**Emergency health for all; basic health for the poor**

Swarna Bharat Party’s health policy

*These policies should be seen in the context of the broader reform agenda outlined in* [*SBP’s manifesto*](http://swarnabharat.in/)*. Free markets require strong and effective governance. Without governance reforms detailed in the manifesto, that will build capacity and honesty in the government machine, the policies detailed below will not deliver the expected results.*

Except in a few extreme situations, there is no case for a government to step into managing people’s health. Citizens of a free nation must shoulder responsibility for their own and their family’s health, particularly given that good health is largely a consequence of preventative actions that people must themselves take. By ensuring that medical costs are met from their savings or through insurance, people remain motivated to look after their health.

There may, however, in addition, be some role for the government in assisting the very poor in health matters, a responsibility arising from the requirement of equality of opportunity.

To more clearly identify the role for government, we can consider health issues in three categories: (1) basic health and elective surgery, (2) emergency hospitalization, and (3) general programmes such as vaccinations against infectious disease and promotion of public health.

## Government support for basic health and surgery for the poor

A government is not required to provide basic health care and elective surgery for everyone, since health is just one of many requirements of daily life and health support at taxpayer expense can lead to people taking less responsibility for their own health or going excessively to doctors.

For the poorest of the poor, who can’t afford basic care or elective surgery, there is some role for government, while being mindful of the moral hazard.

We will automatically pay a premium for basic health insurance and elective surgery for those eligible for negative income tax funding. A co-contribution will be required from those who are relatively less poor (but still below the poverty line), on the pattern of school funding. Being a large purchaser, the government will be able to achieve competitive prices for this service from the health insurance sector.

However, to ensure that insured poor individuals take adequate care of their own health, we will limit the coverage for illnesses that typically arise from an unhealthy lifestyle e.g. chronic obstructive pulmonary disease (mostly due to smoking), and alcoholic liver disease.

## Universal trauma care, cost recovered from those who can pay

Each citizen can either take private insurance, or self-insure for health contingencies. However, if someone turns up at the doorstep of a hospital in a gravely sick or injured condition *that does not permit self-identification or identification of insurance* (including self-insurance) *plans*, such a person cannot be turned away.

It is the obligation of a government to protect the life of its citizens. To ensure that no life is lost under traumatic circumstances only because funding could not be assessed in time, a government should universally insure everyone (including foreign citizens) for immediate treatment for traumatic hospitalisation and emergency care, with later recovery of costs. (Note: this excludes all chronic or other conditions for which self-identification or advance payment is feasible by the patient or his/her family. Such insurance applies, therefore, only to the rarest of cases).

#### Delivery of trauma care

Our government will not directly deliver trauma hospitalization, but procure it through private enterprise based on models that keep competition high, and costs and moral hazard down. Options include (subject to further modelling) tendering for long duration (say 30-year) contracts within specific geographical regions. The country can be carved into reasonably sized regions which are put out for tender. Eligible private health consortiums wishing to provide the prescribed trauma services (at prescribed standards to everyone in the region) will be asked to bid a single, flat per-personannual price. This approach would take into account the local cost of living, and any local difficulties in appointing doctors. The successful bidders would be awarded long-duration contracts for these regions and paid in advance, on a monthly basis, based on the region’s estimated population. This will create certainty in payments and allow appropriate investment.

The health regulator will monitor service quality and timeliness. Stiff penalties for non-compliance with service standards will be imposed. This approach will:

* significantly increase the competition in supply of emergency hospitalisation services; and
* cap costs (providers will receive a fixed amount regardless of quantity). In general, fee-for-service payments create incentives to treat excessively, to undertake more tests, to prescribe more. A flat total cost creates incentives to manage outcomes as efficiently as possible, while delivering service standards.

#### Reimbursement

Except for those eligible for the NIT-type system, citizens, upon their recovery from trauma, will be billed the government-approved standard cost for their treatment. They could thereafter either bill their insurance companies or pay directly, if they have chosen to self-insure. The government will bear the cost of administering the scheme and any cost of being unable to recover from those who die, without being identified, during the treatment.

Foreign citizens who do not pay costs immediately after they have recovered from the trauma will have a noting made in their passport that permits them to leave India only after they provide proof of payment.

## Privatisation of government primary health centres and hospitals

By the end (aiming for completion in three years), government- primary health centres and hospitals will be sold on the broad regulatory pattern outlined for schools. Any private health consortiums successful in purchasing these assets will also be required to take responsibility (under incentive-based conditions) for up to five years for the employees of these centres and hospitals.

Given this reform involves a matter that concerns the lives of hundreds of millions of people, we will ensure that the transition is well-thought out and systematic.

## Other universal health programmes

In addition, we will support (deliverable through the private health system) general programmes to vaccinate children against infectious diseases to help reduce infant mortality. We will also support civil society efforts to educate people about sanitation, nutrition, obesity, diabetes, TB, malaria, leprosy, hypertension, drug abuse, occupational hazards, cancers and other (often preventable) health issues.

## Drug policy

We are concerned that drugs take too long to be approved. We will review and speed up the approval process. On the other hand, the sale of snake oil and fake medicine – often sold in the guise of food product – must be curbed. We will mandate the formal approval of any ayurvedic, homeopathic, unani and other such products that claim to provide curative benefits. With these steps, India can become a key hub of the world’s drug industry.

## Health regulation

### Stringent regulation of private health insurance providers

To ensure that the private health industry operates competitively, we will regulate the health insurance market to allow switching insurers without any loss of existing coverage. We will also regulate private health insurance prices (to be approved by the Government after a detailed assessment by the health regulator).

To ensure that everyone is able to take insurance, if they so wish, we will mandate that no private insurance provider can reject anyone’s application although they may, within reason, vary the premiums for certain categories of patients (e.g. smokers). We will also allow some pre-existing conditions to be excluded for 12 months for new applicants, to prevent gaming by patients who fall badly sick and then try to take out insurance. We will also allow health insurers to impose a penalty premium (at a flat rate, say one third higher than the standard premium) for those who take out health insurance after age 35.

### Occupational licensing of health professionals

We will review current occupational licensing requirements for health professionals to minimise any monopolistic tendencies in the profession, and allow categories of health professionals for paramedics, who could, under the supervision of doctors (and in the coming years, advanced AI-based computers), handle many of the more common health problems and procedures.

In this regard, we will ensure that restrictions are not imposed on options that doctors provide to their patients, in the guise of ‘ethical considerations’. Doctors should be required to provide patients with all relevant facts and let patients make up their own mind.

### Regulated markets in blood, kidneys and organs, and the regulation of surrogacy

India has a huge shortage of organs for transplantation to those with organ failure. Based on Iran’s experience and the recent literature on matching markets, we will establish well-regulated markets for kidney transplants, to be followed up with markets in liver and other organs. This will potentially save hundreds of thousands of lives each year, and dramatically reduce private and public health costs. Similar principles will also be applied to the blood donation market, being mindful of any adverse effects on the rates of donation.

On the other hand, there are numerous unregulated markets in India in health-related matters, including surrogacy. We will strongly regulate surrogacy to prevent anyone abandoning their surrogate child.

## Compensation for death/injury in riots and natural calamities

We will review and identify various situations and risks, and options for insurance for such risks. Thereafter we will legislate an entirely non-discretionary system for any compensation for deaths and injuries in riots or natural calamities.

## Example: alcohol policy

Alcohol policy is a complex matter. In moderation, alcohol can be good for health. In excess it can harm not only the drinker, but others as well (e.g. family, society). Onemay live with an individual’s choice to harm himself, but no individual has the right to harm others. There is therefore a role for government in this area.

A free country’s alcohol policy must be based on a cost-benefit test and evaluation of evidence. As with Swarna Bharat Party’s policy on sex-workers, we take inspiration from India’s greatest economist, Chanakya, whose book *Arthashastra* details a regulatory (not prohibitory) solution to manage this issue, while raising revenues for the state.

Prohibition is not costless. It prevents the vast majority of drinkers, who drink in moderation, from experiencing the associated social and health benefits. It can cost human lives as some people choose illicit liquor, which can sometimes be lethal. It also leads to the emergence of a mafia, given the super-normal profits derived from smuggling. A balance has to be found between total freedom (which can harm others) and prohibition.

Our regulatory approach to alcohol includes:

1) No regulation of any kind for storage and consumption of alcohol in one’s own private premises.

2) No restrictions on purchase of liquor by adults. This means that things like the liquor permit system or prohibition will be abolished.

3) Licencing of traders and premises. We will licence liquor traders and suppliers (packaged liquor stores, retail stores, pubs and restaurants), with local governments given a significant voice in determining the location of the venues for which a licence is issued. Each licensee would be required to conduct a risk assessment and appropriate amenities to deal with the risks arising from sale or service of alcohol.

For example, licensing conditions would require sufficient parking space and place for seating and movement for all customers, so there are no spillovers on the streets; clean toilets within the facility where alcohol is served; sufficient street lights and proximity to public transport of the venue; training of staff in responsible alcohol service, including dealing with rowdy customers. Hours of operation could be regulated by the local government. The establishment would be fined if rowdy customers emerge from the premise into the streets.

4) Local governments that co-approve licences would be required to ensure suitable amenities in the area around the liquor establishment, including sufficient street lighting and parking.

5) The police would be tasked with regular monitoring of such establishments to enforce liquor laws and support the community and the industry. We would facilitate the reporting of victimization and all cases of violence will be acted upon. Police would monitor drunk driving through breath tests. Significant penalties would be applied for blood alcohol levels exceeding the permissible limit. However, public drunkenness would be treated as a health or social problem, not a criminal problem. Instead of being arrested and locked up in a police cell, intoxicated persons could be taken to health care facilities and sobering up centres where they could be treated by properly trained staff. We will allocate significant funding for initiatives to prevent alcohol-related harm, mainly through the not-for-profit sector.

6) Taxation: There is strong evidence that price changes affect alcohol consumption. On the other hand, excessively high taxes will lead to the growth of alternative, illicit and sometimes lethal manufacture of alcohol. We will tax alcohol at a level that puts downward pressure on excessive drinking, even as a balance is struck to ensure that illicit liquor or smuggling is not given a boost through such policy. This is, in the end, an empirical question.

7) We will also limit alcohol advertising and marketing.