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Wealth as Determinant of Healthcare Management: A Perspective in Context of India

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Abstract:
The growing healthcare needs have made health sector into a billion dollars industry in India but making it inaccessible to millions of countrymen living in multidimensional poverty. Wealth in health is eclipsing the moral values in dealing human health as a service to mankind. The current paper, based on the analysis of secondary data on different parameters, is an attempt to understand that how wealth has made a difference in health indicators of rich and poor; how looking for return of investment in health is responsible for downfall of moral values associated with human healthcare and making healthcare inaccessible to poor. Addressing gaps in health care has provided an opportunity to stakeholders to strategically use the increasing health consciousness of people to propel their business. At the same time it has become a cause for rising healthcare cost and eventually the cause for poor health seeking behaviour of people of low wealth quintile and inability of the system to develop quality level public health infrastructure which can be used by all, irrespective to wealth status. The paper concludes that to universalise the healthcare the best possible solution is the revival of moral values in healthcare industry. All stakeholders, dealing directly or indirectly with human health, should adopt socialistic approach to cut down their profits and make health universally affordable.

Keywords: *Health, wealth, return of investment, healthcare cost, affordable, moral values*

1. Introduction

'Health is Wealth' and 'an apple a day keeps doctor away'. Didactic message contained in these maxims is to *go for health*. But it is unable to come out from good books of moralistic society into practice because man is pragmatically inclined to adopt an economist approach. Then how a healthy society can be built if cost of healthcare and price of an apple (indicator of good nutrition, which is a key determinant of health) is going out of reach to millions of people living below poverty line? The dominant economic aspect eclipsing the ethical values of society cannot be ignored just as a hypothesis. In human society the moralistic behaviour is commonly expected by all but defending own immoral behaviour is also not uncommon feature because loss in any form is unacceptable to human personality. Still losses are happening all around and most severe to the health. Perhaps because the wealth has become a determinant of health and health has become a mean to earn wealth.

Health and wealth are equally needed by all. But in many societies the social status of people is determined by wealth not health. It is true for India as well, which is performing much better on economic front but the progress in health indicators is slow. Poor performance of health indicators of the country is also a reason for country's low ranking (134) in Human Development Index (HDR, 2011). The health scenario of the country needs extensive multidimensional efforts and that too with varying approach because mood of various health indicators and existing gaps in healthcare delivery differ not only by region, state, social groups, residence (rural and urban), sex and age but also the income.

Health varies by income even in countries with universal access to care (Adler & Newman 2002), so India is no exception. Country has universalized health in 12th five year plan (2012-2017). The universalization of healthcare made debut in the seventh FYP (1985-1990), although in limited manner, which mentioned for universal accessibility, availability and affordability of health and family planning services (Seventh FYP, 1985). In 1985 the universal immunization program was launched with the objective of providing universal coverage of immunization to pregnant mothers and infants (Eighth FYP, 1992). Through these intensive efforts an overall progress in health indicators is made but the health inequities between rich and poor are not levelled. To achieve parity in health India is trying to boost up the public health expenditure to 2-3% of Gross Domestic Product (GDP) in 12th Five year plan. Otherwise also, it is crucial to gear up health infrastructure because country due to large population has direct bearing on timely achievement of the targets of Millennium Development Goals (MDGs) at world level.

In different researches the healthcare gaps are read as deficient physical infrastructure, inadequate human resource, rising population, deteriorating environment, increasing economic disparities, fund crunch, data deficiency, lack of political willingness and prevalence of socio-cultural factors. But one major factor is undermined for the current situation i.e. an ethical approach toward the public health issue. Ethics in healthcare delivery are largely read as medical ethics. Medical ethics is not a new issue. But the way it is getting

bigger with the downfall of human values it is gradually getting older. How medical ethics are affected with the unethical practices of making money in name of providing healthcare has never been seriously talked because going by ethics is considered as doing well to others at the cost of personal harm. So, whether our society has not matured enough? Moral values are something which can be taught and encouraged to follow but not always forcefully implemented in a civilized society. Responsibility of practicing the moral values in health are decentralized up to the bottom of the pyramid that is 'beneficiary' but perhaps the larger responsibility lies on those who are on above layers i.e. policy makers, law implementers and healthcare providers (both public and private). In the current paper an attempt is made to focus that how the wealth has become a key determinant in healthcare management in context of India. Attempt is made to assess the increasing role of wealth in eclipsing the moral values in dealing with human health.

2. Materials and Methods

The paper is conceptualized on the basis of secondary evidences, collected and reviewed in perspective of wealth as a key determinant of health in context to India. Both quantitative and qualitative data, collected from secondary sources is analyzed. The five year plans, books, journals, research studies, internet and national level reputed newspapers are thoroughly examined to collect data. The qualitative facts have been supported through quantitative data. Quantitative data is collected from various studies and surveys done in context to healthcare. Also, different studies conducted with the perspective of understanding the future of health scenario in India are reviewed to strengthen the argument through factual evidences. Several documents are not referred in the paper but consulted for in-depth understanding about increasing significance of wealth in health management.

The key research questions were- How the growth of different industries, contributing directly or indirectly in healthcare, is projected? How in different empirical studies and in published news the funds shortage identified as gap in public health delivery? How health is now a promotional factor for business by all stakeholders but wealth is the inhibiting factor for poor to get quality healthcare? Is the quality healthcare linked with wealth?

3. Results and Findings

The results and findings are shows that how wealth is becoming a determinant for different behaviour of health indicators in context to rich and poor and how looking for return of investment in health is responsible for downfall of moral values associated with human healthcare and making healthcare inaccessible to poor.

4. Wealthy are Healthy!

A general belief is prevailing that urban India is more prosperous than rural India because health and wealth indicators are found better in urban areas than rural areas in different state and national level surveys like national family health survey and district level household surveys. The common reasons use to substantiate these facts are- urban areas have better opportunities to earn wealth; better access to healthcare; and about three-fourth health infrastructure of the country is concentrated in urban areas. But this was not found absolutely true when urban data of NFHS III (2005-06) was re-analyzed on the basis of wealth index. The segregated data in context of urban poor and urban non poor in table-1 shows replication of poor health indicators of rural India in urban poor localities. The health inequities, which exist among rural and urban population have now created a new divide of urban poor and urban non poor (WHO & UN Habitat 2010; NFHS-3, 2009). If this divide further widen up with urbanization than it is more depressing for the growth of the country because urbanization is equated with development.

Indicators	Urban Poor	Urban non poor	Overall Rural	All India
Total fertility rate (children per woman)	2.8	1.8	3.0	2.7
Mothers who had at least 3 antenatal care visits (%)	54.3	83.1	43.7	52.0
Home deliveries (%)	56.0	21.5	71.1	61.4
Children completely immunized (%)	39.9	65.4	38.6	43.5
Infant Mortality rate	54.6	35.5	62.1	57.0
Under-5 Mortality rate	72.7	41.8	81.9	74.3
Households with access to piped water supply at home (%)	18.5	62.2	11.8	24.5
Household using a sanitary facility for the disposal of excreta (flush / pit toilet) (%)	47.2	95.9	26.0	44.7
Women (15-49 years) with No education (%)	49.8	13.7	49.7	40.6

Table 1: Re-analysis of National Family Health Survey III
Source: Disaggregated data of NFHS III- 2005-06 from fact sheet developed by Urban Health Resource Centre

If basic needs of human being are same then ethically they should not be differentiated on the basis of economic status. Health needs of poor are not different from rich? The average per capita health expenditure in high income countries is over US$3000 while it is just US$30 in poor countries (Saksena & Holly, 2011). Where does the quality healthcare stands in this bracket for a country like India, where about 53.7% population is living in multidimensional poverty, 16.4% population is vulnerable to poverty and 28.6% is living in severe poverty as per the HDI report of 2011. As per the national poverty line 27.5% are living below poverty line whereas 41.6% are living on PPP $1.25 a day (HDR, 2011). The multidimensional poverty situation of India as per the Human Development Report 2011 is shown in table-2.

Parameters	Percent population
Clean water	11.9
Improved Sanitation	48.2
Modern fuel	51.1

Table 2: Share of multidimensional poor with deprivations in environmental services
Source: Human Development Report 2011 - Sustainability and Equity: A Better Future for All

Although India is appreciated to provide cost effective as well as quality health care (Govindrajan & Rammurti, 2013) still even preventive health is out of reach to millions of people in the country because per capita healthcare spending in India is $35, which is among the lowest in the world (Express Healthcare 2014).
Wealth is a determinant of death cases among rich and poor and it really makes distinction between the two. The findings of World Health Organization (WHO) also certify this fact, which says that the diseases associated with poverty account for 45 per cent of disease burden in poorest countries (WHO, 2002). Only 20% of chronic disease deaths occur in high income countries–while 80% occur in low and middle income countries (WHO, 2005). Poor people living with HIV/AIDS suffer more stigma and discrimination then rich (Castro & Farmer 2014). Due to poverty, the diagnosis as well as the treatment of poor is delayed. Like in other developing countries, most of the disease burden in India finds its root cause in poverty. Even funds crisis is blamed for failure to maintain doctor patient ratio as per WHO norms, lack of training to doctors, unavailability of infrastructure facilities like separate investigation room or inability to hire female gynaecologist, which results in poor quality healthcare and eventual breakdown of medical ethics.
Funds shortage is also deteriorating the access to healthcare as well as health determinants, which includes water, sanitation and nutrition. Health is hitting the growth of the country from both ends. On one end the country needs investment of up to $20 billion over the next five years (Debgupta 2014) and on the other hand lack of adequate sanitation has resulted in an annual loss of $53.8 billion ($161 billion in purchasing power parity, or PPP) or $48 per capita ($144 in PPP) in 2006. This was equivalent to 6.4% of GDP in 2006 (WSP, 2011). Thus country first should invest to make saving. It means that wealth has become a determinant of preventive health, which challenges another maxim promoting moral science in healthcare management- ‘Prevention is better than cure’.

5. Wealth in Health!

Health has now become a commodity, which people find in form of branded drugs, sophisticated medical equipments, nutrient rich food, sugar less sugar, mineral water etc. So blaming poverty for healthcare mismanagement is not the only fact. Lot of credit goes to the market of health and health determinants. Liberalization and globalization of economy has also expanded the business horizons in healthcare management to all industries, dealing directly or indirectly with health aspect.
The Indian healthcare industry is expected to reach USD 280 billion by 2020 and expenditure is likely to grow at compound annual growth rate of 12% (CCI, 2013). Some of the projected figures for the growth of healthcare industry in different fields in table-3 are robust examples of growing business in addressing health needs of the country.

Categories of companies	Projected market value	Forecasted CAGR (%)	Source
Pharmaceuticals	$ 55 billion in 2020	14.5	Bhadoriya, Bhanjaka etal
Medical device	$6.4 billion in 2020	17	Deloitte & FICCI, 2011
Medical technology	US$14 billion in 2020	15	FICCI, 2011
Medical tourism	USD3.9 billion in 2014	27	ONICRA, 2013
Health Insurance	Rs. 32,038 crore by 2016	20	ASSOCHAM, 2013
Sanitation products and services	$15.1 billion in 2020.	-	WSP, 2011
Medical Education	Rs. 35 billion	18	Cygnus Research, 2010
Bottled water	1.8 billion $ in 2020	19	Chibber, 2012

Table 3: Expected growth of market of Health and Healthcare determinants in India

Wealth in health is now so prominently discernible to the market that even non-healthcare based companies like cosmetics, food products, bottled water etc. have planned their promotional strategies to transform the increasing health consciousness of people into profit. The increasing cases of food adulteration have led to the hunt for purity and quality in products of daily use which ended up at ‘brand’. Companies manufacturing products of daily consumption are adding words like ‘natural’ and ‘organic’ with product name, mentioning slogans or symbols of medical significance on products and casting health practitioners as ambassador in electronic media. It is a multipronged strategy, which eliminates any apprehension in people’s mind regarding the quality of the product, helps the company in becoming a brand and to increase profit through raised prices. For example, the rising popularity of non-carbonated drinks such as energy drinks, fruit drinks, nectars and juices etc, with children and youth is pushing the market at a CAGR of about 35% annually. This fact is well supported by another fact that, Indian carbonated drinks market in last three years has declined by 15-20% (Mukherji, 2012).
Even, banks have also realised profits in providing capital to the interested entrepreneurs in healthcare. A study shows that over 50% of long-term financing for hospitals is obtained through bank loans from nationalized banks (Price Water House, 2012). Thus, the whole arena of ‘health’ has now become a battle ground, where stakeholders are latently or blatantly using ‘human health’ as a business tool as well as product.

The message is clear that future prospects of earning wealth in fulfilling healthcare needs are brighter for the market. But it should also make the social world equally worried because it indicates that public health can further deteriorate, even at higher rate. All industries are growing at the rate of 15-19% but poverty is not reducing with that pace.

6. Looking for Return of Investment!

Basic needs of human have enormously grown to become an industry. The word industry in itself is symptomatic of business and direct relation of business is with wealth not health. 'Needs' are now read as 'gaps' and rising 'gaps' has increased the scope for investment in the market of healthcare. The returns of investment (ROI) in addressing gaps in public health are visible to the entire business world and have opened up ample business opportunities for them. The urge for ROI, may be in form of money, kind or social recognition is a hurdle in leveraging resources through public private partnership and convergence, in which the optimistic minds are looking for new hopes to promote healthcare. The international development agencies and civil society organizations though have health in their mandate but lack convergence in order to monopolies the health issues.

The doctors, who are the central character of medical ethics, too want ROI because medical education cost is rocketing without ascertaining high income jobs. In countries like China and Russia, where medical education is said to be low than United States, United Kingdom and other European countries, hovers around US$3400 to US$6,000 annually (Mishra, 2012). But earning of doctors is determined by service set-up and rural/urban profile of patients, which is also a cause of improper distribution of physicians and reluctance in doctors to serve in rural areas because in urban areas earning is more (OECD, 2013).

A large number of health staff in the country is on contract basis and there is high income variation in different cadre of health staff. The income differences become cause of resentment which burst into strikes. During strikes the patients suffer the most and a general perception is developing that doctors are greedy even after being paid well and also allowed to do private practice (The Times of India, 2012). Such notions get more firm when specialist doctors move towards private hospitals (Aiyyapa, 2013) in want of more salary. Better earning opportunities in urban areas has made doctors urban bias, leading to the shortage of doctors in rural areas which again prove that doctors lack service attitude towards mankind.

Medical companies are also tactfully using this instinct for money in doctors. Companies find most trustworthy and legitimate face in doctors to prescribe their drugs to patients. In turn, the companies pay incentives to doctors in commission or kind because they can compensate the cost spent in promotion by unethically raising the price of the product. Like the cost of branded drugs is much higher than the generic drugs, even if there is no difference in their quality (Singhal, Nanda & Kotwani, 2011). The medical representatives of companies, where professionalism is vouched as success mantra use valuable time of patients to promote company's products with doctors to achieve incentive based targets. But the daily wage earner patients, whose health is not insured, have to wait in long queues for turn. The real face value elements of doctor patient relationship are time, trust and money. In case of poor patient all these three are nowhere recompensed, whereas the doctors and the medical companies make wealthy profits through same time and trust. Spending money under Corporate Social Responsibility (CSR) is also a way to earn accolade and to improve the social face value (Srivastava, 2013).

7. Rebuild the Maxim 'Health is Wealth'

A general belief is that wealthy people are more health conscious. But it is not like that because poor also well understand link between their living conditions and ill-health (WHO & WB, 2002). But for wealthy people gaining health can also be a part of tourism package (read in context of medical tourism), whereas poor access healthcare services with convenience of finance, distance, timing, social support and trust. The rising cost of preventive and curative health is curse not for poor alone but also to the elderly population who is being neglected by their own family members, irrespective of wealth status of the family, in order to save money.

The real responsibility of making healthcare affordable lies in hands of other stakeholders, not with the patient. Rising healthcare cost has made health a rich people's right. So an ethical approach is desperately needed to bring down the cost of illness to make health universally affordable and accessible. Cutting down the profits is more ethical then to provide healthcare to vulnerable under the aegis of Corporate Social Responsibility. The medicine prices are increasing due to economic policies and market forces but hardly there is any force to increase wages of poor labourer. Direct healthcare cost can be reduced if public health share is increased, which is less than one-fourth in India. Public spending should increase on primitive and preventive health. There should be no compromise in implementation of rules and regulations like legal provision of free treatment to the Economically Weaker Section against subsidies provided to the private hospitals (Free Treatment, 2011). 'Put pain of patient first and then the profit' approach will mark real comeback of moral values.

8. Conclusion

Wealth is health? Probably yes, because any country, region or a household do planning keeping in view the availability of funds. The gaps in healthcare industry can be highly reduced by retrenchment of profits. So, whether human society has not matured enough? World community must accept that health is not a business; it is a service to the mankind. Human health needs may differ in quantity but should not be in terms of quality. Measuring the quality of services in form of beneficiary satisfaction is yet a major challenge to overcome in service delivery. 'How many have been completely treated' is the best return of investment of resources in any form. Revival of moral values is vital to translate wealthy gains of healthcare business in to a healthy society.

9. References

1. Human Development Report. (2011). Sustainability and Equity: A Better Future for All. UNDP (126)
2. Adler NE, Newman K. (2002). Socioeconomic Disparities In Health: Pathways And Policies. doi: 10.1377/hlthaff.21.2.60 Health Affairs, vol. 21 no. 2 (60-76)
3. Seventh Five Year Plan 1985-1990, Vol. II (1985). Planning Commission, Government of India, Printed by Government of India Press
4. Eighth FYP, 1992-1997 (1992). Vol. II, Sectoral Programmes of Development, Planning Commission, Government of India, Printed by Photolitho Press, Faridabad
5. World Health Organisation & UN Habitat. (2010). Hidden Cities, Unmasking and Overcoming Health Inequities in Urban Settings (84)
6. NFHS-3, 2005-06 (2009). Health and Living Conditions in Eight Indian Cities, Ministry of Health and Family Welfare, Government of India
7. Kea X, Saksena P, Holly A. (2011). The determinants of health expenditure, A Country-Level Panel Data Analysis
8. Human Development Report. (2011). Sustainability and Equity: A Better Future for All. UNDP (144)
9. Govindarajan V., Rammurti R. (2013). Delivering World Class Health Care, Affordably, Innovative hospitals in India are pointing the way, The Globe, Harvard Business Review
10. Express Healthcare. (2014). The Great Indian balancing trick: Healthcare for All by 2020, Retrieved from: http://www.investindia.gov.in/?q=healthcare-sector (accessed on July 03, 2014)
11. WHO. (2002). The World Health Report
12. WHO. (2005). Preventing Chronic Diseases a vital investment: WHO Global Report
13. Castro, A., Farmer, P. (2014). Understanding and Addressing AIDS-Related Stigma: From Anthropological Theory to Clinical Practice in Haiti, American Journal of Public Health, 2005; 95: 53–59. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449851/ (accessed on January 18, 2014)
14. Debgupta, A. (2010). Healthcare Infrastructure in India, Express Health care. Retrieved from http://healthcare.financialexpress.com/201012/hiispecial02.shtml (Accessed on March 16, 2014)
15. WSP. (2011). Economic Impacts of Inadequate Sanitation in India, Flagship Report (2011). Water and Sanitation Program
16. A brief report on Healthcare, Telemedicine & Medical Tourism in India. (2013). Corporate Catalyst India, New Delhi
17. Bhadoria V, Bhajanka A, Chakraborty K, Mitra P. India Pharma 2020 Propelling access and acceptance, realising true potential, McKinsey & Company (17)
18. Deloitte & FICCI (2011). Indian Medical Electronics Industry Outlook 2020 (7)
19. FICCI. (2011). Enhancing access to healthcare through innovation, Medical technology in India (14)
20. ONICRA. (2013). Emerging Trends: Indian Healthcare Industry (5)
21. ASSOCHAM. (2013). Press Releases, Health insurance premium to cross Rs 32K crore mark by 2016-17, 2013 December 8. Retrieved from http://www.assocham.org/prels/shownews-archive.php?id=4285&month=&year= (Accessed on March 16, 2014)
22. WSP. (2011). Economic Impacts of Inadequate Sanitation in India, Flagship Report (2011). Water and Sanitation Program
23. Cygnus Research. (2010). Medical Education in India. Retrieved from http://www.researchandmarkets.com/reports/1266163/medical_education_in_india (Accessed on March 16, 2014)
24. Chibber A.(2012). Bottled Water blooms in India. Retrieved from http://www.foodnavigator-asia.com/Markets/Bottled-water-blooms-in-India (Accessed on March 17, 2014)
25. Mukherji, U.P. (2012). Non-carbonated drink industry to touch Rs. 54,000 crore by 2015, TNN Jun 25, 2012, Retrieved from http://articles.timesofindia.indiatimes.com/2012-06-25/india-business/32407984_1_fruit-juices-carbonated-juices-market (Accessed on 25.12.2013)
26. Price Water House Cooper (2012). Healthcare Infrastructure and Services Financing in India, Operation and Challenges (13)
27. Mishra, A. (2012). China has become preferred destination for medical education, 09.09.2012, Issue no. 238, Retrieved from: http://www.universityworldnews.com/article.php?story=20120904100946519 (Accessed on 19.01.2014)
28. OECD. (2013). Health at a Glance 2013, OECD Indicators (142)
29. The Times of India. (2012). Ban pvt practice of doctors working in govt hospitals, The Times of India Pune. Retrieved from http://articles.timesofindia.indiatimes.com/2012-11-01/pune/34856469_1_private-practice-private-hospitals-specialist-doctors (Accessed on March 17, 2014)
30. Aiyappa M. (2013). Govt losing specialist doctors to private sector, The Times of India Banglore
31. Singhal G L, Nanda A, Kotwani A. (2011). A comparative evaluation of price and quality of some branded versus branded–generic medicines of the same manufacturer in India, Indian Journal of Pharmacology, Volume 43, Issue 2 (131-136)
32. Srivastava, A.K. (2013). Mainstreaming As Cost Effective Approach of HIV Management, Indian Experiences and Relevance for South Asia, Man & Development, Centre for Research in Rural & Industrial Development (109-126)
33. World Health Organisation & The World Bank. (2002). Dying for Change: Poor People’s Experience of health and ill-health
34. Free Treatment in the Private Sector: Myths or Reality? A Pilot Study of Private Hospitals in Delhi, A Report. (2011). Sama – Resource Group for Women and Health