A Democrat's view :

Growing Health Inequalities

Trends of Privatising Health Services in Andhra Pradesh

- *N. Purendra Prasad,* Professor at the department of Sociology, University of Hyderabad.

The economic reforms in the post-1990s significantly resulted in heightened inequality among different classes, castes and genders. Two recent reports substantiate the growing inequalities in India. One, India Exclusion Report 2016 which examined 25 years of India's economic liberalization indicated that as India's economy grew rapidly, the inequality between the rich and poor increased, the number of landless farmers increased and employment generation was lowest in 2015. The report further said, the high growth led to 12-fold increase in wealth of the richest 10% people since 2000 while for the poorest 10% the income jumped just three times and the reason was dismal new job creation. Second, a research paper "Indian Income Inequality 1922-2014: From British Raj to Billionaire Raj" by Thomas Piketty and Lucas Chancel indicated that the share of national income accruing to the top 1% income earners is not at its highest level since the creation of Indian Income Tax Act of 1922. The top 1% of earners captured less than 21% of total income in the late 1930s, before dropping to 6% in the early 1980s and rising to 22% today. Thus the authors concluded that income inequality in India is at its highest level since 1922.

Ill-health can be both a cause and a consequence of poverty has long been acknowledged and widely documented in the health literature. This inter-linkage has been reopened for discussion recently because there is an increasing recognition of the devastating effect of illnesses on the capacity of the labouring poor to work, and the high cost of treatment which is causing further impoverishment (Purendra Prasad 2018). In the recent poverty line debates in India, the question raised was how do these 35 crore people survive on Rs 32 per person per day in urban areas and Rs 26 per person per day in rural areas? Similarly, the national commission for enterprises in the unorganised sector (NCEUS) data indicated that 79% of workers in the unorganised sector lived on an income of less than Rs 20 a day (Yadav A, 2014). The pertinent question here, what do they do in contingencies of illness, old age and death? And how do they protect themselves from slipping into further poverty due to ill-health? This paper provides a discussion on the process how public health sector got weakened and privatization strengthened in India in the section one. Section two substantiates how the state of Andhra Pradesh carries forward the neo-liberal reforms in health sector thus resulting in increased health inequalities.

Section I

Government Health Sector :

Government health services have gradually declined, public investments have come down and health care costs for individual households have risen tremendously in the past few decades in India. In 2015, government expenditure on health was only 1.3 per cent of GDP (equivalent to $19 per capita) one of the lowest allocations of national income in the world, compared to 3 per cent in Thailand (equivalent to $164 per capita). Workforce shortages in government health sector are also substantial. As on 31 March, 2015, more than 8 per cent of 25,300 PHCs in the country were without a doctor, 38 per cent without a laboratory technician and 22 per cent had no pharmacist. Nearly 50 per cent of posts for female health assistants and 61 per cent for male health assistants remain vacant. In CHCs, the shortfall is huge in the departments of surgery (83 per cent), Obstetricians and gynecologists (76 per cent), physicians (83 per cent) and Pediatrician (82 per cent).

Several research studies indicated that government health care system grew weak by 1990s and deteriorated further in the post-2000, with the retreat of neo-liberal state. Despite growing health needs, the state did not increase its budgetary allocation rather it pushed the burden on to the individuals to pay for services. Also referral services, from primary to secondary and tertiary levels, became the weak links, and hospitals increasingly levied charges for items such as drugs and surgical supplies. As a result, the cost of health care particularly for the working poor continuously increased. These processes accelerated the flight to the private health care services and decline in the utilisation of public services.

Privatisation of Health Services:

Most hospitals in India were run either by the government or private charities and trusts till late 1970s.In the early 1980s, the state encouraged private nursing homes, small and medium hospitals to supplement the government health care. In 1991, there was a drastic cut in the central government budgetary allocation for healthcare, which favoured the establishment of private hospitals in India. Successive governments encouraged the growth of private sector, in various ways, such as releasing the prime building land at low rates, providing exemption from taxes and duties for importing drugs, high tech medical equipment, etc. In 2000, the liberalisation of foreign investment policy allowed Foreign Direct Investment (FDI) in hospitals and mobilisation of capital through other forms like American Depository Receipts (ADRs) and Global Depository Receipts (GDRs), up to 49 per cent, which stimulated the establishment of corporate hospitals. In 2002, the Insurance Regulatory Development Authority (IRDA) allowed Third-Party Administrators, which made medical insurance with cashless hospitalisation more attractive. In 2007, the de-tariffing of general insurance allowed the creation of customised medical insurance products, which further accelerated this growth and enhanced the acceptance of medical insurance in India.

Thus the economic reforms rapidly accelerated the expansion of private and corporate hospitals leading to commoditisation of health in India. This reflected a shift towards the growth of curative (tertiary) services with a strong commercial focus at the neglect of primary health services. Public-private partnership (PPP) became one of the most appropriate models advocated by the state in health sector. Subsequently, outsourcing of diagnostic, sanitary and other services, taking over hospital land for other purposes, non-renewal of land leases to charity hospitals, attempts to hand over primary health centres to private organizations etc, were some major reforms that occurred in the last two decades. These measures have been justified by the state as being reform measures to increase the viability of health care services.

Out-of-Pocket Expenditure:

Poor government spending on health resulted in inefficient and inadequate services, one of the reasons why people seek private health providers resulting in high out of pocket (OOP) expenses. The National Accounts and Statistics data indicate that private expenditure on health care in India is about Rs.2,750 billion of which 98 per cent is OOP spending. In addition, the public expenditure on health care is about Rs.600 billion. Together this adds up to a total health expenditure amounting to 5.7 per cent of GDP of which OOP expenses account for 78 per cent. Further, OOP spending on medicines is the single largest item of expenditure for households. About 30 million additional people fall into poverty each year as a result of this expenditure. Disaggregated data shows that the share of OOP spending on private sector is relatively higher in India than in most other developing countries.

Several research studies indicated that the cost of health care has become a major burden to the labouring poor, to the extent that seeking medical assistance to recover from illness or injuries is also forfeited.

Due to OOP expenditure and medical debts, it is widely reported that there is increased dependence on money lenders. As a result, more than 40 per cent of all patients admitted to hospitals borrow money or sell assets including inherited property and farmland, to cover expenses,

and 25 per cent of farmers are driven below the poverty line by the cost of their health care. Moneylenders charge exorbitant interest rates between 24 per cent and 60 per cent. One can imagine the catastrophic consequences on the labouring poor and society's productivity when these rates are applied to a major part of Rs. 10,000 crore (Rs.100 billion) being spent every year on hospitalisation of the poor through OOP expenditure.

Public-Private Partnerships (PPP):

If one closely scrutinizes planning commission (NITI AYOG) along with National Health Policy, 2017 documents, the vision of the neo liberal state is quite evident. It sees gains from improved management which could be obtained within a contracting framework. Hence, Indian state adopted contract-based models within a publicly set framework and expanded contractual relationships between public and private health sectors. In pursuit of this model, public health budgets have been redirected to subsidize social insurance for those sections of the population (BPL) judged to be unable to pay. Health insurance became one of the viable protection strategies of the state to address both growing cost of medical care and accessibility concerns though PPP.

This is the broad framework that helps us understand health policies and reforms taken up by Government of Andhra Pradesh which is elaborated in this paper.

The role of the state in the growth of the private sector is not a passive one, but that it has actively promoted the entry of markets in the health services. Several scholars who were critical of private interests in medical care, wrote extensively on the entrenched network of power relations, the rise of business lobbies and their influence on policy. Several scholars studied the manner in which capital consolidated itself in medical services through pharmaceutical, medical devices, insurance and provisioning corporations in the US (Starr 1982).

Much of the scholarship on the Indian private health sector has tended to focus independently on the pharmaceutical products, medical devices, medical education and the provisioning aspects of the private sector in health services. In reality, these sub-systems are not independent of one another but inter related. Markets have a significant presence in all the above and have penetrated the public sector through the introduction of public-private partnerships. This has resulted in the blurring of boundaries between the public and private sectors.

Several of these hospitals entered into partnerships with state governments and municipalities. The hospital industry is a capital intensive project. While the industry lobbied for public subsidies, this was clearly inadequate for sustaining these projects. The liberalisation of the insurance sector that allowed 100 percent Foreign Direct Investment (FDI) in health gave a further fillip to the hospital industry. Partnerships with insurance companies like Apollo-Munich and Max BUPA are some prominent examples. FDI came in the form of venture and private equity firms investing in these hospitals.1The International Finance Corporation (IFC), the private sector lending arm of the World Bank has granted loans to several hospital projects that include Max Healthcare, Rockland, Artemis, Apollo and Duncan Gleneagles. More recently international private equity firms like AIG, JP Morgan Stanley, Carlyle, Blackstone Group, Quantum and Blue Ridge have been investing in hospital projects (Lefebvre 2010).

The transformation of the private sector has led to the partnership of big capital, domestic and overseas, in financing, provisioning, medical education, pharmaceutical and medical devices in the health service system. Holistically, they represent and fulfill the idea of a medical industrial complex. The different actors have exerted power and influenced health policy over the last three decades. The extent of their influence is determined by the relative power that they are able to exercise depending on their size and access to capital across different levels of care. The power to influence policy is graded across the hierarchy with individual private practitioners having the least power, small and medium nursing homes exercising their power and influence through district and state level bodies of the Indian Medical Association to lobby for their interests. The corporate hospitals use the platforms of the Confederation of Indian Industry and Federation of India Chamber of Commerce to collectively articulate their needs and put forth vision documents. At all these levels the various actors are engaged with political parties at the local, state and central levels.

Section II

State government proposed to attach Chittoor Government hospital to Apollo Medical college for three years on a trial basis in order to develop the hospital. This is a clear indicator of privatizing the public hospitals in Andhra Pradesh. It is being projected by the government as its initiative to improve health services in public health sector. Corporate college managements have been creating as many hurdles for the government colleges in its development, more particularly PG seats. In the name of PPP, corporate have been trying to take over government hospitals, land and other resources, weaken medical colleges, and health services (diagnostic services, supply of equipment and medicines).

A.P Government is in the forefront in health sector reforms. The government wants to privatize health services at all levels and is actively advocating public-private partnership (PPP). Government has been making efforts to privatize for instance Guntur medical college and hospital, one of the oldest hospitals in A.P. The state's health budget does not exceed 1% of GDP. Within allocated resources, 25% of it is diverted towards *Arogya Raksha*, a community health insurance scheme as part of *NTR Vaidya Seva..* From the year 2008 onwards, *Aarogyasri* then and *Arogya Raksha* now has been a sacred cow for the corporate tertiary hospitals and private nursing homes in A.P. As public health sector is already starving for resources, there should be separate allocation for these health insurance schemes in the health budget.

The state's patronage to the private sector is sometimes justified on the ground that it would ease out pressure on the government hospitals. In reality, the private hospitals have effectively staked their claims over government resources through reimbursement of medical bills to the government employees. This is evident the way the corporate hospitals have been siphoning off huge amounts of public resources through inflated bills for treatment, employees medical insurance claims, income tax concessions by registering themselves as trusts and research centres etc. The Indian health care system is the most privatized in the world, with 83% of health care expenses being borne privately, mostly out of pocket, compared to 6% in developed countries such as UK. However, there is dismal situation in rural as well as urban India when one looks at the health indicators which are among the worst in the world today.

Conclusion:

The neo-liberal policies pursued by the Congress and TDP government in Andhra Pradesh has lead to corporatization of health care leading to heightened disparities between the rich and poor. The state should strengthen the public health system at primary, secondary and tertiary level by allocating more resources in the health budget and filling the vacant positions. Allocation to the health and allied sectors should be substantively increased in the government expenditure to at least 5% of GDP. The state should withdraw all financial incentives including the reimbursement schemes to the private health sector and route it through government's tertiary hospitals. Public policy towards the private sector should be confined to the regulation of quality and pricing of medical care. **(Endnotes)**

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