

Neoliberalism and the Indian Public Health Sector

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Introduction

Neoliberalism, a term popularized by the writings of Fredrich Hayek and Ludwig Von Mises, emerged through their influential works in the mid-20th century. Hayek's *The Road to Serfdom* and Mises' *Bureaucracy* laid the foundation for this ideology. Their ideas culminated in the establishment of the *Mont Pelerin Society* (1947), comprising millionaires and public figures who shared Hayek and Mises' convictions and perceived neoliberalism as an opportunity to free themselves from regulation and taxes. The philosophy gained traction in the mainstream through favourable political developments and lobbying by powerful industrialists. Today, it is closely associated with Economic Liberalism and Free-Market Capitalism. The philosophy advocates for free trade, deregulation, privatization and reduced governmental control, sharply contrasting with the Keynesian Economic Consensus or the Postwar Consensus which favoured nationalization.

India embraced neoliberalism via a slew of economic reforms aimed at enhancing productivity. Popular economist Jagdish N. Bhagwati of the *Sen v. Bhagwati* debate championed neoliberal policies in India, presenting neoliberalism as the primary tool to reduce poverty and increase growth and development in the country. The current

government's "minimum government and maximum governance" schemes and *Jan Dhan* initiatives are extensions of the neoliberal reforms introduced in the 1990s. The reforms initially had a very positive impact on the economy, with a UNDP report showing a nearly 50% reduction in multidimensional poverty. With liberalized policies, India lifted close to 271 million individuals from poverty in a short span (2000-2010).

Despite Dr. Bhagwati's favourable views and the government's increasingly liberalized economic agenda, the adoption of neoliberal policies has exacerbated inequality in India. According to a 2020 report by Oxfam, the richest 10% in India own more than 74.3% of the national wealth, whereas the bottom 90% own a meagre 25.7%. A 2005 survey conducted by *Bardhan* revealed that over 75% of those who had an opinion on neoliberalism called it an exploitative policy which primarily benefits the rich. David Harvey in *A Brief History of Neoliberalism* defined the concept as a restoration of class divide and the veiled reinforcement of class power. The core issue with Neoliberal policies is that they only consider *prima facie* ideas of growth, neglecting more essential aspects that require governmental support and regulation. They prioritize the economic stability of the already prosperous over the concerns of the marginalized. The rich attribute their success to merit and hard work, overlooking the role of unequal education and limited social mobility within the neoliberal structure. This divisive growth's impact is seen in essential social sectors like public health care. Many scholars, particularly in public health, argue that neoliberal capitalist economic forces worsen economic inequalities, ultimately endangering public health. Accordingly, the public healthcare sector of India provides extensive scope for analysis; however, before studying the impact of Neoliberal policies on Indian healthcare, it is essential to trace the growth of the said sector in the country through different phases of its economy.

Part I of the paper introduces neoliberalism and covers its contemporary existence in India. Part II traces the healthcare sector of pre-liberalization reforms in India. Part III analyses the shift towards market-oriented policies and compares government policies with the efficacies of a growing economy. Part IV covers the most recent National Health Policy in light of the prevailing discussion and provides certain recommendations for reform with respect to the research avenues. The final part summarizes and concludes the discussion.

Tracing healthcare- the post-independence and pre-liberalization phase

Healthcare is a critical aspect of a nation's economic and political agenda, and India has historically prioritized healthcare as a major policy issue. The country's commitment to healthcare dates back to the pre-independence era when The Health Survey and Development Committee, chaired by Sir Joseph Bhore, was established in 1943. In 1946, it submitted its first report and outlined certain short-term measures like health centres, supervised PHCs, and a long-term program known as the three million plan. The core recommendation of the committee was that universal access to basic healthcare must be provided regardless of their socio-economic status. Post-independence, India carried the same approach and established multiple committees like the Mudaliar Committee (1962) and the Srivastava Committee (1975) to formulate a more inclusive and stable healthcare sector. The establishment of the Indian Council of Social Science Research reflected a more state-interventionist approach to healthcare, treating it as a public good. Government involvement aimed to address the non-excludability principle, ensuring that medical benefits reached everyone and curbed inequality by discouraging rival consumption. A free-market approach was discouraged because it could result in uncontrolled healthcare prices

escalation, sustaining disparities in access and quality. The shift towards neoliberal policies and de-regulation has, unfortunately, contributed to increasing healthcare sector inequality.

Nevertheless, India originally established a three-tier integrated healthcare system with primary, secondary and tertiary-level distributions. This development mirrored the approaches adopted by most third-world countries grappling with wide scale diseases like malaria and diarrhoea, necessitating a reformed healthcare system.

In India's early healthcare deliberations, a pivotal debate centred on choosing between preventive and curative systems. The West favoured the curative approach, heavily investing in medical technology to cure diseases while downplaying prevention. The adoption of the curative format was hindered by multiple problems for India, however. Most diseases prevalent in developing countries, such as malaria, could easily be controlled by preventive practices. Developing nations opposed the Western model on five primary fronts as recorded in the World Health Organization's 1978 Kazakhstan summit. They argued that the Western approach neglected the social medicine aspect, the disease prevalence patterns in countries like India didn't align with those of Western nations, the model was financially burdensome and developing countries lacked adequate trained specialists for technical curative care, unlike the West.

Accordingly, India and other developing countries embraced the *Health for All* program, prioritizing state intervention for equitable and universal healthcare. India became a signatory to the *Health for All* vision in 1978 and based its first National Health Policy (1983) on essential HFL ideas. In the early post-independence years, India pursued

primary healthcare initiatives, striving for inclusive and state-supported health services.

The first National Health Plan (1983) marked significant progress in the public health sector. The government's goal was to provide healthcare for all by the early 21st century, leading to increased budgetary allocations relative to the Gross Domestic Product for this sector. The National Health Policy's core focus was ensuring healthcare access to all, leading to the establishment of a three-tier healthcare system. The three-tier system comprised of multiple healthcare institutions with three primary divisions:

- a. Health Sub Centres: These served as the first point of contact between the citizens and the healthcare system, operating at the grassroots level to provide basic healthcare services. Their responsibilities included disseminating medical knowledge to combat communicable diseases and offering basic care to the rural population.
- b. Primary Health Centres: The next tier in the structure, PHCs acted as the first point of contact between villages and medical officers. They provided curative facilities and covered a larger population than sub-centres. PHCs also offered specialized programs such as anti-epidemic programs, Pregnancy-related care and Infant Immunizations.
- c. Community Health Centres: The biggest tier in the healthcare system, CHCs typically housed four healthcare professionals, including gynaecologists, paediatricians, surgeons and physicians, who were present at all times. These centres were initially designed to serve around 1,20,000 citizens in plains areas and over 80,000 citizens in hilly/mountainous regions.

The first national Health Policy showed increased government commitment to healthcare, but insufficient budgetary allocations hampered its impact. Public healthcare investment declined in the late 1980s, leading to a healthcare sector decline preceding the liberalization era.

Liberalization and privatized healthcare

India's liberalization phase in the 1990s aimed to open up the economy and create a service-oriented structure. A key aspect was the adoption of Structural Adjustment Programs (hereafter - SAPs) endorsed by the International Monetary Fund and World Bank. These programs provided loans contingent on implementing their recommendations to adjust the country's balance of payments, improve the economic structure and increase international competitiveness. The World Bank's policies influenced India's liberalized healthcare system, prompting the government to cut expenditures and restructure the entire framework. The primary goal of the SAPs was to decrease government expenditure and increase the stagnant Gross Domestic Product. This meant that government expenditure in healthcare was to be significantly curtailed. Dr. Hooda noted that after India's adoption of SAPs, health expenditure growth stalled, impacting even middle- and high-income states like Kerala, Karnataka and Gujarat.

In 1993, the World Bank released a report advocating for greater privatization to address perceived inefficiencies in government healthcare programs. The Bank outlined the growth in the public health sector and recorded the increase in mortality rates and life expectancy since the 1950s as reasons for reducing the government's role in healthcare. Dr. Milton Fisk criticized the World Bank for not recognizing health as a

public good and promulgating the idea that health should be a matter of individual choice, thereby encouraging private sector involvement. The World Bank argued that once a nation reaches a certain level of development, the government should step back from its primary roles and allow private organizations to play a larger role in the economic structure, this reasoning based on the assumption that as a country develops, its citizens acquire the means to afford healthcare, eliminating the need to view the health sector and its components as public goods.

Following the World Bank recommendations, the Indian government incorporated policies in its five-year plans and related Orders, that curtailed health expenditure. The 8th five-year plan (1992 – 1997) introduced the concept of *user fees* as part of its goal to inculcate sustained economic growth in a just, stable and equitable environment. Many states adopted the *user fees* principle i.e., a base charge for governmental health facilities in their health centres and hospitals. Although the fee was exempted for the economically weaker sections, the definition of “economically weak” was arbitrary, leading to limited relief for the most marginalized members of society. These measures, combined with the World Bank’s suggestions, significantly reduced government expenditure in the healthcare sector, straying from the original goal of *Health for All*. The public sector’s inability to provide healthcare services increased the demand for privatized care, eroding the government’s role in the healthcare sector, and creating an inequitable framework where socio-economic capital became mandatory for guaranteed healthcare. The Indian government also permitted private players to enter the Health Insurance sector in 1999 to expand the healthcare market. Initially only the Central Government Health Schemes and State Government Health Schemes existed as insurance mechanisms. This further increased the privatization of healthcare as private

insurance providers began covering hospital visits and medical care. The Indian government also liberalized the pharmaceuticals markets, introducing the Drug Price Control Order of 1994. As per the DPCO, only a few (74/500) of the commonly used bulk drugs were to be kept under statutory price control. In the 2000s, further liberalization in the drug market reduced governmental control and gave way to private influence. These policies aligned with the World Bank and IMF recommendations, diminishing governmental control and promoting privatization of the healthcare sector.

The 21st century outlook: the neoliberal stronghold and ineffective implementation

The 90s set the route for privatized healthcare and the 2000s took the trend to its logical high. The beginning of the 21st century saw two important developments. Firstly, the much-awaited yet failed introduction of the National Health Policy, 2002 (hereafter – NHP). Secondly, the use of neoliberal ideas to create a private sector stronghold in the health market.

India announced its second National Health Policy in 2002. The policy was promoted as a revolutionary development for the Indian health sector; however, the *Bharatiya Janata Party* led government didn't incorporate the most essential ideas in the policy and failed to deliver on the ideas that they did promise. The 2002 policy was a significant departure from the 1983 agenda which promised *Health for all* through a universal provision of healthcare. The new policy's ignorance of the most fundamental ideas of equal healthcare provided a framework to dismantle the primary healthcare system systematically. The policy was essentially a critique of India's healthcare system and failed to give any effective guidelines to reform the sector. It did accept that a majority of the goals of the previous health policy had not been achieved and that there

was extensive inequality with respect to access to health in the urban and rural regions. It submitted that the spread of communicable diseases has been reduced significantly and mortality rates have decreased; however, equitable access to healthcare still remains a primary concern. Moreover, the burden of disease has been disproportionately shared by the poor, while the gap between the rich and the poor, and the urban and the rural has expanded exponentially. The report explained that aspects such as income disparities, rural-urban differences, inexperienced and insufficient number of medical professionals were the major causes behind the declining performance of the health care sector.

However, even though the government identified these drawbacks, it did very little to improve the status of the sector and further reduced public funding. The promotion of privatized healthcare was justified via the use of Neoliberal agendas of development and again through the World Bank's assertions. The Bank published a report specifically analysing the Indian healthcare sector and encouraged privatized care as the solution for the sector's stagnation. The report mentioned that India's ability to control communicable diseases, mortality rates, malnutrition etc., has been stretched as far as possible and the country will no longer be able to afford the *health for all* and similar initiatives. As per the World Bank, the Indian government would be unable to sustain its trends in the 21st century and it suggested that the healthcare sector should be privatized, allowing for better services for all regions in the country. The World Bank's report and similar assertions were the primary reasons behind the 2002 NHP's move towards an even more market-oriented set-up.

Herein, the ever-long argument made by most neoliberals, was adopted by the World Bank as well as the Indian government. The Bank suggested that since the public

system has largely been inefficient in meeting the population's healthcare needs, it would not be harmful to marketize the healthcare sector. This phase and the acceptance of this particular viewpoint by the government is what opened up the crisis sphere for Indian healthcare. It promulgated a chain of disinvestments followed by an increase in privatization. However, the perspective ignored by both the 2002 NHP and the World Bank was whether the public health system's efficacy was in question or if it merely needed more support. Should the Indian government prioritize the bolstering of the public health system and address its weaknesses or adopt an entirely different system where private players dominate?

A working paper published by the *Institute of Studies in Industrial Development* astutely dealt with this issue and analysed whether the move towards privatization was the only option or whether the government pushed for equal public health. The review conducted by the institute revealed that there had been a traceable growth in the public healthcare facilities of the country; however, the increase was nowhere near the required numbers. Moreover, the healthcare centres did not have the required facilities to treat their patients effectively. The centres lacked doctors, medicines, infrastructure and every other basic element that is necessary to create an effective medical health centre. This happened simply because capital expenditure—which is essential for physical infrastructure and to purchase new medical equipment—on health has seen a declining trend both at the centre and the state levels. As per the report, the declining share of capital expenditure; however, will not be problematic if state(s) fulfil the prescribed norms of basic health facilities. However, most Indian states struggled to meet the stipulated healthcare standards. The diminishing allocation of capital funds further constrained the growth of recurring (revenue) expenditures. Consequently, the

total public expenditure on health saw a discernible decline. In terms of its share in GDP, the institute revealed that public expenditure on health hovered around only 1 per cent of the GDP; falling significantly short of the required 2-3 percent of GDP necessary to ensure provision of essential health services. Lack of investment in the public healthcare sector hindered the expansion and modernization of healthcare services.

Instead of increasing investment in the public healthcare sector, however, the government chose to disinvest and hand over the reins to the private sector. The government increased the Healthcare FDI limit to 100% in the 2000s and allowed direct entry to foreign players. It also decreased the import duty for medical equipment and technology and allowed low-interest rate loans for private players in 2003 and onwards. The government became a facilitator for private organizations in an industry which deals with the lives of the country's citizens and dropped the *health for all* targets. This opened the door for private organizations which have profit as their central motive instead of providing healthcare. The National Health Policy, 2017 was meant to address these issues as well as change the healthcare sector and reduce inequalities. The policy has introduced certain significant changes; however, it still has much scope for improvement.

The 2017 policy and a need for change

The Indian government, after adhering to the 2002 policy for 15 years, introduced a new policy in 2017. This policy aimed to account for the changing healthcare landscape and incorporated terms like “fiscal capacity” and “catastrophic expenditure”, reflecting a shift towards equal healthcare. However, the policy, which took more than two years to finally see the light of day since its introduction in 2014, reflects a conflict between

the equal health agenda and neoliberalism. The policy was meant to be a departure from the 2002 agenda, as articulated by Prime Minister Narendra Modi. He envisioned that the policy would provide healthcare in an “assured manner” to all and will address challenges arising from the ever-changing socio-economic, technological and epidemiological scenarios. Accordingly, the NHP incorporated the viewpoints of three major stakeholders- the health ministry, the Niti Aayog and the public via civil society associations.

However, the final outcome reflects a struggle between public health motives and neoliberal practices. Two core tensions have emerged:

- a. The objective of achieving public health goals contradicts neoliberal aspects such as “Reduced governmental control” and “Fiscal Conservatism.”
- b. The goal of universal health coverage relies on public health objectives but via minimal governmental control and a largely profit-driven private sector.

These contradictions led to compromises between the various stakeholders. The civil associations were promised improved healthcare access; the public health officials were guaranteed increased resources, and the private players were allocated provisions such as strategic purchasing and a largely unregulated medical sphere. Nevertheless, the dichotomies between the public health agenda and a privatized medical sector persisted, and the same can be analysed in a segregated format. The following analysis portrays three divisive segments where the scope of public health goals under the 2017 National Health Policy as well as beyond it, is scrutinized.

A Stronger Public Health System and the (lack of) Essentials

Three years after the policy's introduction, the healthcare sector has seen little change. The policy largely reiterates previous agendas, including subsidized healthcare, increased utilization of public facilities, free medical health support and increasing the health sector expenditure to 2.5% of the budget by 2025. Despite the increased post-COVID healthcare budget allocations, little tangible implementation has occurred. This reveals a neoliberal divide between policy promises and actual implementation. For instance, the government has set an ambitious goal to increase the utilization of public health facilities by 50% by 2025; however, it would require a concrete and decisive plan to even come near those particular figures. To achieve this, a realistic time-bound strategy is essential, focusing on substantial expansion of public health facilities – including personnel, infrastructure, and equipment, with the goal of prioritizing public provisioning in healthcare over the next decade. Such proposals will need to be formulated with population growth in mind, as well as addressing existing gaps while also assessing the financial consequences of each action item.

Strengthening Rights and Increasing Public Participation

Transitioning to a more public-oriented healthcare structure must prioritize public needs over profit-oriented tactics which create inequality. This necessitates a fundamental shift in parliament's notions to empower the public systematically. The substitution of the National Health Rights Act commitment with the ambiguous 'incremental assurance-based approach,' in the NHP 2017 is a huge setback for the medical sector's growth. While increasing ground-level public spending is vital, the

neoliberal agenda cannot be dropped unless the right to healthcare is adopted by the government first. Reforms should focus on institutional changes that reduce inequality and extend beyond budgetary allocations and NHP targets. Strengthening communal accountability, institutionalizing patient rights in clinical establishments and creating medical tribunals to address patient complaints are a few steps in the right direction. Moreover, incorporating global accountability norms and independent monitoring systems will foster health and an egalitarian social sphere. An effectual change in the policies of the government cannot be introduced unless a change in the idea of rights for medical health is institutionalized first.

Conclusion

The healthcare sector of India has gone through certain significant developments ever since Independence. The initial goal was to provide healthcare to all citizens regardless of their socio-economic status. However, the equalitarian agenda was sidetracked post-liberalization and even a few years before it while the sector was increasingly privatized. The various neoliberal policies of the government decreased public control and increased the role of private players, thereby sidelining the *health for all* agenda. The brunt of the less regulated sector was faced by the disabled, who lacked representation as well as support. The government abandoned the egalitarian approach and allowed profit-making entities to seep into the healthcare sector, weakening its core effaces. Moreover, the neoliberal change, over the years, has only increased inequality and hasn't allowed any structural growth for the sector. In order for the government to make a dramatic change, it will have to incorporate some essential features like increased control over private entities beyond the registration stage,

adopt a public rights approach to healthcare and incorporate global norms to increase accountability. The status of the healthcare sector will have to be completely revamped, otherwise the inequalities in the social sphere will continue to increase and access to healthcare would become even more dependent on one's socio-economic status.

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