Lauderdale Paradox in COVID-19 Pandemic Times- A Study on Kerala

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Abstract

Karl Marx explains the Lauderdale paradox as a contradiction between public wealth and private profit and how the latter increases as the former diminishes. The present paper argues that COVID-19 pandemic has been strengthening the Lauderdale Paradox in the healthcare sector, for example in the state of Kerala in India. Kerala, the most literate state and more advanced than most other states of the country, in terms of social development indicators, experienced progress in the public health system in an impressive way, till the 1980's and declined thereafter. Higher levels of literacy and public healthcare services are possible because of government expenditure. With improvements in literacy, standards of living and awareness, consumers of healthcare services start demanding more and better quality of the same. However, public healthcare systems do not develop enough. Private players, especially large private hospitals enter and expand their share in the space created in the healthcare sector. This is an instance of unfolding of the Lauderdale paradox in the healthcare sector.

The present study explains the increasing domination of private hospitals in the healthcare sector development in Kerala, against the backdrop of the Marxian theory. Health is treated like a commodity and offered for sale with mainly profit motive. This trend is strengthened during the pandemic times. A few suggestions for further research in this exciting area of study are given at the end of the paper.

Keywords: Lauderdale Paradox, Healthcare sector, Private hospitals.

INTRODUCTION

Kerala attracted international attention in 1957, when it had the world's first democratically elected communist party government. Later Kerala and the 'Kerala model of Development' attracted world's attention because of its outstanding achievements in social sector development indicators, even though its achievements in agricultural production, industrial development and per capita income growth were relatively poor. The present paper is divided into three parts. In the first part, a brief historical account of development of the healthcare sector in Kerala is given. The emphasis is on the initial growth and relative decline later of the

government's role in healthcare sector development which allowed rapid expansion of private (especially large) hospitals, affecting people's interest. The second part explains how the logic of the market system undermines people's welfare, with the help of Marxian concepts of Lauderdale Paradox and commodification of health. In the third and last part, the strengthening trend in Lauderdale Paradox during the pandemic times in the healthcare sector in India is explained.

Part 1- Development of healthcare sector in Kerala

A brief historical analysis of development of the healthcare sector in Kerala may be provided as a backdrop to the subsequent discussion. Western medical practices were first introduced in 1498, when the Portuguese arrived in Kerala. There were progressive changes in the socio-cultural conditions under the influence of European colonization and the services of Christian missionaries. The control of Cholera was a huge challenge. The princely rulers in the states of Travancore and Cochin of the 19th century allowed and encouraged Christian medical missionaries. For example, the Church Missionary Society (CMS) sent medical supplies and experts in 1816 and later it expanded the services especially in Travancore state. The London Missionary Society (LMS) started a training school in 1864. The Salvation Army began its activities in the medical field and subsequently other societies like Nair Service Society (NSS), the Shree Narayana Dharma Paripalana Yogam (SNDP) and the Muslim Educational Society (MES) started hospitals. However, Malabar and large parts of the neighboring Madras Presidency were relatively backward compared to Travancore and Cochin, in terms of healthcare facilities.

In 1956, the Malabar district of the British India's Madras Presidency was integrated with Travancore and Cochin to form the state of Kerala, during the state reorganization efforts in India. During the initial decades, the Kerala government's commitment to provision of high quality health services to the ordinary people was substantial. Social sector areas, especially education and health, received a large share of government expenditure. The annual growth rate of government healthcare expenditure from 1956 to the early 1980's was about 13 percent, when the annual growth rate of the state domestic product was only 9.8 percent during the same period. (Pannikar and Soman, 1984). This was reflected in the rapid growth of government healthcare facilities in Kerala. The number of beds in government hospitals increased from 13,000 in 1960-61 to 29,000 in 1980-81. Education was another social sector which received huge government expenditure during this period. These government initiatives resulted in positive social sector outcomes during the 1990's, a few of which are given below.

Table 1: Major Indicators of Social Development in Kerala and India

Sl. No	Indicators	Kerala	India
1.	Literacy-Male (Percentage)	93.6	64.1
2.	Literacy-Female (Percentage)	86.22	39.3
3.	Sex Ratio- Female per 1000 males	103.6	92.7
4.	Crude Birth Rate (CBR) - per 1000 population	17.3	28.5
5.	Crude Death Rate (CDR) - per 1000 population	6.0	9.2
6.	Infant Mortality Rate (IMR) - per 1000 population	13.0	74.0
7.	Life Expectancy- Male	68.2	62.3
8.	Life Expectancy- Female	73.6	64.2

Source: *Economic Review*, Government of Kerala, 1995.

The social sector development indicators mentioned in table 1 are largely the outcomes of the pivotal role the government played especially in the healthcare sector. However, due to the fiscal crisis from the 1980's, the government could not spend adequately on the existing facilities in public healthcare institutions, let alone on expansion of the facilities. Even whatever government spending that happened was limited to revenue expenditure rather than capital expenditure.

There arose a paradoxical situation in healthcare sector development in the state of Kerala. There were many positive changes happening in the economy and society which led to increased demand for more and better healthcare facilities. There was an increase in household incomes due to mainly the remittances made by those from Kerala working in the Gulf countries. There was an increase in literacy and awareness about the importance of better health

standards. There was an increase in the size of ageing population which required special medical attention to take care of age-related ailments. There was development of road networks and public transportation which made health related travel easier and less expensive. These are the major reasons for increase in the demand for more and better healthcare services (Kannan et al, 1991). As patients and members of their families began to expect and demand more and better healthcare facilities, the state slowly withdrew giving room for the private hospitals to expand their share in the healthcare sector. One study says that the number of private hospitals was 704 in 1978, which increased to 4288 in 1995 and accounted for about 76 percent of the hospitals in Kerala (Sadanandan R, 1993). Another study points out that between 1986 and 1996, there was 5.6 percent growth in the number of beds in government hospitals whereas it was 37.8 percent growth in the case of private hospitals in the state. (Surendran P, 2002)

Another related and interesting trend is that the state government plays a leading role in building and running training institutions for doctors and different kinds of health professionals. Along with these government institutions, there are a large number of missionary hospitals many of which have facilities to train nurses and other medical personnel. Many young girls in Kerala, mostly from Christian community, wish to become nurses and build successful careers. However, a large number of those who get training in these institutions join in large private hospitals because these hospitals pay two to three times higher salaries compared to government hospitals (Parayil G, 2000). According to one study, the number of doctors per 1000 population was relatively high in Kerala among other states of the country and about 86.4 percent of the doctors worked in private hospitals (*Economic Review*, 2012). Economic motive and availability of modern medical facilities in large private hospitals are cited as major reasons for this trend.

Table 2. Distribution of government and private healthcare facilities by districts in Kerala

District	Population density (per km^2)	Literacy (%)	Income per capita (rs)	Private beds per 100000 population	Private hospital per 10km^2	Govt. beds per 100000 pop.	Govt. hospitals per 10 km^2
Thiruvananthapuram	1437	89.22	8147	153	1.97	220	0.52
Kollam	1019	90.47	7831	283	1.48	81	0.35
Pathanamthitta	463	94.86	8094	359	0.97	77	0.23
Alapuzha	1468	93.87	7026	175	2.60	193	0.64
Kottayam	862	95.72	7429	402	2.15	177	0.38
Idukki	227	86.94	9586	346	0.48	74	0.13
Emakulam	1237	92.35	12665	383	2.25	131	0.47
Thrissur	959	90.13	8126	287	0.95	141	0.40
Palakkad	577	81.27	6943	81	0.40	80	0.24
Malappuram	1006	87.94	4933	93	0.67	60	0.34
Kozhikode	1214	91.10	7768	130	1.59	154	0.40
Wynad	350	82.73	9875	237	0.52	109	0.18
Kannur	824	91.48	7940	162	0.89	86	0.34
Kasergode	602	82.51	7321	108	0.79	56	0.30
State	806	89.81	8007	216	1.10	122	0.32

Computed from *Economic Review* (2012), Government of Kerala

A few inferences can be made from the numbers available in Table 2 to find support to the arguments presented in the present paper. Ernakulam had the highest per capita income among all the districts of Kerala. The gap between the numbers of beds in the private hospitals and the number of beds in the government hospital, per 1 lakh population was also the highest in Ernakulam among all the districts of the state. It is about 3 times and it means that as the state retreats in the healthcare sector and the income of the people increases, the space for the private sector to expand increases. Kottayam had the highest literacy rate among all the districts of Kerala. Again, the gap between the number of beds in the private hospital and the number of beds in the government hospitals, per 1 lakh population was among the highest in Kottayam, among all the districts of the state, when literacy rate is taken as a criterion. It is about 3 times and it means that the state retreats from healthcare sector, when literacy and awareness among the people increase, leaving the space for the private sector to expand. These trends indicate the unfolding of the Lauderdale paradox in the healthcare sector in Kerala and perhaps in other parts of the country as well.

Part 2- Unfolding of Lauderdale Paradox in Healthcare Sector

Karl Marx (1847-1964) explains Lauderdale Paradox as a contradiction between public wealth and private profit and how a decrease in the former progressively increases the latter. In the context of the present discussion, it would mean how a decline in public healthcare services progressively increases the growth of private hospitals and their profit. Marxian theorists like Foster (1975) and Churchill (2004) extended the concept of the Lauderdale paradox to explain the growing contradiction between public wealth and private profit in the modern economy and society. They provide additional insights taking into account the recent trends in the growth of industrialization, urbanization, standards of living, education, awareness and technology. They argue that healthcare is commodified and sold in the market under the influence of western neo liberal economic logic. Health is treated like any other commodity and offered for sale and it is affordable only to those who have the required financial resources (Moynihan R and A. Cassels, 2005). Western neo liberal market system makes use of a consumer culture, nurtured in the beginning with the best of the motives by government agencies which provide basic educational and healthcare facilities.

Kerala experienced progressive changes in the social, cultural and healthcare environment due to European colonization and the services rendered by Christian missionaries even before India's independence and formation of the state in 1956. As already mentioned, there was expansion of medical facilities by the government from the 1960's to the middle of 1980's. Since then there has been a relative decline in both the quantity and quality of healthcare services provided by the government hospitals (John, Sara, 2018). According to one study, about 95 percent of the total number of hospitals in Kerala were under the ownership of either private or voluntary organizations and only 5 percent were run by either state government or local bodies in the year 1991 (Leversque et al, 2006). Private hospitals increasingly adopted advanced medical technology for diagnosis as well as treatment like MRI, endoscopy and CT scan while government hospitals failed to show progress in this area. A study points out that in 1995, out of 26 CT scan centers in Kerala, 22 were in private hospitals (John, Sara, 2018). The disparity could have increased since then. The recent trend is the rise of super specialty hospitals even in small towns in the state. There are several reports about "unnecessary" medical investigations conducted in corporate hospitals. Patients and their families, especially those belonging to middle income groups are at the mercy of corporate hospitals. This unfolding of the Lauderdale Paradox in healthcare has become worse during COVID-19 pandemic times, which is briefly explained in the third and final part of the paper.

Part 3- Lauderdale Paradox in Healthcare Sector during Pandemic Times

The high cost of medical treatment in private hospitals and its adverse consequences are not adequately addressed in India. According to a World Bank study, more than 40 percent of all the patients admitted to private hospitals borrow heavily or sell assets including inherited property in the form of house or farm land to meet medical expenses. The same study points out that about 25 percent of farmers in India are pushed below poverty line when a member of the family gets medical treatment in private hospital (World Bank, 2001). It is common among doctors in private hospitals who perform unnecessary surgeries with a profit motive. A report says that the number of Caesarean section (CS) deliveries is several times more in private hospitals compared to government hospitals. Hospitals and doctors get more money when they conduct a CS rather than a vaginal delivery (Sreevidya and Sathiyasekaran, 2003). The high cost of medical treatment and unnecessary surgeries raise issues of affordability, equity and ethics. There are less effective regulatory professional and statutory organizations like the Indian Medical Council (IMC) and the Indian Medical Association (IMA) to maintain standards of practice among hospitals and doctors. It is reported that doctors get commissions

from CT scan and other testing centers under the pretext of "referral fees" when the test is not necessary for diagnosis and treatment (George K.K, 1993). This trend found in hospitals and doctors gets additional strength during pandemic times as patients become more vulnerable, desperate and helpless.

The private healthcare sector bloomed because the state retreated. Public spending on drugs and other medical supplies was progressively reduced due to fiscal difficulties. This affected government hospitals at all levels, district hospitals, taluk hospitals and primary healthcare centers. According to one survey, only 23 percent of even poor households wanted to utilize government hospitals even in the year 1987 (Kannan et al, 1991). The percentage would have gone down further in recent years. When this trend is happening, the governments at the center and state levels were encouraging private investment in the healthcare sector. For example, The National Health Mission, launched in 2013 which was extended in 2018 envisages active participation of the private investments in the healthcare sector. The government offers several concessions like sale of land at subsidized prices, reduced utility charges, loans at low interest rates and import of medical equipment for research at reduced import duties. When employees of public sector undertakings and state and central government departments avail medical treatment in private corporate hospitals, it becomes a huge income for these hospitals because the medical bills are reimbursed by the government agencies. Since there is a negative perception about government hospitals among the patients, it becomes a huge revenue loss for the government. The direct and indirect patronage of the government to encourage private investments in corporate hospitals explains the unfolding of another dimension of Lauderdale Paradox in the healthcare sector.

According to one report, the COVID-19 pandemic has led to a sharp decline in the number of patients seeking normal healthcare services in private hospitals due to the fear of the virus. It is said that even the number of emergency medical cases has declined during the pandemic times. So, the "business" of private hospitals was affected. The report goes to say that India will be missing the woods for the trees. Even before COVID-19 pandemic there were vulnerable health conditions caused by non-communicable diseases (NCD's) resulting in a large number of deaths aggravated by the neglect of social and health sectors over decades in India (Mint, October 19, 2020). Then there was a resurgence of unethical "business" practices by the hospitals and doctors who tried to make up the loss with a vengeance. A corporate hospital charged Rs.80,000 for Coronavirus treatment for 24 hours. The patient was asked to take body temperature six times in a day and for each reading he had to pay Rs. 3000 (Times

of India, June 30, 2020). A recent report in the British Medical Journal (Sept 10, 2020) explains the high cost of COVID virus treatment in a corporate hospital in Kolkata. A businessman admitted his 57-year-old mother in a corporate hospital when she developed breathlessness. Many tests were conducted and he could not understand the hidden cost involved. On May 9, the patient died and the final medical bill was Rs. 15 lakhs. The high prices of healthcare services provided by corporate hospitals can be regulated by the government, but they are not. This is another dimension of the Lauderdale paradox in the healthcare sector. According to recent reports, about 86 percent of India's rural population and about 81 percent of urban population has no health insurance or social security protection of any kind (Financial Express, June 7,2020). India is one of the few countries in the world which lacks Universal Health Coverage (UHC) in the real sense.

India is again one of the few countries which deliberately created fear and patriotism among people with a sudden four-hour warning of a national lockdown. There were no trains and buses and the migrant workers started walking back to their villages. As per 2011 census, there were 450 million internal migrants in India and many of them chose to walk on the highways and railway tracks spreading fear, desperation and disease. Citizens were asked to applaud from the balconies of their houses to appreciate the services of health workers, doctors and hospitals. On another day, people were asked to switch off the lights of their houses at 9PM for 9 minutes, and light lamps to spread a message of hope. Actually, these deliberately crafted moves created an emotional atmosphere dominated by fear and uncertainty in the minds of the people who were rapidly losing their jobs, incomes, and self-esteem (Foster J.B and Intan Suwandi, 2020).

The effects of massive reverse migration of people from towns and cities to their native villages caused by the lockdowns imposed during pandemic times be mentioned briefly. One report says that it was the most heart-breaking migrant crisis since the partition of the country in 1947. Men, women and children were walking back home in dangerous journeys, dying due to hunger on the road or on the railway tracks (The Hindu, May 30, 2020). There was inadequate support, from the government, corporate sector and the middle class. On the one hand there was a lack of empathy for the poor and on the other hand there was a great enthusiasm for privatization projects in the form of opening of the economy to private capital including foreign capital in coal, defence production, railways, infrastructure and even space travel (Deccan Herald, June 11, 2020). State government set up relief camps and shelters for migrant labourers and about 69 percent of all such shelters were started in Kerala. However, the conditions in these camps were so poor that many opted not to stay in such camps (The Hindu, May 17, 2020). One could

see political and administrative responses from the government and not public health responses, during the pandemic times creating space for the private sector to expand activities and exploit vulnerable people.

It was reported that when there were less than 500 cases and 10 deaths from the pandemic, India declared the world's longest, largest and the most restrictive lockdowns in history (Times of India, August 8, 2020). It could be observed that the pandemic related reports and strict lockdown parameters produced behavior change based on a sense of terror and uncertainty among people, especially among the vulnerable sections of the society. This provided a fertile ground for hospitals, doctors and testing centers to exploit the patients and their families during the pandemic times. This phenomenon can be explained in terms "Amygdala hijack", which means an immediate, strong and overwhelming emotional response experienced from a threat. Amygdala is a small region of the brain which is involved in experiencing emotions such as sadness, fear and anger.

In evolutionary terms the survival value of Amygdala is crucial. The critical milliseconds' response in times of danger decides the life and death of organisms. Those who react in time survive and others perish. In the brain of the modern man, amygdala works in times of crisis or crisis perception (Goleman, Daniel 1995). There are studies which explain disruptive events in terms of this phenomenon. For example, a recent study says that when demonetization of Rs. 500 and Rs. 1000 currency notes was announced at 8pm over national television channels on 8, November, 2016, "Amygdala hijack", was at work (Jaffer, N.M, 2020). When the world's longest lockdown was announced with less than four-hour notice, at 8pm, on 24, March 2020, again "Amygdala hijack" was at work. This time among the beneficiaries were corporate hospitals. A recent report says that India's super-rich saw their wealth grow during the pandemic times, when the economy was shrinking in India. The wealth of Mukesh Ambani, of Reliance industries, the richest person in Asia, increased by 73 percent and that of Dilip Shanghvi, of Sun Pharma, the ninth richest person in India, increased by 17 percent (Mint, September 30, 2020). In general, a sense of terror, uncertainty, loss of income, humiliation and fear of illness and death prevailed, in the minds of the people. The general perception was that going to government hospitals would spoil a patient's health further and it would be better to go to private hospitals even though they followed exploitative practices (Prashad V. 2020). There are studies which point out how commodification of healthcare increases during crisis times (Kassirer J.P, 2004, Loayza, 2020). This trend is increasing in the Indian context, in

recent times. There is scarcity of good healthcare and capitalism feeds on scarcity (Foster J.B and Intan Suwandi, 2020).

CONCLUSION

The major arguments presented in the paper may be recapitulated. The Marxian concept of Lauderdale Paradox has been extended by later writers to explain the increasing contradiction between public wealth and private profit in various fields of activity including healthcare service provision in a modern economy. Kerala, a socially progressive state with relatively less industrial development compared to other states of India, was taken as a case in point. It experienced rapid expansion of the public health system in an impressive way till the 1980's. With increase in literacy, educational attainments, standards of living and general awareness, demand for more and better healthcare services increased impressively. The state retreated thereafter giving room for the expansion of private hospitals including large corporate hospitals. The government also encouraged private investment in the healthcare sector through various incentives. This was an instance of unfolding of the Lauderdale Paradox in the healthcare sector. The trend of commodification and commercialization of healthcare services increased during pandemic times as the government created an atmosphere based on fear, panic, uncertainty, loss of income as well as patriotism. This trend further unfolds Lauderdale Paradox in the healthcare sector in the country. The state should be advancing instead of retreating in the field of healthcare services, especially in the pandemic times. This does not seem to happen in India. Healthcare is treated like a commodity and sold with exploitative commercial motives by the private players and ordinary people suffer in silence with fear and patriotism. This exciting but disturbing scenario needs further study and analysis by extending the scope to include other major states of India. Further research efforts to find possible solutions should be undertaken in the interest of people's welfare.

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