CHAPTER 3

THE SYSTEM OF HEALTHCARE PROVISION

3.1 Introduction

The health sector in India is characterized by a government sector that provides publicly financed and managed curative, preventive and promotive health services from primary to tertiary level throughout the country free of cost to the people and a fee-levying private sector that plays a dominant role in the provisioning of curative care. The provision of healthcare by the public sector is a responsibility shared by the state government, central government and local governments in India. General health services are the primary responsibility of the states with the central government focusing on medical education, drugs, population stabilization and disease control. The National Health Programs of the central government are related to reproductive and child health and to the control of major communicable diseases. Besides, it also contributes significantly to state health programs.

While, the private sector in India has a dominant presence in all the submarkets including medical education and training, medical technology and diagnostics, pharmaceutical manufacture and sale, hospital construction and ancillary services and, finally, the provisioning of medical care. The respective role of the public and private sectors in healthcare has been a key issue in debate over a long time. As public healthcare has always played an important role for India, it is important to examine its significance especially in the context of contemporary issues related to increasing privatization in the health sector in India.
The following section 3.2 discusses rationale for state intervention in healthcare; section 3.3 provides a brief on the growth of public health services in India, its role, public health expenditure, policy and evaluation of public healthcare in India; section 3.4 deals with the introduction to private healthcare, the need for private healthcare; provides the structure, role, expenditure, policy and evaluation of private healthcare in India; section 3.5 highlights Mumbai city’s health profile, section 3.6 deals with healthcare scenario in the city and finally section 3.7 gives the summary.

3.2 Rationale for State Intervention in Healthcare

Healthcare is a part of social infrastructure. Availability and accessibility to health facilities is inevitable for the acceleration of the economic development of a country. There is a case for government intervention in infrastructure, as it is believed that a temporary surge in public spending for infrastructure causes a multiple expansion of output (Crain and Oakley, 1995).

The ultimate objective of a healthcare delivery service, to quote the famous words of Aneurin Bevan, is that the ‘rich and the poor are treated alike, that poverty is not a disability, and wealth is not advantaged.’(Baru, 2003). It is the duty of the state to provide access to universal healthcare. The access to health services should, thus depend upon individual need, and not on financial status. One observes that the financing strategy has to be country-specific, depending on per capita income, size of the formal sector, poverty levels, and administrative capacity. In case of federal structure like India health financing strategy needs to be state – specific, even while following the broad framework of the national strategy.
Although the market mechanism is supposedly an admirable way of producing and allocating goods, many a time, market failures lead to deficiencies in the economic outcomes. Government steps in to correct these failures (Samuelson, 1954). Samuelson recognizes the two main functions of the government, namely provision of public goods and transfer payments for the purpose of redistribution of income (Colm, 1954).

Apparently, the World Development Report (1993) examined the rationale of government role in health, identifying three economic rationales for government action.

- The poor cannot always afford health care that promotes productivity and well-being. Publicly financed investment in health can play a pivotal role in the alleviation of poverty and its consequences.
- Some health promoting actions are pure public goods or create large positive externalities. The example are vaccination, immunization etc. Private markets would either not produce them at all, or produce too little in such cases.
- Government intervention can improve the functioning of these markets in health and health insurance, thus raising welfare.

This has also been highlighted in the World Health Report (2000) that describes government role as stewardship, listing its stewardship functions:

- Formulating health policy-defining vision and direction
- Exerting influence-approaches to regulation and
- Collecting and using intelligence.
In this context, it is essential that the government intervenes in health through policies, regulations, record-keeping and surveillance so as to work out maximum benefits to the people.

3.3 Public Health

Public health has often been defined as a science dealing with the determinants of health at the population level, while clinical medicine deals with multiple maladies and their remedies at the level of an individual patient. Public health aims to understand and influence the social, cultural and economic determinants of health. It also aims to study the structure of health systems as efficient channels for health services delivery. Public health is thus, a discipline built on the academic tradition of inquiry involving research, teaching and professional practice to prevent disease and promote health in populations (The Public Health Foundation of India and Indian Institutes of Public Health, 2011).

Public health is the science and the art of preventing disease, prolonging life, and organizing community efforts to do the following: keep the environment clean, control communicable infections, educate individuals in personal hygiene (like hand washing for example), organize medical and nursing services for the early diagnosis and treatment of disease, and develop the social machinery to ensure everyone a healthy standard of living.” The mission of public health is to “fulfill society’s interest in assuring conditions in which people can be healthy.” (The Future of Public Health, 1988).
Public health carries out its mission through organized, interdisciplinary efforts that address the physical, mental and environmental health concerns of communities and populations at risk for disease and injury. This is achieved through the application of health promotion and disease prevention technologies and interventions designed to improve and enhance quality of life. There are three core public health functions-

1. **Assessment and Monitoring**: Health of the communities and populations at risk needs to be assessed and monitored; this is essential for identifying health problems and priorities.

2. **Formulating Public Policies**: This is done in collaboration with community and government leaders, designed to solve identified local and national health problems and priorities.

3. **Health Promotion, Disease Prevention Services and Evaluation of the Effectiveness**: Assuring that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care (ibid).

From, the above it is clear that public health calls for public action. However, according to classical economists like Adam Smith the invisible hand of the market would lead to optimal economic outcomes as markets are assumed to be ‘Pareto-efficient’. Pareto efficiency criterion allocates scarce resources in a way that no reallocation can make any individual better-off without making at least one other individual worse-off. This is the idealized picture of a private market economy. This according to Smith would help to allocate scarce resources efficiently for the health sector. But, in reality various difficulties arise due to market failure or market inadequacies (Wolf, 1979). A market inadequacy implies that a market may fail to
produce economically optimal or socially desirable outcome as noted in the earlier chapter and therefore state intervention is needed.

3.3.1 The Origin of Public Health Initiative in India during the British Rule

The Colonial Legacy:
Public health policy during the British period was a response to crisis and emergency. The first document of ‘public health policy’ in British India was the 1863 report of the Royal Commission on the sanitary state of the British army in India (Harrison, 1994). The concern about threats to the health of the Indian Army, particularly after the rebellion of 1857, motivated a wide-ranging inquiry into health conditions in the country. Apparently, this interest in the health of the troops led to a more general interest in the health of the population.

The great famines of the 1870s and 1890s caused both mass mortality and mass migration. It was fear of unrest and social disruption that caused the colonial state, belatedly, to take some interest in famine relief and public health (Dreze, 1988; Hodges, 2004). It is a well known fact that one of the ‘benefits’ of colonial rule in Asia and Africa was the advent of modern medicine. Institutions of public health—hospitals, health centre’s, medical research laboratories, pharmaceutical production facilities were amongst the new colonial institutions that appeared in South Asia, along with the railways, the telegraph and new forms of land tenure and law. These had lasting and important consequences for the future of public health. However, colonial public health policy was inherently limited and self-limiting; it focused only on keeping epidemics at bay and responding to crises. A crucial institutional innovation came in the 1880s (Jeffery, 1988), when much of the responsibility for local health and
sanitation was devolved to partly elected local government bodies, a responsibility shared by the 1920s with provincial governments. This had a long lasting impact on the division of responsibility and has put significant limits on the capacity to enact public health policies. Then, as now, the ability of local and even provincial governments to raise resources is very limited.

The ambivalent nature of the colonial state’s engagement with questions of public health had following two notable consequences.

i) The Indian elites began to take up the ideas of the colonial state in order to hold it to account. Health, that is to say, was politicized. By the 1920s, this had evolved into the argument that only a representative national government could truly care for the health of the Indian people. As India’s modernizing nationalists set their sights on power, in the 1930s, they committed themselves to precisely this kind of ‘deep’ intervention by the state in society. The health of the population became part of a much broader agenda of transformation.

Thereafter, the All India Institute of Hygiene and Public Health (AIIH and PH), was established in Kolkata, in December 1932, making it the oldest school of public health in Southeast Asia. In this way, Indian nationalists could argue not only that the colonial state had failed in its duty to care for the welfare of the population, but that they, as genuine representatives of ‘the people’, could and would do so, using the latest technologies of government (National Planning Committee [NPC], 1948).

ii) The second consequence of the colonial state’s unwillingness to spend much money on public health was that in late-colonial India, there was much scope for ‘civil society’ or
voluntary initiatives in health. Devolving responsibility to charities and voluntary bodies suited the colonial state, which was imbued with the ideals of Victorian liberalism, and its belief in the power of civil society to solve social problems; relying on philanthropy was cheaper, too (Amrith, 2009).

Thus, at the moment of India’s independence, the value of public health was deeply contested. Within the thinking of the Congress Planning Committee, health was, at once, a basic human right. It was a tool for the improvement of the ‘Indian race.’ Health was an instrument for economic development. The need for public health has stemmed from an egalitarian commitment to welfare of the masses.

3.3.2 The Origin of Public Health Initiative in India in the Post-Independence Period

The growth of public health in independent India can be discussed in four phases-

- **A Period of Growth at all the Levels of Public Healthcare (1950-65):** Public health emerged as an independent sphere of activity in India. Research institutions were set up in first three decades of 20th century. Municipalities provided some health services in urban areas with dispensaries and hospitals growing sporadically. In post-independence period of 1950s and 60s medical colleges with tertiary hospitals and public health services were set.

- **A Period of Growth of Village Level Services (1966-1980):** The Alma-Ata resolution of Primary Health Center (PHC) in 1978 came to be internationally accepted as the approach for health service development after 1961 and 1965 droughts
and 1970s oil crises. The pace of infrastructure development picked up markedly at the sub center level.

- **A Period of Boom in Healthcare Institutions (1980-1990):** In the beginning of 1980s health care institutions proliferated especially at primary level in both public and private sectors. Research institutions primarily followed the advanced countries. But by the end of 1980s the public health system was in crisis. Apparently, ‘People’s participation’ was viewed to tackle this crisis situation.

- **Growth at Secondary and Tertiary Levels with Commercialization and Corporatization (1990s onwards):** Though there was development in public health infrastructure by 1990-91, it was slow. It is in the gap between expectations of health and the availability of health facilities that we can look for an explanation of why, despite the centrality of the state to public health policy in India since independence, India has developed one of the most extensive, and least regulated private markets in health in the world. The medical technologies that circulated as a result of the public health campaigns of the 1950s ‘were not supposed to become common commodities’, but the effort to control them was ‘doomed to failure’(Whyte, etal, 2002). Measures for health sector reforms were put forth by international agencies like the World Bank over taking World Health Organization (WHO) and United Nations Children’s Fund (UNICEF). The central and state governments were working out diverse measures to improve public health affairs while the private sector experienced a boom especially after 1990s. However, since 1990s there has been a drastic cut in public healthcare expenditures for public sector health services.
3.3.3 Role of Government in Public Healthcare in India

There is no denying to the fact that government’s role is very crucial in providing public health facilities to the people. This role can be briefly discussed as follows-

- **Health System Strengthening**

  Important issues that the public health systems must confront are lack of financial and material resources, health workforce issues and the stewardship challenge of implementing pro-equity health policies in a pluralistic environment (Park, 2007). The National Rural Health Mission (NRHM) launched by the Government of India in 2005 is a leap forward in establishing effective integration and convergence of health services and affecting architectural correction in the health care delivery system in India.

- **Health Information System**

  Information is an important instrument of through which state intervention in healthcare takes place. The Integrated Disease Surveillance Project was set up in 2004 to establish a dedicated highway of information relating to disease occurrence required for prevention and containment at the community level. However, the slow pace of implementation is due to poor efforts in involving critical actors outside the public sector. Health profiles published by the government should be used to help communities prioritize their health problems and to inform local decision making. Public health laboratories have a good capacity to support the government's diagnostic and research activities on health risks and threats. But, they need to be utilized efficiently. Mechanisms to monitor epidemiological challenges like mental health, occupational health and other environment risks are yet to be put in place.
❖ **Health Research System**

State has the responsibility of strengthening research infrastructure in the departments of community medicine in various institutes. It needs to foster partnerships with state health services to promote various research programs and projects.

❖ **Regulation and Enforcement in Public Health**

A good system of regulation is fundamental to successful public health outcomes. It reduces exposure to disease through enforcement of sanitary codes, e.g., water quality monitoring, slaughterhouse hygiene and food safety. Wide gaps exist in the enforcement, monitoring and evaluation, resulting in a weak public health system. This is partly due to poor financing for public health, lack of commitment of public health functionaries and inadequate community involvement. Revival of public health regulation through concerted efforts by the government is possible through updating and implementation of public health laws, consulting stakeholders and increasing public awareness of existing laws and their enforcement procedures.

❖ **Health Promotion**

Development of community-wide education programs and other health promotion activities need to be strengthened. Stopping the spread of STDs and HIV/AIDS, helping youth recognize the dangers of tobacco smoking and promoting physical activity are a few examples of behavioral change communication that focus on ways that encourage people to make healthy choices.
Human Resource Development and Capacity Building

The State has a significant role to play in the development of human resources for public health services. There is a dire need to establish training facilities for public health specialists along with identifying the scope for their contribution in the field. The Public Health Foundation of India which was setup in 2006 is a positive step to redress the limited institutional capacity in India by strengthening training, research and policy development in public health. It has a mandate of establishing new institutes of public health, assist the growth of existing public health training institutions, establish a strong national research network, generate policy recommendations, and develop a vigorous advocacy platform. Pre-service training is essential to train the medical workforce. Along with this; changes in the undergraduate curriculum and in-service training are among a few priorities of this initiative. Equally important is the need to increase the number of paramedical workers and training institutes in India (Lakshminarayanan, 2011).

3.3.4 Public Health Expenditure in India

It is a well-known fact that health expenditure in India is dominated by private spending on health. To a large extent this is a reflection of the inadequate public spending that has been a constant though unfortunate feature of Indian development in the past half century. There is a consensus among social scientists that healthcare is different from other goods and services, because of greater likelihood of “market failure”.

The two main characteristics of healthcare which lead to market failure and thus necessitate state intervention are the presence of externalities and information asymmetries. These necessitates state intervention in order to ensure that sufficient resources are directed to the
production of such goods or services, which in turn would result in an increase in the society’s welfare.

It has been argued that such externalities are less evident for general healthcare services such as physician and hospital care and greater in the area broadly known as “public health”. The latter relate to interventions targeted at overall conditions of nutrition and sanitation that determine health, as well as communicable diseases which are passed either directly among humans or indirectly through the physical environment. An action taken by one person (e.g. ensuring clean, safe water, immunizing oneself against, or seeking treatment for, a communicable disease) generates direct health benefits for other individuals, through reduced rates of disease. Clearly, purely market oriented or individually based activities would ignore the wider positive external effects, and therefore yield less than socially optimal levels of such activity. However, even general healthcare services that apparently affect only individuals have positive externalities, not only because of the social costs of morbidity, but because inequalities in healthcare create other social concerns. These positive externalities make government intervention essential.

**Asymmetric information** is yet another form of market failure. It reflects any situation in which one party has access to some information that is not known to the other party. Such information asymmetries, primarily between the health service provider and the patient, pervade the health sector and cause market failure. For example, patients know best how improvements in the health affects their own well-being, while providers have better information regarding both the causes of ill-health and the effectiveness of alternative health care services in restoring health or preventing the further deterioration of health. Here, there is also a problem of “incentive incompatibility”, in which the interests of the patient and the
healthcare provider need not coincide. Therefore, there is a need for government intervention to sort out the problem of information asymmetries. Such intervention can be in any form. For example, regulations like licensing of healthcare providers, limits on advertising, insistence on some professional norms that prohibit low quality, etc. Such regulation has to ensure balance between the need to increase welfare by improving or ensuring quality, and the welfare reducing effects of inadvertently granting monopoly powers to providers. Therefore, from both the efficiency and equity grounds there, is no alternative to the public provision of healthcare.

3.3.5 Public Health Expenditure Trends in India

The total healthcare expenditure in India was around 5% of GDP in 2008 (Health Spending in India, 2011). However, this figure only tells part of the story. The mid-term appraisal of the 11th Five Year Plan recognized that, “while total expenditure on health in India as a percentage of GDP was broadly in line with the level achieved in other countries at similar per capita income levels, it was skewed too much in favor of private expenditure. Public expenditure on health in India was less than 1 per cent of GDP.” Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.
### TABLE 3.1: PUBLIC EXPENDITURE ON HEALTH AS A PERCENT OF GDP

<table>
<thead>
<tr>
<th>Year</th>
<th>National Level Spending on Health (% of GDP)</th>
<th>State Level Spending on Health (% of GDP)</th>
<th>Total (% of GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-06</td>
<td>0.29</td>
<td>0.67</td>
<td>0.96</td>
</tr>
<tr>
<td>2006-07</td>
<td>0.29</td>
<td>0.67</td>
<td>0.96</td>
</tr>
<tr>
<td>2007-08</td>
<td>0.32</td>
<td>0.70</td>
<td>1.02</td>
</tr>
<tr>
<td>2008-09</td>
<td>0.35</td>
<td>0.71</td>
<td>1.06</td>
</tr>
<tr>
<td>2009-10</td>
<td>0.39</td>
<td>0.70</td>
<td>1.09</td>
</tr>
</tbody>
</table>

Source: Mid-term appraisal of the 11th Five Year Plan, Planning Commission, GOI.

As one can observe, from the above table, that on an average the state level spending has been slightly higher than the national level spending as a percent of GDP. Over the years both national and state spending on health has increased very very marginally. However, this expenditure on health is very minimal in order to take care of the increasing population’s healthcare needs. Now, the government is proposing to hike public spending on health by half a percentage point i.e. 1.6 percent of GDP for 2012-2017 under the twelfth plan. Even this is considered to be very meager especially when the high level expert committee had suggested that public health spending should at least get 2.5 percent share of GDP.

#### 3.3.6 Review of Public Health Policy in India during the Five Year Plans in India

The first formal health care policy for India was laid out by the Bhore Committee report (1946). This committee prepared a detailed plan of a National Health Service for the country, which would provide a universal coverage to the entire population free of charge through a comprehensive state run salaried health service. Despite the fact that it was adopted by the Government of India, but its recommendations could not be implemented fully due to the
financial stringency of the central government. The importance of the development of health services and health infrastructure has been duly recognized in the various five year plans drafted by the Planning Commission, however, never implemented seriously.

During the **First and Second** five year plans the basic structural framework of the public health care delivery system remains unchanged. Urban areas continued to get over three fourth of the medical care resources where as rural areas received ‘special attention’ under the Community Development Program (CDP). To evaluate the progress made in the first two plans, the Mudaliar Committee was set up in 1959. The committee admitted that basic health facilities had not reached at least half the nation and the rural areas had no access to them. Even the Primary Health Care (PHC) program was not given due importance (Gangolli, etal, 2005).

The **Third** plan launched in 1961 discussed the problems affecting the provision of the PHC, and directed attention to the shortage of health personnel, delays in the construction of PHC buildings and staff quarters and inadequate training facilities for the different categories of staff required in the rural areas. Later, the Jain Committee report (1967) suggested integration of medical and health services at district level and for the first time reported on strengthening curative services in rural areas.

The **Fourth** plan that began in 1969 with a three year plan holiday continued on the same lines as the third plan without a major change in the policy approach towards the healthcare services.
It was in the **Fifth** plan that the government acknowledged that the urban health structure had expanded at the cost of rural sectors. Despite advances in terms of IMR (Infant Mortality Rate) going down and life expectancy going up the number of medical institutions, functionaries, beds, health facilities etc. were still inadequate in rural areas. The Kartar Singh Committee in 1973 recommended the conversion of single purpose workers including Auxiliary Nurse Midwives (ANMs), into Multi-Purpose Workers (MPWs) and integration of various vertical progresses into primary healthcare package for rural areas.

The Shrivastava Committee came up in 1975 to look into medical education and man power support. The committee proposed to rectify the dearth of trained manpower in rural areas. The committee pointed out that “the over-emphasis on provision of health services through professional staff under state control has been counterproductive. On the one hand it is devaluing and destroying the old traditions of part-time semi-professional workers, which the community used to train and throw up and proposed that with certain modifications can continue to provide the foundation for the development of a national program of health services in our country. On the other hand the new professional services provided under state control are inadequate in quantity and unsatisfactory in quality”. This very direct statement from the committee that was set up to review medical education and its related components assumes significance because it showed that the investment on healthcare had not been going to the people. The main recommendation of the committee was to have part-time health personnel selected by the community from within the community. They would act as a link between the Multi-purpose Worker (MPW) at the sub-centers and the community. A new policy Health for All by 2000 AD (1977) announced a long term objective of population stabilization by bringing down net reproduction rate to one by 1995.
The **Sixth** plan was to a great extent influenced by the Alma Ata declaration of ‘Health for All’ by 2000 AD, Indian Council of Social Science Research’s (ICSSR) and Indian Council of Medical Research (ICMR) report. The plan emphasized the development of a committee based health system. It was the first time in year 1983 that India adopted a formal or official National Health Policy (NHP). The NHP in light of the Directive Principles of the constitution of India recommends ‘universal, comprehensive primary healthcare services which are relevant to the actual needs and priorities of the committee at a cost which people can afford ‘. It had many salient features like emphasis on preventive, promotive and rehabilitative primary healthcare approach, decentralized system of healthcare etc. However, the NHP 1983 did not reflect the ground realities adequately.

The **Seventh** plan too recommended the progressive measures for strengthening public healthcare, along with the focus on privatization.

The **Eighth** plan emphasized on health for the under privileged keeping with the selective health care approach. The Bajaj committee report of 1987 recommended bringing all health sciences together provide for continuing medical education and improve medical and health education through such integration. During the eighth plan period a committee to review public health was setup. It was called the Expert Committee on Public Health Systems. This committee made a thorough appraisal of public health programs and showed that there was a need to drastically improve disease surveillance in the country.

The **Ninth** plan has a number of innovative ideas. The Bshore Committee report reference was made once again and recommendations were made to suit it to the current scenario. It suggests the consolidation of Primary Health Centers and Sub-Centers and positions it is an
important goal under the basic Minimum services program. State specific strategies and urban healthcare was also another focus of the plan.

On the eve of the **Tenth** plan the Draft National Health Policy was announced. The Tenth plan also acknowledged that public health system is grossly short of defined requirements. It showed the need for reorganization and restructuring of health infrastructure and maintained its commitment to PHC, emergency and life saving services and national program free of cost. However, it introduced user charges for those above poverty line.

Presently, the National Health Policy (NHP), 2002 has the objective to achieve an acceptable standard of good health amongst the general population of the country. The NHP, 2002 needs to the lauded for its concern for regulating private health sector through statutory licensing and minimum standards by creating a regulatory mechanism. The NHP, 2002 aims at reviving and emerging the ailing health system and increasing the primary health sector outlay to ensure a more equitable access to health services across the social and geographical expanse of the country. The approach of the policy is to increase access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions. The contribution of the private sector in providing health services is also to be enhanced, particularly for the population group which can afford to pay for services.

*Rashtriya Swasthaya BimaYojna (RSBY)* is a central government new health insurance scheme for the **Below Poverty Line (BPL)** families in the unorganized sector. It was formally launched on October 1, 2007. The objective of RSBY is to provide the insurance cover to below poverty line (BPL) households from major health shocks that involve hospitalization.
Besides, the National Rural Health Mission (NRHM), a national effort at ensuring effective healthcare, especially to the poor and vulnerable sections of the society was launched on 12th April, 2005 for a period of seven years (2005-2012) throughout the Country with special focus on 18 states viz. Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh.

The NRHM covers all the villages through village-based "Accredited Social Health Activists" (ASHA) who would act as a link between the health centers and the villagers. One ASHA will be raised from every village or cluster of villages. The ASHA would be trained to advise villagers about Sanitation, Hygiene, Contraception, and Immunization to provide Primary Medical Care for Diarrhea, Minor Injuries, and Fevers; and to escort patients to Medical Centers. They would also deliver Directly Observed Treatment Short (DOTS) course for tuberculosis and oral rehydration; distribute folic acid tablets to patients and alert authorities to unusual outbreaks. NHRM also mandates improvements in health infrastructure, human resources for health, and availability of drugs. It is a flexible, decentralized program comprising:

i. Mission flexible pool

ii. Reproductive-health flexible pool

iii. Pulse polio immunization

iv. Infrastructure maintenance and

v. National disease control program.
Under NRHM, for allocating funds, the states are divided into high-focus states and non-focus states. The states with poor health status are categorized into focus states.

The Eleventh plan will provide an opportunity to restructure policies to achieve a New Vision based on faster, broad-based, and inclusive growth. One objective of the Eleventh Five Year Plan is to achieve good health for people, especially the poor and the underprivileged. In order to do this, a comprehensive approach is needed.

In the eleventh plan, a Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure was established under the Department of Health and Family Welfare to achieve the following objectives:

1. To review the existing system of Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure (Public, Private, NGO) in urban and rural areas with a view to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, and also achieve goals set under the National Health Policy and the Millennium Development Goals.

2. To identify the potential areas/infrastructure/ institutions involved in providing accreditation with a view to ensure cost-effective and standardized delivery of health services to people in rural and urban areas and

3. To suggest a practical and cost efficient system of accreditation of healthcare infrastructure.
Similarly, another working group on healthcare financing including health insurance was established under the Department of Health and Family Welfare, to review the present position of health financing at state, centre and individual levels; to suggest management strategies for community based health insurance; to assess disease burden and cost of ill health in the country; to give cost estimates of healthcare-public, NGO and private-current and for the 11th plan period and to suggest alternative strategies for health financing.

Besides, The Planning Commission constituted a Working Group on Public Private Partnership to improve health care delivery for the Eleventh Five-Year Plan (2007-2012) with the following aims:

1. To review existing scenario of Public Private Partnership in healthcare (Public, Private, NGO) in urban and rural areas with a view to provide universal access to equitable, affordable and quality healthcare which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization and also achieve goals set under the National Health Policy and the Millennium Development Goals.

2. To identify the potential areas in the healthcare delivery system where an effective, viable, outcome oriented public-private partnership is possible and

3. To suggest a practical and cost effective system of public private partnership to improve healthcare delivery system so as to achieve the goals set in National Rural Health Mission (NRHM), National Health Policy (NHP) and the Millennium Development Goals (MDGs) and makes quantitative and qualitative difference in implementation of major health and
family welfare programs, functioning of health and family welfare infrastructure and manpower in rural and urban areas.

Besides, a Steering Committee on Primary Healthcare was also established to assess the situation of primary healthcare in rural and urban areas provided by government, as well as voluntary and private sectors after the launch of National Rural Health Mission. Also, a steering committee on secondary and tertiary healthcare was established to assess the situation of secondary and tertiary healthcare in rural and urban areas provided by government, as well as voluntary and private sectors and suggest appropriate mechanism for restructuring and rationalization of secondary and tertiary healthcare services.

The Eleventh Five Year Plan aims for inclusive growth by introducing National Urban Health Mission (NUHM), which along with National Rural Health Mission (NRHM) will form Sarva Swasthya Abhiyan (SSA).

- NRHM has been launched for meeting health needs of all age groups and to reduce disease burden across rural India.
- NUHM will be launched to meet the unmet needs of the urban population (28.6 crore in 2001 and 35.7 crore in 2011).
- NUHM based on health insurance and Public-Private Partnership will provide integrated health service delivery to the urban poor. Initially, the focus will be on urban slums. NUHM will be aligned with NRHM and existing urban schemes.
- Overall, Sarva Swasthya Abhiyan will aim for inclusive growth by finding solutions for strengthening health services and focusing on neglected areas and groups.
3.3.7 Critical Evaluation of Public Healthcare in India

In spite of a dominant role of public healthcare in India, there are unfulfilled targets and failures of public healthcare. The comprehensive review indicates that after independence in 1947, India decided to expand and improve the health services of the country as one of a comprehensive package program to raise the standard of living of the people.

In fact, in the Indian Constitution the fundamental right of protection of right of life and liberty (Article 21) include right to health, implying state obligation to protect citizens from medical negligence. The state is required to concentrate on the development of health infrastructure because of its welfare oriented goals, market failures, to promote rural health facilities and the recommendations of Bhore Committee. The Constitution places ‘public health and sanitation, hospitals, and dispensaries’ in the state list.

However, the Centre has played a dominant role in all aspects of health, mainly because of its financial clout in centrally planned economy. Though, there is no doubt that India has achieved a good deal during the last 65 years still one cannot turn a blind eye to the failures in public health.

In recent period, the policies of economic reforms, emphasizing Liberalization, Privatization and Globalization (LPG) have their implications for all the sectors of the economies of these countries. Health sector also has been experiencing changes, which are worthy of consideration. India has adopted LPG policies due to which drug prices have found to be rising, access and utilization of healthcare services by the poor has been adversely affected, inequalities in access and utilization have been found to be widening, secondary and tertiary
care is being encouraged at the cost of primary care, urban healthcare facilities are growing at the cost of rural healthcare facilities, etc.

Before independence, number of solemn pledges were made by the planners to the people of India viz., that we shall abolish poverty, ignorance, and ill health and raise substantially the standard of living of the masses. But over the years these promises were not entirely fulfilled.

Firstly, a ruling class rules for its own benefit and often fails to take into account the health needs of the people, particularly the poor and under-privileged. It was hoped to provide health care services through the universal provision of comprehensive primary healthcare services. In retrospect, it is observed that the financial resources and public health administrative capacity was far short of that necessary to achieve such an ambitious and holistic goal in reality.

Secondly, in India, the present health delivery system provides healthcare services mostly to the urban areas. The distribution of health services is skewed across the country and the rural-urban health divide across rural and urban areas is quite visible. A doctor to population ratio is lower by six times in rural areas as compared to the urban areas. Similarly, a hospital bed to population ratio is fifteen times lower in the rural areas (Jhunjhunwala, 2011).

Thirdly, the healthcare system is still over-weighted in favor of curative programs in spite of the clear conviction that, in the present situation, it is the preventive, socio-economic, and educational aspects of the healthcare systems that are most significant and most effective.
Fourthly, access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially disadvantaged sections of society.

Fifthly, in India, the present day most of the doctors are commercial physicians, motivated by profits. They are no more social physicians, but motivated by profits. They are not the ones who generally attract the people and guide them for healthier and happier life.

Sixthly, the multiple systems of healthcare services in India - allopathy, ayurveda, homoeopathy, unani, siddha; various types of ownership patterns - public (central and state governments, municipal and panchayat local government), private (for-profit and not for profit); and different kinds of delivery structures - teaching hospitals, secondary level hospitals, first level referral hospitals (Community Health Centre’s CHCs or rural hospitals), dispensaries, Primary Health Centers PHCs, Sub-Centers SCs, health posts, occupational groups such as, Employee State Insurance Scheme ESIS, defense, Central Government Health Scheme CGHS, posts and telegraphs, railways, and mines; have resulted a complex plurality that makes the development of an organized system difficult.

Seventhly, inappropriate policies, poor governance structure and inadequate financial arrangement in the supply side and high incidence of poverty, ignorance and traditional practices and cultural factors operating at the demand side influence the health outcomes of India.

Eighthly, as per the United Nations Development Program’s (UNDP), Human development Reports, the value of the Human Development Index (HDI) - composite indicator based on
income, education and health - has increased consistently over the years. However, India’s relative global ranking on this index has remained at a low i.e. 134th among 182 countries (Human Development Report, 2011). This indicates that public health system has failed to provide services to the poor in terms of accessibility, equity and quality. Besides, over the past few years’ imposition of user charges have further reduced the use of public health facilities.

From the above analysis, one can interpret that the various health policies and programs have hardly benefited the poor people in India. Clearly, the government has failed in public health sector provisioning in meeting the requirements of people. Hence, there has been an increasing importance attached to the growth of the private health sector which is perceived to be more efficient.

However, one cannot deny that public health services produce “public goods” of incalculable benefit for facilitating economic growth and poverty reduction. It is true that a lot has been achieved in the past: The milestones in the history of public health that have had a telling effect on millions of lives – launch of Expanded Program of Immunization in 1974, Primary Health Care enunciated at Alma Ata in 1978, eradication of Smallpox in 1979, launch of polio eradication in 1988, Framework Convention on Tobacco Control FCTC ratification in 2004 and Cigarettes and Other Tobacco Products Act COTPA Act of 2005, National Rural Health Mission NRHM in 2005 to name a few. This is an evidence of past events in the health sector and a proof of the government efforts in the area of public health.

The future of a healthy India lies in mainstreaming the public health agenda in the framework of sustainable development. The ultimate goal of great nation would be one where the rural
and urban divide has reduced to a thin line, with adequate access to clean energy and safe water, where the best of healthcare is available to all, where the governance is responsive, transparent and corruption free. Also, where poverty and illiteracy have been eradicated and crimes against women and children are removed – a healthy nation that is one of the best places to live in.

However, the diminishing role of the government as provider of healthcare infrastructure is much beyond India’s commitment at General Agreement on Trade in Services (GATS). India has autonomously liberalized its health sector to a greater extent than required according to New Delhi based policy think tank Centre for Trade and Development (CENTAD), in 2007. Interestingly, The National Commission on Macro Economics and Health in its report in 2005 had also indicated this evolution of India’s health system. The Commission had pointed out that India’s health policy is shifting towards privatization of services.

To summarize,

With the overall swing to the right after the 1980s, it is broadly accepted that private provision of healthcare is inevitable to support the existing inadequate supply of public healthcare services. The private sector plays an important role in India’s healthcare system. In this context, it was thought that it is essential to study the private healthcare sector which is growing by leaps and bounds in recent times. Also, though state intervention in private health sector is crucial, the fact cannot be denied that in spite of increasing demands for healthcare; state expenditures on public health are not increasing due to resource crunch. As a result, there is an obvious unchecked growth of the private health facilities which is promoted by the state through various incentives to meet the unmet demand of the increasing population for healthcare. Through a wide network of healthcare facilities, this sector caters to the needs of
both urban and rural population and has expanded widely to meet the increasing demands and challenges (Bhat, 1999). The next section discusses the evolution and increasing role of private sector in India.

### 3.4 Private Healthcare Services

Privatization of welfare services in the industrialized countries had ramifications for the developing ones as well. In case of India and several other developing countries one finds that the growth of private hospitals took place during the late seventies and early eighties, which was linked to developments in the international as well as the national scene. The seventies was a period of recession in the industrialized world. India too, was hit by the recessionary trend and the investments in healthcare suffered the most as discussed in the previous section. During the late 70s and early 80s there were concerted efforts to encourage private investments in the health sector. Several concessions were offered by the government which further helped the expansion of the private sector. These policy shifts had an impact on the structure of the private sector in medical care.

The last four decades have seen the expansion of the private sector’s role in healthcare in India. A lot of public debate and research has focused on the private sector in the provisioning of medical care. Macroeconomic policies and Structural Adjustment Program influenced health sector reforms in a major way. The nature and the trend of health services in India experienced tremendous change due to liberalization and privatization policies. The crucial transition in the orientation of the healthcare has been from ‘service delivery mode’ to ‘profit making mode’ due to immense development in technology and decline of the public sector vis-a-vis growth and boom of the private sector (Patel, 2006). The commodification
of the health care has serious implications for people in India particularly in the context of increasing poverty levels and growing unemployment rates (Duggal, 1999).

3.4.1 The Need for Private Healthcare Services

Economic reforms towards liberalization began in the early eighties. There has been a decline in the number of public hospitals and dispensaries as well as public health expenditures since the 1980s (Duggal, et al, 1995). This trend is coincided with growing state support for private hospitals and privatization. In 1990s, a number of corporate hospitals sprung up on land allotted to them by the government in prime urban locations, in exchange for their providing a proportion of their services free to the poor (Baru, 2000). Due to inadequate public health facilities, the private healthcare sector grew by leaps and bounds in India. It is said, “The Indian health sector is among the most privatized in the world” points out K.N. Nagaraj of the Madras Institute of Development Studies (Sainath, 2000).

The 1990s also saw the privatization of public health institutions and specific involvement of private providers in public health system. In some places, privatization meant contracting the services of private bodies for non-medical essential services (like laundry, equipment maintenance, catering, and media campaigns) in government hospitals (Bhatia and Mills, 1997; Bennett and Murleedharan, 2000). In others, it led to contracting the services of private specialists and hospitals for first referral services (Purohit and Mohan, 1996). Private sector is becoming a major provider of services in almost all states in India. It is observed that 2/3 rd of doctors are from private healthcare and even from financial point of view, contribution of private sector is larger i.e. only 1/5th of public financing, the rest 4/5 of the share in health expenditure is contributed by private healthcare (Duggal, 2005).
The healthcare market in India, as elsewhere in the world, is based on a supply-induced demand and keeps growing geometrically, especially in the context of new technologies. For instance, the pharmaceutical companies today are creating demand for drugs and medicines through advertisements. This is exerting pressure on cost and prices which escalate tremendously. A study was done in Satara district of Maharashtra for drug supply and use. This study lends credence to increasing irrational drug prescription and use. The study also reveals that wastage of resources due to irrationality in 1993 was Rs. 4.76 per prescription per day in the private sector and Rs 2.08 in the public sector and this amounted to a whooping of 69% and 55%, respectively of expenditure on drug by patients (Phadke, et al, 1995). In spite of this wastage of resources and increasing out of pocket expenditure private services are observed and are needed to take care of the health needs of the teeming population in lieu of the declining public investment in this sector and rising demand for healthcare.

Besides, the above reasons the need for and the growth of the private sector in recent times is justified on the following grounds:

- **Competition among Private Providers will bring out Efficiency in Healthcare and Decrease the Welfare Loss**: If there is competition amongst the various healthcare players it will definitely help to provide maximum health benefits to the majority people at affordable prices.

- **Expanding Services to the Areas and the Groups where Public System is not able to Cover**: Private participation in healthcare will improve the accessibility to the underserved areas especially the rural segment.
- **Supporting Resources in the Healthcare Sector**: The public sector faces the resource crunch. In such a situation, private players in healthcare market will support the existing resources and also build up new ones especially by the big private corporate class.

- **Encourage Rich and Well-off People to Use Private Healthcare**: The rich people often use public health facilities for curative care. This deprives the poor people from using those services due to lack of sufficient facilities with public health sector. Increasing the efficiency of the private sector in the curative care will decrease the burden on the public sector. Thus the resources can then be directed for the use of poor and under privileged sections of the society.

- **New Public Management argues Decreasing Role of Government**: The introduction of new economic policies paves greater role for the private sector and reduces the role of the state from provider to the facilitator of services.

### 3.4.2 Structure of Private Healthcare Services in India

Healthcare in India is provided by public and private sectors. There are multiple systems of practice in India - allopathic, ayurvedic, homeopathy, unani etc. The private health sector consists of the not-for-profit and for-profit health sector. The not for profit health sector which is very small includes various health services provided by nongovernmental organizations, charitable institutions, missions, trusts etc. Healthcare in the for profit health sector is provided by various types of practitioners and institutions. These practitioners range from general practitioners to the super specialists, various types of consultants, nurses, licentiates, registered
/rural medical practitioners (RMPs) and a variety of unqualified persons. Then, there is an informal sector which consists of practitioners not having any formal qualifications like the quacks, hakims, vaidyas, tantriks who also provide healthcare (Duggal, 2004).

The institutions falling within the ambit of the private health sector are hospitals ranging from small nursing homes with fewer than five beds to large corporate hospitals and medical centers as well as medical colleges, training centers, dispensaries, clinics, polyclinics, physiotherapy and diagnostic centers, blood banks and the like. In addition, the private health sector includes the pharmaceutical and medical equipment industries that are predominantly multi-national.

In the private sector, some hospitals have been functioning from pre-independent times. These are mostly ‘mission’ hospitals run by charitable institutions under religious authority. Some hospitals, mostly small urban hospitals are under private proprietary ownership, often of doctors’ themselves. But, a recent phenomenon is the explosive growth of large, multi-specialty, urban hospitals in the corporate sector: here the money for investment is generated from the sale of equity shares of the hospitals in the share market. The investor expects a competitive rate of return for their money. Though these hospitals are for the most part confined to metropolitan cities their influence on policy is enormous because of their access to those in power. These hospitals pride themselves in bringing to India the ‘latest’ in medical technology, and partly because of the high investments and expectation of returns, the cost of care in such institutions is so prohibitively high as to make them irrelevant for the large majority of the population. Because of the ‘demonstration’ effect of such hospitals, even the ‘charitable’ hospitals are imitating them in their style of care, with the result that for the client there is hardly anything to distinguish but between the ‘charitable’ and the ‘profit making’
hospitals. Further, these problems are compounded by the fact that there is very little legislative and other control by the government over the hospital industry in India.

Hence, let us now turn our attention to understand the structure of hospital industry. In India on the basis of ownership / control hospitals can be divided into four categories:

1. **Public Hospitals**: These hospitals are run by the central or state governments or local bodies on non-commercial lines. These may be general hospitals or specialized hospitals or both.

2. **Voluntary Hospitals**: These hospitals are established and incorporated under the societies registration act 1860 or public trust act 1882 or any other appropriate act of central or state governments. They are run with public or private funds on a non-commercial basis.

3. **Private Nursing Homes / Hospitals**: These are generally owned by an individual doctor or a group of doctors. They run the hospital or nursing home on a commercial basis. They accept patient suffering from infirmity, advanced age, illness, injury, disability etc. But, do not admit patient suffering from communicable disease, alcoholism, drug addiction or mental illness.

4. **The Corporate Hospitals**: These experience rapid growth in recent times. These are built with huge investments and modern technology. They are normally run on commercial lines. They can be either general or specialized or both (Basavanthappa, 2003).

**3.4.3 Role of the Private Sector in Healthcare in India**

The role of private sector in healthcare in India is significant. The involvement of private sector is explored by a number of states in India to mitigate the problems of adequate
resources in curative and tertiary care. The role of private sector to augment the supply of necessary services in remote areas is also one of the policy initiatives being implemented in number of areas. At present though the government has vast infrastructure in healthcare in rural India in the form of primary healthcare centers, but the common man still to a large extent depends on the private sector (Bal, 2003). Private General Practice is the most commonly used healthcare service by patients in both rural and urban areas.

Studies by National Sample Survey Organization (NSSO) and National Council of Applied Economic Research (NCAER) provided the necessary evidence to show the overwhelming dominance of the private health sector in India. The developed countries government can have a say in controlling the expansion and nature of private healthcare as public financing is still a major source. But, in developing countries like India, government has limited role in terms of exercising control over private health care because of dwindling public financing in health sector. The involvement of the private sector is based on the argument that it helps to improve the efficiency of existing limited resources and also it ensures the availability of services, which is important to improve access to healthcare. The role of private sector in health is assumed to provide opportunities in strengthening the health systems since India has already a high presence of private providers. The private sector accounts for more than 80% of total healthcare spending in India. Private firms are now thought to provide about 60% of all outpatient care in India and as much as 40% of all inpatient care. The private sector has experienced significant presence in providing curative primary and high-tech secondary care (Emerging Market Report, 2007).

Also, in India, privatization of healthcare is taking all forms from divesture (hospitals are being handed over on outright purchase and/ or long term leases) to lease contracts (built,
operate and transfer), to contracting out of services (laundry, diet, diagnostic services, pharmaceutical supplies, private consulting facilities and others). It is also done through introduction of user fees (user charges for various services in dispensaries and hospitals) and by plain default through neglect of public provision (Duggal, 2004).

3.4.4 Role of the State in Promoting the Growth of the Private Healthcare

The private sector has grown and diversified over the last three decades and has emerged as an important practitioner in the provision of medical care in both rural and urban areas albeit the variations it presents across states. It is a heterogeneous entity offering service of variable sizes and patterns of ownership (Bhat 1993; Baru 1998). The private health sector in India, as indicated earlier, is very large, perhaps the largest in the world. The private sector in India has managed to permeate through primary, secondary and tertiary levels of health care, in the urban and rural areas, in all system of medicine. Private health services, especially the general practitioners are the single largest category of healthcare services utilized by the people. The private health sector, especially the allopathic constitutes a very strong lobby in India. The not-for- profit private sector (NGOs and charitable organizations) has made a significant contribution to public health programs such as family planning, HIV/AIDS, leprosy, blindness and mother child health program.

Privatization is not only limited to healthcare delivery but also penetrated the medical equipment and pharmaceutical industry, dominated by multi-national and national corporate companies. The private pharmaceutical industry (largely multi-national) is a very powerful lobby in India. The private sector is presently in the process of making another transition in its rapid growth. This is the increased participation of the organized corporate sector. New
medical technologies have opened new avenues of corporate investment that is going to bring about far reaching changes in the structure of healthcare delivery.

Besides, it is important to reemphasize the role of the state in contributing to the growth of the private health sector. Direct and indirect support to the private health sector by the state is the main form in which privatization takes place in India. Some instances highlighting this point are as under:

1. Medical education is overwhelmingly state financed and its major beneficiary is the doctor who sets up private practice after his/her training; three fourths of the medical college graduates from public medical schools work in the private sector. Though they are trained at public expense their contribution to society is negligible because they engage in healthcare as business activity.

2. The government has allowed the highly profitable private hospital sector to function as trusts which are exempted from taxes. Hence, they do not contribute to the state exchequer even when they charge patients exorbitantly.

3. The government provides concessions and subsidies to private medical professionals and hospitals to set up private practice hospitals. It provides incentives, tax holidays and subsidies to private pharmaceutical and medical equipment industry. It manufactures and supplies raw materials (bulk drugs) to private formulation units at subsidized rate/low cost. It allows exemptions and duties in importing medical equipment and drugs, especially the highly expensive drugs and new medical technologies.
4. The government has been contracting out its programs and health services selectively to NGOs in rural areas where its own services are ineffective. This will further discredit public health services and pave the way for further privatization.

5. The government has pioneered the introduction of modern healthcare services in remote areas by setting up PHCs. While the latter introduces the local population to modern healthcare it also provides the private sector an entry point to set in the remote rural areas as well.

6. Construction of public hospitals and health centers are generally contracted out to the private sector. The latter makes substantial money but a large part of the infrastructure created, especially in rural areas are inadequately provided. Hence, cannot meet the healthcare demands of the people.

7. Medical and pharmaceutical research is largely carried out in public institutions but the major beneficiary is the private sector. Development of drugs, medical and surgical techniques, etc. are pioneered in public institutions but commercialization, marketing and profit appropriation is left with the private sector. Many private practitioners are also given honorary positions in public hospitals which they use openly to promote their personal interests.

8. In recent years, the government health services have introduced selectively fee for services at its health facilities. This amounts to privatization of public services because now utilization of these services would depend on availability of purchasing power. Increasing private sources of income of public services would convert them into elitist institutions, as is evident
from the functioning of certain specialty departments of public hospitals. This automatically compels people to switch to private healthcare.

9. The government has allowed private health sector to proliferate uncontrolled. Neither the government nor the Medical Council of India (MCI) has any control over medical practice, its ethics, its rationality, its profiteering, etc.

Thus, due to the new policy regime after 1991 and the supportive policies of the state the private sector has been able to considerably flourish in India. With a view to encouraging investment in hospitals in non-metro areas, the benefit of sub-section (11B) of section 80-IB had been extended to hospitals located anywhere in India, other than defined “excluded area”. Sub-section (11B) of section 80-IB provides for a tax holiday for five consecutive assessment years, beginning from the initial assessment year, to an undertaking deriving profits from the business of operating and maintaining a hospital in a non-metro. In a move that would benefit the corporate hospital chains expanding in urban areas, the government has decided to extend its provision of tax relief to ‘new’ hospitals with over 100 beds in previously ‘excluded area’ which includes the urban agglomerations of Greater Mumbai, Delhi, Kolkata, Chennai, Hyderabad, Bangalore and Ahmedabad and the districts of Faridabad, Gurgaon, Ghaziabad, GautamBudh Nagar, Gandhinagar and Secunderabad. Tax benefit is now available to hospitals which are constructed and have started or would start functioning at any time during the period beginning the 1st day of April, 2008 and ending on the 31st day of March, 2013. Besides, the above in its attempt to promote private sector to cater to the healthcare needs of the burgeoning population base, the government took several measures to enhance investments in the private sector. Some of these decisions included-
• A paradigm shift at policy level resulted in market segmentation, whereby government resources were to be used only for the deserving section of the society (National Health Policy, 2002), while the affording population was expected to purchase medical care services from the private sector.

• As per industry experts over 50% medical devices and equipments are imported (National Institute of Pharmaceutical Education and Research NIPER, 2010). Most of the equipments have to be purchased in foreign exchange, in a medical equipment market which is highly fragmented. This puts a considerable strain on hospital resources (Bhat, 2006). Further with rapid technological advances, medical equipment technology tends to become obsolete. As noted earlier, in order to benefit the private sector, the government has consistently worked towards reducing import duty on medical equipment and technology. Recent budgets have reduced the customs duty of medical devices to a standard slab of 5%, with a Counter Vailing Duty (CVD) of 4 per cent, for all medical equipments and devices. On the other hand parts or accessories of equipments and essential devices such as assistive devices, rehabilitation aids, etc are completely exempted from CVD (Union Budget 2010-11).

• Similarly, to facilitate financial flexibility to healthcare institutions, the GOI increased the depreciation rates for essential equipments and consumables from 25% to 40%. This in turn allows considerable amount of tax savings while computing the tax returns for the hospitals and healthcare institutions (Jain, 2006).
• The government relaxed the procedures to attract Non-Resident Indian doctors from the United States and United Kingdom, to return to India, which further boosted the growth of the private sector (Baru, 1998).

• In 2000, 100% Foreign Direct Investment in the hospital sector was permitted by the Reserve Bank of India along with additional benefits for Private Equity funding to promote healthcare infrastructure in India (Express Healthcare, 2010). These policies and the booming healthcare market in India have resulted in an investment of US$ 379 million in 2007 which is about 6.8 percent of the total private equity (PE) investment of US$ 5.93 billion (International Labour Organization, 2009).

• The affordability for medical care increased with advent of several private sector healthcare insurance companies, post liberalization (Ahuja, 2004). The introduction of Third Party Administration, under the Insurance Regulatory and Development Authority IRDA Regulation, 2001, increased focus on managed care (National Commission for Macroeconomics and Health, 2005), which allowed cash-less service payments. Further, with the introduction of the Rastriya Swasthya Bima Yojana, in 2008, a government insurance scheme, for underprivileged and economically backward sections, the affordability of BPL population for quality medical care services also increased.

• Hospitals and Healthcare Institutions were conferred with Infrastructure Status in the Union Budget 2002-03, which made long term capital and loan cheaper for most of the private healthcare Institutions (Income Tax Act, 1961). Similarly the subsequent
Union Budget of 2003-04 conferred an Industry status to hospitals and provided for benefits to financial institutions providing long term capital for hospital projects

- Medical tourism was also given a thrust with the introduction of Medical Visa (M Visa) and Attendant Visa (MX Visa) mid 2005 (The Telegraph, 2005). A medical visa can be granted for a period of one year with as many as four multiple entries allowed. This promoted the growth of medical tourism which was estimated to have generated revenue of $ 600 million in 2006 with over 0.5 million international health travelers visiting India during the same year (Gautam, 2008). Estimates are suggestive a $100 billion industry by 2012, provided the Indian healthcare infrastructure is upgraded to accept the opportunity (Times of India, 2010).

In addition, various state governments designed special packages to promote private investment in the creation of healthcare infrastructure and medical colleges across the country. The benefits include land allocation on subsidized rates, partial or complete waiver on stamp duty, electricity duty, conversion duty, etc. Thus, to lend proof to this increasing utilization of the private healthcare services by the people we discuss below the private health expenditure trends in India.

3.4.5 Private Health Expenditure in India

**Pre-Reforms:** The table 3.2 shows a historical trend of public and private health expenditures in India since 1951 till the reforms period 1991. As one can observe from the data, private health expenditure as a percent of GDP has always been on a higher side as compared to the public health expenditure after independence and till the reforms era.
TABLE 3.2: GROWTH OF PRIVATE HEALTH EXPENDITURES IN INDIA IN COMPARISON TO PUBLIC HEALTH EXPENDITURES (1951-1991)

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</thead>
<tbody>
<tr>
<td>Health Expenditure as percent of GDP</td>
<td>Public</td>
<td>0.25</td>
<td>0.71</td>
<td>0.84</td>
<td>1.05</td>
<td>0.92</td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td>2.25</td>
<td>2.60</td>
<td>4.06</td>
<td>3.61</td>
<td>3.04</td>
</tr>
</tbody>
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Post-Reforms: In fact, World Bank led economic reforms (1991 onwards) have set in a trend where the private health sector has taken control of the health sector in India at the cost of the public health sector. Budgets since 1991 have set in a linear downward trend and this has drastically impacted the public health system. It has affected adversely the vast majority of the poor who are the main users of the public health system and have forced them to migrate to the private health sector which often pushes them into the vicious trap of indebtedness. At the other end of the spectrum, the private health market is booming and India is becoming a major international centre for what is disgustingly referred to as medical tourism. In recent times, the following broad private health expenditure trends can be observed. Private out-of-pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure. Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations.
from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.

Table 3.3: PRIVATE AND PUBLIC EXPENDITURES ON HEALTH IN INDIA

<table>
<thead>
<tr>
<th>Year</th>
<th>Private Expenditure (% of Out-of-Pocket Expenditure)</th>
<th>Public Expenditure (% of Total Health Expenditure)</th>
</tr>
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<tbody>
<tr>
<td>1995</td>
<td>91.4</td>
<td>28.6</td>
</tr>
<tr>
<td>1996</td>
<td>91.0</td>
<td>27.9</td>
</tr>
<tr>
<td>1997</td>
<td>92.0</td>
<td>27.8</td>
</tr>
<tr>
<td>1998</td>
<td>91.9</td>
<td>28.4</td>
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<tr>
<td>1999</td>
<td>91.3</td>
<td>29.4</td>
</tr>
<tr>
<td>2000</td>
<td>92.2</td>
<td>27.5</td>
</tr>
<tr>
<td>2001</td>
<td>92.5</td>
<td>27.1</td>
</tr>
<tr>
<td>2002</td>
<td>92.3</td>
<td>25.0</td>
</tr>
<tr>
<td>2003</td>
<td>91.8</td>
<td>25.7</td>
</tr>
<tr>
<td>2004</td>
<td>89.6</td>
<td>22.5</td>
</tr>
<tr>
<td>2005</td>
<td>87.9</td>
<td>23.0</td>
</tr>
<tr>
<td>2006</td>
<td>88.9</td>
<td>24.8</td>
</tr>
<tr>
<td>2007</td>
<td>87.7</td>
<td>25.8</td>
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<tr>
<td>2008</td>
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<tr>
<td>2009</td>
<td>86.4</td>
<td>30.3</td>
</tr>
<tr>
<td>2010</td>
<td>86.4</td>
<td>29.2</td>
</tr>
</tbody>
</table>

Source: World Health Organization, National Health Account Database.

Observations from the above table indicate the consistent trend of the private health expenditures been on a higher side as compared to the public health expenditures even after the economic reforms. This shows that how the public sector’s share in the health provision
has been gradually declining over the years and that of the private sector is increasing year after the other.

3.4.6 Review of Private Healthcare in India

The involvement of the private sector was recognized to augment the supply of health services in rural areas especially because the public sector health services were inadequate as well as facing the resource crunch. This gave a rationale for the greater role of the private sector. The National Health Policy, 1982 recognized the financial constraints of the government. Hence, the NHP encouraged the establishment of practice by private medical professional and government agencies in establishing curative centers.

In the words of Gro Harlem Brundtland, ‘stewardship’ is ultimately concerned with oversight of the entire system, avoiding myopia, tunnel vision and the turning of a blind eye to a system’s failings. Engaging the private sector has not been a part of such ‘oversight’. The initiatives have been sporadic, in response to perceived needs in national, local or program context, or as a reaction to the demands of pressure groups. The private policy has to set a framework for policy and an action plan to immediately improve the status of healthcare in India so as to promote national health goals which focuses on-

- Increase coverage area to include the needy
- Address needs of the poor
- Improve quality
- Promote accountability
- Reduce costs and
- Improve effectiveness.
3.4.7 Evaluation of the Private Healthcare Services in India

Realizing the importance of the role played by the private healthcare, there is an urgent need to evaluate the provision of private health care services on the following grounds-

- **Unmet Demand**: Private healthcare providers are able to provide felt needs and expressed demands to the majority of the population. They are able to fill the gap i.e. unmet demand for health services left by inefficient public healthcare delivery system in ambulatory care as well in in-patient care.

- **Sustainability**: It is evident that private healthcare providers are able to sustain because of their responsiveness to the health care needs of the population and on the willingness to pay of the community for better treatment and services.

- **Equity**: Penetration of the private healthcare providers in the underserved areas makes them a potential vehicle for delivering the targeted services to the poor and vulnerable groups who at times may not be able to access public services due to its inadequate provision in those areas.

- **Health Impact**: The overall health impact of private providers is a debatable topic. Currently, there is no empirical evidence to reach on any robust conclusion but the simple fact that they are the only available help to a large section of population at the time of crisis (ill-health) and as such accessibility and improved health through treatment makes argument in their favor.
Thus, the private sector services are extremely crucial in the Indian context to take care of the demand for health services from the population. In recent times, tremendous growth of the private health care sector has been observed, which goes unregulated, with lack of minimum standards and therefore needs to be studied. The next section of the chapter enlightens us on the plight of public and private healthcare in Mumbai: the city in which our research study is carried out. To begin with, let us discuss the profile of the high profile city: Mumbai.

3.5 Profile of the Mumbai City

Mumbai is one of India’s largest cities and an important commercial and industrial centre. It is primarily divided into 2 regions- city and suburbs. It is one of the most populated cities in the world. The business capital of India is home to more than 20.5 million people according to 2011 census. Like other metros of India, the population of Mumbai has also grown rapidly in last 10 years. According to 2001 Census, the population of Mumbai was only 11.9 million; so population of Mumbai has grown almost double in the last 10 years. Population explosion combined with pollution and competition, speedy and stressful life has caused serious health related problems for a large number of people in the city.

Despite everyday pronouncements of major breakthroughs and advances in medical and health technology, the basic health needs of a majority of the population in Mumbai are not yet met even in a rudimentary manner. Conventional health services, patterned along the Western lines, have proved inappropriate and far too expensive. Hospitals have become visible symbols of medical care, caring for those who come to it, not necessarily of those who are most affected or most needy.
The Bombay Municipal Corporation listed 907 private hospitals and nursing homes in Mumbai city alone (excluding Thane), on the basis of its registration data which is also an underestimate (Nandraj, etal, 1997). The private sector, as per CEHAT database, consists of 1,157 private hospitals/nursing homes in Mumbai city run by individuals, co-operatives, corporate bodies, companies, religious bodies, trusts and Non-Governmental Organizations.

The city, is therefore, dominated by the private hospitals. 75-80% of households prefer to use private sector treatment in Mumbai for minor and major illnesses (Gangolli, 2005). With a technology and skilled super specialists coupled with sound infrastructure and professional management, Mumbai is indeed ready to take on international competition. The cost of treatment in Mumbai hospitals is 1/10th of the cost in Europe and USA.

To support the growing needs of a growing population, Mumbai has world-class facilities in specialty hospitals and healthcare centers. These facilities are well spread out to all parts of the city for easy and fast access. The big corporate hospitals to name a few within the city are Wockhardt, Tata Memorial, Lilavati, Asian Heart Institute, etc. (Mumbai Hospital Report, 2010). This trend indicates that the health facilities for the rich who can afford are ample. But, they are grossly inadequate for the majority of the poor people who cannot afford these hi-tech corporate hospitals. For them the only source is the public hospitals. Therefore, let us have an insight into Mumbai’s public healthcare facilities provision.
3.6 Mumbai’s Healthcare Scenario

Mumbai has a vast supply of public and private healthcare services. The services range from the super-specialty, tertiary level care hospitals to the general practitioners. Employees’ State Insurance Scheme (ESIS) cater to employees in the organized sector. The various government organizations, such as ports, railways and defense, have their own healthcare services for their employees. For the general population, the Municipal Corporation of Greater Mumbai (MCGM) provides major facilities in the public sector along with the State Government of Maharashtra.

3.6.1 Municipal Corporation of Greater Mumbai (MCGM)

Municipal Corporation of Greater Mumbai (MCGM), the largest municipal corporation in India, is the major provider of public healthcare services in Mumbai. It is also known as Brihan Mumbai Municipal Corporation (BMC). The structure of public healthcare infrastructure in Mumbai can be discussed with the chart below.
As observed from the above figure 3.1, MCGM has a network of 5 specialty hospitals, 16 peripheral hospitals and 27 maternity hospitals across Mumbai. Apart from these there are 163 dispensaries and 168 health posts to provide outpatient care and promote public health services in the city and 23 post-partum centers. In addition, it has four medical colleges (KPMG analysis, 2006).The Public Health Department of the MCGM not only provides basic healthcare facilities but also manages other aspects related to preventive and social or community medicine. The Department is divided into zonal set-ups for administrative
purposes. There are six such zones, which cover 24 Wards of the city. Zone 1 covers wards A to E, Zone 2 wards F and G (north and south), Zone 3 wards H and K (east and west), Zone 4 ward P (north and south) and ward R(north, south and central), Zone 5 ward L and M (east and west) and Zone 6 covers N, S and T wards. The Deputy Municipal Commissioner handles each zone. Each Ward has a separate Ward Office and the Ward Medical Health Officer (MHO) heads the Public Health Department in that Ward. The Department carries out the following major activities:

- Registration of births and death and maintenance of statistics
- Regulation of places for disposal of dead
- Maternity and child welfare and family welfare services, school health services
- Control of communicable diseases
- Food sanitation and prevention of adulteration of food
- Control of trades likely to pose a health hazard
- Insect and pest control
- Impounding stray cattle, immunization and licensing of dogs
- Regulation of private nursing homes
- Medical relief through hospitals
- Issuance of international health certificates for travelling abroad
- Ambulance and hearse services and
- Treatment of contagious diseases.
Mumbai hasn't had a new public hospital in decades. The last hospital built by the BMC was in 1998- Siddharth Hospital, Goregaon. This was followed by an 8-bed expansion at Bhagwati Hospital, Borivali. Out of 39,200 beds, 11,000 beds belong to BMC and 6,700 beds belong to the state and central governments. Around 21,500 beds belong to private and trust hospitals (Mumbai Hospital Report, 2010). As noted earlier, Greater Mumbai the commercial capital of India is the largest city in the country having a population of 20.5 million (Census, 2011). The high density of population in the city has put tremendous pressure on hospitals and other health infrastructure amenities.

Apparently, the infrastructure at municipal hospitals has been stretched to its limits. Public health sector’s out-patient and inpatient care is inadequate or under-utilized because of inconvenient timings or location, long queues, language barriers and indifferent staff (which, in turn, is because of the over burden of work). Inadequate equipments, poorly maintained equipments, lack of manpower, delay of financial approvals from the bureaucracy, overcrowding and the sharp deterioration in the quality of their services have forced many patients to turn to private hospitals. Even for the subsidized public health care, the poor have to pay extra as bribes due to rampant corruption. The other expenditure is on the medicines, which the public hospitals do not provide, the reason often quoted as “not in stock”, although they are funded to provide medicines. Due to excessive patient load in these tertiary-care hospitals, peripheral hospitals have to refer cases that require specialized care to private hospitals.

But, only a fraction of the population can afford private healthcare. As much as 52.5% of the population in Mumbai lives in slums (Census, 2011). Half of this population comes under below poverty line (BPL) status, who cannot afford costly healthcare in private hospitals. In
spite the poor households in the city largely pay for healthcare in the private sector. Mumbai city’s public healthcare system does not meet more than 40% of hospitalization demand which means that 60% of the needs of the people are met by the private sector. Because when people rich or poor suffer from health problems cost becomes secondary proposition while cure and care becomes top priority. Hence, in Mumbai city not only the rich but also the middle class and poor people utilize private facilities for healthcare.

A close look at the epidemiological profile of the city indicates that the situation is bad.

Firstly, for data one has to rely on the records of the MCGM, which are insufficient, as they only cater to a small fraction of the population.

Secondly, no uniform data is available from the private health sector, as the private sector works independent of the public sector.

Thirdly, there is no proper system being followed with regard to the notification of communicable disease and the interaction has become almost non-existent or only at times of epidemics.

Fourthly, pathological laboratories, which can provide the actual data, are completely left out of this system.

Finally, the doctors who treat patients symptomatically do not keep proper records and hence, no reliable data can be collected.
3.6.2 Shrinking Status of Public Healthcare in Mumbai

Mumbai’s population is rising but its health facilities are shrinking. BMC the civic administrator of Mumbai has put in place a privatization initiative in various areas including municipal health facilities. Lokshahi Hakk Sanghathana, a democratic rights organization said in its report\(^2\), that ‘BMC has modernized and upgraded six health facilities in Mumbai through private participation. All future development and expansion of the municipal health network is fully dependent upon private participation’, the report said, indicating the in the absence of private funds, no expansion would take place.

According to this report, privatization of health facilities has been taking place in various ways-hospitals, services such as blood banks, dialysis centers and intensive e coronary care units (ICCU) have been handed over to NGOs or private entrepreneurs. Patients are being directed to buy medicines from commercial chemists. They are being asked to pay for laboratory investigations. State funding to build and to maintain existing public health facilities has drastically reduced in Mumbai. So people are left with no other alternative but to shift to private healthcare.

\(^2\)Creeping Privatization in Public hospitals in Mumbai- Private Profit, People’s Loss, 2010.
3.6.3 Growth of the Private Health Sector in Mumbai

The situation is very complex and multi-dimensional; on the one side is the pitiable situation of health of individuals and, on the other side, is the inadequate and insufficient role played by the state to provide healthcare for the needy. This obviously paves the way for the growth of the private health sector. This private health sector does take care of the large population’s health needs, both in terms of outpatient and inpatient treatment. However, it has its own cost burden attached with it.

Apart from this, there is a large segment operating in the private sector consisting of private practitioners, polyclinics and dispensaries. Recent years have also seen plush corporate hospitals mushrooming all over the suburbs to cater to the tertiary ailments of those living in the city. While with the common man, the problem in health continues to be one of tackling infectious and communicable diseases, the “packages” provided by these corporate hospitals cater to the tertiary healthcare diseases that are due to life-style changes.

However, in the contemporary times with changing lifestyles, demands for quality healthcare services are increasing. Though at higher costs, quality care is provided by the private sector. This is the general perception amongst people especially in urban areas who spend on the private sector treatment due to the kind of quality and services provided. Besides, in recent times, consumers have become increasingly aware of their rights vis-à-vis the healthcare system. The rising middle class population has increasingly been demanding better quality of healthcare. These trends have definitely assigned greater role of the private sector in healthcare service provision.
3.7 Summary

Thus, India’s large unregulated private for-profit market of ambulatory and inpatient care is largely ignored in public policy. It is not in the interest of the nation to ignore significance of the private sector that massively supplies and supports healthcare resources. Instead, the state should devise new innovative strategies to use these resources for building accelerated, technically optimal and financially viable healthcare delivery system to provide maximum benefits to the population. It is important that the government should not leave the private sector unregulated. It has to provide for mechanisms for the private sector like enforcing regulations for minimum standards, establishing accreditation, enforcing obligations for the poor, providing strategic incentives, developing partnerships, promoting dialogue, ensuring public information and disclosure for improving its overall functioning. The next chapter deals with the methodology adopted for conducting this research study.