COMMERCIALIZATION OF HEALTH SERVICES

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***Abstract:** India's stance has gradually shifted from welfare state to that of capitalist economy owing to winds of privatization and liberalization. An attempt is made in this paper, how the healthcare sector has responded to these trends of neoliberal capitalism. The trends seem to suggest that healthcare sector, once primarily served by public and charitable hospitals and private clinics and viewed as service oriented institutions, have been commercialized to the extent of assuming the structures and functioning as streamlined business with corporate culture on par with any other industry, trade and commerce with an emphasis on economic performance and economic efficiency to maximize returns for the corporate stakeholders. With rise in lifestyle diseases and incidence of epidemics and pandemics, the sphere of healthcare, which also includes diagnostics, medical insurance and other auxiliary services, has come to be the dominant player in the service sector in India, still growing at an exponential rate. This trend toward corporatism in healthcare is further accentuated by the rise in medical tourism, of which India is the most sought-after destination. Healthcare industry in India now-a-days is dominated by the listed companies having chains of hospitals in every area of medical specialty, managed professionally like streamlined corporate bureaucratic entities, devoid of ethos and ethics of medical profession (service) which is inherently inimical to delivery of affordable and inclusive healthcare. The paper, based on the survey of reports and factual accounts concludes that healthcare in India, which was once spearheaded by socially embedded institutions guided by socialist and philanthropic ethos has come to assume the structure of an aggressive and competitive industry, profiteering from sickness, owing to the winds of commercialization and corporatism sweeping through this sector of immense public interest.*

***Key Words:** Healthcare, Corporatism, Commercialization, Profiteering, Neo-liberalism*

Introduction

Neoliberal reforms lead to deep changes in healthcare systems around the world, on account of their emphasis on free market rather than the right to health. People with disabilities can be particularly disadvantaged by such reforms, due to their increased

healthcare needs and lower socioeconomic status. Pillars of neoliberalism are "privatization of the public sphere, deregulation of the corporate sector, the lowering of income and corporate taxes and also cuts to public spending. Neoliberalism has restructured healthcare delivery into a commodity to be purchased rather than natural born right. Medical neoliberalism is characterized by a commodification of health that transforms individuals from patients to consumers. Patients as consumers have embraced the neoliberal logics of health care so that they too see illness in reductionist terms and seek pharmaceuticals as targeted magic bullets. This orientation toward health and medicine has been referred to as the pharmaceuticalization of health care in which the conditions of health and illness are ever more cast in terms of products that can be purchased by health-engaged consumers.

Health is considered a fundamental human right and an important human development indicator. Good health status not only increases labour productivity but also helps in the overall development of the nation. The promotion and protection of health of the people is essential for sustained economic and social development and for achieving better quality of life. The attainment of better health levels is considered as one of the important worldwide social goals whose realization requires the action of many other social and economic sectors. In ancient India the gods were often held responsible for one's good health and making offerings to them, reading out spells or wearing amulets was a common way to make sure illness stayed far away. But there soon developed a whole body of professionals who believed they could help where the gods could not. Causes, symptoms and remedies were all examined and experimented with and even philosophers got in on the act by creating theories of what exactly made up the human body and why an imbalance might occur.

Indian medicine has a long history. Our country began with a glorious tradition of public health, as seen in the references to the descriptions of the Indus valley civilization which mention “Arogya” as reflecting “holistic well-being.” Its earliest concepts are set out in the sacred writings called the Vedas. Later the system of medicine

called Ayurveda was received by a certain Dhanvantari from the god Brahma, and Dhanvantari was deified as the god of medicine. The physicians collected and prepared their own vegetable drugs. In diagnosis, detailed questions are asked about the history of the illness and about such things as the patient’s taste, smell, and dreams. Conclusions are drawn from the quality of the voice, and note is made of the colour of the face and of the tongue. The most important part of the investigation, however, is the examination of the pulse.

However, in India health care system falls into two major sectors; the private sector that mostly provides curative services and the government sector that provides publicly financed and managed promotive, preventive and curative health services.

Public Health Sector

The public health sector consists of the central government, state government, municipal and local level bodies. Health being a state responsibility, the central government contributes in a substantial manner through grants and centrally sponsored health programs/schemes. There are other ministries and departments of the government such as defence, railways, police, ports and mines which have their own health services institutions for their personnel. For the organized sector employees’ (public and private) provision for health services is available through the Employees’ State Insurance Scheme (ESI).

Private Health Sector

Like all other sectors in the economy, the private players have sizeable presence in the health sector also. They comprise a wide array of institutions with varying degrees of sophistication in terms of services and qualified personnel. The private health care delivery system in India is made up of two major subsystems like individual practitioners and institutions comprising of nursing homes and hospitals. The majority of the individual practitioners in the country, in both the modern and traditional systems of medicine, are in the private sector. They are often referred to as Private Medical

Practitioners. The hospitals in private sector of India comprise Profit and Corporate hospitals and nursing homes.

In recent days, the private sector in India has been playing a dominant role in all the submarkets—medical education and training, medical technology and diagnostics, pharmaceutical manufacture and sale, hospital construction and ancillary services and finally, the provisioning of medical care or services. Since the 1990s, owing to liberalization-privatisation measures, many Non Resident Indians (NRIs) and industrial/pharmaceutical companies have set up super-specialty hospitals to attract India's rich and medical tourists (Appannaiah et al., 2013).

In recent times, while the public health sector has not been so successful in delivering the health needs of the people, private sector has grown by leaps and bounds. Today, more than 70 percent of the hospitals in India are run by the private sector and they control nearly two-fifth of beds available in the hospitals. Nearly 60 percent of dispensaries are run by the same private sector. They provide healthcare for 80 percent of outpatients and 46 percent of inpatients. The private medical sector in India accounts for 61 percent to 86 percent of the total medical expenditure and 73 percent of allopathic doctors (Phadke, 1993).

Such a private health care system in India operates at three levels:

• The tertiary level includes large specialist and super- specialty hospitals promoted by big business groups and managed as corporate entities. It comprises only 1 to 2 percent of the beds in private sector institutions.

• The secondary level consists of small and large nursing homes and hospitals owned by physician entrepreneurs. They usually provide outpatient and inpatient services. Majority of these are small institutions with 85 percent having less than 25 beds. The secondary and tertiary hospitals are largely skewed towards urban areas and developed states (GOI, 2006).

• Finally, at the primary level private sector is operating largely with informal practitioners. This number is high in both urban and rural areas. A vast majority of PMPs in the country are unqualified and lack especially those working in rural areas (Rao, 2012).

At the time of Independence, the health sector was dominated by public sector and the private health sector accounted for only 5 to 10 percent of the total patient care. Later on, the convergence of decreasing public investment, emergence of non communicable diseases, the poor quality of care, an effective demand and the liberalization-privatization process since the 1990s enabled the entry of private sector in health care delivery system. Further, the government policies such as National Health Policy (2002), NRHM (2005) framed in the background of global health commitments and the indirect support from the Government of India in the form of financial concessions, namely, subsidized sale of land, reduction in import duties, tax concessions for medical research, low interest loans and treatment cost reimbursement for treating state and central governments employees have also triggered the growth of private sector in the country's health sector (Duggal. R, 2000). This has made health sector a blue-chip industry, by attracting individuals as well as institutional investment.

Considering that the private sector is the major player in healthcare service delivery, there have been many programs aiming to harness private expertise to provide public healthcare services. The latest is the new nationwide scheme proposed which accredits private providers to deliver services reimbursable by the Government. In an ideal world, this should result in the improvement of coverage levels, but does it represent a transfer of responsibility and an acknowledgment of the deficiencies of the public health system?

The scope of profit has attracted several Non-Residence Indians (NRIs) and industrial/pharma companies to set up various super-speciality hospitals with the capacity to provide world class care at a fraction of the cost available in the West. All this has

provided enormous potential for India to become a hub for medical tourism. But, the focus of the private sector is maximization of profit and this hardly concerned with public health goals. Dominance of private institutions is noticed in the field of treating both inpatients and out-patients at all-India level. Consequently their growth in health sector has resulted:

- The raise of overall cost of health care in the country making the poor and vulnerable section of the society non-accessible and un-affordable to high quality health care services.
- Generate pressure for increased budgetary allocations to government hospitals to stay competitive.
- The unhealthy competition between private providers leading to compromise with quality of care.
- The creation of huge disparity in health facility distribution and health service utilisation between rural and urban areas. This in turn has widened the gap in health indicators between rural and urban areas.

Today, sustained propaganda by the votaries of neoliberalism seeks to promote a vision of the human body and of health which is rooted in the principle that all human activities can be converted into market-based contractual relations of a commercial nature. The process of commodification extends beyond healthcare to include other social aspects which determine health. By such a strategy, working at the cultural and ideological planes, institutional processes and healthcare practices are being transformed. Consequently, new practices and concepts that help convert health and healthcare into a commodity, have taken shape. These include, for example, ‘standardization’ of medical interventions, through hospital ‘reform’ policies, ‘pay-as-you-go’ principle, etc. and promotion of the notion that ill health and disease are merely individual conditions and influenced only by medical factors. These are transforming care into a commercial relationship between doctors and patients.

The covid-19 pandemic has exposed the longstanding structural drivers of health inequities, such as precarious and adverse working conditions, growing economic disparities, and anti-democratic political processes and institutions. These important determinants of health have interlinked with class, ethnicity, gender, education level, and other factors during covid-19 to exacerbate existing social vulnerabilities in society. As a result of deficient infrastructure, deficient manpower, unmanageable patient load, equivocal quality of services, high out of pocket expenditure and poor conditions of our government hospitals the patients have faced lot of problems and lost their lives. During that time the private corporate hospitals have taken advantage of the pandemic. The fear of the people is being exploited. High fees charged by these hospitals should be dealt with severely by the government. The only objective of the hospitals even during such a pandemic was profit, which is why the public health system needs more attention. The room rent varied between Rs 5,000 and Rs 12,000 while cost of PPE was Rs 10,000 per day. The fee for COVID-19 confirmation test also varied from Rs 6,000 to Rs 8,000 (even though the government had fixed a cap of Rs 4,500 for private labs until recently).

Since India faced the onslaught of SAPs and ‘liberalization’ in the 1990s, neoliberal trends have continued to inform social policies in the country, leading to unregulated expansion of the for-profit private sector (Sengupta A, Mukhopadhyay I, Weerasinghe M, et al.2005, Rao M 2010). In 2004, the government sought to undo the negative effects of the SAPs, initiated the National Rural Health Mission (NRHM), and increased health budgets. However, simultaneously they opened opportunities for outsourcing government health services and facilities, and increased subsidies to the private sector (Mackintosh M, Channon A, Karan A, et al. W 2016).

Privatization of healthcare services was cemented in India’s health policy through the launch of the Publicly-Funded Health Insurance (PFHI) scheme, the Rashtriya Swasthya Bima Yojana (RSBY) in 2007 that brought in the for profit sector to provide publicly-funded services. Despite evidence of inequity in utilization, ‘cherry picking’,

and the lack of financial risk protection in the private sector (Prinja S, Chauhan AS, Karan A, et al. 2017, Ranjan A, Dixit P, Mukhopadhyay I, et al. 2018), PFHI was expanded further in 2018 through the Pradhan Mantri Jan Arogya Yojana (PMJAY) under the right-wing government's Ayushman Bharat initiative (Chatterjee P. 2018). Simultaneous reductions in budgets for the government health system and public health programmes have been seen over the years. This neglect of the public health system has led to gaps and weaknesses in service provision, which was then used as a rationale to privatise or outsource these services. However, these initiatives faced similar problems that they were supposed to address, e.g. attrition of health personnel (Nandi S 2018).

The commodification of health care is destroying the long-revered doctor-patient relationship. Doctors who joined this once-noble profession hoping to make a difference in their patients' lives are disillusioned by endless paperwork, bureaucracy, and arguments with insurance companies that steal time away from their patients. Doctors rarely mind working hard when the work is meaningful. But filling out forms and scrolling through computer screens instead of focusing on their patients doesn't contribute to a sense of purpose — it contributes to burnout. Burned out doctors not only lose compassion for their patients, but they make mistakes.

It is also sad that most patients are unable to afford comprehensive healthcare services – they are available to only those who can pay. This leads to the creation of a multi-tiered health system, which caters selectively to patients based on their capacity to pay cost of treatment. Patients today have lower expectations of their doctors, having never experienced a strong bond forged through generations of caregiving. Unless they need a prescription, patients seek out the help of their physician only after exhausting their own resources and well-intended advice from friends. When they do go to a doctor, it's often at an urgent care or with someone other than their primary physician. The inability of patients to receive care from their own doctor when needed results in fragmented care.

The doctor-patient relationship has become complicated in India. During training, emotional attachment to patients is discouraged in part to protect doctors when patients inevitably become ill or die. Separation is also meant to promote objectivity and better patient care. The erosion of the doctor-patient relationship could be dismissed as the price of progress as healthcare facilities become more technologically savvy and rural patients are able to access doctors through telehealth. The potential health consequences of the disconnect, though, can't be ignored. Exasperated by escalating bills and rushed appointments, patients turn away from their doctors and toward the internet — and the distance widens. Patients with chronic illnesses and high deductibles often only seek out their doctor when they're sick enough to need hospitalization. Victims of abuse won't disclose trauma to a doctor staring at a computer screen.

To say a doctor's words of encouragement can improve the efficacy of drugs. Good rapport between doctor and patient isn't just an added bonus, it's an essential component of healing. This is something doctors have intuitively known for decades. There are changes that can be made on a national level to help reverse the trend of disconnect between doctor and patient. This is the result of medical corporatism. It is time for a policy on health human power to be articulated, which must outline measures to ensure that the last Indian is taken care of by a sensitive, trained, and competent healthcare worker.

Conclusion

Public health needs to be based on the principles of solidarity and separated from relations based on the market. Citizens must have the right to collectively define the objectives, priorities and needs of their health system. Further, health systems and all involved actors should be bound by clear and democratically defined objectives which foster the common good. Experiences show that commercial interests run contrary to public health interests and more generally to the right to health. This is true at a practical level as regards efficient management of a health system in relation to the fair allocation

of financial resources, and also at a philosophical, cultural and political level given how dehumanizing the commercial approach to health is.

Doctors must find a way to reconnect with the compassion that attracted them to the healing profession in the first place — before they became defeated by the business of medicine. We can smile, make eye contact and be curious about our patients. These small acts may be more important than wielding the stethoscope or prescription pad. Patients should understand that while the credentials of their doctors are important, their connection with them is even more critical. They should seek out doctors whose opinion they trust and who listen and hear what they say. Together, doctors and patients can work to build the doctor-patient team again. It is an essential and urgent to reject the commercial and mercantile logic being pursued in most regions as regards the health sector. It is no mere coincidence that several struggles across the world are making this demand. As we get ready to face a future which is full of possibility and uncertainty in equal measure, let us recognize these and other challenges and prepare to meet them, remembering that the fight against ill health is the fight against all that is harmful to humanity.

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