

Country Briefing (South India)

Economy and Business Climate

Macroeconomic, human development, and other broad indicators (overall)

India's economic growth has slowed to a pace not seen since the beginning of the 2000s. At the same time, the current account deficit has reached a record high. The World Bank projects growth in the current fiscal year to reach around 6%, a slowdown from the already low 6.5% growth in the previous year. This growth projection is predicated on an improving domestic and external environment, but the risks for a worse outcome are high. On the domestic front, recently announced measures to reduce subsidies and boost FDI were important to lift sentiment, but investors are waiting for signals on other issues: the reform of direct taxes, the implementation of the long-delayed GST, and passage of the land acquisition and mining bills.

Demography

The estimated population of South India is 233 million. The largest linguistic groups in South India include the Telugus, Tamils, Kannadigas, Malayalis, Tuluvas and Kodavas. About 83% of South Indians follow Hinduism. Islam has the second-highest number of followers in the region, with 11%, while 5% follow Christianity.

The average literacy rate of South India is approximately 73%, considerably higher than the Indian national average of 60%. Kerala leads the nation with a literacy rate of 92%. The sex ratio in South India is fairly equable; Kerala is the only state in India with a favourable sex ratio. Scheduled Castes and Tribes form 18% of the population of the region. Agriculture is the major employer in the region – 47.5% of the population is involved in agrarian activities. About 60% of the population lives in permanent housing structures. 67.8% of South India has access to tap water. Wells and springs are other major forms of water supply.

The languages of South India are the Dravidian represented by Kannada, Malayalam, Tamil and Telugu, besides Gondi and other minor dialects, and the Austro-Asiatic by the Munda languages. South India's predominant language family is Dravidian, a family of approximately seventy-three languages spoken in South Asia. The States Reorganisation Act of 1956 divided states in India along linguistic lines and led to the creation of separate states of Andhra Pradesh, Karnataka, Kerala and Tamil Nadu in areas where Telugu, Kannada, Malayalam and Tamil respectively were dominant.

Tamil was accorded the status of classical language by the Government of India in 2004 and has about 60 million native speakers in India and over 10 million in other countries. Kannada and Telugu were accorded the classical language status in 2008. In the 2001 Census, Telugu had the third largest base of native speakers in India (74 million), after Hindi and Bengali. Kannada has about 38 million native speakers, while Malayalam has 33 million native speakers.

Each of these languages is listed as an official language of India, per the Official Languages Act (1963).

Urdu is spoken by over half of the 25 million Muslims in southern India. South Indian Muslims in some regions of Andhra Pradesh and Karnataka speak a dialect of Urdu called Dakhni, while some in the Dakshina Kannada region of Karnataka and regions in Kerala speak Beary bashe. Both Dakhni and Beary bashe are influenced by other South Indian languages. Tulu, a Dravidian language prevalent in coastal Kerala and Karnataka, is spoken by about 1.5 million people in the region, while Konkani, an Indo-Aryan language, is spoken by over half a million people in the region. English is also widely spoken in urban areas of South India.

Geography

Hyderabad is situated in the north-western part of Andhra Pradesh, located 1,566 kilometres (973 mi) south of Delhi, 699 kilometres (434 mi) southeast of Mumbai, and 570 kilometres (350 mi) north of Bangalore by road. It lies on the banks of the Musi River in the northern part of the Deccan Plateau in South India. The city is spread over 650 km² (250 sq mi), making it one of the largest metropolitan areas in India. Hyderabad, with an average altitude of 1,778 feet (542 m), has predominantly sloping terrain of grey and pink granite, dotted with small hills; Banjara Hills, at 2,206 feet (672 m), is the highest. The city's lakes are often called *sagar* ("sea"). Hussain Sagar, built in 1562, is near the city centre. Osman Sagar and Himayat Sagar are artificial lakes created by dams on the Musi. As of 1996, the city had 140 lakes and 834 water tanks (ponds).

Trade, assets, and regional and global economic role and relations

The Economy of South India is largely agrarian, dependent on monsoons, as are most people in India. Some of the main crops cultivated in South India include rice, sorghum, and ragi. South India was and still is the "promised land" as far as spice cultivation is concerned. Areca, coffee, pepper, tapioca, and cardamom are widely cultivated on the Nilgiri Hills and Kodagu. But frequent droughts in Northern Karnataka, Rayalaseema and Telangana regions are leaving farmers debt-ridden, forcing them to sell their livestock and sometimes even to suicides. Scarcity of water has been a major problem for past few years in these regions along with cities like Hyderabad.

Information Technology is a growing field in South India. Bangalore is India's Information Technology hub, and is home to over 200 software companies. It is often referred to as the Silicon Valley of India. Four of the country's top seven exporters of software viz. Bangalore, Chennai, Hyderabad and Coimbatore are located in South India.

State of Andhra Pradesh

Andhra Pradesh's gross state domestic product is the second largest in India. Agriculture has been the chief source of income for the state's economy. Two important rivers of India, the Godavari and Krishna, flow through the state. Rice, tobacco, cotton, mirchi, and sugarcane are the local crops. The state has also started to focus on the fields of information technology and biotechnology.

Hyderabad, the capital of Andhra Pradesh, is the fourth-largest cosmopolitan city in India, rich in culture, enduring history and industrial growth. Hyderabad beat IT heavyweight Bangalore to bag the Fab City project, which will host India's first major silicon chip manufacturing facility. It is due to the Governments Unique FDI Policies and the City Infrastructure.

The advent of information technology growth in India, the so-called "Blue Chip Revolution", has fostered the growth of Hyderabad's economy. The city is sometimes referred to as "Cyberabad" because of the large number of IT firms in the city. Andhra Pradesh has witnessed a major jump in software exports. Hyderabad's IT export revenue was Rs. 81,450,000,000, an increase of 62% from fiscal 2004. For Andhra, fiscal 2004 is particularly significant as the 62% growth in exports in fiscal 2005 was almost double the 37% it grew in 2003–2004. Other cities such as Vizag and Vijayawada have shown growth in IT exports on an annual basis. Vizag's contribution was Rs 700,000,000, while it was Rs 240,000,000 from Vijayawada. State-owned APSRTC Bus Service entered Guinness World Record for owning the largest fleet of buses IN 1999.

AP is one of the largest producers of rice (considered the 'Rice bowl of India'), Chilly, turmeric in India.

The government has initiated the Rajiv-Internet Village. Its plan is to establish broadband network across the state by connecting Districts with 10 GB/s and up to Mandals with 1 GB/s and up to villages with 100 MB/s bandwidth within June 2007.

Several Indian research institutes and companies are located in Hyderabad such as: 'NIN - National institute of Nutrition', 'NGRI-National Geographical Research Institute', CCMB- Centre for Cellular & Molecular Biology, NRSA, ICRISAT, BHEL, BDL, DRDL, DRDO, ECIL, NGRS, NHI, TIFR, IICT.

Infosys Technologies have signed a MoU Andhra for the expansion of its presence in Hyderabad. It is planning to ramp up headcount to 25,000 with an added investment of Rs. 1250 crore

Regulatory environment

Regulation of the Indian economy is generally unpredictable and a hurdle to doing business. India as a country scores in the bottom 10% for key indicators including contract enforcement, respect of intellectual property law, tax payment, and government bureaucracy.[6] Government bureaucracy is often cited as a major impediment to growth. Recently, a major consulting firm ranked India as the most over-regulated Asian nation.[7] Land use disputes often delay construction projects for years.[8]

The ubiquity of governmental regulation also appears in the healthcare space. As an example, a majority of India hospitals were founded with some government assistance and the assurance that some portion, typically 25%, of the hospital capacity be dedicated to serving the very poor.

A whole industry has sprung up around defining what this relatively vague requirement means in the context of complicated hospital care environments.[9] Ironically, in the medical device sector there are actually voices calling for an increase in governmental regulation. Medical devices, including stents, catheters, and other more specialized equipment, are highly regulated in the United States. However, they can be made and sold with relative freedom in India. It was only a few years ago that the Indian government assigned an agency to review and approve new devices.[10]

Region of the country: Your project locale vs. the nation

In 2008, Hyderabad ranked 93rd in the Lists of Richest Cities in the world by GDP (PPP) with US\$60 billion and the 4th in India with a 29.55% workforce participation. Hyderabad is ranked as the 2nd best Indian city for doing business. Indian School of Business, ranked 12 in global MBA rankings. There has been a shift from a primarily service-oriented city in the 1990s to being one with more diversified spectrum including trade, transport, commerce, storage, and communication. Service is still a dominant entity with 90% of the workforce contributing towards the field. With the economic boom, Hyderabad has seen an increase in retail and real estate business. Development of technological infrastructure allowed Hyderabad to become an epicenter of IT industry with several multinational corporations such as Microsoft and Oracle.[5]

Must equip readers to consider: What is the impact of the business climate on enterprises' roles in delivering health care?

In a growing economy where consumers have higher levels of income and deeper awareness of their health needs, demand for quality healthcare becomes more apparent. As a result healthcare sector in India has been growing in its emphasis on delivering quality care that is responsive to patients needs. (Source: <http://jhm.sagepub.com/content/13/2/177.short>) In addition to quality of care, patients start to demand reduction in waiting times and traveling distances to obtain services. Healthcare costs are becoming less critical and penetration of insurance increases with up to 40% of patients seeking care in urban hospitals. Report by IDC and McKinsey indicates that Indian healthcare sector will grow to \$125 billion in the next five years. This projection is based on the fact that currently there is currently a significant unmet healthcare demand. According to WHO recommendation of there should be a supply of 4 beds per 1000 patients, India is currently at 1.5 beds per 1000. Most urban hospitals in India experience chronic provider shortages and extended waiting times due to excess in demand. However as government and private sector invests and builds more hospitals, existing enterprises will need to compete on quality of healthcare delivery as patients will start having more options to choose from.

Health

• Eye Care Indicators

- Number of cataract operations performed per year
- % Surgery with IOL
- Number of mishaps

- Total number of person affected
- Number of free spectacles provided to school age group children with refractive errors
- Number of eye surgeons trained

• **Prevalence of Eye Diseases**

In India, 5% of the population is visually impaired. Considering a population of 1.24 billion people, that equates to approximately 63 million who are visually impaired, and of these 8 million people are blind. India alone thus accounts for 20% of 39 million global blind population. The estimated national prevalence of childhood blindness/low vision is 0.8 in 1000 children in age <16 years age group, implying a 300,000 blind children in India. While most of the poor live in rural India or urban slums, 80% of approximately 12,000 ophthalmologists in India live and practice in urban areas.

| Cause for Blindness | Percentage of Contribution |
|----------------------------------|----------------------------|
| Cataract | 62.6% |
| Refractive Error | 19.7% |
| Corneal Blindness | 0.9% |
| Glaucoma | 5.8% |
| Surgical Complication | 1.2% |
| Posterior Capsular Opacification | 0.9% |
| Posterior Segment Disorder | 4.7% |
| Others | 1.2% |

(Source: NPCB website, Ministry of Health & Family Welfare)

• **Overview of Eye Care Systems**

India was the first country in the world to launch a 100% centrally sponsored programme for the control of blindness - the National Programme for Control of Blindness (NPCB). The objectives of NPCB are the following:

- To reduce the backlog of blindness through identification and treatment of blind;
- To develop Eye Care facilities in every district;
- To develop human resources for providing Eye Care Services;
- To improve quality of service delivery;
- To secure participation of Voluntary Organizations in eye care.

The Cabinet Committee on Economic Affairs (CCEA) had approved a budget of 1250 core for NPCB's 11th five year (2007-2012) plan, confirming the high level of health care commitment

that MoHFW accorded to blindness control activities. NPCB is expecting enhanced funding for the 12th five year plan as challenges of reaching the unreached & underprivileged and delivery of the quality eye care services will remain the focus area.

(Source: NPCB website, Ministry of Health & Family Welfare)

• **Current Eye Care Issues**

- Quality of dispensed spectacle lenses and timely distribution to the needy children
- Quality of surgery performed
- Corneal collection and utilization
- Lack of availability of adequate number of Eye Donation Counselors
- Integration and networking of eye banks
- Availability of high quality storage medium

(Source: NPCB website, Ministry of Health & Family Welfare)

• **Access to eye care, eye health equity**

Despite significant foreign investment (US \$2.6 billion between 1970 and 2000 by the World Bank alone), progress in India's health system, particularly in serving the poor, has been slow and inconsistent in comparison with other countries at a similar level of development. A study conducted by World Bank's Operations Evaluation Department (OED) identified factors contributing to this issue:

- 1 A population growth rate that puts a strain on government resources;
- 2 Per capita public health expenditures that are half those of comparable countries and one-third the estimated cost of an essential package of health services;
- 3 Inadequate funding of programs used mainly by the poor, and limited access for the poor to the programs that are available;
- 4 Insufficient provision of safe drinking water and sanitation;
- 5 Poor quality of service, as a result of supply shortages, absenteeism, improper staff behavior, unrealistically large workloads, and low staff morale, and consequent underutilization of facilities;
- 6 Inadequate mobilization of private and NGO resources;
- 7 Excessive focus (until recently) on sterilization and use of financial incentives to achieve targets; and
- 8 Inadequate focus on maternal and child health.

(Source:

[http://Inweb90.worldbank.org/oed/oeddoclib.nsf/DocUNIDViewForJavaSearch/B2227521CC2956FE852567FC005829EC/\\$file/187precis.pdf](http://Inweb90.worldbank.org/oed/oeddoclib.nsf/DocUNIDViewForJavaSearch/B2227521CC2956FE852567FC005829EC/$file/187precis.pdf))

Efforts have been made by the Government of India to remedy this situation, and to provide access to health care throughout the country. The National Rural Health Mission (NRHM) was launched in 2005, aimed at correcting the health care system, specifically targeting those living in rural parts of the country, including the poor, women, and children. To that end, they recommended changes at both a policy and provider level.

Policy Recommendations:

- Increase in health expenditures
- Reduction of regional imbalances (current spending is allocated on a per capita basis, ignoring differences in demographics and capacity)
- Emphasis on district decisionmaking and management of health programs
- Pooling resources across providers
- Standardization of Community Health Centres into functional hospitals

Provider Recommendations:

- Involvement of the community (e.g. Community Health Workers)
- Integration of organizational structure
- Optimization of human resources
- Application of business principles (e.g. management, finance)

(Source: <http://www.measuredhs.com/pubs/pdf/FRIND3/FRIND3-Vol1AndVol2.pdf>)

• Must equip readers to consider: What is the impact of public health and health system issues on enterprises' roles in delivering health care?

Due to the noticeable inefficiencies in the public health system, private institutions have become the predominant method of health care delivery in India. 80% of current health spending is directed towards private clinics, and the poor often completely circumvent the public system by seeking private care directly.

(Source:

[http://lnweb90.worldbank.org/oed/oeddoclib.nsf/DocUNIDViewForJavaSearch/B2227521CC2956FE852567FC005829EC/\\$file/187precis.pdf](http://lnweb90.worldbank.org/oed/oeddoclib.nsf/DocUNIDViewForJavaSearch/B2227521CC2956FE852567FC005829EC/$file/187precis.pdf))

In 1995, the World Bank, in conjunction with the Government of India, NGOs and private sector players, introduced the Cataract Blindness Control Program, with the goal of expanding the country's National Program for the Control of Blindness (NPCB) to the poor, especially for women, tribal and isolated areas. The program targeted the states that accounted for over 70% of cataract blindness in India (Andhra Pradesh, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, Uttar Pradesh) and aimed to strengthen existing infrastructure, as well as raise awareness on the curability of cataracts, in hopes of increasing attention and resources.

By the end of the project in 2002, significant advancements in technology, awareness and operations had resulted in 15.3 million cataract surgeries, 50% of which were for women and tribal populations. Perhaps most important is that the program was phased out by passing management of the program on to the central, state and district governments.

(Source:

<http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/IDA/0,,contentMDK:21917842~pagePK:51236175~piPK:437394~theSitePK:73154,00.html>)

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