Commentary

Health at the time of demonetization

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Abstract

Health care is one of the key essential services to be traditionally impacted by financial turbulences. The Government of India announced the demonetization of INR 500 and INR 1000 currency notes in November 2016 to curb corruption and introduce economic transparency. The present commentary analyzes the impact of this economic reform on the availability/delivery of health-care services and also its transient effect on the general population availing such services during the first 2 weeks post demonetization. While print and electronic media indicated initial setback and displeasure with reference to delivery and access of health-care services, personal interaction with caregivers or patients suggested that there was no lasting adverse effect on health-care delivery. In fact, the enthusiasm for a cleaner economy meant for the greater good of the country prevailed among the general public and allowed them to bear these hardships. Our assessment suggests that demonetization and its consequential transition were viewed favorably. Financial and economic reforms initiated in the national interest can therefore be managed well with public support.

Keywords: Demonetization, digital economy, health-care services, note ban, public health

The Government of India announced the demonetization of INR 500 and INR 1000 currency notes with effect from the midnight of November 8, 2016, in an attempt to curb corruption and bring in economic transparency. The primary concern was the fake in circulation of these two currency notes which were usually used for illicit transactions and hoarding. New currency notes of INR 500 and INR 2000 were introduced. Persons stranded with the demonetized INR 500 and 1000 currency notes were allowed for conversion to newer currency after depositing them in bank accounts. Besides this, the older demonetized notes could be utilized for essential services, such as health care, travel, fuel etc. at designated places till a specific date. Newer easily accessible methods of cashless transactions were introduced by the government, with a vision toward a cashless digital economy that was more transparent. Where cash withdrawals and transactions were restricted, cashless modes such as demand drafts, cheques, online transactions, or debit cards had no such restrictions. Consequently, the initiative seemed to have realized its desired objective as the unaccounted illegal notes found difficulty returning to circulation.

Health care is one of the vulnerable essential services traditionally affected by financial and economic policy decisions.[1] Evidences suggest that adverse health situations demand urgent attention and at times need high-cost financial expenditure.[2,3] Against this backdrop, we assessed the effect of demonetization on health-care delivery, if any, in both public and private sectors. Simultaneously, we also attempted to explore the challenges during financial transactions while availing of health-care services, particularly during the first 2 weeks of post demonetization. The information was extracted from the print and electronic media pertaining to the effect of demonetization interfering with normal delivery of health-care services. This was complemented with eliciting experiences of few patients, physicians, and pharmacists through direct interviews.

As reported by the print and electronic media apparently there was a decline in the outpatients of around one-third in peripheral hospitals. The media cited that persons on daily wages had difficulty in obtaining money for their treatment. There were

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reports that several hospitals refused treatment in exchange for the demonetized INR 500 and INR 1000 currencies. Apparently, they misinterpreted government instructions that these were meant for public sector hospitals only. The state governments in these cases had to issue additional instructions for private hospitals to accept demonetized notes. Some hospitals accepted the demonetized notes perceiving that "hospital services" could be categorized as "essential services." There were sporadic reports of few unconfirmed causalities and delayed arrival of lifesaving drugs and commodities. According to the media, the nonresident Indian patients as well as their caregivers who had come to India for planned surgeries or interventions might have faced difficulties though transient. However, contrary to the media highlights of adverse health events attributable to financial duress, no such substantiating incidences were reported by the hospitals. There were no noted hindrances in transaction in pharmacies selling medicines. All most all pharmacists did accept old notes currencies.

The personal interviews of caregivers and health-care workers did not indicate any such adverse effect on the health-care delivery. Few patients in private hospitals did acknowledge the challenges with paying of bills or purchasing of medicines, but also agreed that these were manageable through cashless or online transactions. For those belonging to the poorer sections of the society, the note ban did not affect them much since lower denomination currency was mostly in use. Interestingly, the prevailing enthusiasm to usher in a clean economy allowed these persons to bear the hardships of demonetization. The whole initiative was perceived by patients, physicians, and pharmacist alike to be in the greater interest of better financial reforms and to allow for bridging economic disparity among masses.

Analysis of the country-level situation immediately after demonetization reflects that good coping mechanisms were also simultaneously in place the government and altogether, the demonetization and its consequential transition were viewed favorably. In addition to public support, the extended permission for transaction of demonetized currency notes in health-care institutions and the quick adaptation to cashless payments helped smooth tide. Throughout, banking structures demonstrated remarkable alacrity at transiting to cashless transactions. The small population coverage under health insurance and growing dominance of private health-care sector might have contributed to a cash-dependent health-related transaction culture in the country. Thus, in order to envisage universal health assurance, it is imperative to infuse the practice of cashless digital transactions in the health service sectors in the country.

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Conflicts of interest

There are no conflicts of interest.

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