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Distributive Considerations in Health care Service on Common People

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Abstract

The World Health Organisation (WHO) defines health as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Thus, along with physical and mental aspects, another dimension of social well-being is being attached that cannot be ignored. In that context, an important consideration in the provisioning of healthcare is the distribution aspect and how just this distribution is regardless of any socio-economic consideration. The challenge in contemporary healthcare prospect is the structuring of such a framework regarding distribution of healthcare service through which distributive justice is achieved for all citizens. Healthcare having a public good character, it cannot be provided by the private sector on a market-oriented basis at the welfare maximisation level as it will deprive those who are unable to make payments; it makes the case for government provisioning of the service based on equality and just distribution. But the healthcare landscape of the country reveals a picture of undersupply of the service along with continuous withdrawal thereby making provisions for private sector to occupy the space. This has raised a serious question on the equality aspect where everyone should get healthcare service at the time of need. This paper makes an attempt to study how the poor and the disadvantaged sections of the society becomes more and more vulnerable due to inaccessibility to healthcare services in the phase of growing privatisation leading to commercialisation of the service.

Keywords : *1. Deprivation, 2. Government, 3. Healthcare, 4. Poor,5. Private Sector, 6. Provisioning.*

Introduction

An important consideration in the provisioning of healthcare is the distribution aspect and how just this distribution is. The challenge in contemporary healthcare prospect is the structuring of such a framework regarding distribution of healthcare service through which distributive justice is achieved for all citizens. According to Smith (2002),"when applied to basic health care, the theory [of distributive justice] provides that everyone- the poor, the rich, the young and the old have an unqualified right to health care". As provisioning and distribution of healthcare is being affected by the persistent socio-economic differential in society, there lies the importance of the principle of equal distribution being related to the right to healthcare. Daniels (1981) advances two purposes that are fulfilled by the theory of healthcare needs: firstly, it helps in understanding healthcare as 'special' which should be treated differently from other social goods and secondly, the theory provides the basis that helps in distinguishing the healthcare service between more important and less important. The answer to why distributive principles are to be applied to the heath sector can be grasped from the first argument as 'healthcare as a social good' cannot be afforded to have pervasive inequalities as in case of other 'social good' that are being tolerated(glorified?) in a society(Daniels, 1981). The second argument can be fairly interpreted in terms of importance of providing more important services to all equally over providing luxurious services to a few.

Promoting equal health in a country like India, where most of the people are poor, would require giving priority to the low status first. The question of justice and equality in the delivery and distribution of healthcare has become all the more relevant now-a-dayswith the ever-increasing initiative of privatisation in the country where, even the public goods like education and healthcare are in the private hands that operates solely on profit motive. This paper aims to understand the relevance of the

distributional equality applied to healthcare in the present-day context and the real divergence in the real world due to growing privatisation along withthe issues associated.

Research Question

The basic question that arises regarding the study is whether thepoor and disadvantaged are less prioritised in providing the healthcare service.

Methodology

The paper is descriptive and analytical in nature. It uses secondary information from various government reports, journal articles, books and other relevant online sources.

Principles of Distributive Justice and its Contemporary Relevance: Literature Review

It is due to the existing social stratification and the growing inequality in income distribution that John Rawls' Maximin Principle of the Theory of Justice has become more and more pertinent, where the solution to deprivations and lack of availability of opportunities is through the benefit maximisation of the least advantaged (Gwatkin, 2000). Rawls (1971) put forwarded two principles of justice chosen in 'original position' as follows: 1) "Each person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for others" and 2) "Social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all".Extending Rawls' theory of justice as fairness to healthcare, Daniels' (1981) urge was to make a normative claim regarding the theory of justice that includes a principle of fair opportunity, that is, distributive theory as the basis of healthcare. But Daniels (1981) holds a different view from Rawls when the later regards health as a 'natural' and not 'social' primary good claiming its possession to be less influenced by basic institutions. Daniels (1981) also asserted that it is actually the 'opportunity' and not 'healthcare' which is the primary 'social' good, but it is not due to less institutionalised effect, rather, because here, the institutions provide for fair and equal opportunity unlike income and wealth providing fair opportunity in case of primary social goods. Therefore, it is the healthcare institutions which are to protect fair equality of opportunity by addressing the needs.

Different literatures concerninghealthcare access and provisioning reveal how economic status has become a social indicator determining a person's capability to be able to access the service. Equal access to healthcare requires healthcare to be allocated according to need without any consideration to socio-economic status of people. But in reality, attaining equality in healthcare delivery cannot be isolated from socio-economic deliberation. It is, therefore, required that the governments, particularly in less developed and developing countries, where most of the people are poor, spend a considerable amount for social sector expenditure, specially, on healthcare and education. An increasing percentage of GDP spent on healthcare reflects the priority given to that service, but in India, expenditure on healthcare as percentage of GDP is still 1.4 percent (HDI, 2016, UNDP) which was below 1 percent up to 2009.Higher income associated with declining mortality and rising longevity is well recognised by literature (Preston, 1975; Deaton, 2002; Kitagawa, 1973; Zimmer, 2008; Chen et al., 2010; Liang et al., 2000 etc.). Bollen et al. (2001) argued that so far as economic status is loosely defined because of differences in choice of measures due to data availability considerations, it will be a challenge to get the causal relationship between economic status of an individual and health. However, because of paying little attention to this relationship as being less sensitive to the choice of indicators, Barik et al. (2016) made a study about the reciprocity of the relationship between economic status and adult mortality in India and tried to find out whether the relationship is sensitive to the choice of indicators. The study used data for two periods concerning 1,32,116 adults: 2004-05 for their economic status and 2011-12 for the likelihood of their deaths and the results showed strong linkage between higher economic status and lower mortality. The strong relation between economic deprivation and ill-health is actually a circular process, where poverty further leads to decline in economic status, that is, catastrophic expenditure further impoverishing the

poor (Smith, 1999). Although some researchers (Desai et al., 2010; Mohan et al., 2010) tend to find growing income associated with negative influence on health (like consumption of diverse foods, lower obesity etc.)and in that context, an interesting remark is made by Ramachandran (2016) calling it to be a 'dual burden of malnutrition' with 'undernourished poor' and 'rising obesity among the rich', but at the same time, it is the poor who is more vulnerable as with higher economic status, it is easier to get treatment which the poor cannot afford intensifying the existing health-wealth nexus.Looking at all these, question arises regarding the relative importance of the concept of distributive justice in the provisioning of healthcare service and equal access by the people to the service at the time of need.

Deteriorated Public Health Priorities

The design of health system and the implementation of the health policies should be envisaged to address the urgent need of meeting the healthcare requirements of particularly those who are unable to bear the expenses on their own. But the contemporary healthcare landscape of India reveals a very poor picture of healthcare provisioning along with continuous withdrawal of the service by the government. This has allowed the private sector to occupy the space. The gaps in the service delivery, shortage of manpower and infrastructure, lack of attention to the comprehensiveness of healthcare service by neglecting issues like sanitation and water supply provisionsetc. have very much undermined the public health priorities anddilapidatesthe affordable accessibility to the service.

Contemplating health inequality as an important driver of health policy making, so as to reduce the socio-economic disparity in healthcare delivery, it should be provided by the government. But unfortunately, in India, gradually the service is being privatised where data shows that 76 percent of healthcare is provided by the private sector with 67 percent being out of pocket expenditure (National Health Accounts Estimates of India). The following table shows disgracefully bad position of India in terms of expenditure in healthcare comparing with other countries along with BRICS and OECD countries.

Table 1: Healthcare Expenditure in Selected Countries

Country	Total Health Expenditure Per Capita (USD)- 2011	Total Health Expenditure as Percentage of GDP- 2011	Government Health Expenditure as Percentage of Total Health Expenditure- 2011
India	$62	3.9%	30.5%
Thailand	$214	4.1%	77.7%
Sri Lanka	$93	3.3%	42.1%
BRICS Countries			
Brazil	$1119	8.9%	45.7%
China	$274	5.1%	55.9%
Russia	$803	6.1%	59.8%
South Africa	$670	8.7%	47.7%
OECD Countries			
USA	$8467	17.7%	47.8%
United Kingdom	$3659	9.4%	82.8%
Germany	$4996	11.3%	76.5%
France	$4968	11.6%	76.8%
Norway	$9908	9.9%	85.1%
Sweden	$5419	9.5%	81.6%
Denmark	$6521	10.9%	85.3%
Japan	$4656	10%	82.1%

Source: Situation Analysis: Backdrop to the National Health Policy, 2017;Ministry of Health and Family Welfare, Government of India

From the above table, India's dismal performance in terms of expenditure on public healthcare very well reflects the gap where the rich can purchase the service from private providers even though it is expensive and the poor, on the other hand, due to insubstantial public spending, will be deprived from the service, even from the most basic and needed ones. The condition is even worse for the rural areas of the country where the Sub Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) are suffering from acute shortage of health personnel and infrastructure. Data shows that against the requirement of 25650 doctors at PHCs, 5624 physicians at CHCs and 31274 pharmacists at PHCs and CHCs, there is the availability of 27124, 864 and 25193 respectively; thereby having a shortfall of 3027, 4760 and 7092. Out of total 25650 PHCs functioning, 1974 are functioning without doctors, 9183 without laboratory technicians and 4744 without pharmacists. Out of total 156231 SCs functioning in the country, 6371 are without female health workers (ANMs), 78569 without male health worker and 4243 operating without both. Out of 5624 CHCs functioning, 5170 CHCs are running without having all the four specialists (Surgeons, Physician, Gynaecologist and Paediatricians)at the same time, 928 are lacking operation theatres and 438 are not even having the labour room (Source: *Data.Gov.in*, Rural Health Statistics, Ministry of Health and Family Welfare, Government of India). Although many reform initiatives are being introduced in the name of achieving universal healthcare, yet in actual practise the deteriorated public health sector deprives the poor and needy that ultimately trivialises the healthcare achievement.

Marginalisation of the Socio-Economically Vulnerable Groups

In recent times, in the provisioning of basic healthcare services to the people, private financing has increased significantly. According to Mazumdar (2015), the fast-paced transitions in the health sector are due to the gradual erosion of the role of the government which is substituted by over enthusiastic private sector. Typically, private health care is dominant for ambulatory treatment of illness in developing countries andaccordinglyitaccountsforthelargestshareoftotalhealth care spending (Berman and Hanson, 1998). Although literature has established that income (GDP) is a very important determinant of public expenditure on health care, yet according to Barman et. al. (2010), the existing conceptual framework does not make a clear prediction about the relative share of public and private sector as income increases. According to them, with the increase in the countries income, resources are available to purchase all types of health services including those provided by the private sector and thus the supply of private health care services also increases with the increase in income. The authors' concern is to look at whether public and private sectors are complements or substitutes. If the level of public investment is relatively high and if private sector shares of supply are lower, then the public and private sectors are described as "substitutes"; if private supply is also higher, then the two sectors can be regarded as "complements". But healthcare having a public good character and healthcare market being characterized by asymmetric information (Kethineni, 1991), private sector cannot make welfare maximizing level of investments and thus substitutability of government and private sector in the provisioning of the service is being ruled out.

Mazumdar (2015) has identified that pilferage of government funds by private empanelled hospitals are because of the factors like lack of standard guidelines and auditing, "abnormal" economics of induced demand in clinical services, quality of health care providers, lack of infrastructural facilities etc. which are also responsible for growing the private services. According to him, the central issues in the health economics literature are moral hazard problem and supplier induced demand which have ensured reckless system of privatisation characterised by fragmented, unregulated market that lack institutional sophistication but a few badly mauled normative assumptions. Bearing the costs of the healthcare service in a private sector are beyond the reach of the poor. The publicly financed healthcare programmes are aimed at universal accessibility, yet due to lack of coverage to the entire spectrum of the population in healthcare needs, there is a considerable increase in the catastrophic health expenditure along with consequent impoverishment. Due to the out of pocket expenditure on healthcare costs, over 63 million people are pushed to poverty every year (Berman et al., 2010). The NSSO Report on 'Household Consumer Expenditure in India' for the period 2011-12 (NSS 68th Round, 2013) revealed the share of out-of-pocket expenditure on healthcare as a proportion of total household monthly per capita expenditure to

be 6.9 percent in rural areas and 5.5 percent in urban areas. As such the number of households facing catastrophic expenditure due to the increase in healthcare costs increased from 15 percent in 2004-05 to 18 percent in 2011-12 (Karan et al., 2014). According to the Health Bulletin, 2014, Published by the Directorate of Health Services, India, there has been a rise in the healthcare expenditure in private sector from 49 percent to 60 percent from the year 1997 to 2006 that has further inflated to as high as 83 percent in 2014. The greater reliance on private sector has caused diversion of funds from government provisioning which otherwise would have proved to be just and equitable to the profit oriented private sector. The result is high degree of inequality in access and health outcomes. In a report by UNICEF entitled 'The Situation of Children in India' reveals how poor and marginalised communities continue to remain in the state of poverty. The survey report found only 45 percent children in the scheduled tribe areas of Orissa aged 12-13 months to be fully immunised while the figure for other states was 62 percent. While skilled attendants at birth is 26 percent for the people of scheduled tribe areas of Orissa, it is 51 percent for other statesof India (UNICEF, The Situation of Children in India - A Profile, New Delhi, 2011). The following tables reveal the health outcome inequalities for the vulnerable population groups mostly in deprived areas of India.

Table 2: Health Outcome Disparitiesfor Rural and Urban Areas in India

Indicator	Total	Rural	Urban	Percentage Difference
Total Fertility Rate (2013)	2.3	2.5	1.8	39%
Infant Mortality Rate (2013)	40	44	27	63%

Source:TFR: Statistical Report, 2013; Registrar General of India and IMR: SRS Bulletin, 2014; Adapted from 'Situation Analysis: Backdrop to the National Health Policy, 2017';Ministry of Health and Family Welfare, Government of India

Here, with just two health indicators, the rural-urban divide in health outcomes is being shown. The highly skewed mortality rates towards rural areas raises serious concern towards achieving healthcare equality. From the census 2011 data, out of 1210.2 million population, rural population is 833.1 million that constitutes 68.84 percent, but ironically, the National Commission on Macroeconomics and Health itself admits the fact that to serve those 31 percent urban population, about 80 percent of the health infrastructure including manpower and other resources are concentrated in the Urban areas (Goli, 2012). Again, the following table shows the disparities in health outcomes for different states of the country.

Table 3: Health Outcome Disparities for Different States in India

Indicators	States with Good Performance	States with Greater Challenge
Total Fertility Rate (2013)	West Bengal (1.6), Tamil Nadu (1.7), Punjab (1.7), Himachal Pradesh (1.7), Delhi (1.7)	Bihar (3.4), Uttar Pradesh (3.1), Madhya Pradesh (2.9), Rajasthan (2.8)
Infant Mortality Rate (2013)	Goa (9), Manipur (10), Kerala (12), Puducherry (17), Nagaland (18)	Madhya Pradesh (54), Assam (54), Orissa (51), Uttar Pradesh (50), Rajasthan (47)
Maternal Mortality Rate (2011-13)	Kerala (61), Maharashtra (68), Punjab (141), Tamil Nadu (79)	Uttar Pradesh/ Uttarakhand (285), Bihar/ Jharkhand (208), Madhya Pradesh/ Chhattisgarh (221), Rajasthan (244), Orissa (222)

Source: TFR: Statistical Report, 2013 (Registrar General of India); IMR: SRS Bulletin, 2014; MMR: MMR Bulletin, 2015 (Registrar General of India); Adapted from 'Situation Analysis: Backdrop to the National Health Policy, 2017';Ministry of Health and Family Welfare, Government of India

The comparative analysis of the health outcomes reflects the inter-state disparity in the country and the good performance states clearly depicts favouring of the high-income states in terms of health resources and utilisation, while the low-income states are still facing the challenges.

Where Does the Problem Lie? Privatisation, Commercialisation and Increasing Healthcare Costs

For healthcare needs, it is important to have a clear notion of health and disease for having equality of opportunity for all along with a just distribution of healthcare services. Daniels (1982) argued that it is because of the nonhomogeneous nature of healthcare services where some functions are more urgent and important than others, the question of equal access to healthcare has become a complex issue and hence it is important to make it clear what actually is the access that is required concerning the key services. The author further has reflections on the question of distributive justice, which he considers to be the most fundamental, that while assessing the divergence from equitable access, what is the factor that counts. Scanlon (1975) in his scholarly article 'Preference and Urgency' talks about distinguishing between subjective and objective criteria of well-being so as to assess the importance of competing claims in a variety of moral contexts. He discussed how the criteria of well-being constitute morel arguments: while the individual's own assessment of being well-off having or without having the claimed benefit that would determine the significance of his claims or preferences will constitute the subjective criterion; the objective criterion uses a measure which is independent of the individual's own assessment, like the strength of his preferences (Scanlon, 1975). Daniels (1981) interpreted this in distributive justice context and claimed for objective criteria of well-being to be morally justified without relying on the subjective ones solely. Cropanzanoet al. (2015), while explaining distributive justice, talks about 'equality in allocation' and 'allocation on the basis of need'. While the former provides everyone with the same amount without consideration to contributions, the later provides outcomes to people with particular needs based on a perceived deficit.

Having discussed the theoretical considerations and their importance, what actually is happening in the practical world provides a completely opposite picture where privatisation has led to the commercialisation of the service. The private healthcare industry, which is currently valued at $40 billion is estimated to grow to $280 billion by 2020 as per market sources (Business Standards, Healthcare sector to touch $280 bn by 2020: FICCI, Press Trust India, New Delhi). In the private healthcare industry, while hospitals and clinical care accounts for the highest 50 percent of share, insurance and equipment accounts for about 15 percent, pharmaceuticals over 25 percent and diagnostics for about 10 percent ('Situation Analysis: Backdrop to the National Health Policy, 2017';Ministry of Health and Family Welfare, Government of India).

Inflated medical bills by private sector health service providers makes them inaccessible to the socio-economically vulnerable groups. It is mostly the high prices of unnecessary and irrational use of medicines, medical devices, consumables like syringes, gloves etc., which otherwise the private hospitals purchase at very cheaper rate, raises the medical bill so high that goes beyond the reach of a poor. In fact, the National Pharmaceutical Pricing Authority (NPPA) comes to recognise that the profit margin for an institutional purchase of medicines and medical products can be as high as 1737 percent for private hospitals (NPPA Report on overcharging of medicines, 2017). Hence there is an urgent need to check and regulate the unwanted rise in medical bills by the private sector service providers.

Due to the private sector operating, the free market policies have led to continuous rise in the prices of medicines and pharmaceutical products where the consumer (patient) has no other choice but to agree to what the doctor asks for taking. Overpricing of medicines due to inadequate pharmaceutical policies in India, being the key issue, the poor are the worst sufferers as most drugs required for the diseases of public health importance are not represented in the list of drugs by the Drug Prices Control Order (DPCO). DPCO initially placed 347 medicines in 1979 from spiralling drug prices that were deemed essential in India, but by 1995, the national and multinational drug companies succeeded in persuading

the government to limit the number and it has been reduced to 76 drugs by 1995 (Srinivasan, 1999). The following table gives a comparative statement of a few drug prices by a non-profit public trust (LOCOST Baroda) and the prevailing market prices (DRUG TODAY compilation).

Table 4: Comparison of Generic Medicine Prices and Retail Market Prices

Name of Drug	Strength	Use	LOCOST Baroda Price: June-Sep 2003	MRP of Standard Company as per 'DRUG TODAY': April-June 2003
Albendazole Tabs	400 mg	Against worm infestation	Rs 11.00 per strip of 10 Tabs	Rs 9.00 per Tab (strip of 1 Tab)
Amlodipine Tabs	5 mg	Anti-hypertensive	Rs 2.50 per strip of 10 Tabs	Rs 21.77 per strip of 10 Tabs
Amoxycillin Capsules	500 mg	Antibiotic	Rs 19.75 per strip of 10 Tabs	Rs 68.60 per strip of 10 Caps
Atenolol Tablets	50 mg	Anti-hypertensive	Rs 2.80 per strip of 14 Tabs	Rs 20.00 per strip of 14 Tabs
Enalapril Maleate	5 mg	Anti-hypertensive	Rs 3.00 per strip of 10 Tabs	Rs 22.58 per strip of 10 Tabs
Fluconazole Capsules	150 mg	Antifungal	Rs 35.00 per strip of 10 Caps	Rs 29.50 per caps (Strip of 1 Cap)
Glibenclamide Tablets IP	5 mg	Anti-diabetic	Rs 1.50 per strip of 10 Tabs	Rs 3.73 per strip of 10 Tabs
Metformin Tablets	500 mg	Anti-diabetic	Rs 3.00 per strip of 10 Tabs	Rs 6.45 per Strip of 10 Tabs
Paracetamol Tabs – 500 mg	500 mg	Fever reducing	Rs 2.00 per strip of 10 Tabs	Rs 6.90 per strip of 10 Tabs
Rifampicin Capsules	450 mg	Anti TB	Rs 32.00 per strip of 10 Caps	Rs 59.12 per strip of 10 Caps

Source: Srinivasan, 1999

The fact that competition between public and private sector would have lowered the prices of drugs, but poor-quality evidence base regarding competition from the public sector, particularly in terms of deficiencies in availability of drugs, lack of management and technical skills, less concentration in the rural and primary healthcare centres etc., healthcare delivery gets concentrated mostly in private hands and the inability of the government to regulate and control the private sector leads to rising prices of drugs and other medical facilities.

Conclusion

Socio-cultural and economic facets tend to have reflections in social stratification and situations will intensify if the government does not interfere in terms of distribution of resources in the social sphere. Unequal distribution of health resources, iniquitous healthcare structure, concentration in urban areas etc. have led to disparities in health outcomes. Evidently, poor coverage of health and nutritional services undervalues the mission of achieving Universal Health Coverage in India. Serious undermining of the distributive aspects serves the interest of only the commercialised market oriented private sector.Hence, the effectiveness of different health policies and programmes will require strengthening of the public health system for catering to the needs of the socio-economically vulnerable groups, more particularly the rural population.

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