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## *Chapter - 1*

# **Private health sector and state health policy in India. An introduction**

Public financing and provision of health care services has been the mainstream of health policy for nearly half a century of post independence India. Such a policy climate took roots in an era (1940s) that witnessed setting up of the British National Health Service (NHS) in the year 1948 (Rivett, 1998). The Health Survey and Development Committee report (Bhore and others, 1946 Volume-II p2-3), set its vision for a National Health Service similar to the one adopted by the United Kingdom (UK). These ideas were elaborated by the Bhore committee under "The Long-Term Programme" (Bhore and others, 1946, Vol-II, p17-34). Early planners of health care delivery system for India were concerned about availability of resources for provision of National Health Service. There was clearly an yearning for a National Health Service. But concerns about availability of resources and adequacy of public funding appear to have contributed to the absence of a clear statement about the system of health care delivery in the directive principles of the constitution of India. The chapter on directive principles was used by the framers of the Constitution of India to clearly spell out their idea of socioeconomic goals and priorities for public policy. Article 47 of the directive principles, which deals with health, lists raising the level of nutrition, standard of living, and public health as primary duties of the state. Regulation to prevent abuse of alcohol and drugs is mentioned in particular. But the Directive Principles, do not mention any thing about provision of curative services.

The idea of public provision for all types of health care services was reinforced by the fact that the size of private sector was insignificant at the time of independence. For example, as the Bhore Committee report (1946 Volume I) noted, only about 8% of all medical institutions in the provinces were maintained wholly by private agencies. Another 5% were in the non-government sector but received grant-in-aid from government. Most probably these were nonprofit and charitable institutions. Since private hospitals are generally smaller in size compared to public hospitals the share of private hospital bed capacity would have been less than 13%. Compare this with some estimates of private health sector in the 1990s. According to one estimate (FRCH, 1993 table IX-4, Bhatt, 1997 table 8.1) for the year 1991 for all India 58% of all hospitals and about 30% of all hospital beds were in the private sector (both for profit and not-

for-profit). An estimate for Andhra Pradesh, for the mid 1990s found that about 59% of the hospital beds in the state was in the private sector (Mahapatra, 1998).

All plans and policy statements by government of India remained silent on the role of private health care institutions for nearly 35 years after independence. The National Health Policy (Government of India, 1983) mentioned about the existence of “private and voluntary organisations active in the health field”. Thereafter the eighth five year plan (Government of India, 1992) mentioned about a “new policy of the government to encourage private initiatives”. The plan envisaged governmental support, mainly by way of tax incentives to private hospitals / clinics subject to maintenance of minimum standards and suitable returns for the tax incentives. The eighth five year plan also envisaged development of norms for minimal facilities and accreditation of private hospitals / clinics. However, specific programmes are yet to appear to operationalise these intentions.

Many factors have contributed to an interest in the structure and dynamics of private health sector in India. Firstly the private health sector has grown in many parts of the country, particularly in the areas experiencing agricultural, industrial and service sector developments. The private health care institutions and services have grown in the absence of explicit policy to define their role. The vision for a National Health Service allowed for the existence of a small private sector providers to meet the demands of people who would be willing to pay for their services. Since a comprehensive National Health Service is yet to take shape, more and more people are willing to pay for services from the private health sector, leading to its growth. The general economic reforms with its emphasis on privatisation have also contributed to policy interest in private institutions and services in the health care sector. Public financing and private provision of health care is being talked about in this context. Health policy makers have to operate in an environment of rising fiscal deficit and increasing pressure on government budget. Private provision of health care services appears attractive to health policy makers faced with budgetary constraints for expansion of health services in the public sector. There is a hope that private provision of health care will help ameliorate the need for increased allocation of public funds for health care and at the same time keep up expansion of services to meet growing demand from people. Growth of private forprofit health care institutions in an unregulated market has raised concerns about exploitation of consumers (High Court of AP, 1999) and quality of care. Concerns have also been raised about utilisation of tax concessions by the state and responsiveness of private corporate health care institutions to the needs of poor (AP legislative Assembly, 1996).

Several studies have established the rapid expansion of the private sector in both the provisioning and financing of health care services in India. See for example, Mahapatra (1998), Bhatt (1993, 1997), IHS (1996). Some have also sought to analyse the structure of the private sector, its composition and roles (Mahapatra and Nagarjuna, 1998). There is a wide range of private sector providers, including forprofit and nonprofit organisations, solo practitioners, operators of small nursing homes to large super-specialty hospitals, medical diagnostic centres, providers of Indian systems of medicine and providers without any formal professional qualification (e.g. rural medical practitioners). The dominance of the private sector is recognised. But there is a paucity of information regarding the manner in which different parts of the private health markets operate, the incentives and the motivation and systems which form the basis for their sustenance. A comprehensive view of potential policy alternatives is yet to emerge (Bhatt 1993, 2000). Recently Bhatt (2000) reviewed some state level policy initiatives towards the private sector. He summarises public-private partnership initiatives from three states namely; Rajasthan, Punjab and Delhi. All three states sought to grant land at concessional rates for hospitals. These initiatives are yet to succeed. Major problems, according to Bhatt are; (a) inadequate incentives for the private sector, (b) simplistic solutions for a complex situation, and (c) lack of a comprehensive policy.

This study seeks to understand the structure and dynamics of the private health sector in Andhra Pradesh, in order to provide insights for meaningful policy intervention to define the role of private health sector and realise its potential in improving the population health status. Government has responsibilities beyond the public provision of health services. Because of its concern for the health of the population and for the poor in particular, government is caretaker for the societal goals of ensuring access to an affordable, appropriate high quality health services. To what extent can the private health sector support these goals? This study would help in identifying: (a) how national and state health policies can clarify the roles for the public sector interactions with different parts of the private sector; (b) enhance opportunities and overcome constraints to enable the private sector to fulfill social goals; and (c) possible avenues for cooperation between the public and private sectors.

This work is presented in fifteen chapters, including this introduction. Each chapter takes up a theme or collection of related themes, relevant to formulation of policy bearing on the private health sector. A summary of the evidence and information about the respective themes is presented at the end of each chapter. In chapter-2 we provide details of the study methodology including, details about the sample of private and public health care institutions (HCIs), formats and questionnaires for collection data, etc. Chapter-3 deals with institutional forms in the private health sector, and their growth patterns. Differences

in character of private forprofit and nonprofit health care institutions, their size and growth patterns are presented. Forprofits are further classified into proprietary and corporate HCIS. Chapter-4 deals examines evidence about accessibility character of private and public HCIs. Evidence on differences in geographic distribution and patient composition of private and public HCIs is presented. Chapter-5 reviews the literature and analyses secondary data on health seeking behaviour and patterns of resort to private or public HCIs. Factors affecting pattern of resort behaviour are examined. In particular, it is argued that accessibility character of HCIs may not show through pattern of resort data if there are constraints to expression of preference to those institutions. For example, if nonprofit institutions are preferred but not available in an area, people's pattern of resort behaviour would not show them as an important source of care. Patterns of resort for ambulatory medical care and hospitalisation services from various National surveys are analysed. Evidence about differences in pattern of resort by socioeconomic status is also examined. Private provision of health care is often recommended on the ground that private HCIs would be more efficient compared to public HCIs. It is assumed that since private HCIs operate in an open market environment and have to survive through competition, they must be more efficient. Chapter-6 examines available evidence comparing efficiency character of private forprofit, nonprofit and public HCIs. Most of the evidence is from studies in the United States (US). In addition some evidence about comparative performance of private and public HCIs in terms of capacity utilisation is also presented. Chapter-7 takes up the issue of quality of health care in private and public HCIs. First a framework for assessment of healthcare quality is presented. A major difficult is in the paucity of information about quality of healthcare in different type of health care institutions. Whatever evidence is available comparing healthcare quality in private and public HCIs is reviewed and analysed. The chapter includes methodology and results from the patient exit interviews taken up as a part of this study. The exit interview covered a sample of patients from private and public HCIs. Chapter-8 examines the range of services in private and public health care institutions. An important component of this study was to survey a sample of diagnostic facilities, in addition to collection of information about diagnostic services in the primary sample of health care institutions. Findings about the range of intramural diagnostic services provided by the HCIs and extramural services available from primarily diagnostic facilities are presented in this chapter. Chapter-9 describes findings of this study about utilisation human resources by private HCIs. We did a job satisfaction survey among randomly chosen health care professionals from private and public HCIs. The findings and comparative study of job satisfaction in private and public HCIs is also presented in this chapter. The next chapter presents our findings on financial aspects of private health care institu-

tions. Data on sources of revenue, and capital investments is presented. Information about currently prevalent rates and charges for common clinical and diagnostic services is furnished. We collected information about the degree of transparency in rates and charges for various health care services. We also asked about prevalence of fair financing practices for poor and needy patients. These results are also included in chapter-10. Chapter-11 presents data collected by this study on a various themes non included else where. In a way this chapter collects residual themes not classifiable under other chapters. These are patient referral practices, regulatory environment and infrastructure problems faced by private HCIs. We did a survey of alternate private practitioners (APP) in Andhra Pradesh. APPs are defined to include those who practice alternate systems of medicine or who may practice allopathy but is not formally qualified to do so. One alternate private practitioner was identified for each of the private and public clinic included in the primary sample. Chapter-12 presents findings from the survey of the APPs. Chapter-13 reviews experiences from policy interventions in the United States (US) directed or otherwise affecting the private health sector. Since the US happens to have a mixed health care system like India, we feel the American experience may provide some insights for policy formulation in India. It turns out that the private health care institutions in America have to operate under a fairly strong regulatory regime. Since the US is generally regarded as a free market economy, experience of American policy on private health sector would be of added importance. In chapter-14 we discuss policy implications of our findings and present a set of policy recommendations. Chapter-15 is an executive summary. Readers who may be short of time or want to get a quick glance of the material covered in this report would find it useful. No new material is presented in this chapter. In fact it is essentially a collection of the chapter summaries. We recommend that the full report should be read to facilitate a more informed interpretation of our recommendations in chapter-14. In addition, recommend reading of some of the important references cited in the study. We have provided the summary in chapter-15 only to facilitate quick browsing and review of the findings of the study.

