



THE INDIAN HEALTHCARE SECTOR – Comparison with the British National Health service:

Buddhdev Pandya MBE CEO- GAPIO EUROPE
Buddhdev.pandya@gmail.com

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In good healthcare should be available to all, regardless of wealth. When the National Health Service (NHS) was launched on July 5th, 1948 by it has three core principles embodied in the shaping culture of the population in the context of creating of services; it meets the needs of everyone, it is uniformity in the health care sector across the nation. available free at the point of delivery and based on These practices are not optional and form an integral clinical need – from cradle to grave, not ability to pay. part of the healthcare landscape that exists in India.

It was to be fully funded through public funds with limited use of the private sector. In contrast, in India, the private sector, which includes service providers and pharmaceutical companies, has the largest influence on India's 'Health Care' policies. Last year alone the interest from private equity funds in the healthcare industry in India was projected to reach \$155 billion in terms of revenues (Source: LSI Financial Services). A senior doctor in the Bhartiya Janata Party, described India's private healthcare sector which "treats patients as revenue generators" (February 24, 2015). There are genuine fears that the private healthcare providers in India seem to be "above the law, leaving patients without protection."

In relation to the argument of creating an 'inclusive society' that can be viewed somewhat parallel to the British NHS, the Indian government spends around 1.3% of its GDP on healthcare, much lower than the global average of 6%. The Indian Medical Association (IMA) has demanded that it be increased to 5% as per the recommendations of an inter-ministerial committee. The government is failing to provide primary and secondary medical care as 80% of this is provided by the private sector; 70% by small hospitals and private doctors. The present administration has made the private sector its main 'mascot' for health care policy drivers, perhaps recognising the potential of capitalising on the multi-billion 'health care and wellbeing' industry across the globe.

India has a massive legacy of the use of traditional remedies such as Ayurvedic medicine ("Ayurveda" for short). It is one of the world's oldest holistic ("whole-body") healing systems, developed more than 3,000 years ago in India. There are also other similar medical streams that impact upon the sector. There are many international companies that are engaged in exploiting valuable properties in plants and other natural elements in order to repackage them as modern medicine and securing trademarks. The incumbent administration has invested in developing Ayurvedic and Homeopathic medicine as major pillars of its strategy and its integration with the mainstream medical diagnostic and treatment processes.



Many areas of concern have been raised against the proposed National Medical Commission (NMC) Bill, 2017; the most troubling of them are the clauses which approve a “bridge course” for practitioners of Ayurveda and Homeopathy to prescribe mainstream medicines like an MBBS graduate can. The NMC bill proposes to abolish Section 15 of the Indian Medical Council Act, which states that the basic qualification to practise modern medicine is MBBS, thus throwing open the doors for all types of alternative medicine practitioners to ply their trade in the mainstream and prescribe modern drugs without any fear of punishment.

In a report by Reuters in 2015 a worrying set of statistics indicated the quality of existing medical professionals and the sorry state of healthcare in India. The report highlighted, “About 45 percent of the people in India, who practise medicine, have no formal training, according to the Indian Medical Association. These 700,000 unqualified doctors have been found practising at some of India’s biggest hospitals, giving diagnoses, prescribing medicines and even conducting surgery,” it says. In other words, there seemed to be a total lack of any effective regulatory processes; either by the medical fraternity or the medical policing authorities of the national or state governments.

In a joint initiative of the Ministries of HRD, External Affairs, Home Affairs and Commerce and Industry, the government of India recently commissioned a ‘Study in India’. The programme was mainly aimed at boosting the number of international students coming to India that was steadily declining with more students going to Singapore and Australia. It has made the visa process easier for foreign students and has included fee-waiver schemes.

This year, 15,000 seats have been offered by 160 institutions. The critics welcome the move for its potential to boost the economy and achieve better global rankings but also ask, “Will it benefit domestic students?” It is no secret that there are Indian students who have not been able to get admission into Indian institutions despite a good score, simply due to lack of availability of seats.

Health Care is often left in dire neglect on many levels mainly due to lack of strategic planning, effective structures for implementing monitoring and almost non-existence of clinical governance or care standards. Health Care has remained a low priority in the debate of political agenda, except sporadic bursts full of emotional anger when a fatality or irreversible harms are exposed now and then by the community and media alike. Where there is evidence of ‘sanitation’ and better services, the cost of high- quality clinical diagnosis and treatment as well as aftercare remains outside the range of affordability of the largest population of the country; mainly the poor and middle-classes. In the real India, the grass- roots reality is filled with exposed ‘exploitation’ of patients at almost every stage of their experience with the clinicians, where the system is purely driven by making monetary benefits; the culture of care is pushed to a lower level of priority, to put it mildly.

The Challenge: Thus, it is a real challenge to address the debate on ‘private sector vs public sector’ and the relationship under the concept of public and private sector (PPP) arrangement that can sustain the core principles upon which the NHS was built.



The new cohesive strategic policy would need to be compatible with resource matching commitments against the interest of the thriving private sector. It needs more robust and unpopular implementation of monitoring and governance programmes which are at the core of the NHS policy powerhouses.

The government would also be subject to 'hands off' demands by the professional's community in medical- clinical and nursing, in order to protect their 'independence' and right to regulate the health care sector. Engaging with all the stake holders on a common theme would be the real test of the government, particularly when the interests of many international educational and service providing agencies have found access through FDI's door.

The other option, to find ways of ensuring the development and growth of the private sector, is also workable but there would need to be mandatory access to their services by the poorest and those teetering around poverty, so that they can experience the benefits.

It is feared that 'insurance schemes' could easily be milked by the medical service providers by undertaking unnecessary examinations and retests, leaving the beneficiaries with the 'fait accompli', forced to seek further funds to meet the cost of their unfinished treatment.

Recommendations:

I would recommend that in the absence of any credible 'Planning Commission' that could provide a coherent and effective five-year strategic direction and delivery plan, the incoming government would need to consider establishing an independent judiciary commission in order to consult widely on the state of the health care of the nation to assist in providing a debate on the future of provisions.

This commission should preferably be led by medico-legal experts under Supreme Court guidance (equivalent to a Royal Commission). In addition, there should be a national Independent Health Observatory at state level to provide much needed insight into the performances that meet the needs of the country in the meantime. The government would need to develop much more healthy and effective debate with the training and licensing establishments in order to improve the 'core culture' that needs a shift in developing leadership in clinical governance as well as managing ethics where the environment for 'patient safety' takes priority.

Finally, any attempt to shift focus from 'customer based' (the gravy train) services to make profit, to the 'patient-centric' services that are based on the ethics of promoting services which are accessible to all at the point of need, regardless of the ability to pay, would be a 'poisoned political chalice' for any government in India!

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