CHAPTER 1

Health Policy and the Emergence of Private Health Care in Independent India.

CHAPTER ABSTRACT

The main focus of this chapter is to trace the growth and development of private health care in independent India. This chapter begins by emphasising the distinction between existence of a private health care sector and the process of *privatistion of health services*. Thereafter it identifies *three distinct phases* of the growth of private health care sector in newly independent India. The newly independent welfare state promised to ensure the overall well being of its population. But within the 'promises'and 'commitments'as reflected in the committee reports and policies, there was a silent confession of the weaknesses and inadequacies of the public health care infra-structure. This provided the platform for the private health care to emerge as an alternative to public health care services. (1) In the first phase, private health care emerged through the independent initiative of medical practitioners for establishing small private nursing homes and clinics, without the support of the government. (2) The second phase was that of Incremental Privatisation, which is largely a unplanned response to the failure of the public sector. The development of this phase has a relation with the policies of the welfare state, as there has been a fiscal cutting back on state intervention in the economy and privatising numerous state owned enterprises. (3) The third phase was that of Programmed Privatisation which originates from the implementation of pro-private government policies. This phase, however has a wider implication since it marked the Corporatization of health care services with direct state support. It is in the third phase that the Indian story gets linked to the story of global privatisation.

Introduction.

The discussion on the private health care sector or on the privatisation of health care services has engaged the attention of the policy makers in India for a long time. Yet, in discussing private health care a basic confusion continues to persist.

This is the confusion between "private health care sector" and "privatisation of health care services".

By Private Health Care sector one means the health sector that is privately managed and funded – including both 'for profit' and 'non-profit making' providers. *On the other hand*, **privatisation is a *process***, meaning the take-over of the public sector by private agencies. Actually, **PRIVATISATION** of health care sector in the Indian context combines several processes. On the one hand it includes the process of reducing the state expenditure especially on subsidies and transfer payments[1] and on the other it is removing the state controls, leading ultimately to the 'retreat of the state'. We shall see the process in action but now we must begin on a different note, how the Indian state began its journey as a welfare state.

The welfare state in India, created after Independence, promised to ensure the overall well being of the people in terms of their both physical and mental development. But at the same time, private interests and policies towards privatisation of health care services were accommodated within the model of welfare services. World wide wave of privatisation in every sector had direct linkages towards the influx of private capital in health care**.** India, being a welfare state also responded to this trend and the health policies formulated in the post-Independence era illustrated the existence of private provisioning of health care services. Interestingly, it has been observed that there is a general tendency to associate the 'privatisation phase' in the Indian scenario mostly from the 1980's onwards. Nonetheless in the name of "health sector reform", privatisation polices and planned privatisation programmes made their appearance in the government documents and reports in this period. This move towards planned privatisation was due to the global recession, specifically the oil shock of the late 1970's. As a result there was a direct threat on the fiscal constraints on government budget in both developed and developing countries. This period thus witnessed the reduction in public expenditure and greater role for market in providing health care.

But what is striking and important for our study is that in India, both incremental privatisation and planned privatisation programmes were present prior to this period.

[1] Money given by the government to its citizens. Examples include Social Security, unemployment compensation, welfare, and disability payments.

Within the 'promises' and 'commitments' of a newly independent welfare state, there were certain lacunae which provided the platform for the incremental private sector to flourish in an unplanned manner.

I would like to agree on the basis of Baru's[2]argument that 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. But on the other hand, private health care services in their institutionalised forms were present from post-Independence era or even in the colonial period. Their emergence should never be studied as a response to the failure of the public sector or as the implementation of programmed privatisation which originates from the pro-private government policies.[3]

Thus what has been put forwarded by Bennett, McPake and Mills[4] seems more pertinent in respect of our study. Although during the 1970's and early 1980's government policy had an almost exclusive focus on the directly provided, publicly - funded health care, in many instances private providers of one sort or another continued to operate under this policy of relatively benign neglect. Traditional healers and mission hospitals in Sub-Saharan Africa, small clinics operated by private practitioners in much of Asia and some parts of Africa, and the ubiquitous private-drug-sellers existed prior to the current international emphasis on privatisation. Particularly, in case of Kolkata, there was the rapid mushrooming of small nursing homes and private clinics (specially the maternity homes), which were the outcome of small independent, private initiative in the decades of 50's, 60's and 70's [Discussed in detail in Chapter 3 and Appendix III]. This effort of private initiatives in health sector was undoubtedly beyond the ambit of the government support or intervention. The conscious attempt to undertake or private-'ise' the health sector was indeed the effect of state's intervention. Thus in India, there are three distinct phases of the emergence of private health care sector :

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2 Baru, Rama V. *Private Health Care in India. Social Charecteristics and Trends*.New Delhi:Sage Publications,1998.P 40. (Hereafter cited as Baru : *Private Health care*)

3 Bennet, Sara,McPake, Barbara and Mills, Anne "The public/private mix debate in health care". In *Private Health Providers : In Developing Countries-Serving the Public Interest?,* Ed by Bennet, Sara,McPake Barbara and Mills, Anne. London and New Jersey: Zed Books, 1997.P 5

4 Ibid P 3

(1) The independent initiative of medical practitioners for establishing small private nursing homes and clinics, without the support of the government.

(2) The incremental privatisation[5] which is largely a unplanned response to the failure of the public sector. The development of this phase has a relation with the policies of the welfare state, as there has been a fiscal cutting back on state intervention in the economy and privatising numerous state owned enterprises. Mention should be made that this move towards private initiatives in health care had a link with the world recession of 1970's having and adverse impact on the financing of public services that resulted in the growth of markets in the welfare sector.

(3) Programmed privatisation[6] originates from the implementation of pro-private government policies. This phase, however has a wider implication since it marked the Corporatization of health care services with direct state's support. An important development during the 1980's was the influence of international bodies like the International Monetary Fund (IMF) and the World Bank in giving loans to developing countries under Structural Adjustment Programme for both the economy and social sectors. [7]

The aim of this chapter in Section A is to trace the history of state intervention in health care and to locate the existence of private interest in the health policies (promises and commitments) pursued by the government of a welfare state upto 1983. In the Section B, an attempt will be made to historicise the root of privatisation as a universal physical development around the globe and India with special emphasis on private health care sector (pre liberlisation era).

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5 Ibid P 5

6 Ibid P 5

7 Baru, Rama V. "Health Sector Reform : The Indian Experience". In *Health Care Reform Around the World*, Ed by Twaddle, Andrew C. Connecticut: Auburn House, 2002. P 268.(Hereafter cited as Baru : Health Sector Reform)

Section A:

Role of the State: A Historical Evolution.

Ancient Period:

Looking at the historical role played by the state from ancient times, it is worthy to plunge into the conditions prevailed in Ancient India. Archaeological examinations revealed that along with the well planned cities, proper drainage system and water supply facilities, the public health services in Mohenjodaro were superior to those of any other community of the ancient Orient. Medical knowledge in the Indus Valley Civilisation was mostly a combination of religeous, magical and empirical rites and procedure. Amulets were worn by the inhabitants to protect themselves from evil and hence from diseases.Health and sanitation of the entire city were a part of chief concerns of the town planning process.[8]

During the Buddha period, there were evidences to show that the state supported University of Taxila, provided medical education to the students. In the reign of Ashoka (270 B.C.), the state showed interest in the public works and the provision of medical care. Ashoka founded hospital all over his empire with medical attendance at state expense The state also undertook planting of medicinal herbs, trees and supply of potable water from wells along the highways. Ashoka also assisted in the establishment of medical centre in the neighbouring countries. Further evidence on the state's interest in medicine is available from the Chinese pilgrim Hsuian-Hsang who studied at the monastic University of Nalanda.[9]

Medieval Period:

Around 12th Century A.D. the Muslims brought their own physicians with them and thereby introduced a new system of medicine known as "Unani". Jeffrey has suggested that in this period, "successful practitioners were those who served

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8 Sigerist, Henry E. *A History of Medicine: Early Greek, Hindu, and Persian Medicine.* Vol 2 New York: OUP, 1961. P 141-142

9 Kosambi, DD. *An Introduction to the Study of Indian History*. Bombay: Popular Prakashan, (revised 2nd edition) 1975, Thapar, Romila. *A History of India: Volume1*.Penguin:1966,Thapar, Romila. Ashoka and the Decline of the Mauryas. Oxford: OUP, 1973.In Jesani A and Anantharam, S. *Private Sector and Privatization of the Health Care Services.* Bombay: FRCH, 1993.P 7. (Hereafter cited as Jesani and Anantharam: *Private Sector and Privatization.*)

successfully or because of some special healing actswere granted an area of land. These grants may have been supposed to fund specifically medical activities - a dispensary or a small medical activities - a dispensary or a small medical school or they may have been grants to the man and his heirs, even they ceased practicing medicine."[10] In Medieval South India both state and religious institutions often subsidised and supported medical care. Charitable endeavours from antiquity and medieval times certainly provided food and shelter, and sometimes ayurvedic treatment to the disabled and patients suffering from leprosy.[11]

Colonial Period:

In 1764, the East India Company established the Indian Medical Service. European doctors were brought to Company Personnel. However, these doctors were not found so useful for treating certain local diseases and thus, the British Personnel often sought help of local healers. Jeffrey mentions that between years 1814 and 1835,some processes of mutual involvement between local healers and European medicine took place. He says that in 1814 under the instruction of the court of Directors in London, some attempts were made to investigate the value of local medicines and medical text. He also mentions that the informal training scheme at Calcutta was established on much more substantial grounds in 1822, as a Native Medical Institute (N.M.I.), teaching indigenous and European Medicine.[12]

Apart from hegemonization, Mark Harrison mentions that the European's attitude towards Indian systems of medicine underwent a change after 1820. European medical men borrowed extensively from indegenous medicine. They made extensive use of indegenous medical knowledge, using local medicinal plants and consulting Indian medical texts and practitioners of Indian systems of medicine. But the dominance of the western medicine was enshrined in the institutions of colonial state with the abolition of Native Medical Institution in 1835.[13]

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10 Jeffrey, Roger. *Politics of Health in India*. California : University of California Press, 1988. P 46. (Hereafter cited as Jeffrey : *Politics of Health*)

11 Reddy, DVS. Medical relief in medieval South India. *Bulletin History Medicine* 9: 1941 385-400.

12 Jeffrey : *Politics of Health*. P 51

13 Pati, Biswamaoy and Harrison, Mark. Ed *Health Medicine and Empire Perspectives on Colonial Medicine*. New Delhi: OUP, 2001. P 37-87.

After 1857, according to Radhika Ramasubban the main factors which shaped colonial health policy in India were it concern for the troops and the European Civil Population. The genuine public health measures remained confined to the well planned cantonment areas housing British people. She also contends that as the era of sanitary reform was superseded by the professionalisation of medicine in England, the colonial government shifted the focus from the sanitary reforms to public health research in India.[14]

Jesani and Anatharam have correctly pointed out that, despite the lack of sufficient documentation in general and availability of all material written on this subject, it is clear from the above narration that during British period the overall organization of health care and public health measures by state largely remained confined to select group of people, namely the British army, the British Civilian Population and some indigenous elites. It was only in the later period of British rule, also the period of rising nationalist sentiments and movements, that some measures essentially half hearted and ad hoc were taken to extend state support to health care for the people at large.[15]

Indigenous medicine on the other hand declined due to three reasons, namely disunity of the indigenous practitioners, perceptions by the clients that indigenous treatment were less effective than western alternatives; and state's active actions deliberately introduced and pushed western medicine to the detriment of local medical practices.[16] It was marginalised, subjugated and pushed back to the periphery. The interaction between 'colonial' medicine and indegenous medical systems was limited by strong sense of superiority of western medical ideas. Indigenous medical system was not incorporated into colonial medicine. Western medicine assumed a position of clear authority over Indian medicine and Indian bodies. Its attitude was monopolistic not pluralistic. [17]

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14 Ramasubban, Radhika. *Public Health and Medical Research in India: Their Origins under the Impact of British Colonial Policy*. Stockholm : SAREC Report, 1982 In Jesani and Anantharam: *Private Sector and Privatization*. P 9

15 Jesani and Anantharam: *Private Sector and Privatization*. P 10

16 Ibid P 11-12

17 See Arnold, David, Colonizing the Body: *State Medicine and Epidemic Diseases in Nineteenth Century India*. Delhi: OUP, 1993.

It is clear that in the ancient and medieval periods of history, the involvement of state in health care provision was minimal and perhaps episodic and it took place in context of the state having direct function in the economy namely, extraction of surplus from the labouring masses. In this sense, political and economic functions of the state showed greater degree of fusion under the pre-capitalist order of all variations.[18]

The process of colonisation encompassed a great concern for health which also acted as an instrument of controlling the ruling masses.The European doctors who accompanied every naval despatch from Europe emerged as powerful interlocutors. They not only looked after the sick on the on board and land, but were also the first to report on the flora, fauna, resources and cultuiral practices of the new territory.They were surgeon, naturalist, in the true sense. The medical training which they had was different and made them feel superior while encountering other medical practices. Epistemologically, the sytem that he represented was not very similar to that of the East, and some of them did show respect to the latter.[19]

But this was gradually lost in the victorious march of the colonizer's army. Gradual assimilation or sysnthesis was not on their agenda. Absolute supramacy of the one and the total subjugation of the other charecterized the Victorian Imperialism for which the colonial medical men worked implementing colonial medicine.Preservation of European health in new and hostile lands was colonial medicine's first responsibility. Gradually the colonial doctors developed into cultural force. They began defining what they saw in the colonies in terms of their own training and perceptions. Their work included not only the understanding and possible conquest of new diseases, but also extension of western cultural values to the non western world. Imperialism both as an impulse and attitude required a set of skills and rules.[20]

During the 18th century colonial medicine was wrapped in legendary adventures and medical geography in some scientific sense. But in Victorian era, it graduated into an organised colonial effort. Though the name given to it was tropical medicine, there

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18 Jesani and Anantharam: *Private Sector and Privatization.* P 12.

19 See Dharampal. Ed. *Indian Science and Technology in the Eighteenth Century: Some Contemporary European Account*s.Delhi, Impex India, 1971, Kumar, Anil, *Medicine and the Raj: British Medical Policy in India 1835-1911*, New Delhi: Sage Publication, 1998, Kumar, Deepak. Ed. *Disease and Medicine in India :A Historical Overview.* New Delhi: Tulika Books, 2001.

20 Kumar, Anil. *Medicine and the Raj: British Medical Policy in India 1835-1911*. New Delhi: Sage Publication, 1998. P 10-11. (Hereafter cited as Kumar Anil : *Medicine and the Raj*)

was hardly anything tropical about it, apart from the fact that it operated in atropical environment. Most of the so called tropical diseases, which the tropical doctors dealt with were to be found in Europe as well. Europe had known for cholera, plague and small pox for centuries. What distinguished them in the tropical climate, was their intensity and ferocity. In the settlers colony, where the Europeans had found a permanent home, medical discourses took the language of practical public health and also professional advancement. Settlers colonies were the extension of the European culture itself. In other areas, both physical and cultural encounters took place in which the prevailing epistome and system had to be defeated and subordinated. The prevalent Indian medical practices, therefore received more opprobrium than it deserved. Condemnation was easier but finding the cause of and a solution to the prevalent diseases was something different and difficult. Hence the blame was put on climate, heat and humidity became the major obsessions of the tropical 'miasmatic' medicine and miasma held its sway till pasteur arrived.[21]

Yet the fact remains that whether, it were the early mismatic theories of the 18th century or the tropical medicine of the 19th century, both were determined and influenced by the colonial conditions and imperatives ; hence the use and relevance of the term 'colonial medicine'[22]

According to Indian Medical Gazette,various types of hospitals came into existence by the mid 19th century which can be placed under four broad catagories. First and foremost of these were the 'military hospitals' meant for the treatment and rehabilitation of the soldiers and sailors of the Company. The second category comprised all such hospitals either at the metropolis or the district headquarters which exclusively attended on European civilians. The third category comprised the general hospitals meant for all including natives. In the fourth and last category came the charitable hospitals and dispensaries which were mostly the outcome of native effortsand were maintained by public subscriptions. However, few of the prominent charitable hospitals received government aid as well.The first three cataegories of hospitals were mainly financed and maintained by the government.[23]

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21 Ibid P 11

22 Ibid P 11

23 D.M. Muir. 'Notes on the Origin of the Presidency General Hospital Calcutta', Indian Medical Gazzette, vol 38, no 1, 1903. P 3 In Kumar Anil : Emergence of Western Medical Institutions in

DG Crawford has mentioned that besides this system of graded hospitals, the British set up temporary lunatic asylums wherever the Europeans resided in sizable numbers. It offered a good business to few of the surgeons, as initially such mental asylums were put to private management. Some of these asylums were later on taken over by the government, and by the 1850's, few of them were operating in almost every province of British India

To meet the requirements of chronic and contagious diseases like leprosy, tuberculosis and different kinds of fever, another sets of hospitals came up from time to time in the form of leper asylums, TB sanatoriums and fever hospitals respectively. Temporary hospitals came up to mitigate the epidemic diseases like small pox, malaria and plague. These hospitals were abolished once the diseases subsided. In the endemic areas, they were granted a longer existence.[24]

Induction of Western Medicine in India has been one of the components of domination by western civilization. The two features of this process were : First, the military formed the conduit for induction. Second, western medicine was imposed on a pre-existing system of indigenous health practices which different strata of the society had developed over the millennia. It was almost "automatic that those who played an important role in perpetuating the unjust colonial rule enjoyed the advantage of having access to Western medical services. Reciprocally the exploited masses were kept out.[25]

The rapid growth of the colonial organization for the governance of the country led to the formation of a cadre of medical personal called Indian Medical Service (IMS). The IMS had played a key role in the making of the health services in the Indian region. In the course of their service in the IMS, the Indian Officers were properly socialized and sanitized so that they became the Brown Englishman. Commenting on this aspect in relation to the medical education in 1929, B.C. Roy made some

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India, 1822-1911. In History *of Medicine in India: The Medical Encounter* Ed by Palit, Chittyabrata, Dutta, Achintya. Delhi:, Kalpaaz Publication, 2005. P 166. (Hereafter cited as Kumar Anil: Emergence of Western Medical Institution)

[24] DG Crawford. ' Notes on the Early Hospitals of Calcutta' Indian Medical Gazette', Vol 38, No 1 1903, P 6-8. In Kumar Anil: Emergence of Western Medical Institution. P 166-167.

[25] Bannerji, Debabar. "Landmarks in the Development of Health services in India. Published". In *Public Health and Poverty of Reforms* Ed by Quadeer Imrana, Sen Kasturi,. Nayar K.R. New Delhi: Sage Publications, 2001 P 41. (Here after cited as Banerji : Landmarks in the Development of Health Services.)

pertinent observations on the overwhelming dominance of the IMS in the health services. These observations reflect the understandable frustation and anger among those Indian physicians who had acquired high qualifications but were denied access to a large number of posts in the government simply because they did not join the IMS.[26]

However, this should not obscure some very positive outcomes. The establishment of three medical colleges in Calcutta, Bombay and Madras in 1835 was an important landmark in the history of health services in the country. These medical colleges followed the guidelines laid down by the General Council of Great Britain. Perhaps no other country outside the Western World could match India in this regard. [27]

But mention should also be made in brief that the deep interest of the colonial rulers in developing health services for their employees can be understood from the scraps of the epidemiological data that have been culled out of the archives. For instance, it is stated that in the mid nineteenth century as many as 69 out of every 1000 soldiers sent from Britain died of various diseases during the first year of their arrival.[28] This led to the setting up of cantonments and civil lines exclusively for the rulers and their army, where sanitary practices like protected water supply,and proper disposal of wastes were adopted.Spectacular discoveries in the West in the medical sciences, leading to the development of chemo therapeutic drugs and vaccines provided the motive force for the development health services for the ruling classes.The outbreak of the massive epidemic of plague towards the end of the century reinforced this trend.[29]

It is perhaps important to mention that the emergence of an organised public health system,in fact dates back to the appointment in 1859 of a special Royal Commission to inquire into the cause of the poor physical conditions of the sepoys in the British Indian army.[30]

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26 Ibid P 41

27 Ibid P 41

28 Ramasubban Radhika. *Public Health and Medical Research in India: Their Origins under the Impact of British Colonial Policy*. Stockholm : SAREC Report, 1982. In Banerji : Landmarks in the Development of Health Services P 42

29 Banerji : Landmarks in the Development of Health Services P 42

30 Rao, K.N. "Public Health and Health Services", Encyclopaedia of Social Work, vol I. New Delhi: Publication Division. P 364.

Bannerji in another article pointed out that these conditions typified the health problems of the Indian people at large. However the large scale extension of the medical services to the rural areas occurred only during the periods of massive epidemics of diseases such as plague, cholera and small pox. Public health services in the form of sanitation and public works were limited to the larger town and cities. Only a small elite segment of the Indian population had access to western medical facilities : the rest of the population relied upon the indigenous practitioners or what little medical care they could get from the few government dispensaries, private practitioners, missionary and philanthropic institutions.[31] The exploitative nature of the imperialists only served to impoverish the masses.

Thus the state of health of the " subalterns" and their access to health services was materially different from that of the rulers. The colonial exploitation in the form of ruthless extortion of revenues added substantially to their already miserable conditions. This made them much more vulnerable to diseases of various kinds. At the very time when the disease load became heavier, these "forgotten people" were also fast losing access to the various mechanisms for coping with the problems which they had developed over the centuries.This was so because the elite of the society, who had earlier been enriching the indigenous systems of medicine, had now transferred their loyalty to the Western system.[32]

The Report of the Health Survey and Planning Committee[33] (Bhore Committee) gave the portrayal of the miserable health conditions of the country on the eve Independence.

General Death Rate:	22.4 (per 1000 population)
Infant mortality Rate:	162 (per 1000 live births) Maternal
Mortality Rate:	20 (per 1000 live births)
Expectation of Life at Birth:	26.45 yrs (females)
	26. 91 yrs (Males)

31 Banerji, D. "Social and Cultural Foundations of Health Services Systems." *Economic and Political Weekly*, Vol IX, No 32-34, August, 1974, P 1333. (Hereafter cited as Banerji : Social and Cultural Foundations of Health Services Systems)

32 Banerji : Landmarks in the Development of Health Services. P 42

33 Government of India. *Health Survey and Development Committee (Bhore Committee)* Report Volume 1-4 (New Delhi : Manager of Publications, 1946)

Death Rate of Children Under 10 yrs.	48%
Disease-wise causee of deaths:	
Cholera:	2.4%
Small-Pox:	1.1%
Plague:	0.5%
Fevers (Including Malaria):	58.4%
Dysentery:	4.2%
Respiratory Diseases:	7.6%
Others:	25.8%

Total:	100.0%

* All figures are for British India in 1944 & do not include the Princely States.

On the eve of Independence, medical services were scattered and highly inadequate, not only in number but in the kind of medical services they delivered[34].During this time British India (population 300 million) had 17,654 medical graduates, 29,870 licentiates,7000 nurses, 750 health visitors 5000 midwives,75 pharmacists and about 1000 dentists.[35]

Some of India's most eminent medical professionals such as Dr A.R Ansari, Dr Khan Saheb, Hakim Ajmal Khan, Dr Jeevraj Meheta, and Dr N.M Jaissurya, occupied leadership position in the national struggle. Inspired by the welfare state movements in the United Kingdom and the socialized health services in the soviet union, they demanded a more egaliterian health sevice system and made this demand an important plank in the anti colonial struggle. Dr B.C.Roy at the All India Medical Conference at Lahore in 1929 presented many important facets of health services during the movement. [36]

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34 Banerji : Landmarks in the Development of Health Services. P 42

35 Government of India, Health Survey and Development Committee (Bhore Committee) Report Volume 1, (New Delhi : Manager of Publications, 1946)

36 Roy, B.C : The Future of Medical Profession in India. Reprint of the Presidential Address delivered at the All India Medical Conference at Lahore in 1929. *Journal of Indian Medical Association*, 78 (1and 2) 1982: P 24-30.In Banerji : Landmarks in the development of health services. P 43.

Welfare State and Health Care in India : Global Linkages.

Along with the influence of the welfare state movement in U.K and the socialist development in USSR, the recommendations of the Beveridge Committee Report emphasizing state provision on the welfare services were also insrumental behind the formulation of plans and policies on health and health care issues in post Independence India.In the international context Beveridge Plan indicates that the charge of health should be taken up by the State.

The famous Beveridge Plan was elaborated in the year 1942.This plan served the model for the organization of health after the Second World War in England and in many other countries.The date of this Plan has a symbolic value.In 1942 – at the height of the World War in which 40,000,000 people lost their lives- it was not the right to life that was adopted as a principle, but a different and more substantial and complex right: the right to health. At a time when the War was causing large scale destruction, society assumed the explicit task of ensuring its members not only life, but also a healthy life.[37]

The Beveridge Plan signals that the State was taking charge of health.It might be argued that this was not new, since from 18th century onwards it has been one of the functions of the State, not a fundamental one but one of vital importance, to guarantee the physical health of its citizens Nonetheless, untill middle of the 20th century, for the State guaranteeing health meant essentially the preservarion of national physical strenght, the work force and its capacity of production, and military force. Until then the goals of State medicine had been, principally, if not racial, then at least nationalist. With the Beveridge plan, health was transformed into an object of State concern, not for the benefit of the State, but for the benefit of individuals. Man's right to maintain his body in good health became an object of State action. As a consequnce, the terms of the problem were reversed : the concept of the healthy individual in the service of the State was replaced by that of the State in the service of the healthy individual.[38]

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37 Foucault, Michael. 'The Crisis of Medicine or the Crisis of Antimedicine?' English Translation c *Foucault Studies*: 2004 No 1 P 5-19'Translated by Edgar C. Knowlton,Jr, William J. Kingand Clare O'Farrell.(Hereafter cited as Foucault :The Crisis of Medicine) P 5

38 Ibid P 6

It is not only a question of a reversal of right, but also what might be called amorality of the body. The concept of cleanliness, of hygiene, occupied a central place in all these moral exhortions concerning health. Cleanliness ensured good health for the individual and those surrounding him. In the second half of the 20th another concept arose. It was no longer a question of an obligation to practice cleanlines and hygiene in order to enjoy good health, but of the right to be sick as one wishes and as is necessary. The right to stop work began to take shape and became more important than the former obligation to practise cleanliness that had charecterized the moral relation of individuals with their bodies.[39]

With the Beveridge Plan health entered the field of macroeconomics. From then on, health – or the absence of health – the totality of conditions which allowed the individuals to be insured, became an expense, which due to its size became one of the major items of the State budget, regardless of what system of financing was used. Health began to enter the calculations of the macro economy.Through the avenue of health, illness and the need to ensure the necessities of of health led to a certain economic redistribution. From the beginning of the present century one of the functions of budgetary policy in many countries has been ensuring a certain equalization of income, if not of property, through the tax system. Health, illness and the body began to have their social locations and at the same time, were converted into means of individual socialisation.[40]

Health became an object of intense political struggle. At the end of the Second World War and with the triumphant election of the Labour Party in England in 1945, there was no political party or political campaign, in any developed country, that did not address the the problem of health and the way in which the State would ensure the finance this type of expenditure. The British elections of 1945, as well as those relating to the pensions plans in the France in 1947, which saw the victory of the representatives of the General Confederation of Workers, [French labour-union federation that is most influential among white-collar civil servants and clerical workers. It was formed in 1948 after a split within the General Confederation of Labour (Confédération Générale du Travail, or CGT). In 1947 the socialist minority

[39] Ibid P 6
[40] Ibid P 7

withdrew from the CGT after communists had gained control of the federation's leadership apparatus. The socialists' departure was triggered by the CGT's communist-inspired policy of fomenting violent strikes that seemed intended to destabilize the new government of the Fourth Republic][41] mark the importance of the political struggle over health. [42]

Taking the Beveridge Plan as a point of symbolic reference, one can observe over the ten years from 1945- 1950 the formulations of a new series of rights, a new morality, a new economics a new politics of the body.Since then the body of the individuals has become one of the chief objects of which the State must take charge.[43]

In the new concept of welfare state, there could be no exploitation, for man would not live on man but would live with him and for him. It was the culmination of democratic ideal which had been preached by the national leaders so often and so for long. It was in its practical application that their ideology was vindicated and their choice for the governance of the state justified, that choice being confirmed four years later in general elections. Nowhere can this be seen to be more advantageous than in the realm of social welfare and more particularly in the region of medical relief and public health activities, initiated and purposefully promoted by the Government in the last nine years.[44]

Indian National Congress(INC) in 1930 set up the National Planning Committee (NPC). Subhash Chandra Bose, who was the president of INC nominated Jawaharlal Nehru as the chairman of NPC and a sub-committee was established under the the chairmanship of Col Santok Singh Sokhey to assess the health scenario and services of the country along with the measures for improvement.After the submission of the interim report by the Sokhey Committee in 1940, a resolution was adopted emphasizing the integration of curative and preventive functions in a single state agency and the responsibility of the state in the maintenance of health conditions. The recommendations of the Bhore Committee was also approved by the National Planning Committee.

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41 www.britannica.com. Accessed on 16.7. 2010.

42 Foucault :The crisis of Medicine P 7

43 Ibid P 7

44 Borker, G. *Health in Independent India*. New Delhi: Ministry of Health and Family Welfare. 1960 P 3.(Herafter cited as Borker: *Health in Independent India*)

Bhore Committee Report: Its Linkages with The Growth Of Private Health Care Sector.

The Health Survey and Development Committee (appointed in 1944 by the British authorities under the chairmanship of Sir Joseph Bhore) was deeply influenced by the aspirations of the national movement.[45] Infact several of its influential members had been in the forefront of the struggle for Independence. The impact of the committee was clearly seen in shaping of health services in independent India.The report, to this day, is regarded as an authoratative document, not only because of its distinguished authorship, but also because many of its proposal and recommendations continue to be pertinent and valid even today.[46] The committee set out a vision for the development of a nation wide health care system and also outlined a comprehensive act programme to realise this vision.This report has a powerful impact on the evolution of health policy in Independent India.[47] It was a plan that was almost equivalent to Britain's own National Health Service but having features closer to the Russian model.[48]

Impact of Colonial Rule over Health Care:

However after 1947, for the first time in India's long history, a democratic regime was established and the economy was channelised to a new concept of the foundation of a Welfare State.

Borker[49] in his Health in Independent India, wonderfully describes the episode of the transfer of power and the emergence of India as a welfare state, after gaining political freedom from the colonial masters.

According to Borker, the 'Little Man' had atlast come into his own. For one thing, he was the master in his own house, governed by people of his choice as his

45 Banerji: Landmarks in the Development of Health Services. P 43.
46 Ibid P 43.
47 Satia, et al.*Study of Health Care Financing in India*, Ahmedebad: IIM,1987, P 1.(Hereafter cited as Satia: *Study of Health Care Financing in India*)
48 Duggal, Ravi &N.H,.Antia "Health Financing in India: A Review and an Agenda"In *Paying for India's Health Care*. Ed by Berman, Peter and Khan, M.E,. New Delhi :Sage Publications, 1993.P 54.(Hereafter cited as Duggal and Antia : Health Financing in India)
49 Borker: *Health in Independent India*. P 3.

representatives and responsible to him. Politically, economically and socially he was well on the to complete emancipation. He had no longer to look to the 'Ma-Baap-Sarkar'(paternalistic government) for scraps but could demand, as a right, all that a free individual requires, not merely for existence, but to live as free men do. To effect this, just a change in Government was not enough, but a change of heart was badly needed if problems were to be viewed in their human perspective and results counted in human values.[50]

The entire political and economic system of India had been disturbed and the Department of Health could hardly escape unscathed. It was the aftermath of the war that created the first serious problem of the Government. Economy which had been geared to war production and distribution had to be channelled into a successful 'prosecution' of peace. War –time tightening of the belt had to allow for gradual loosening of consumption controls.In short, a transition had to be effected from a 'destructive' economy to a 'constructive' one, not an easy task for any Government and doubly difficult for a new one.[51]

A second problem was created by the political partition of the country with all the consequent chaotic conditions entailed in the mass migration of the entire communities from one geographical area to another. Yet the third problem that the new Government had to face was that of maintaining administrative efficiency in the face of a grave depletion in the ranks of trained administrators, the British element having elected to retire rather than serve the new Government and a large part of the Muslim element having opted for service in Pakistan for manning the newly formed Government there. Each of these problems by itself would have been serious menace to stability but the three together almost threatened to cripple an infant democracy.[52]

The impact of the new ideology of a 'Welfare State' was perhaps greater in the sphere of public health than in many of the other activities of Government.Under the previous regime, medical relief was nobody's right but a kindly Sarkar's gift. Mass health and hygiene programmes had no real place the social economy of the country. Only when epidemic threatened to annihilate entire communities, did the authorities

50 Ibid P 3
51 Ibid P 4
52 Ibid P 4

bestir themselves into hasty action.Programmed control measures were the exception rather than the rule.Medical relief was meagre as is shown by the per capita expenditure which varied from one to five annas in the larger province in 1930's.It had no doubt stepped up to the minimax of 2.5 annas and 13 2/3 annas by 1947, but that could hardly be termed adequate.[53]

In the period after Independence, in most of the ex colonial countries a native Western educated elite took over power from the colonialists. To retain power and further strenghten it, the native elites actively became dependent on the ex colonial powers and the latter enthusiastically responded by providing 'aid' of various measures and kind and used it as a weapon to retain their control over the political, economic and social life of these countries.[54]

The weakening of British imperialism directly accounts for the stepping up in the rate of economic growth after First World War. The exit of British imperialism from direct control of India in 1947 accelerated the process and pace of economic development. But soon it ran up against all those contradictions. These were bridged in part by 'aid' from abroad. To put it crudely, India's industrialisation has been sustained to a significant degree, on foreign credit. But foreign credit is not on condition, it has to be repaid with interest and cannot go mounting for ever.[55]

Apart from being aided by having to buy the most expensive commodities available on the world market, there are other important implications of foreign aid. The significant of all is that India has lost a considerable margin of autonomy vis-à-vis its creditors in the advanced capitalist economies- for foreign aid is used as an instrument of control.[56]

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53 Ibid P 5

54 Banerji, Debabar. 'Political Dimensions of Health and Health Services'. *Economic and Political Weekly*.Vol XIII, No 22, 3rd June 1978. P 926.(Hereafter cites Banerji: Political Dimensions of Health)

55 Davey, Brian. *The Economic Development of India: A Marxist Analysis.* Nottingham: Spokesman Books, 1975. P 142 (Herafter cited as Davey: *The Economic Development in India*)

56 President Kennedy put it baldly but truthfully:
'*Foeign aid is a method by which the United States maintains position of influence and control around the world and sustains a good many countries which would definitely collapse or pass into the Communist bloc.' (*Harvard Business Review article quoted in Harry Magdoff 'The Age of of Imperialism : The Economies of US Foreign Policy', Monthly Review, London 1969 P117. In Davey: *The Economic Development in India* P 144)

These newly independent countries thus not only followed broadly the old colonial pattern of health services which subserved mostly the small elite and urbanised classes, but due to rapid increase in dependence and commercialisation of the medical establishment within the ex colonial countries,these privileged class oriented and urban based health services started to absorb more and more of the national resources. They also developed strong overtones of dependence and commercialisation, rapid expansion of the market for the drug industry, both foreign and native, more specialisation and professionalisation and more and more of sophisticated medical institution.[57]

Against these backdrop of adversities, a newly independent country inherited the modern health services from the British which was limited in infra structure.It served the ruling classes and the native gentry comprising only a small portion of the population.

Health Care after Independence.

Formulating Policies, Reports and Recommendations: Promises and Commitments.

After Independence, the health services system of the country was shared by two political decissions of the new leadership. Following political commitments made during the struggle for Independence, provision of the plank of the Directive

According to Davey,it was precisely for this type of reason that the Indian Government had tried to attract private foreign capital in the first few years after Independence with little success. It was very wary of of accepting foreign official aid. Experience of American pressure in India to modify the nutral stand during the wheat loan negotiations of 1950, led the Planning Commission to the following conclusions when it came to formulating the first Five Year Plan.

The aid givers have influenced the Indian states policies in a number of important respects. Most importantly they have put pressure on the government to widen the sphere of operation for private capital in general and for foreign capital in particular.

Penetration by the imperialists whether in the form of investment, or in the form of technical colaborartion aggrement distorts Indian Economic Development in a number of ways. The record on drug prices is also a very bad one. Foreign subsidiaries control about one half of the private sector sales. An American Senate Committee found that prices in India for the broad spectrum antibiotics, aureomycin brelationship between per capita income and the level of drug prices. (Kidron Michael 'Excess Imports of Capital and Technology' in *Foreign Collaboration*, ed by RK Hazari, Bombay 1967, P 252. In Davey: *The Economic Development in India* P 148.)

[57] Banerji: Political Dimensions of Health. P 926.

Principles of the people- particularly to those living in rural areas-was made an important plank of the Directive Principles of the State Policy of the Constitution.[58]

The other political commitment, which turned out to be even more of overriding importance, was to bring about the the desired changes in the health service systems without making any basic changes in the then existing machinary of the government.[59]

Thus the people oriented health service and the high level of public participation, as reflected in the recommendations of the Bhore Committee were accepted by the national Government as the blueprint for the development of health and medical service in India.

Since the purpose of this study is to delineate the root of the emergence of private health care sector in India, therefore the surveys conducted by the Bhore Committee(since it was set up prior to independent) on the medical institutions of pre independent India bear immense significance in respect of this particular search.

The assessment of the sectoral employment of allopathic doctors in India during the forties revealed that 27% of the doctors were in government while the remaining 73% were in private practice.[60] The committee report also revealed that the 92 % of the institutions were maintained on public funds and the remaining 8% were wholly maintained by private agencies.[61]

Nevertheless the proportion of allopathic doctors in private practice was as high 73% and the remaining 27% were employed in government service.[62]

The Bhore Committee's standpoint regarding the role of the private practitioner and the private health care institutions were however confusing.The intrusion of private interests in health care, whether in the form of organisation, or in the form of individual practice was not entertained wholeheartedly in the recommendations.

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58 Basu D.D. Shorter Constitution of India. Calcutta S.C. Sarkar.Calcutta.P 230-235. In Banerji : Social and Cultural Foundations of Health Services Systems. P 1334.

59 Ibid P 1334.

60 Government of India. 1946.*Report on the Health Survey and Development Committee (Bhore Committee)* volume 1. (Hereafter cited as GOI 1946.)

61 Ibid P 13

62 Ibid P 42-43.

On the basis of the Committee report, Baru argued that when the recommendations of the Bhore Committee were adopted, there seemed to be reservations regarding private practice by doctors in government service but as far as the individual private practitioners were concerned, the committee assured them that their interests would not be affected.[63]

On this issue the Committee report mentioned that :

We consider that any apprehension that private practitioners will be seriously affected to their detriment by our proposals for a state health service is unfounded.[64]

Mention should be that the Bhore Committee had strongly recommended a ban on private practice by government doctors and the Second Five Year Plan also reinforced this need due to the negative impact of private practice on teaching and research in medical colleges. However, these recommendations proved to be difficult to implement because efforts at banning private practice were being short –lived due to the lobbying power of the doctors.[65]

Along with the other recommendations of the Bhore Committee emphasizing the need for a comprehensive health care system in India, it also provided some useful insights on the health care expenditure of the country.

What is important for our study is that if the ratio of health expenditure of US and Britain to their national income is taken, then about Rs 3 and 3 annas should have constituted the Indian State's health expenditure.Moreover the plan chalked out by the Bhore Committee required only half that investment, that is about Re 1 and 13 annas, to achieve a level of health infrastructure which would have been over five times more than what exists even today, requiring less than 15 % of total government expenditure.[66]

When the Bhore Committee set out to examine the state of the health sector in India it had only one estimate of private household expenditure. This was R.B. Lal's Singur

63 Baru: *Private Health Care in India*.P 49
64 GOI 1946.
65 Baru: *Private Health Care in India*. P 49.
66 Duggal and Antia : Health Financing in India P54

study which showed that in 1944 private household expenditure on health care was Rs. 2 1/2 per capita. In comparison the State health expenditure in the same year was only 36 paise per capita. This totalled upto 4% of the GDP with private health expenditure having a share of 87%.[67]

But the recomendations of the Bhore Committe remained unimplemented. The main reason for this and also for the poor performance of other social sectors was the role of the Bombay Plan in shaping India's economic policy. The Bombay Plan directed the nation's economic policy to serve the needs of the private capital by making the state invest in heavy industry and economic infrastructure under the cover that such participation by the state in economic production would evolve a socialist society. As a result the welfare sector (health, education, social security and so on) was ignored.[68] Moreover, in the health services sector, the government let the private practice of medicine flourish. For this the government significantly subsidized the growth of private medical practice by training medical personnel from tax payer funds.[69]

It is has been thus observed that the first policy formulated on the health and health care in a welfare state like India, acknowledged the substantial presence of private health care sector. It also skillfully provided the solid footing for the private individual practitioners to flourish.Though the Bhore Committee had championed the role of state in delivering health care it protected the intersests of the private practitioners by assuring that their practices will be always safegaurded.

Bombay Plan : Its Impact upon The Health Care Sector.

Parellel to the Indian National Congress which set up the National Planning Committee to look after the socio –economic issues of independent India, several other influential groups like the big business houses and Left Political Parties also brought about the detailed plan on the social and economic sectors of India.

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67 Duggal, Ravi :Tracing the root of Private Health Care Sector published. *Express HealthCare Management* (Issue dt 1st-15th April).In http://www.expresshealthcaremanagement.com Accessed on 28.12.2007 (hereafter cited as Duggal : *Private Health Care Sector*)

68 Duggal and Antia : Health Financing in India. P54-55.

69 Duggal, Ravi. 'Medical Education in India: Who Pays?' *Radical Journal of Health*, 3, 4, March. 1989

The authors of the Bombay Plan included the owners of big business houses like Puroshattam Thakurdas, JRD Tata, GD Birla, Ardeshir Dalal and Shri Ram.[70]

The Bombay Plan did not address itself specifically to the role of the private sector in welfare services but at amore general level it did visualise a role for the private sector in several spheres of the economy. The various options put forward by the authors included private finances taking over certain spheres of the economy or allowing both the private and public sectors to co-exist.[71]

The private sector got a state subsidized capital goods and services sector (steel, minerals, transportation, communication and later finance capital) from which to reap benefits.It is clear that the state investment has dominated in areas which help the growth of the private capital.[72] Moreover the government took the entire responsibility of public health – largely preventive and promotive programs – with curative services (the primary need of the population in terms of demand) taking a backseat.[73]

Thus along with Baru[74], the present researcher also likes to point out that the First Five Year Plan of the Government of India reflected the direct influence of the recommendations of Bombay Plan. According to Baru, the general approach of the authors of the Bombay Plan was not to abolish private interests but to in fact accommodate and in certain spheres even encourage them.[75]

On the issue of planned development vis-à-vis the private setor, the First Five Year Plan of the Government of India[76] states that :

> *The distinction between the public and the private sector is, it will be observed one of relative emphasis ; private enterprise should have public purpose and there is no such thing under present condition as a completely unregulated free enterprise. Private enterprise functions within the conditions created*

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70 Baru: *Private Health Care in India*. P 46
71 Ibid P 47.
72 Duggal and Antia : Health Financing in India. P 55
73 Ibid P 55
74 Baru: *Private Health Care in India*. P 47.
75 Ibid P 47
76 Government of India. 1957. *First Five Year Plan Document*. New Delhi.

> *largely by the state.Apart from the general protection that the state gives by way of maintenance of law and order and the preservation of sanctity of contracts, there are various devices by which private enterprise derives support from the government through general or special assistance by any tariffs, fiscal concessions and other direct assistance, the incidence of which is on the community at large.Infact, as the experience of recent years shown, major extension of private enterprise can be rarely undertaken except through the assistance of the state in one form or another.*

At the time of Independence the investment in health sector was at best marginal.Low level of spending in health care sector, especially on hospitals, dispensaries,health centres and pharmaceutical production, hardly brought about any qualitative change in the health of the population at large.

Between Independence and present day, the growth of the state health sector has not kept pace with the needs of its population. On the other hand, the private health sector has grown from strength to strength because there is a vast demand which must be met. The government has failed to meet this demand but the private sector has served it, whatever manner or quality.[77]

Between the beginning of the First Plan and 1986, the number of hospitals increased from 2,694 (117000 beds) to 7,764 (594,747 beds). However in terms of availability to the population, the improvement in the situation is only modest. Thus, in 1951, one hospital served 134,001 persons (3085 persons per bed) and in 1986, 99176 persons (1295 persons per bed)[78]

It also appears that compared to the growth of the private health sector; the growth of the state health sector was very low. For instance, in 1974, 16.0 percent of all hospitals were in private sector (16.2 beds) but, within a decade, in 1984 private hospitals had grown to 42.3 per cent of all hospitals (26.7 per cent beds), and by 1988, the proportion of private hospitals further increased to 56 percent and hospital beds to 30 percent.[79] This means that the availibility of the public health care services to the

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77 Duggal and Antia : Health Financing in India. P 56

78 Government of India. Central Bureau of Health Intelligence. (Respective years). In Duggal and Antia: Health Financing in India. P 56

79 Ibid P 56.

poor classes, who constitute more than three –fourths of the population, was becoming more and more expensive as they have to increasingly rely on market forces.[80]

Thus, this data makes clear that the government of a newly independent welfare state accomodated the interests of the private health care sector. By allocating poor funds in public health care sector, the state had indirectly encouraged the growth of private sector.It was the welfare state which deliberatly weakened the possibilities of the public health care infrastructure in India.The chief responsibility of the failure of the state –funded health care system lies on the pro-private policies of the government.

Mudaliar Committee.

As the progress towards the development of these centres at various level was gathering momentum, another committee under the chairmanship of Dr Mudalier was appointed in 1959 to review the progress of the development of health services.[81] This committee felt that the norms suggested by the Bhore Committee are very optimistic and it will not be possible to achieve them. It moderated the goals to be achieved in the health sector and set the goal of one bed per thousand population in the country by the Five Year Plan.[82]

As far as the Mudalier committees' position regarding the private health care sector is concerned, it has been observed that this committee encouraged the private practitioners to provide both curative and preventive services due to shortage of manpower in public sector. Further it has recommended that the government hospitals should allow the private practitioners on a part time or honourary basis and the hospital authorities should encourage them to admit their patient needing in-patient care.The committee identified that nearly 40-70% of doctors in different states were private practitioners and they will be considered as a separate entity and their legitimate interests must be protected.[83]

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80 Ibid P 56.
81 Satia: *Study of Health Care Financing in India*. P 3.
82 Ibid. P 3.
83 Government of India: *Report of the Health Survey and Planning Committee.1961.(Mudaliar Committee).*New Delhi.P 134-135.

Jungalwallah Committee Report (1967) and The Report of The Committee on Integration of Health Service.(1968).[84]

The Jungalwalla Committee Report in 1967 did not mention individual private practitioners but did observe that a large percentage of doctors in government services were practising privately.It stated that :

> no government medical officers should normally be allowed to private practice. Elimination of private practice is however, beset with problems, financial and administrative. Judicious and more reasonable procedures would be to eliminate private practice on a phased basis, beginning with teaching or reasearch post health officer, health centre doctor and supervisory posts at the state headquarters and district levels. Compensation for loss of private practice should however be reasonable.

However the private health care services had exhibited a steady growth from the mid seventies onwards and the mushroomoing of smaller nursing homes all over the country further complicated the relatioship between private and public health care sector.Comparing the growth of the public and private hospitals in India, it is easy to infer that the latter had multiplied at a faster pace. It can be seen from Table 1.1 that the number of government hospitals and beds in 1983 was 3932 (49%) and 348861(68%) respectively. But the percentage of hospitals and hospital beds reduced to 38% and 64% respectively in the year 1987. On the other hand the hospitals and hospital beds in the private sector increased substantially from 1983 to 1987 ranging from 2764 (37%) hospitals and 84,206 (16%) hospital beds to 4488 (47%) 104018 (18%) respectively.Other sectors voluntary and local also expanded over time.

Table 1.1: Distribution of hospitals and hospital beds according to ownership.

Ownership	**1983**				**1987**			
	Hospitals	%	Beds	%	Hospitals	%	Beds	%
Government	3632	49	348,861	68	3664	38	367,380	64
Local	433	6	25,894	5	516	5	27,682	5
Voluntary	569	8	53,513	11	935	10	74,498	13
Private	2764	37	84,206	16	4488	47	104,018	18
Total	7398	100	512,474	100	9603	100	573,578	100

Source: Directory of Hospitals in India, 1985 and 1988.[85]

[84] Baru: *Private Health Care in India.* P 50

[85] Central Bureau of Health Intelligence.*Directory of Hospitals in India. 1985 and 1988* Ministry of Health and Family Welfare. Government of India. New Delhi.

Studies have shown that a fairly large percentage of doctors employed in the public sector practise privately. They often use the government hospitals to treat their patients.[86] A majority of the doctors who practice privately, do so along with a government jobs. According to them a government job offers security, contacts, status and also helps in gaining good experience.[87] Since the data about all other states are not available, the limited information in Table 1.2 show that along with the sectoral employment in public sectors, substantial number of doctors are engaged in non government sectors and are also practicing privately.The case of practicing privately is alarming in the states of Goa Daman Diu, Gujarat and Haryana.

Table 1.2: Number of doctors affiliated to health care organizations in India as of December 31, 1987.

Doctors engaged under:						
States/Union Territories	**Government**		**Non-government**		**Practising Privately**	
	Number	**%**	**Number**	**%**	**Number**	**%**
Arunachal Pradesh	237	91.51	20	7.72	2	0.77
Assam	2660	77.76	168	4.91	593	17.33
Goa Daman Diu	535	41.44	6	0.46	750	58.09
Gujarat	2608	23.69	1944	17.66	6458	58.66
Haryana	1294	47.28	163	5.96	1280	46.77
Manipur	610	97.76	4	0.64	10	1.60
Mizoram	96	85.71	10	8.93	6	5.36

Source: Central Bureau of Health Intelligence, Health Information India, 1988.[88]

Report Of The Indian Council For Social Science Research/ Indian Council For Medical Research.[89]

The inter connectivity of the public and privare health care sector has been extensively argued by this committee.It has argiued that:

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86 Devi, Rama. *Practices of Doctors in some Government Hospitals in Hyderabad*. Unpublished MPhil Dissertation. University of Hyderabad. 1985. In Baru: *Private Health Care in India*. P 51.

87 Ibid P51.

88 Central Bureau of Health Intelligence. 1988, *Health Information India*. Mnistry of Health and Family Welfare. Government of India. New Delhi.

89 Indian Council for Social Science Research and Indian Council for Medical Research. 1981. '*Health for All: An Alternative Strategy'* Report of the study group set up jointly by ICSSR and ICMR.Pune: India Institute of Education. P 83-84.

Like our mixed economy, the health care services also are based on the principle of simultaneous operation of the private and public sectors. But it has not yet been possible to demarcate the roles of the private and public sectors and the system suffers from several evils that arise from overwhelming profit motive of the private sector, both medical and pharmaceautical.

Statement On National Health Policy.[90] : A Major Breakthrough.

After the implementation of the Sixth Five Year Plan, a demand was raised from all quarters, especially from the domain of the health personnel that the Government of India should formulate a National Health Policy (NHP).All the political parties were unanimous regarding the need for a NHP and the country –wide movement through meetings, seminars and debates were organised to influnce the government for formulating the policy on health care.Nevertheless, Indian Medical Association (IMA) also strongly voiced the need for NHP. Along with these attempts in the nationaal leve, the Alma Ata conference in 1978,proclaimed that every country should have a declared NHP.Finally the National Health Policy was formally adopted in the Parliament in December 1983.

The significance of National Health Policy is enormous in respect to the legitimisation of the private health care sector in India.This Health Policy Document for the first time mentioned the role of the private sector in delivering health care to the population at large.Government made an open reference of the private health care sector stating that,

> *With a view to reducing Governmental expenditure and fully utilizing untapped resources, the planned programmes may be devised, related to the local requirements and potentials to encourage the establishment of practice by private medical professional, increased investment by non–governmental agencies establishing curative centre and by offering organized, logistical, financial and technical support to voluntary agencies active in health field.*

[90] Government of India. 1982. *Statement on National Health Policy*. Ministry of Health and Family Welfare New Delhi.

The National Health Policy is a landmark in the evolution of health services in Independent India because a change in the position of the government emphasizing the need for the private health sector has been identified.

The government openly declared for the first time that the foundation stone of privatisation of health care was being laid as an integral part of the state policy.[91]

Meera Chatterjee[92] in her magnificent work analysed in detail the various aspects of the NHP 1982.The Policy Statemnt was the first of its kind although over the past 40 years, a series of committees has advised the Central Government on the country's health problem and their solution.The policy is broad in its approach to health needs and possibilities, and ambitious in its goals. Besides acknowledging many mistakes of the past and recalling for their redress, it embodies concepts of social justice and democratisation which have been eclipsed in the process of health development.[93]

As far as the question of private health care sector or the privatisation process is concerned, Chatterji argues that the Health Policy Statement makes frequent reference to the need to involve the private medical world (both individual practitioners and voluntary agencies) closely with the government health effort.However, the Policy does not specify how the government will co ordinate with the private sector.The goal of 'health for all' can be a 'collective responsibility' only if the actions of each partner are clearly defined and well- coordinated. [94]

The Policy Statement suggests that the services being rendered by these private voluntary health agencies should be adequatetly 'utilised' by the government in the provision of universal primary health care. In addition, the government is to encourage new voluntary efforts in the cause of health for rural and urban slum areas.It is envisioned that voluntary agencies' "service and support would require to be utilised and imtermeshed with the governmental efforts, in an integrated manner". Analogously, the services of private indegenous practirioners are also to be "integrated" in the overall health delivery system for " preventive, promotive and

91 Dr Paria, Biswanath. *An Appeal*. Medical Service Centre: Kolkata, 1985, P 9.
92 Chatterjee, Meera. *Implementing Health Policy*. Centre for Policy Research. New Delhi:Manohar, 1988.P1
93 Ibid P 1
94 Ibid P 12-13

public health objectives," but those of private allopathic practitioners have been excluded from this intention.[95]

The policy also mentioned that along with joining hands with the private health care sector for primary health care, the government, also wishes to increase investment by private agencies in curative medical centres, particularly "speciality" and "super-speciality" facilities, to ensure that they are adequately available within the country. Chatterjee rightly argues that the avowed intention here is to reduce government spending on these, so that more moneys become available for basic health services and existing government curative facilities are eventually used to treat the needy. To achieve this, it is proposed that the government offer logistic, financial and technical support to the private medical sector.[96]

Thus in a spirit of "privatisation", the government is devolving on the private sector some responsibilities. If the health sector is viewed as a conventional pyramidal structure, government services would be limited to the intermediate levels, while private agencies occupy the bottom of the pyramid. Their situation implies that both community–based voluntary agencies and sophisticated urban medical organisations will have 'interfaces' with the government health system.[97]

It is however important to mention that the NHP 1982 has been strongly criticised from several section for its pro–private drive. One of the senior physicians of Kolkata, thinks that perhaps the most sad part of the whole health policy statement lies in inviting private agencies to replace the Government efforts.According to his opinion, the government in no circumstances can abdicate its final resposibility of ensuring people's health, nor can it allow private profit seekers to flourish at the expense of people's welfare.[98]

Chatterjee has pointed out certain possibilities for justifying the government's pro-private approach towards the health care sector.[99] They are:

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95 Ibid P 125
96 Ibid P 126.
97 Ibid P 126-127.
98 Interview with Dr Gauripada Dutta at East Nursing Home Private Limited, on 24.07.2007
99 Chatterjee: *Implementing Health Policy.* P 129-131.

- In a most fundamental way, privatization signifies the government's desire to expand private enterprise in all spheres of health in order to increase people's access to health care. By the absorption of private agencies and personnel in state policy and programmes the 'joint' health sector may receive a fillip so that it becomes bigger, more varied and more effective.

- At this juncture "privatization" may be a part of a strategy for decentralization, necessary to achieve better results in health, just as in other development sectors such as agriculture and education. This may help to circumvent a major problem encountered in governmental efforts to decentralize.

- The desire of the government to privatize means to involve voluntary agencies in national health development to meet policy and planning objectives and targets. The decentralized and socially – committed nature of the voluntary sector and its superior ability to organize people compared with bureaucratic structures are given as reasons for privatization.

- It has been further argued that the privatization is strategy to co-opt the voluntary sector in order to quell shouts about bureaucratic inefficiency, corruption and so on, and to dilute threats to existing power structure. In this view, the provision of funds or technical assistance to voluntary agencies, to the placement of private sector leaders on governmental committees or giving consultancies to them, are considered tactics of diffusion

- Finally, privatization has been identified with the process of 'denationalization'. Although devolution may be gradual, the government may hope eventually to turn over the provision of health care entirely to the private sector. This aspiration may stem from the realization that, despite the immense resources the State has sunk into health services over the past 35 years, it still fails to reach the majority people. The corollary of denationalization is greater privatization of the state, which is increasing reservation of government health services for "the few".

Thus what is significant for this particular study is that India, being a welfare state had not only provided deliberate space for the private health care sector to flourish successfully, but at the same time it has given a official legitimization of this sector by mentioning its considerable role in health services. Government took proficient measures to establish the private health care sector in India as the remedy against the degenerating public health care condition, which was the result of their intentional act of shirking their basic responsibilities. Promotion of capitalist economy in every sector resulted in transforming health care from a service to a commodity and the state played deliberate but subtle steps in providing a solid platform to private health care to flourish.

From the above discussion it is thus clear that prior to the advent of the process of economic globalization in India, private health care sector not only occupied a considerable physical space, but it also made its appearance in the policy documents. So the conventional way of identifying the starting point of the emergence of private health care sector in India along with other developing countries with the publication of the *World Development Report 1993* subtitled *Investing in Health Care* is never fully accepted.

Section B:

Introduction.

In the previous section, an attempt was made to trace the history of state intervention in health care and Government attitude towards private health care sector as reflected in the plans and policies of the newly independent state was critically analyzed. This section intends to trace the history behind the emergence of the concept of privatization as a universal phenomenon in all spheres from the global perspective. It will also unfold the definition, nature, size and the scope of private health care sector of India in pre-liberalization era.

Privatization surfaced when private property made its appearance in the society. The social division of labor and private property divided society into classes and led to the appearance of state as a socio-political entity distinct from the society in general.

Thus, the first social process of "privatization" paved the way for the emergence of state power that regulates and reproduces the social structure of the society. Privatization in its earlier form transformed the communal sphere of economy into private property; the privatization of contemporary times seeks to transform and transfer the state –sphere – changing the public sphere of economy into the private sphere.[100]

Jessani and Anantharam have correctly pointed out that while discussing the issues of privatization, one should consider that it is intimately linked with the existence of state intervention in the economy as well as services.[101]

Privatization : Its Emergence.

For the last five decades, subject of privatization has attracted much scholarly attention. In the decades of 1960's and 1970's and even in early 1980's privatization as a process emerged as a reaction against the poor economic policies based on government intervention and public ownership.

Privatization is such a new word that it found no dictionary before 1980. The word 'privatize' first appeared in a dictionary in 1983 and was defined narrowly as 'to make private, especially to change (as a business or industry) from public to private control or ownership.[102]

However, the term 'Privatization' appeared for the first time in 1969 in Peter F Drucker's book 'Age of Discontinuity'.[103]

E.S Savas in his monumental work 'Privatization –The key to Better Government' defined privatization as the act of reducing the role of Government or increasing the role of the private sector in an activity or in the ownership of assets.[104]

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100 Jesani and Anantharam : *Private Sector and Privatisation*. P 4
101 Ibid P 5
102 Ramanujan, TCA. *Privatization: Lessons for India from International Experience*. Madras:Institute of Economic Education,1996. P 1.(Hereafter cited as Ramanujan: *Privatisation : Lessons for India*)
103 Ibid P 9
104 Ramanujan: *Privatisation : Lessons for India*. P1

According to Elliot Berg, Privatization in its broadest sense means making the economy more private, changing the private –public mix in several dimensions, and giving private sector a bigger role in deciding how production is to be organized.[105]

The massive decolonization of the post war decades created new, ethnically diverse, weak, fragile governments, (characterized by Gunnar Myrdal as 'Soft States') to intervene in state affairs.[106] But it has been observed that the need to improve the standard of living and the welfare measures, an attempt was initiated to abandon the poor economic policies based on government intervention and public ownership. In its place, emphasis was being led on market driven economies based on private ownership.

Alfred Shipke[107] has argued that the economic constraints in these newly independent countries forced the policy makers to search for new alternatives. Former socialist countries had experienced a bankrupt on its economic model based on public ownership. The developing countries had experienced the poor economic growth performance and high rates of inflation in the 1970's and 1980's. Industrialized countries on the other hand were faced with the sustainability of their generous and growing welfare states and the limits on taxation of their citizens since There have been huge subsidies for the rich. The frequent call for 'fiscal consolidation' in these countries has often been synonymous with a call for less government involvement and less public ownership.[108]

Following William L. Megginson and Jeffrey M. Netter[109], the present researcher also intends to understand the rise and the impact of the process of 'privatization' and its precursor 'nationalization' in different economies, from a historical perspective.

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105 Ibid P 1

106 Ibid P3

107 Shipke, Alfred: Why *do Governments Divest? The Microeconomics of Privatizations*. Printed in Germany. Springer 2001 P 2. (Hereafter cited as Shipke : *Why do Governments Divest*?)

108 World Bank (1997). In Shipke : *Why do Governments Divest* ?P 2.

109 Megginson, William L. and Netter, Jeffrey M.:From 'State to Market. A Survey of Empirical Studies on Privatization.' *Journal of Economic Literature.* Vol XXXLX(June 2001) pp 321-389 In *Privatization and Globalisation: The Changing role of the State in Business.* Ed by. Mudambi,Ram. UK. Edward Elgar Publications. 2003 P 338 (Hereafter cited as Megginson and Netter : *From State to Market*)

Throughout history, there has been a mixture of public and private ownership of the means of production and commerce. Robert Sobel[110] writes that the state ownership of the means of production including mills and metalworking was common in the ancient Near East while private ownership was more common in trading and money lending. In ancient Greece, the Government owned the land, forest and mines but contracted out the work to individuals and firms. In the Ch'in dynasty of China, the Government had monopolies on salt and iron. In the Roman Republic, the '*publicani*'(private individuals and companies) fulfilled virtually all the state's economic requirements.

Dennis Rondinelli and Max Iacono (Policies and Institutions for Managing Privatisation: International Training Centre, ILO, Turin Italy)[111] noted that by the time of the Industrial Revolution in the western industrialized societies and their colonies, the private sector was the most important producer of commercial goods and was important in providing public goods and services. This pattern with more government involvement in some countries and less in others, continued into the 20th century in Western Europe and its colonies and former colonies. In the United States, there was less government involvement than in many other countries. The Depression, World War II and the break –up of colonial empires pushed government into a more active role including ownership of production and provision of all types of goods and services in much of the world. It was much debated in Western Europe about the government's role in regulating national economy and controlling industrial sectors. Until Margaret Thatcher's Conservative government came to power in Great Britain in 1979, the Government should at least own the telecommunications and postal services, electric and gas utilities and most of the non-road transportation. Many politicians also believed that the state should control certain 'strategic' manufacturing industries. [112]

Rondinelli and Iacono[113] further argued that Government ownership grew in developing countries for slightly different reasons. It grew because:

- Government ownership was perceived as necessary to promote growth.

[110] Sobel, Robert : The Pursuit of Wealth. New York: Mc GrawHill, 1999. In Megginson and Netter : *From State to Market.*P 338
[111] Ibid P 338
[112] Ibid P 339
[113] Ibid P 339

- In the post –colonial countries of Asia, Africa and Latin America, Government sought rapid growth through heavy investment in physical facilities.

- Government ownership, often through nationalization was a historical resentment of the foreigners.

As a result, there has been a tremendous growth in the use of State Owned Enterprise throughout much of the world after World War II, which in turn led to privatization several decades later. However, there has been a tendency to associate modern privatization programme with Thatcher's government. But the Adenauer Government in the Federal Republic of Germany launched the first large –scale ideologically motivated "denationalization" program in the post war era. [114]

The perceived success of the British privatization program helped to persuade many other countries to begin divesting SOE's through public share offerings. Jacques Chirac's government, which came to power in France in 1986, privatized 22 companies. Several other European governments including those in Italy, Germany and most spectacularly Spain also launched privatization programe during 1990's.[115]

Two Asian countries are already the world's second and fifth largest economies on a purchasing power parity basis, and promise to become even more important over time. The People's Republic of China launched a major economic reform and liberalization programme in the late 1970's that has transformed the productivity of the Chinese economy. The other special Asian case is India, which adopted economic reform and economic liberalization program in 1991, after being wedded to state directed economic development for the first 44 years of its Independence.[116]

Indian Scenario: A Brief Narrative.

The preamble to the Constitution of India was itself amended to ensure a 'socialistic pattern of society'. Both ideology and practical considerations necessitated a major role for the state in the early years of the Independence.

[114] Ibid P 339
[115] Ibid P 340
[116] Ibid P 341

Capital markets were practically non-existent and private capital was shy enough to take up projects involving high costs and long gestation periods. There was a scarcity of trained work force to run modern complex and industrial organization. In the initial years, the public sector captured the 'commanding heights' of the economy. However, disillusion sets when it was found that despite the increase in size, the public sector failed to deliver results. Losing public sector enterprise became a drain on public exchequer. Instead of contributing to the state revenues, the public sector enterprises incurred huge losses over the subsequent years.[117]

The state undertakings incurred net loss at Rs 1,928 crores in 1990-91. Subsequently there were large-scale proposals for the closure or privatization of these Public Sector Undertakings. The Narasimha Rao Government accepted privatization as one of the policies to be pursued from 1990's onwards. The object has been to bridge the fiscal deficit and the government has chosen the path of "dis-investment". The shares of companies like BHEL, HMT, SAIL, NLC, STC, FACT, and ITI were offered in blocks in auctions.[118]

Moreover, the fiscal laws of the country did very little for the promotion and development of infra structure facilities. Probably the 17th World Development Report 1994 provided the insights that the government policies and finances have important roles to play in development infra structure because of its pervasive impact on economic development and human welfare. The Finance Act 1995 brought in concepts like BOT (Build –Operate-Transfer) and BOOT (Build –Own –Operate – Transfer) in the scheme of Income Tax Act.[119]

It is noteworthy that private airlines have been licensed to operate in India for the first time in competition with Indian Airlines.[120]

Thus, privatization was a part of a general process of reversing social welfare and reconcentrating income. Instead of transferring income from private corporations through public welfare programs to wage and salary workers, privatization involved

117 Ramanujan: *Privatisation : Lessons for India*. P 36.
118 Ibid P 38.
119 Ibid P 42
120 Ibid P 42

the transfer of publicly owned and tax payer financed enterprises to private corporations.[121]

The image of India as a nation of mass poverty is not unjustified. However, fulfillment of basic needs of the mass of its population is in a sense an odd standard for judging a capitalist economy's performance. The test of a successful capitalism is not whether it lays the foundation for the reproduction of capital on an ever-expanding scale. In this light, India's performance can either be judged in relation to its potential compared over different periods since 1947, contrasted internationally.[122]

India is a backward capitalist country having a number of economic and sociological features characteristic of the poorer third world countries. However, in terms of its fundamental economic structure and its dynamics of growth, it is much closer to the weaker of the advanced capitalist countries. In the forty years since Independence, its quantitative and qualitative achievements have been undoubtedly impressive. In 1950, consumer goods accounted for almost 75% of industrial output. By Second and Third Five Year Plan, (1956-60 and 1960 -65), the essential foundation of India's industrial structure were established.

By the early 70's, India, had achieved near total self-sufficiency in the standard modern capital goods required by domestic industry; though by the best international standards, the technology is outdated. India produced its own machine tools; chemical equipments transport equipments, professional and scientific equipments basic metals and alloys. It also own steel and power plants while developing its all important railway network.[123]

State capitalism is and will remain central to the whole economic structure. No other developing country has such an array of public controls over the private industrial

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121 Petras, James and Veltmeyer, Henry. *Globalization Unmasked: Imperialism in the 21st Century*. Delhi: Madhyam, 2001.P 94. For Privatization, also see Patnaik, Prabhat. *Whatever happened to Imperilism and other essays.* New Delhi: Tulika, 1995 and Trivedi, Prajapati 'What is India's Ptivatisation Policy?' *Economic and Political Weekly.* Vol XXVIII. No 22, 29th May. P M 71-76. For privatization debate see Jesani, A and Anantharam, S.*Private Sector and Privatisation in the Health Care Service.* Bombay: FRCH, 1993, P 75-79 and Saxena, AP. 'Privatization:Cure or Curse?' *Economic and Political Weekly.* Vol XXVII, No 21, 22nd May. P 1036.

122 Vanaik, Achin. *The Painful Transition : The Bourgeois Democracy in India*. London: Verso Books, 1990. P 30.(Hereafter cited as Vanaik: *Painful Transition*)

123 Bhargava, MR ' Indian Industrialization and The Key Role of the Capital Goods Sector' *Journal of Contemporary Asia*. Vol 15, No 3 1985. In Vanaik: *Painful Transition*. P 31

sector, control which have only began to be streamlined in the last decade. The growing criticism about the stifling of effect of these controls on the private sector and therefore on overall industrial growth is broadly correct. The Indian economy has reached a stage of capitalist maturity where private capital must take the lead; with the state seeking increasingly play a supportive role.

The private industrial sector has grown and diversified. In 1947, the 20 largest firms owned 25% of the total private corporate assets. Today they own 40%. Corporate investment is rising steadily as private firms tap more financial resources from capital market as well as credit institutions.

The capital markets – which accounted for 1% of domestic savings as recently as 1981, presently accounts for 5%. Though limited, this relative shift from government-controlled credit agencies does give the corporate sector more leverage vis-à-vis the state.[124]

State capital dwarfs private domestic capital, which in turn is far more important than foreign capital. Of the top 50 companies, only seven belonged to the indigenous private sector, of which only 2 make it to the top twenty and only one to the top ten. Slightly over 1000 public sector companies have almost four times as much paid up capital as that of over 170000 non-government companies. It is true that the Indian state has no alternative but to promote the indigenous industrial bourgeoisie. In the Seventh Plan, for the first time ever, the public sector refrained from setting up new projects in manufacturing. It is in this sense that the leading role has been handed over to the private sector which has also for the first time been invited to invest in domains like power and energy generation that were earlier monopolized by the public sector. Privatization of certain public sector companies is also a trend that is likely to gather force in the decade to come.[125]

Thatcherism in the West is a response to the failure of the Fordist model of accumulation of through mass production, mass consumption and mass employment. Thatcherism in India is the response to the failure of a larger and somewhat more

[124] Vanaik: *Painful Transition.* P 32
[125] Ibid P 44-45

generous Nehruvian vision of populist welfare and liberal democracy where both mass prosperity and popular power would systematically expand.

The essence of the Indian Thatcherism is that it legitimizes the promotion of more differentiated production and distribution of almost everything- from tangible consumable product to health, education and transport. It formalizes the growing unconcern in an increasingly hedonist middle class, and Americanized upper elite about 'other India'. More specifically, it reassures intellectuals that high agricultural growth will resolve the problem, that class collaboration rather than institutional reform is enough.[126]

The Thatcherite bandwagon in India thus carries a diverse range of passengers. They may not agree on what Indian Thatcherism consists of, but they agreed on more liberalization, more scope for private capital and more freedom for market forces.[127]

The Private Health Care Sector.

Concentrating on the emergence of private health care and the privatization of health care in India it can be said without any doubt that this particular sector mushroomed, much before the conventional trend of Privatization in other sectors had surfaced. As has been mentioned in the previous section the welfare state had skillfully acknowledged the presence of the private health care sector in its various policies and plans. The entire public healthcare infrastructure had shown signs of unsatisfactory performances and degeneration from the time of its inception. The welfare state had proficiently deprived this sector by allocating poor funds incommensurate with the population demand. On the other hand, due to these inadequacies the private health sector emerged as an obvious alternative to meet the health care need of the population at large. The politics of the government to destabilize the importance of the public healthcare sector from the post independent period was one of the significant causes behind the rapid emergence of the private health care sector.

At the outset, it is essential to mention that there is a glaring lacuna regarding the availability of authentic data on the private health care sector. Unavailability of

[126] Ibid P 55
[127] Ibid P 57

systematic data on this sector made the entire scenario ambiguous affecting its relation with the public sector and making it much more complex.

In a recent study conducted by the Foundation for Research in Community Health Care[128], it has been estimated that the private sector in India accounts for 61% to 86% of the total medical expenditure, 73% of allopathic doctors, 56% of hospitals and 30% hospital beds. In spite of a dominant share that the private sector occupies, hardly any studies have looked into the role and functioning of this sector.

Narrating the history of the emergence of private health care sector, both in respect of India and Kolkata is indeed a difficult job as there is dearth of systematic sources.

India Health Report has recorded that the data on private sector in total health infrastructure is both inadequate as well as unreliable, and this is an area demanding urgent attention of both the government and the research institutions. There is no reliable government data on the number of hospital beds, clinics, dispensaries, or practitioners in the private sector. [129]

In spite of these negativities in the government data, one has to depend upon the figures provided by the *Health Information of India* (Central Bureau of Health Intelligence), Central Statistical Organization, Planning Commission (Government of India) and the 42nd and 52nd Round of National Sample Survey, conducted during July 1986- June 1987 and July 1995-June 1996 respectively. Collected data from these sources is the only possible alternative to present the growth pattern of private health care sectors in India over the subsequent years. Along with these, it also provides useful insights to the inter-state growth rate of private hospitals, nursing homes and throws light on the utilization pattern of private health care in comparison with the public sector. Mention should also be made that the information provided by the Government is sometimes faulty, inconsistent and insufficient. Because though the welfare state is a silent supporter of the private health care sector but it cannot publicly bring out its accurate size and content, since it might challenge the poor growth rate of public health care infrastructure compared to the private. Thus, the

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128 Phadke, Anant: *Private Medical Sector in India*. Bombay: FRCH, 1994. P iii. (Hereafter cited as Phadke : *Private Medical Sector*)

129 Mishra, Chatterjee, Rao. Ed. *India Health Report.* New Delhi: Oxford University Press, 2003. P 103.(Hereafter cited as *India Health Report*)

State always tries to highlight the predominance of the public health care services as the significant health care provider.

For the last five decades, the government has systematically nurtured the private health sector. This unwritten policy of the government runs parallel to the neglect and gradual withdrawal of the state from the responsibility of people's health. Such a consistent support and encouragement to the private health sector are very important reasons for the failure to provide universal basic health care to all people of the country.[130] India after Independence followed the guiding principles adopted by the Bhore Committee in shaping the health care services of India. Among several people oriented recommendations of the Committee, what is interesting for our study is that if the ratio of health expenditure in UK and US is taken, then about Rs 3 and 3 annas should have constituted the India's state health expenditure. Surprisingly the plan chalked out by Bhore Committee required only half that investment that is about Rs 1 and 13 annas, to achieve a level of health infra structure which would have been over five times more than what would exists even today.[131]

Health Care Finances and Expenditure.

It is interesting to note that although the state has always played a central role in providing medical care in India, private interests were never curbed and as a result, they have grown over the years.[132] Influx of private capital in healthcare is not a new phenomenon in India. It has been estimated that there are three sources of private expenditure on health. The first is the private household's or private individual's consumption expenditure on health. The second include private practice and private institutional facilities for medical care. The third source is the expenditure incurred by private industrial groups and the voluntary groups (NGO'S). [133] The share of the private healthcare sector in India is between 4 and 5 per cent of the gross domestic product. This share at today's prices works out to between Rs 16,000 crores and Rs 20,000 crores per year. Compared to state expenditure on health the private household

130 Duggal : *Private Health Care Sector*
131 Duggal and Antia : Health Financing in India. P 54
132 Baru :*Private Health Care.* P 38
133 Health Status of the Indian People.P

expenditure is nearly four to five times more than that of the state.[134] The private sector is by far the largest sector & is responsible for three-quarters of all medical care whether rural or urban. Interestingly R.B. Lal's Singur Study which was the first known pre-Independence private healthcare expenditure study in 1944, revealed that private household expenditure was as high as Rs 2.5 per capita/year.[135] At least three quarters, if not more, of all doctors, whether allopathic or non-allopathic, are trained chiefly at government expense but they earn their living through private practice. As general practitioners, consultants, or running their own diagnostic clinics and nursing homes, they are mainly concerned with curative medicine and maximizing earnings. There are an increasing number of private hospitals in the larger cities, which offer expensive modern medical and surgical care. The lucrative nature of this sector is revealed by the extent of pressures exerted for admission to medical colleges and by the rush of corporate sectors in opening five star superspeciality medicare centres investing several hundred crores of rupees in each such centre. [136]

Table 1.3: Aggregate Expenditure on Health Care by Public and Private Sectors in India during 1984-85.[137]

Sector	**Rs. Million**	**Per cent**
Government Expenditure		
Central Government	6939.70	7.92
State Government	20167.20	22.72
Local Bodies	5815.90	6.55
Total Public Expenditure	329228.8	37.09
Private Expenditure		
Household	52912.40	59.62
Non-household	2915.70	3.29
Total Private Expenditure	55828.1	62.91
Aggregate Expenditure	88750.9	100

[134] Nandaraj, Sunil. 'Beyond the Law and the Lord, Quality of Private Health care.' *Economic and Political Weekly*. Vol XXIX, No 27, 2nd July, 1994.P 1680.
[135] Duggal and Antia : Health Financing in India. P 54
[136] N.H.Antia &R.Awasthi, '*Health for All: Concept versus Reality*'Paper presented at the Seminar on Health for All: Concept &Reality. Bombay : Foundation for Reasearch in Community Health. (November 15-16 1986) P 7-8.
[137] Satia: *Study of Health Care Financing in India*. P 3-17.

According to Table 1.3, it can be inferred that out of aggregate expenditure on health care only the Government is shouldering 37.09 % (including central state and local bodies) while 62.91 % is spent by the Private Sector. The state government and the private household sector, in general undertake the maximum cost of health sector spending in India.

It has also been estimated that in the states of Maharashtra and West Bengal, the total public expenditure is 38.64% and 28.42% respectively. While the total private expenditure goes to 61.36% and 71.58% respectively in the year 1984-85.[138]

Table 1.4: Expenditure on Health and Family Welfare. (in crore rupees)

Plan	Period	Amount	Total Plan Investment (All Development Heads)	Health (Centre and States)		Family Welfare		Control of Communicable Diseases	
				Outlay/Exp	% of Total Plan	Outlay/Exp	% of Total Plan	Outlay/Exp	% of Total Plan
First	51-56	Actual	1960	65.2	3.33	0.1	0.01	23.1	16.5
Second	56-61	Actual	4672	140.8	3.01	5	0.11	64	28.4
Third	61-66	Actual	8576.5	225.9	2.63	24.9	0.29	69	27.7
Annual	66-69	Actual	6625.4	140.2	2.12	70.4	1.06	23.1	10.2
Fourth	69-74	Actual	15778.8	335.5	2.13	278	1.76	127	11.1
Fifth	74-79	Actual	39426.2	760.8	1.93	491.8	1.25	268.12	11.5
79-80		Actual	12176.5	223.1	1.83	118.5	0.97		
Sixth	80-85	Outlay	97500	1821	1.87	1010	1.04	524	27

Source: Government of India, Planning Commission (1997). Ninth Five-Year Plan, 1997-2002. Vol II.

According to the above table, it can be inferred that the total outlay on the health and family welfare sector has increased significantly over the successive plans. However marked differences are revealed as far as the trend in the distribution of resources in two sub-sectors are concerned. The share of expenditure on health sector in the subsequent plan periods has declined consistently. However, the rise in allocations to the family welfare sector in the Five Years Plans has been at the expense of the public health sector. The percentage share of family planning in the total health and family planning outlay has risen substantially from a negligible amount in the First Five Year Plan to Sixth Five Year Plan Period.

[138] Ibid P 3-19.

It is thus clear that the poor allocation of funds in the health sector on behalf of the state is one of the major reasons for the gradual degeneration of the public health care. The lack of expansion of the public health care infrastructure and its unsatisfactory performances pushed it to the only choice for the economically challenged section of the society. On the other hand the private health care sector flourished, taking advantage of the weakness of this situation by widening the path of converting health care to a commodity of a welfare state.

Utilization Pattern.

Evidences from studies in 1963 reveal that private providers treated most illness episodes in rural areas and only 10% of the population used government facilities.[139] Thus what is important for our study is that the initial treatment of any illness is usually handled by private practitioners (whether qualified or unqualified) for majority of population. Later depending upon the nature of illness (whether the patient requires admission or in-patient treatment) and the 'purchasing power' (ability to pay) of the patient party, the patient is either shifted to government hospitals or to private health care institutes. However even in case of emergency, it has been observed that 'purchasing power' factor plays a dominant role. Patients generally under the lower income group category are suspicious of private hospitals and tend to think that these institutions extract money from the patient parties without providing any real service. One patient, who was not poor also described these establishments as 'dacoits'[140] Comparing particular health care providers with thriving businesspersons or profit makers, indeed reveal the true picture of the highly equipped, commercial private five-star hospitals and nursing homes. However, expressing the truth, on the other hand is also a sign of disguising one's inability to purchase a certain 'quality' of treatment and also accepting a silent confinement within the periphery of the government hospital. Keeping aside these two qualities,

139 In *India Health Report*. P 102.

140 The present researcher interviewed 27 patients (mostly indigent) in Calcutta Medical College Hospital who clearly articulated their preference for public health care. See also Appendix IV and n. 103 in Chapter 4. The term 'dacoit' was used by a patient named Suren Sau whom I have interviewed in Medical College O.P.D of Cardiology Department on 24.11.08.Suren Sau is a retired man who worked in Bengal Chemicals and his monthly income ranged between Rs 5000-10,000. He believed that government hospitals are still the best places in the city that provide quality care.

one aspect should be acknowledged that among a certain section of the populace a belief persist that the doctors in the government hospitals are the best healers of all kinds of diseases

Table 1.5: Percentage Distribution of In-Patient Cases over Type of Hospital for States/ U.T.- Urban.

SL No.	State/U.T.	Type of Hospital						
		Public Hospital	Primary Health Centre	Private Hospital	Charitable Institution run by Public Trust	Nursing Home	Others	All
1.	Andhra Pradesh	37.98	-	55.15	3.75	2.74	.38	100
2.	Assam	79.88	2.45	10.14	.11	7.42	-	100
3.	Bihar	44.69	1.02	32.98	1.56	12.43	-	100
4.	Gujarat	59.21	-	37.01	3.13	.26	.39	100
5.	Haryana	55.31	-	34.25	1.80	8.64	-	100
6.	Himachal Pradesh	77.13	3.85	19.02	-	-	-	100
7.	Jammu and Kashmir	93.23	2.73	3.44	.11	.49	-	100
8.	Karnataka	48.51	.39	40.49	1.26	9.06	.29	100
9.	Kerala	54.77	.88	41.79	.64	1.92	-	100
10.	Madhya Pradesh	76.01	.97	15.24	1.98	5.01	.79	100
11.	Maharashtra	45.74	.49	47.63	3.41	1.81	.92	100
12.	Manipur	91.66	1.16	1.02	-	1.30	4.86	100
13.	Mehgalaya	51.68	1.74	44.29	2.29	-	-	100
14.	Orissa	78.94	2.54	13.90	1.15	1.28	2.19	100
15.	Panjab	48.37	.40	43.21	3.22	2.01	2.79	100
16.	Rajasthan	84.98	.64.	7.92	1.24	3.05	2.17	100
17.	Sikkim	91.75	4.12	3.12	-	1.01	-	100
18.	Tamilnadu	57.74	.30	34.14	.41	5.61	1.80	100
19.	Tripura	94.40	5.60	-	-	-	-	100
20.	Uttar Pradesh	57.97	1.28	19.43	2.04	15.53	3.75	100
21.	West Bengal	72.64	1.26	10.06	2.45	13.48	.11	100
22.	Chandigarh	92.89	-	7.11	-	-	-	100
23.	Dadra and Nagar Havelli	-	-	-	-	-	-	100

24.	New Delhi	70.15	.92	15.17	1.48	11.29	.99	100
25.	Goa, Daman and Diu	61.71	-	38.29	-	-	-	100
26.	Mizoram	91.39	-	6.79	1.82	-	-	100
27.	Pondicherry	85.68	-	12.90	-	1.42	-	100
28.	Andaman and Nicobar	93.74	-	6.26	-	-	-	100
29	Lakshadweep	70.29	10.78	18.93	-	-	-	100
30.	All- India	59.51.	.75	29.55	1.91	7.04	1.24	100

According to Table 1.5 it can be said that states like Andhra Pradesh, Karnataka, Kerala, Maharashtra, Meghalalya and Panjab exhibited the maximum percentage of distribution of In-Patient Cases in private hospital. While states like Assam, Himachal Pradesh, Jammu and Kashmir, Madhya Pradesh, Manipore, Orissa, Rajashthan, Sikkim, Tripura, Chandigargh, West Bengal, New Delhi, Mizoram, Pondicherry, Andaman and Nicobar Island and Lakhshwadweep have more percentage of the distribution of In Patient Cases in Government Hospitals.

The states show sharp variations in in-patient care. Certain states with underdeveloped and thinly spread private sector facilities, show lower utilization, such as Himachal Pradesh,Orissa, West Bengal, the north-eastern states, Rajasthan and Madhya Pradesh. More advanced states, with a developed private sector, show a greater reliance on private health facilities. These include Haryana, Punjab, and Maharashtra. The trend indicates that where the private sector is better developed and distributed, there appears to be a growing preference for its service.[141]

On the basis of the 42ND Round of the National Sample Survey it has been observed that both the private health care organizations and private doctors dominate largely in Indian health care sector.

Following the Enterprise Survey, Baru has indicated that urban areas had more institutions than the rural and the states like Haryana, West Bengal, Uttar Pradesh, Maharashtra, Kerala and Karnataka had a large number of institutions per millions persons than other states. The data on utilization shows that Andhra Pradesh, Kerala,

[141] Mahal et al.: Who *Benefits from Public and Private Health Spending in India*, NCAER, 2000. In *India Health Report*.P 107-108.

Haryana Panjab, Gujarat and Maharashtra had a larger percentage of hospitalized cases in private hospitals than public ones. It thus shows that this kind of a pattern seems to match the trends observed in the growth and spread of private institutions in these states.[142]

Although Andhra Pradesh does not rank very high in terms of number of private institutions according to the Enterprise Survey, other studies have shown that in certain districts the number of private institutions and bed strength is almost double that of public institutions. It also points to the fact that these institutions are no longer restricted to cities but have penetrated smaller towns and larger villages. Similarly, studies in Kerala have also shown the significant presence of the private sector, which has overtaken the public sector in terms of bed strength.[143]

A study by Duggal and Amin analyzes the socio –economic demographic determinants of utilization of facilities by 590 households in Jalgaon district of Maharashtra. For over three fourths (77%) of the illness episodes, the patients chose private practitioners and hospitals. The patients utilized government –run facilities in only 13% of the episodes.[144]

A study on diarrhea in rural India by Vishwanathan and Rhode, found that 65% of the diarrhea cases go for medical consultation. Of these, more than 80% go to private practitioners while only 10% go to government health facilities. Thus, it is well established that these findings confirm the preference of health care seekers in utilizing private facilities.[145]

Moreover, it has been estimated that even in the year 1985, 74% of the patients opted for private out patient care while 40% chose private in patient care.[146]

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142 Baru: *Private Health Care in India.* P 82.

143 Ibid P 82.

144 Duggal, Ravi and Sucheta, Amin. *Cost of Health care: A Household Survey in an Indian District.* Bombay:The Foundation for Research in Community Health, 1989. In Bhat Ramesh.'The Private Health Care Sector In India.' In *Paying for India's Health Care*. Ed by Berman & Khan. New Delhi Sage Publications. 1993. P 172. (Hereafter cited as Bhat : The Private Health Care Sector In India,)

145 Vishwanathan, H and J E, Rhode. *Diarrhoea in Rural India* : *A Nationwide Study of Mothers and Practitioners.* New Delhi: Vision Books. (1990), In Bhat : The Private Health Care Sector In India. P 173.

146 Government of India, Central Statistical Organization, *Morbidity and Utilization of Medical Services*, 42nd Round National Sample Survey. (New Delhi : Government of India 1989)

The Doctors.

The percentage of physicians engaged in private sector is also alarming. Unfortunately, serious studies have not been undertaken to look into the sectoral employment of the medical professionals. Foundation for Research in Community Health (FRCH) has made serious attempts to resolve the dilemmas in this area. However, their initiatives are also plagued by certain amount of irrationalities.

The present researcher agrees with the study by FRCH regarding the discrepancies and inadequacies of the sources published by the Government on the sectoral employment scenario of the medical professionals.

The Central Bureau of Health Intelligence (CBHI) has been publishing the data since 1979 on the number of doctors employed in the public sector. But there are inadequacies in their information, as many states are not regular in sending their corresponding updates to the CBHI. The biannual report of the 'Employment Review' published by the Director General of Employment and Training (DGE&T), Ministry of Labour is another source of information on the sectoral employment of doctors in the country. But a major drawback of the DGE &T data on the sectoral employment of doctors is their unreliability due to their gross underestimation.[147]

In the Bhore Committee Report, the earliest sectoral references of the doctors are available for the year 1942-1943. Another study conducted by the Institute of Applied Man Power Research (IAMR) also focuses on the number of allopathic practitioner in India.

The study conducted by the FRCH mainly depended upon the Bhore Committee data and the estimates put forward by the IAMR for the year 1942-43 and 1963-64 respectively. CBHI data were used for the years 1978-79, 1984-85 and 1986-87.

Deduction of exact number of doctors engaged in private sector was indeed a difficult task because there are eight non-reporting states (Andhra Pradesh, Bihar, Gujarat, Maharashtra, West-Bengal, Jammu and Kashmir and Tamilnadu). Since these states

147 Jessani and Anantharam. *Private Sector and Privatisation* P 26.

account for higher proportion of total number of doctors in the country, a rough estimation was called for.[148]

The sectoral distribution of doctors shows an interesting pattern. The Bhore Committee reported 27.4% of doctors in the public sector in the year 1942-43. The IAMR study on the other hand observed a significant increase in the proportion of government doctors to 39.6% in 1963-64. FRCH estimates show that there has been a sharp decline since 1963-64 in the proportion of government employed doctors up to 1970's and 1980's.Moreover, FRCH study observes that in 1986-87, 88,105 doctors accounting for 26.6% of total number of allopathic doctors, were in government services. However, when compared with the total number of doctors of all systems of medicine (7, 63,437), the proportion of government doctors comes to only 11.54%. However keeping aside the inconsistency, it is correct to infer that only 13 to 15% of all doctors are employed in the government services.[149]

The information about the private sector employment of the doctors is even more ambiguous. The IAMR study shows that in 1963-64, there were 100189 doctors, out of which 39% were employed in government services (Mentioned above) and 60,502 doctors (61%) are attached in the private sector. Out of those in the private sector, 53,461 (88.4%) doctors are self employed and the rest 7041 (11.4%) were employed in the private health establishments.[150]

One study estimates the number of private practitioners using the assumption that all doctors complied from the list of medical councils (about 12, 00, 0000) minus public sector doctors (140,000), equals doctors in the private sector. Assuming that 80% are active, the study arrives at a figure of 850,000 private sector doctors. The study thus estimates that 85% of doctors are in the private sector, this, of course, does not include the substantial number of Government doctors who practice in the private sector.[151] Thus, the unavailability of systematic data on this sector made the entire

148 Ibid P 27.
149 Ibid P 27-28.
150 Ibid P 28.
151 Government of India, Ministry of Health and Family Welfare. *Health Information of India*, Central Bureau of Health Intelligence, New Delhi: Government of India, various years. In. *India Health Report*. P 103.

scenario ambiguous affecting its relation with the public sector and making it much more complex.

However, in case of private practice by the medical professionals, the role of the government can never be ignored. As in case behind, the emergence of private health care sector in India, the welfare state directly and indirectly supported the interests of the entry of private capital, similar attention and emphasis was given in case of the private practice by the medical personnels.

The quality of private practice is also affected by the government policy. There is absolutely no attempt to stop medical practice by unqualified persons, nor any attempt to prohibit allopathic prescriptions by non-allopathic practitioners and vice versa. The rural people are thus left to the mercy of unqualified practitioners who use allopathic drugs in the most irrational way. The government used to make it compulsory for a fresh MBBS graduate to work on a bond service of two years after graduation in the government sector. Now this practice has been abandoned since the government cannot absorb 12000 to 14000 fresh graduates every year in its service. As a result, all the public money spent on training of doctors contributes to the flourishing of private practice. Cost of training one MBBS doctor works out to around Rs 4 lakhs. All this expenditure is a help to the private sector for supplying it with trained doctors migrate abroad every year. Their number has swollen from 810 per year in the first plan period to 4637 per year in the sixth plan.[152]

For the Sixth Plan period, the number of doctors migrating abroad was 39.6% of the out turn of allopathic doctors. The government is thus spending Rs six crores every year to train doctors for health services of other countries. The over production of doctors (not in relation to the needs of the Indian people but in relation to the capacity of the government health services and the urban market to absorb them) is a case of ineffective planning. The government policy has thus supplied or trained doctors to the private sector and has created a potential market for private practice in health services by its neglect of curative services in the state sector.[153]

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[152] Phadke : *Private Medical Sector.* P 21
[153] Ibid P 21

The Growth Pattern.

The information on the nature and extent of growth is limited but a few studies have demonstrated the significant presence of the private sector in some parts of the country.[154] Even at national level, if one compares the rate of growth of Government and private hospitals from the mid 70s, the latter seems to have grown at a faster space. [155] India probably has the largest private healthcare in the world.[156] However, it is interesting to locate that though this sector is large and an important constituent in the country's healthcare delivery system, the data on the share of private sector in the overall healthcare is highly unsatisfactory and highly unreliable. Data on sectoral distribution of doctors is not easily available, as many states do not file the required information to the Ministry of Health[157]. As the Tenth Plan document notes, there is no uniform nationwide system of registering either practitioners or institutions in the private sector. Nor is there any system for obtaining and analyzing information about this large sector.

Table 1.6: Growth of Private and Voluntary Hospitals and Beds in Major States.

Sl No	State	1973		1983	
1	Andhra Pradesh	113	9,213	266	11,103
2	Bihar	N.A.	N.A.	125	8,447
3	Gujarat	41	1,219	669	16,929
4	Haryana	17	1,877	18	2,566
5	Karnataka	38	5,106	53	6,894
6	Kerala	N.A.	N.A.	606	18,203
7	Madhya Pradesh	8	1,601	N.A.	N.A.
8	Maharashtra	68	8,300	682	32,033
9	Orissa	35	1,741	34	1,227
10	Punjab	20	2,070	35	2,913

154 Baru: *Private Health Care in India*. P 51
155 Ibid P 51
156 Nandaraj, Sunil, 'Beyond the Law and the Lord, Quality of Private Health care.' *Economic and Political W*eekly, Vol XXIX, No 27, 2nd July, 1994.P 1680.
157 Ibid P 1680

Sl No	State	1973		1983	
11	Tamilnadu	69	9,618	61	8,562
12	Uttar Pradesh	151	19,897	160	12,083
13	West Bengal	78	8,452	126	6,424
14	All-India	718	66,926	3,022	1,34,266

Source: Health Information of India. (Various years)[158]

It is clear from Table 1.6 that the private and voluntary health care sectors have successfully multiplied their numbers both in terms of organizations and in terms of bed strength over the ten years (1973-1983). In some states like Andhra Pradesh, Maharashtra, Tamilnadu, Uttar Pradesh and West Bengal there have been substantial presence of these sectors and their numbers in two respective years have increased significantly. In Andhra Pradesh the private and voluntary hospitals had increased from 113 to 266, the bed strength from 9213 to 11103.In Maharashtra there has been a jump in the number of hospitals from 68 to 682, and the number of beds rose from 8300 to 32, 033. Uttar Pradesh has also exhibited rise in the number of hospitals from 151 to 160, but in this state, there has been a decrease in the number of beds from 19,897 to 12,083. However, Tamilnadu has experienced a decline both in the number of hospitals and beds. Though there has been an increase in the number of hospitals from 78 to 126 in West Bengal, the number of bed strength declined from 8452 to 6424.It is interesting to mention that in states like Haryana, Karnataka Orissa and Panjab, the presence of the private and voluntary health care sector is not so alarming.

Existence of private nursing homes can also be traced back to the fifties and sixties. According to some estimates, well over half the available health services were being provided by the private sector even as early as the 1960s. [159] Indeed, as far as Kolkata is concerned, the traces of small nursing homes (in terms of bed strength and services) could be found even from the early years of Independence. Recollecting the presence of private nursing homes in Kolkata, a senior resident of metropolis narrated that in the early 50's, the doctor entrepreneurs started very few nursing homes and

[158] Government of India., Central Bureau of Health Intelligence Health *Information of India.* Ministry of Health and Family Welfare. New Delhi: various years.

[159] Baru: *Private Health Care in India*. P 51.

these institutions mainly dealt with delivery cases.[160] At the same time it is also worthy of mention that the need for private nursing homes was not seriously felt by the patients and the concept of nursing homes as a separate health care organization did not take proper shape in their minds. They were satisfied with the services provided by the public hospitals and the doctor patient relationship was far beyond the boundaries of commercialization. Again contrary to this argument, mention should be made that there was a general tendency among the patients who, whenever get affected by any kind of illness initially consult either his family physician or a private practitioner in his private chamber or in the clinic or even in the OPD (Out Patient Department) of any private hospital or to any charitable trust organization. Patients mostly in the B.P.L (Below Poverty Line) category use the OPD of Government hospitals.[161] This indeed is not only a recent development but was present even in the 50's. According to *India Health Report*, over half the available health services were being provided by the private sector as early as the 1950's.[162]

Table 1.7: Number of Hospitals and Beds According to Ownership as on 1 January 1988.

States/UTs	**Government**		**Local**		**Private & Voluntary**		**Total**	
	H	B	H	B	H	B	H	B
Andhra Pradesh	345	25251	4	46	266	11103	615	36400
Arunachal Pradesh	13	675	0	0	1	135	14	810
Assam	108	10777	0	0	31	2978	139	13755
Bihar	208	19652	1	49	90	8519	299	28220
Goa, Daman & Diu	16	1781	0	0	79	1223	95	3004
Gujarat	150	15005	63	3943	1211	21128	1424	40076
Haryana	59	4706	0	0	20	2798	79	7504
Himachal Pradesh	52	3582	5	58	8	447	65	4087
Jammu &	54	7476	0	0	2	140	56	7616

[160] Interview with Prof Ranjit Sen at Calcutta University on 27.09.2007.

[161] I made this observation from the interviews which I have conducted in private nursing homes at Kolkata and in Calcutta Medical College and Hospital in the entire course of my study.

[162] Foreword by D.R.Gwatkin to Bhat Ramesh. *Private and Public Mix in Health care in India,* Ahmedabad: I.I.M, 1995. In *India Health Report* P 102.

Kashmir								
Karnataka	169	24324	29	738	51	7339	249	32401
Kerala	159	29363	0	0	1894	44321	2053	73684
Madhya Pradesh	346	21582	0	0	0	0	346	21582
Maharashtra	442	47623	89	9503	1350	35837	1881	92963
Manipur	17	1261	0	0	3	70	20	1331
Meghalaya	9	1449	0	0	4	616	13	2065
Mizoram	7	605	0	0	2	300	9	905
Nagaland	31	1038	0	0	2	45	33	1083
Orissa	270	11265	4	153	21	1092	295	12510
Punjab	221	12150	4	103	43	3466	268	15719
Rajasthan	207	18162	2	54	38	2034	247	20250
Sikkim	5	425	0	0	0	0	5	425
Tamil Nadu	283	35849	7	479	73	9505	363	45833
Tripura	22	1501	0	0	0	0	22	1501
Uttar Pradesh	534	34267	42	985	159	12026	735	47278
West Bengal	264	46727	22	609	126	6511	412	53847
Andaman Islands	10	813	0	0	1	20	11	833
Chandigarh	3	1530	0	0	0	0	3	1530
Dadra and Nagar Haveli	1	50	0	0	0	0	1	50
Delhi	27	9302	20	3500	20	3314	67	16116
Lakshadweep	2	70	0	0	0	0	2	70
Pondicherry	8	2291	0	0	2	150	10	2441
Total	4042	390552	292	20220	5497	175117	9831	585889

Source: Health Information of India. (1988)[163]

Note: H indicates number of hospitals and B indicates the number of beds.

Table 1.8: Percentage of Hospitals/Dispensaries and Beds According to Ownership as on 1 January 1988.

Sates/UTs	**Hospitals**						**Dispensaries**					
	Government		**Local**		**Private & Voluntary**		**Government**		**Local**		**Private & Voluntary**	
	H	B	H	B	H	B	D	B	D	B	D	B
Andhra Pradesh	56.1	69.4	.7	.1	43.3	30.5	38.6	65.7	56.8	34.3	4.7	00

[163] Government of India., Central Bureau of Health Intelligence *Health Information of India.* Ministry of Health and Family Welfare. New Delhi: various years.

Arunachal Pradesh	92.9	83.3	00	00	7.1	16.7	100	100	00	00	00	00
Assam	77.7	78.4	00	22.3	21.7	100	100	00	00	00	00	00
Bihar	69.6	69.6	.3	.2	30.1	30.2	100	100	00	00	00	00
Goa, Daman & Diu	16.8	59.3	00	00	83.2	40.7	19.5	00	00	00	80.5	00
Gujarat	10.5	37.4	4.4	9.8	85	52.7	2.5	4.6	9.7	42.2	87.9	53.2
Haryana	74.7	62.7	00	00	25.3	37.3	94.8	96.7	2.2	3.3	3.0	00
Himachal Pradesh	80.0	87.6	7.7	1.4	12.3	10.9	97.7	96.2	.9	.9	1.4	3.0
Jammu & Kashmir	96.4	98.2	00	00	3.6	1.8	100	00	00	00	00	00
Karnataka	67.9	75.1	11.7	2.3	20.5	22.7	97.4	97.7	1.8	2.2	.8	.1
Kerala	7.7	39.9	0.0	0.0	92.3	60.2	18.9	100	00	00	81.1	00
Madhya Pradesh	100	100	00	00	00	00	100	100	00	00	00	00
Maharashtra	23.5	51.2	4.7	10.2	71.8	38.6	2.7	12.7	14.3	49.0	83.09	38.3
Manipur	85.0	94.7	00	00	15.0	5.3	51.9	00	48.1	00	00	00
Meghalaya	69.2	70.2	00	00	30.8	29.8	100	100	00	00	00	00
Mizoram	77.8	66.9	00	00	22.2	33.2	100	100	00	00	00	00
Nagaland	93.9	95.8	00	00	6.1	4.2	100	100	00	00	00	00
Orissa	91.5	90.1	1.4	1.2	7.1	8.7	88.4	00	3.1	00	8.5	00
Punjab	82.5	77.3	1.5	.7	16.	22.1	97	98.2	2.4	1.6	.7	.2
Rajasthan	83.8	89.7	0.8	0.3	15.4	10.0	95.4	98.4	0.0	0.0	4.6	1.6
Sikkim	100.0	100.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	100.0	0.0	0.0
Tamil Nadu	78.0	78.2	1.9	1.1	20.1	20.7	44.6	17.4	49.6	82.7	5.8	0.0
Tripura	100.0	100.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0
Uttar Pradesh	72.7	72.5	5.7	2.1	21.6	25.4	88.9	98.6	7.2	0.0	3.9	1.4
West Bengal	64.1	86.8	5.3	1.1	30.6	12.1	44.7	0.0	44.1	0.0	11.3	0.0
Andaman Islands	90.9	97.6	0.0	0.0	9.1	2.4	100.0	0.0	0.0	0.0	0.0	0.0
Chandigarh	100.0	100.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0
Dadra and Nagar Haveli	100.0	100.0	0.0	0.0	0.0	0.0	100.0	100.0	0.0	0.0	0.0	0.0
Delhi	40.3	57.7	29.9	21.7	29.9	20.6	64.0	0.0	31.9	0.0	4.1	0.0
Lakshadweep	100.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pondicherry	80.0	93.9	0.0	0.0	20.0	6.2	76.5	54.1	0.0	0.0	23.5	45.9
Average	41.1	66.7	3.0	3.5	55.9	29.9	39.4	79.6	11.2	11.2	49.4	9.2

Source: Health Information India (1988)[164]

Table 1.9: Number of hospitals and beds according to ownership as on 1.1.1996.

States/UTs	**Government**		**Local**		**Private & Voluntary**		**Total**		**Reference Period**
	H	B	H	B	H	B	H	B	
Andhra Pradesh	148	3640	0	0	2802	42192	2950	45832	1.1.94
Arunachal Pradesh	262	2476	0	0	0	0	22	2476	1.1.92
Assam	141	9687	47	982	80	1992	268	12661	1.1.91

[164] Government of India., Central Bureau of Health Intelligence *Health Information of India.* Ministry of Health and Family Welfare. New Delhi: various years.

Bihar	237	20522	1	49	90	8519	328	29090	1.1.92
Goa	15	1881	0	0	99	1763	114	3644	1.1.93
Gujarat	312	22229	64	4321	2152	36867	2528	63417	1.1.95
Haryana	59	4948	0	0	20	2232	79	7180	1.1.96
Himachal Pradesh	46	4810	5	58	6	200	57	5068	1.1.96
Jammu & Kashmir	65	8062	0	0	2	140	67	8202	1.1.89
Karnataka	209	27736	28	714	56	9999	293	38449	1.1.96
Kerala	141	28030	0	0	1899	49169	2040	77199	1.1.94
Madhya Pradesh	363	18141	0	0	0	0	363	18141	1.1.92
Maharashtra	445	34261	87	6901	2583	37758	3115	78920	1.1.93
Manipur	27	920	1	594	4	100	32	1614	1.1.96
Meghalaya	5	1217	0	0	4	650	9	1867	1.1.93
Mizoram	13	884	0	0	4	420	17	1304	1.1.96
Nagaland	31	1050	0	0	0	0	31	1050	1.1.92
Orissa	411	14572	5	111	14	201	430	14884	1.1.96
Punjab	177	10936	4	103	39	3782	220	14821	1.1.96
Rajasthan	218	21187	-	-	-	-	218	21187	1.1.96
Sikkim	5	575	0	0	0	0	5	575	1.1.96
Tamil Nadu	282	37935	7	479	119	10366	408	48780	1.1.90
Tripura	26	1810	0	0	0	0	26	1810	1.1.96
Uttar Pradesh	534	34267	42	985	159	12026	735	47278	1.1.86
West Bengal	243	47825	22	646	134	6759	399	55230	1.1.96
Andaman & Nicobar Islands	9	864	0	0	2	37	1	901	1.1.96
Chandigarh	1	500	0	0	0	0	1	500	1.1.96
Dadra and Nagar Haveli	1	75	2	40	0	0	3	115	1.1.96
Daman & Diu	1	100	0	0	2	50	3	150	1.1.92
Delhi	36	12315	20	3694	17	2787	73	18796	1.1.95
Lakshadweep	2	70	0	0	0	0	2	70	1.1.96
Pondicherry	8	2462	0	0	2	146	10	2608	1.1.92
Total	4473	375987	335	19677	10289	228155	15097	623819	

Source: Health Information of India.[165]

Note: H indicates number of Hospitals and B indicates the number of Beds.

On the basis of Tables 1.7, 1.8 and 1.9 a comparative growth of hospitals on ownership pattern can be estimated. Out of 9831 hospitals, 55.9 %(5497) are private and voluntary sector and out of 585889 hospital beds, 29.9% (175117) beds are in the private and voluntary sector. However, there was a sharp increase in the number of private hospitals and hospital beds in the year 1996. Table 8 shows that the number out of 15097 hospitals, 10289 are in the private and voluntary sector while

[165] Government of India., Central Bureau of Health Intelligence *Health Information of India.* Ministry of Health and Family Welfare. New Delhi: various years.

government sector occupies only 4473 hospitals. The number of hospitals in public sector was 4042 in the year 1988 and it rose to 4473 only in 1996. But the private hospitals were 5497 in number in 1988 and it expanded to a maximum of 10289 in 1996. In case of bed strength, also a significant proportion is being dominated by the private and voluntary sector. State wise variation in the growth of private health care sector is always evident both in 1988 and in 1996. Substantial presence of private health care sector is seen in the states like, Andhra Pradesh, Gujarat, Kerala, Maharashtra, and Uttar Pradesh. However the state funded health care service have radically reduced in numbers in the above mentioned states. But in the all India context also there has been an upward trend in the growth of private health care sectors over the years. Thus it is clearly evident from the data provided by the CBHI, that the welfare state provided conducive atmosphere for the growth of private health sector in India. But with some few exceptions in some of the states, there has been a shrink in the growth pattern of government hospitals.

Defining Private Health Care.

Studies on the private health care sector have long occupied the attention of historical scholarship. Historians and social scientists all round the globe have identified the importance of this sector as an important constituent of health care delivery services. The definition of private health care as stated by the *India Health Report*[166] give a broad understanding of the term private health care. According to this, the private health care sector comprise the corporate hospitals, super speciality consultants, general practitioners, small clinics and state of the technologies at one end of the spectrum, and illiterate, unqualified practitioners dispensing their own brand of healing at the other end. Its structure is complex, different types of providers practice formal and informal systems of medicine in a wide range of facilities.[167] *India Health Report* characterizes this sector under four broad heads.

- Nature of provider: private company, trust. N.G.O, qualified and unqualified individual provider.

166 *India Health Report*. P 102.
167 Ibid. P 102

- Nature of services :hospitals, maternity and nursing homes, clinics, dispensaries, traditional practitioners, ancillary services (pharmacies, diagonistic facilities, ambulance services)

- System of care :formal (allopathy, ayurveda, unani,siddha,homeopathy); informal –unqualified, traditional (faith –healers, local medicine men and woman, traditional birth attendants)

- Ownership styles: for profit and not for profit.

Both Bhat[168]and Baru[169] have characterized Indian private health sector by heterogeneous structure consisting of institutions of varying sizes and patterns of ownership. According to Bhat private health sector is divided into two segments on the basis of ownership style.

- The organized private sector including general practitioners, private hospitals and dispensaries (popularly called nursing homes), registered medical practitioners, and other licentiates.

- Informal private health care sector consisting of practitioners without formal qualification, faith healers, tantriks, herbalist, priests, hakims, baidyas and so on.

While defining it Bhat illustrated private health care sectors consisting of organizations practicing in allopathic, homoeopathic and traditional systems of medicine providing health care services privately, through organized or informal channels or through voluntary agencies.

Baru on the other hand mostly echoed the same tone as mentioned by Bhat. But she is more specific in distinguishing the primary, secondary and tertiary level of private health care services. Baru has categorized that primary level out patient care is mainly provided by both qualified and unqualified individuals located in both rural and urban areas. The secondary level of care consists of nursing homes with a bed strength

[168] Bhat, Ramesh. The Private/Public Mix in Health Care in India, *Health Policy and Planning* (1993)*:8(1):43*-56. O.U.P.
[169] Baru. Health Sector Reforms: P 275

ranging from 5 to 50 and promoted by single owners or partners. Multispeciality hospitals mainly comprise the tertiary level of care. These are mostly located in the larger cities and have a strong nonresident Indian connection with doctors based in the United States.

Mohan Rao[170] has also followed the same line of defining private health care as was outlined by the *India Health Report*.

In light of the above, there is little need to spell out a new definition of private health care. For our purposes, the simplest possible definition shall suffice. Private health care sector may simply be defined as the health sector which is privately managed and funded; unlike the hospitals under the state rule which may be identified as the public health care sector. It must be borne in mind that private health care is business, and like all businesses, the overriding motive is profit. This is not to deny that in many cases the drive for profit may be linked to providing quality service, but this does not dilute the basic profit orientation of the enterprise.

[170] Rao, Mohan. 'The State of Health in India.' *South Asian Journal: Indo –Pak Dialogue.* 2006. October December. P 39.