

## Book Review

Lawton Robert Burns, ed.

*India's Healthcare Industry: Innovation in Healthcare Delivery, Financing, and Manufacturing*  
New Delhi, India: Cambridge University Press, 2014

Reviewed by Howard A. Doughty

Lawton R. Burns is the Chair of the Department of Health Care Management at the Wharton School at the University of Pennsylvania. Professor Burns' background is in Sociology (PhD) and Health Administration (MBA), both from the University of Chicago. His research preoccupations are with what is called the "healthcare supply chain" (Burns, 2002) and "healthcare innovation" (Burns, 2012). He has also produced a substantial textbook (Burns, 2011). His overall focus is on healthcare from a business perspective.

Burns' early contributions involved discussions of matters such as "the strategies of group purchasing organizations and wholesaler/distributors," "the role of e-commerce in the health care value chain," "insights into the hospital customer of the future," and advice to "health care executives to form strategic alliances, increase their market power, and gain competitive advantage." He has continued in the same vein (so to speak) as he has explained how best to form "strategic alliances and partnerships ... between pharmaceutical firms/distributors, disposable manufacturers, medical device manufacturers, group purchasing organizations, and organized delivery systems." If he deals with "healing" at all, it most likely concerns the proper managerial therapy to be applied when commercial facilities begin to "bleed" money.

Dr. Burns is plainly good at what he does. His studies are read to advantage by investors, executives, managers and students of the health industry, a vast and growing field on a planet where population growth is arguably exceeding what environmentalists call the Earth's "carrying capacity." Every reasonable effort is being made to provide acute and chronic care to so many people that health budgets in prosperous countries normally come close to 10% of the Gross National Product and incessant demands for more resources are being made both in advanced and in underdeveloped countries. Add to this the enthusiasm for high technology diagnostic and therapeutic devices at one end and the imminent threat of pandemics at the other, and it is easy to see that the industry is prospering like few others.

Burns is a successful contributor who has certainly provided invaluable advice to all who wish to get involved. For example, as a Visiting Professor at the University of Wisconsin's Department of Preventative Medicine, he taught physicians about the intricacies of "corporate strategy." Few lessons could be more valuable. Indeed, he would probably not be insulted to carry the title of unofficial guru to the pharmaceutical-medical complex. In fact, it would not surprise me to learn that the people who persuaded President Obama to drop the prospect of a single-payer universal health insurance system from his deliberations about the American *Affordable Care Act* had been avid readers of Burns' books.

In the volume under review, Professor Burns has taken his expertise and applied it to very different circumstances than those experienced by most of his compatriots in the domestic American healthcare industry. He examines the conditions and possibilities for expansion in India as a vital new frontier for investment and profitable product delivery. There are evidently extraordinary opportunities for health industry growth in this still poor, but potentially ever more powerful economy.

Like generations of experts before him, the main features of Burns' approach were developed in the USA, but they are applied elsewhere under a general template for development that purports to be universal. So confident is he in his model for medical modernization that he is currently at work on a book that will examine the situation in China and explain how to exploit openings there as well. According to Burns (Knowledge@Wharton, 2011), "the trends in China are remarkably similar to what has happened to the [healthcare] sector in India." Though there are "challenges," he leaves very little doubt that US business methods, appropriate technology and entrepreneurship will not only reap a tidy profit but will also meet rising consumer demands.

While the U.S. spends a whopping 17 per cent of its GDP on healthcare, India spends a measly 4 per cent. Compared to the U.S., where the government accounts for nearly half of national health expenditures, Central and State governments in 'socialist' India account only for a little more than one-fourth of the total spending on healthcare.

– J. Amalorpavanathan (2014)

*India's Healthcare Industry* describes a system that is undergoing profound transformations as this emerging nation with more than one and one-quarter billion people tries to manage the almost overwhelming needs of its increasingly urban population, to coordinate its transformational economy and simultaneously to balance its complicated international relations with China and Pakistan, all the while coordinating services for more than two thousand ethnic groups and at least thirty languages whose speakers number more than one million.

India has promulgated high-minded plans and mandated well-meaning programs over the past several decades. To be fair, efforts are being made to provide a level of health care approaching Western standards. But, as the US Bureau of Consular Affairs (2015) advises: "The quality of medical care in India varies considerably. Medical care in the major population centers approaches and occasionally meets Western standards, but adequate medical care is usually very limited or unavailable in rural areas [where almost 70% of the people reside]." So, however heroic the measures might be, there are enormous gaps in the national system and immense shortages of the hospitals, clinics, physicians, ancillary healthcare professionals and medicines required to permit proper facilities and treatment, particularly in rural areas where healthcare services are all but absent. So, the claim that India has little more than a nominal health care system has more than a little truth to it.

Burns, therefore, seems ever so slightly disingenuous, not when he observes that India's private sector health care providers are taking over from the previously primarily public sector system and that there is a "rise of private hospital chains [and an] enormous number of private sector physicians," but when he explains that this is so because "that's really what the public prefers — the private sector over the public sector, which is very similar to the U.S."

[In India], you have both public and private sector health care providers. It used to be primarily public sector. But now we have the rise of private hospital chains, and you have this enormous number of private physicians. That's really what the public prefers — the private sector over the public sector, which is very similar to the U.S.

– Lawton R. Burns

I make the claim of disingenuousness on the basis of the obvious fact that the only people able to make use of the private system are those who can afford it. Since about 40% of Indian people fall beneath the international poverty line of an income of \$1.25 per day, their *preferences* do not count for much, whereas the preferences of the roughly 100,000 people who perish from diarrhea annually do not count at all (Borgen Project, 2014).

Burns is admittedly quite clear about whom his analyses are intended to help. He correctly states that Indian health care services are very fragmented, chronically underfunded by both national and state governments (the latter of which are constitutionally required to take the bulk of the initiative in the provision of health care), and chaotic in terms of the structure of health care delivery with a proliferation of clinics, individual medical practices and almost no coordination of activity. So, he tells beaming aspirant medical moguls, “there’s lots of room to grow and consolidate.”

Of course, such consolidation of services under a corporate model is not apt to be easy. After all, as he is quick to point out, there are almost three-quarters of a million qualified physicians who have been educated in the United States or Great Britain. There are also about three-quarters of a million domestically trained and registered medical practitioners whose skills involve largely non-Western methods ranging from Yoga to Homeopathy. Moreover, in addition to the difficulties assessing the quality of these traditional practitioners and integrating them into the proposed corporate structure, there are also as many as two million “totally untrained, unsupervised practitioners ... [whom] people normally refer to as quacks.” Taken together, sorting out the array of potentially employable health care professionals and putting them to work in the industry presents a daunting task for any corporate human resources department.”

In Burns’ view, however, we need not despair. Despite the obvious fact that health costs will rise with privatization and professionalization, Burns seems confident that India is prepared to follow the American model (both before and after the still highly contested *Affordable Care Act*). There will be trouble with ensuring high quality care, but this can be ameliorated and ultimately overcome with sufficient managerial expertise and, of course, the application of the market mechanism to guide supply and demand.

To help us grasp the possibilities, Burns presents a stunningly simple conceptual framework containing three “invariant principles” of healthcare systems. He dubs his conception “the Iron Triangle.”

Imagining an equilateral triangle with each internal angle equalling 60°, he argues that each point represents an essential feature of the system: at the top is Efficiency and Cost Containment; at the bottom left is High Quality Care and at the bottom right is Patient Access. The trick for executives is to grow the internal space of the triangle without unduly disturbing the three “vertices” and throwing the design out of balance. So, although the obstacles to progress

are “formidable,” it is necessary to improve all three aims — reduced costs, improved quality and population health outcomes simultaneously to ensure that the system will increasingly benefit the “customers” and “suppliers.”

It would be churlish to disregard some of this book’s many strengths. It concentrates on the private sector, of course, and discusses the substantial generic drug manufacturing industry and the nascent biotechnology industry, while almost contemptuously dismissing “medical tourism,” both as a source of inexpensive treatment especially for Americans, and as a source of much needed revenue for investment in Indian healthcare.”

There are huge expectations that the private hospitals in India will flourish with this influx of Western and U.S. patients ... That’s been on the discussion table for about 10 years. What we found out is that those expectations are overblown and that the medical tourism business going from the West to the East is really a lot of hype. — Lawton R. Burns

At the same time, the theme of disingenuousness re-emerges. Burns is convinced that Americans *prefer* private sector health care which they can get at home. Comparing personal experience to that of an American for the same medical procedure, I can report that a surgery that would have cost upwards of \$150,000 in the USA deprived me of \$12.00 (for a bedside television) plus parking. Yet, according to Burns, sales employees in “big box retailers” who may be earning \$10.00 per hour are not going to go to India because they can just fly to Cleveland. Really?

Of course, Lawton R. Burns is a believer, but that doesn’t detract from the thoroughness of his research. *India’s Healthcare Industry* reports on the providers (hospitals, physicians, pharmacies and diagnostic laboratories), the payers (government ministries, insurance companies and individuals from their own resources) and the producers of health care product (medical devices, biotechnology and pharmaceuticals. Since, as he reports, as much as 60% of Indian health care spending is on retail drugs but only 10% of the pharmacies are retail chains, it’s not too hard to figure out where profits can most easily be made.

It should also be mentioned that Burns did not work alone. He relies on the expertise of others with specific knowledge of many aspects of health care and the experience to provide case studies of the Aravind Eye Care System (the largest eye care system in the world, performing over a quarter-million surgeries and treating almost two-and-a-half million outpatients annually), the L. V. Prasad Eye Institute (a non-profit teaching facility which has treated over seventeen million patients since 1987) and Vatsaya Healthcare (an advertised for-profit hospital focused on rural India that offers “no-frills” care to people who might otherwise be completely deprived, as innovative indigenous institutions. Special praise has been given to the coverage of “grass-root” initiatives and to Viswas Seshadri’s discussion of the Indian pharmaceutical sector, a “must read for all practitioners of medicine.”

I will conclude by quoting J. Amalorpavanathan (2014) whose assessment is that “this is a very useful compendium on one of the most vital, fast-growing industrial sectors which touches the lives of everyone — you and me included,” and add only that I await a similarly meticulously constructed volume that is not accompanied by a similarly merry jingle of the cash register.

### **About the Reviewer:**

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