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In search of human face for health care

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The glittering economical success of Indian economy over a decade has ensured expansion of Indian middle class. Yet a large section of the population lives below the poverty line. Access to health care, hence, is patchy and highly heterogenous. The poor are deprived of even the basic facilities. Mega hospitals in the metropolis run by giant corporates with top of the line infrastructure overshadow the stark reality of the under privileged. These high-end hospitals are beyond the pale of ordinary citizens. Access to health care should be a basic right for all. Tragedy should not be just one diagnosis of illness away.[1]

India is a land of contradictions. The contradictions are the manifestations of multilayered economic realities. The basic health needs of Indian populations are catered by family physicians, trained in allopathic medicine, homeopaths, Unanic and Ayurveda specialists.

There are nursing homes both small and big. Of course, there are corporate hospitals in major cities. Health care in the public sector is served by a pyramidal system. Primary health center in taluks, civil hospital in district head quarters with multiple specialties and, large teaching hospitals at the appose make a very sensible arrangement in principle.

Sadly, the government barely spends 1% GDDP on health care. As a result, most hospitals in apex public sector are devoid of any meaningful infrastructures and human resources.

Access to health care should be a basic right of every citizen. It would not be enough to province any such legislation without capacity building and enhance allocation for public sector hospitals. Health insurance in India does not necessarily pay for the entire treatment. The total entitlement depends on the premium paid by the companies. Thus penury, is one illness away even those who are modestly insured or marginally above the poverty line.

There is a need for a paradigm shift in the way we treat patients. The standard of care should be decided based on the research conducted in India. The standard of care is unique to each country and should not be extrapolated to different socio-economic milieu without validation. Cancer care is expensive. Radiation therapy with contemporary technology is more expensive than before. Innovations in chemotherapy have made many new drugs beyond the reach of a common man.

A great divide is emerging based on affordability. Even NHS faces a similar dilemma. The drugs deemed poor on cost-effective scale by National Institute for Clinical Excellence (NICE) are not adopted by National Health Scheme. In response, pharmaceutical companies have developed patient access scheme (PAS) or risk share schemes, which allow drug companies to offer discounts and rebates to reduce the cost of drug to the UK National Health Service (NHS).[2] Velcade response scheme was the first of the PAS. Under this scheme, patients were offered bortezomib for four cycles. Patients who responded continued to be treated by NHS, while the cost amounting to Rs. 12000 was refunded to NHS if patients did not respond. The scheme has its own set of problems. Bevacizumab is another example of a very expensive drug with limited benefits being used literally for recurrent glioblastoma multiforme. The drug was approved by FDA following phase II studies. The drug since then is being used in India as well. In India, it is the patient, who pays for the medicine. It is one of the most expensive drug costing USA $100 000 per year per patient. American insurance companies have refused to pay to all parts of the costs, and in countries with National health care systems, such as the UK and Canada, the health care systems have restricted its use because of the low ratio of benefits to cost.[3]

Patients in the impoverished countries can barely dream of availing such expensive cancer care. The rich however may indulge in the luxury of paying for the drug.

How can one reduce the glaring inequity in health care delivery? There are no answers. However, for starters, indigenization of technology can definitely

reduce the capital cost of radiation therapy equipments. Expert bodies should develop appropriate criteria relevant to our country. Patient access schemes must be encouraged with much greater enthusiasm. Pharmaceutical companies must be persuaded to reduce profit margins so that drugs can be made available at a lower cost. All these are possible when physicians decide to restore human face to health care.

REFERENCES

1. Sarin R. From 3D to 5D Radiotherapy: A blitzkrieg of DTH. J Cancer Res Ther 2009;5:223
2. Williams S. Patient access schemes for high- cost medicines Lancet Oncol 2010;11:1111-2.
3. Bredel M. Patient access schemes for high- cost medicines Lancet Oncol 2010;10:928-9.