

# Globalisation and health: a blessing or a curse? Case review of the Indian health system

| Marianne Emler

Examination of the healthcare system in India and in particular the disparities in access to health services that exist between the rural poor and the urban rich and the impact that the increasing privatisation of health services is having on these populations. The article also considers the impact of medical tourism on the changing landscape of health services in the country and whether the benefits of this trickle-down to the poor.

Ever since the term globalisation was first coined by Harvard Business School professor Theodore Levitt (1) there have been heated debates between pro and anti-globalists about its impacts, particularly on the poor in low and middle income countries (2). These debates have stemmed, in particular, from those who argue that globalisation is not so much a sharing of global cultures, norms, ideologies and beliefs, but rather a westernisation of societies around the world (3) marked in particular by the adoption of neoliberal political and economic policies by states around the world. One area in which the potential impacts of globalisation are the most pronounced is in the field of health. Indeed, increased interactions and increased knowledge-sharing have allowed huge milestones to be reached, notably the global eradication of Smallpox in 1979, resulting from a global effort spearheaded by the World Health Organisation; itself a product of globalisation (4). In response to discussions on the benefits and shortfalls of globalisation, scholars such as Giovanni Cornia have put forward that idea that “if properly managed, globalisation can lead to important health gains” (5).

This article will consider this statement by examining the case of India and changes in its health care system that have been driven by globalisation. Firstly, it will consider the evolution of the health care system in India, following the country’s independence in 1947, to determine what motivated these changes. Following this, it shall examine the impact that these changes have had on Indians’ access to care. Finally it shall consider the rising importance of medical tourism for India and the role this is playing in shaping the country’s health care system.

Upon gaining independence in 1947, India had many reasons to celebrate. The state of its population’s health and its health system, however, were not amongst them. Indeed, for a long portion of their rule in India, the British had focussed

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Centre for Global Health Research,  
The Usher Institute, University of  
Edinburgh, Edinburgh, UK

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almost exclusively on the health of their colonial population and their army in the country. When the colonial administration later began to take interest in the health of its Indian subjects, it focussed mainly on improving sanitation in order to limit the spread of water borne diseases, such as cholera following the creation in 1868 of the country's Cholera Committee (6). However, this was done with very limited input from Indians and thus the system left behind was plagued by poor governance and inadequate planning (7). This inadequate management continued after independence as the government took insufficient actions to increase funding for health care in the country (8), not recognising the important link between health and development. This link is illustrated by the fact that health is one of three factors contributing to a country's score in the Human Development Index. The absence of strong political support and funding meant that the public health sector, despite making up around 90 per cent of the health care sector in India at independence, was rapidly overshadowed by the private sector (9). The private sector had already begun to grow prior to independence and was often the only available option in certain parts of the country (8).

Indeed in the 1980s faced with the declining quality of the care it could provide in its public hospitals, the Indian government began to focus on the privatisation of hospitals (10). This push was driven by several measures such as decentralisation, user fees and state withdrawal from public services, measures put forward by the World Bank's 1987 World Development Report (WDR). This report called for states to divest themselves from so-called "state-owned enterprises" such as hospitals in order for these to increase their efficiency and profitability (11). This was despite the fact that some scholars claimed that privatisation was not suited to the health care sector in developing countries such as India, as these lack the necessary conditions for it, namely: "high competition among providers, information availability and transparency, and management capacity" (12). In addition to this it had been observed in some developed countries such as the United Kingdom (UK) that the privatisation of health services did not necessarily increase their efficiency. Indeed, the outsourcing of some National Health Services (NHS) in the UK has actually doubled its administrative and management overhead costs in proportion to its overall costs as a result of its increased monitoring and implementation costs (12). Irrespective of this, in the early 1980s the Indian government began to decrease its grants to states, with these dropping from 19.9 per cent to 3.3 per cent in the period from 1984 to 1993 (12). This decrease in state funds for health care was to be countered, in part, by the introduction of user fees in Indian hospitals.

The introduction of user fees as a substitute for state funding was also a suggestion put forward in the 1987 WDR (11) as well as in the 1987 Bamako Initiative (13). The positive case made for these user fees is that:

"i) payments for services will discourage frivolous use of health facilities, ii) by making payments consumers will become conscious of quality and will demand it and iii) the greater availability of funds through user fees at the point of service will increase both the availability and quality of services" (12).

Indeed, studies have been conducted examining the price elasticity of demand for health care services in India and these have concluded that the demand for these services is unlikely to be altered by an increase in the prices charged for them (14). However, while this may well be the case, the absence of a change in the demand for health services does not imply that the ability to access these services will remain unchanged. If people do not have other viable alternatives they will have to pay these user fees, or forego any medical care (10). A point can also be made that by increasing the efficiency with which health care services are used, and subsequently by decreasing waiting time, user fees are able to decrease the economic losses arising from the revenue that a patient is foregoing by waiting for treatment (14). Nevertheless, user charges have been heavily criticised for preventing the poor from accessing health services, but also exacerbating the inequality gap between the rich and poor.

The accusation that globalisation is contributing to widening inequalities between populations nationally and internationally is a commonly heard rhetoric, even within developed

countries (15). In the case of India and its health care system it would seem that sadly critics of globalisation and liberalisation are right. Indeed, those Indians who still experience significant barriers to accessing health care are overwhelmingly found to be the rural poor. According to the World Bank, in 2007, 70 per cent of the Indian population lived in rural areas (16). However, health care infrastructure statistics for that same year highlight the fact that only 20 per cent of the country's hospital beds were located in rural areas (17). While this statistic takes into account both public and private hospital facilities, private sector hospitals, clinics and dispensaries now make up a significantly larger share of rural facilities compared to public hospitals (17). Overall, however, even the number of private facilities remains too low. Indeed, in 2007, 12 per cent of those living in rural areas who did not seek care for a medical ailment stated a lack of access as their main inhibitor, irrespective of their ability to fund their care (17).

Alongside a lack of access, the imposition of user fees has often been cited as a barrier to accessing health services, suggesting that overall they are detrimental to a country's health system despite the economic rationale for implementing them. The effect that such fees have had on those seeking care both in rural and urban areas has been profound; widening inequality and pushing many into poverty. A 2014 review of access to health care in India published in *The Lancet* found that in 2004 around 25 per cent of the Indian population were unable to access health care. Of those that did, in 2010 60 million Indians fell below the poverty line as a result of out-of-pocket spending for health care of which user fees represent a significant proportion (18). The share of out-of-pocket spending as a proportion of total spending on health care has been increasing since independence and it now stands at roughly 80 per cent of total health expenditure (8). This out-of-pocket expenditure has also increased in absolute terms so that it is now one of the main causes of direct debt and poverty (8). Out-of-pocket expenses are largely made up of user fees, drug prices, and travel costs, as well as the economic loss incurred from not working during this time. These economic losses also disproportionately affect those living in rural areas as their household income lost per treated person for non-hospitalisation cases stands at around Rs135 in rural areas, against Rs96 in urban areas (17). For at least 40 per cent of patients in both urban and rural areas, their lack of insurance means that they will be forced to borrow money or sell assets of theirs such as farmland in order to cover these expenses (9). Furthermore, the economic benefit that user fees bring to hospital budgets can be called into question. Indeed a review of their use in multiple Indian states found that in general they account for less than 2 per cent of hospitals' total budgets (10). Therefore it does not seem that such a small proportion hospitals' budgets justifies the implementation of user fees, considering the negative impact that these have on the poor's access to medical care.

Alongside its decision to decrease government expenditure on health care, the Indian government introduced measures to encourage the expansion private medical facilities in the country as part of its commitment to the World Trade Organization's General Agreement on Trade and Services (19). These measures include: allocations, favourable taxation, decreased import levies and personnel training (20). However, following the recommendations of the 1993 WDR that "government policy has a role in providing information and incentives to improve allocation of resources by the private sector" (21), the Indian government attached certain conditionalities to its support. Chief amongst these was the requirement that private hospitals set aside beds in which they would treat the poor for free. Problematically though, it has been left to the discretion of individual hospitals to define who they consider to be poor and therefore eligible for free treatment (22), leaving the system open to abuse. As a result, the commitment of hospitals to provide free care to the poor has not always been carried out. Indeed, it has been revealed that 10 of the 37 hospitals granted access to subsidised land by the government were not providing any free treatment to the poor (23). In response to this the Indian Supreme Court ruled in 2011 that hospitals built on subsidised government land would be required to "reserve 25 per cent of their out-patient department capacity and 10 per cent of bed at the indoor level for free treatment of the poor" (23). However, this ruling remains shaky as further rulings in 2014, have swung in favour of the private hospitals

and them not being obliged to treat the poor (24). The lack of clear governance on this issue probably arises because of the conflicting nature of private hospitals and the difficulties in regulating a highly heterogeneous and unregulated sector. While these may not be helping to improve the health of the poor in India, they are helping to draw in foreign direct investment (FDI), retain doctors and solidify the country's new expanding industry: medical tourism.

Up until this point, this article has depicted the move to privatise the Indian health sector as having had a largely negative impact on the country. However, many benefits have been drawn from the focus on private health services. Chief amongst these is development of the medical tourism industry. Medical tourism can be defined as travel outside of one's country for the purpose of seeking medical attention (25). Over the past decade, the medical tourism business has grown at a phenomenal rate. In the period between 2011 and 2014 alone, the value of this industry more than doubled from USD1.9 billion to USD3.9 billion (26). India has been extremely successful in capitalising on this booming industry as a result of pre-existing conditions and government efforts to promote this industry. The availability of well-trained, English speaking medical staff, investments in new state of the art medical facilities, and the attractive pricing of medical interventions have helped India position itself as an important player in this global industry (20). The government has played an active role in supporting the creation of facilities geared towards medical tourists as expressed in its 2002 National Health Policy where it announced that:

“to capitalise on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as ‘deemed exports’ and will be made eligible for all fiscal incentives extended to export earnings.” (27).”

In addition, the government also created new categories of visas aimed specifically at those wishing to travel to India for medical services (M visa) and their accompanying spouses (MX visa) (27).

Medical tourism has the potential to grow to represent 25 per cent of India's gross domestic product (28). This huge growth potential is helping to attract significant FDI, particularly from non-resident Indians. In fact, from 1991 to 1997 USD100 million were invested into the Indian health care system through FDI (12). The increased investments in medical infrastructure, which is providing doctors with state of the art facilities is also having the beneficial effect of helping India retain medical personnel. This is countering the medical brain drain the country had previously been experiencing and even helping to lure some doctors back in a “reverse brain-drain” (*Brain regain*, 2014). However, the former brain-drain is being replaced by an internal brain-drain as doctors seek to leave under-funded public facilities and move to the private sector, particularly to those hospitals which seek to attract medical tourists (20). These facilities will be able to offer doctors higher salaries and as they are mostly located in urban areas, physicians often have increased opportunities for specialisation (29). Thus, medical tourism seems likely to contribute to widening the unequal distribution of the health care system in India as the facilities targeting medical tourists will have benefitted from land allocations and tax concessions from the Indian government without helping to improve the access of the country's poor to health care services.

The redistributive rationale behind India's health care policy based on charging those that can afford it and, parallel to this, providing free medical care to the poor is commendable. This system is not unique and has been central to the Cuban health system for decades (27). However, the inadequate enforcement and governance of the health care system has created a two-tiered system which caters to the needs of the wealthy whilst preventing the poor from accessing medical care (20). This sentiment was summed up in a 2005 report by the Indian government's public accounts committee which declared that: “what started with a grand idea of benefitting the poor turned out to be a hunting ground for the rich in the garb of public charitable institutions” (30).

Overall we have seen that the liberalisation of the health care industry in India has created a system running at two different speeds. While we should not ignore the huge strides India has made in improving the health of its population since 1947, as illustrated by the doubling of its life expectancy (31), much remains to be done. The weakening of the public health care sector since independence, coupled with the introduction of user fees has made it difficult for the country's poor to access health care services when these are available in their vicinity. A central theme to the issues discussed in this article are the lack of central governance and monitoring. The absence of these has enabled private hospitals to avoid having to treat the poor for free, instead focusing on attracting fee paying patients and medical tourists. However, the fragmentation and the lack of proper regulation of private hospitals by the government or by an association like the Indian Medical Association (12, 32) has proven to be a hindrance and may be preventing India from positioning itself as a world leader in medical tourism (26). In conclusion therefore it seems that whilst India's public health policies do not fail to recognise the need to ensure the accessibility of healthcare services for the poor, more must be done to ensure that these policies are properly implemented and enforced. This will ensure that the development of the medical tourism industry does not conflict with every Indian's right to "the highest attainable standard of care [...] without distinction of race, religion, political belief, economic or social condition." (33).

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