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**International Trade & Health Equity: Have Benefits of Medical
Tourism ‘Trickled Down’ to India’s Poor?**

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ABSTRACT

In the late 20th century, international trade was projected as a tool for development with regard to global, social and political formations. Traditional political economic models claimed wealth generation through ostensibly maximising ‘comparative advantages’. The free market economy model claims that the whole society will receive material welfare from such international trade, as benefits of economic growth ‘trickle down’ either directly through increased income or indirectly as the increased government revenues are spent on infrastructural development, health, education, etc. Convinced by this theoretical claim, India gradually changed its stance from opponent to proponent of international trade in services during the WTO Uruguay round negotiations. Accordingly, the Indian government’s policy shifted towards capitalising India’s ‘comparative advantage’ in medical tourism, while contending that foreign exchange and revenue earned can be used to subsidise the treatment of poor patients. Thus, promotion of trade liberalisation in hospital services has been viewed as a tool to fulfil the mandate of social justice and promote health equity. However, the present paper argues that, instead, the health inequities have only grown throughout the period of neo-liberal globalisation, while there is no empirical evidence to prove the ‘trickling down’ of any material benefit to the poor resulting from opening up the healthcare sector to privatisation and internationalisation. Moreover, while the Indian health policy shift facilitated the burgeoning of a highly variable private sector, the absence of a comprehensive regulatory framework and a just grievance redress system has resulted in dubious quality and unethical practices in healthcare service provision in both the public and private sectors and inflation in healthcare costs. The paper will conclude with reiterating the importance of healthcare as intrinsic to ‘health capabilities’ imperative for enjoying a meaningful life.

KEY WORDS

Social Justice, International Trade, Health, Medical Tourism

1. Introduction

Since the late 1990s, the tension between neoliberalism led international trade and social redistributive justice is becoming more and more apparent. While the World Trade Organisation is trying to regulate the world trade order through dictating hegemonic global economic rules, a subaltern or anti-hegemonic globalisation is emerging centred around concerns of social and global justice (O'Connell 2007). It is true that a State surrenders some sovereignty when it becomes signatory to an international agreement, nevertheless, it cannot surrender welfare concerns solely to market forces (Higgott & Weber 2005). Although there is no accepted standard definition,¹ 'welfare state' is understood as a State built around social rights guaranteed to all citizens. Thus while states are obligated to follow the world economic regimen, they are equally required to mitigate the adverse social consequences of open markets.

As noted above, safeguarding health and provision of healthcare services is an indispensable feature of a welfare state. With the nature of healthcare services transforming from a social good to premium tradable commodity, the present paper aims to enquire whether India has been able to achieve its Constitutional objective of becoming a welfare state focusing on health and healthcare services. In order to meet the stated objective, the present paper will examine the gradual change in India's healthcare policies moving towards liberalisation in the health sector including policies promoting medical tourism. Medical tourism is promoted in India on the basis that the increased medical tourist traffic will generate revenues and economic benefits that will trickle down to the most disadvantaged strata in terms of good quality, widely available free of cost medical services. Thus the present investigation will assess whether it is delivering what it claimed to deliver i.e. economic welfare for everyone? To that end, it will centre on the financing of healthcare services in the post-liberalisation era. In the end, the status of healthcare services delivery in the era of medical tourism will be analysed within the framework 'welfare state' to ascertain the proposed enquiry. To begin with, the present investigation first encapsulates the importance of health and healthcare in social justice discourse.

2. Why Health and Healthcare?

‘Health’ is a multivalent construct that includes psychosocial as well as physical aspects that varies in different contexts (Ruger 2010). As opposed to a biomedical definition of health as absence of diseases or abnormalities, the World Health Organisation defines health as ‘a state of complete physical, mental and social well-being, and not merely the absence of diseases or infirmity’. This expanded notion, as an expansive understanding of health forming the foundation for prevention and treatment is not without its critique. Regarded as being too broad and muddling the distinction between health and well-being, such a conception is denounced for potentially medicalising social problems and resulting in finding a technical solution unsuitable for a political problem. The medical approach is criticised² for directing attention only to diseases and their remedy and, thus, losing sight of issues such as meaning or importance of good health for people and the broader social context in which these issues are constructed. A social sciences approach,³ on the other hand, puts health problems in a social context and aims to understand the social and economic factors responsible for health problems (Peter 2001).

Importance of health and healthcare services is increasingly being recognised in academic scholarship on social justice. Venkatapuram (2012) views health as both intrinsically and instrumentally valuable since good health constitutes well-being as well as makes possible the planning, pursuing and revising of life plans. Harris (2009) on the other hand regards health, among other things, as liberating. He argues that while sickness either confines or makes a person immobile, health is what liberates her from that confinement. Daniels (1982) values health for its role in equality of opportunity and healthcare for its function in restoring ‘normal species functioning,’ which is an important component of *opportunity range* (i.e. the array of life plans that are reasonable to pursue within the conditions prevalent in a given society).

Since the late 1980s, 'health equity' started to gain credence as an important policy consideration. As a concept, equity in health reflects concern for unequal opportunities and distribution of public resources for health and well-being of disadvantaged groups

(based on socio-economic status, gender, race, geographic location, age, ethnicity or religion) within a given society and for eliminating systematic health disparities (Braveman 1996). Mooney (1987) noted that, in the absence of a clear definition and policy objectives, resources may be wasted or misdirected. Braveman & Gruskin (2003) noted that a technical definition of equity in health is further needed to guide measurement of actions and hence accountability for the effects. Whitehead (1992) was the first to define 'health inequities' in as differences in health which are unnecessary and avoidable and, in addition, are also considered unfair and unjust. While this definition raised awareness and stimulated the debate, it was not a technical definition and left many questions concerning what is avoidable, how to judge unfairness and injustice, etc., unanswered (Peter 2001). Braveman (1996) proposed a definition of health equity as 'the absence of systematic disparities in health (or its social determinants) between more and less advantaged social groups'. In the proposed definition, social advantage means attributes that group people in social hierarchies, and health inequities result in diminishing opportunities to be healthy, subsequently putting disadvantaged groups at further disadvantage. This definition attempts to compare health disparities between identifiable social groups, like the health of different ethnic groups with each other, or health of men and women with similar health conditions (Braveman & Gruskin 2003).

Pereira (1989) argued that health equity is not health equality, though the terms have been used interchangeably at times. Whereas equity is a value-based normative concept, equality is more concerned with equal share in distribution of goods or resources. Since not all health disparities are unfair (for example, young adults are healthier than elderlies or men are prone to prostate problems and women to breast cancer), equity in health focuses attention on only those health inequalities that are unfair or unjust (for example, differences in immunisation levels or nutritional status between girls and boys or difference in appropriate treatment on the basis of ethnicity or religion) (Braveman & Gruskin 2003). Sen (2002) posits that health equity cannot be established by looking at inequalities in health and healthcare alone, but by taking into account how resource allocation and social arrangements link health with other features of the state-of-affairs. Referring to Dworkin's (1981) distinction of equality of welfare from equality of

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resources, and argument for equalising the resources available to people and not their welfare, Pereira (1989) highlights flaws inherent in this distinction. For instance, does equality of resources require only equality of access or use of resources in equal quantities? Is this equality applicable only to healthcare provided by States, or across all resources, public and private? He thus argues that being too vague a concept as a principle of distribution, equality is unable to provide a rigorous and consistent solution.

Fox & Thomson (2012) hold that Sen's capability approach is the most plausible approach for health justice as it views health as an intrinsic part of human flourishing and all aspects of flourishing are impossible or limited in the presence of ill-health. Capability, as the substantive freedom or practical possibility of being or doing something X, reflects the interaction of an individual's internal biological and mental endowment with external physical and social environment (Venkatpuram 2012). Sen (2002) maintains that the justice of social arrangements cannot be deliberated in absence of health equity at its epicentre. Giving the example of basic healthcare, Sen (2009) argues that an opportunity to access socially supported healthcare gives people capability to enhance their state of health. Thus, even if a person chooses not to make use of such opportunity, it cannot be considered as deprivation in the same sense as the failure to provide that person with the opportunity for healthcare in the first place. Venkatpuram (2012) contends that the concept of a moral right to basic capabilities – health being an overreaching capability to achieve or exercise a cluster of basic and inter-related capabilities and functioning – arising out of human dignity that their own society as well as other societies must respect, gives health capability an overarching effect. As, to be healthy is to be capable of being or doing some basic things that constitutes a life with equal human dignity and as such, a well ordered national and global society need to ensure that all individuals have the capability to be healthy at a level that corresponds with equal human dignity, which is their right.

Health equity is complex for it is not about the distribution of health alone or concerned with health in isolation. Sen (2002) observes that the ambit of health equity is enormously wide, reaching out to larger issues of fairness and justice in social

arrangements and economic allocations, while simultaneously bringing in the role of health in human life and freedom. As the discussion above shows, theorists often seek some set of political and material means that we can all agree everyone needs. Whereas it cannot be denied that there are definitional problems and the issues affecting the distribution of resources are wide and varied, it is to be understood that health equity is a multidimensional construct wherein different dimensions of values are irreducible to one another. Thus, as much as economists want, it is not possible to calculate the value of all the relevant results in exactly one dimension in order to measure the significance of all the distinct outcomes on a common scale, a problem of non-commensurability as Sen (2009) identified. This certainly does not render the whole concept void or invalid, he asserts, if the results are non-commensurable, that only indicates that the choice and weighting may render the decision-making difficult, but that does not make it impossible to make reasoned choices over combination of diverse objects. Above all, 'justice is by definition social, if at all' as Baxi asserts (Baxi 2004). Grounded in social disparities, health inequities highlight unjust health differences as demonstrated by social epidemiology that emerged with compelling evidence that health outcomes are grounded in social conditions and illuminated a whole range of social determinants of ill-health. Such findings thus motivate the understanding the causes of preventable ill-health as well as extend the moral scope of the concern for health inequities wide and deep into the basic structures of domestic and global society brought closer in the era of neoliberal market led globalisation (Venkatpuram 2012).

3. Healthcare in India: Social Good or Premium Commodity?

Upholding health equity is thus integral role of a welfare state, understood as a state built around social rights. Vogel (2003) defines social rights as 'an extension of democratic right defining welfare rights monitored on the political arena by collective decision making'. Regardless of typologies, 'welfare state' is used, in the period after second world-war period, as a shorthand for the state's role in housing, education, health (including public healthcare services), poverty eradication and social insurance etc. Social policies and welfare provisions have long been acknowledged as important

determinants of health and health inequalities (Eikemo & Bambra 2008). Inspired by the principles of welfare and recognising the importance of health and healthcare provision for social justice, the constitution makers of then newly independent India set out the objective of a welfare and socialist state through democratic means. By requiring the state to 'promote the welfare of the people by securing and protecting as effectively as it may, a social order in which justice-social economic and political-shall pervade all institutions of national life', Article 38 of Indian constitution provides a broad framework for the establishment of the welfare state. Thus, soon after the independence, (following Bhore Committee's report),⁴ India established a national health system delivering comprehensive preventive and curative healthcare services through a three-tier public system, financed by the government.

However, since late 1980s and following the Structural Adjustment Programmes of the World Bank, India slowly started to move towards opening the health sector for private participation. With accession to the WTO and thereby to the General Agreement on Trade in Services (GATS), India committed itself to liberalisation of trade in healthcare services. Subsequently India opened the hospital sector for foreign direct investment and has been actively promoting medical tourism (discussed in detail later). 'Medical tourism' i.e., 'consumption of healthcare services abroad' under Mode 2 of GATS, refers to situations where the patients residing in one country travel abroad to receive treatment in another country. Also referred to as health tourism, it covers export of the healthcare services like specialised high quality treatment or diagnostic to the affluent and privileged patients who travel to the country of the service provider to use these services, which may either not be available in their home countries or, if available, may not be of a particular standard (Chanda 2002).

4. Medical Tourism: India's Competitive Strength

Trade is projected as a tool for development with regard to global, social and political formations. Traditional political economic models (premised on Adam Smith's 'wealth of nation') defined how creation of wealth between nation-states can be organised through

ostensibly maximising comparative advantage (Higgott & Weber 2005). This theoretical framework asserted that the Ricardian theory of comparative advantage⁵ for goods can equally be applied to the service trade sector (Kierzkowski 2002). Accordingly, trade liberalisation and investment in healthcare services would lead to development, which would improve growth, income and employment in related industries and result in better health outcomes (Adlung & Carzaniga 2001). This ‘comparative advantage’ mantra that claimed that economic benefits will result in economic welfare for the whole society caused India’s stance, to swing from an opponent to a proponent of international trade in services over the successive rounds of GATS negotiations. As stated in the beginning, India’s committed itself to Hospital services and embossed its willingness towards further liberalisation. The National Health Policy (NHP) 2002 also recognised the significant role played by private sector in provision of secondary and tertiary level care and recommended the government aid in application of information technology in the area of tele-medicine in the tertiary healthcare sector. The NHP 2002 also endorsed capitalising on the comparative cost strength in the secondary and tertiary health sector by providing these services on a payment basis to foreign patients. It further recommended all fiscal incentives which are available to other exporters of goods and services, including status of ‘deemed exporters’, for encouraging private participation in tapping the emerging medical tourism niche.

Following these recommendations, the Indian government took a number of policy initiatives to encourage the private sector participation in medical tourism. For example, the 2003-04 budget of the central government saw reduction of custom duties on life saving medical equipments from 25% to 5% and tax exemption for long term capital investment in more than 100-bed hospital projects. The 2008 budget further offered a new five year tax exemption to any new hospital opening in urban agglomerations apart from the six largest metropolitan areas (Mumbai, Delhi, Kolkata, Chennai, Hyderabad and Bangalore) (Lefebvre 2010). In 2003, the Indian government introduced a public-private partnership policy in infrastructure, including the health sector and comprising contracting out hospital subsidiary services, as well as outsourcing the management of public healthcare facilities. The States and Union Territory (UT) administrations also

develop schemes to promote medical tourism in their respective State/UT. The Ministry of Tourism promotes medical tourism through its 'Incredible India' campaign, which includes promotion in overseas markets through road shows, participation in travel marts, production of brochures, CDs, films and other publicity material. In 2005 the Indian government introduced the 'medical visa' category to help foreign visitors who have sought preliminary medical advice from their country of origin or residence and have been advised to seek specialised medical treatment, and therefore wish to utilise Indian healthcare services. It was claimed that the number of medical tourist increased from 405,000 in 2007 to 650,000 medical tourists in 2009 that brought in foreign exchange worth US\$ 1160 million in that year (Medhekar 2013).

5. Medical Tourism: Are Economic Benefits Resulting in Economic Welfare?

As noted earlier, medical tourism was promoted by the Indian government on the basis that it will bring economic welfare for the lowest segment of the society. As result of promotion of the private sector participation in medical tourism, a number of super-speciality and multi-speciality corporate hospitals surfaced in urban India, subsequently not only tilting the availability and accessibility of hospital services towards urban areas, but also amplifying the costs of medical and healthcare services manifold. As NSSO (60th Round) report indicated, the average expenditure for an episode of hospitalisation has almost doubled in both rural and urban areas between 1996-97 and 2004; the maximum rise recorded in the private sector hospital services in urban areas (NSSO 2006). These expenditures are borne by consumers, major sources of financing being current income, past savings and sale of assets/borrowing (Dilip 2005). India's total health spending is one of the highest in the world, wherein about 80% of all healthcare expenses are borne out-of-pocket (OOP) by consumers, placing an enormous burden on underprivileged households (Mondal 2013).

Even though the costs of medical and healthcare services rose substantially in both the public and the private sector in the post-liberalisation era i.e. 1995 onwards, the public health spending stagnated at around 0.9 - 1% of the GDP. In 2009, India's total health expenditure as a percentage of the Gross Domestic Product (GDP) was 4.2%, out of

which the public health spending by the Indian government was only about 1.2%. About 80% of public healthcare funding comes from the State government's budget and the balance from the Central government and local bodies (12% and 8% respectively) (Duggal 2005). Lack of public funding has resulted in the shortage of trained and specialist human power, medical equipment, consumables and diagnostic facilities in the public sector, especially in rural areas (Hazarika 2010). Moreover, the introduction of user fee for hospital beds, medicines and diagnostic services in public hospitals has further removed hospital care from the reach of the poor. Technological advances, which are otherwise associated with lowering the costs, are actually leading to increase in healthcare expenditures in India. Capital-intensive technological developments are resulting in excessive and irrational use of these technologies making over-referral, over-testing, over-medication and overuse of diagnostic techniques a norm in the private sector healthcare. These pro-profit, unethical practices in the private sector healthcare are making healthcare unaffordable and a major drain on the resources of low and middle income households (Misra, Chatterjee and Rao 2003). As the National Sample Survey Organisation (NSSO) documented, in the absence of a well-functioning, needs-sensitive public healthcare system, India's poor are forced to avail themselves of private sector healthcare services, despite the fact that medical expenditure for hospitalised treatment from a private sector hospital is much costlier than the public sector hospital (MoHFW 2007).

In addition, minimal State intervention and lack of a policy framework to regulate private sector healthcare has further fuelled this unbound increase in the cost of healthcare services. Since inpatient treatment has become too costly, an increasing number of families are refraining from getting treatment because they cannot afford the hospital charges. According to NSSO, the number of untreated ailments due to financial reasons in 1986-87 was reported to be 15% in rural and 10% in urban areas, which rose to 28% in rural and 20% in urban areas in 2004 (MoHFW 2007). On top of excessive medical expenditure, lack of a financial protection mechanism to mitigate the financial burden is further causing an increased number of poor households to slip deeper into poverty every year (Selvaraj & Karan 2009). In the absence of a cost sharing mechanism, middle and

low-income households are often unable to recover healthcare expenses from their current income flow. This results in depletion of assets and a permanent fall in income, which subsequently plunges these families into intergenerational poverty (Mondal 2013). Studies have reported that about 44% of households in rural areas and 25% in urban area fall into debt due to OOP expenses incurred on an inpatient treatment. The risk of falling into debt is much higher (49% in rural and 28% in urban areas) if the treatment is sought from the private sector (Dilip 2005). The household expenditure on health, i.e., the OOP has pushed approximately 39 million Indians into poverty in 2004-05 (Selvaraj & Karan 2009). Prohibitive costs in the private sector healthcare along with the inadequate responsiveness to needs in the public health system have been the biggest barriers for accessibility of healthcare services for India's poor (Misra, Chatterjee and Rao 2003).

In an imperfect health market, public financing plays a very crucial role; it ensures minimum provision of healthcare services in economically backward States and acts as a corrective force for market failure (MoHFW 2005). Although the Indian government has accelerated healthcare spending since 2005 through a number of policy initiatives like the National Rural Health Mission, National Urban Health Mission, Pradhan Mantri Swasthaya Suraksha Yojana and Rashtriya Swasthaya Bima Yojana (RSBY, discussed below) etc. and has committed itself to increase public health spending to 2-3% of the GDP by the end of 12th plan (2012 – 2017), the desired outcome of universal healthcare for all is still elusive (Berman & Ahuja 2008). Health insurance penetration is very low in India, covering only about 3-5% of the population through: a) voluntary private health insurance, b) mandatory social health insurance for the employed population, and c) community based health insurance in a few locations (Ray 2008). The government of India has introduced some social health insurance schemes like RSBY,⁶ which provides insurance coverage for selected hospitalisation expenses and day care procedures to unorganised workers and their families who live under poverty. The actual implementation of this scheme lies with insurance companies, while the State governments identify the eligible poor families for the scheme. Whereas these social insurance schemes ensure that the poor can access tertiary healthcare, the choice element drives people to seek care from supposedly 'high-quality' private hospitals (Selvaraj & LGD 2015 (1)

Karan 2009). At the same time, cost-escalation puts the sustainability of the social insurance schemes at risk and poses the question whether the public funds are being channelled into the corporate hands in the name of the poor (Selvaraj & Karan 2009).

One may contend that the ‘medical tourists’ avail themselves of the private sector healthcare services and, as such, have no direct bearing on the subsidised/public funded healthcare services that cater to the needs of the poor. Yet, in a country with inadequate healthcare resources (there are still 6.5 doctor, 10 nurses and less than 1 hospital bed per 100,000 population including both public and private sector), foreign patients consuming healthcare services further remove these limited resources from the reach of socio-economically disadvantaged population. International patients often occupy high-end beds, pay higher price for the same treatment and are therefore more profitable for the private hospitals. Thus hospitals often overlook their legal, social and contractual obligations and, instead of providing free/subsidised healthcare services to poor patients, they give the beds reserved for the poor patients to foreign/wealthy patients (Rath et al., 2012).

The revenues generated from medical tourism can be beneficial if only the services related thereto are taxed sufficiently; however, the institutional failure to maintain records centrally has led to revenue loss. In 2002, the Comptroller and Auditor General (CAG) of India reported that, in the absence of a central agency in the income tax department to maintain records of all private hospitals and nursing homes in India, 66% of private hospitals and nursing homes evaded income tax payment between years 1997 – 2000 resulting in a revenue loss of approximately US\$ 2,461,967 (CAG 2002). Statistics have also revealed that, due to poor health infrastructure and unavailability of medical facilities in their own towns/cities, around 126 million Indians travelled in 2008-2009 to other cities/States to use medical services and spent about US\$ 3,886, on these services. While international medical tourists visit India for the cheaper cost of treatment, domestic medical tourism not only highlights the poor health infrastructure in rural areas and small towns, but it also renders obvious the waste of money and increased cost of medical services for people of India (Sharma 2013).

Health is a State subject and, as such, tourism is also undertaken by the State administration that earns revenues generated through such tourism. However, in the absence of any State intervention or policy framework to have a common set of regulations for the private sector healthcare throughout India, the private sector medical tourism is thriving unchecked. A dearth of institutional mechanisms to address private sector issues resulted in the weak implementation and enforcement of existing regulations (Hazarika 2010). For example, in 2004 the CAG reported that the failure by the Delhi Development Authority to enforce the terms of allotment of institutional land at concessional rates to hospitals and dispensaries not only resulted in a revenue loss of approximately US\$ 6,511,789, but also defeated the primary objective of such allotment of land at concessional rates and deprived the indigent patients of the benefit of free treatment (CAG 2004). In a bid to regulate private sector, the Indian government has finally passed the Clinical Establishment Act 2010, but it will take a while before its impact can be assessed.

6. Conclusion

Healthcare is important to maintain 'species functioning' (as Daniel argued) and to that end to financially accessible healthcare services are a basic entitlement. Moreover, health equity includes the fairness of processes and non-discrimination in the delivery of healthcare, making it crucial for capability to be healthy. As noted earlier, prohibitive costs and financial burden of inpatient treatment is preventing increasing number of poor patients from accessing hospital treatment and further pushing millions of people in the trap of poverty, which incapacitates a person from enjoying fundamental freedoms, i.e., capability to be healthy. Consequently, governments, especially in underdeveloped and developing countries, have a significant role in providing and regulating healthcare services as well as according financial protection, to which end, public funding is critical (Rao & Choudhury 2012).

Medical tourism is a private initiative based solely on profit maximisation. Even a widely available, well-functioning healthcare system in a country is of little use if the costs of healthcare services are exorbitant, especially for those who need it the most i.e. socio-
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economically deprived segments of society. The nexus between poverty and unaffordable healthcare services has been reiterated time and again by the scholars. Ill health, due to disease or injury, results in loss of work and income, reduces productivity and earnings and medical expenses often supported by borrowing and sale of assets inevitably push low and middle-income families into the poverty trap (Misra, Chatterjee and Rao 2003).

While theoretically trade liberalisation should not only be pro-growth but also be pro-poor, practically the health inequities have only grown throughout the period of neo-liberal globalisation. Vast literature has emerged contending that free trade does not necessarily promote growth and that growth does not necessarily reduce poverty or helps promote development (Brock 2009). On the other hand, no empirical evidence has proved the trickling down of any material benefit to the poor resulting from opening up the healthcare sector. The current investigation also indicates that there is no evidence that greater economic growth in the commercial healthcare services sector has benefitted India's poor, either in terms of improvement in healthcare service provisions, or better health outcomes. In fact, it has created two Indias: one where rich and foreigners enjoy world class healthcare facilities and another where the poor and destitute die for want of adequate healthcare (Pricewaterhouse Coopers LLP 2007). There is also no evidence that the economic gains generated by the niche medical tourism market are channelled to improve the domestic healthcare infrastructure and public sector hospitals. Instead, the absence of a credible system of data collection and analysis at any administrative institution, coupled with the lack of a centralised mechanism for revenue collection, has in fact resulted in tax-evasion by the private sector hospitals. The lost revenue, coupled with direct and indirect subsidisation of commercial services to promote the private sector participation in medical tourism, may in fact offset any resulting economic benefits. In a scenario where the right to health is derived through expansive judicial interpretation, universal healthcare for all is still a distant dream, pro-poor policies are sparse and ineffective where exist due to absence of an adequate legal, regulatory and monitoring structure; it will not be imprudent to conclude that the economic growth following economic liberalisation in healthcare sector has failed to improve the health of

India's poor, failing all the assertions of potential economic welfare while rendering the constitutional objective of 'welfare-state' a perpetual aspiration.

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¹ After Epstein-Andersen's 'Three Worlds of Welfare Capitalism' in 1990, a number of scholars reviewed

² In the late 20th century. literature emerged focusing on medical anthropology critically examining the meaning of illness for people, health in cultural context and development of biomedical model etc. for example, G. Canguilhem, *The Normal and the Pathological* (Zone Books 1991), B. Amick III et al. (eds.), *Society and Health* (OUP 1995), A.W. Frank, *The Wounded Storyteller: Body, illness and ethics* (Pantheon Books 1995) quoted in Peter, *Health Equity and Social Justice* 161

³ As advanced for example by the Black Report, published in 1980 that showed that despite a continued improvement in health during the first 35 years of the National Health Service across all the classes, there still exists a co-relation between social class. For more, See Department of Health and Social Security, *Inequalities in Health: Report of a Research Working Group* (Black Report) (DHSS, Government of UK 1980)

⁴ In 1943, the government of India constituted the 'Health Survey and Development Committee' (popularly known as Bhole Committee) to draw up the health services framework for the soon to be independent India that submitted its report in 1946

⁵ According to the classical principle of comparative advantage, countries have (relative) technological advantage in certain goods, so they specialise in those and growth is promoted by specialisation.

⁶ Interestingly, RSBY is a policy initiative taken up by the Labour Ministry and the Central Health Ministry of India has not envisaged any health insurance scheme as such for poor people.

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