public and planners has had unfortunate consequences for health delivery. Although the relationship of a doctor and patient is subject to cultural influences, the scientific basis of medical care is universal and should not be the prisoner of misconceived nationalism.

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We should be clear about which aspects of human society are universal and which are culture specific. A failure to make this differentiation has led to much harm. The natural desire to resist and overcome the colonial project of demeaning and ridiculing indigenous cultures and practices has grown into an irrational nationalism that projects and promotes all tradition as the most scientific and most evolved — even when the inevitable progress of science has proved otherwise. Unless we dissipate this toxic miasma that enshrouds all activity, including science, in India today, we will be doing great harm to society.

Traditional medical care available anywhere in the world till the late 19th century was not very useful and much of it was quite harmful. Traditional medicine in the western hemisphere was no more scientific or useful than traditional medicine elsewhere in the world. Scientific medicine, based on an understanding of the structure of the human body (anatomy) and the functioning of these structures in health and disease (physiology and pathology), was slow in developing and really took off only in the late 19th century.

This knowledge, however, did not translate into useful therapies. Many treatments, for example, such as bloodletting were downright harmful. In contrast, the diluted potions dispensed by Samuel Hahnemann and sanctified as homeopathy were less harmful, and became popular. The present state of medical knowledge shows that homeopathy is not therapy and it should not be pursued.

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Medical care as we know it today is a product of the industrial revolution and the tools that have become available. No traditional medical system anywhere in the world has been based on a scientific understanding of the human body. Ayurveda, Unani, and Siddha are no exceptions. A sensible course of action would be to incorporate what is useful from these traditions into a single system of modern medicine for the country.

Medical personnel and training

In order to achieve the sustainable development goals of the World Health Organisation (WHO), the number of doctors, nurses, and midwives required are 4.45 per 1,000 people. At present, according to the World Bank, India has 0.9 doctors and 1.7 nurses and midwives per 1,000 people. A report by the WHO on the health workforce in India based on the 2001 census details not only the absolute shortage of healthcare personnel, but also the disparities between states and between urban and rural areas.

One of the solutions to the shortage of doctors advocated by successive governments and supported by many civil society organisations is a short-course medical education to train 'barefoot doctors', a concept borrowed from the early days of the People's Republic of China. The scientific basis for this is that around 85% of illnesses, at the population level, require only very basic medical care. However, this ignores that, at the level of the individual patient, it requires high cognitive ability to be able to differentiate between what is a simple illness and what is more complex. This ability to differentiate lies at the core of medical treatment and is a highly valued attribute of doctors.

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Instead of creating a cadre of healthcare workers between fully trained doctors and qualified nurses and midwives, it would be far more sensible, far less controversial, and far simpler to permit nurses and midwives, who already study subjects similar to modern medical graduates though in less detail, to treat simple medical conditions. Many countries with very good health infrastructure already have nurse-practitioners and the working of this system has been well observed.

The unequal distribution of health professionals, especially doctors, in India is well documented. For example, the WHO study shows that Chandigarh has 10 times the density of doctors in Meghalaya. It is quite clear that a healthcare system that depends on market forces will inevitably lead to this situation. The desire for specialisation and super-specialisation among doctors is greatly driven by opportunities for financial and social success. The shifts in which disciplines in medicine are most valued for specialisation clearly reflect market forces.

Thus, in the last two decades, the most sought-after discipline is radiology, where the possibility of earning a large income is virtually guaranteed. This is in marked contrast to the situation about 30 years ago when the broad specialties of general medicine, general surgery, and obstetrics and gynaecology were the preferred courses. The current lack of interest in disciplines once seen as very desirable — for example, cardiac surgery, paediatric surgery, and plastic surgery — shows that the market no longer guarantees satisfactory returns for these specialties.

Unless we abandon the market in healthcare provision and move towards a system similar to the National Health Service in the United Kingdom, we will not be able to address the maldistribution of health personnel. We need data on how many personnel we need in every specialty, starting with general practitioners. We then need to train the appropriate numbers. Ensuring near equal remuneration irrespective of specialty will help ensure that students aspire for appropriate specialisation.

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Another potent cause of the urban concentration of doctors is the desire for a good quality of life, which is inextricably linked to cities. This is a more difficult problem to solve. A career plan that makes it possible for doctors to move to a place of their choice after a fixed number of years could be a solution.

The drift from a commitment to public provision of healthcare, as envisaged in the Bhore Committee report, to a market in health services has been steady. The overwhelming dominance of the private sector in healthcare delivery, present since Independence, is now matched by a creeping dominance in training as well. At present, there are 541 medical colleges providing the MBBS degree, 280 in

the government sector and 261 in the private sector. There has been a 45% increase in medical seats in the last six years.

It would, however, be premature to celebrate this increase in medical graduates who could provide better services in underserved areas. Private medical education is very expensive. The only way to recoup the costs of this expensive education is to provide expensive private care, which, in turn, can only be done in urban areas. Far from reducing the inequitable distribution of healthcare personnel, this exacerbates the situation.

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It is essential to recognise that training in medicine requires a certain cognitive ability. There has to be a gateway for admission to medical courses. This gateway has to be equitable and fair. Allowing a market in medical admissions is harmful, not merely from the point of view of equity, but also from the perspective of the larger public interest. Not everyone who desires to be a doctor and has the means to purchase a seat has the requisite cognitive abilities. The best method of selection to medical colleges can be debated and admission policies may change with time, but it is wrong to pretend that medical education does not require intelligence of a high order. That is a misconceived understanding of what equality in human societies means.

Nurses and midwives

Nursing education and the working condition of nurses require a separate essay. Let me note here that nursing education is overwhelmingly provided by private institutions. Compared to the government sector, the private sector has nine times as many institutions and seats.

Medical care is very hierarchical and there is a sharp dichotomy between the status of doctors and nurses. The remuneration of nurses is far less than that of doctors and their working conditions require a lot of improvement. The contradiction between projecting nursing as an expression of caring and love and at the same time perceiving it as a 'dirty profession' because it deals intimately with other human bodies, has meant that nursing worldwide is generally provided by those of a lower socio-economic status. In India, ideas of purity and ritual pollution ensure that there is a caste element too.

In addition, it is predominantly women who take up nursing as a profession. This has made it difficult for nurses to make their voices heard. The recent WHO report on the state of the world's nursing is disappointingly quiet on these issues.

Learning from the past

Several governments have set up committees to study healthcare delivery and human resources and suggest plans to improve what is admittedly a dismal situation. After the Bhore committee (1946), we have had the Mudaliar Committee (1962), the Jangalwalla Committee (1967), the Srivatsav Committee (1975), and the Bajaj Committee (1986). More recently, the High-Level Expert Group constituted by the Planning Commission submitted a report in 2011.

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A recurring theme in all these reports has been the need to strengthen the delivery of healthcare in the public sector and the necessity of moving away from high-cost private care. The High-Level Expert Group even suggested a financial plan to achieve this in a stepwise fashion. Comprehensive primary care has been repeatedly stressed as a basic facility any civilised nation must provide. It is possible to argue that if this advice had been heeded, much of the suffering of the people during the pandemic could well have been avoided.

Influenced more by Milton Friedman than Amartya Sen, our planners and policymakers paid little heed to all these committees. Either out of callousness or sheer ineptitude, they have overseen the perpetuation of an abysmally poor healthcare system at the population level, with islands of excellent care for the privileged. If you have the means, you can buy medical care at a level comparable to anything that the most developed countries can offer. But this was of little avail when the pandemic exposed the dismal state of medical care in India, and even the supply of a basic medical necessity such as oxygen was found to be inadequate. Perhaps for the first time in their lives, the privileged found that their islands were soon engulfed because the basic infrastructure was so woefully inadequate.

All previous governments ignored the recommendations of their committees. We have paid the price. Unfortunately, we seem to have learned nothing. The document "Health System for a New India: Building Blocks – Potential Pathways to Reform" published by the Niti Aayog in November 2019 has insurance as its great new reform. This, in spite of several studies all over the world, including the High-Level Expert Group, showing that insurance is an inefficient, inequitable, and expensive method to provide healthcare. We are now confronting a situation where the planners are recommending a pathway that has already been shown not to work.

Changing for the better

What should we do? First, we must accept the reality that science is the best foundation for medicine. We must abandon the false nationalism that makes us persist with and prop up unscientific practices, often disguised as alternative medicine. Let us integrate all that is useful in traditional medicine into a single system of modern medicine. This is a sensible utilisation of resources.

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Second, we must plan our health workforce. We must find equitable means of educating those most suitable, and plan their career pathways so that we get the best health outcomes and avoid unhealthy competition for patients in private practice, which leads to deleterious outcomes.

Third, we must accept international best practice and move towards a system of medical care delivery that is free at the point of service, but financed through general taxes. As a first step towards this objective, we could co-opt all private practitioners into a primary care network, where each practitioner is paid a fixed amount for looking after a certain number of families. This will eliminate the competition for patients, which fosters many irrational and harmful practices such as the overuse of antibiotics and steroids. In rural areas, there are a large number of unqualified people practising medicine. They should be co-opted into the system, supervised, and replaced by qualified doctors as soon as possible, giving them a dignified and secure exit plan. Nurse-practitioners should also be deployed wherever possible and necessary.

If we want to avoid another calamity like the coronavirus pandemic, we need the honesty to accept that tinkering will not do. We need vision to understand the changes required. We need courage and strength of mind to find the resources to carry out these reforms. All previous governments have failed us. We await a government that will not fail.