HEALTH CARE AND NEW ECONOMIC POLICIES
The Further Consolidation of the Private Sector in India

Ravi Duggal, CEHAT, Mumbai

ABSTRACT

Economic reforms towards liberalisation began in the early eighties. The classical 'Hindu' rate of growth in the eighties had doubled from 3% to 6%, without much inflation and with declining levels of poverty. Thus we were already liberalising our economy and speeding up growth without the World Bank running the show. Infact, the post (1991)-reform period slowed down growth, increased poverty and inflation, and reversed many trends of the eighties. Today health care has become fully commodified and the private sector is the dominant provider of health care globally, as well as in India. New medical technology has aided such a development and the character of health care as a service is being eroded rapidly. This process of commodification has created a unique characteristic of the health sector making health care a supply-induced demand market.

Provision of routine medical care for a wide range of diseases and symptoms in India is mostly in the private sector. As regards the public sector the large investment in health care is being wasted due to improper planning, financing and organisation of the health care delivery system. While public health services are inadequate to meet peoples health care needs the private health sector whatever be its quality and / or effectiveness has filled the gap.

Private medical practice flourishes almost everywhere. Medical practice in India is a multi-system discipline and in addition is also burdened with a large number of unqualified practitioners. Private general practice is the most commonly used health care service by patients in both rural and urban areas. This translates into a whopping Rs.400 to 600 billion private health care market in the country at today's market prices. This large private health care market has grown with direct and indirect state support. The government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. The government has pioneered the introduction of modern health care services in remote areas by setting up PHCs. While the latter introduces the local population to modern health care it also provides the private sector an entry point to set themselves up. Construction of public hospitals and health centres are generally contracted out to the private sector. In recent years the government health services have introduced selectively fee-for-services at its health facilities. The government has allowed the private health sector to proliferate uncontrolled. The above are a few illustrations of how the state has helped strengthen the private health sector in India. In today's liberalised scenario, and with World Bank's advice of limiting state's role to selective health care for a selective population, the private health sector is ready for another leap in its growth. And this will mean further appropriation of people's health and a worsening health care scenario for the majority population.

Finally a very clear impact one sees is declining state investments in the health sector. New medical technologies have helped complete the commodification of health care and this has attracted increased interest of the corporate sector that has jumped into the health care business in a very big way. This has led to the further consolidation of the private health sector in India.

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Background

Economic reforms towards liberalisation began in the early eighties. This is important to note because most often there is a tendency to look only at the post-1991 period. Data available upto now clearly shows that economic performance of the eighties far outweighs that in the nineties. And the underlying fact about this is that in the eighties there was no structural adjustment or World Bank dictat. The classical 'Hindu' rate of growth in the eighties had doubled from 3% to 6%, without much inflation and with declining levels of poverty. Thus we were already liberalising our economy and speeding up growth without the World Bank running the show.

Infact, the post(1991)-reform period slowed down growth, increased poverty and inflation, and reversed many trends of the eighties. No doubt it caught up towards the mid-nineties, but it has not yet surpassed the achievements of the eighties. Thus in the eighties India was developing rapidly with a gradual globalisation process and with the advantage of its inner strength which insulated it from global shocks. In the nineties there was rapid globalisation which exposed India to global fluctuations; if India survived the Asian shock which destroyed Indonesia and other south east Asian economies it was because of its sheer size and the strengths of its own local markets.

Another fact to contend with is the as yet dependence of over two-thirds of the population on agriculture and 70% of the population living in rural areas. Since the larger impact of macro-economic reforms is on the urban-industrial sector, which integrates globally with much ease, the rural population in a sense still has relative protection from global impacts. Further, it is the consistent good performance of agriculture that has helped ward off the severities of SAP, which many other countries have faced. In addition, India's strong investments in the past in rural development, especially employment guarantee programs and agricultural subsidies aided in reducing the adverse impact of SAP. And this is not likely to change thanks to the strong farm lobby that is in fact demanding greater investments and subsidies for the rural economy.

The other fact to note is that in 1991 the crisis, which emerged due to forex reserves falling to USD 1 billion, was an artificial one engineered by large scale NRI withdrawals. Post SAP after the first budget of the new govt. in July 1991, which resorted to massive devaluation of the rupee, the forex reserves zoomed again. Again this was not due to rapid increases in exports nor due to increased foreign investments. It was the NRIs again who brought in the resources to boost forex reserves. Even now foreign investments and exports have not seen the kind of increase which was expected.

Thus at one level India is much more exposed to the global market with increasing vulnerability. But at another level it continues to enjoy an inner

strength and autonomy because of its sheer size, its large rural-agricultural population and a large local market of its own, despite the fact that politically the situation is very fluid. This background is important for understanding the impact and changes in the health sector.

The Nature and Dimensions of Health Sector in India

Historically, provision of health care services has moved away from the traditional, non-institutional trained and home-based petty-commodity producer, to the sophisticated, institutionally qualified, market and commodity dependent service provider on one hand and the completely corporate, institution-based service on the other hand. Today health care has become fully commodified and the private sector is the dominant provider of health care globally, as well as in India (though not necessarily in financing, and especially in the developed countries where public financing is the dominant mode). New medical technology has aided such a development and the character of health care as a service is being eroded rapidly. This process of commodification has created a unique characteristic of the health sector making health care a supply-induced demand market.

Provision of routine medical care for a wide range of diseases and symptoms in India is mostly in the private sector. While government health centres exist across the length and breadth of the country they have failed to provide the masses with the basic health care which the latter expect. It will suffice to say that a large investment by the public sector in health care is being wasted due to improper planning, financing and organisation of the health care delivery system. The national public health expenditure today is Rs.130 billion per year (Rs.133 percapita, less than 1% of GDP), being spent on 5000 hospitals and 500,000 beds, 11,500 dispensaries, 24,000 PHCs, 150,000 subcentres and various preventive and promotive programs, including family planning. The State employs only 140,000 doctors although it produces each year 14,000 doctors of just modern medicine alone in the 108 medical colleges it runs. However, the services provided by the state do not meet the expectations of people and as a consequence only 20% of routine morbidity and about half of the hospitalisations are treated through public institutions / providers. The rest is taken care of by the private health sector whatever be its quality and / or effectiveness.

Private medical practice flourishes almost everywhere. The range of providers are also varied, from the herbal and witch doctor to the modern unqualified or quasi-qualified 'quack', and to the qualified practitioners of different systems of medicine, many of whom also indulge in quackery. There is no firm data available on the entire range of practitioners. Even the medical councils of the various systems of medicine have failed to maintain a complete register of active practitioners. The census is another source but the latest available census data for occupations is for 1981. Hence estimates from various studies or indirect extrapolations are the only methods for fixing a proximate size of medical practitioners.

Our estimate based on indirect extrapolation using the assumption that all doctors (compiled from lists of the various medical councils) minus government doctors is equal to the private sector. Today there are about 1,200,000 practitioners registered with various system medical councils in the country and of these 140,000 are in government service (including those in administration, central health services, defence, railways, state insurance etc..). This leaves 10,60,000 doctors of various systems of medicine floating in the private sector and one can safely assume that atleast 80% of them (850,000) are economically active and about 80% (680,000) of the latter are working as individual practitioners. Apart from this there are as many unqualified practitioners according to an estimate based on a study done by UNICEF/ SRI-IMRB in Uttar Pradesh (Rhode and Vishwanathan, 1994). If we accept this estimate then the total medical practitioners active becomes about 1,400,000, that is one such practitioner per 700 population. Another study done in Ahmednagar district by FRCH showed that the district had 3060 active medical practitioners (FRCH, 1994). Ahmednagar being socio-economically an average district, if we multiply this figure by 452 districts we get a proximate figure of 13.8 lakh practitioners for the country as a whole, which is quite similar to the earlier estimate. This problem of poor availability of information, especially about the private health sector, calls for intervention to make the various medical councils and the local bodies more accountable and to improve their recording and information systems. This is crucial if health care has to become a right.

Urban concentration of health care providers is a well known fact - 59% of the country's practitioners as per 1981 census (73% for allopathic) are located in cities, and especially metropolitan ones. For instance, of all allopathic medical graduates in Maharashtra 60% are located in Bombay city alone which has only 11% of the state's population! This selective concentration of health care providers then becomes a major concern to be addressed to, especially since the health care market is supply induced and when people fall ill they are wholly vulnerable and forced to succumb to the dictates of such a market. The consequence of this is that access to health care providers gets restricted to those living in urban and developed pockets and the vast majority of the rural populace have to make do with quacks or travel to the urban areas for satisfying their health care needs. Infact, studies have shown that those living in rural areas spend about as much on health care as those in towns (Duggal and Amin, 1989; George et.al., 1993; NCAER, 1992 and 1995) and hence relocation can become economically viable for qualified private practitioners. Thus the state and the local bodies must intervene to restrict the number of practitioners from setting up practice in urban areas. This calls for some locational policy that can establish a relative socio-geographic equity.

Medical practice in India is a multi-system discipline. Some of the major recognised systems are allopathy or modern medicine, homoeopathy, ayurveda, unani, and siddha. Apart from these there are others like naturopathy, yoga, chiropractic etc.. as well a large number of unqualified practitioners. All this creates a complexity which makes information management, recording, monitoring etc.. a daunting task and it is this very diversity and complexity

which is in part responsible for the chaos and lack of regulation and quality control. Further, those qualified in modern medicine tend to locate themselves in urban areas, whereas those with non-allopathic qualifications are located in equal numbers in both urban and rural areas. The 1981 Census shows that the allopaths in urban areas are three times more than in the rural areas, and the Indian system doctors distribution is more or less similar, 55% in rural areas and 45% in urban areas (Census, 1981). In the Ahmednagar study 77% of allopaths were in urban areas and 23% in rural and for Indian systems and homoeopathy qualified practitioners the percentage distribution was 68 and 32, respectively (FRCH, 1994).

The diversity and complexity discussed above becomes a serious concern in the context of the fact that an overwhelming majority of them, including unqualified, are practising allopathy. Thus, a major question that needs to be addressed is how do we view practitioners of different systems of medicine, how should they be distributed in the population and what type of care should each group be allowed to administer? While recognising the advantages that each system may have, overall it is generally accepted that modern medicine deserves the priority it commands. Hence it should be recognised the basic system of medicine (until another system establishes its superiority) and hence medical education must produce a single stream of basic doctors trained in modern medicine. Those who wish to acquire knowledge and skills of other systems should have the necessary facilities to pursue those as electives or specialisations.

Related to having an accredited qualification is the question of registration with the appropriate authority and that of renewing the registration periodically. Legally speaking registration gives the qualified practitioner the right to practice medicine and it is the duty of the concerned authority to assure the consumers that no practitioner without appropriate registration is treating patients. For instance the Maharashtra Medical Council registers all doctors qualified in allopathy and permits them to set up medical practice in the state. Similarly each state or region has such a council. The Indian systems and homoeopathy also have their respective councils and give registration for practising the relevant system of health care. The registrations given are not permanent and are usually for five years and it is the responsibility of every practitioner to renew their registration at the appropriate time failing which the council can prevent the practitioner from practising. It is well known that the various medical councils have been lax and negligent and have not been performing their statutory duties. Because of the latter the medical practitioners have also become lax and a large number of them are practising today not only without proper registration but also without the requisite qualifications. All this then becomes a threat to the patient who is thrown at the mercy of doctors who may not have the necessary skill and who practice with half-baked knowledge. Thus, even something for which there is a law and an authority to administer it, it is being neglected. It is the responsibility of the State to see that its own constituted authorities are carrying on with their responsibilities effectively.

All this clearly demonstrates both the laxity of the concerned authorities and the unconcern of the medical profession for proper standards and quality care for treatment of patients. The health care administration needs to pull up its bootstraps on the one hand and the concerned medical professionals must take a lead to put their own house in order on the other hand.

When people fall ill the first line of contact is usually the neighbourhood general practitioner (GP) or some government facility like a dispensary or primary health centre or a hospital. That the GP is the most sought after health care provider has been confirmed now by a number of studies, and this ranges from 60% to 85% of all non-hospital care which patients seek (NSSO, 1989; Duggal and Amin, 1989; George et. al. 1993; Kanan et. al, 1991; NCAER, 1992 and 1995). But we have already seen above that many types of GPs are there in the market place, and more so in the rural areas where the majority of the population resides, who may be more a risk than help to patients seeking care.

While modern medicine has simplified treatment of most illnesses and symptoms to afew drugs (even making many of us self-prescribers) its commercialisation has brought in more problems than the benefits it has created. The pharmaceutical industry and the medical equipment industry have both caused much harm to the character of the medical profession. Their marketing practices have lured a large majority of medical professionals (and not the unqualified quacks alone) to increasingly resort to unnecessary and irrational prescriptions of drugs, the overuse of diagnostic tests, especially the modern ones like CAT Scan, ultrasound, ECG etc... and uncalled for references to specialists and superspecialists (for all of which a well organised kickback system operates - the givers and beneficiaries calling it commission!). These issues, while they fall within the context of standards and quality of care, are extremely difficult to study and hence only anecdotal information is available. However through indirect methods some amount of information may be derived as was done in one study in Satara district of drug supply and use. This study lends credence to the anecdotal evidences we so far had about unnecessary and irrational drug prescription and use (Phadke, 1998).

As suggested in the preceding section something needs to be done at the policy level about this wild cross-practice and the large presence of unqualified practitioners. Action has to begin from reorienting medical education to create a basic doctor in rational modern medicine and strengthening regulation and control of medical practice by getting the regulatory bodies to become active and committed to the cause of quality and standards of health care.

The rural areas have as much a demand for health care as the urban ones and hence there is much sense in implementing a policy of locational restriction in over-served areas and locational encouragement in under-served areas through, for instance, fiscal and tax related measures. Further, the question of a lack of purchasing power, which is very valid, can also be overcome by involving the qualified practitioners into a State sponsored universal health care system which assures them a clientele and income through a system of family practice. For the latter to be successful a statute backed locational policy for setting up

medical practice becomes essential. Along with this regulation, standards and quality care are necessary features. Only such an organised system can assure right to health care.

The Dominance of the Private Health Sector

As pointed out in the discussion above the public health infrastructure in the country is very small and grossly inadequate to meet the health care demand. Therefore the private health care sector has taken a dominant position, especially with regard to treatment of routine illnesses. Private general practice is the most commonly used health care service by patients in both rural and urban areas. While this has been known all these years, data in the eighties from small micro studies as well as national level studies by the National Sample Survey and the NCAER, provided the necessary evidence to show the overwhelming dominance of the private health sector in India. These studies show that 60-80% of health care is sought in the private sector for which households contribute out-of-pocket 4% to 6% of their incomes. This means a whopping Rs. 400 to 600 billion private health care market in the country at today's market prices. This includes the hospital sector where the private sector has about 50% of the market share.

The dominance of the private health sector is not something that has emerged recently or out of specific policies favouring privatisation under the new economic regime of liberalisation and globalisation. It has always been there, including the state's support for it to grow and flourish. While some policies of the state have actively promoted the private health sector's growth others have done this through sheer inaction and lack of concern. Some examples are as under :

medical education is almost wholly state financed and its major beneficiary is the doctor who sets up private practice after his/her training. More than three-fourths of medical college graduates from state institutions work in the private sector or migrate abroad. Though they are trained at public expense their contribution to society is very little because they engage in health care as a business activity.

the government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. It provides incentives, tax holidays, and subsidies to private pharmaceutical and medical equipment industry. It manufactures and supplies raw materials (bulk drugs) to private formulation units at subsidised rate/low cost. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially the highly expensive new medical technologies.

the government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes. Hence they don't contribute to the state exchequer even when they charge patients exorbitantly.

the government has been contracting out its programs and health services selectively to NGOs in rural areas where its own services are ineffective. This will further discredit public health services and pave the way for further privatisation.

the government has pioneered the introduction of modern health care services in remote areas by setting up PHCs. While the latter introduces the local population to modern health care it also provides the private sector an entry point to set themselves up.
construction of public hospitals and health centres are generally contracted out to the private sector. The latter makes a lot of money but a large part of the infrastructure thus created, especially in rural areas is inadequately provided hence cannot meet the health care demands of the people.
medical and pharmaceutical research and development is largely carried out in public institutions but the major beneficiary is the private sector. Development of drugs, medical and surgical techniques etc.. are pioneered in public institutions but commercialisation, marketing and profit appropriation is left with the private sector. Many private practitioners are also given honorary positions in public hospitals which they use openly to promote their personal interests.
in recent years the government health services have introduced selectively fee-for-services at its health facilities. This amounts to privatisation of public services because now utilisation of these services would depend on availability of purchasing power. Increasing private sources of income of public services would convert them into elitist institutions, as is evident from the functioning of certain speciality departments of public hospitals.
the government has allowed the private health sector to proliferate uncontrolled. Neither the government nor the Medical Council of India have any control over medical practice, its ethics, its rationality, its profiteering etc..

The above are afew illustrations of how the state has helped strengthen the private health sector in India. In today's liberalised scenario, and with World Bank's advice of limiting state's role to selective health care for a selective population, the private health sector is ready for another leap in its growth. And this will mean further appropriation of people's health and a worsening health care scenario for the majority population.

Impact of New Economic Policies

Liberalisation and globalisation policies being pursued since the beginning of this decade have had both positive and negative consequences for the macro economy. We will not look at these but instead focus on the micro impacts. In the opening paragraphs we had briefly discussed the post-1990 scenario and concluded that there were certain strengths our economy has which prevented a collapse during the recent south-east Asian shock.

Poverty constitutes the core of the micro economy and anti-poverty programs are both big businesses in India as well as crucial for political survival. It is precisely these investments which have prevented a collapse although poverty statistics have shown an increasing trend in proportions and numbers in the

nineties. Health care is a very crucial part of this poverty syndrome because unlike education you cannot avoid it.

One very clear impact one sees is declining state investments in the health sector. With rising debt burdens of the state the social sectors are the first to receive the axe. There has been a declining trend since 1991 in social sector expenditures, especially by the Central government and this is best reflected in compression of grants to the states for social sector expenditures (Tulasidhar, 1992 and Duggal, 1995). Health care expenditures too have been affected both in quantitative terms (declining real expenditures) and qualitative terms (increasing proportion of establishment costs and declining proportion on medicines, equipment, maintenance and new investments). Another very striking impact is the rapidly rising cost of medicines. With a large dependence on the private health sector even by the poor this has meant extreme hardship. With the drug price control virtually on its way out we are moving closer to international prices of drugs. The combined effect of the above two facts makes a deadly mixture which results in reduced access of the poor to health care.

Another trend which further reduces access is the increased corporate control of health care. New medical technologies have helped complete the commodification of health care and this has attracted increased interest of the corporate sector which has jumped into the health care business in a very big way. This has led to the further consolidation of the private health sector in India.

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