Plenary Speech ISSC December 2016:

Health for all Indians: a goal afar?

R Srivatsan

INTRODUCTION

This paper is a broad landscape of illness and healthcare in India developing over the past 60+ years. It is my picture, with its limitations, from a political theory perspective, evolved over study and intervention in different discussions of health and healthcare over the past 12 years. During this period, it has been my endeavor to speak political theory to doctors and health activists in a language they accept as legitimate in the health discourse while being conceptually true to my field. On being given this challenge to do this broad sketch of health and quality of life in India for the Social Science Congress 2016, I have tried speak medicine to social scientists in a way that practitioners and activists of healthcare would find acceptable. Let me record my gratitude to the Indian Association of Social Scientists for this opportunity.

This essay is divided into 7 parts:

1. Health indices and performance
2. Public health systems
3. Medical education
4. Policy debates
5. Community health/mission hospitals/quasi government initiatives/activism
6. Privatization, corporatization insurance and capital
7. Conclusion: where is healthcare headed?

1. LOOKING AT HEALTH INDICES AND PERFORMANCE

At the level of the nation state, the parameters used to determine the health of a population (in pursuit of health policy and administration), are based on international indices of human development. The most important among these indices are *maternal and child mortality.* These are followed by immunization statistics, life expectancy, infectious disease and chronic disease mortality, etc.

Government's focus on mother and child

Mortality – what it indicates

Child mortality (under 5 years) is the primary indicator of the population's health and ability to reproduce. Reduction of child mortality is fourth among the Millennium Development Goals (MDGs).[1] Maternal mortality is the fifth MDG, the sharpest indicator of physiological, psychological and social

health of women of child bearing age. On the one hand, death of the mother during childbirth or within 5 years after indicates extremely poor public health systems, hunger and social discrimination against women and on the other maternal ill-health raises child mortality, morbidity and affects the population's survival in the long run.

The child mortality rate has fallen from around 126 deaths per 1000 births in 1990 to about 53 as of 2015. The maternal mortality rate has fallen from 560 deaths per 100,000 live births in 1990 to about 190 in 2015. This fall, while short of the MDGs, results from focused Indian public health programmes (discussion of this a bit later). In addition, fewer seriously ill children brought into secondary hospitals die since reasonably competent emergency care is available.[2]

The reduction of maternal and child mortality is an absolute good in itself. However, these targeted indices can no longer simplistically indicate overall development in the status of women, children and the population as a whole (more on this in the following section).

Some notes on childhood undernutrition and its implications

While the mortality rates have improved, the same is not true of childhood undernutrition.[3] Nutritional deficit and imbalances may result in a) an underweight baby (for a given age) and increased probability of the child's death on the one hand, and/or b) stunting (low height for a given age) with consequences throughout the life of the individual on the other.

Stunting, which measures chronic food deficit, is a complex sign of poor overall physiological development, including that of the brain and other organs of the body; its lasting effects may be diabetes, cardiovascular disease and general vulnerability to illness throughout life.[4]

Policy wisdom among many institutions worldwide is that the 1000 days from conception to the age of 2 years is absolutely critical for the development of the child. Most of the important international health institutions including the UNICEF have established collaborative programmes to provide nutritional, educational and medical support during the critical 1000 day window.

In India, the Integrated Child Development Services (ICDS) scheme, which is, among other things designed to provide food and nutritional support to mothers and children up to six years of age, has been criticized for being less than successful in the nutritional dimension of the programme.

According to the UNICEF Website:

> In India 20 per cent of children under five years of age suffer from wasting [low weight for height] due to acute undernutrition. More than one third of the world's children who are wasted live in India […] Forty three per cent of Indian children under five years are underweight and 48 per cent (i.e. 61 million children) are stunted due to chronic undernutrition, India accounts for more than 3 out of every 10 stunted children in the world.[5]

The recent debate on childhood undernutrition[6]

Thus there is a paradox: while child mortality reduces, childhood undernutrition remains as high as in sub-Saharan Africa – so do the indicators show India is developing?

In a controversial paper written in 2013,[7] the economist Arvind Panagariya argued against received policy wisdom and nutrition science, proposing that the genetic difference between Indian and African children was probably the main cause of the anomaly, and that stunting and underweight figures therefore did not indicate poor development. The suggestion was that they may be ignored, and the implication that India need not spend so much money on its child nutrition programmes. Arun Gupta et.al., responded[8] arguing that that among many factors leading to child survival, was better emergency short term medical care to ensure sick children don't die. However, this didn't mean that the long term nutritional programmes were running well. Rather than deploying creative statistics to justify cutting child nutrition, better ensure effective programme implementation to eliminate childhood malnutrition in India.

Thus the improving development indices of child and maternal mortality are contradicted by indices of the persistent prevalence of stunting as an extensive sign of chronic hunger in India.

Is the adult population 'healthy'?

The general population disease indices are broadly classified into two types: a) communicable diseases (those that are infectious or communicable); b) non-communicable or chronic diseases (those that last for extended periods). The two in theory are related to the developmental process of populations in Omran's influential theory of epidemiological transition.[9] Put very crudely, this theory states that in early development, human populations suffer infectious diseases (traditionally tuberculosis, pneumonia, typhoid, cholera, malaria, polio, etc,) and die early because of low standards of living, inadequate food, clothing, shelter and sanitation. As populations develops, life becomes easier—the infectious disease mortality goes down, life spans increase and human beings suffer non-communicable diseases (diabetes, cardiovascular diseases, etc.) later in life.

However, the patterns in India are not so straightforward.

New and old avatars of communicable diseases

Even though communicable diseases have reduced in absolute terms, they constitute 30% of the disease burden in India.[10] E.g., while HIV and leprosy seem in check, tuberculosis, malaria and kalaazar are not. All these diseases are under what are called vertical control or eradication programmes. However, there are also outbreaks of infectious diseases that are not under vertical control programmes e.g., hepatitis B.

In addition, the plague in Surat (1994), Simla (2002) and Uttarakhand (2004), dengue, chikungunya in Hyderabad, Nalgonda, Rayalaseema (2005) and Delhi (2016), Crimean-Congo hemorrhagic fever in Gujarat (2011), and H1N1 flu in Hyderabad (2011), all indicate persisting infectious disease burdens with a changing epidemiological profile.[11]

For different reasons infectious disease burdens in India do not reduce as predicted by one arm of the Omran thesis. These include a) poor execution of vertical control programmes; b) infectious diseases that fall outside programmes; c) difficulty in accessing healthcare; d) poor life conditions (food, sanitation, clothing, shelter); e) new infectious diseases, and f) last but not least, the mutation, survival and spread of disease carriers as autonomous life forms (e.g., MDR and XDR tuberculosis).

Non-communicable diseases – among rich and poor

The global big four of non-communicable diseases according to the medical canon are cardiovascular diseases (heart attack, stroke, and problems related to high blood pressure), cancers, respiratory diseases and diabetes.[12] The WHO states these can be controlled by addressing what are called modifiable risk factors: increasing exercise, reducing smoking, alcohol and salt consumption. Unaddressed they may lead to obesity, high blood pressure, high blood glucose and high levels of fat in the blood that cause these diseases.

Statistical trends show increasing prevalence of diabetes, hypertension and heart disease among the urban, rural and other marginalized populations in India.[13] 60% of all medically certified deaths occur due to non-communicable diseases, and 45% of these are due to cardiovascular diseases. The prevalence of hypertension among the rural population is 22% of the adult population, while for diabetes it is of the order of 7-8% .[14]

Veena Shatrugna has argued[15] that the most prevalent causative factor of all and an ailment of its own importance that detracts from the quality of life is widespread adult undernutrition. This has been estimated to prevail among nearly 35% of the population in 2013.[16]

It is important to note that one of the causes of non-communicable diseases is poor organ development due to nutritional insult to fetus and in early stages of childhood, discussed in the earlier section on childhood undernutrition and its consequences.[17] Therefore, while childhood mortality has gone down, the persistent childhood undernutrition is one of the distal causes of adult morbidity and mortality.

Thus the other arm in Omran's model of the epidemiological transition, consisting of non-communicable diseases, shows the expected rise in prevalence. However, the normal opinion that the prevalence of chronic diseases rises in those who live an easier life under better conditions is questionable. Studies show distinct profiles of heart disease among the rich and the poor, with different patterns of causation and different prognoses. There is a heart disease of the rich and a heart disease of the poor.[18]

The poor in India are subject to a double burden of both communicable and non communicable diseases with higher rates of morbidity and mortality.

New medical thinking on non-communicable diseases[19]

Recent discussion questions the big four of cardiovascular diseases, cancers, respiratory diseases and diabetes as the last word in non-communicable diseases. Hospitals and clinical practice see a wide variety of chronic afflictions, sometimes having catastrophic or crippling consequences, but mostly having debilitating effects on patients and preventing them from living a reasonable and productive life free of pain and exhaustion. There are a variety of such conditions (e.g., gastrointestinal illnesses, asthma, chronic skin problems, sickle cell disease, congenital deformity, backache, and chronic consequences of accidental injury and falls) that form a "long tail of non-communicable diseases", all of which call for responsible medical practice. In addition perpetual exhaustion and chronic hunger are present across the Indian landscape.[20] There is as yet no governmental health programme that looks at such 'invisible' ailments which afflict millions, though the Lancet has commissioned a study.

A brief caution on mental health

There have been in the past decade several efforts to place mental illness on the map of general morbidity in India (and the world).[21] It is estimated that a large and unserviced burden of mental illness exists, that in addition to causing distress in itself, appears as a complicating factor in several diseases like cancer, diabetes, HIV, tuberculosis, rheumatoid arthritis, etc. And yet, many suggest caution in both diagnostic protocols and analytical categories to ensure that grief and distress that are inevitable responses to the tensions of modern life do not become a business opportunity through over-medicalization and drug therapy.[22, 23]

Health crises due to industry or occupation

The poor who suffer serious injury or illness due to industrial negligence or occupational hazard have little healthcare. India's flagship here is the Bhopal gas disaster which has taken, maimed and crippled thousands, and perpetuates a legacy of chronic ailments and intergenerational effects. Indian government and the Union Carbide company (and now the parent Dow Chemical Company) demonstrate a shared callousness toward the plight of the victims.[24] However, behind this dark monument to ethical neglect, hides a landscape of caste occupational diseases, accidents, and industrial negligence crippling, maiming and taking the lives of the underprivileged.[25,26]

Thinking about indices of health[27]

Health indices which seem to point to objective health problems actually determine what problems are in need of intervention and thus create prioritized disease categories. They act as blinders that make other diseases invisible. Opposed to this, the initiative to highlight "the long tail of chronic diseases", the caution against over-medicalization of mental illness, the will to keep the Bhopal gas tragedy alive in public memory are exemplary countercurrents against the hegemonic determination of disease categories. They mark a democratic force that influences science, policy and political activism in ways that modify them.

In another register, indices that point to objective disease levels also point back at science, the state and industry. The interplay of these domains and their contradictions (both within and between each of these), constitute the subjective strategic intention driving medical and healthcare policy priorities, knowledge and business opportunity. The mismatches, incoherence and gaps in this ever-changing unity thus open windows of opportunity for a democratic politics of health. However, the terms of this democratic politics of healthcare are not based on abstract or naturally given freedom – the freedom of this politics emerges in new health sensibilities and unexpected demands among people who are themselves also partially constituted in this field as passive targets of medical care.

2. A Brief Overview Of Public Health Systems

This section deals with the Indian state's programmes for tackling healthcare since independence. The medical infrastructure hierarchy of public health systems ascends from the sub-centres, primary health centres, taluka hospitals, district hospitals, government medical colleges and the All India Institutes of Medical Sciences. Policy, programmes and implementation are coordinated by the National Health Mission.

Primary healthcare as biomedical prevention: immunization and disease control programmes

The original model of healthcare in independent India tried to follow the Bhore Committee Report of 1946 recommendations of a network of primary healthcare for all citizens. Primary healthcare was envisaged as both curative and preventive (imagined somewhat differently from a biomedical immunization programme). However, within a decade the budgetary priority of industrial growth in postcolonial development framed the impossibility of allocating adequate resources to meet such a utopian healthcare goal (Mudaliar Committee Report, 1962). In a coincidental parallel, a paradigm shift across the world had made the biomedical perspective the primary one. As a result of these complex historical moments at both the national and global level in medicine, the primary healthcare effort began to focus on 'vertical' programmes of a) immunization (currently BCG, DPT, OPV, Hepatitis B, Measles, and Tetanus Toxoid); and b) disease control and eradication (iodine deficiency, vector borne diseases, tuberculosis, blindness, leprosy, non-communicable diseases and burn injuries – in addition to general disease surveillance and mental health).

These programmes were like war efforts to tackle disease in a population. The immunization programmes targeted women and children, while the other communicable disease eradication programmes targeted the ill (typically tuberculosis). The latter programmes were short-medium duration engagements with unilateral governmental action: taking samples for tests, providing shots, giving advice, medicines.

The mother and programmes are of a longer duration, executed by the health infrastructure hierarchy composed almost entirely of women. The health sub-centres at the village level (1.5 lakhs in number as of 2014) are expected to be staffed by (currently) two trained Auxiliary Nurse Midwives (ANM), who are the first point of contact for the population, taking care of immunization and disease control, family planning, sanitation, nutrition and medical emergencies. Deeper reach into the social structure is achieved by nearly nine lakh voluntary Accredited Social Health Activists (ASHA) at the village level. Parallel to these vertical preventive programmes, and interlocked with them are the ICDS based mother and child care programmes initiated by government, the logic of which I have already covered in the first section of this paper. The ICDS working at the rural level with 13 lakh Anganwadi centres with Anganwadi workers has a component that facilitates immunization, supplementary nutrition, medical and referral service and educational assistance.

There are several criticisms of the detailed functioning of all these components of the public health system that would take more than one landscape paper. However, worth mentioning is a recent study by Madhumita Biswal that points to the unexpected location of intensive disciplinary/governmental power in the extensive network of agencies and agendas that control the lives and birth practices of women of childbearing age. Her paper opens out a new field for theoretical (how do we think of the Foucauldian concepts of discipline/government in Indian healthcare?) and empirical (how can we use them effectively in empirical work?) analysis.[28]

Structural problems and lacunae in healthcare

The key issue in all this is that the healthcare programmes are majorly funded by the central government (85% of the NHM budget). Now, vertical programmes have a clear focus and targets that lend themselves to supervision and measurement. On the other hand, the non-programmatic curative care element depends on patient demand, catered to by the physician running the PHC, and is not as amenable to vertical control. It is also starved of funds. Thus curative care in primary health centres has been sidelined by the budget/administrative force of the vertical programmes.

It is important to note here that the politically catastrophic coercive family planning programme of the 1970s forced conversion of the primary health centres and their agenda for broad healthcare decisively into single focus vertically driven machines to implement specific developmental health indices.

Two factors affect this bias of public health systems towards vertical programmes: one, liberalization's pressure to cut governmental budgets, which we will deal with further in the paper. The second is the 'liberal' training of doctors which (in government medical colleges subsidizes students massively and yet) does not link medical education with the country's needs (see following section).

The development of the general public health infrastructure till date makes it ill equipped to deal effectively with the emerging chronic/non-communicable diseases sketched earlier. This is because many chronic diseases require sustained monitoring, medical assistance, dietary and exercise regimens, education and emergency services over a lifetime of the patient. They cannot be tackled through warlike strategies. Thus, though government policy gets good marks for its timeliness in recognizing the criticality of non-communicable diseases,[29] the medical infrastructure and logic of hierarchical operation are not equipped to deal with them. However, it may be possible that the extensive mother and child infrastructure with its medium term engagement with their target population may serve as a practical prototype for the necessary infrastructure for chronic disease engagement.

3. LEARNING ABOUT MEDICAL EDUCATION

The Parliamentary Standing Committee in its 2016 report on the functioning of the Medical Council of India[30] has pointed to severe lacunae in medical education in a list of twenty points: poor quality; complete disconnect between healthcare needs and content of education, unrelated specialization; rampant privatization of colleges; corruption, lack of accountability and conflict of interest in functioning of the MCI, etc. At root, medical education is amputated from the governmental programme need for doctors. The educational system churns out qualified doctors, as free radicals to practice either in corporate hospitals or abroad, with no commitment to rural areas. Thus in spite of having over nine lakh qualified doctors in the medical register, in practice, India has one tenth of the minimal targeted ratio of 1 accessible doctor to every 1000 population in India.[31] Worse, doctors in government primary health centers often have private practice and don't come to the PHC to serve the population. The end result of this irresponsible mismatch of training undercuts many of the best laid governmental plans for healthcare. Ultimately the high social prestige and cost of medical education, the low paying capacity of the average patient, and the lack of social opportunity in an impoverished rural life for doctors and their

families from privileged backgrounds make it unviable for the market to provide the desirable doctor patient ratio.

The MCI is the guardian at the gates of professional qualification of medical doctors and strives for the elimination of 'quacks' who seem to exploit unmet medical needs from the Indian healthcare scene. However, as Veena Das has confirmed in some recent field research[32] on the poor urban populations in three different cities, most people have no other recourse except these 'quacks'. She proposes that rather than try futilely to regulate them out of existence, providing them with training and legitimate referral linkages/protocols would perhaps go a long way in filling the current vacuum in medical care.

In an effort to try and make good the gap between demand and supply of medical needs of the population, the government in 2014 has set up a ministry of AYUSH (Ayurveda, Yoga and naturopathy, Unani, Siddha and Homeopathy) to foster the development of non-allopathic systems of medical care. In addition, diplomas and new certificate training programmes in public health attempt to bypass the professional exclusivity and standardization of the MBBS trained doctor with more on the ground expertise of a limited range. While these are not unqualified successes yet, what is clear is that there are several qualified paramedical personnel who try to take the chance and practice medicine with these alternative qualifications.

Discrimination in healthcare?[33]

Immense caste prejudices exist in medical practice and in medical education.

On the one hand, the privatization of medical care is a filter of economic inequity that makes medical access prohibitively expensive for the poor who also most often don't belong to the privileged castes. This is especially true for Adivasi and other marginalized communities.

On the other hand, public health functionaries may also be discriminatory about the 'lower castes'. In a recent meeting on discrimination in healthcare in the Medico Friend Circle,[34] one of the participants showed a video (recorded in secret) of how a woman who suffered a stillbirth was left on the floor of the PHC with her placenta lying beside her. Questioned, the health workers said that they would not touch an Adivasi woman's birth fluids.

Lest we think that discrimination is a barbaric practice in remote regions, it is important to remember that some of the most important battles for social equity have been fought in the hallowed hallways of the AIIMS against upper caste students and faculty who have notoriously been public in decrying the lack of merit of SC/ST students and effectively practicing a form of social ostracism against them. [35,36]

As I have argued elsewhere, discrimination is not an atavistic throwback to ancient mores. It is a current form of political exclusion, ostracism and systematic bodily insult to the 'lower castes'. Discrimination bars the underprivileged castes and Adivasi communities from the benefits and opportunities of a democratic society. It infects medical practice and medical education at root.

4. THE POLICY DEBATES – A BRIEF LOOK

On the one hand, the health expenditure in India is of the order of 6% of the GDP. However the public health expenditure borne by government has been of the order of 1%. The balance expenditure has been out of the pocket of the patient – most of who are extremely poor. This abysmal public expenditure on healthcare is arguably among the lowest in the civilized world.

On the other hand, it is well known that in India, privatized medical care is poorly regulated. There is no control over how it functions with respect to the patient. In medicine, the market cannot function equitably due to asymmetry of information: the medical system knows everything but the patient knows nothing. Hence medical intervention engages the patient as a passive, ignorant being at its mercy. In a market system geared toward profit this leads to economic exploitation through over-medicalization and disease mongering. The staunchest advocates of privatization of medical care have suggested governmental methods to regulate the market players.[37] *Yet, the patient is a lucrative consumer today!*

Regulation of the market by government also has no simple answers. Does the government simply take over all medical care under public health or does it govern privatized care through a system of protocols and regulations? While it seems like a good idea to have a public health system that takes care of the individual from the womb to the tomb, the problem that arises in practice is the lack of accountability (or in other words, of regulation), as evident in the callousness, discrimination, corruption and sheer irresponsibility in many aspects of the public health system today. It is easier to say 'clean up the system' than to do it! On the other hand, privatizing with poor regulation through non-existent protocols is also completely open to over-medicalization and exploitation of the patient's body through a regulatory system that approves subsidized treatment over the patient's head. Given these policy impasses, the following recent trends need to be understood:

1) In response to the Planning Commission's request in 2011, the High Level Expert Group[38] under the direction of Srinath Reddy proposed a system of regulation and budgetary allocation that drew on the consolidated experience of healthcare available across the world. It suggested a budgetary allocation of 3% by 2022. It also proposed a mixed (private/public) delivery system with a degree of free choice available to the patient.
2) The Planning Commission was unhappy with the Report and had proposed an increase to 1.5% of the GDP, and more, to curtail the government's extensive commitment to public health programmes. In the uproar that followed the Health ministry pushed back against the Commission to redraft its proposals.[39]
3) More recently the NITI Aayog has mooted cutting public expenditure down from the current level of 1%, in 'efficiency improvement' measures. It has also sought extensive reorganization of the public healthcare system privatizing it at the grass roots level.[40,41]
4) This provides the context for the NITI Aayog Deputy Chairman Arvind Panagariya's position in the debate on childhood undernutrition, proposing reduced government expenditure on nutrition and public health.

There is a policy drive to curtail public expenditure on healthcare and move into a purely regulatory role so that the entire delivery of healthcare is by the private sector. There is little evidence of any serious

regulatory mechanism being mooted by the planning body. Indications are that the current government will take drastic large steps to dismantle the health system in pursuit of a fully privatized 'efficient' delivery process. While this move is healthy for industry, it will have at best highly ambiguous effects on the health of the people, and at worst may turn out to be a health catastrophe for the nation.[42]

5. CIVIL SOCIETY INITIATIVES – THEIR STRENGTHS AND LIMITATIONS

Community health organizations

There have been since independence, many small institutions providing healthcare to the poor (and also to those afflicted with stigmatized diseases like leprosy). The Comprehensive Rural Health Project founded by Raj and Mabelle Arole was one such, which pioneered a strong community health programme training and involving local participants of all castes. Such institutions work in remote locations or among the desperately poor and marginalized communities (Adivasi, Dalit, informal workers), through individual commitment to social well being. Jan Swasthya Sahyog near Bilaspur, SEARCH in Garchiroli, the ant near Bongaingaon, Gudalur Adivasi Hospital, Emmanuel Hospitals, Shaheed Hospital for Bhilai workers, and the Sambhavana Trust Hospital for the survivors of the Bhopal gas tragedy are a few. While a small and diminishing proportion[43] of healthcare is being provided by these community health institutions, their role has been more of breaking new and difficult ground with novel models of health delivery among those with very little access to care. There is in addition a well developed network of Christian mission hospitals across the country providing healthcare to the needy, with specialty referral services in hospitals like the Christian Medical College in Vellore.

Non-governmental health organizations

Building on community health experience, diverse non-governmental organizations undertake health research and education. Some are government run or assisted NGOs which undertake large scale programmes of healthcare without the financial and administrative overhead of a government bureaucracy. Among these the pioneering State Health Resource Centre (SHRC) of Chhattisgarh has become a potential model for such units across the country. At the upper end of the spectrum is the Public Health Foundation of India (PHFI) which conducts extensive research/teaching programmes, and provides advisory services to the central government. Many non-governmental organizations are either funded by agencies like the Tata Trusts, Action Aid or Oxfam.

Voluntary activism

Several voluntary organizations have worked (some for decades) on advocacy, policy and activism on the health front in India, often making major impacts on policy and government – some names being Medico Friend Circle (described as a 'thought current'[44]), All India Drug Action Network and Jan Swasthya Abhiyan.

6. CAPITAL, PRIVATIZATION, CORPORATES, INSURANCE

Capitalism and the focus on pure economic growth have indubitably affected the poor and most of all marginalized Adivasi communities across India. Health is a casualty alongside life itself in the tribal areas

of Chhattisgarh; Jharkhand, Bengal, Telangana, Andhra Pradesh and Tamilnadu too have a one hundred year old history of industrial growth that has taken a toll on Adivasi lives and health.[45] Thus on the one hand, the poor are marginalized, displaced in the wake of growing industrial modernity's insatiable thirst for more land and natural resources. They migrate desperately in search of work opportunity, only to serve as a reserve army of labour for industry. Industry and government show little care or responsibility for the welfare or health of populations at the mercy of capitalist growth (see sub-section on occupational diseases above). They serve as a near sub-human productive force.

On the other hand, the poor serve as an opportune and lucrative market for the medical industry.

How primary healthcare is changing

Received wisdom is that the privatization of healthcare began with the withdrawal of government after liberalization in the early 1990s. I argued that government had abandoned curative primary healthcare to private sector by 1970s under pressure from vertical programmes. Privatization began within the planning regime from the 1960s onwards with its focus on vertical programmes. What remains of governmental curative care, largely in the government hospitals at the taluka, town and city level, is due to interplay between everyday unsung professional commitment to sensible healthcare, budgetary inertia and the inexhaustible demand for good medical services at affordable cost. Privatization has simply changed the strategy: from letting curative care by government institutions languish due to lower programme and financial priority, to pursuing a more active process of ideological, policy and financial asphyxiation.

The World Bank's 1993 report,[46] envisages radical privatization of clinical services as differentiated from public health measures. For example, immunization or mosquito eradication measures with extensive social benefits form part of governmental public health expenditure. In contrast, clinical curative services for many diseases with low externalities beyond the individual treated will be paid for by the patient. The logic of liberalization here is clear – all individual ailments regardless of causation (occupational diseases, industrial negligence, road accidents, low immunity caused by nutritional insult) become the responsibility of the individual. This thrust towards *procedural individualism* by the World Bank is also evident in its later report on private healthcare for the poor.[47] The NITI Aayog's latest proposals on healthcare take this drive towards privatization forward by merging private and public healthcare through the empanelment of all GPs into a system of partial government financing, which would in time be withdrawn.[48, 49, 50] If this plan is accepted, public sector expenditure on the immunization programme as part of the mother and child health scheme would also most likely be gradually withdrawn, leaving it to the network of GPs to implement at some cost to the people.

The effect of corporate hospitals

By the mid 1980s corporate hospitals enter the national landscape. These hospitals foster specialty skill and investment in equipment (e.g., arthroscopy, angiography) to provide treatment to the privileged classes for rarer diseases/ailments. These are second level referral hospitals providing tertiary care to exceptionally ill patients. Needless to say, a) the rarity of the disease; b) the cost of importing the specialty equipment; c) the cost of the specialist acquiring skill; and d) the profit motive of the hospital—all lead to exorbitant costs to the patient.

However, this specialization of medical care is not a phenomenon that is determined only by corporatized medicine and capital growth in India. As pointed to earlier, the orientation of what constitutes a true cure for a disease has gradually shifted toward a scientific biomedical model which jettisons most attempts at framing disease in paradigms of nutritive, life practice, social and economic determinants of health. This biomedical orientation is further accentuated by the dominance of expensive biomedical, bioengineered, biochemical procedures, all invented at inflated research expenditure and with a profit motive. Most of these new forms of specialty medicine have emerged under the impetus of medical philanthropy in the US and the social insurance plans in the UK and Europe. [51,52]

So while the tertiary care model dominates corporate hospitals, primary preventive healthcare too is wooed by commercially driven costly biotech vaccines for immunization programmes that may or may not meet the needs of a developing country like India.

Insurance dilemmas

Corporate insurance begins in the erstwhile state of Andhra Pradesh.[53] The Aarogyasree programme, started on 1 April 2007, was a partnership between the corporate hospitals and the AP government where empanelled corporate hospitals provide specialized and advanced treatment to BPL card holders at governmental expense. The coverage is currently Rs 2.0 lakhs. Treatment is provided for listed medical/surgical procedures with package costs predetermined in a contract between the government and the hospitals. Predictably, the procedures listed in the Aarogyasree packages were specialties offered in the empanelled hospitals. The logic of the programme thus is not the cure of the illness that the patient suffers, but of the sale of the specialty the corporate hospital possesses. This has led to distortions where the hospitals sometimes perform procedures that were not needed by patients, notoriously hysterectomies in some hospitals,[54] and to hospitals overcharging patients for excess components over required procedures. On the whole however, the patient perception is that the government is taking care of them in a health catastrophe. However what is overlooked, because never experienced, is that many of these ailments would have been avoided if there was an effective curative primary healthcare system.

The Rashtriya Swasthya Bima Yojana on the other hand provides an annual cover of Rs 30,000 for BPL workers' families, with specific inclusion of different categories of APL workers. This governmental insurance scheme is intended to cover the poor against heavy out of pocket expenses on sudden illnesses. Expectedly, an investigative study in Chhattisgarh has revealed that the poor are often turned away or charged unnecessarily in spite of having an RSBY card, and that ultimately the beneficiary is the private hospital which negotiates sharply to extract a maximum payment from the government and yet manages to choose who and what ailment it services.[55]

The original Employee State Insurance Scheme started immediately after Independence, was modeled along the Social Security and Insurance Scheme of post WW II Britain (the basis of the NHS today), and works with partial efficacy towards the more privileged classes. The ESI system refuses patients whose employer neglects payment of employee insurance premium to government (often the case) or if the employee is not on the rolls of an employer (a casual worker). Thus it is the neediest employee who is

penalized by non-treatment in the ESI hospital.[56] As a result, a company that, due to industrial negligence, injures the most vulnerable class of worker also goes scot free because the ESI hospitals turn this worker away and thus in effect collude with industry by withholding medical expertise that could help determine blame. The failure of ESI for the truly needy is a true paradigm of abandonment of the laboring poor by government through apathy and abysmal implementation mechanisms.

Pharmaceutical juggernaut

The pharmaceutical industry overshadows corporate hospitals as a major capitalist industry in medicine. Indian pharmaceuticals have grown since the 1960s through an aggressive-defensive relationship with global pharma, with an enabling and relaxed Indian patent regime. This became the bone of contention with the World Trade Organization and talks for further liberalization from the 1990s onward. The Indian industry is seen as a David against the Goliath of global capital, and hailed as the producer of low cost medicines especially in the context of the AIDS pandemic in the 1980s and 1990s.[57] Thus on the one hand, the industry has been instrumental in removing the stranglehold of large global corporations on new drugs protected by patents, not only in India, but across the world. This is now under serious pressure by liberalization policies in pursuit of WTO friendly business regimes.

On the other hand, the Indian pharmaceutical industry has a diverse and vast array of branded drugs/combinations selling at a huge profits exceeding 1000 percent in the Indian market.[58,59]

The pharmaceutical industry also exerts pressure to institute new vertical programmes of immunization using the new biotechnologically developed vaccines. Such programmes are goldmines of single point sales worth several crores of rupees. The testing for safety and efficacy many new vaccines has been challenged.

Pharma activism has been directed at these two somewhat contradictory poles: one, protecting the local pharmaceutical industry from the aggressive hegemony of global players and exerting legal and moral pressure on the multinationals to lower the price of exclusively patented drugs; two, putting pressure on the Indian pharmaceutical industry to reduce the price of branded drugs and/or move to cheap generics, and on the government to have essential medicines sold to people at price control.[60,61]

7. CONCLUSION: WHERE IS HEALTHCARE HEADED?

The impasses and opportunities of a politics of health in India

It should be clear from the above account that health activism thrives on the Indian landscape. However, it should also be equally clear that this is a middle class activism with very little participation from the people. The reason is evidently the lack of everyday priority of healthcare in the minds of ordinary people who struggle for wages, food, clothing and shelter in an economic system that abandons them to appalling levels of industrial irresponsibility and unregulated economic growth at the cost of their bodies and lives.

But given the catastrophic costs of health emergencies and their trail of destitute victims, the Aarogyasree programme, despite corruption, cartels and unnecessary expenses, has imprinted

healthcare as a possible political issue in people's minds. With all signs that RSBY and Aarogyasree like programmes are establishing themselves in different states, this political awareness of health as an issue will figure in political calculations in the near future, though to what effect remains to be seen.

Is it possible to suggest policy correctives?

The signs point to the rapid and precipitous emergence of fully privatized healthcare in India. All wisdom in healthcare and health economics points to the inadvisability of private capital investing in an uncontrolled manner in healthcare. This is because of the deeply entrenched asymmetry of information across the medical transaction – the medical system knows all and the vulnerable, ignorant patient is at its mercy.[62]

If labour is extracted at abysmal wages at one end, meager savings are extracted by rapacious exploitation of disease at the other.

It is also clear that the business of medicine in the current inequitable socio-economic configuration and distribution of wealth will make privatized care through the market inaccessible to people; hence the tension – capital wants to privatize, yet make the government pay through forms of insurance since people cannot. Thus, structurally, the Indian population will have no say in its healthcare and will be the pawn in "public-private partnerships". In such a moment the invisible hand of the market needs a strong visible hand of regulation and policy.[63]

In addition, it is also administrative wisdom to make small changes to solve small problems, rather than undertake radical overhaul of systems according to abstract principles[64] that don't take account of the many, many small grips on life the existing system provides people who eke a survival in them.

It is also becoming increasingly obvious that the field of healthcare should pull away from a scientism abstracted from the social field, and move towards curative and healing practices that see health in a way that is both objectively correct and meets the needs of the patient. This would mean addressing social, cultural, political and economic determinants that would prevent and cure disease wherever feasible. The implication of this focus would be that a responsible health administration and medical practice should develop an ear to listen carefully to people's problems.[65,66] Whether the objective conditions biomedical capitalism described permit this is the 'sawa sau crore'[67] question!

A goal afar: Where is health headed?

This paper has tried to describe the scenario of ill health and healthcare in India emerging after 60 years of independence. It has sketched the field of care between need, economic conditions, medical science, health policy/administration, and activism, under the relentless force of capitalist growth.

Yet, even in the unlikely scenario where healthcare improves in absolute terms, we will never 'achieve good health'. In both the global and national arena the ideas of health, medicine and healthcare are being continually constituted by interlocking governmental, scientific, industrial and broadly global priorities beyond the individual patient's ken. The gap between disease and health structures our perception and desire of what we need to strive toward, in the conceptual and social space created by market, state and science.

In philosophical terms, health is defined best as a perpetually receding negative, a lack of ill health. Our Sisyphean destiny as a democratic nation is to critically comprehend, steer and strive toward the relentlessly receding of the idea of health as an infinite goal.

Acknowledgments

This essay has been possible due to the teaching and guidance of comrades and mentors from Anveshi Research Centre for Women's Studies, the Christian Medical College-Anveshi Health Collective, and the Medico Friend Circle. Errors and blunders are mine.

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