t dusk in front of Benares Hindu University’s medical college hospital, Ram Ashish Rajbhar, a day labourer from a village 200km away, settles on a mat on the pavement, where he will spend the night with his 12-year-old, cancer-stricken son, Karan.

The hard ground — shared with scores of other ailing Indians from far-flung places — has grown familiar to the father and son since the boy was diagnosed a year ago. His treatment requires chemotherapy every 21 days; a doctor sees him some days later.

But beds in the overcrowded public hospital are in short supply; patients are discharged as quickly as possible, leaving the duo to camp on the pavement while awaiting a follow-up doctor’s visit. The four-hour train ride home, then back a few days later, is too arduous.

That is not the only hardship. While the government medical college ostensibly provides free care, patients must pay for their own drugs — a huge expense for diseases such as cancer. Mr Rajbhar, who earns about Rs7,000 ($104) a month when working full time, says he has spent over Rs170,000 on his son’s fight against cancer, wiping out his savings, and pushing the family into debt.

“Tusk, I had saved to build a house is gone. I also have a 21-year-old daughter to marry off. All of that will be difficult now.”

Such stories are all too common in India, where chronic neglect and low funding of public health are hampering efforts to lift families out of poverty and stabilise the fragile middle class. Nearly 70 per cent of India’s total health spending comes out the pockets of patients’ families, straining household budgets and creating severe inequities in access to care.

While wealthy Indians check into well-equipped, private “super-speciality” hospitals — including publicly listed corporate chains such as Apollo Hospitals, Max India and Fortis Healthcare, the poor are relegated to cash-strapped, overstretched public facilities, where they must pay out of their own pocket for drugs, diagnostic tests and even basic medical supplies.

A transformative programme

Narendra Modi has ambitious plans to tackle this health crisis. The prime minister’s government is preparing the imminent rollout of a national health protection scheme, which aims to provide India’s poorest 100m households — an estimated 500m people — with insurance covering annual hospital expenses of up to Rs500,000.

Dubbed “Modicare” by local media, the programme — likely to be launched this year — is to allow beneficiaries to receive “cashless” inpatient care at government hospitals or approved private facilities, which will be paid at fixed rates for treating various diseases.

Trumpeted by the administration as “the world’s largest government-funded healthcare programme”, the scheme comes as India is dealing with rising incidents of non-communicable diseases — such as diabetes, heart disease and cancer — on top of its existing high burden of infectious diseases.

“You can’t consider yourself an emerging country when millions go into poverty because of health incidents’

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needed," says Nilaya Varma, head of KMPG India’s healthcare practice. "You can’t consider yourself an emerging or developed country when millions go into poverty because of health incidents and the government can’t provide for it."

Despite decades of high growth, India still lags far behind other developing countries such as China, Brazil and Thailand in tending to the comprehensive health needs of its citizens. Due to this neglect, India’s health outcomes in key indicators such as maternal and infant mortality are poorer than many other countries at similar, or even lower, levels of development.

But Mr Modi is betting that the promise of public support for citizens to secure treatment at private hospitals will not only transform India’s healthcare landscape but could yield rich electoral dividends when he seeks a second term in next year’s general elections.

"The main lesson that the government should have learnt is that you have to have checks and balances in place," says Dr Devadasan. "It’s just going to lead to all kinds of cost escalation," says Ms Ravi. "That is the nature of an insurance driven market. Neither the caregiver — the doctor — nor the patient has any incentives to reduce costs."

Some critics believe New Delhi would be better off investing more on modernising the dilapidated public healthcare system, where there are no incentives to overtreat, and strengthening primary and preventive care. "It’s a good intention, but first build your health system — which is full of inadequacies of personnel, infrastructure and medicine supply systems," says Supriya Bhayana, India’s former health secretary. "You have to invest in hospitals, otherwise prices will go so high you can’t contain them."

New Delhi plans to spend $184m to enhance 150,000 public primary health centres, which are now focused mainly on prenatal care and immunisations.

But Ms Rao says other aspects of the public care system should be bolstered too. "We are too poor a country to just go on the idea that the private sector will deliver," she says. "You have to have both public and private."

Regulating the system

India’s experience with smaller-scale insurance schemes highlights the implementation challenges ahead. In 2008, New Delhi launched the Rashtriya Swasthya Bima Yojna, or RSBY, to cover up to Rs30,000 in hospitalisation costs for poor families, including informal workers. Today, about 35m families are ostensibly covered.

But Dr N Devadasan, co-founder of the Bangalore-based Institute of Public Health, says that years later many beneficiaries did not know how or where to access free treatment, and instead wound up in private hospitals that were not part of the programme, ultimately paying out of pocket for their care.

Dr Devadasan, who has tracked RSBY since it began, says the failure to fully brief poor, uneducated beneficiaries appeared to be a "deliberate strategy of the insurance companies" to minimise claims. "You distribute the card, but you don’t inform the patient or people what it is for, or how it is used, and then claims are less," he says.

Efforts to game the system were also rampant, he says, with individuals and hospitals jointly forging medical records to share the subsequent payout. Suspecting widespread fraud, insurers regularly delay payments, or reimburse only a fraction of what was claimed.

"The main lesson that the government should have learnt is that you have to have checks and balances in place," Dr Devadasan says. "There was no capacity at the state level to do this, and it was kind of a free-for-all."

In Delhi, Dr Paul acknowledges the magnitude of the challenges — including that of hospital regulation — but is confident the government will tackle them.

"We will learn. We will continue to build the ship as we sail," Dr Paul says. "If they cheat, which they will, and if they commit fraud, which they will, not
all but a few, there are ways to tackle it using technology, using robust oversight and managerial mechanisms.”

But Dr Paul insists that India is poised to transform healthcare for the better.

“There is a huge vision behind it. Getting translated will take a while, but it is a game-changer,” he says. “My guess is that in 10 years’ time, we will push our life expectancy by 10 years. And we will reduce our out-of-pocket payments for catastrophic medical expenses by 50 per cent.”

India has made some progress on child mortality, but not as much as China

Patients receiving treatment for infections such as dengue fever lie on the floor in Siliguri District Hospital, West Bengal. Below: Indian prime minister Narendra Modi — Getty Images