BACKGROUND PAPER

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- Technology in Health Care : Issues and Perspective

Medical services, Medical Technology and Privatisation

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The growth and development of private capital, especially monopoly capital, has an umbilical connection with the State. Without the latter's assistance capital accumulation would not have reached its stage of monopolistic concentration, what in radical political economics is referred to as imperialism.

Monopoly capitalism implies complex social division of work that is reflected in a general trend towards specialisation; health services are no exception to this and that brings about costlier personnel reproduction (Breilh, 1981). High technology and more efficient managerial and administrative practices, especially since the late seventies, have given capitalism/imperialism a new lease of life.

In the field of health and medicine "new medical technology" and "community medicine" (it may appear contradictory to the former) have provided a new strength for private capital to flourish in an area where State intervention has historically a dominant force. It is in this context that the issue of privatisation emerges. We raise this issue because there is concrete evidence of the State's support and encouragement of the private health sector (similar to many other sectors of the economy).

Defining Privatisation:

At the outset we would like to clarify that privatisation does not mean or refer to the existence or growth of a dominant private sector. As indicated earlier it refers to the relationship (especially the changing process) of the private sector with the public sector. Thus privatisation is a process. It is a process that has been going on for a long time and has accelerated in recent years due to certain developments in health sector globally.

Privatisation may be best explained through the forms it takes:

a) Divestiture (transfer of ownership): This involves the selling out of public provision to the private sector. Isolated cases of such privatisation may be cited from the past but this form of privatisation is still in an infantile stage in India. In U.K. and France this is becoming the dominant form of privatisation and in the years to come it could become a major trend globally.

b) Contracting/Leasing: This is a very common form of privatisation that exists globally. It is a dominant form in the service sector of the economy and is widely practiced in the U.S.A. In the health sector certain hospital functions, construction activity, purchasing, programme management and implementation, leasing out for a short period etc. are the common types of this form of privatisation which is quite rampant in India, both in the health sector and outside it.

c) Source of Income: Privatising the source of income like, 'fee for services', permitting private practice etc. in the public hospitals and health centres has been a dominant trend globally since the late seventies. This form of privatisation is already becoming a major trend in India.

d) Strengthening the Private Sector: This form of privatisation is the historically dominant form. Its main characteristic is that public resources are used for the development, growth and strengthening of the private sector - the public sector provides inputs (medical education, soft loans, tax concessions and subsidies, social and economic infrastructure etc.) and the profits are appropriated by the private sector.

There is also another emergent trend, which however cannot be labelled as privatisation. The trend is one of increasing corporate control of the health services sector. This has been aided largely by the new sophisticated medical technology and a more efficient management of resources which has made the operation of private health services more profitable. This trend is bound to make major changes in the future in private practice of medicine because the medical practitioner in all probability will be reduced to being an employee (albeit well paid and pampered) rather than an independent professional. One may call this process 'corporatisation'.

Thus privatisation broadly is a process whereby public provision is transfered (in whatever manner or form) to the private sector. This amounts to, on the one hand increased profitability and concentration of private capital and on the other a more expensive and difficult acess health care delivery system for the consumer because services availability gets related to the proportion of one's income.

The Historical Context of Privatisation in India:

After Independence from colonialism, inspite of the analysis of India's health situation and recommendations of the Bhore Committee Report, the government preferred to let the private sector domineer in the provision of health care services. The Bhore Committee Report clearly favoured the establishment of a broad based integrated national health system that would be equally accessible to the entire population, irrespective of their ability to pay.

The Indian State and the bourgeosie rejected the Bhore Committee's recommendations and preferred a system of health care services where health care and medicine would be commodities. The private health sector geared and flourished, with adequate State patronage, to provide curative services which is the primary need/demand of the population and the State was left with the responsibility of public health and health care services for the periphery. The State was also made to provide the infrastructure-medical education and research, bulk drugs, tax rebates and subsidies - as a support to the private health sector.

Private medical practice developed as the core of the health sector in India, initially strengthening the enclave sector, then [illegible] into the periphery as opportunities for

expropriation of surplus, by providing health services, increased due to the expansion of the socio-economic infrastructure through public funded programmes. Today three fourths of the health care is catered to by the private sector.

India is even today largely a subsistence economy. The poor majority is placed at the mercy of the private health sector to meet their health care needs because of the lack of adequate (free) and easily accessible government health services. The government has failed to develop a proper health infrastructure that could meet the needs/demands of the majority underdeveloped population of the country. On the contrary the government has supported the expansion and strengthening of the private health sector. The result is that the health care sector remains underprivileged for the majority of the population whereas a small elite group (enclave sector) enjoys special treatment.

In spite of this appaling situation the government is talking of privatisation of health services. The National Health Policy of 1983 clearly speaks in favour of privatisation: ' The policy envisages a very constructive and supportive relationship between the public and the private health sectors in the area of health by providing a corrective to re-establish the position of the private health sector .... With a view to reducing government expenditure and fully utilising untapped resources, planned programmes may be devised, related to local requirements and potentials to encourage the establishment of practice by private medical professionals, increased investment by non-government agencies in establishing curative centres and by offering organised logistical financial and technical support to voluntary agencies in the health field.' (GOI, 1983).

Thus, historically the private sector has been the major provider of health care services in India. Over the years it has been nurtured and strengthened by State interventions and today large scale privatisation of public health services is in the offing. Why privatisation is becoming an issue today is because the forms it is taking is moving away from the traditional patterns of privatisation i.e. it is changing from State support to more direct forms.

The State and Privatisation:

As pointed out earlier, State support of the private health sector is the historically dominant form of privatisation in India. What are the areas of State intervention ?

a) Medical Education is almost wholly a State financed activity. The major beneficiary of this is the trained doctor who practices medicine privately. Between 2/3rds and 3/4ths of the trained allopaths work in the private health sector. Though they are trained at public expense, their return to society is negligible because most of them engage in health care as a business activity. Also a substantial proportion migrate to developed countries and thus subsidising even in the latter's health care development.

b) The government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. It provides incentives, tax holidays subsidies to private industry (pharmaceutical, medical equipment). It manufactures and supplies raw material (bulk drugs) to private formulation units at subsidised rates/low cost. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially the highly expensive new medical technology.

c) The government has allowed a highly profitable private hospital sector to function as trusts which are exempt from income taxes they don't contribute to the State exchequer even though they charge patients exorbitantly.

d) The government has permitted non-government organizations (NGOs) to run its programmes (contracted out) in selected areas and have provided NGOs financial support. This has been largely in rural areas where ineffective public health services have been set up. The result has been that the government's own services have suffered a further loss of credibility thus creating a justification for future privatisation.

e) The government has pioneered introduction of allopathic medici in untouched areas thus creating a basis for the entry of private medical services in these areas. The setting up of PHCs, for instance, in backward areas and provision of other supportive infrastructure has provided both an entry point and incentives to private practitioners and hospitals to set up their services.

f) Construction of hospitals and health centres are generally contracted out to private persons. The latter make a lot of money in the construction process but most of the hospitals and health centres, except in selected urban centres, that have come up through substantial public investment do not function adequately to meet the demands of the population.

g) Medical Research and Pharmaceutical Research and Development is largely carried out in public institutions but the major beneficiaries are private sector institutions. Development of drugs, medical and surgical techniques etc. are generally pioneered in public institutions but commercialisation, marketting and profit appropriation is left to the private sector.

h) In recent years the government health services have introduced 'fee-for-services' at its health facilities. This amounts to privatisation of public services as utilization of the latter would now depend on the availability of purchasing power. Increasing private sources of income of publicly owned services would convert them into elitist institutions. In fact it is well known that specialist facilities in public teaching hospitals and other well known public hospitals are monopolised by influential persons.

i) The government has allowed the private health sector to proliferate uncontrolled. Neither the government nor the Medical Council of India have any control over unqualified, unethical, irrational for-profit practice of medicine. Even doctors working in public institutions who are paid a non-practicing allowance (even this is questionable) run a successful private practice with the full knowledge of the concerned authority and no action is taken.

The above are some illustrations about linkage between the private and public sectors. Historical evidence does show that the State sector has contributed to a strengthening of the private health sector in a significant way. In this light the recent

trends in privatisation, which involve more direct action like divestiture and leasing out or privatising the source of income of public institutions raise serious questions about the future of the health sector and even more so about the vast majority of the underprivileged and underserved population that village affected by it.

New Medical Technology and Privatisation:

We have stated earlier that the new high technology medicine along with more efficient managerial and administrative methods is accelerating the process of privatisation.

By its very nature the new genre technologies (especially of the electronic and computer aided variety) has made concentration of monopoly capital even more simpler and the control easier. This is true for all sectors of the economy but more so for medicine.

The new medical technology (NMT) has opened new avenues of corporate investment that is going to bring out far reaching changes in the structure of health care delivery. NMT has brought health care delivery to the doorsteps of monopoly capital. The various forms of privatisation are early signs, and corporatisation the virus that helps complete the cycle.

In a country like India where basic health care is still a dream for the masses, the fast paced introduction and proliferation of NMT is only strengthening unequal health care distribution. NMT and privatisation go hand in hand. Corporatisation follows and adds strength to it.

Historically the introduction of modern medicine, its technology and practices have been characterised by an enclave sector patterns of development. During the colonial period modern health care was available/accessible to those in civil and military services. Introduction to the periphery was largely restricted to setting up of civil hospitals at the district level which had very restricted access. Provincial governments did make some efforts in setting up dispensaries in 'mofussil areas' but they were too few to have had any impact. In fact it was the missionaries who made successful attempts at introducing modern medicine in quite a few remote and difficult access areas. In the post-independence period, the State undertook the responsibility of providing health care to the periphery but the development has been very gradual to the extent that even today there is only one 6 bedded PHC with two doctors and about 8-10 paramedics placed at sub-centres for about one lakh population. (In 1946 Bhore Committee had recommended a 75 bedded primary unit with 6 doctors, 6 public health nurses, 6 mid-wives and 66 other paramedic and non-health supportive staff for a 10,000 to 20,000 population, supported by a 650 bedded secondary unit serving 500,000 population with 140 medical officers of a wide variety of specialists and the secondary unit will in turn be supported by a 2500 bedded hospital with 269 doctors serving a 3 million population) (GOI, 1946). In the public sector hospital services are only available at the district level through a 100 to 200 bedded civil hospital for 2 to 3 million population.

The above description clearly shows that the proliferation of modern medicine through public sector has been a slow process. It's access is very dispersed. On one hand the private sector, even though of questionable quality, piggybacking on the public sector, has sunk deeper roots and is more easily accessible (physically) to the population - only the access is subject to purchasing power. A strong curative medical care system, as had been suggested by the Bhore Committee, has never been established by the State for the mass of unorganised population in the periphery. However, in major industrial centres and cities the public health care facilities are relatively far better developed and also better utilised. This unequal development clearly substantiates the enclave sector patterns of development of the health sector.

The same holds good for the NMT. The difference between NMT and introduction and development of modern medical services is only academic. In the case of the latter, the public sector did the groundwork of introduction of modern medicine (of course, missionaries had already done it in a few areas much earlier) on a wide scale in the periphery and the private sector followed and established themselves - it is very clearly established that the public health services in the periphery are only an appeasement and not a well grounded and proper health care service that meet the needs of the proper health care services of the population. In the case of NMT it is the private sector that is introducing the technology but again with the assistance (tax subsidies, duty exemptions etc.) of the State. The NMT is very expensive to use and thus has restricted access to an insignificantly small proportion of the population. But given the nature of private medical practices in India with its system of kickbacks an overuse/misuse of NMT is taking place and its use proliferating to groups of population who even find preceding medical technologies an extreme financial burden to use. And NMT is the forerunner of corporatisation.

Another important development that has diverted the development of a proper medical care system is the community health or medicine model exported to underdeveloped countries by ideologues of imperialism. Talking of community medicine in a class society is absurd because a community in such a society does not exist - 'it appears only as a mystifying label placed on poor peasants, urban subproletarians and the family of workers, and the ultimate intention of such community services is not to provide the people with the best possible care but to install a cheap invisible structure of "concession" and "repression" through medicine' (Breilh, 1981).

Community medicine as a concept has existed for a long time but it was demonstrated in India by the John Hopkins' project at Narangwal, Punjab, in the late sixties under the leadership of Carl Taylor who had earlier been associated with community development projects in India. For capitalism the community medicine type of low cost technology serves as an instrument of redistribution and helps provide health services (albeit of an inferior kind) to a wide area and population (in periphery) with a negligible investment (of course) by the State) that appears as a special concession and demonstrates the humanitarian concerns of the State (Ibid).

It may also be noted that this model of health care has been promoted very actively in India with the collaboration of a host of NGOs. This again shows strong public-private linkages and indicates a unique trend in privatisation because resources used by NGOs are invariably of government, if they are not imperialist.

Thus, the lack of properly organised basic health care/medical care services for the masses, the emergence of NMT that contributes to further inequality and the model of community medicines that reeks of

double standards and ofcourse institutionalises an unequal health/ medical care service, all are indicative of the vested interests that are served in the process of providing of health care and the development (rather underdevelopment) of the health sector in India.

CONCLUSIONS:

The NMT has provided a firm footing for the growth of monopoly capital in the health sector. Since historically the health sector has had large scale public investments, monopoly capital can only survive and grow further through the process of privatisation.

In India privatisation has always existed; only presently the forms are changing in keeping with trends the world over.

Privatisation, if furthered in India is going to have drastic consequences. The health sector in India, unlike those in developed countries, is inadequate and underdeveloped and it is highly unequally distributed. If steps are not taken to arrest its growth it will generate further inequality. The developed countries already have well developed health care systems which are either national systems or insurance based, or a combination of the two. Privatisation in those countries will not have as serious a consequence as in underdeveloped countries because the former have a well organised workforce which demands health as a right - whether the government provides it or it pays the private sector to provide it. One thing must be made clear, that the State health expenditures will not decline either in developed or underdeveloped countries because of privatisation - the difference will be that the state will contribute more to the private sector :

Thus a demand for a national health service in India and other underdeveloped countries becomes even more urgent because of privatisation.

Arguments in favour of privatisation stress the importance of cost containment and cost-efficiency in health care delivery. The privatisation lobby promises more efficient services that would not cost the State much; fees payable by the patient are supposed to act as disincentives for 'overutilising' health services. Their arguments are based on the following principles -

- The individual is responsible for his/her own health.
- Access to unlimited free health care is a privilege, and not a right
- There must be an unitary health care delivery system.
- The individual, rather than the institution should be subsidised.
- User charges should be levied.
- Medical aid schemes should be restructured, over-usage of health services should be curbed, and a more market-oriented health care delivery system should be developed (Critical Health, 1987)

If one looks closely at these arguments and principles it becomes clear that the privatisation lobby is not interested in meeting health care needs but in serving vested interests such as private hospitals and practitioners and the pharmaceutical and the medical equipment industry. Also privatisation will make access to health care dependent on buying capacity of the individual. This would mean if you don't buy, you won't get good health care, but if lucky you may have access to third rate indigent health aid packages or community health care.

For the capitalist State, privatisation is a welcome step, because health has become highly political and privatisation could help depoliticise it and liberate the state from this responsibility.

Thus privatisation will help the state to break its umbilical connection with the private sector (if not that of its protector) and leave the masses at the mercy of the whims of the market.

All these manoeuvres of capitalism have thus to be arrested and the demand for health as a right and a national health service has to be pushed vigorously as an answer to privatisation for the sake of "Health for all".

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