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Outpatient inpatient

RAHUL GOSWAMI WITH RAMYA KANNAN IN CHENNAI, AARTI DHAR IN NEW DELHI AND SAHANA CHARAN IN BANGALORE

The state is obliged to provide healthcare to the poor but has limited public finances. Is developing medical tourism the answer?



In November 2007, India's overburdened public health system was the stage for another battle about policy. About 24,000 medical students in Tamil Nadu and Maharashtra protested the central government's intention to add a compulsory year of rural service to the MBBS course.

Two sides: Iraqi children at Madras Medical Mission Hospital, Chennai

Their question, as put by one striking medical student in Mumbai, goes to the root of the country's public health problem. "If government doesn't have infrastructure at municipal and basic levels, how is it saying that infrastructure is waiting for us there?" asked Dr. Vasant, a member of the Maharashtra Association of Resident Doctors.

Financing healthcare

On India's health map, the 'there' is the country's *talukas* and *tehsils*, blocks and districts, a landscape in which only 30 per cent of our government hospitals and 15 per cent of government hospital beds exist. On average, a household spends Rs. 250 per capita per annum on health services but expenditure on health is 40 per cent higher in urban households. Who collects these payments?

Today the private healthcare sector accounts for 82 per cent of outpatient visits, 58 per cent of inpatient expenditure, and 40 per cent of births in institutions. Yet out-of-pocket expenditure on health in India is one of the highest in the world and indicates an inefficient way to finance healthcare that leaves people highly vulnerable.

Into this uncertainty of policy and practice is introduced the market dimension. Companies in the healthcare sector and investment firms are preparing to deploy sizable funds in the hospital sector in India to seize the vast potential offered by a mix of poor facilities, changing disease profiles and demand for quality healthcare.

The sums today are as large in this sector as in any other: the Apollo Hospitals Group plans to spend Rs. 800 crore by 2009, while Fortis Healthcare aims to spend Rs. 1,970 crore up to 2010-11.

According to a study by global accounting and consulting firm Ernst and Young and the Federation of Indian Chambers of Commerce and Industry, private hospitals in India earned Rs. 62,000 crore in fiscal 2006 and revenues from the sector are expected to top Rs. 130,000 crore (at current prices and exchange rates) in 2012, which represents an annual revenue growth rate of about 19 per cent a year.

Even though the private sector consists largely of sole practitioners or small nursing homes with between one and 20 beds, serving an urban and semi-urban clientele and focused on curative care; for investors, those national numbers are highly compelling.

Union Minister for Tourism and Culture Ambika Soni's flippant remark, about wanting "a nose job", at the fourth India Health Summit in November 2007 did not distract from the convergence between official and industry views of the future of healthcare in India. The Finance Ministry's Investment Commission emphasises that healthcare delivery is already one of the largest service-sector industries in India, and expects the industry to grow to contribute about five per cent of GDP (at around Rs. 240,000 crore) by 2010.



"The sector is getting focused from an investment perspective," said Vishal Bali, chief executive of Wockhardt Hospitals, which plans to double its hospitals to 30 from 15 in two years. "The drivers for the future are falling in place."

A long queue at Victoria Hospital's OPD ward in Bangalore.

Policy sweeteners

Key among those drivers is policy sweeteners. India permits 100 per cent foreign direct investment for all health-related services under the automatic route, infrastructure status is accorded to hospitals, lower tariffs and higher depreciation apply on medical equipment, and hospitals in rural areas don't pay income-tax for five years. These make the sector attractive for private sector investment, but do little to answer Dr Vasant.

Nor are they likely to. Two years ago, writing in the *British Medical Journal*, two commentators — Amit Sengupta of the Peoples Health Movement and Samiran Nundy of Sir Ganga Ram Hospital — urgently flagged the growing contradictions.

"The recent remarkable growth of the private health sector in India has come at a time when public spending on health care, at 0.9 per cent of GDP, is among the lowest in the world and ahead of only five countries: Burundi, Myanmar, Pakistan, Sudan, and Cambodia. This proportion has fallen from an already low 1.3 per cent of GDP in 1991 when the neo-liberal economic reforms began."

Can the gap between public spend on health infrastructure and affordable primary and curative care be helped by medical tourism, a fast-growing element of the new health industry?

The central government, industry associations and the private healthcare industry argue that it can, with medical tourism serving as the bridge. India now hosts and treats an estimated 150,000 medical tourists a year and the catalytic CII-McKinsey report of 2002 projected that medical tourism could contribute up to Rs. 10,000 crore in revenue by 2012.

At the same time, Dr. Pratap C. Reddy, chairman of the Apollo Hospitals Group, explained: "We need to invest \$60-70 billion over the next five years in hospitals and healthcare education to expand this sector and reach out to as many people as possible."

The equation taking shape is: this volume of investment is needed to add another million hospital beds (and full-gamut healthcare services) in India over the next 20 years, the return on such investment can best be provided by high-paying foreign clientele (and growing numbers of urban middle-class Indian

patients), and that this model can subsidise the cost of providing services for economically disadvantaged patients.

What about public health?

Public health practitioners in the country's creaking government hospitals and in state health departments believe otherwise. "The benefits of medical tourism are noticeable mostly in the private health sector, not so much in government health institutions," said Thelma Narayan, a public health activist with Bangalore's Community Health Cell, a voluntary organisation. "More investment pumped into corporate hospitals for expansion has a negative impact on government hospitals as their highly trained medical professionals look at better prospects in the private sector."

Ravi Duggal, a researcher with the Mumbai-based policy analysis group, Centre for Enquiry into Health and Allied Themes, explained that "the problem starts when a developing country, which has 75 per cent of its population either poor or living at subsistence level, collaborates in promoting medical tourism when it cannot meet the basic healthcare needs of a majority of its citizens." Medical tourism creates a climate of inequitable services that undermine the goal of health for all, in the view of Dr. Nergis Mistry, scientific researcher with the Foundation for Medical Research, Mumbai. She warns against a technology- and urban-centred approach to delivering health care: "It raises the cost of healthcare for the local population because it forces the use of expensive technology and drugs."

For thousands of medical tourists like George Marshall, this debate is invisible. In 2004, a heart bypass was recommended for the 73-year-old British citizen, which would have cost him up to £20,000. "I would have had to wait over three months to see the cardiologist and potentially a further six months for the operation," he said. Instead, he paid £4,400 to Wockhardt Hospitals for the operation. Airfare and travel insurance cost extra, and he paid with his own money as insurance didn't cover his outsourcing of medical needs.

On offer today for similar patients are specialised services ranging from cardiology and cardiac surgery (angioplasty, bypass, valve replacement), to oncology and onco-surgery, organ transplants (liver and kidney), bone marrow transplants, joint replacements, eye surgery and in-vitro fertilisation. For them, as it was for Marshall, the cost differential is significant.

That differential brings in the numbers that matter to the corporate hospital and medical services sector. But there is another growing section that matters as much. The most visible impact of a nine per cent rise in GDP over three years has been the rise in health-related spending by the urban family with one professional earner. Such a family of four is today estimated by the industry to spend Rs. 8,000-Rs 12,000 per year, compared with Rs. 2,000 (adjusted for inflation) in the late 1980s. What of rural or peri-urban India and its spending levels?

"Poor patients depend heavily on public health services because the cost of treatment of illness is higher in private health care facilities," noted the authoritative Health System Performance Assessment for India, part of the 2003 World Health Survey.

The Assessment was carried out by the World Health Organisation (WHO) and the central Ministry of Health and Family Welfare to provide evidence-based health information and to develop capacity for policy makers to monitor health system responsiveness over three major components: burden of disease, health financing and health system responsiveness.

In the major states, health departments issue guidelines to private hospitals specifying their obligation to provide beds, treatment and services to the public patient, and to return a portion of revenues from medical tourism into serving the public health overburden, but neither are these hospitals held to account on these points by their respective state governments, nor does a standard country-wide regulatory system exist to ensure such compliance.

A signal of state-directed change however comes from Tamil Nadu, Karnataka and Andhra Pradesh. “As of now, it is only the private sector that is reaping the benefits of medical tourism in Tamil Nadu,” said Health Secretary V.K. Subburaj, “while the government sector remains out of this loop so far: we have been focusing on public health. However, with the concept of ‘pay wards’ coming up in government hospitals for certain speciality segments, we can expect this trend to change.”

Karnataka is now preparing to promote premier government institutions as medical tourism destinations. “The Department of Tourism with the Health and Family Welfare department has identified centres of excellence in the government health sector — such as Jayadeva Institute of Cardiology and the Kidwai Institute of Oncology — which will be promoted abroad as places for specialised treatment at affordable costs,” said Health Commissioner Basavaraju.

Moreover, what is now being called the Andhra Pradesh model stems from the provision of universal health insurance in three districts, and AP chief minister Y.S. Rajasekara Reddy has called for bids in six other districts. Thus, as Dr. Pratap C. Reddy of Apollo Hospitals emphasised, insurance cover and accessibility can drive change. “In Aragonda, Andhra Pradesh, with a contribution of a rupee a day a constable’s son was able to have a bone marrow transplantation done at the best facility. Nobody can afford to pay for major illnesses, and we need a mechanism to make hospital procedures cashless. That is possible only with insurance.”

Key factors

Such measures would seem sound if the severe shortage of medical professionals, the extant huge gaps in medical and health insurance cover (only three per cent of the population has any form of insurance), and the fact that healthcare entrepreneurship is a business investment are ignored as key factors.

What direction should public health policy take from this point? Should government confine itself to providing only public goods and primary care and leave all curative care to market forces; or regulate the private sector, selectively contract its services to achieve public health goals and compete with it?

Dr. Srinath Reddy, president of the Public Health Foundation of India, suggests regulation of the private sector to ensure appropriate and ethical as well as fair pricing, especially where the state directly or indirectly subsidises or supports private sector health services.

With medical tourism or without, for state funding on health to reach the Rs. 1,400 per capita per year as recommended by the WHO Commission on Macroeconomics and Health (it is currently Rs. 200) depends a great deal on the private health financing model followed, one that today hurts not only poorer sections of society but also the middle classes.

What drives medical tourists?



They come from all over the industrialised world, from countries with relatively poor healthcare infrastructures and, in the case of the U.S., places with exorbitantly expensive health care systems.

Seeking CARE: A Kenyan after kidney transplant in Bangalore.

Reasons

The reasons for seeking treatment abroad differ according to country. In Canada and Britain, long waiting times for surgeries encourage those with sufficient financial resources to look for alternatives.

In countries with relatively poor healthcare infrastructures, quality is the driving force for those with money.

Medical tourists from the U.S. are usually those seeking procedures not covered by their insurers, those seeking necessary procedures and who are provided with incentives to find lower cost options, and those who cannot secure medical insurance. Where they go depends on the procedures and the physicians. Cosmetic procedures are easily found in South America, while complex heart and orthopaedic procedures are found in India, Thailand and Singapore, and specialists in in-vitro fertilisation can be found in South Africa, Israel and Spain. In the global medical tourism industry, from cosmetic surgery to complex oncology, bargain prices can be found at a medical centre somewhere in the world.

Time and money provide the incentives for seeking healthcare outside the home country. In the case of public health systems with long delays, such as Britain, time is the motivation.

These medical tourists are choosing to pay for a procedure that would be cheap or free in their home environments, but is close to inaccessible due to the rationing of care. For U.S.-based medical tourists, money is usually the motivation. For the uninsured or for cosmetic procedures, savings of 50-90 per cent are common; even when those savings include transportation costs, recovery time, travel and lodging for close family members. For the insured, usually those covered by organisations that self-insure, financial incentives might be offered which for the middle-class worker can be significant.

Accreditation

Quality is a concern for potential medical tourists and what are now being called 'offshore hospitals' address these concerns by seeking and obtaining accreditation from bodies such as Joint Commission International (JCI), a subsidiary of the Joint Commission on Accreditation of Healthcare Organisations (JCAHO), which offers accreditation to hospitals in the U.S. Several hospitals that offer medical tourism in India meet or exceed the standards of care of the finest hospitals located in the U.S.

The lower cost structure of these hospitals allows them to be more generous with resources for their well-paying clientele. Nurse-to-patient ratios are higher, private rooms are readily available and family members are often included in the trip and made comfortable in luxury facilities that resemble five-star hotels.

Dr. Milica Bookman, professor of economics at St. Joseph's University in Philadelphia, US, is author of the book *Medical Tourism in Developing Countries*. According to her research on the economic impact of medical tourism, 750,000 Americans are expected to have travelled abroad for treatment in 2007 and over six million will do so by 2010.

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The view from Delhi

The central government is strenuously countering the view that private sector domination in healthcare, and particularly medical tourism, is raising cost barriers for the average Indian. "There is bound to be an increase in the cost of treatment due to the high standards of quality being followed," said Union Health and Family Welfare Minister Anbumani Ramadoss, "but we have been specifically telling stakeholders that their priority should be domestic patients and health facilities should be within their reach."

"The government will not hesitate to intervene, if need be, though we believe that medical tourism is primarily a private sector initiative," he added. "From our side the government has not given them any leverage, even while many in this sector had even mooted a Special Economic Zone concept for establishing exclusive medical cities, which was turned down."

Meanwhile, government institutions like the All India Institute of Medical Sciences (AIIMS), Post Graduate Institute for Medical Education and Research (PGI) and Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER) are being officially encouraged to upgrade their facilities to cater to foreign patients. An important aspect of medical tourism, from the government's perspective, has been the reverse brain drain with a large number of doctors returning given the growing opportunities here.

Rejecting the contention that private healthcare in India is beyond the reach of ordinary citizens, Sanjay Rai, Director Sales and Marketing, Max Healthcare, said "We give free treatment to those below poverty line as per the government guidelines and treat those covered under the Central Government Health Scheme, which is highly subsidised."

There are at least two medical cities' coming up in National Capital Region: One promoted by Dr. Naresh Trehan called MediCity and the other by Fortis Healthcare.

A.D.