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J.S. MAJUMDAR

Corporatization of the Healthcare System

HEALTH AS NEOLIBERAL AGENDA

The Modi government at the Centre announced two programmes as their flagship programmes. One was the Swachh Bharat Mission (SBM) announced in 2014 and another was the Ayushman Bharat – National Health Protection Mission (AB-NHPM), now renamed as Pradhan Mantri Jan Arogya Yojna (PM-JAY), announced in the budget speech on February 1, 2018.

After the end of the Second World War, imperialist countries established three instruments for rebuilding the world capitalist order – World Bank, IMF and GATT. After the collapse of the Soviet Union and the setback to socialism in East European countries, neoliberalism became the main thrust for reordering the capitalist world; and GATT was renamed as WTO, shifting from consensus basis decisions to majority basis decisions by it.

The capitalist system of production has an inherent problem. Increasing exploitation of the workers and deprivation cause workers' ill-health and disease with decreasing level of productivity; and to increase workers' productivity the capitalist system introduces the healthcare system.

At the stage of neoliberalism, the Vajpayee government at the Centre launched the '*Total Sanitation Campaign*' in 1999 with the main objective of providing toilets to all by 2012; and

sanitation facilities in all schools and Anganwadi centres by March 2013. In 2012, it was renamed as '*Nirmal Bharat Abhiyan*', with some additions, by the Manmohan Singh government with the objective of achieving 'Nirmal Bharat' by 2022. In 2014, the Modi government renamed it as '*Swachh Bharat Mission*' with the single aim to eradicate open defecation by 2019.

Repackaging and marketing of this 'high priority' sanitation programme continued despite the change of the governments. *Swachh Bharat Mission* has World Bank support of US $1.5 billion, granted in 2015, with preconditions for payment – third party independent verification showing reduction in the prevalence of open defecation and sustaining its results in the villages.

MARXIST VIEW ON HEALTH

Karl Marx made extensive study of the poor health conditions of the British working class at that time from Parliamentary and other governmental reports and made descriptive details in the chapter '*The General Law of Capitalist Accumulation*' in *Capital*, Volume 1. He particularly laid emphasis on food intake and, added to this, the standard of living including housing, sanitation, clothing etc., as the cause of ill-health and diseases.

In their extensive studies and writings Marx and Engels, for the first time, laid out a critique of health and medicine offering sociological theories of illness and disease, a thesis of the connection between capitalism and poor health.

Not entirely blaming the lack of medical care contributing to poor health, Marx and Engels did not consider the lack of drainage, garbage collection, poor design of the houses, etc., as the fundamental cause of disease and poor health. Marx and Engels argued that ill-health and diseases are products of the way humans organize and act in a particular kind of society. They saw the connection between disease and poverty. Marx and Engels

challenged those who closed their eyes to the 'consumptives, the overworked, and the starving'.

Marx and Engels proposed that the association between poverty and disease is a social, not individual, phenomena. Thus, Marx and Engels were arguing for a new theory of disease.

Since Marx and Engels' writing in the mid-nineteenth century, there have been real gains to populations from widespread public health measures and the creation of national healthcare systems. Each such gain has been the outcome of intense and protracted political struggle.

COMMODIFICATION OF HEALTH AND RISE OF THE MEDICAL INDUSTRIAL COMPLEX

With commodification of health, the healthcare system has become a system of commercial transactions – a marketplace composed of corporate hospitals and medical centres, research and diagnostic laboratories, pharmaceutical firms, medical equipment manufacturers, health insurance companies and so on. Healthcare in the capitalist system is entwined with the relations of capitalist production and exchange.

All studies have shown the importance of governments' role in healthcare and state-run healthcare systems in improving health outcomes and ameliorating the more negative effects of market-driven healthcare. It comes as a conflict between the modern state and the market. Where a democratic government has a duty to provide health for all, corporations have legal obligations to their investors which take priority over obligations to patients or customers. Hence, there are attempts to replace public healthcare services by the corporates in the healthcare business.

In this context let us now examine the Modi government's Ayushman Bharat Scheme.

PUBLIC HEALTHCARE SYSTEM – INTEGRAL PART OF THE PLANNING PROCESS

In India, the public healthcare system evolved out of and remained an important part of the planning process after independence. Health planning was an integral part of the Community Development Programme. It adopted a primary healthcare model based on the principle that inability to pay should not prevent people from access to health services. It envisaged public spending and people's participation. However, all these remained deficient due to successive governments' faulty policies and failures in implementation.

India is a signatory to the 1978 Alma-Ata Declaration 'Health for All by 2000 AD' of the World Health Organization (WHO). The Declaration defined Primary Healthcare, which serves the community including the mother and child, which includes family planning, immunization, prevention of locally endemic diseases, treatment of common diseases or injuries, provision of essential facilities, health, education, provision of food and nutrition and adequate supply of safe drinking water.

Based on the WHO Declaration, the first National Health Policy (NHP) was adopted in 1983 with the objective of (i) comprehensive primary healthcare service linked with health education; (ii) involvement of 'health 'volunteers'; (iii) a referral system for treatment; and (iv) an integrated network for speciality services free for the needy. This was supposedly to be achieved by 2000. NHP-1983 admittedly failed to achieve these goals within the time frame of about two decades.

It was replaced and diluted by NHP-2002 in the neoliberal stage by the then NDA government. Instead of reviewing and correcting the deficiencies in policies and in implementation, it blamed the failures on the earlier health policy itself being 'optimistic' and beyond financial resources and administrative capacity and, therefore, designed NHP-2002, claiming to be

'realistic' in expectation and regarding financial resources and administrative capacity, with the involvement of the private sector, by saying, 'Considering the economic restructuring under way in the country, and over the globe, in the last decade, the changing role of the private sector in providing healthcare will also have to be addressed in this policy.'

Added to these are the National Rural Health Mission, 2005, and National Urban Health Mission, 2013, integrated in the National Health Mission, 2013, for selected backward States in health indicators for establishing a health delivery system with simultaneous action on health determinants like water, sanitation, education, nutrition, social and gender equality within a time frame up to 2018, later extended to 2020. ICDS has had an important contribution in healthcare while the ASHA scheme is an integral part of the public healthcare system.

PUBLIC HEALTHCARE NETWORK

Public healthcare organizational structures have, as in March 2015, 1,53,655 Sub Centres (SCs), 25,308 Primary Health Centres (PHCs) and 5,396 Community Health Centres (CHCs) and district hospitals and medical colleges. In urban areas, there are also hospitals/dispensaries in subdivisions and under municipal local bodies.

Each SC serves a population of 5,000 (3,000 in hilly and tribal areas); consists of at least one Auxiliary Nurse Midwife (ANM) and Multipurpose Health Worker (MHW); and the expenses are entirely borne by the Central government. SCs also work to educate the rural people on health.

Each PHC is staffed by a Medical Officer and other paramedical staff; serves 30,000 population (20,000 in remote areas); supervises over 6 SCs; acts as referral hospital from SCs; and its expenses are borne entirely by the respective State governments.

Each CHC serves 1.2 lakh people (80,000 in remote areas);

funded entirely by the State governments; acts as a referral hospital from PHCs.

District Hospitals are the final referral centres for the primary and secondary levels of the public health system. In 2010 there were 605 district hospitals when there are 640 districts in the country.

Medical Colleges and Research institutions under both the Central and State governments and jointly owned also act as referral hospitals.

LOW HEALTH INDICES AND DEFICIENCIES

Despite all these, due to faulty policies and lack in implementation by successive governments, India's healthcare indices are among the lowest in the world. According to the Global Burden of Disease Study 2015, published in the prestigious medical journal *The Lancet* in October 2016, India stood a dismal 154th among 195 countries on the healthcare index. The journal lists India among the biggest underachievers in Asia in healthcare access.

The statistics released by the WHO (Global Health Observatory) in July 2016 reveal India to be below the global averages in providing basic healthcare services. Life expectancy of Indians is lower than the global average; mortality rate is 130 in one lakh population and 167 in one lakh population due to TB; maternal mortality is 174 in one lakh births.

Twenty per cent of all maternal deaths and 25 per cent of all child deaths in the world occur in India; 69 out of 1,000 children are dead by the time they reach the age of 5; communicable diseases are the cause of death for 53 per cent of all deaths.

The public health network suffers due to lack of adequate funds, infrastructure, personnel, and administrative failures. The shortage of doctors was one of the health-management failures cited by the report of the Parliamentary Committee on Health

and Family Welfare placed in the Parliament on March 8, 2016. With more than 7.4 lakh active doctors at the end of 2014, the doctor-population ratio stood at 1:1,674, worse than Vietnam, Algeria and Pakistan, needing 5 lakh more service doctors. The proportion of births attended by skilled health personnel is 74 per cent according to the WHO report. As per the rural health statistics 2014-15, more than 18,000 posts of ANMs were vacant in the Sub Centres as on March 31, 2015.

There are serious infrastructural deficiencies. A survey report on infrastructure of PHCs shows that the all India average of availability was: Water – 62.3 per cent; Electricity – 81.3 per cent; Labour Rooms – 47.4 per cent; and Laboratories – 45.4 per cent.

High out of pocket cost in the private healthcare sector has led many households to incur catastrophic health expenditure.

UNEMPLOYMENT AND VULNERABLE EMPLOYMENT

According to the ILO report India will have 18.9 million unemployed, rising from 9.49 per cent of the world population in 2017 to 9.67 per cent in 2018 to 9.76 per cent, in 2019; youth (15-24 years) unemployment was higher – 10.5 per cent in 2018 and 10.7 per cent in 2019.

Among those employed, 77 per cent will be in the vulnerable employment category according to ILO's *World Employment and Social Outlook* report, 2018. The vulnerable employment level is higher than that of the world or the South Asia region. Out of the 535 million strong labour force in India in 2019, some 398.6 million will have poor quality jobs. Vulnerable employment is characterized by inadequate earnings, low productivity and difficult conditions of work. They are informally employed. Poor quality of jobs and high informality, the ILO said, is key for the high level of 'working poor' or those living on incomes of less than Rs 198 per day.

It was necessary to briefly note above the existing healthcare system to understand the nature of attacks on people's healthcare since the Modi government came to power at the Centre. The Modi government has been demolishing all existing structures in the healthcare system and bringing basic changes in people's healthcare.

Coming to power, the Modi government abolished the Planning Commission, ending the planning process altogether leaving economic development entirely to market forces. The public healthcare system, which was integral to the planning process, became the worst victim.

In the neoliberal stage of capitalism, healthcare remained a big-ticket business for profit. But, in the ongoing stage of the world economic crisis, for maximizing profit through public funding, privately owned insurance-driven healthcare system is rapidly replacing the governments' responsibility in healthcare throughout the capitalist world.

In India, there is a two-pronged attack on the ailing people: (i) privatization of public healthcare system and (ii) privately owned insurance-driven healthcare system. These are epitomized in the Modi government's '*Ayushman Bharat for a New India – 2022*' programme announced in the Union government's 2018-19 budget. Both of the two components of Ayushman Bharat were announced as 'flagship programmes' of the Modi government. BJP is trying to popularize *Ayushman Bharat* as 'Modicare' in the 'Obamacare' style of USA.

NATIONAL HEALTH POLICY-2017 FOR PRIVATIZATION DRIVE

The stage was set earlier by adopting the National Health Policy (NHP)-2017, replacing NHP-2002, giving four reasons: (i) changing health priorities due to growing non-communicable

diseases and some infectious diseases; (ii) emergence of a robust healthcare industry estimated to be growing at double digits; (iii) incidences of catastrophic expenditure due to healthcare costs; and (iv) enhanced fiscal capacity in public funding. The policy thrust revolved round the 'emergence of a robust healthcare industry' and increased fiscal capacity in public funding.

NHP-2017 aims to 'align the growth of private healthcare sector with public health goals' to 'enable private sector contribution to making healthcare systems more effective, efficient, rational, safe, affordable and ethical'. For these, NHP-2017 also decided to establish Health and Wellness Centres (HWCs) by upgrading existing Centrally Funded Sub Centres (SCs).

It may not be out of place to note here that all World Bank projects and funding in the health sector in different States in India since the mid-nineties with the onset of neoliberalism have had a common feature, that is, the private sector's involvement in all public healthcare programmes.

AYUSHMAN BHARAT: PROGRAMME OF PRIVATIZATION

For the implementation of one 'flagship programme' of Ayushman Bharat, the Union Budget 2018 allocated a measly sum of Rs 1,200 crore for more than 1.53 lakh SCs, renamed as HWCs, across the country for the purpose of providing free 'essential drugs and diagnostics' for primary healthcare. If the entire amount is meant for purchase of essential drugs and diagnostics, then how would the deficiencies in infrastructure and staff shortages in SCs be removed and these be 'upgraded' as HWCs? Therefore, NHP-2017 suggested aligning with the private sector.

In Rajasthan, even before the Ayushman Bharat project of privatization of the public healthcare system, the BJP ruled State government was already on a privatization spree of the public healthcare system, handing over PHCs to private hospitals and others. It has already privatized 42 rural PHCs in 2016, 19 to WISH

Foundation, and 43 urban PHCs in 13 districts in 2017, and issued tender notices in August 2017 for privatization of 50 more rural PHCs. In the Rajasthan PPP model in healthcare the government offers to pay up to Rs 30 lakh per PHC in return for the private entity taking over the PHC management and all its operations. Rajasthan has 2,211 rural and 245 urban PHCs.

In Chhattisgarh, immediately after the Ayushman Bharat programme was announced in the Central budget, the BJP State government decided, in March 2018, to hand over 9 government-run CHCs, including 4 in the State capital Raipur and 2 in the Steel City Bhilai in the PPP model, listing the reason as shortage of staff including doctors even in the heart of the cities!

In Uttar Pradesh, the BJP government's health minister announced to the press (PTI) on April 29, 2018, that the UP government planned to establish around 1,000 hospitals in the PPP model as part of the Central government's Ayushman Bharat programme, and that it had already asked the UK consultancy firm Ernst & Young to prepare a project report. The PPP model envisages the government providing 3 acres of land in CHC areas with the hospital to be built by the private company for healthcare business. And to fill the shortage of doctors in existing hospitals, the minister informed that a tender will be issued for the private firms to recruit doctors on contract basis.

The NITI Aayog in July 2017, issued a Guideline for 'Public Private Partnership for Non-Communicable Diseases (NCDs) in District Hospitals' on a 30 years' contract, making the State governments accountable if they default on paying their private partners through a penalty. 'This is a very positive attempt to make the PPP contract more equitable. Businesses cannot run in a sustainable manner if outstanding payments are not cleared in a timely manner,' president of Fortis Healthcare Ltd said, reported *Economic Times* on July 24, 2017.

LOW BUDGET ALLOCATION

Although the Modi government's National Health Policy 2017 aimed to raise budgetary allocation in the health sector from 1.15 per cent of GDP to 2.5 per cent by 2025, the ratio to GDP has actually come down in the 2018-19 budget compared to the 2017-18 budget. Budgetary allocation in Financial Year (FY) 2018-19 was merely 5 per cent higher than the revised estimate of Rs 50,079.6 crore in FY 2017-18; and it declined to 2.1 per cent of the total budget from 2.4 per cent in the previous year despite the claim of enhanced fiscal capacity and launching of the two 'flagship programmes' of Ayushman Bharat.

INSURANCE-DRIVEN AYUSHMAN BHARAT – NHPS

The other 'flagship programme' of Ayushman Bharat is the National Health Protection Scheme (NHPS) for hospitalization expenses up to Rs 5 Lakh per family each year covering 10 crore poor and vulnerable families (about 50 crore people) for secondary and tertiary healthcare announced in the budget FY 2018-19.

Former Union secretary of the Ministry of Health and Family Welfare, Sujatha Rao has aptly said, 'The NHPS, however, raises a more important issue: The decisive redefinition of the role of the state from being a service provider to a financier' (*Indian Express*, February 13, 2018). Financing whom? Of course, the corporate hospitals and private insurance companies. 'This will be a big boost for us. The current insurance schemes were unviable, but with the increase in cover, I think we will see a growth in our state-sponsored scheme patients,' said Suneeta Reddy, MD, Apollo Hospital Enterprise, reported *ET* on February 2, 2018.

Data released by the Department of Industrial Policy and Promotion (DIPP) shows that hospital and diagnostic centres attracted FDI worth $4.83 billion (Rs 3.45 lakh crore) during 2000-17. According to the National Family Health Survey-3, the

private medical sector remains the primary source of healthcare for 70 per cent of households in urban areas and 63 per cent of households in rural areas. The burgeoning private sector hospitals having substantial FDI must have a growing market.

Seeking new investment, the government had relaxed FDI norms in 2016 in the insurance sector permitting 49 per cent FDI though the automatic route. Two public sector insurance companies were listed in 2017 for disinvestment. The 2018-19 budget proposed a merger of three public sector insurance companies.

The UPA government led by Manmohan Singh has already allowed 100 per cent FDI through automatic route in Greenfield projects (new ventures) and, under approval by FIPB (Foreign Investment Promotion Board) in Brownfield projects (existing companies) in India. Those foreign drug companies which left India during the pre-neoliberal stage, started coming back through FDI's Brownfield route. To facilitate the process of Indian companies' take-over by drug MNCs, the Modi government has taken one more step allowing up to 74 per cent of FDI in Brownfield in pharmaceuticals through the automatic route.

A disciplined, integrated and pan-India market has to be provided for this troika of corporates in the hospital, insurance and medicine producing business with substantial foreign capital. NHPS is meant for that.

REAPING OF HUGE PROFITS BY INSURANCE COMPANIES

One can draw the conclusion on the insurance companies reaping huge profits out of public funding from the experience of the Modi government's much touted Pradhan Mantri Fasal Bima Yojna (PMFBY). Ayushman Bharat NHPS is on a much bigger scale.

According to the data available from the Insurance Regulatory and Development Authority of India (IRDA), 11 insurance companies have hugely benefited by Rs 10,000 crore in just one year

in 2016. Insurance companies got Rs 15,891 crore in premiums while total claims amounted to a little over Rs 5,962 crore due to crop failures during the June-November 2016 Kharif season.

On June 6, 2018, NDA ally and Bihar Chief Minister Nitish Kumar, rejected the Centre's PMFBY accusing the scheme of being beneficial for insurance companies rather than farmers and launched the Bihar Rajya Fasal Sahayata Yojana. Bihar's Principal Secretary (Cooperatives) in a statement said that Bihar had paid its 49 per cent share of insurance premiums amounting to Rs 495 crore. The Centre also paid its 49 per cent share and the farmers paid the remaining 2 per cent share of insurance premiums in 2016 to cover crop failures in the Kharif season. As against that Bihar's farmers received only Rs 221 crores, benefitting the insurance companies by Rs 788.80 crore.

LAUNCHING OF PRADHAN MANTRI JAN AROGYA YOJNA

On March 21, 2018, the Modi government announced the launching of 'Ayushman Bharat – National Health Protection Mission' (AB-NHPM). It has now been renamed as Pradhan Mantri Jan Arogya Yojna (PM-JAY). From the Red Fort's ramparts on Independence Day, addressing the nation, the Prime Minister announced the launching of PM-JAY on September 25, 2018, and Jharkhand has been selected as the State for launching the programme. PM-JAY will subsume ongoing centrally sponsored schemes – Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS). It also proposes to subsume State sponsored healthcare schemes.

In line with PM Modi's concept of 'cooperative federalism' in Centre-State relations, an Ayushman Bharat National Health Protection Mission Council (AB-NHPMC) has been set up, to be chaired by the Union Health and Family Welfare minister and State health ministers as its members at the apex level to take policy decisions in line with the GST council. Centre and States'

contribution in insurance premiums would be in the ratio of 60:40. PM-JAY will be governed in corporate style by the Ayushman Bharat National Health Protection Mission Governing Board (AB-NHPMGB) with a CEO as its Member Secretary.

An Ayushman Bharat National Health Protection Mission Agency (AB-NHPMA) will be registered as a 'Society' to manage the AB-NHPM at the operational level which will be headed by a full time CEO. On March 27, 2018, the Modi government appointed Indu Bhushan, Director General of the East Asia Department of Asian Development Bank in Manila (Philippines) as the CEO of PM-JAY.

Each State must have a State Health Agency (SHA) to implement the scheme. Transfer of funds from the Central government will take place through AB-NHPM directly to SHAs. Like GSTN, under NITI Aayog, an IT platform will be made for 'paperless, cashless transactions' at all levels.

SUPPLY OF ESSENTIAL DRUGS TO HWCs

It has already been mentioned above that Rs 1,200 crore was allocated for primary healthcare at HWCs in the FY 2018-19 budget for purchase of essential medicines and diagnostics. Who will supply these essential drugs for HWCs?

The budget 2018-19 speech said, 'More than 800 medicines are being sold at lower price through more than 3 thousand Jan Aushadhi Centres.' The privately-owned 'Jan Aushadhi Stores' were established by the predecessor UPA government led by Manmohan Singh, in 2008. 'Bureau of Pharma PSUs of India' (BPPI) consisting of the Department of Pharmaceuticals and 5 public sector drug companies – Indian Drugs and Pharmaceuticals Ltd (IDPL), Hindustan Antibiotics Ltd (HAL), Bengal Chemical and Pharmaceuticals Ltd (BCPL), Karnataka Antibiotics and Pharmaceuticals Ltd (KAPL) and Rajasthan Drugs and Pharmaceuticals Ltd (RDPL) – with its headquarters at the IDPL

office in Gurgaon, was registered under the 'Societies' Act in 2010 to 'supply, fix prices and monitor sale of generic drugs through the network of "Jan Aushadhi Stores"'. The Modi government's Health Policy, 2017, also had to admit that 'Public sector capacity in manufacture of certain essential drugs and vaccines is also essential in the long term for the health security of the country'.

But, as recommended by NITI Aayog, the same Modi government has already declared the outright sale of all these pharmaceutical PSUs. Hence, the supply of essential drugs has become entirely dependent on the private sector. The allocation of Rs 1,200 crore for the supply of essential drugs in primary healthcare through 1.53 lakh HWCs is entirely for creating a market for private drug companies by state funding.

CORPORATIZATION OF THE ENTIRE HEALTHCARE NETWORK

In addition to the privatization drive of the public healthcare network and the insurance-driven healthcare system designed in the Ayushman Bharat scheme, the Modi government has taken other steps for handing over the entire healthcare system in India to the troika of corporates in the insurance, hospitals and drug making business to decide everything – level of treatment, medicinal prescriptions and supply of medicines and diagnostics, and the costs, determined by and amongst the troika.

To facilitate this process, the Modi government allowed e-retailers like Amazon and now Walmart to enter the medicine supply market as corporate suppliers replacing about 7.5 lakh medicine retailers. In protest, about 20 lakh people of 7.5 lakh medicine retailers with an average of 2/3 employees each, went on strike on May 30, 2017.

Much before the NDA government decided on the dissolution of the UGC and directly controlling higher education through the Higher Education Commission of India (HECI), it introduced the National Medical Commission Bill, 2017, in Lok Sabha on

December 29, 2017, which is now pending before the Parliamentary Standing Committee. The purpose is the same – corporatization of higher education and direct control by the Centre.

In protest, on January 2, 2018, nearly 3 lakh doctors joined the 12-hour countrywide shutdown of out-patient department (OPD) services at all private hospitals and the Indian Medical Association (IMA) observed this day as a 'Black Day' in protest against the National Medical Commission Bill. The National Medical Commission (NMC) Bill replaces the Medical Council of India (MCI) and revokes the Indian Medical Council Act, 1956.

Some of the objections raised by the medical practitioners and their organizations, including IMA, across the country against the NMC are as follows:

(i) MCI is an elected body by the States and Universities and within themselves to regulate both medical education and practice, whereas the proposed NMC is a nominated body under the Central government to administer medical education and practice through appointed boards.

(ii) To start a medical college, regulatory approval is required under MCI. NMC removes such regulatory approvals altogether allowing the automatic approval route.

(iii) The proposed NMC raises managements' quota from the present 15 per cent to 60 per cent of seats in private medical colleges; the government regulated quota will be cut down from 85 per cent to 40 per cent; fees will be entirely at the discretion of the management. This will cut down seats for economically weaker sections and for SCs/STs.

(iv) The proposed NMC allows any foreign doctor to practise in India without any restrictions. The existing screening test for the Foreign Medical Graduates will be abolished. At the same time licentiate examination for the Indian Medical Graduates will be introduced to allow them to practise medicine in India. This is nothing but double standards by the NMC.

(v) The NMC proposed mixing of different systems in medical

treatment like Ayurveda, Siddha, Unani, Yoga, Homeopathy, Naturopathy, etc. to practise Allopathic modern medicines once they complete a short term 'Bridge' course.

NO LAW TO PUNISH BRIBE-GIVER DRUG COMPANIES

More than 1 lakh Medical and Sales Representatives were on one day's countrywide strike on February 3, 2016. In addition to pursuing their own job- and work-related demands, they were demanding drug price reduction, reverting to cost-based fixation of drug prices, zero GST on all essential drugs, revival of drug PSUs and to frame a law to punish bribe-giver drug companies (who promote their products by selectively bribing, replacing sales promotion through medical representatives) under the 1954 drug law and the 1994 judgement of the 5-member Constitutional Bench of the Supreme Court.

Prime Minister Narendra Modi, sitting in London (April 15-23, 2018), publicly accused the entire fraternity of Indian medical practitioners taking bribes from drug companies, which is already a punishable offence for medical practitioners under MCI Rules. But, despite being urged, the Modi government, in line with 'ease of doing business', is not prepared to touch the bribe-giver drug companies and make it a punishable offence, including imprisonment, under law. There is no specific law in the country yet to punish such bribe-giver drug companies.

MEDICINE PRICE CONTROL

Drug prices control was introduced for the first time in India after a 20-year-long discussion inside and outside the Parliament, adoption of the Indian Patent Act, 1970, not allowing patents on pharmaceutical products, and on the recommendation of a Parliamentary committee, the Hathi Committee report, 1975.

The Drug Prices Control Order (DPCO), 1979, was issued under Section 3 of the Essential Commodities Act bringing *all medicines under price control* and *fixing cost-based pricing* of all medicinal formulations using bulk drugs divided in 3 categories – category I for 'essential medicines', category II for important medicines and category III for the rest of the medicines – with 40 per cent, 55 per cent and 100 per cent additions (called as 'mark-up') over the total cost of production plus excise duty as ceiling price, plus 16 per cent retailer's margin, fixing the total amount as the maximum retail price (MRP) of the medicines, irrespective of their being 'brands' or 'generics'. On Kelkar committee's recommendation, DPCO 1987 was issued completely removing category III medicines from price control and diluting the lists and mark-ups in categories I and II. In the neoliberal stage and after accepting the 'product patent' of medicines in 1994 in the Marrakesh Conference of WTO, DPCO 1995 was issued, further diluting the drug prices control limiting it *only for essential medicines* in the category I list, reducing the number of essential bulk drugs in the list from 140 to 76, and increasing the mark-up to 100 per cent plus excise duty.

This cost-based price fixing of essential medicines based on 76 bulk drugs continued till there was a complete departure from the past when DPCO 2013 was issued. The Supreme Court of India on March 10, 2003, issued an order giving two directions to the Government: (1) on controlling medicine prices and (2) for preparing the list of Essential Medicines. These are recorded in the proceedings of Lok Sabha in the written statement of the then Minister of State for Chemicals and Fertilizers on October 23, 2008.

Accordingly, the Government prepared a new list as 'National List of Essential Medicines' (NLEM) of 348 single or combinations of medicines and issued DPCO 2013, changing from the hitherto followed cost-based price control to *market-based ceiling prices of drugs*. DPCO 2013 in clause 4 states, '*First the Average Price to Retailer of the scheduled formulation*' is to be calculated from the

'*total number of such brands and generic versions of the medicine having market share more than or equal to one per cent of total market turnover on the basis of moving annual turnover for that medicine*', and then adding 16 per cent as retailer's margin the total amount becomes the MRP of that medicine.

The Government is relying on the 'Fortune 500' listed US multinational company 'IMS Health' for the data for fixation of prices of essential medicines in India. Surprisingly, the 2013 Order carries the name of this particularly selected company. Its clause 9 states, '*The source of market based data shall be the data available with the pharmaceuticals market data specializing company – IMS Health (IMS)*.' IMS Health has since merged with another US company and become QuintilesIMS operating in health information technologies, clinical trials, as a biopharmaceutical developer and in commercial outsourcing services.

DPCO 2013 also provides that '*the manufacturers may increase the maximum retail price (MRP) of scheduled formulations once in a year, in the month of April, on the basis of the wholesale price index with respect to previous calendar year and no prior approval of the government in this regard shall be required*'.

As such, DPCO 2013 did not reduce prices of existing essential medicines in the earlier DPCO 1995 list. It further allowed already decontrolled and existing high prices of medicines, which were outside the earlier essential drug list and now included in the list of 348 medicines in the NLEM. Added to this, it has the provision of annual increase of 348 essential medicines prices. As a result, after DPCO 2013, the prices of all medicines jumped upward and are continuously rising. It may be noted that under DPCO 2013 there is no drug prices control on the medicines which are outside the NLEM. The Modi government increased the number of medicines in NLEM from 348 to 376 in 2015 as per the core committee's recommendation. It should be remembered that these out-of-price-control medicines added to NLEM shall carry the existing market price with them in the NLEM and shall contribute further

in increasing the ceiling prices of essential medicines.

The Modi government is aggressively implementing the deregulated 'market-based' name-sake price control of essential drugs. The National Pharmaceutical Pricing Authority (NPPA) under the Department of Pharmaceuticals of GOI has so far fixed ceiling prices of 700 plus medicines in different forms, strength and dosages as required under clause 14(1) of DPCO 2013. This the Prime Minister Modi claimed as the singular achievement of his government in capping the prices of medicines for the 'poor'!

FRAUDULENT METHOD IN FIXATION OF GST RATE ON MEDICINES

The GST structure includes the erstwhile Central Excise Duty (CED), which was fixed quantity-cost based, and VAT, which was retailers' price level based. Both are now embedded in GST. CGST in place of CED has also become ad valorem with its rise with each MRP rise. This is substantially adding to the price of medicines.

The Modi government adopted a fraudulent method in fixing the GST rate on Essential Medicines. Firstly, GST Rate Schedule, as applicable from July 1, 2017, under SL 30, Chapter 30 (Pharmaceutical products), column 5, item 8, states: '*Formulations manufactured from bulk drugs specified in List 1 of notification No. 12/2012 - Central Excise, dated 17th March, 2012.*' That means the government fixed 5 per cent GST Rate Schedule on the *medicinal formulations based on 74 bulk drugs in the 'List 1' of DPCO 1995* (!). 'List 1 of Essential Drugs' under DPCO 1995 was already replaced by 'NLEM' under DPCO 2013. How then was the GST Rate on July 1, 2017, fixed on a non-existing 'List 1' of DPCO 1995? Obviously, for GST calculation, the majority of NLEM drugs are not treated as 'essential medicines' at all, charging high rates of GST escalating drug prices manifold.

Further, vide Central Excise Notification No. 22/2013-CE, dated July 29, 2013, as amended by 29/13, the then UPA government *exempted 'the scheduled formulations as defined under*

the Drugs Price Control Order (DPCO), 2013'. By that notification all formulations based on NLEM were exempted from Central Excise Duty. Several State governments also exempted sales tax on all essential medicines. Virtually no tax was being collected on essential medicines prior to GST in line with the Supreme Court's direction.

By the July 29, 2013, notification, the then UPA government had already (i) exempted central excise duty (CED) on all formulations based on 348 drugs in the NLEM; (ii) exempted CED on several other drugs; and (iii) introduced 6 per cent CED on the rest of the drugs at cost/kg. That means there was no excise duty on any of the 348 NLEM and many other drugs beyond the NLEM list and only 6 per cent on rest of the drugs vide Central government's notifications of March 17, 2012, and of July 29, 2013.

These notifications were nullified by the Modi government by its notification on May 18, 2017, by imposing a minimum 5 per cent GST only on 74 drugs, 12 per cent on many other NLEM drugs and much higher on several drugs. Fifty per cent of this GST goes to the Central government which had already exempted most of the drugs from Central taxes.

As a result, the prices of essential medicines jumped immediately due to the increased rate in Central taxes under GST and the National Pharmaceutical Pricing Authority (NPPA) had to revise upward the cap on NLEM drugs.