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CAPABILITIES AND ENTITLEMENTS 'THE POLITIK OF HEALTH ECONOMICS IN INDIA'

Bhaskar Chakraborti

B.A. (Delhi), Economics; M.A. (TISS).Development Studies, M.Phil (Sociology)

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Corresponding author

ABSTRACT

The paper aims to capture the essence of political economy of health with the sighting theoretical underpinnings of different schools of thought – Marxist, Cultural Critique and Development of the underdeveloped. It further attempts to reflect on the way in which Indian health professionals and thinkers in the field engage with the discourse. The paper travels from historical events in the field of public health in India and reflect the emerging current day issues in the light of International Political Economy and the withdrawal of the state in health activities and a large percentage of market captured by the private sector. With examples of health programs from India, the paper attempt to unpack, the role of state in the Indian Public Health System and analysis of the factors which perpetuate in defining the arena of the political and economic stratifiers of Indian Health System and health care economy.

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INTRODUCTION

Political economy assumed the definition of the discourse of the study of polity of economies of polities or nation states in the 18th century. Gradually, the concept of Physiocracts that land was the source of all wealth was impinged by the labour theory of value by John Locke, Adam Smith and Karl Marx. Notably, Political Economy incorporates liberal, realist, Marxist and constructivist theories political sciences.[1] The label of 'political economy' was so a commonly used word in English-speaking world during the 19th century, however it had fallen from it stature by the middle of the 20th century with increased writings and contributions in the mainstream economics, resulting in gradually fading away of the term. A classical shift and revival of political economy raises several questions in the discourse of political economy, till what extend these two terms can be differentiated or can be used interchangeably or it is just the change in the literary style over the period of time.

For some authors political economy is same as economics, while some other see economics and political economy as being opposite of the same coin. For example Lor Robbin (1981) refers political economy as the 'application of economic sciences to solving problems of 'social policy'. Some other thinkers like Shaun Hargreaves, Heap and Martin Hollis consider it is an existence of a need for political economy as a mode of analysis arising out of the logical inadequacies of the orthodox economic approach. (Whynes,1979). The latest version of the term is International Political Economy (IPE), which studies the effect of domestic monetary and fiscal policies on international trade and finance in relation to a specific country. The new political economy stresses the importance of institutions like unions and associations, but interprets their behaviour as a derivative of their member's individualistic preferences and the process through which they are aggregated. This in a way differs from the traditional Marxist political economy where the understanding is more or less understood as institutions tend to develop in the specific context of the class struggle under capitalism.

[1] *Also see:http://www.economywatch.com/political-economy/political-economy-definition.html*

In one's understanding in trying to construe how the global economy works, the discipline/field of political economy seeks to locate economic analyses within a political environment and seeks to understand the interplay between politics and economics.

WHAT IS THE POLITICAL ECONOMY OF HEALTH?

From the post-modernist Kantian perspective ,one may let the discourse flow from the linkages amidst health and political philosophy to contemplate the politik of health policy .The immediate context of Kant's text, however, was the tightening of the censorship following the accession of Frederick William in 1786 with the intention to reverse the process of enlightenment encouraged by Frederick II.The first essay concerns the conflict of philosophy with the theology faculty .First published by Nicolovius in autumn 1798, Conflict of Faculties[2] comprises, in Kant's words,

'three essays that I wrote for different purposes at different times' with a preface and an introduction. The three essays – 'The Conflict of the Philosophy Faculty with the Theology Faculty', 'The Conflict of the Philosophy Faculty with the Faculty of Law' and 'The Conflict of the Philosophy Faculty with the Faculty of Medicine' – address the general problem of the relationship between knowledge and power and the specific problem of the relationship between the university and the state by means of a discussion of the relationship of the 'lower faculty' of philosophy to the three 'higher faculties' of theology, law and medicine. The broad background to CF was the increasing tension throughout the second half of the eighteenth century between the claims of higher faculties largely dedicated to vocational training of priests, lawyers and doctors and those of the lower, philosophical faculty to speak philosophically upon theological, legal and medical issues."

Without going in much detail in defining health and the aspects of health care,it may be mandatory to focus on the health as good and the *political economy of public health*. Though many people mention about political economy of health in the sector, not many of them define it, For example Doyal (1979) in his book titled 'Political Economy of Health' has not defined the term. Baer (1982) defines the political economy of health as a critical endeavour which attempts to understand health related issues within the context of the class and imperialist relations inherent in the capitalist world system. However Baer limits the field of analyses of capitalist countries, while in fact the approach has also been applied to research on socialist and communist countries (Navarro, 1976). Morgan (1987) defines the political economy of health as a macroanalytic, critical, and historical perspective for analyzing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political and economic relations within the world economic system. Classical Marxist analysis of health draws close parallel to Marxist understanding of capitalism and how it operates, and seeing health status and the organization of health care as direct results of the capitalist socioeconomic formation. The orthodox Marxist political economists have a dual agenda: they seek to explain the socioeconomic and political nature of medicine within a Marxian framework, using concepts such as class struggle and the desirability of socialist revolution; and they also wage a constant battle to convince mainstream health professionals to accept their interpretations.Cultural critiques question the value of Medical services, arguing that biomedicine is often detrimental to individual health and to standards of social equality. It is in a way like the orthodox Marxist approach, because both attempt to analyze individuals within the context of unequal power relations based on gender, race and socioeconomic status. Navarro (1985) who takes a orthodox Marxist position explains the inadequacies of evading class analysis and labels the approach as that of 'power elite'. On the other hand, dependency approach/world systems theory/development of underdeveloped school of thought analyses 'under-development of health' in the third world and focuses on the unequal relationship between developed and underdeveloped countries. Imperialism, colonialism and capitalist penetration are identified as the major precipitating determinants of disease, poverty and underdevelopment. Theoretical underpinning of this approach lies with the works of A.G. Frank and I. Wallenstein. Some of the political economists of health were initially enthusiastic about the approach, because it could be applied in understanding global analysis of social and health consequences of capitalist expansion. However, Marxist political economist realized that the approach was not based on close rendering of Marx and that it emphasized economic determinism over social relations. It is argued that health like almost all other aspects of human life, is political in numerous ways: Health is political because like any other resource or commodity under a neo-liberal economic system, some social groups have more than others, where its social determinants are amenable to political interventions and thus in a way dependent on political action and it is political because the right to 'a standard of living adequate for health[3] and wellbeing is or should be, an aspect of citizenship and a human right. (Bambra, Fox and Samuel, 2005). The beginning of the 19th century was the period of rapid industrialization which led to the migration of a large number of people from the countryside into major cities in the U.K.. The lack of adequate amenities for the working population leads to overcrowding of cities. The housing that was hastily thrown together by the employers was of poor quality crampled in huddles around the factories, deprived of clean water supplies and with inadequate sanitation systems. These conditions proved to be a breeding ground for disease and death (Engels 1973). A host of infectious diseases like tuberculosis, diphtheria and cholera were the major causes of typhus, diphtheria and cholera were the major causes of morbidity and mortality, especially in working class neighbourhoods. Doyal (1979) mentions about three central assumptions which are problematic about medicine and health. Firstly, the determinants of health and illness are predominantly biological in nature. Secondly, it to be a science

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[2] Also see Foucault on '*Health and Statecraft*' in "Foucault, Health and Medicine", pp.182-186.

[3] The definition of health that has conventionally been operationalized under Western capitalism has two interrelated aspects to it: health is both considered as the absence of disease (according to biomedical model) and as a commodity (economic definition). And both focus on individuals, as opposed to society, as the basis of health: health is seen as a product of individual factors such as genetic heritage or lifestyle choices and as a commodity that individuals can access either via market or the health system. Health in the sense is an individualized commodity that is produced or delivered by the market or the health service, where on the one hand individual takes responsibility of one's own health and on the other the welfare state takes it as its responsibility. The inequalities among the distribution of health thus exist either as a result of the failings of individual through choices, or because of the reason how health products are produced, distributed and delivered among people.

and thus assumed that it is possible to separate the doctor form his/her subject matter and finally scientific medicine as the only viable means for mediating between people and disease.With the advent of the new public health, social scientists, economist, anthropologist and psychologist are all represented in public health research communities around the world. While there are rifts between the medical and social science communities, the divides are less evident than in the past[4].

THE POLITICAL ECONOMY OF HEALTH INIINDIA

At the end of 70s and beginning of 80s, a dominant ideology originating in the United States and United Kingdom spread world, which mentioned the role of the state in all dimensions of economic and social life should be reduced in order to free up the enormous potential of market forces, in short 'free markets' and full development and expansion of capitalism. Consequently capitalism without borders became the buzz word and became to be known as liberalism and with new broader aspects getting added it was termed as 'neo-liberalism'. This ideology became guiding force behind international economic relations, and now it almost 30 years with neo-liberal globalization where its hegemony is event not only in international institutions but also in the majority of governments in developed and developing nations. (Navarro, 2002). India joined in the list with the reform in its policies in early 90s, subsequently resulting in privatization in health care too.

In India, State plays a centric and crucial role in social sector – health and education of the population, however, in India the spending on public health has remained low since independence. The Planning Commission and the Five Year Plans allocated a double digit number to the public health spending, but the spending struggles near 1% and below of the Gross Domestic Product, where the global average is that of around 5.5%. On the other side there is phenomenal growth in private health care arena, takes the share of 4.25% of the GDP. After the colonial rule, the south Asian countries, including India carried out two pronged strategies – one for the structural reforms at the social level (which is where health sector falls) and one in promotion and use of technology for higher levels of production. Gradually these nations began to come out with their own histories within a broad liberal welfare development framework. Structural reforms and resulting privatization of market forces began in early 90s in India. In 1997, the total external debt in India accounted for US $ 94 billion (HDC 1999) and end of 1999 it was around $ 98.87 billion (GOI, 2000).This debt crisis lead to throw autonomy away and accept the terms of International Monetary Fund and World Bank for reconstruction and development[5].

It took series of epidemics such as Malaria, Cholera, Gastroenteristis, Kala azar, Hepatitis, encephalitis, and finally plague of 1994 to shake the existing confidence and it was then the criticism of the reforms started surfacing and received some attention and space. The reform package did not necessarily ensure health of people. Post reform, there was in fact increase in indicators of Infant Mortality and Maternal Mortality in several states like Gujarat, Madhya Pradesh and Punjab. There were two responses to SAP, ones who saw it as bold, desirable which believed in promoting private initiatives and removing bottle necks of government rules, whereas ones who saw this as step backward in its efforts at independence and questioned importance of the role of state as a regulatory body.

The supporters of reforms argued that there were not enough resources to invest in public provision and that the only way forward was to privatize as the quality of public services would never be improved. The Bhore Commitee of 1946 strongly recommended a ban on private practice by government doctors and the second five year plan also reinforced this need due to the negative impact of private practice on teaching and research in medical colleges. However these recommendations were difficult to implement because efforts at banning the private practitioners were short-lived due to lobbying power of doctors. People's Plan (Banerjee & Roy 1944) representing the working classes, unlike the Plan from Indian National Congress or Bombay Plan categorically warned against the accommodation of private interest and called for its abolition (increasing percentage of allopathic doctors in private sector). Also, several state governments have tried several times to ban government doctors to carry out private practice in Uttar Pradesh and Bihar in 1975 and 1986 respectively. It is without much debate that doctors constitute an important political pressure group and have lobbied with political parties to protect their interests.

Role of private and voluntary sector gradually increased from 80s and its mention in the 4th and the 5th FYP. A large number of partnerships with Non-government organizations were carried out to implement state programs such as Reproductive child health, Integrated Child Development Scheme (ICDS) etc. simultaneously Govt. offered a number of concessions for the growth of the private sector, by reducing import duties on high technology medical equipment also where special concessions are given to NRIs and it recognized medical care as an industry thereby making it eligible for loans from several public finance companies. And in addition, total duty exemption has been granted to hospitals and diagnostic centres, willing to treat at least 40% of their patients free of cost. This concession has now resulted in the current billion dollar industry of medical tourism, which is in a position to contribute Rs 50 to 100 billion additional revenue for upmarket tertiary hospitals by 2012, and will account for 3-5 percent of the total healthcare delivery market[6].

[4] Class differences in morbidity and mortality are very pronounced. Working class people die sooner, and generally suffer more ill health than do middle class people. We therefore need to look at other aspects of capitalist social and economic relations – especially distribution of income and patterns of work and consumption in order to explain these differences. The distribution of ill health in capitalist societies broadly follows the distribution of income. Those with lower incomes tend to have higher rates of morbidity and mortality, for a number of reasons. In a capitalist society income is a major determinant of the standard of housing individuals and families can obtain, of where one lives, one's diet, etc, which are factors significant to health.

[5] Only during the second world war, under duress, did the colonial state take up the more ambitious schemes for the transformation of India's health services, discussed by the National Planning Commission in the 1938 and 1939. Health planning took place alongside a range of other plans for "post-war reconstruction" in industry, agriculture and social security. In the field of health, the negative consequences of the structural changes began to emerge only when the thrust of the reforms creation of a medical market and the lowering down of the costs of public services became evident through the cuts in the welfare sector restricting upon its growth.

[6] Confederation of Indian Industry (CII)-McKinsey study on healthcare. The push for privatization of medical care under the Structural Adjustment Policies has been largely based on inadequate empirical evidence from the third world and an assumption that markets are more efficient than state-provided services.

FUND DRIVEN HEALTH PROGRAMMES IN INDIA

Indian National Malaria Eradication Program reflects in many ways the political culture of public health that evolved overtime. During the period between 1959 and 1963, the programme took around 70% of the India's budget for communicable disease control and around 30% of the total health budget. (Jeffery, 1988). India quickly became the world's largest market of DDT and the program was heavily dependent on the foreign funding. One of the strong arguments was that Malaria eradication would allow for an increase in food production and agricultural productivity, however, later this argument proved fatal for malaria eradication as malaria control was transforming agricultural productivity, particularly as the Indian economy moved towards agrarian crisis in the 1960s, or when other interventions such as population control seemed more cost effective. Statistics reveal number of cases to drop from 75 million in 1951 to just 50,000 in ten years time. However, eradication programme faltered with the significant resurgence of malaria in 60s with absence of adequate health infrastructure and by some views resistance to DDT and anti-malarial drugs. At a very crucial juncture, USAID the primary funder, stopped its aid for DDT concerning the safety of DDT. After which American Aid was sought, which also dropped following the Indo-Pak war. Despite of much investment and human resource allocation in eradication, controlling Malaria still remains a challenge for Public Health with provisional data (2006) revealing 1.67 million cases of Malaria (including 0.77 million cases of P. Falciparum) and resulting 1487 deaths in the country.[7]

Gill (2008) criticises certain individuals and institutions accountable for the decisions taken at a given period of time, and the resulting catastrophe in HIV/AIDS. He further asserts that main beneficiaries of the epidemic have been the Big Pharma drugs companies, of North America and Europe which manoeuvred to protect their patents and profits at the expense of the poor. Government in the poor world must make an earnest priority of health and education, and the rich world must never put demand for fiscal discipline ahead of people's lives. HIV/AIDS in last decade has received immense funding from UN and other bilateral agencies. HIV/AIDS has found its place as a vertical National Disease Program under National AIDS Control Organization (NACO), which funds each state agencies from implementing preventive and curative programs. One of the critique of the program is data distortion (Priya, 1994) through which it could find its place as a vertical national program.

Conclusion

Indian writers contributions to the discourse on health, still largely most of the part of the research is dominated by the field of Health Economics, and argument surrounding health as good available to every individual and a responsible rational human being attains his or her wellbeing. Analysis in health mainly decipher in two major divisions of analysis on individual health behaviour level and at a macro level. The writings of Quadeer or Baru reflect a large amount of reflection on the historical journey made by Indian in the health sector, with severe criticism to the current scenario in health care market. Quadeer criticizes the existing power of free market and private capital, which transforms anything and everything into commodities, be it body or intellect, and to her public health also has become one of this commodity. Most of the latest writing of Quadeer is her analysis on transnational political economics and arguments are strongly those of 'dependency syndrome' of the international funding agencies and their profitable plans for the third world nations with increasing Global Public Private Partnership (GPPP) invasion.
Dasgupta (2006) mentions how mainly because of political economic situations the public health services in India have been constantly neglected with large amount of focus on medical services. She argues regarding a virtual absence of modern public health regulations and of systemic planning and delivery of public health services. The history of public health in India, since Independence till the present day governmentality of the state (its legitimate role of carrying out welfare activities) has coexisted with the continuing weakness of the state and to fulfil the required health safety for the people. Political activism in the field of health is not completely missing in India, but it is rather unheard by the state. Recent years have certainly witnessed a lull, but hopeful, moves by a range of groups to make health, once again, a subject of public debate – a state subject, that of great attention. (Amrith[8], 2007)

Basu's study show how growth of private sector has a negative impact on the public sector and in the process raises questions regarding quality of care, efficiency of services and the social responsibility of medical professionals.

[7]National vector borne disease control program, GOI.Provisional data, 2006. *Also see: http://www.nvbdcp.gov.in/malaria3.html.* Like National Malaria Eradication Program, Population Control program also faced the same politico-economic challenges during its course of implementation. Mohan Rao has shown with great clarity how the agenda of population control in India came to "dominate concerns in the field of health and contoured the directions of health policy". The First Five-Year Plan, he shows, "envisaged demographic change as a dependent variable responding to wide-ranging shifts in social-structural factors"; by the time of the Second Five-Year Plan, in 1956, the government appeared to believe that "population growth is an independent variable and economic change the dependent one". By 1961, and the third plan, the shift was resolutely in favour of population control. A major shift came, Rao argues, when a UN advisory mission convinced the Indian government, in 1964, that the Intra utrine contraception device (IUCD) could be used on a massive scale, thus overcoming the problems faced thus far. Resulting, the central government undertook to fund population control activities in the states (even as they refused to cover the costs of their public health apparatuses), and from 1966, family planning was created as a separate ministerial responsibility, granted almost as much in funding as the entire public health service of India. In Rao's words, family planning in India has "damaged the growth of health services in the country". The state admits as much, declaring in 2002 that: "the rural health staff has become a vertical structure exclusively for the implementation of family welfare, with the result that "for those public health programmes where there is no separate vertical structure, there is no identifiable service delivery system at all".

[8] Amirth stresses on the unequal political, military and economic relationships between a dependent and dominant eternal economy. He asserts that the political economy is not only shaped by the interaction with a more powerful external economy, but also shaped by the process. The argument put forward is that the concern of the dependency theory revolves around the notion that the underdeveloped countries are referred to as ''developing'' countries, to mention their development is evolutionary and that the current 'developed' nations have never had the same historical experience compared to that of the impoverished countries of the world. He asserts the historical situations of dependency have conditioned contemporary underdevelopment Africa, Asia and Latin America and this not original in itself. Writing of most of the radical Indian thinkers in the arena of political economy of health tilts somewhere or the other on the 'dependencia' school and misses out of the analysis of the social class and oversights an anthropological lens. The fact about the regional difference gets mentioned but clear analysis of how what works and why certain politico-economic situations curtain the development of proper infrastructural facilities or policy considerations is not adequately elaborated. The questions like hegemony of international agencies and 'dependency syndrome' of third world nations including India is addressed, however the politics of aid and workable alternatives for a welfare state is remotely touched upon.

In India, like other countries like Sweden, Britain have a definite history of planned development of health services, where the state has played an important role in their finance, supply and management. It is disconcerting to witness, especially from an ethical perspective, regarding the management of equity in health, it is still the poorer section - The marginalized population, Scheduled Caste, Schedules Tribes, who have special needs is bearing the brunt of health disadvantages. Participation of vulnerable groups, belonging to the lowest strata of the socio-economic life and have a low affordability of health care becomes essential in any public health delivery. The health outcome among the Schedule Caste and Schedule Tribe is much lower than the general population. (NHP, 2002). For example the infant mortality rate among the SC and ST is 83 and 84.2 among per 1000 live births which is much higher than the national average. State should acknowledge the fact that social sector expenditures, particularly on health and education, are of key importance and adequate amount of budgetary allocation is of high requirement[9].

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[9] Health needs and demands for every region are different, especially if the region consists of marginalized population or is in a difficult geographical terrain. For instance, for some, availability may be an issue while for others it may not actually be of major worry. Similarly, for some others availability alone may not be sufficient; unless it is supported by a policy of greater subsidization of health facilities through special schemes. Question remains is it possible to take care of this section of the population with the common for all the vertical programs or it is high time we pay attention to these social classes and marginalized population and have a sectoral tailor-made strategy ?