**Sustaining for-profit emergency health care services in low resource areas - commentary on Emergency care in rural settings: Can doctors be ethical and survive? By Dr. Bawaskar HS, Bawaskar PH.**

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Word Count: 2074 ( including references)

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The issues that the Bawaskar doctor couple raise though their article[[1]](#endnote-1) are rather contextual and don’t have universal relevance. They are relevant to the concerns of those physicians working rationally in the for-profit private sector in the underserved areas.

This context specific question about provision of emergency care in rural, low resource areas could be broadened to “What efforts are needed to sustain emergency care systems run by private sector in rural, low resource areas without catastrophically affecting patients or healthcare providers? There are lots of studies which show that emergency care expenses, especially in private health services push patient’s families below the poverty line.[[2]](#endnote-2) [[3]](#endnote-3)

Achieving this balance means provision of such emergency care services as part of free public healthcare for all or it would need people to have enough surplus money to access emergency care nearby in the private sector. As a signatory of UN declaration[[4]](#endnote-4), India has already committed to provide accessible and affordable healthcare to all citizens.

This question in fact leads us further to “What is the relevance and space for private health facilities in emergency care in underserved areas”? Ideally, the state should run and provide healthcare to all people for their needs including emergency care, and there should be no compulsion for people to go to private health facilities.

Even in the real world where private facilities arguably provide more than 70% of care even in rural areas[[5]](#endnote-5) due to poor quality and ineffectiveness of services in public health facilities, can the community be expected to pander to various considerations of private providers? Bawaskars make a problematic statement that asserts ‘doctors in small communities are easy prey’ to the machinations of the public which they serve. Prey to what- the poverty of the people or their poor paying capacity? Is the community often not a prey to the rapacious private sector physicians who would charge extra, do irrelevant investigations and often not reach a correct diagnosis and prescribe unnecessary admission and treatment? One wrong does not justify another though.

The main thesis of their article is that it is difficult for ethical and rational doctors to survive in rural underserved areas because several people in the community they serve don’t live up to their promises of being able to pay later for emergency care.

Preservation of life and saving life is the absolute constitutional obligation according to Article 21st of the constitution of India. There is a certain ethic[[6]](#endnote-6) that guides care for emergencies in all shades of health systems- whether state run or dominated by private health care providers. Even in the market driven US health system, even though over 10% people don’t have any health insurance, every health facility is obliged to provide free emergency care to all. Certainly, in countries that provide Universal Health Care such as Thailand, Canada and Brazil, emergency care is available without the sick person having to pay anything.[[7]](#endnote-7) [[8]](#endnote-8) [[9]](#endnote-9) In other capitalist economies such as Germany, France and Spain too, emergency care is provided free too, even though certain routine services are not even provided to those that are insured.

In India, while we have legal rules that prevent any health facility from denying emergency care[[10]](#endnote-10), the scope of which is variable, quality and spectrum of care is poor[[11]](#endnote-11). The proportion of people with a myocardial infarction who reach a hospital and get thrombolytic treatment is 35-50%.[[12]](#endnote-12) Similarly, those with stroke who could reach a hospital in the window of four hours in a metro city like Mumbai is 42%.[[13]](#endnote-13) The proportion of people with snake bites with envenomation who get proper dose of ASV is less than 50%.[[14]](#endnote-14) The situation in most rural hospitals can only be imagined to be far worse. It may not be incorrect to say that most rural hospitals (CHC and PHC) rarely provide any effective emergency care for most common emergencies that rural folk face except obstetric care, even if they provide some routine care[[15]](#endnote-15). Apart from providing emergency obstetric care of some modicum, these institutions serve mainly as referring nodes[[16]](#endnote-16).

In the context of such a state of emergency health care services, what is the place of private for profit health facilities? It would be clearly desirable that all such institutions get empanelled under the National Health Protection Scheme that the state provides funds for, and they could use the packages specifically meant for emergency care. We agree that we need to expand the different packages offered under the health insurance schemes and ensure inclusion of emergency care. A law commission report guides the state to allocate a separate fund to support emergency care expenditures by medical professionals, hospitals and even ambulances[[17]](#endnote-17). Recently the states of Delhi[[18]](#endnote-18) and Kerala[[19]](#endnote-19) have passed orders that all emergency care for trauma and selected emergencies for the first 48 hours will be paid for by the state for care in private health facilities too. The West Bengal Clinical establishment Bill 2017 recommends that expenses incurred by private hospitals in emergency care in those who are not able to pay will be paid by the state ‘in due course’[[20]](#endnote-20). Since the Law commission’s 2006 report categorically suggests that the state has to ensure payment for emergency care including during childbirth incurred in the private sector, this provision should be used by individual state governments to ensure adequate emergency care in both public and private hospitals irrespective of the sick person’s ability to pay. Compliance with this is unknown except for the Delhi and Kerala.

A second problematic statement the authors make is ‘the public has the prejudice that doctors overcharge often, and that they don’t understand the expectations for the return on investment of time and fees that doctors make’. Is overcharging a mere prejudice of the community towards doctors[[21]](#endnote-21)? No. Every year about 7% (63 million) people Indians fall below poverty line due to catastrophic healthcare expenditure[[22]](#endnote-22) [[23]](#endnote-23) [[24]](#endnote-24). The investment of money that the state makes in the training of physicians both at MBBS and post-graduate comes from the taxpayers’ money and the community cannot be expected to underwrite the expenses certain physicians make in getting trained in private, paid training institutes.

Finally, how many doctors has anyone heard of slipping down on the economic ladder after being a doctor? I would argue that almost all private physicians only rise up in their financial situation even in the rare event that their practice may not show up to be generating profit occasionally.

How does the private sector find its place in the health care scenario? Clearly, the expansion of private health care services has been in response to the ineffective and unavailable public health system in rural areas, a process that acquired speed in 1980s and galloped towards corporatisation in 2000s. However, in an unequal society that India is, with large swathes of rural areas being underserved, private sector would naturally have found relevance there in establishing their pre-eminence. However, the formal private sector only thrives in those areas where the public system thrives, even if the quality is variable[[25]](#endnote-25). What then is available to most rural areas is usually informal practitioners whose rationality and effectiveness is often questionable. There are only a handful of voluntary organizations who provide clinical care that includes secondary level emergency care in rural areas. The number of private clinics that provide inpatient and emergency care in the villages are fewer in our villages than cities.

To summarise, we opine that there are enough constitutional, legal and ethical imperatives to ensure that all emergency care should be available for free for everyone, regardless of their paying abilities. This should ideally be provided by the public services. If the state is unable to make it available levels of effective and needed tertiary, secondary and primary emergency care, then it could strategically purchase it from the private sector. Even if that arrangement is not available, the private sector providers can’t expect that the community underwrites the sustainability of their services plus return on investment they may have incurred on their training. That would be unacceptable. We should work on arrangements that makes the state underwrite emergency care expenses for indigent patients who seek treatment in the private sector. Finally, we suggest that principles of ethics can’t be invoked for justifying the financial viability and sustainability of the private sector in an unequal world.

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