Chapter - 3

Motivation, establishment, and growth of private health care institutions

Private health care institutions (HCIs) can be broadly divided into (a) forprofits, and (b) nonprofits. Forprofit health care institutions have different organisation forms. For the purpose of state policy it is useful to distinguish between proprietary and corporate HCIs. Proprietary institutions include proprietary and partnership firms. These are usually solo clinics and small hospitals. Corporate HCIs are companies with capital contributed by its shareholder's. The shareholders control the company through their rights to vote in annual general body meetings. The important difference between proprietary and corporate HCIs is the manner in which owners are involved in management of the HCIs. In case of proprietary institutions, the owners are usually directly involved in management of the HCIs. Corporate HCIs are usually managed by professional managers. Gray (1991) refers to the corporate hospitals as investor-owned hospitals, which term appears to be prevalent in the US. We have used term corporate hospitals and analogously corporate HCIs keeping with the Indian usage of the term corporate hospitals. Nonprofit institutions do not share any profit or assets with its founders, members, trustees or directors. These include charitable institutions, voluntary agencies, and non government organisations. Nonprofits have special significance for the health sector. The concern for distributive justice in health care largely contributes to setting up nonprofit health care institutions. Clearly motivation of the founders plays an important role in choice of organisation form. A physician wanting to set up a practice facility and self employment would usually consider a proprietary firm that involves least amount of paper work and is fully owned by its founder. Two or more physicians wanting to collaborate may consider the partnership firm. A group of individuals may recognise unmet need for healthcare and volunteer to set up a nonprofit healthcare institution. In addition state policy may explicitly or implicitly facilitate certain organisational forms. Thus founders' motivation, economic, social, and political environment contribute to incorporation, and sustenance of various institutional forms to deliver health care.

In this chapter, we first review literature and overseas experience, mainly from the United States of America (US) about institutional forms in private health sector. This is followed by a presentation of the Indian experience with institutional forms in private health sector. We then present findings about motivating circumstances and institutional forms of the sample of private health care institutions covered by this study.

I. Overseas experience with institutional forms in private health sector

A lot of the overseas experiences presented below are from the US. Some data from other industrialised countries about the prevalence of nonprofit and forprofit HCIs are also presented. The US is a mixed economy like India. Studies documenting appearance and characteristics of private HCIs are more easily forthcoming from the US. Moreover, the dominant economic philosophy in the US favours the forprofit enterprise. Hence the American experience of organisational forms for healthcare delivery has a lot of relevance for policy formulation in other mixed economies like India.

A. Forprofits response to demand for services

One advantage of forprofit HCIs is their quicker response to demand for services. Steinwald and Neuhauserr (1970) argue that proprietary hospitals are more adaptable to changes in demand from paying patients. Lave and Lave (1974) believed that this argument is plausible since entrepreneurs typically adjust to changing conditions more rapidly than nonprofit organisations. Gray (1991) based on the Institute of Medicine studies on forprofit enterprises in health recognised the ability of forprofit organisations to move rapidly to meet demand. The flip side of quick response by the forprofit sector to demand for services is that capital also is quick to flow out if demand reduces. Particularly, in case of corporate hospitals mergers and take overs may affect patient confidence on specific health care institutions. Experience in the US suggests that forprofit health care institutions have a greater chance of going out of business. This can be a disadvantage if say a forprofit hospital is the only source of hospital services in an area.

B. Proprietary and corporate health care institutions

Steinwald and Neuhauser (1970) have traced the history of growth and decline of proprietary hospitals in the US. Exact figures of proprietary hospitals in the US prior to 1910 is not available. But qualitative observations in the National Hospital Record cited by Steinwald and Neuhauser (1970) suggests that proprietary hospitals grew in numbers between 1890 and 1909 in response to growing demand from paying patients. There after the share of proprietary hospitals declined gradually from about 56% in 1909-10 to about 11% in 1968. Many closed while others became nonprofits (Morril, 1947). Steinwald and Neuhauser (1970) observed that the relative frequency of entry and exit by proprietary hospitals (Table-3.1) is higher compared to nonprofits and public hospitals whereas 37% of all new hospitals in the US opened between 1962-68 were forprofits mainly proprietary, 59% of all hospital closures during this period was of proprietary type. Proprietary hospitals had comparatively low assets per bed.

Table-3.1: Opening and closure of hospitals in US between 1962-68 by ownership.

	Opened (N=1292)	Closed (N=954)
Proprietary	37%	59%
Nonprofits	30%	26%
Government	33%	15%

Source: Steinwald and Neuhauser (1970) Table-7

Steinwald and Neuhauser (1970) also analysed change in ownership and institutional form of forprofit hospitals in the US between 1962-68 (Table-3.2). Single owner hospitals had the highest proportion of closure where as corporate hospitals had the lowest proportion of closure. Partnership hospitals were in between.

Table-3.2: Change in institutional form of forprofit hospitals in US between 1960-67 by ownership.

	Ownership in 1960		
Status in 1967	Single owner (N=234)	Partnership (N=212)	Corporation (N=435)
Single owner	26%	3%	1%
Partnership	5%	41%	2%
Corporation	14%	9%	65%
Nonprofit	4%	7%	13%
Closed	51%	40%	19%

Source: Steinwald and Neuhauser (1970) Table-8

Gray (1991 Ch-3) observes that the following factors contributed to the decline of proprietary hospitals in the US.

1. Life span of proprietary hospitals is usually linked to the professional careers of their physician founders.
2. Introduction of more stringent standards increased capital cost for establishment and recurring cost for maintenance of hospitals. Many proprietary hospitals could not keep up with these requirements.
3. Small size (average of 37 beds in 1940) limited the ability of proprietary hospitals to offer a wide range of services that modern practice demanded.

4. Some people might argue that the tax advantages granted to nonprofit hospitals might have contributed to decline of proprietary hospitals. Gray (1991) observes that much of the decline of proprietary hospitals in the US took place at a time when corporate taxes were low. Much of the growth of the corporate hospitals in the US took place during a period of relatively high corporate taxes.

Steinwald and Neuhauser (1970) noted that by 1967 the trend toward corporate ownership of forprofit hospitals in the US had been clearly established. Gray (1991, p31-60) describes further evolution of corporate (investor-owned) hospital companies in the US. We give a brief summary of factors affecting private forprofit hospital sector in the US based on the analysis and reviews by Gray (1991) and Ginzberg (1990, Ch-2 and 4).

1. Factors contributing to growth of corporate hospitals in the US (Gray, 1991 Ch-3).

   i. Introduction of federal health care cost coverage schemes like the Medicare (for the elderly) and the Medicaid (for the poor) substantially increased the revenue potential of hospitals and improved the scope for profitability of hospitals.

   ii. Medicare and Medicaid payment rules favoured corporate hospitals since they allowed for cost of capital to be included in computation charges for services. This favoured acquisition of hospitals since the costs could be counted as capital. Gray (1991 p33) observes "The reimbursement environment from the late 1960s until the early 1980s made it difficult *not* to make money operating hospitals, so long as they were located away from concentration of low-income populations and in states that did not regulate hospital income".

   iii. Growth of corporate hospitals in the US took place through different routes overtime.

      a. Purchase of proprietary hospitals by corporate entities was the primary source of early growth of corporate hospitals during the 1960s.

      b. By the early 1970s construction of new facilities emerged as the second source of growth of corporate hospitals.

      c. Acquisition and merger was the major source of corporate hospital growth in the US during the later half of 1970s.

      d. Acquisition of nonprofit hospitals by corporate hospitals was the primary source of growth during the early 1980s. This, Gray (1991) argues, was a result of continuing pressure from corporate hospitals to acquire more hospitals, problems faced by some nonprofits to generate capital or meet operating costs and development of legal alternatives for transfer of nonprofit to forprofit institutions.

e. Gray (1991 p36) observes that historically hospitals in the US had been unprofitable institutions. In 1963 the American Hospital Association (AHA) started its National Hospital Panel Survey. At that time the average community hospital had a 6% revenue deficit, mostly made good by other collections of these charitable institutions. The Medicare and Medicaid programmes improved the financial climate of hospitals. As a result the gap between patient revenue and expenses on patient care reduced. Only in 1980s the average community hospital was reported to generate more revenues than expenses from patient care.

2. Factors contributing to reversal in growth of corporate hospitals in the US (Gray. 1991, Ch-3; and Ginzberg 1990, Ch-2).

i. The Medicare, Medicaid and other third party reimbursement climate changed by the late 1980s. People were concerned about rising cost of health care. Reimbursement rules gradually rationalised to remove some anomalous incentives. Gray (1991) finds that the following three changes in reimbursement rules and methods made the maximum impact.

a. Once a life time depreciation allowance for the same equipment irrespective of the number of times the capital stock changed hands. Originally, Medicare allowed depreciation on cost of acquisition of old hospital equipment even if the previous owners had been allowed depreciation in respect of the same equipment.

b. Reduction in the rates allowed for return-on-equity in case of forprofit hospitals.

c. Rationalisation of prospective payment rates based on diagnostic related groups (DRG) instead of the number of days of hospitalisation or number of procedures performed.

ii. As a result the drive for expansion of corporate hospitals waned. Corporate hospitals in the US responded to the changed environment in the following ways.

a. Process of expansion reversed and corporate hospitals began to shrink by selling and disinvestment.

b. A shift to psychiatric and substance use treatment where reimbursement rules continued to be liberal in view of the technical difficulty of quantification of these services, etc.

c. Setting up new lines of business and vertical integration linking the hospital business with hospital supply business or activities to funnel patients to the hospitals.

C. Nonprofit health care institutions in the US and other industrialised countries

Nonprofit hospitals and health care institutions have all along been a major constituent of the health care infrastructure of most developed economies. In a country like the US, known for its dominant ethos of private market economy, in 1998, 60% of all short term HCIs were nonprofit and about 70% of all short-term hospital beds were in nonprofit HCIs (Table-3.3). Forprofit private HCIs accounted for about 15% of institutions and 13% of hospital beds. Eli Ginzberg (1990) observed that all through the 20th century and in case of major urban centres the 19th century as well, the nonprofit community hospital was the predominant health care facility.

Table-3.3: Distribution of short term hospital capacity in the USA by type of ownership

Year	Hospitals				Beds			
	Total	Public	Nonprofit	Forprofit	Total	Public	Nonprofit	Forprofit
1979						39%	54%	8%
1996	5134	26%	59%	15%	862352	18%	69%	13%
1997	5057	25%	59%	16%		17%	69%	13%
1998	5015	24%	60%	15%	839988	17%	70%	13%

Source: American Hospital Association, Hospital Statistics 2001 Edition.

Silverman and others (1999) study has assigned each of the American Hospital Association (AHA) hospital service area to an ownership category such as nonprofit, forprofit or mixed. They collected hospital ownership data for the years 1989, 1992 and 1995. If a service area did not have any forprofit hospital, it was classified as "nonprofit area". Where all hospitals were in the forprofit sector it was classified as "forprofit area" and the rest were labeled as mixed areas. Using these criteria and data for the years 1989, 1992 and 1995 they classified all hospital service areas in the US as shown in Table-3.4. Silverman and others (1999) did this to compare Medicare cost differences between forprofit and nonprofit areas. These results have been described where. Their classification of hospital service areas by ownership type incidentally gives us an idea about the prevalence of nonprofit hospitals in the US. As can be seen from Table-3.4, about 84% of hospital service areas in the US did not have any forprofit hospital in 1995. These areas were served by nonprofit or public hospitals. Clearly, the American health care system consisted largely of nonprofit hospitals as recently as 1995.

Table-3.4: Ownership characteristic of 3421 hospital service areas in the US between 1989 and 1995.

Ownership trend between 1989 and 1995	N=3421
All hospitals in the area remained nonprofit or public	83.60%
Remained as mixed ownership hospital service areas	5.64%
All hospitals in the area remained as forprofit	6.08%
All hospitals converted from nonprofit to forprofit	0.96%
All hospitals converted from forprofit to nonprofit	0.73%
Others	2.98%

Source: Silverman and others, 1999.

In Table-3.5 we reproduce data on the share of private forprofit and nonprofit hospitals in the delivery of health care for some more economically developed countries. The data are taken from Poullier (1986). Countries for which disaggregates of health care capacity by forprofit and nonprofit HCIs is available are included. Except for Turkey, the share of nonprofit HCIs in most economically developed countries shown here was more than 12%. In Turkey most HCIs are in public sector. Hence the share of private forprofit HCIs was only 4% and nonprofit HCIs was about 3%. Japan and Greece are the only two countries where more than 40% of their HCIs are in the private forprofit sector. In all other countries the size of private forprofit sector is less than 20%. In other words, majority of HCIs in most economically developed countries are either in the public sector or in the private nonprofit sector.

Table-3.5: Private forprofit and nonprofit health care institutions in selected economically developed countries.

Country	Ref year	Forprofit			Nonprofit		
		Beds	Adm.	IP days	Beds	Adm.	IP days
Australia	1981	13%			14%		
France	1982	18%			13%		
Germany	1983	13%	8%	11%	36%	38%	37%
Greece	1981	41%	35%	33%	13%	16%	17%
Ireland	1980	8%			25%		
Japan	1981	50%			12%		
Luxembourg	1981	2%	6%	2%	28%	33%	30%
Spain	1981	19%	25%	18%	13%	12%	15%
Switzerland	1976	7%	9%	7%	30%	30%	33%
Turkey	1981	4%	5%	4%	3%	3%	3%

Source: Extracted from Table-2.4 in Poullier Jean-Pierre. Levels and trends in the public - private mix of the industrialised countries' health systems, in: Culyer Anthony J. , Jonsson Bengt, Editors. Public and private health services. New York: Basil Blackwell, 1986: 11-40.

The nonprofit institutional form appear to meet certain important requirement of a health care delivery institution. The healthcare field is characterised by information asymmetry between the consumers and providers, and such other market failures like adverse selection, and moral hazard. This special vulnerability of the healthcare market is usually met with public sector provision of healthcare. But there are other problems, mainly of responsiveness, associated with public provision of healthcare. The nonprofit institutional forms have the potentiality of minimising market failure and at the same time providing a higher level of responsiveness. Of course, most nonprofit HCIs in the world did not appear as a result of such premeditated policy or program. Many of them are there simply as a result of spontaneous expression of charity, or voluntary movement to meet a certain felt need. This has happened more so in the health sector. Thus nonprofits attract policy attention firstly because they are already a significant part of the healthcare service sector. In addition the theoretical advantages of this organisation form is a major consideration for health policy makers dealing with environments where nonprofit HCIs are yet to gain any significance. Weisbrod (1988) has reviewed features of the nonprofit economy and recognises two types of nonprofits, namely (a) the trust type and (b) the club type. The trust type nonprofits provide services useful to the community beyond the members of the organisation. Club type nonprofits usually exist for the collective benefit of its members. We are concerned with the trust type nonprofits as far as health care delivery is concerned.

The nonprofit institutional form have certain distinct intrinsic character making it an attractive vehicle for delivery of health care services paid by governments through service contracts. However, large scale government funding of human services delivered by nonprofit organisations invariably changes the nonprofit sector itself. Smith and Lipsky (1993) have described these interactions between nonprofits and public programmes under a regime of contracting of human services by the state from nonprofit delivery organisations, in the US. In this context, they recognise three subclasses of trust type nonprofits, namely (a) charities set up by philanthropists, (b) spontaneous voluntary organisations appearing in communities to meet unmet needs, and (c) nonprofit organisations set up directly in response to availability of government funds for health and human services. Questions have been raised about accountability of nonprofit organisations (Herzlinger, 1999). Herzlinger (1999) lists four potential accountability problems with respect to nonprofits. Firstly, a nonprofit institution may be ineffective and not achieve its goal. Secondly, they may be inefficient. Thirdly, there is the scope for private inurement of nonprofit organisation directors to excessive benefits for themselves. Finally, nonprofit organisation directors may take excessive risk and expose their clientele to its adverse consequences. One issue is the comparative incidence of these vulnerabilities at the aggregate level between nonprofits and other institutional forms. Empirical evidence of efficiency, and quality of care described in subsequent chapters appear to favour the nonprofit HCIs as a whole. Otherwise there will not be much ground to encourage the nonprofit institutional form as a matter of state policy. However, the potential vulnerabilities of nonprofit institutions deserve policy attention, particularly if a state policy encourages nonprofits. In that case appropriate safeguards have to be put in place to minimise the incidence of misuse of public funds and betrayal of public trust. Herzlinger (1999) recommends an environment of disclosure, analysis, dissemination and sanctions to protect overall health of the nonprofit sector.

II. Indian experience with institutional forms in private health sector

A. Private and voluntary health care institutions in India

Table-3.6: Share of private (forprofit and nonprofit) health care institutions in India

Year	Private HCIs		Beds in Private HCIs	
	Hospitals	Clinics	Hospitals	Clinics
1988	56%	49%	30%	9%
1991	58%		29%	
1993	67%		35%	

Source: Central Bureau of Health Intelligence, 1988, 1991, 1994

Indian data on health care institutions by ownership is available only in two broad categories namely, public and private. Further breakdown into forprofit and nonprofit health care institutions is not available. The Central Bureau of Health Intelligence (CBHI, 1991, 1994) Health Information Bulletin clubs both private forprofit and voluntary nonprofit health care institutions together. The CBHI data is based on reports sent by district health officials of the list of public and private health care institutions in their area. There is no mechanism for registration or licensing of health care institutions. So the reports are based on common knowledge about private HCIs among the public health officials. Since private health care institutions are increasing rapidly, these reports are likely to miss many of them. Table-3.6 shows the percentage share of private health institutions in India in terms of the number of institutions and total bed strength. Percentage share of private health care institutions is much higher compared to the percentage share of private beds. That means most private HCIs are small.

Table-3.7: Andhra Pradesh - regional and district wise hospitals beds in forprofit and nonprofit health care institutions.

District	Forprofit	Nonprofit	District	Forprofit	Nonprofit
All AP	58.94%	5.69%	Chittoor	33.19%	18.70%
Coastal Andhra	64.99%	7.49%	Cuddapah	51.45%	17.15%
Rayalaseema	36.97%	11.44%	Ananthapur	30.63%	0.00%
Telengana	57.78%	2.22%	Kurnool	34.42%	5.84%
			Mahaboobnagar	53.96%	5.02%
Srikakulam	46.28%	3.63%	Ranga Reddy	66.71%	1.86%
Vizianagaram	20.54%	0.00%	Hyderabad	56.85%	0.00%
Visakhapatnam	38.33%	3.83%	Medak	52.89%	0.00%
East Godavari	70.15%	5.95%	Nizamabad	62.13%	2.22%
West Godavari	87.07%	0.00%	Adilabad	38.48%	2.16%
Krishna	58.16%	15.10%	Karimnagar	65.52%	8.51%
Guntur	60.79%	13.65%	Warangal	43.73%	3.94%
Prakasam	82.39%	3.17%	Khammam	70.40%	5.16%
Nellore	69.09%	7.36%	Nalgonda	63.35%	6.67%

Source: Mahapatra, 1998

Mahapatra (1998) analysed the data from the AP Health Institutions Database (APHIDB) around the year 1993-94. Table-3.7 shows the percentage of hospital beds in private forprofits and nonprofits for the state as a whole, by region and by districts. Considering the state as a whole private forprofit hospitals had about 59% of total hospital bed strength. There are, however, regional differences. For example share of public sector and voluntary hospitals appear to be more in the Rayalaseema area. The regional differences become evident if we look at the district level figures. For example public sector hospitals account for more than half of the total hospital beds in the following seven districts, namely Srikakulam, Warangal, Visakhapatnam, Adilabad, Kurnool, Ananthapur, and Vizianagaram. In Chittoor district the public sector and nonprofit hospitals provide more than half of the hospital beds. In the rest 15 districts, private forprofit hospitals alone are providing more than half of the hospital beds. A large proportion (87%) of forprofit hospitals had 30 or less beds. Most (37%) private hospitals and nursing homes are between 10 to 20 beds in size. Another 33% are in the 1 to 10 bed category. Only four hospitals in the private sector had more than 250 beds. Another 37 hospitals had beds ranging from 100 to 250 beds. In terms of bed capacity about 58% of private hospital beds were in small nursing homes with bed strengths of 1 to 30 beds. Large private hospital with 100 or more beds accounted for 17% of bed capacity.

A. Nonprofit HCIs in India

Jesani and others (1986) have traced the history of development of nonprofit health care institutions in India. They note that nonprofit HCIs in India may be traced to Christian missionary activity. The Hindu reform movements contributed to setting up of some nonprofit HCIs in the country during the 19th and 20th century. Another source of nonprofit HCIs was the Gandhian-Sarvodaya movement. All these nonprofit HCIs were mainly charitable in nature, consisting of hospitals or dispensary set up at central places to deliver free medical care to poor and needy. During the 1960s, nonprofit HCIs were set up by community activists to organise healthcare with help of community funding and fee for services with professional management. During the 1980s some "struggle oriented" nonprofits appeared with a mission to empower people to access existing public healthcare facilities. Jesani and others (1986) studied 45 healthcare nonprofits (NGOs) in Maharashtra state. Following is a brief summary of their findings.

1. While selecting districts for locating their projects, nonprofits prefer districts with average and above average economic development where infrastructure is better developed. Within these district, they tend to prefer backward areas.
2. Service delivery and program implementation was the primary objective pursued by most of the nonprofits.
3. About 20% of the nonprofits had religious affiliations. A little less than 20% of the nonprofits were affiliated to Gandhian-Sarvodaya ideology. For about a third of the nonprofits studied by Jesani and others it was not possible to identify any specific affiliation.
4. Till mid 1970s the primary strategy, adopted by nonprofits, to gain entry into the community was to deliver medical care. Thereafter, community health gained prominence over medical care.

Jesani and others (1986) have also noted in their review, development of government policy towards the nonprofits. Government funding for nonprofits mainly of project-based picked up during the 1980s. However, the quantum of government funding of healthcare services provided by nonprofits still remains miniscule. Project based funding is the dominant form. Government purchase of health care services from nonprofits based on service contracts is yet to take roots in the absence of any significant government scheme to pay for medical and healthcare availed by poor from the private sector.

Table-3.8: Probability of resort to charitable HCIs in India.

Type of care	Rural areas				Urban areas			
	1986-87	1993	1995-96	1998-99	1986-87	1993	1995-96	1998-99
Ambulatory	0%	1%	0%	1%	1%	1%	1%	2%
Hospitalisation	2%		4%			1%		1%

Source: Estimates for 1986-87 and 1995-96 are from NSS 42nd and 52nd round respectively (NSSO, 1998 Table-4.10, p22). Estimate for 1993 is from the NCAER-MISH on health care utilisation (Sundar, 1995). Estimates for 1998-99 from India NFHS-2 Table-9.1, IIPS & ORC Macro, 2000.

No doubt there are charitable and nonprofit health care institutions in almost all parts of the country. Many of them have demonstrated creative strategies to deliver health care. Some of them have done exemplary work worthy of emulation elsewhere. But their numbers and capacity is too small compared to the overall size of the country. A glaring gap in the Indian health care sector is the near absence of nonprofit health care institutions. The AP Health Institutions Database (APHIDB) showed that in 1993 about 6% of all hospital beds in Andhra Pradesh was in the nonprofit sector (Mahapatra, 1998). The pattern of resort data collected through various surveys on household consumption of health care services gives an indirect account of health care facilities by ownership. Table-3.8 shows the probability of resort to nonprofit health care institutions for ambulatory care and hospitalisation services. Nonprofit HCIs account for a maximum of 1% of ambulatory care and a 4% of hospitalisation services. Evidently the size of nonprofit sub sector of health care institutions in India is very small.

III. Motivations, establishment, and growth of private health care institutions in AP.

A. Motivating circumstances and incorporation status of Pvt HCIs

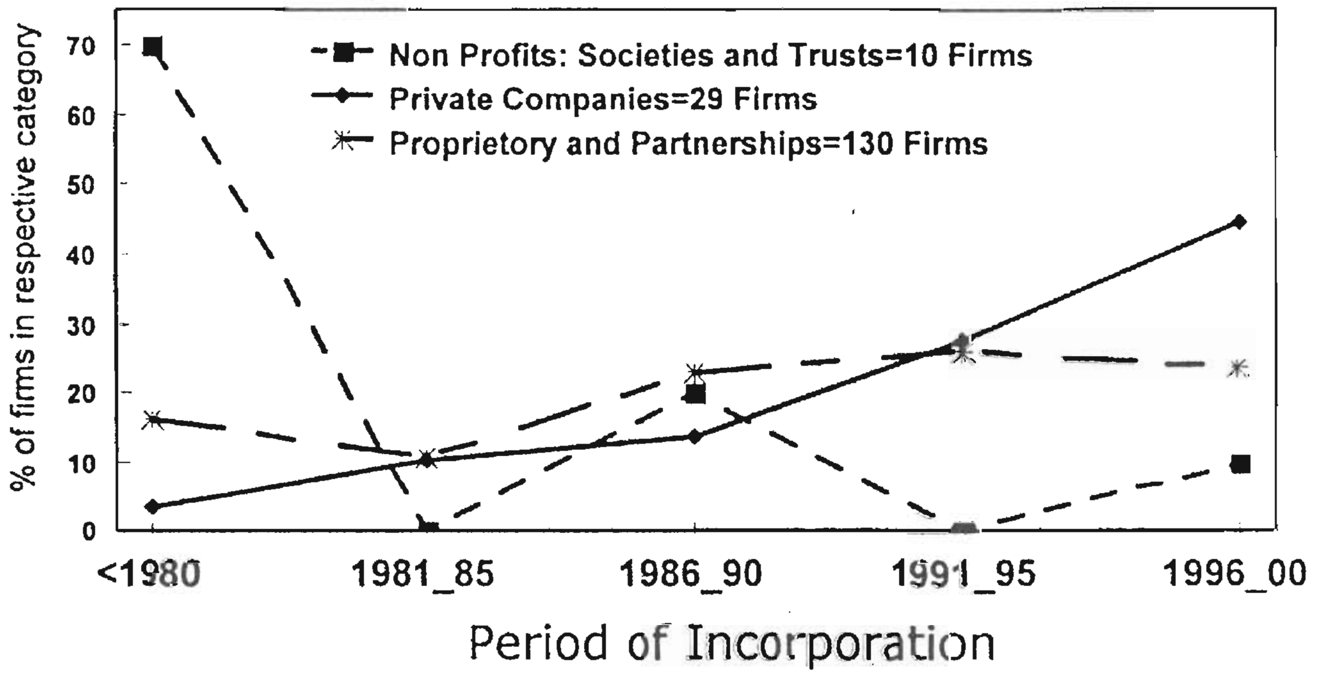
Table-3.9: Motivating circumstances and legal incorporation of private health care institutions in Andhra Pradesh, 2000.

Type of health care institution (HCI)	n	Pre establishment motivation				Incorporation Status		
		Practice	Profit	Vol.	Others	Prop.	Company	Soc./Trust
Solo clinics	71	79%	15%	4%	1%	98.59%	1.41%	0.00%
Small hospitals	69	83%	10%	4%	3%	84.06%	11.59%	4.35%
Big hospitals	10	20%	30%	50%	0%	20.00%	30.00%	50.00%
Diagnostic facilities	139	73%	25%	1%	0%	87%	11%	2%

Table-3.9 gives data on motivating circumstances and shows distribution of private HCIs by their incorporation status. Evidently the prime motivation for establishment of solo clinics and small hospitals is to provide a practice facility and / or enable the concerned doctor - proprietor to earn his / her livelihood. The right half of the table corroborates this situation. 99% of all solo clinics are proprietary. Organisation behaviour of these institutions will be largely determined by the motivations of individual professionals. Almost all solo clinics, all APPs and a large proportion of small hospitals and diagnostic facilities in the private sector are proprietary firms, justifying the doctor-proprietor label used by us earlier. These are mainly practice facilities of physicians. Small hospitals are more like solo clinics in terms of the motivating circumstances of their origin and the incorporation status. Most big hospitals in the private sector have been incorporated either as companies or non profit organisations. Some big hospitals (27%) continue to operate as proprietary or partnership firms.

There are altogether 29 private companies and 10 non profits in the sample including HCIs in the primary sample and diagnostic facilities. Distribution of these institutions by the period of their incorporation can give us some idea about the nature of hospital building activity in the private sector. Figure-3.1 plots distribution of these institutions by the period of their incorporation. Although the sample size is not large enough to draw definite conclusions, there is clearly a pattern. Setting up of private for-profit hospitals are currently on the rise. Building up of hospitals in the nonprofit sector has clearly declined. This is a cause for concern and points to lack of interest in hospitals and health care services by philanthropic, social and religious organisations in the country. See that the proprietary and partnership firms have a fairly stable rate of appearance. More than 60% of all such firms existing in 2000 were set up between 1986-2000. The rate of appearance of these 60% firms was evenly distributed between the three five year blocks shown in Figure-3. Most of these physician practice facilities would start a physician's career and close down at a rate linked to physicians retirement.

Figure-3.1: Change in motivations for establishment of private health care institutions.



B. Period of establishment and growth of HCIs in Andhra Pradesh

Table-3.10: Age in years of private and public HCIs in the sample

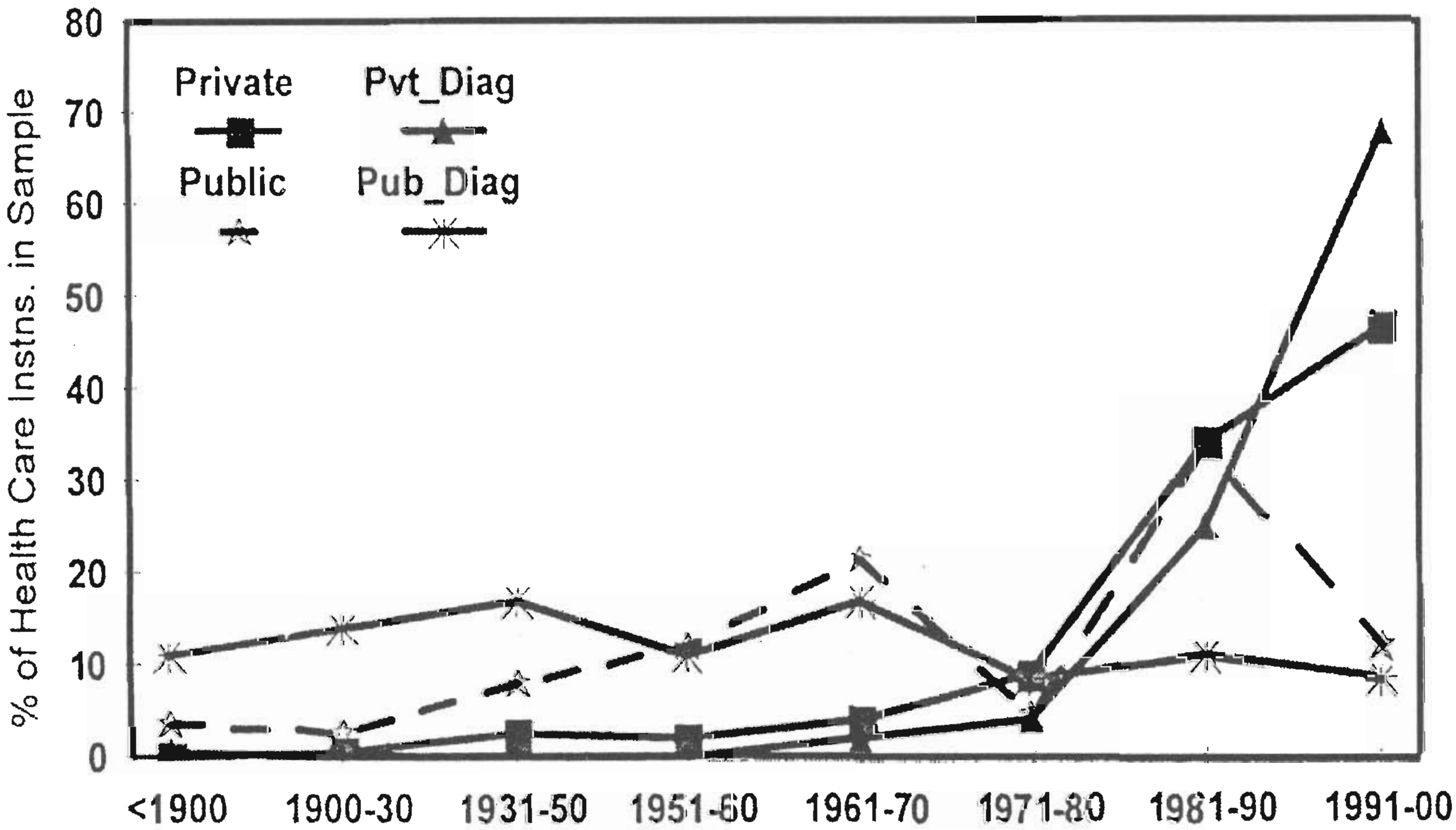
Type of HCI	Private			Public		
	Range	Mean	Median	Range	Mean	Median
All	0, 85	13	10	1, 160	32	30
Clinics	1, 69	13	10	1, 71	23	16
Small Hospitals	0, 85	12	9	3, 100	31	28
Big Hospitals	5, 55	23	16	11, 160	77	50
Diagnostic facilities	0, 110	8	5	2, 120	48	41
APPs	0, 76	13	10			

Age of HCI = Year of Survey - Year of Establishment. Year of Survey = 2000 AD.
If we exclude the one private diagnostic HCI with highest age of 110 years, the max age among the rest is 34 years. This HCI happens to be a non profit hospital.

Age of the HCIs in different sample categories gives an idea about the period of development of those institutions and their sustainability over time. Age of HCIs has been calculated in years by subtracting the year of establishment from the year of survey. Table-3.10 shows data on age of HCIs in various sample categories. Private HCIs are generally younger than public HCIs. Within the private health care institutions, bigger hospitals tend to have been in existence for longer periods (mean= 23 years, median= 17.5 years) than solo clinics and small hospitals (mean =12 - 13 years, median=13 years) or for that matter alternate private practitioners (mean=13 years, median=10 years). This is on expected lines. The solo clinics, APPs, and most of the small hospitals in the private sector are proprietary firms, established by doctors to serve as a practice facility. On the other hand bigger hospitals are institutions with an existence of their own, independent of their founders.

Distribution of HCIs by the period of their establishment and age of HCIs also gives us an idea about the period of development and growth of different types of health care institutions in the state. Figure-3.2 shows the distribution of sample HCIs by the period of their establishment. In Andhra Pradesh there has been a steady increase in establishment of health care institutions in the public sector from 1931 till the decade ending 1970. There was some slow down in establishment of new HCIs in the public sector during the decade of 1971-80. Establishment of new HCIs in the public sector picked up momentum in the decade 1981-90 and reduced again in the current decade from 1991-2000. Growth of HCIs in the private sector started picking up in the decade 1971-80 and has since then continued to show an increasing trend. In other words, growth of the private health care institutions in Andhra Pradesh is mostly of recent origin and has taken place mostly in the twenty years from 1981 to 2000 AD. If we look at the period of establishment of diagnostic facilities, a similar pattern emerges. The percentage of private diagnostic facilities established during recent decades is comparatively higher than private hospitals and clinics suggesting a preference for diagnostic services among the private sector.

Figure-3.2: Distribution of sample HCIs and diagnostic facilities by period of establishment



C. Growth in size of HCIs after establishment

Table- 3.11 shows post inception growth in size of HCIs by different categories. This table shows three indicators of growth in size of HCIs. The column titled "Growing" is based on a simple question. Has the HCI grown in size after establishment? Thus 52% of private clinics, 88% of small private hospitals, 89% of big private hospitals in the sample experienced some growth in size after inception. Bed capacity of the rest mostly remained same as at the time of inception. Occasionally there was a reduction in bed capacity. We have already noted earlier (methodology section) that seven private health care institutions moved to a lower size classification in this study after completion of the survey. On balance, however, more private HCIs operating now experienced growth. In the public sector, 20% of PHCs, 54% of small hospitals, and 91% of today's big hospitals experienced growth after inception. Note that this question regarding growth after inception is not limited by time of establishment. Thus HCI established long ago is bound to experience some growth over a long period and hence will be counted here. That could explain the higher percentage of today's big public hospitals experiencing some growth after inception. Most of today's big hospitals in the public sector were established long ago.

Table-3.11: Growth after inception experienced by private and public health care institutions.

		Private				Public			
	Sample/Type of HCL	n	Growing	Growth in beds	Growth rate/HCI	n	Growing	Growth in beds	Growth rate/HCI
HCI Sampe	Clinics / PHCs	71	13 %	1, 6	.5, 20	53	38 %	2, 8	0.5, 6
HCI Sampe	Small hospitals	69	59 %	1, 35	0.8, 53	41	80 %	4, 40	1, 67
HCI Sampe	Big hospitals	10	90 %	95, 200	17, 400	12	75 %	50, 992	4, 350
Diag. Fac. sample	Small hospitals	15	53%	5, 60	4, 25	17	76%	4, 75	1, 40
Diag. Fac. sample	Big hospitals	7	43%	40, 60	5, 250	0	94%	34, 992	4, 350

n= Number of HCIs surveyed. Growing: This column gives percentage of sample HCIs, that has shown some increase in size after inception. Growth in beds means range of beds added after inception till the date of survey i.e. 2000. The period over which this growth took place will vary for different institutions. Growth rate is measured as increase in beds after establishment per decade. Coincidence of the upper range growth in beds for public big hospitals from both HCI sample and diagnostic facility sample is by chance. There is no overlap of institutions between the two samples.

The second measure of growth is a count of the number of beds added after inception. This figure is obtained by subtracting the beds at the time of inception from the current bed strength. Note however, that there is built in bias in this statistics. A long standing hospital having added a few beds since inception will be in the same category as another experiencing rapid growth over a short period of time. Moreover this is a retrospective survey. The HCIs experiencing a decline in size would not survive for long to have been included in our sample. Only those continuing to be in operation at the time of the survey only have a chance for inclusion in the sample. Some inference about the trend of HCIs in the recent past is however possible, despite this bias. If private health sector is in a shrinking phase, the proportion of HCIs retaining their original size or reducing in size will be higher, since it would take some time for the institutions to close down. Table-3.11 shows the range of beds added in different HCIs. For example, the 52% of private clinics which show some growth, added beds after inception ranging from 1 bed to a maximum of 25 beds. In the public sector, PHCs which experienced some growth added beds ranging from 2 to 168 beds. The third measure is the decadal growth rate per HCI. This is simply the growth in beds for an HCI divided by the age of the HCI in decades to give an idea about average number of beds added by institutions over a decade. The private clinics and PHCs in the public sector, which experienced some growth, added between 0.5 to about 30 beds per decade. Private sector small hospitals, which experienced some growth, added between 1 to 30 beds per decade. The range is wider at 2 to 86 beds per decade for small hospitals in the public sector. Most big hospitals both in private and public sector experienced some growth at a decadal rate ranging from 3 to 400 beds per hospital.

IV. Summary of evidence about institutional forms in health care

Private HCIs can be broadly divided into (a) forprofits and (b) nonprofits. Forprofits include proprietary and corporate HCIs. There are important differences between proprietary and corporate HCIs. Proprietary HCIs have usually single owner, physician practice facilities or joint partnership of physicians. Life span of proprietary hospital is usually linked to the professional career of their physician founder. Some of these may change to corporate or nonprofit hospitals. Proprietary hospitals usually have lower assets per bed. Corporate hospitals tend to remain in business for longer terms and are usually of bigger size. Corporate hospitals grew in the US during a period of liberal reimbursement by government through the Medicare and Medicaid programs. As the reimbursement climate changed there was a decline in corporate hospitals. Nonprofits play a major role in healthcare delivery in the US. Majority of HCIs in most economically developed countries are either in the public or nonprofit sector. Major advantage of forprofit health care institutions is their quick response to changes in demand. Hence a small complement of forprofit health care institutions can be useful to ensure responsiveness of the health system changes in demand for healthcare services.

A glaring gap in India is the near absence of nonprofit health care institutions. No doubt there are some charitable and nonprofit health care institutions in various parts of the country. But their numbers and size is too small compared to the overall size of the health sector. There appears to be a decline in building of nonprofit healthcare facilities in AP. This is a disturbing trend. It will be desirable to encourage development of nonprofit HCIs in the long run. This is best achieved through social movements and by building up awareness among community leaders. Policies to encourage nonprofit healthcare institutions should be accompanied by streamlining of the general regulatory environment for nonprofit organisations. This is required to minimise the risk of misuse of public funds.

Growth of private forprofit HCIs in AP started during the 1970s and has continued to show an increasing trend since then. A large number of private diagnostic facilities have also appeared during this period. Almost all (99%) of solo clinics, 84% of small hospitals and 87% of diagnostic facilities in the sample were proprietary. Only 20% of big hospitals were proprietary. Another 30% of big hospitals were corporate and the rest 50% were trust (nonprofit) hospitals. The number of corporate hospitals in AP is currently very few. At present the private forprofit HCIs largely consist of proprietary firms. The private forprofit HCIs are definitely experiencing a period of growth in many parts of the state.