Chapter 10

Financial aspects of private health care institutions.

In this chapter, we describe financial aspects of private health care institutions (HCIs) based on information collected from the owner-managers. First, we present data on revenue sources for private HCIs. The next section describes capital investments in private health sector and their financing. Thereafter, information about currently prevalent rates and charges for common health care and diagnostic services is presented. The following section describes owner-manager statements about existence of fair financing practices for the poor and needy. Finally, we summarise the findings from this study about financial aspects of private health care institutions.

I. Revenue sources for private HCIs

Data on sources of income, especially the extent of direct payment by patients, employer reimbursement, and health insurance payments are of considerable importance for planning of organisational changes. Unfortunately, little data is available about sources of income by private HCIs (Mills, 1990). Dave (1993) visited 12 nonprofit HCIs in India and examined their sources of revenue. The organisations studied by her were nonprofits delivering ambulatory, preventive and promotive health care in various communities. Their main sources of revenue were (a) community and self financing, (b) government grants, and (c) donor agency grants. Community and self financing sources included fees, user fees, and insurance, etc. Satia and Deodhar (1993, p244), in a study of hospital cost and financing in Maharashtra, observed that private (forprofit) and trust (nonprofit) hospitals are financed largely through direct payment by patients. Mills (1990) reports that owner-managers of private hospitals in Jordan informed her that there were substantial number of payment arrangements designed to limit the burden on individual patient. A number of hospitals had agreement with private employers. Private hospitals would provide medical care to covered employees either through its own insurance (effectively a health maintenance organisation) or claim reimbursement of charges from the employer. Mills (1990) also reports her discussion with Abbel-Smith, about Indonesia, where employers pay substantial sums to the private HCIs for coverage of their employees.

In this study we adopted a simple approach to collect as much information on sources of income of private HCIs as is feasible. We asked the owner-managers to rank various possible sources of revenue of their respective HCI. Table-10.1 shows the top three sources of revenue and its trend with respect to the previous year. Patient fees are clearly the primary source of revenues for the private HCIs. Pharmacy sales and laboratory services are also significant revenue sources for health care institutions (HCIs). Two revenue sources which could have been important but are reported to be insignificant are; (a) service contracts with employers, and (b) insurance payments. These two sources of revenue for HCIs play an important role in most industrialised countries. Many factors could be contributing to the insignificance of service contract with employers as a source of revenue for HCIs. Health care benefiting employers are either providing health care services in house or do not see potential advantages from service contracting with health care providers. The Employees state insurance (ESI) scheme covers workers below a cut off salary limit, which is currently fixed at 6500 rupees per month (ESI Corporation, 1997). Unlike the Provident Fund, the ESI does not provide for voluntary coverage of employees earning higher salaries. In other words employers are not allowed to purchase coverage for high paid employees by paying the premium. So many employers would pay ESI premium for their eligible employees and provide health care benefit to the rest on an ad-hoc basis. Moreover, employers may not see the potential of service contracting as a means of better health care at lower cost, simply because such packages are yet to be available in the private health care market. The insignificance of insurance payments as a source of HCI revenue is because of health care insurance is yet to develop in the country. The two major social health insurance schemes in the country are the (a) ESI, and (b) Central Government Health Scheme (Nabhi, CGHS). Both provide ambulatory health care and some hospital care as well. These two organisations do have rate contracts with some hospitals. But the size of their operation is quite small compared to the country's population. Moreover, as will be seen below, the rate contracts are usually with big hospitals, since most of the ambulatory care and some of the basic hospital service requirements are met by ESI and CGHS through their own facilities. As a result, employer service contracts and insurance payments do not yet show up as important sources of revenue for private HCIs.

Table-10.1: Top three sources of income reported by owner-managers of private HCIs (n=146)

Revenue Source	Rank-1	Rank-2	Rank-3
Patient fees - directly collected	71.23%	4.11%	1.37%
Laboratory services	4.11%	19.18%	10.27%
Pharmacy sales	2.05%	12.33%	9.59%
Service contract with employers	0.68%	2.05%	1.37%
Insurance	0.00%	0.68%	2.05%
Fees share from diag. centres	0.00%	1.37%	1.37%
Not stated	21.92%	60.27%	73.97%
Top revenue source - trend over previous year			
Gone ↑	57.53%	19.18%	22.60%
Gone ↓	4.79%	6.16%	6.85%
No change	15.75%	4.11%	9.59%
Not stated	21.92%	70.55%	60.96%

There is a perception that private HCIs have revenue sharing arrangements with their preferred diagnostic service provider and pharmacies. This would be an unethical practice. To assess the extent of such practices, we also prompted the owner-managers about (a) fees shared from diagnostic centres outside the hospital, and (b) fees shared from pharmacies outside the hospital. None of the owner-managers ranked these as important sources of revenue. A few (1.4%) ranked it as second or third source of revenue. We can not interpret this finding to mean that the practice of revenue sharing with preferred laboratory and pharmacy facilities does not exist. Rather, it would be correct to say, that such revenue sharing arrangements are not the primary source of revenue for private HCIs. However, such practices may not be desirable even if they are only marginal sources of revenue for private HCIs. Our study design and resources did not allow us to probe this matter further.

Majority of owner-managers reported that their top ranking revenue source experienced growth over the previous year. Since directly collected patient fees were ranked by most as the top ranking revenue source, we can infer that most private HCIs have experienced growth in patient fees. This would mean

that, the private health care sector is in a growing stage, largely driven by existence of demand for health care services from people who can afford to pay.

Table-10.2 shows owner-managers report about steps taken by their HCIs to stabilise revenue flow with the help of agreement and understanding with big employers like the government and companies. Various payment related problems reported by the private HCIs are also shown. Nearly about 20% of all private HCIs have some agreement to provide services for reimbursement by the government or companies. Such arrangements are maximum in case of big hospitals (38%) and a little less for small hospitals (25%). Only about 11% of clinics have such agreement. This is consistent with our common observation that big hospitals are generally able to secure mutual agreements with major employers for provision of medical care to their employees. Non payment of fees by patients, very few paying patients, i.e. lack of capacity to pay and high competition were reported as major revenue related problems.

Table-10.2: Payment related problems faced by private HCIs. Percentage of HCI-Owners or managers reporting that they face the respective problem often or very often.

No. of respondents				Revenue stabilisation measure/	% HCI facing obstacle			
CI	SH	BH	Diag	Revenue realisation problem	CI	SH	BH	All Diag
8	17	3	20	Agreement to provide services for reimbursement by government	11	25	38	19 11
8	17	3	22	Agreement to provide services for reimbursement by companies	11	25	38	19 12
63	67	8	106	Non payment by patients	43	66	25	53 68
45	50	6	110	Non payment by government	2	10	0	6 31
0	51	6	130	Non payment by contractors	7	20	17	14 22
61	63	8	121	Too few paying patients	28	25	13	26 53
60	62	7	74	High competition	45	61	29	52 43

CI = clinics, SH = Small hospitals, BH = Big hospitals, Diag = Diagnostic facilities

II. Sources of capital for private health care institutions

Some capital is invariably required for starting up of health care institutions and for continued development of facilities. We asked owner-managers about both. First, we asked if they availed any loan to start up their health care institution (Table-10.3). A little less than half (45%) reported that they did take a loan and the rest (55%) informed that they did not take any loan. Almost all of those who did not take loan said that they did not require a loan. In other words difficulties if any in the credit market was not the reason why they did not take a loan. For those who took loans to start up the facility, commercial banks were the commonest source (63%) followed by relative or friend and other financial institutions. About 20% owner-managers reported that they had difficulty in accessing land and office space to start up their health care institutions. Managers of the few nonprofit HCIs in the sample informed about the decline in philanthropy and donations for construction or equipment of health care facilities.

Table-10.3: Sources of capital and other difficulties for starting up private HCI

	Clinics	Small H	Big H	All	Diag.
Availed loan for start up	22%	67%	29%	45%	56%
Source of loan for those who took loan for start up					
Commercial bank	58%	68%	0%	63%	63%
Relative or friend	25%	8%	0%	11%	12%
Dev. Financial Institution	0%	10%	50%	9%	6%
Government	0%	8%	0%	6%	1%
Other Financial Institution	17%	8%	50%	11%	17%
Difficulties if any for those who did not take a loan to start up					
Didn't need a loan	95%	95%	100%	96%	75%
Collateral too much	0%	0%	0%	0%	0%
Interest too high	5%	0%	0%	3%	4%
App. process too difficult	0%	5%	0%	1%	4%
No credit available	0%	0%	0%	0%	11%
Owner-managers said they face following obstacles severely or very severely					
Accessing land	22%	22%	25%	22%	15%
Getting office space	22%	21%	0%	20%	15%
Reduced donations	3%	6%	0%	5%	5%

To understand current investment and credit needs of private health care institutions, we asked the owner-managers about investments in the previous year and plans for the coming year (Table-10.4). We asked if they invested in buildings or equipment in the past one year and if so what was the source of funding of the investment. About 43% of private HCIs invested in buildings or equipment during the year preceding the interview. Half of these institutions (21% of private HCIs and 49% of those who invested in building or equipment) met the expenditure from their earnings. A little more than a quarter of them (13% of all private HCIs and 30% of those who invested in building or equipment) took bank loan. Another 10% (5% of all private HCIs) met the cost of building and equipment from personal funds. About 6% (3% of all HCIs) met the cost of building and equipment from donations or charities. Thus, revenue earnings is the major source of financing of capital investments in private HCIs.

Table-10.4: Current investment and credit needs of private health care institutions

	Clinics	Small H	Big H	All	Diag.
Private HCIs who invested in buildings or equipment in the past year.					
Donors and / or charitable sources	0%	4%	13%	3%	0%
Earnings	14%	29%	13%	21%	2%
Government allocation	0%	1%	0%	0%	2%
Personal / Family resources	3%	7%	0%	5%	5%
Bank loan	4%	19%	38%	13%	5%
Other investors.	0%	1%	0%	0%	1%
All sources	21%	63%	63%	43%	15%
Plan to invest in building / equipment	21%	24%	13%	22%	25%

The owner-managers were asked if they plan to invest in building or equipment in the near future. About 22% private HCIs replied in the affirmative. We would expect this figure to be around 43%, i.e. about equal to percentage of private HCIs having actually made capital investments during the last year. Probably many private HCIs end up investing in building or equipment during the course of their operation without planning it out in advance. Capital investments in private HCIs appears to take place gradually as surplus revenue becomes available. This may explain why the percentage of HCIs planning to invest in the coming year is almost half of the HCIs who actually invested in the last year.

We also asked about credit related obstacles perceived by the owner-managers if any (Table-10.5). Too much paper work, excessive collateral requirements and high level of interest rates were reported more often. About 36% of owner-managers felt that availing of credit involved too much paper work. About 23% of owner-mangers felt that the pressure of excessive collateral requirement. A similar percentage of owner-mangers (21%) also felt the pressure of high interest rates. These percentages are with respect to the total owner-manager sample. Note that only about 45% of them reported to have availed loan to start up their facility. If we view these responses with respect to those who did in fact use the credit market to avail some loan, the figures will be much higher. Accessing of land was also reported as a major obstacle for setting up of private HCIs. A significant percentage (16%) of owner-mangers felt the need for connection with bank officials to avail loan facilities.

Table-10.5: Credit obstacles faced by private HCIs. Percentage of HCI-owner or managers reporting that they face the respective obstacles severely or very severely.

# respondents				Nature of the credit obstacle	% HCI facing obstacle				
CI	SH	BH	Diag		CI	SH	BH	All	Diag
37	53	4	138	Level of interest rates	19	23	25	21	14
37	54	4	137	Excessive collateral requirements	19	26	25	23	18
36	54	4	139	Too much paper work	28	43	25	36	27
36	54	4	135	Need for connections with bank officials	17	15	25	16	13
35	52	4	137	Problems with letters of credit	6	15	0	11	8
36	52	4	133	Problems with money transfers and checks	3	6	25	5	3
34	52	4	133	Lack of supplier credit	6	10	25	9	6
34	52	4	133	Corruption of bank officials	9	13	0	11	5

III. Rates and charges

The survey sought information about various service charges. These questions were semi structured. The questionnaire included a section for recording of charges for different service components and included a few indicative conditions. Space was provided to gather charges for specific services as reported by the respondents. This meant that response to these questions

was largely at the discretion of the respondent. In fact most of the respondents were reluctant or disinterested to give out information about user charges. For many institutions, we had to make a repeat visit to specifically collect information about user charges. Where the respondent was unwilling to give out user charge information, our surveyor simply tried to find out by posing as if (s)he wanted to avail the services.

Table-10.6: Charges for clinical services by Health Care Institutions. (H = Hospitals)

	Private				Public			
↓ Service	Clinics	Small H	Big H	All	PHCs	Small H	Big H	All
n →	71	69	10	150	53	41	12	106
General Out Patient (OP) Consultation								
# Rptg	54	61	10	125	0	0	1	2
Mean chg	34	45	55	41	0	0	50	115
Range	5 - 200	10 - 200	0 - 125	0 - 200	0 - 0	0 - 0	50 - 50	0 - 50
Specialist Out Patient (OP) Consultation								
# Rptg	21	55	10	86	0	0	0	0
Mean chg	58	64	82	65	0	0	0	0
Range	5 - 150	5 - 200	0 - 175	0 - 200	0 - 0	0 - 0	0 - 0	0 - 0
Normal delivery								
# Rptg	10	52	7	69	0	0	0	0
Mean chg	465	1,060	1,843	1,053	0	0	0	0
Range	100-1000	150-5000	300-6000	100-6000	0 - 0	0-0	0-0	0
Caesarian section								
# Rptg	5	54	6	65	0	0	0	0
Mean chg	2,310	3,676	3,708	3,574	0	0	0	0
Range	250-4000	500-8000	250-12000	250-12000	0 - 0	0-0	0 - 0	0-0
Room charge								
# Rptg	11	54	5	70	0	0	3	3
Mean chg	114	127	385	139	0	0	38	38
Range	20 - 400	20 - 1500	60 - 1400	20 - 1500	0 - 0	0 - 0	10 - 80	10 - 80
Boarding charges								
# Rptg	0	7	0	7	0	0	0	0
Mean chg	0	46	0	46	0	0	0	0
Range	0 - 0	20 - 100	0 - 0	20 - 100	0 - 0	0 - 0	0 - 0	0 - 0

Table-10.7: Charges for diagnostic tests by Health Care Institutions. (H = Hospitals)

	Private				Public			
↓ Service	Clinics	Small H	Big H	All	PHCs	Small H	Big H	All
n →	71	69	10	150	53	41	12	106
Total Count & Differential Count (TCDC)								
# Rptg	3	35	9	47	0	0	1	1
Mean chg	27	25	42	29	0	0	50	50
Range	20 - 30	10 - 40	15 - 100	10 - 100	0 - 0	0 - 0	50-50	50-50
Erythrocyte Sedimentation Rate (ESR)								
# Rptg	3	37	9	49	0	0	1	1
Mean chg	22	22	35	24	0	0	30	30
Range	15 - 30	10 - 40	2 - 80	2 - 80	0 - 0	0 - 0	30-30	30-30
Urine test - routine								
# Rptg	3	34	9	46	0	0	2	2
Mean chg	28	21	38	25	0	0	38	38
Range	20 - 35	10 - 45	5 - 85	5 - 85	0 - 0	0 - 0	5 - 70	5 - 70
Stool								
# Rptg	3	36	9	48	0	0	0	0
Mean chg	25	24	43	28	0	0	0	0
Range	20 - 30	10 - 40	5 - 120	5 - 120	0 - 0	0 - 0	0 - 0	0 - 0
X-Ray								
# Rptg	3	3	9	42	0	0	4	4
Mean chg	117	87	101	92	0	0	69	69
Range	100-150	50-100	70-160	50-160	0 - 0	0 - 0	25-150	25-150
Electro cardiogram (ECG)								
# Rptg	8	38	9	55	0	0	1	1
Mean chg	75	71	79	73	0	0	25	25
Range	60-100	30-100	50-110	30-110	0 - 0	0 - 0	25-25	25-25
Ultra sound								
# Rptg	2	30	8	40	0	0	2	5
Mean chg	250	224	345	250	0	0	138	175
Range	250-250	30-400	150-600	30-600	0 - 0	0-0	75-200	75-200
Blood sugar								
# Rptg	3	40	9	52	0	0	1	1
Mean chg	25	26	56	31	0	0	50	50
Range	25-25	15-50	25-130	15-130	0 - 0	0 - 0	50-50	50-50
Pap smear								
# Rptg	0	21	7	28	0	0	0	0
Mean chg	0	35	82	46	0	0	0	0
Range	0 - 0	20 - 80	20 - 150	20 - 150	0 - 0	0 - 0	0 - 0	0 - 0

Table-10.6 and 10.7 show the user charges prevalent in the private and public sector health care institutions. The services for which charges are well settled and recurring would appear in this table rather than services for which charges are fixed on a case to case basis. Each of the two tables devote a panel of three rows for the services for which user charge data was reported by some HCIs in the study. The first row shows the number of HCIs who reported user charges for the concerned service. The second row shows the mean user charge computed for the reporting institutions. This is a simple average of rates charged by the reporting institutions (sum of rates / number of reporting HCIs). The third row gives the range of charges. The emphasis in public sector HCIs is on free service. This might be one of the reasons why many respondents from the public sector HCIs did not report information about user charges. Where user charge information is reported by public sector institutions, they would apply only to the paying category of patients. Table-10.6 gives us some idea about prevalent charges for commonly delivered clinical services. An out-patient consultation in the private sector health care institutions costs around 40 rupees. A specialist consultation costs around 65 rupees. Normal deliveries in private sector cost around 1050 rupees and average charge for Caesarean sections was about 3600 rupees. Room charges were about 140 rupees per day. Most private health care institutions appear not to provide food services. This may have been the reason why many private HCIs did not report any rates for boarding.

Table-10.7 shows rates and charges for diagnostic services provided by health care institutions to their inpatients and to others. Response in these sections was not uniform. Here again, to avoid any false sense of confidence in the values reported here we have given the number of reporting institutions for each test. The range of charges is also shown in addition to the mean values. As before, most public HCIs did not report any rates or charges which connote that the services are mainly provided free. Charges for common blood, urine and stool tests range from 10 to 100 rupees. Mean charges for pathological and biochemical tests range from 20 to 50 rupees per test. X-rays cost about 100 rupees, ultrasounds cost about 250 rupees and ECGs cost about 75 rupees per test. A simple blood count costs around 30 rupees. ESR is about 25 rupees. Routine and microscopic examination of urine costs about 25 rupees. Stool tests costs about 28 rupees. Blood sugar test costs about 31 rupees and a Pap smear is charged around 46 rupees. X-Ray and ECG costs around 100 rupees and ultrasounds are a little more expensive at 250 rupees. These are average figures. The range can be sometimes quite wide including within it HCIs charging very low fees and some others charging much higher rates. The rates charged by bigger private hospitals appear to be generally higher than the rates charged by small hospitals.

Table-10.8: Service charges by diagnostic facilities

Private (n = 167)			Public (n=35)r			←Tests/mo Rate→	Private		Public	
n	Mean	Range	n	Mean	Range	↓ Service	Mean	Range	Mean	Range
26	57	5-200	7	567	10-3000	TCDC	25	10-90	7	0-50
18	197	10-2000	4			Blood tests (All)	37	15-150		
36	136	5-1000	8	431	20-790	Comp. blood pict.	37	10-80	0.4	0-15
26	100	10-750	7	490	30-978	Comp. urine exam.	26	10-45	4	0-21
48	61	4-300	13	459	10-3000	Urine-routine	29	5-130	10	0-70
28	31	5-240	6	35	18-50	Stool	43	5-250	13	
55	58	3-400	11	224	25-500	ESR	22	2-180	4	0-30
86	94	2-750	16	492	10-2500	Blood Sugar	33	10-120	7	0-50
20	36	3-120	8	202	20-900	Blood Grouping	34	10-80	2	
53	44	5-300	12	501	30-2300	Blood Urea	41	15-100	8	0-75
15	29	5-130	2			Uric Acid test	56	25-130		
33	41	2-200	0	0	0	Bile pigments	50	10-100	0	0
19	30	1-150	3	303	30-600	Liver function test	154	20-325		
12	28	2-100	6	214	27-750	Hepatitis-B antigen	135	10-300	37	0-225
25	24	3-75	5	78	5-300	Serum Bilirubin	51	15-100	4	0-20
16	24	5-70	0	0	0	Serum Gluconate	48	15-90	0	0
16	60	2-150	2			Creatinine	42	25-65	37	0-75
64	229	1-6000	8			Hormone test	313	30-1000		
23	47	3-120	4	110	20-350	WIDAL test	39	20-80	5	0-20
25	26	3-90	2	288	270-507	VDRL test	47	15-200		
19	35	5-100	8	250	25-1500	Sputum for AFB	41	15-100		
13	166	10-500	1			Microb. cultures	115	50-300		
74	56	2-1500	15	96	30-200	Pap Smear	130	10-300		
81	136	1-1100	20	590	10-2400	Ultra Sound	266	80-550	25	0 - 200
114	180	5-1800	28	501	10-3875	XRAY	89	25-300	10	0 - 150
54	121	3-450	12	287	10-550	CT Scan	1,014	80-2000	56	0 - 600
19			0	0	0	ECHO	533	125-800	0	0
49	26	1-80	9			Treadmill test	432	50-800		
45	26	3-150	10			Gastro- scopy	441	100-650	150	
12	74	5-300	2	202	40-365	Biopsy	167	45-300	10	
20	267	1-4000	1			HIV	314	150-2000	1,800	

Table-10.8 shows rates and charges for diagnostic services reported by the diagnostic facility sample. The rates are based on responses from 167 (n) private diagnostic facilities and 35 (N) public diagnostic facilities. The left half of the table shows the number of facilities reporting about the concerned test and a quantitative estimate of the tests done per month. Both mean number of tests per reporting institution and the range of monthly workload are given. The right side of the table shows rates per test charged by private and public facilities. Both mean rates between reporting facilities and the range of rates are shown. A non profit hospital in the private sector charges very nominal rates for diagnostic tests. That explains the very low rates like two rupees for ESR, or five rupees for stool / urine tests. In case of the public sector, the lower end of the range is always zero, since these hospitals do not charge any fee for poor patients. These rates reported by diagnostic facilities are quite consistent with rates reported by the HCI sample for similar tests. For example, the mean charge for most pathological tests are in the rupees 20 to 50 range. Ultrasounds cost around 260 rupees and X-rays cost around 90 rupees.

IV. Transparency in rates and charges

With the growth in number of private health care institutions, public concern about openness and transparency in billing practices is growing (High Court of AP, 1999). One step towards a more open system of billing is the availability of published rates and charges. To understand the extent of openness and transparency in fixation of rates and charges, we ascertained information about publication of rates and service charges by private health care institutions. While asking about the rates for different services, we also asked if those charges are fixed on a case to case basis or are published. Responses were sought under four graded levels of transparency such as (a) fixed on a case to case basis, (b) unpublished but known, (c) displayed or locally published within the institution, and (d) published. After data collection, we found that only one big hospital reported itself under the category "displayed or locally published". This is probably because respondents did not see much difference between the category "unpublished but known" and "displayed or locally published". Hence for purposes of analysis, we have merged the "displayed" category with the "widely known" category.

Table-10.9: Transparency in fixation of rates and charges by private HCIs and diagnostic facilities

Openness ↓ category	Pvt. HCI Sample				Diagnostic Facility Sample			
	Cl	SH	BH	All	PDF	SH	BH	All
n→	71	69	10	150	139	21	25	185
Case to case	3%	7%	10%	5%	11%	5%	4%	9%
Known	27%	49%	10%	36%	13%	19%	12%	14%
Published	8%	17%	50%	15%	35%	14%	28%	31%
No response	62%	26%	30%	43%	42%	62%	56%	46%

Cl = Clinics, SH = Small Hospitals, BH = Big Hospitals, PDF = Primarily Diagnostic Facility. Case to case = Charges are fixed on a case to case basis. Known = Rates are unpublished but widely known. Published= Rates are published. We did have a category called "displayed or locally published". But only one big hospital classified itself under this category. We have merged this to the widely "known" category.

Table-10.9 shows the distribution of private HCIs by the level of transparency in rates and service charges. Many HCIs (43%) and diagnostic facilities (46%) did not provide any information about publication of service charges. About 36% of private HCIs reported that their service charges are unpublished but known. Another 15% of private HCIs said that they have published their service charges. Only about 5% private HCIs said that service charges are fixed on a case to case basis. These percentages are with respect to the total sample including those who did not respond to the question about publication of rates and charges. Ignoring the non-responses, we find that majority (63%) of private HCIs operate with unpublished but known rates for their services. These rates would be known to the billing personnel and the HCI employees. Patients will have to ask someone to find out about the rates. Non-response to the questions about service charge means that people working in the concerned HCI did not have the information readily available. For purposes of assessing transparency in rates and charges, we can classify these non-responding HCI with those reporting that they fix service charges on a case to case basis. That would mean that about 48% of private HCIs did not have fixed rates and service charges. Table-10.10 shows the services in respect of which the transparency in rates and charged data was available. Note that these are mostly diagnostic services, or room and board charges. Cardiology and physician consultation are the only two clinical services for which information about openness in fixation of service charges was provided. In other words the information about tariff transparency relates mostly to diagnostic services which

are more readily defined and easy to deal with as far as fixation of rates and charges are concerned. If the level of transparency is low for these well defined services, the price fixation and publication for other clinical services would be still more ill defined.

Table-10.10: Services in respect of which transparency-in-rates data was available

Service	n	Case to case	Known	Published
Biochemistry	93	18%	23%	59%
Radiology	85	16%	26%	58%
Cardiology	68	13%	29%	57%
Pathology	86	16%	29%	55%
Lab services	321	20%	40%	40%
Others	28	11%	50%	39%
Room Charges	86	13%	59%	28%
Board Charges	11	9%	64%	27%
Consultation	86	13%	63%	24%

n= # HCIs or diagnostic facilities reporting transparency in fixing of charges for the respective service

It is well known that health care market is characterised by information asymmetry. This means that the consumer do not have all the information they need to make a choice of provider. However, the provider does have more information about the nature of the consumers problem and what the provider intends to offer. This information asymmetry arises from the fact that patients are not equipped with the knowledge to assess their medical problem. Adoption of such practices as unpublished rates and service charges further adds to the information asymmetry problem. Patients can, at the least, make some sense of rates and charges, if they were available. Hence it will be desirable to require private HCIs to publish their rates and service charges, at least for well defined and commonly encountered services.

Table-10.11: Time since last revision of rates and charges for health care service by private institutions.

↓ Time Period	Pvt. HCI Sample				Diagnostic Facility Sample			
	CI	SH	BH	All	PDF	SH	BH	All
n→	71	69	10	150	139	21	25	185
1 to 2 years	6%	22%	20%	14%	17%	14%	20%	17%
3 to 4 years	6%	12%	10%	9%	14%	0%	8%	11%
5 to 6 years	4%	9%	10%	7%	7%	5%	4%	6%
7 to 8 years	0%	3%	0%	1%	1%	0%	0%	1%
9 to 10 years	0%	1%	0%	1%	1%	0%	0%	1%
>10 years	6%	1%	10%	4%	3%	0%	4%	3%
No response	79%	52%	50%	65%	58%	81%	64%	62%

CI = Clinics, SH = Small Hospitals, BH = Big Hospitals, PDF = Primarily Diagnostic Facility.

To understand the periodicity of revision of service charges, we ascertained the time of last revision of tariff by the private HCIs (Table-10.11). Most HCIs did not provide information about the date when the current rates and service charges were fixed. From the limited responses, it appears that most HCIs and diagnostic facilities revise their rates and charges at intervals ranging from 1-2 years to 5-6 years. About half of those who gave some response said that their last revision was less than four years ago.

V. Fair financing practices

We asked the owner-managers of private HCIs about fair financing practices for poor patients (Table-10.12). We did not verify the claims of the owner-manager respondents. Hence it will be proper to interpret the reports here as the attitude and perceptions of the owner-managers. Almost all (91 to 100%) private HCIs including the diagnostic service facilities reported that they do about at least some fair financing practice. There are differences in the manner of concessions to the poor by various types of institutions. Discounted prices appear to be favoured by all. Clinics appear to favour free care for the poor. To some extent big hospitals and diagnostic facilities appear to tolerate free care as well. Doctor's discretion appears to be the predominant means of identifying beneficiaries for various concessions in payment for services.

Table-10.12: Private HCIs who reported that they follow some fair financing practices for poor patients.

Fair financing practice	Clinics	Small H	Big H	Diag.	All HCIs
n →	70	68	8	202	146
Some fair financing practice exists	97%	99%	100%	91%	98%
Free care	83%	15%	63%	61%	78%
Discount prices	70%	72%	75%	70%	71%
Deferred payment	36%	34%	25%	27%	34%
Payment in kind	7%	9%	13%	4%	8%
Less expensive care	23%	26%	25%	8%	25%
Free samples of medicines	66%	63%	38%	15%	63%
Free financing process					
Doctor's discretion	91%	88%	88%	67%	90%
Recommendation from local rep.	7%	21%	25%	25%	14%
Assessment by social welfare agent	7%	7%	25%	4%	8%
Ration card	6%	13%	38%	7%	11%
Keep records on assistance to poor	10%	16%	63%	12%	16%

H = Hospitals, Diag = Diagnostic facilities, All HCIs = Clinics + Small Hospitals + Big Hospitals

The owner-managers were asked if their hospital kept a record of assistance given to poor patients and if so how many persons were assisted by their hospital during 1998 (Table-10.12). Differences between the perceptions and reports about existence of records may give some idea about the attitude and practice gap. Only 23 HCIs reported that they kept a record of assistance to poor. Four of these did not assist any poor patients during 1998. Two of these 23 HCIs reported a specific number of poor patients assisted by them, but did not want to give the figure of total admissions or outpatients served by them. Both are big private corporate hospitals. When we asked about basic hospital statistics, these two hospitals were uncooperative. But they were quite willing to provide figures about poor patients served by them! The list of 23 HCIs claiming to assist poor patients consisted of five big hospitals, 11 small hospitals and seven clinics. Out of the five big hospitals, two did not provide admission and outpatient figures. So we can not even check the plausibility of the number claimed as a reply to the question on assistance to poor patients. The other three were all in the voluntary sector and their figures appeared plausible, i.e. the number of assisted poor patients was less than the total admissions/

outpatients served by them. These three voluntary hospitals assisted 20 to 40% poor patients of their outpatients. Among the 11 small hospitals, which claimed to assist the poor and keep a record of it, nine assisted less than 6% of their outpatients. One of the remaining two assisted 27% of its outpatients and the other assisted about 63% of its outpatients.

Overall there is a large gap in the percentage of HCIs reporting that some fair financing exist and those who said they keep record of assistance to poor. About 98% HCIs said that they have some sort of fair financing practice in place. However, only 16% private HCIs informed that they keep record of assistance to poor. Beneficiaries of free care or discounted prices are identified mostly through doctor's discretion. On the whole, we find that fair financing practices in private HCIs are essentially informal and ad-hoc. These practices would benefit some poor and needy patients, but are incapable of meeting the needs of most of them.

VI. Summary of findings about financial aspects of private HCIs

Direct payment by patients is currently the primary source of revenue for private HCIs in AP. Employer reimbursement, and health insurance payments are yet to be important sources of income for private HCIs. The increasing trend of patient fees suggests that the growth in private health care institutions will continue for some more time. If the environment for employer reimbursement improves and health insurance schemes expand, growth of the private health sector may gain additional impetus for growth. Patient revenue income also appears to be the dominant source of financing of capital investment in private health care institutions. More than half of the owner-mangers reported that they did not require a loan. Those who needed, took loan mostly from commercial banks, and some took loan from relatives and friends. Although some credit market difficulties like too much paper work, unrealistic collateral, etc. are experienced, owner-managers were not deterred by these to take loans if they needed them to start or develop their health care institutions. Data on rates and charges for commonly delivered clinical and diagnostic services, collected from HCIs and diagnostic facilities are presented. Majority of private HCIs operate with unpublished tariffs for their services. It will be desirable to require private HCIs to publish service charges for commonly encountered and well defined services, to bring about some openness in billing practices. Although almost all private HCIs claimed to have some fair financing arrangement for poor patients, these are mostly informal and ad-hoc. These informal arrangements of free care or discounted fees based on doctor's discretion would benefit some poor and needy patients, but is incapable of meeting the needs of most of them.