Privatisation of Healthcare in India

Public health system collapsed due to under-financing of public health services

Historically India has always had a very large private health sector, especially for ambulatory healthcare services. These include providers of modern medicine as well as traditional practitioners. Hospital services until the mid-seventies were predominantly in the public domain. Medical education was almost a public monopoly until late eighties after which private sector grew rapidly but even today 75 per cent of outturn of medical graduates is from public medical schools. Post mid-seventies the State provided various incentives like concessional land and tax breaks for setting up of private hospitals and duty exemptions for imports. The private pharmaceutical industry also received substantial State patronage for its growth through process patent laws, subsidised bulk drugs from public sector companies and protection from MNCs.

While constitutionally the Indian State was committed to providing healthcare to its citizens via the Directive Principles of State Policy, provision of healthcare was not a fundamental right. Through the policy route various healthcare entitlements were created over the years like one primary health centre (PHC) per 30,000 population, one first level referral hospital per 5 PHCs and one civil hospital per district. But public commitments of resources for healthcare were very small and hence public healthcare has remained under-developed. However in the nineties the public health sector was woefully neglected with new public investments being virtually stopped and expenditures declining. During the same period the private health sector, including the hospital sector, expanded rapidly on one hand, and on the other the public health system was being reformed to fit the private model through introduction of user charges and contracting out of services.

Issues and Concerns

During the nineties the public health system was collapsing due to under-financing of public health services. The structural adjustment and economic reforms program which began in 1992 after the 1991-92 fiscal crises further shrunk resource allocations for public health services. In the mid-nineties the 5th Pay Commission added to the catastrophe leading to allocative inefficiencies due to budgetary allocations being sufficient only for financing salaries. The recovery from this has only been marginal but the introduction of user fees struck the final blow for the poor who are the vast majority of users of public health facilities. Another evidence of the collapse of public health facilities is from another national survey of public health infrastructure, which reveals that in 1999-2000 the critical public health facilities were grossly inadequate. The 2002 National Health Policy acknowledges this severe indictment and recommends that public health investment and expenditures need to be more than doubled in the next 5 years in order to provide reasonable level of primary healthcare.

Social Watch Report

The above trend is in fact a global phenomena and this is well documented in the 2003 Social Watch Report. This report focuses on privatisation of basic services and documents the shift from social contract to private contract for basic services like health, education and water. World Bank whose 2004 WDR background papers are debunking the government provision model for basic services in favour of private contracts is encouraging this shift. The Social Watch Report declares access to basic services as a human right and advocates for maintaining the social contract for these basic services as social contracts promote equity and universality ensuring a minimum level of access for all.

Premiums paid by the State

For a country like India that still faces mass poverty this situation is not good and needs to be radically changed. We need to maintain the social contract paradigm and prevent healthcare becoming fully an economic commodity. We see three imminent things that need to be done. Firstly, the healthcare system needs to be organised into a single, regulated system, which given the prevailing circumstances will have to be an organised public-private mix. The financing of such a system will have to be through a single payer mechanism which would be an autonomous collective entity which will pool all resources (those who have capacity to pay will pay through payroll taxes/deductions and through insurance premiums and the poor and subsistence population - about 60 per cent in India - will have their premiums paid by the State). Secondly the medical profession will have to be reigned in to organise it self under the proposed system and to self-regulate so that the norms laid down are adhered to. And thirdly, healthcare will have to be proclaimed a fundamental right through an Act of Parliament.

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