Privatization of Health Care, Medical Tourism and Elderly: A Review

Qasim Masumi
Research Scholar at Jawaharlal Nehru University, Delhi, India

Abstract

Health sector is the lifeline for a nation's wellbeing. It is the sum total of the health of its citizens, communities and settlements in which they live. In the Indian Constitution, healthcare is provided for in the Directive Principles along with other social and economic rights like education, livelihoods etc. It is one of India's largest sectors, in terms of revenue and employment, and the sector is expanding rapidly. The Indian healthcare sector has emerged as one of the most challenging sectors as well as one of the largest service sector industries in India. The large domestic market is complemented by the inflow of medical tourists. On the other hand the health care delivery environment in India has distinctive challenges. Inadequate infrastructure and a constrained health care delivery work process further intensify the complexity. The health care system in India consists of public sector, private sector, and an informal network of care providers (also known as voluntary health system). The very size, scale of India is a huge challenge that many well intended guidelines and regulations had just gone haywire. The Indian Health sector operates in a largely unregulated environment, with minimal controls on the type of services to be provided by whom at what cost and in what manner. This is further complicated by the usual Indian tendency to lack of standardization and minimal compliance though there are norms and guidelines.
This paper therefore is an attempt to critically analyze and understand the issues of poor access to health care to vulnerable and specifically of the elderly population in the context of privatization of health services.

KEYWORDS: Elderly, public health, privatization, medical tourism, health care.

Introduction

Public and private healthcare facilities in India are at different levels of advancement in terms of technology and services. With government privatizing the healthcare industry, many private hospitals and health centers have mushroomed around in cities. They along with specialized doctors and medical personnel have better technology and resources and thus, they are able to attract the population who can afford the services. However, public sector hospitals or health centers have meager resources and sometimes inadequate number of doctors. Since technology is developed incurring high costs, they are made available at private centers and the public hospitals are left with basic and out-dated technologies. Privatization of health care industry has also given rise to medical tourism and patients from across the world visit India to avail world class healthcare facilities at minimal costs.

This phenomenon has gravely affected the vulnerable population like the poor and the elderly population. Due to high treatment cost at private clinics or hospitals, the vulnerable population have to visit the public health care facility where there are often no or shortage of specialized doctors and nurses. There are two different scenarios of health care system that one can see in India

- A country that provides state of the art medical care to middle-class Indians and attracts medical tourists; and
- Another where a majority of its own citizens cannot afford or even get access to basic healthcare.

The pricing of services rendered by the private sector are greatly influenced by the cost of investment with the result that most of these services have remained out-of-reach to most of Indians This phenomenon has gravely affected the vulnerable populations in general. Within the vulnerable population, health concerns of the elderly population are an emerging concern. With the increase in life expectancy, the health care concern of the older population in India needs to be addressed. According to the Senior Citizen's Guide Revised Edition 2016 complied and published by Policy Research and Development Department (www.helageindia.org), India has 112 million elderly people with multiple physical, social psychological and economic problems with unmet needs in all domains of health.

In 2017, 55% of the people fell below the poverty line in our country just due to one reason and the reason is healthcare spending, people did not have enough money to spend on their healthcare expenses. 38 million out of 55 million went below poverty line just because they had to spend exorbitant amounts on their healthcare and medicines, (Report by Public Health Foundation in June 2018). The actual poverty line that has been considered after research, is Rs1000 per month in urban and Rs 816 per month in the rural areas. So, one can imagine the pitiable condition where people for affording medicines had to spend so much that they fell below the poverty line.

Health infrastructure in India's urban and rural community: Poor health affects the economy not just directly but also if one examines the opportunities cost and in terms of the longer term having a sick population is going to be a less productive population, days of work will be compromised as a result of illness, it is one of the matrix of true cost of health gap. This means more investment has to be made for preventive and promotive health care. The cost is also high, in terms of what it does to the society in the long run, because poor health and high morbidity, impacts cognitive ability. It leads to higher health cost in the long run for the society, which becomes unsustainable at a point. India also has a very large young population which is going to age, so our median age is going to increase over time and ailments because of one's lifestyle will become rampant that will include not only under-weight but also over-weight. There are huge disparities, which is not just regional because in states like Kerala there is enough spending in terms of health care. While, states like Bihar, Madhya Pradesh, Uttar Pradesh compare very badly even into Indian average. Kerala has been progressive about many things and not just healthcare. A large part of Kerala's social outcome development indicators have been driven by the social fabric of Kerala society. It has excellent education literacy outcomes, it has excellent health outcomes. Though economically, it is average but it has done most

of its policy changes early on where it has invested in public health education and infrastructure. So, the development process that is for all to see and emulate in for the rest of the country. With rising middle class in India and its expanding burgeoning economic aspiration investment in health infrastructure is of outmost importance. Improvement of points of access in rural India is necessary because we tend to assume that middle class is more of an urban phenomenon, however, there exists very large middle class in rural areas as well. It is also crucial to acknowledge that India is still very much a rural society. Close to 80% of the doctors, 75% of the dispensary, 65% of the hospitals are in the urban area. Therefore, there is a mass flow from rural to urban area whenever there is health concern; however, these are not sustainable in the long run. Less than half of the population now is in urban areas, which is growing at a steady pace, but India's rural base is still very large, so from a long term perspective effective investment in rural health infrastructure is required. Also 75% of the rural household in our country earns less than or equal to Rs5000 per month. This can easily be calculated that how easy it is for the poor people to slip into the poverty line just due to the healthcare expenditure. A 2014 survey, from National Survey Office revealed that medicine is the biggest contributor of the health care expenditure, 72% of the health care expenditure from the rural households goes towards medicines and 68% healthcare expenditure from the urban households goes towards medicines. The central government and the state governments have released many schemes related to healthcare and to make medicines affordable some of them were successful but most of them were unsuccessful in their implementation.

PRIVATIZATION AND HEALTH SERVICES

After the 6th five year plan, when the government opened the healthcare services to private sectors there has been a radical decline in the health access to the citizens because of high cost at private hospitals and unavailability of medical practitioners at government hospitals. The higher salary at private hospitals has attracted the specialized doctors and nurses, whereas the poor are provided with substandard infrastructure, paramedical and volunteers to attend to the village with primary health care facilities. The focus had shifted from proper healthcare to all Indians to amassing huge profits by allowing corporatization of health care industry. The politically elected officials tend to serve for the interest of the wealthy and the needs of the poor are mostly ignored. The highly advanced and complicated technologies were designed for the rich, and thus it became unavailable to the poor and lower middle class.

> "The National Health Policy proclaimed urban medical institutions as service production units at par with production units, and therefore, important sources of foreign exchange earnings (Government of India 2002). Cutbacks in the public sector no doubt lead to its shrink age and the deterioration of public institutions. This has been used to rationalize the introduction of user fee, public-private partnerships (ppps) and opening up the public sector to private investment"[1]

[1] Singh, Lakhwinder, An evaluation of medical tourism in India, *African Journal of Hospitality, Tourism and Leisure* Vol. 3 (1) - (2014), p 5.

a) MEDICAL TOURISM AS A BY-PRODUCT OF PRIVATIZATION:

Millions of people travel to Asian countries for medical treatment that ranges from dental work to major heart surgery all done at a fraction of a cost as compared to developed countries. Medical tourism brings in billions of dollars a year worldwide.

Table 1: Cost Comparison between India, USA, Thailand and Singapore
(Approximate figures in US Dollars)

Procedure	US	India	Thailand	Singapore
Heart bypass	130,000	10,000	11,000	18,500
Heart valve replacement	160,000	9,000	10,000	12,500
Angioplasty	57,000	11,000	13,000	13,000
Hip replacement	43,000	9,000	12,000	12,000
Hysteractomy	20,000	3,000	4,000	6,000
Knee replacement	40,000	8,500	10,000	13,000
Spinal fusion	62,000	5,500	7,000	9,000

Approximate retail costs. US figures based on Healthcare Cost and Utilisation Project data. International figures based on hospital quotes in named countries.
Source: Accessed 19 April 2010:http://www.docstoc.com/docs/12163631/MEDICAL-TOURISM/ p 36.

[2]

Western patients who do not have health insurance, medical tourism offers a lucrative and beneficial alternative. For the western population Thailand, Mexico, India and Cuba remain the most preferred medical tourism destination. In these developing countries, medical tourism represents a viable and growing source of economic revenue. Countries are actually competing for the medical tourist.

With introduction of medical tourism designed for global tourists, has further made it impossible for the poor to access proper healthcare because of high cost due to increase in demand. Since the foreigners are willing to pay the high cost for their treatment, certain therapies or medical care have become very expensive for the general population.

b) PRIVATIZATION AND VULNERABLE POPULATION.

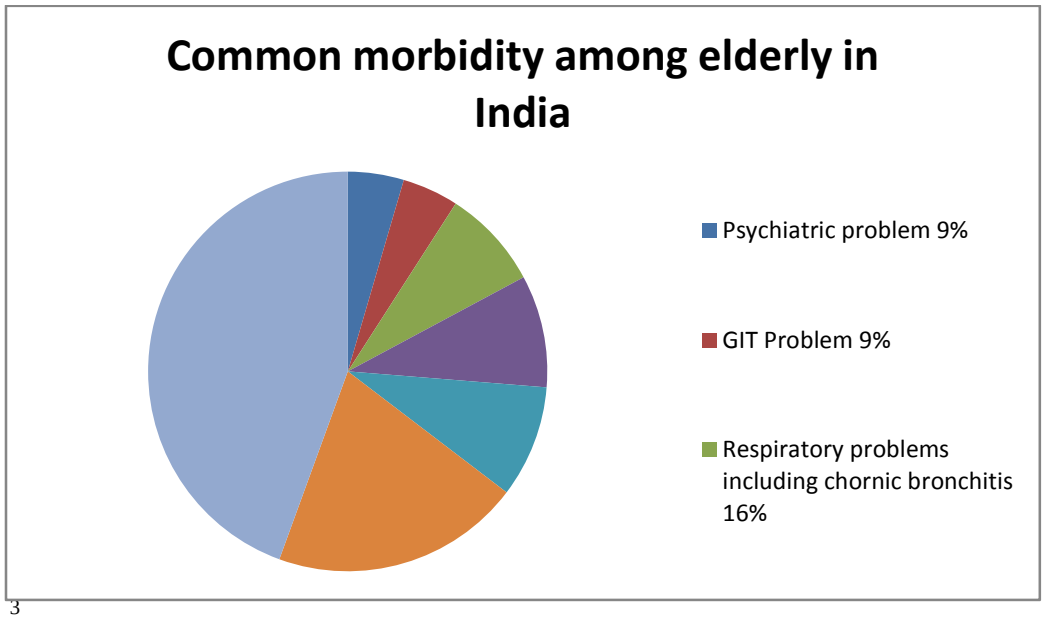
According to IIHER Vulnerable populations include children, women, elderly, socioeconomically disadvantaged and people who belong to oppressed class. Members of vulnerable populations often have health conditions that are exacerbated by unnecessarily inadequate healthcare.

Lack or insufficiency of funds at public healthcare facilities has deprived the poor who access the public hospitals of proper facilities. Private medical sector caters to the needs of the people who can afford the services, their surgery and treatment whereas, mal-nutrition, maternal and infant mortality and high prevalence of communicable disease is still on a rise among the Indian marginalized group. According to NSSO, in 2004 around 28% of rural population could not access health care due to financial constraints.

[2] Reddy, Sunita, Qadeer Imrana, Medical Tourism in India: Progress or Predicament?, *Economic and Political Weekly*, Vol. 45, No. 20 (MAY 15-21, 2010),p 71.

Elderly: The elderly population requires long term health care because of declining physical and mental capabilities which can cost huge sums of money. Due to their decreasing functional capacity they need a range of health care services that includes, physical, mental and emotional. Along with their health their general well being is also required. The elderly require services like assisted living, hospital care, caregiver support and rehabilitation.
If we look at the physical and psychological domain for the elderly, we have the following figures from the previous studies conducted in India.

- 3.7 million suffer dementia
- 40 million suffer from poor vision
- 1.6 million annual stroke cases
- 1 in 3 suffer from arthritis
- 1 in 3 has hypertension
- 1 in 5 has diabetes
- 1 in 5 has auditory problems
- 1 in 4 suffer from depression
- 1 in 10 falls and sustains a fracture
- 1 in 3 bowel disorder
- Cancer is 10 times more common.



[3]

In addition, we have data to show that Indian elderly face several social issues such as loneliness, elder abuse, neglect, lack of income security, and poor access to health care. We also have lack of policies on advanced directive, palliative care, and end-of-life care for the elderly. There is lack of data on the spiritual health of older people. With the

[3] ICMR report survey, 1984-85

growing senior population, is India prepared to face the challenge of providing health care?

Elderly being one of the most vulnerable population needs proper health care facilities which becomes difficult to access for elderly living in rural areas as most of the secondary and tertiary level health care system is available at urban areas and due to old age and low mobility it is difficult for the elderly population living in rural areas to access their health care needs. Also, the economic constraint which is faced by rural elderly is of great concern because most of them are dependent on their families and do not have freedom to spend on their health care needs. They also require someone to accompany them for their treatment because of low visibility, low mobility and fragile body.

Life of many elderly after retirement is of humiliation, isolation and abuses. There are instances where they are denied food, denied medical attention, clean clothes etc and are also tied in case of disability. Elderly population feels great deal of anxiety such as, fear and intimidation by the young members of the family, they mostly suffer from anxieties related to becoming terminally ill, and being cut off from the loving support of families, serious and sudden illness, falling and breaking a bone because of their movements, they are also concerned about their ageing and getting close to death.

> "Although some privileged individuals enjoy excellent health outcomes, others experience "the worst imaginable conditions. Among the elderly, we observed a number of barriers: from pathological progression to family nuclearization and dependency, from reductions in earning potential, to the salience of pre-existing inequities on the axes of gender, caste, and religion Across the board, we found that the elderly population (and subpopulations that form it) does not receive care commensurate to the conditions it suffers (access) and, second, that even where the care is physically accessible, costs of accessing this care hinder uptake (affordability)."[4]

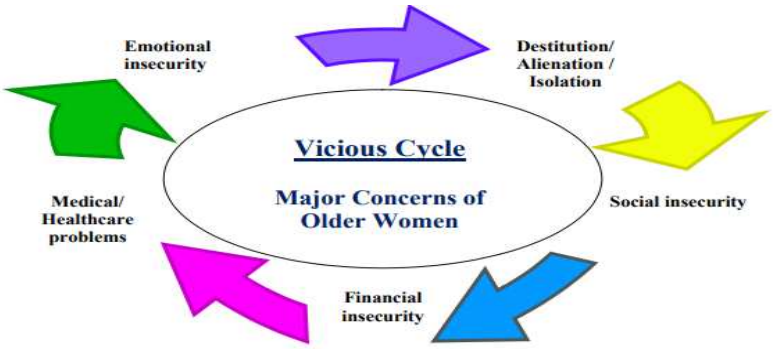
The public health care system and its condition has made it very difficult for the elderly population of our country to get treated as there is long line of people standing in queue for several hours for a visit to the doctor, and it becomes very difficult for the elderly to stand in queue for so many hours for a medical visit.

Due to privatization and lack of specialized doctors at public health centers, the elderly are left unattended according to their requirements. High paying patients are only admitted at private health centers, whereas the needy, poor and elderly population are left to rely on under-staffed and under-resourced public hospitals.

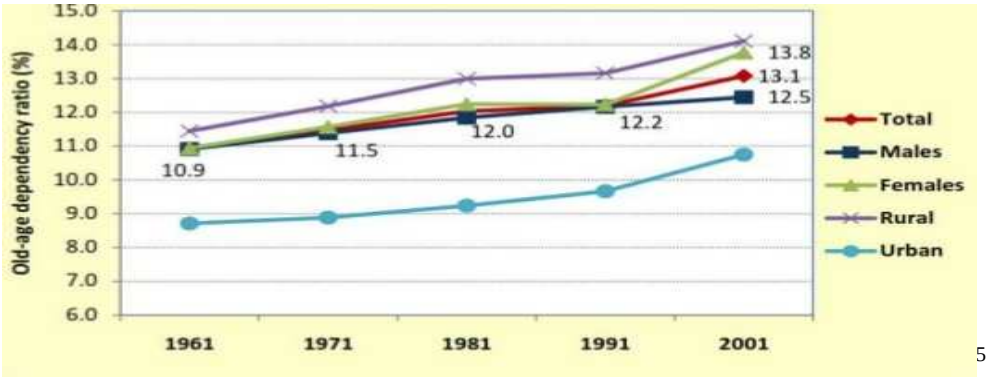
Intersectionality: Along with political and economic inequality, caste distinction has also created disparities in health access. Owing to intersection of age, caste, class and

[4] https://www.ncbi.nlm.nih.gov/books/NBK109208/, consulted 15 April 2019

gender, lower caste poor elderly women have very weak health status as compared to the rest. With restricted provision of safe and clean water, nutritious food, denial of health service by medical professionals, the marginalized group within India, face a lot of health burden. While health plans, insurances, policies and implementations by government is mostly directed to the younger population, children or pregnant women, the older generation are often left neglected. Even researches on oppressed castes are done for women of reproductive age. Due to discrimination based on caste, they don't get employment easily and thus, remain poor and are consequently denied proper housing, food, education and standard of living. With low income they are unable to look after their health needs and therefore have major health concerns. Elderly dalit women face violence and exclusion based on their age, caste, gender and economic status. They therefore constitute one of the most vulnerable populations that require maximum care and attention. Due to old age, dalit women face isolation insecurity from their family, financial dependence on children, medical healthcare problems like heart problems, joint pain, and others.



Dalit elderly women population is deeply affected by the privatization of health sector. Due to old age they have reduced mobility and functioning capacity and along with financial constraints they are unable to afford a visit to a private health centre for their treatment. Elderly women face a number of health concerns such as osteoporosis, menopause, UTI, breast and cervical cancer, prolapsed cervix etc. According to studies, cases of osteoporosis are higher among females after Menopause. The graph below shows the financial issues faced by the elderly population.



[5]

[5] https://www.BireshwarSinha1/geriatric-health-needs-and-gaps

Since pension schemes are designed for those who have worked in public sector a large number of the population is not able to benefit from this scheme and are therefore dependent on their savings or on their children. Lack of specialized doctors in public health care system, their severe health concerns are left untreated or misdiagnosed.

Conclusion:

Privatization of medical industry has poorly affected the general population of the country. With most funds directed towards innovation and upgrading the private hospitals, the public sector health care institutions stand in dilapidated conditions. Being an emerging medical tourist hub, India lags at position of 112 on survey of Global Health System by WHO in 2002. India's status at United Nations Human Development Index is also very low which stands at rank 130 out of 189 countries for the year 2017-18. Treatment in India is rather paradoxical, while one wealthy patient gets the best of facilities for his/her treatment, a poor Indian patient dies waiting for being treated either due to the high cost, unavailability of doctors or poor facilities.

The government policies promoting private sector, where the one who can afford can get treated, the health of majority of citizens remain poor and their needs unmet. Such framework of policy implies that there is certain kind of acceptance, that there exists disparity in standards of healthcare for the rich and the poor.

Studies by India's Central Bureau of Health Intelligence National Health Profile (Ministry of Health and Family Welfare, 2007) suggest that only 10% of doctors are engaged in public sector health care institutions. Also, only 17% of expenditure was spent on public health care facilities, and around 83% on private set-ups.

	India	United States	Thailand
Govt. health expenditure as a percent of total health expenditure	17.3	44.7	64.7
Private health expenditure as a percent of total health expenditure	82.7	55.3	35.3
Out-of Pocket Expenses as a percent of private health expenditure	93.84	23.80	74.70
Per Capita total expenditure on health (Current US $)	31.4	6096.2	88.1
Per Capita govt. expenditure on Health (Current US $)	5.4	2724.7	57
Per Capita private expenditure on health (Current US $)*	26	3371.5	31.1
Per Capita Income (Current US $)**	630	40930	2530
Private per capita expenditure as a percent of per capita income***	4.12	8.23	1.22

*Author's calculations: Per Capita total Expenditure-Per Capital Govt. Expenditu
**World Bank World Development Indicators
***Author's calculations: Private Per Capita Expenditure/Per Capita Income

Source: World Health Organization Statistical Information System (2008).

6

Concisely, introduction of private healthcare system has hampered the growth of public health care. Along with shortage of doctors because of brain drain and towards private health care institutions, poor infrastructure, low fund allocation, doctors are also now specializing in diseases prone to wealthy domestic or global patients, whereas specialization in community medicine is widely decreasing that is vital for a large section of the population. Reeling under various communicable diseases, mosquito-borne

[6] VIJAYA, Ramya, Medical Tourism: Revenue Generation or International Transfer of Healthcare Problems?, *Journal of Economic Issues*, Vol. 44, No. 1 (MARCH 2010), p 60

diseases, tubercolosis and maternal health has seen few specilaization as compared to joint replacements, spinal surgery or organ transplants that foreign patients visit India for. The commodification and corporatization of health care has substantially affected vulnerable patients. The elderly is also facing distress because of such policies which are inroduced by the government. Effective interventions for elderly need to be developed and evaluated, which addresses the needs of elderly and the vulnerable population.

REFERENCES

Acharya, Sanghmitra (2010): *Caste and Patterns of Discrimination in Rural Public Health Care Services* in Sukhdeo Thorat and Katherine S Newman (ed.), Blocked by Caste-Economic Discrimination and Social Exclusion in Modern India (Delhi: Oxford University Press)

– (2002): *Health Care Utilisation in Rural North India – A Case of Nirpura*, District Meerut, study undertaken as part of the Monitoring Shifts in Health Sector Policy in South Asia Project, Unpublished repot. Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi.

Achutha Menon Centre of Health Sciences (2005): *Current Status of Services Delivery in the Health and Family Welfare Sector in Kerala,* Sri Chitra Tirunal Institute of Medical Sciences, Thiruvananthapuram, January.

Banerjee, A and E Duflo (2007): The Economic Lives of the Poor, *Journal of Economic Perspectives, 21 (1).*

Banerji, D (1985): *Health and Family Planning Services in India: An Epidemiological, Socio-cultural and Political Analysis and a Perspective* (New Delhi: Lok Paksh).

Baru, R (1998): *Private Health Care in India: Social Characteristics and Trends* (New Delhi: Sage Publications).

Baru, Rama, Acharya, Sanghmitra, nagaraj, K., (2002) *Inequalities in access to Health services in India, Caste, Class and Region*

Bloom G, B Kanjilal and D H Peters (2008): *Regulating Health Care Markets in China and India, Health Affairs*.

Bonu, S, I Bhushan and D H Peters (2007): Incidence, Intensity and Correlates of Catastrophic Out-ofPocket Health Payments in India, *ERD Working Paper No 102, Asian Development Bank*, October; Manila, Philippines.

CBHI (2004): Central Bureau of Health Investigation, Ministry of Health and Family Welfare, www. nrhm.nic.in, accessed on 6 March 2009.

DFID (2002): *Study of the Dynamics and Structure of Private Health Care in Madhya Pradesh.* Department for International Development, India and Government of Madhya Pradesh, New Delhi.

IIPS (1995): National Family Health Survey (NFHS) 1992-93, Institute of Population Sciences, New Delhi.

Khan, Shamus, (2012), The Sociology of Elites, *Annual Review Sociology*, 38:361-77
L V Gangolli, R Duggal, Abhay Shukla, (2005): Private Health Sector in India: Raising Inequities in (ed.), *Review of Health Care in India* (Mumbai: Centre for Enquiry into Health and Allied Themes).

NSSO (2006): "Morbidity, Health Care and the Condition of the Aged, National Sample Survey", 60th Round (January-June 2004), Report No507, Ministry of Statistics and Programme Implementation, Government of India, New Delhi.

Nundy, M (2005): "*The Not-for-Profit Sector in Medical Care in Financing and Delivery of Health Care Services in India*", National Commission on Macro economics and Health background papers, Ministry of Health and Family Welfare, Government of India, New Delhi.

Qadeer, I, K Sen and K R Nayar (2001): *Public Health and the Poverty of Reforms: The South Asian Predicament* (New Delhi: Sage Publications)

Reddy, Sunita, Qadeer Imrana, (2010), Medical Tourism in India: Progress or Predicament? *Economic and Political Weekly*, Vol. 45, No. 20, May 15-21 2010

Sabharwal, Nidhi, Sonalkar, Wandana, (2015), *Dalit Women in India, At the crossroads of Gender, Class and Caste*

Sengupta, Amit, (2011), Medical Tourism: Reverse Subsidy for the Elite, *Signs*, Vol. 36, No. 2

Vijaya, Ramya, (2010), *Medical Tourism: Revenue Generation or International Transfer of Healthcare Problems?*, *Journal of Economic Issues*, Vol. 44, No. 1

WHO (1978): Report of the International Conference and Primary Health Care, Alma Ata, USSR, 6-12 September, World Health Organisation, Geneva. – (2008): National Health Accounts, http://www. who.int/nha/country/en/index.html, World Health Organisation

https://www.businesstoday.in/current/economy-politics/oxfam-india-wealth-report-income-inequality-richests-poor/story/268541.html

https://www.jstor.org/stable/20764312?seq=2#metadata_info_tab_contents