

## **COST OF MEDICAL CARE**

### **Issues of concern in the present scenario**

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**This paper examines the financial aspects of various components in the health care delivery system of the country. It attempts to highlight some of the major issues of concern that need to be addressed in the present economic scenario.**

The health care sector in India has come of age. There has been a tremendous amount of growth in terms of physical size, investments, expenditures and utilisation of health care services. Unfortunately, it continues to be maldistributed and the average quality of services, not commensurate with what it is capable of achieving. There is an absence of a holistic approach for the provision of services which has led to a lack of comprehensiveness. Health planners and policy makers among others have failed to take a holistic picture of the health services in the country. They failed to take into account the role, functions, size, investments, distribution of the private health sector which was operating and growing by leaps and bounds. Recent studies conducted bring out that for indoor care around 50 percent and ambulatory care (out-patient) nearly 70 to 80 percent of people utilize private health facilities in the country **(NSSO 1989, Duggal and Amin 1989, Kannan et al. 1991, NCAER 1992, George et al. 1994)**. Compared to state expenditure on health the private household expenditure is nearly four to five times more than that of the state. Today, the nation knows very little about a sector which is consuming 80 percent of health expenditure and being utilized by majority of the people in the country.

This has been in spite of the fact that the Bhore committee in 1946 had set out a detailed plan for the development of health care services in the country. This plan was well studied, comprehensive and suited to Indian conditions. It recommended that the resources for health should be increased by three times of that existing then. Health services were to be provided universally to all free of cost. It gave greater emphasis to rural areas in correcting the wide rural-urban disparities. **(Bhore Committee, 1946)** If implemented fully in a time period of twenty-five to thirty years the level of health services would have improved in a substantial manner spread proportionately all over the country. This would have made the private health sector dispensable. The first and second health ministers conference after independence accepted the Bhore committee's recommendations in principle only, citing lack of resources as a major constraint. The first five year plan made some effort on the recommendations of Bhore committee, but subsequently there was no mention of the committee's recommendations.

### **Components of health care services in the country**

India's health care system is characterized by a mixed ownership pattern. To compound this plurality of provision, there are different systems of medicine- Allopathy, Ayurveda, Unani, Siddha and Homeopathy. There are three major groups in the provision of health care and consumption of health resources in the country. These are the public sector, private health sector and thirdly the households who utilize the health service constitute the largest constituent who spend on health care.

The public health sector consists of the central government, state government, municipal & local level bodies. Health is a state subject and therefore the primary responsibility of providing health services vests with the concerned state government. However the central government does contribute in a substantial manner through grants and centrally sponsored health programs. There are other ministries and departments of the government such as defense, railways, police, ports, mines etc. who have their own health services/schemes and institutions that provide care for their own personnel. For the organised sector employees (public & private) provision for health services is through the Employee's State Insurance Scheme (ESIS).

The private health sector consists of the 'not-for-profit' and the 'for-profit' health sectors. The not-for-profit health sector includes various health services provided by non government organisations (NGO's), charitable institutions, missions, trusts, etc. Health care in the for profit health sector is provided by various types of practitioners and institutions. The practitioners range from General Practitioners (GPs) to the super specialists, various types of Consultants, Nurses and Paramedics, Licentiates, Registered/Rural Medical Practitioners (RMPs) and a variety of unqualified persons (quacks). The practitioners not having any formal qualifications constitute the 'informal' sector and it consists of tantriks, faith healers, bhagats, hakims, vaidyas and priests who also provide health care. The institutions falling in the private health sector range from single bed nursing homes to large corporate hospitals, and medical centres, medical colleges, training centres, dispensaries, clinics, polyclinics, physiotherapy and diagnostic centres, blood banks, etc. In addition to these, the private health sector includes the pharmaceutical and medical equipment industries which are predominantly multinational.

### **Issues to be addressed**

Privatisation and liberalization characterize the new economic policies being pursued in the country. It is in this context that we have to view the various dimensions and aspects of health care costs. These are, majority of the people living under extreme poverty conditions, non-availability of basic amenities for the majority of the people, poor nutritional status, impoverishment due to health, poor availability of public services, presence of a dominant and unregulated, unaccountable private health sector along with strengthening of market forces and helplessness of the consumer against various odds.

### **The Finances of the Public Health Sector**

The Indian constitution in its Directive Principles of State Policy has vested the state with responsibility for providing free health care services to all citizens. In the present scenario the state is abdicating its role of providing health services to the people. There was no attempt post-independence to radically restructure health care services in spite of the recommendations of the Bhore Committee Report. On the contrary, aspects contributing to inequality were strengthened; for instance, under funding of public health services, concentration of medical services disproportionately in the urban areas, production of doctors for the private sector, financial subsidies by the State for setting up private practice and private hospitals.

### ***Under-funding***

The investment by the public sector for health care has been inadequate to meet the demands of the people. The State has over the years committed not more than 3.5% of its resources to the health sector. The budgeted expenditure for 1994-95 was at 2.63% of total government expenditure which is the lowest ever. As a percentage to Gross Domestic Product (GDP) it has been around 1 percent only, woefully short of the World Health Organisation's (WHO) recommendation of five percent.

Further when we calculate per capita expenditure we find that the state spends a meager amount of Rs 60 per year (1990-91) on health. At today's market prices providing all the above services free of cost requires much more expenditure than that is spent presently. Raising this to 5% of GDP would mean an additional expenditure of Rs. 175 billion. This sounds like a lot of money. But given a population of 860 million it works out to only Rs. 260 per capita. At present day prices this amount is equivalent to 35 kgs. of wheat or 40 kgs. of rice or 7 kgs. Of ordinary edible cooking oil or an ordinary rail ticket between Bombay and Calcutta at a little less than a well known medical consultant's fees for a single consultation or 9 GP consultations or 11 days wages of an organised sector industrial worker or 15 litres of petrol. This is not a very extraordinary demand. Given a political commitment, financing of the health sector along with other social sectors needs to be substantially strengthened because ultimately it is these provisions that become the foundation for improvement in the quality of life. **(Duggal R, Nandraj S, Shetty S, 1992)**

Expenditure on health has not kept pace with increase in government expenditure. Under structural adjustment there has been further compression in Govt. spending in an effort to bring down the fiscal deficit to the desired level. Analysis of data by National Institute of Public Finance and Policy gives evidence for this compression which has taken place over the last decade. It shows the state's share in health spending has increased from 71.6% in 1974-82 to 85.7% in 1992-93 and that of the grants from centre declined drastically from 19.9% in 1974-82 to 3.3% in 1992-93. Further the breakdown of central assistance to states reveal that central programmes or centrally sponsored programmes are the most severely affected. The Share of central grants for public health declined from 27.92% in 1984-85 to 17.17% in 1992-93 and for diseases programme from 41.47% in 1984-85 to 18.50% in 1992-93 **(NIPFP, 1993)**. The investment by the state in the health sector is very small both in the overall economy as well as within the public domain.

### ***Rural-urban disparity***

It has been clearly shown time and again by various studies that the rural-urban disparities in terms of health infrastructure is wide and should suffice to show where the state's investment in health sector is going. Analysis of state expenditures on health reveals that between 70 to 80 percent of the investment and expenditure goes to 30 percent of the population in urban areas. For instance, in 1991 of all hospitals and beds in the country only 32%, and 20% respectively were in the rural areas i.e., 0.57 hospitals and 20.2 beds per 100,000 population in rural areas as compared to 3.5 hospitals and 238 beds per 100,000 population in urban areas. **(CBHI, 1992)** This is inspite of the fact that urban areas also have access to other public and quasi-public

health facilities such as municipal and other local body hospitals and dispensaries, ESIS and CGHS for industrial and government workers and so on. Most municipal bodies spend between one-fourth to one-third of their budget on health programs whereas rural local bodies don't spend anything significant on this account (**NIUA 1983, 1989**).

There is utter neglect of rural areas in provision of medical care services. The State took up the responsibility of preventive and promotive health services and left the curative care largely in the hands of the private health sector. The poor in the villages were given inferior health services in the name of Primary Health Care, National Programmes etc. For the rural population there is very little provision of state funded curative care though the major demand of the people is curative care. Studies conducted bring out the fact that PHCs are grossly underutilized primarily because they are inadequately provided (staff, medicine, equipment, transport, etc.) and because the entire focus of the health program through PHCs is in completing family planning targets (**ICMR 1991, Gupta JP, et.al 1992, Ghosh B 1991**). The loss of faith in the public health sector has provided the private health sector an opportunity to thrive and make its presence felt as the sole provider of curative care in the rural areas.

### ***Mis-placed priorities***

The state funding for health care as seen above is very meager and insufficient to meet the needs of the population. Within this meager amount available the state's prioritization and allocation of health expenditures are misplaced. The major emphasis of the state health program has been on population control. From among its various developmental efforts the population control program stands as the most priority activity the Indian state has pursued with a zest bordering on obsession. The under development and poverty of the country is blamed entirely on its population growth rate. Family planning is the single largest plan health program swallowing more than half the plan resources for the health sector. Over the year's expenditure on family welfare program has increased at a very fast pace. From an annual average expenditure of Rs 4.40 million during the second plan (1956-61) it went upto Rs 49.80 million in the 3rd plan period (1961-66) and further to Rs 235 million during the plan holiday (1966-69). (**Duggal R, Nandraj S, Shetty S, 1992**) It went on increasing at a rapid pace in the consecutive plan periods. Family planning expenditures are spent mostly in rural areas through the PHCs and sub centres. On an average each PHC spends around Rs 200,000 to Rs 300,000 on family planning. Besides the allocation of resources it uses the entire infrastructure and human power to meet the targets of its programme. This has resulted in a neglect of other health programs but also the discrediting of the rural health services as a family planning services. This has made the entire rural public health service defunct. In spite of such large quantum of funding the FP programme has been a miserable failure. The Total Fertility Rate continues to remain around 4.5 per women and the growth rate has remained near constant for the past three decades at around 2.2 percent per annum.

### ***Shifting priorities***

Another area of concern is the expenditure incurred by the state on diseases control program. At present there are around 15 national diseases programs functioning in the country. These are for diseases and illness like TB, malaria, filaria, leprosy, diarrhoea, blindness, STD, mental health, cancer, etc. The latest addition is AIDS. These programmes were funded and sponsored

by the centre. Every plan period brought out a new national diseases program. The policies and priorities to various diseases programmes kept shifting. The shifting priorities within the diseases program was more due to the international pressure than the diseases profile of the country. The union government has played a far more significant role in the health sector than demanded by the constitution. It has pushed various national programs in which the states have had very little say in deciding the design and components of the programs. The states have acquiesced to programming due to the central government funding that accompanies them. The expenditure on this programme across the various plan periods has been between 12 to 13 percent of the total health expenditure except during the 1955-65 period when expenditure on malaria was over one-fourth of total health expenditure. On an average only Rs 7 per capita per annum is spent on diseases program. Low priority, under-funding and shifting priorities for diseases programmes persist in spite of an increase in morbidity and mortality due to various diseases. The share of central grants for diseases program declined from 41.47 percent in 1984-85 to 18.50 percent in 1992-93. The decline of expenditure on diseases program has been considerable in the states of Assam, Karnataka, Madhya Pradesh, Punjab, Rajasthan, West Bengal, Bihar and Orissa. **(State Government Budgets, Various Years).**

### ***Health Finances to support Salaries***

Though the reach of the public health services is very limited it supports a very large bureaucracy from the union capital down to the PHC level. The support for this elaborate bureaucracy and line workers forms a major chunk of the states health budget. This fiscal control by the centre and top heaviness of the health organizational structure has made administrative costs of the health ministry's programme phenomenally high. For instance, as of March 1991 the rural areas the State was employing 311,455 line workers (doctors, nurses, pharmacists, paramedics) and 293,400 support staff (clerks, wardboys, drivers, surveyors, etc.).

It may be noted that these were 39% less than the stated requirement for the existing health infrastructure in place **(DGHS 1991)**. The Central Ministry of Health employs over 30,000 persons. The figures for the States is not available but it must be a whopping amount considering the fact that health services are a State-subject !. Analysis of the expenditure on health in Maharashtra during 1990-91 shows that out of a total expenditure of Rs 1767.13 millions on public health account, 43.40 percent was incurred on direction and administration, this is addition to the expenditure on salaries under each program head. Diseases control programmes accounted for 35.23% of total expenditure under public health account. Out of a total expenditure of Rs 31.56 millions on filaria control, malaria Rs 372.51 millions, cholera Rs 19.03 millions, leprosy Rs 130.17 millions it was seen that 74%, 66.66%, 86.21% and 78.87% went into salaries respectively. **(Demand for grants ,Govt of Maharashtra, 1992)**. Salaries take away an exceptionally large proportion of expenditure leaving very little for drugs and supplies. The major expenditure on the public health sector is incurred to maintain a huge army of personnel employed rather than on the provision health services.

### ***State funding for the private health sector***

The state directly or indirectly supports the growth of the private health sector at the cost of public resources. The areas where the state support is clearly evident is production of doctors for the private health sector. The other areas are financial assistance for setting up private

practice, hospitals, diagnostic centres, pharmaceutical manufacture etc. through soft loans, subsidies, tax and custom duty waivers, income-tax benefits etc.

The expenditure on medical education was around 11 percent of total health expenditure in 1992-93 as compared to 5 percent in 1950-51. Nearly 16,000 doctors are being produced every year from some 140 medical colleges in the country. Until recently the role of the private sector in medical education & training of this human resource was very limited. At today's prices on an average each doctor costs the state around Rs 500,000 (for a five year period) and each medical college costs about Rs 80 million per year. Though the state spends a fairly large proportion on medical education the state services are unable to fill in the vacant position. Between two thirds and three fourths of those qualifying from public funded medical colleges practice in the private sector. That means for every 3 doctors the government trains for its own health services it also trains 7 doctors for the private sector at public cost. A further distressing fact is that out of every 100 doctors who go into the private sector 40 migrate out of the country. This is a gross injustice to the poor people in the country who have contributed their mite in training these doctors. Thus the massive investment made by the state from public resources is not only drained away but those who have gained from this exploit the very people who have contributed to their acquiring skills by charging them exorbitantly, thereby making huge profits in the bargain.

### **The Finances of the Private Health Sector**

The private sector has grown to be the most dominant one in the health sector. The share of the private health sector is around 4 percent of the Gross Domestic Product as compared to the government spending which is less than one percent. The share of the private health sector at today's prices works out to between Rs. 16,000 crores and Rs. 20,000 crores per year. India probably has the largest private health sector in the world (**Duggal R, Nandraj S., 1991**). This sector has expanded greatly in the post independence period, especially in the eighties. This is because the state did not take seriously the responsibility of regulating, monitoring and making the private health sector accountable. Due to the unregulated nature of this sector the data available is inadequate and often inaccurate.

It has become all the more important in the current context where the private sector is being encouraged to actively involve itself in almost all sectors of the economy. In the new lexicography of Indian economics privatisation and liberalization are the new panacea for ills in the economy. The structural adjustment policy which is being pushed by the World Bank and the International Monetary Fund (IMF) along with other bilateral and multilateral agencies, has helped expedite this process. The World Bank team's paper on 'Health Financing in India' and the 'World Development Report 1993' advocated a similar approach for the health sector.

The unchecked growth of the private health care and its absolutely unregulated functioning in India has made profiting from human misery a big business. It will not be an overstatement to say that due to the predominance of the private health sector, the Indian health care market has turned out to be a largely supply-determined market.

There are various irrational and unethical practices being followed. The major concern is how to make profit in the shortest possible time. Health has become a healthy business. The trend in the private health sector is towards irrational therapeutics, overcharging, subjecting patients to unnecessary tests, investigations, surgeries, and over prescriptions for monetary reasons, their highly commercial nature among others. Only recently attention has been focused on the serious anomalies with regard to the functioning of private health sector. This was possible because a number of cases of medical malpractice and negligence filed in the court of law by the victims and their relatives. It is also due to the role played by different consumer organisations in raising awareness on the various issues related to the care being provided by the private health sector.

### ***Irrationality of Charges***

There are not enough studies conducted on this vital aspect of the charging practices. Due to the secretive nature of the private health sector functioning there is not enough information available. Not many of them maintain proper books of accounts. With regard to the nursing homes and hospitals the charges are diverse and mind boggling. The charges include consultation fees, charges for bed, nursing, operation, operation theater, various investigations and disposables used, for medicines, etc. In many it has been observed these charges are levied by different entities ; for instance the Doctor conducting the operation would be different from the one who owns the nursing home, the anesthetists who is present his/her's charges are different. The charging practices in the private health sector more often is purely based on a profit motive. The charges levied are arbitrary, irrational and without any proper basis. There are no restrictions or guidelines for fees and amounts charged by the practitioners, hospitals, nursing homes, diagnostic & therapeutic centres, medical centres, corporate hospitals etc. in the country. It varies in terms of place of practice, demand in the area, years of practice put in by the doctor, competition among them, understanding between them, etc. It is left to the whims and fancies of the providers in the private sector to charge as much as they like. The charges are never displayed openly. The consumer does not know how much s/he would be charged when visiting the providers in the private health sector. **(Nandraj S, 1994)**

### ***Earnings of the practitioners and hospitals***

As there is insufficient information on the charging practices we have looked at the earnings of the doctors and nursing homes operating in the private health sector. The earnings of the doctors have been studied only recently. A study undertaken by FRCH in Bombay city found that a GPs net income, on an average, works out to Rs 16,560 per month. **(George A, 1991)**. Another study conducted in Delhi found that on an average the net income of a GP practicing in a clinic or residence was Rs 24,290 p.m., and a graduate gynecologists income was found to be Rs 28,910 p.m. With regard to those having post graduate qualifications in medicine, the average income was found to be Rs 27,880 p.m., for general surgery Rs 37,870 p.m.; and for gynecology Rs 53,870 p.m. With regard to that of the ones running nursing homes with graduate (MBBS) qualifications, their net income per month was Rs 73,650/ and the ones having post graduate degrees had earnings going upto Rs 79,960. **(Kansal S M, 1992)**. The high income of the doctors & nursing homes has been extracted by making illness an industry. Many patients and

their family members have been pauperized during the course of treatment from the private health facilities.

### ***Standardization of charges***

There is no standardization of fees charged. In a study conducted by Medico Friend Circle (MFC), for the question regarding standardization of fees charged by the doctor, it was found that 65% of them felt that there should be some form of standardization of fees charged by the doctors. The study also found that nearly 76% of the doctors did not give a receipt for the payments made, only 24% of them gave receipts after being asked for it. **(Medico Friend Circle Bombay Group, 1993, Draft Report)**. Despite having one of the largest private health sector in the world, providing 70 percent of care in India, the fact that it should function practically unregulated is a matter of grave concern. There is no rationale behind the level of fees charged by them and the law of market operates. Majority of the people utilize the services of the private health sector but have, little or no control on the quality or pricing of the private health services.

### ***Unethical practices***

The rising costs of health care are also due to the irrational and unethical practices resorted to by the private health sector. One of the major reasons of irrational practices among doctors is due to the fact that they are supplier induced demands.

The use of unnecessary injections is quite well known due to the strong financial incentive. In a study conducted in Madhya Pradesh it was found that out of 884 illness episodes which received medicines along with injections, 86.09% of them received it from the private health facility. **(George, A, Shah, I. Nandraj, S., 1993, FRCH)**.

### ***Cut Practice/Kickbacks***

Referrals are often made to specialists and laboratories for a kickback. Over production and competition among doctors in the private health sector has led to harmful competition among them and has made them create unnecessary demand for their services amongst the people. For specialized treatment like hospitalization and investigations, the GP would refer the patient elsewhere. For referrals made, a part of the fee charged to the patient is given to the referring doctor. A GP/consultant gets a cut if s/he refers a patient to a consultant, hospital/nursing home, laboratory, diagnostic center etc. In Bombay, the cut-ratio is as high as 30 to 40 percent of the fees charged. In some towns of Maharashtra informal associations of doctors have standardized the ratios of cuts to be given. Cut-practices inevitably leads to unethical and unnecessary investigations, referrals, hospitalization, high costs, etc. Those doctors who want to practice ethically and rationally cannot survive in this atmosphere.

### ***Unnecessary surgeries and investigations***

Private hospitals tend to perform unnecessary investigations, tests, consultations and surgeries. Due to the fact that surgeries are profitable many of them conduct them rampantly without any regard for the patients well being. The KSSP study revealed that 31 percent of deliveries were by cesarean section. More significantly 70 percent of the hospitals where cesareans were routine were privately owned. **(Kannan et.al)** The Mangudkar committee in Maharashtra



found that the average rate of cesarean childbirth in private hospital was 30 percent as compared to government which was only 5 percent. The private hospitals on an average in Bombay charge anywhere between 10,000 to 20,000 for a cesarean delivery. Ultrasound investigations, amniocentesis, epidural anesthesia etc. are done unnecessarily more often since the facility is there and there has been an investment made on it.

There are other forms of unethical and irrational practices carried out by the private health sector for economic reasons. In many hospitals there is pressure on the doctors to ensure that the beds are occupied all the time and the equipment in the hospital are utilized fully. Many hospitals fix the amount of 'business' a physician/surgeon has to bring. Many of the private hospitals refuse admission to patients unless a certain deposit is not paid before hand. This is in spite of the fact that the patient may be serious or an accident victim. It is also well known that there is demand for more money especially when the patient is vulnerable (operation). Many big hospitals in the private health sector use the facade of registering themselves as trust hospitals. This is done with a view to get various benefits from the state and escape the provision of various taxes.

### ***The business of health***

A rather new feature in the health care delivery system is the entry of corporate hospitals. These hospitals cater to only the rich class of people. The cost of treatment in these hospitals is beyond the reach of common person. During the last one and half decades the growth of corporate hospitals has been at very fast pace. In 1983, the first corporate hospital in India was set up in Madras. It was established by Apollo Hospitals Enterprise Ltd. (AHEL), which recorded a turnover of Rs 11.48 crores and a net profit of Rs 1.66 crores in 1988. Many corporate houses and non-resident Indians have recently joined this enterprise. Several large business houses in addition to their regular business have diversified into the field of health. Some of those who have entered are the Hindujas, Escorts group, Standard Organic group, Surlux Diagnostic Centers, United Breweries group, Goenkas, Birlas and the Modis. This is due to the realization that health could also be transformed into an industry with such desirable features as: a large and available market of illness, access to a ready qualified and trained labour, and the new miraculous state of the art medical technology. They also boast of the latest diagnostic and therapeutic facilities. In a span of two years 1984 to 1986, over 60 diagnostic centers have entered the market with an investment of over Rs 200 crores in sophisticated equipment. Today Bombay has 13 body scanners, Delhi has 11, Madras has 8, Calcutta has 3, Hyderabad has 2, Pune has 3 and Ahmedabad has 3. (**Jesani. A & Ananthraman S. 1993, P 82**). Surlux Diagnostics Ltd. with five centers in India had declared a dividend of 19% during 1988. The United Group owns over 32 body scanners and 14 brain scanners in the country (**Indian Express, May 18th, 1989**). Suffice to say that with the rise of the corporate sector, the cycle in health care does not start with a trained medical person and a sick person in search of each other, but with an investor in the share market in search of profitable investment : the availability of newer medical technology and a market in medical care being merely an attractive form of investment (**Phadke A, 1993**).

### **Health finances of the Households**

The households constitute a major component in terms of expenditure and utilisation of the health services. The various studies conducted have brought out the fact that the households spend a substantial amount on health care and the poorer class spends more on health care in terms of their proportion to consumption expenditure and income. The criteria used for defining classes in these studies differ, but then no comparisons are possible if we insist on academic sophistry. A study conducted in two backward districts of Madhya Pradesh, in 1991 showed that the per capita expenditure incurred by the household on health worked out to Rs.299.16 per year with 73.85% of the expenditure going into doctors fees and medicines. The percentage of consumption expenditure works out to 8.44%. The upper class spends only 3.91% of their consumption expenditure, while the lowest and lower middle classes spend as much as 7.91% and 9.9% respectively on health. **(George, A, Shah, I. Nandraj, S., 1993)**. Kerala Shastra Sahitya Parishad (KSSP) which undertook a study in rural Kerala in 1987 found that the per capita cost per year incurred by the household on health was Rs. 178.33. The percentage of the reported income spent on health was found to be around seven percent. Comparing it across class it found that the lowest class spends as high as 14.36% of their income on health as compared to the highest class which spent only 4.36% of their high incomes. **(Kannan, K.P., Thankappan K R, Raman Kutty V, and Aravindan K P, 1991)**. A study conducted in Jalgaon district of Maharashtra brought out that the per capita expenditure on health was found to be Rs. 182.49 per capita per year, 7.64% of total consumption expenditure and 9.78% of reported income were spent by the household on health care. Out of this total per capita expenditure, 68.50% of the expenditure goes into practitioners fees and medicines. **(Duggal, R., Amin, S., 1989)**. National Council of Applied Economic Research (NCAER) conducted an all India study in 1990 brought out that the average household expenditure for treatment worked out to Rs. 142.60 per illness episode in urban areas and Rs. 151.81 per episodes in rural areas. **(NCAER, 1992)**.

The findings make it evident that a substantial financial burden of the household is borne for meeting health care needs. Households spend between 4 to 7 times of what the state spends on health care services. This certainly is not a happy state of affairs, since such expenditure on health care would mean cutting down on the food consumption of the households. This gains significance when we realize that nearly half of the country's population does not have enough resources to meet their food requirements, and worse still the capacity to earn it the patient happens to be the sole earning member. Given this socio economic situation in the country the purchasing power becomes a crucial factor. As we know the accessibility of the public health service is poor especially in rural areas of the country. The private health sector becomes unaffordable for the vast majority of the poor in the country. There is impoverishment of the lower class or middle class due to illness which could be of a chronic nature or that involving hospitalization or surgery. The high cost of health care makes the poor more marginalised. There is a need to question the commodification of health care, the dominant role of the private health sector and as a result spending a enormous amount of money on health care.

## **Conclusions**

The broadest possible platforms should be created for bringing in some amount of change in the health sector. The states allocation need to be questioned. The underfunding of medical services is matter of serious concern. The need for more resources and greater decentralisation has to be taken up on a priority basis. The priorities within the health sector need to be changed drastically. More funds need to be made available for the rural areas, especially with regard to curative services. Increasing support for population control needs to be questioned. There should be additional resources especially for non-salary expenditures, reducing wastage and improving efficiency by better management practices and setting up of proper referral systems. There is a need to use the existing resources more efficiently and effectively.

There is hardly any regulatory intervention or interference of the government in the private sector and on the health care market. Even the few existing laws and regulations are either toothless or not implemented at all. People's dissatisfaction with the private sector and their disillusionment with the medical establishment is quite high. There is an urgent need for regulation and monitoring of the private health sector. Through licensing and other means the proper geographical distribution should be done. Legislation should be enacted where there is no legislation. There should be regular prescription and medical audits and the renewal of licence should be dependent on it. The findings of the various studies on earnings of the medical profession shows that it is one of the best paid professions. Large sections of the population have become pauperized due to the large sums of money spent on private health care. With regard to charges and fees there should be standardization of fees charged by the practitioners and fixation of reasonable charges by hospitals and nursing homes, diagnostic centres, investigations for the services provided. These should be displayed prominently in a conspicuous place.

There is a trend of favouring user charges/fee-for services for public health services. This should be counted as in the present socio economic conditions the poor would be hit the hardest. Additional revenues specifically for the health sector could be generated through additional tax on degrading health products such as cigarettes, liquor, pan masala etc. Those with a capacity to pay especially in the organised sector, middle and rich peasantry and other self-employed should be made to contribute for health care services. This could be through insurance and other pre-payment programs. In India no single system can work. What we would need is a combination of social insurance, employment related insurance for the organised sector employees, voluntary insurance for other categories who can afford to pay and of course tax and related revenues.

There should not be any kind of payments done at the point of provision of care since they are unfavourable to patients. Payments should be made to providers by a monopoly buyer of health services who can also command certain standard practices and maintain a minimum quality of care - payments could be made in a variety ways such as capitation or fixed charges for a standard regiment of services, fee-for-service as per standardised rates, etc. The move towards monopoly purchase of health services through insurance or other means and payment to providers through this single channel is a logical and growing global trend. To achieve universal access to health care and relative equity this is perhaps the only alternative available at present, but this of necessity implies the setting up of an organised system and for this the

State has to play the lead role and involve the large private sector within this universal health care paradigm if it must be successful. **(Duggal R, 1995).**

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