User charges in public hospitals: money for nothing

On January 10, opposition parties in Kolkata called a bandh opposing the hike in fees for public hospitals and related services. Charges for case papers and private rooms, had doubled, and those for X-rays and other investigations had also been hiked. All public services up to the sub-division level were asked to open an afternoon pay clinic. The morning 'free' OPD clinics will charge Rs 2 per patient; the afternoon clinics will charge fees. The fee in these clinics will be split between doctors, technicians and the state coffers.

Though the announcement carried a rider that all services would be 'free for the poor', the question is: how are the poor identified? To avail of this facility, people would have to obtain a certificate from a corporator, panchayat pradhan, MLA or MP. Need one say more?

Though there are varying opinions on the bandh's success, the government has put a hold on the hike in rates.

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The government charges Rs 1,200 for a CT scan. Outside, the charges are Rs 1,500. But everyone knows that private scan centres give referring doctors commissions of 20 per cent, and still make a profit from the remaining Rs 1,200. Which means the government is making a profit when charging for this test. This is not cost recovery; this is profit.

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Neither the proponents and opponents of rate hikes have raised the question of medical auditing, rational therapy, and the use of drugs. That is, what is going on in hospitals? Does paying more guarantee better care? No.

At the same time, if there is no hike, is what is going on acceptable? Is there any monitoring of the investigations and drugs being prescribed and/or used? Will there be a change if people pay more? If so, that means if you get something free, you should not complain if it is of unacceptable quality.

The afternoon pay clinics have not been officially revoked, but one hears that attendance is negligible. Now, since the same doctors who run the morning OPD will attend the afternoon clinic, will there be a qualitative change in care at the afternoon clinic? Does payment mean value for money? Will those who cannot pay be forced to take inferior service? Will doctors talk softly to the afternoon patients?

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Another topic of debate here has been the spate of government 'policies' in health.

Look at the National Health Policy — a policy without entitlement, which is no policy at all. Surely only an independent can formulate a policy. But our policies are dictated by donor agencies. We make changes according to their dictates. We worry what to do if our funders back out.

In the 1983 health policy, the government's intention was to make general health services and personnel available to people. We promised to implement the WHO's programme for Health for All through universal primary health care – this means using appropriate technology and services compatible with the country's needs. But that was only a policy statement. Instead, in the last two decades, we have manufactured specialists in a large way, and promoted high-technology medical care.

A 'new drug policy' was announced in February. But India has never formulated a drug policy — by the ministry of health, assessing and responding to our health needs. The drug policies is an industrial pricing policy written by the ministry of chemicals and fertilisers. It assesses only market needs. If trash has a demand, if useless, irrational drugs can bring profits, companies will devote themselves to making them. There has never been an attempt to determine an essential drug policy: to decide how many drugs we need, keep only them and do away with the rest.

In India, it is said that there are 100,000 formulations. This is guesswork because there is no centralised registry of the number of drug licenses issued.

In Bangladesh in 1983, the Drug Policy Ordinance removed more than 1,700 irrational drugs from the market. This policy stayed effective for more than a decade, though more recently World Bank pressure has reversed much of the gains.

As a result of our drug policy, people are duped by doctors, and companies use high pressure sales tactics to increase their markets.

The 1986 Drug Policy called for the setting up of two agencies: the National Drug Authority to examine the number of formulations needed in our country, and the National Pharmaceutical Pricing Authority. The latter was formed overnight because that was in manufacturers' interests, for pricing, profit, etc. But almost two decades down, the National Drug Authority is still not established. And the latest drug policy does not even mention the National Drug Authority. It does not even talk about the prevalence of irrational, dangerous or marginally useful formulations.

In the Drug Policy, too, the question of entitlement is absent. Will the poorest of the poor get essential drugs? The number of drugs under price control has steadily gone down over the years, from 432 to barely 30 under the new policy. The argument has been that free competition between companies will push prices down. That is possible only when drugs are sold as generics, when the buyer has a choice. But drugs are sold as brands, and these brands are prescribed by the doctor.

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