THE PRIVATE HEALTH SECTOR IN INDIA -

Nature, Trends and a Critique

Ravi Duggal

Centre for Enquiry into Health & Allied Themes (CEHAT)

Aram Society Road, Vakola, Santacruz East, Mumbai 400055

Email: cehat@vsnl.com *or* raviduggal@vsnl.com

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1. The Historical Context

The way we perceive and understand the health sector today is shaped largely by Capitalism and its critique and contradictions. For it is under Capitalism that health care evolved as an institutional system, almost like any other sector of the economy. In pre-capitalist times the health care provider was an independent producer who catered to the local market. His/her skills were acquired through personal contact, usually within the family; ofcourse, there were institutions which provided knowledge and practice skills, especially for higher levels of learning and often under state patronage. The average producer of health care then was not dependant on any external inputs, whether in training, formulation of medicines etc..

Pre-colonial Period

In pre-capitalist times in India right down to the very ancient times of the Indus valley civilisation there is evidence as pointed by historians to suggest that State patronage for both public health as well as medical care was common - well planned urban centres, universities, medical texts of ayurveda, siddha and later unani. While there is vast documentation and discussion on the systems of medicine, the philosophical context etc.., literature on health care provision, health care providers, health care spending, organisation of health care services etc.. is conspicuous by its absence. Oral history and folk traditions, however, do indicate that a large variety of individual practitioners existed - vaids, herbal healers, snake-bite specialists, birth attendants, abortionists, psychic healers, faith healers etc..

Hospitals, more in the nature of infirmaries or dharmashalas to house the sick, crippled and destitute were very much there which provided care freely and free of cost (Fa-Hein as quoted in Jaggi,1979 XIV:3). For instance during Ashoka's reign such hospitals were built all over the empire and also in other countries by the State and facilities were made available free (Kosambi, 1975 and Thapar, 1973). Similarly during the Mughal Sultanate the rulers established such hospitals in large numbers in the cities of their kingdom where all facilities were provided to patients free of charge. These activities were financed not only by the kings but also through charities of the rich traders and wealthy persons in the kingdom (Jaggi,1979 XIV:3-4).

Hence in the pre-capitalist period, which coincides with the pre-colonial period, structured health care delivery had clearly established three characteristics. Firstly it was considered a social responsibility and thus State and philanthropic intervention were important. Secondly the services provided were free of cost to all who could avail them or had access to - ofcourse, caste, class and other such biases were there. And thirdly most of these facilities were in towns thus showing a neglect of the countryside.

Colonial Period

Under colonialism Indian medical science declined rapidly. Ayurveda, both due to its unwillingness to become open and adapt to changing times and due to reduced patronage with Unnani-Tibb becoming dominant in the medieval period had already suffered a set back. With the coming of the Europeans even unnani medicine suffered reduced
patronage.

The impact of colonialism was far reaching. The gradual destruction of the local economy also destroyed local medical practices. However, the diffusion of modern medicine which was emerging was poor, especially in the rural areas, hence people living in these areas had to resort to whatever remained of what was now called folk and/or traditional medicine.

While the first 'modern' hospital was established by the Portuguese in Goa as early as 1510 it was only under British colonialism that modern health care established itself firmly, expanded its influence and was available more widely, albeit restricted for access to the elite and the middle classes and ofcourse the urban areas. The English East India Company set up its first hospital in 1664 at Fort St. George in Madras because they could not see the "English men drop away like dogs" (Crawford, 1914, II:401).

As the needs of the British population, especially the armed forces, increased due to larger territories coming under their administration and an increased number of English troops, a more organised medical establishment was necessitated. Thus on the New Year day of 1764 the Indian Medical Service(IMS) was founded, initially as the Bengal Medical Service (Jaggi, 1979, XIV:27).

The IMS catered mostly to the needs of the armed forces. However, by early 19th century hospitals for the general population were established in chief moffusil towns, besides the Presidency headquarters (Crawford, 1914, II:430).The expansion of the medical facilities followed the devolution of the imperial government, especially after 1880 with the setting up of municipalities and district boards.

However, these medical facilities had a distinct racial and urban bias. Separate provisions were made on employment and racial grounds, though in some places non-official Europeans might be allowed access to hospitals designed for civil servants. In general hospitals wards for Europeans and Eurasians were separated from those for the rest of the population (Jeffery, 1988, 87). These facilities, atleast until the Montagu-Chelmsford reform of 1919, were located in urban areas in the military and civilian enclaves of the English.

The rural areas had to wait till the Government of India Act 1919 whereby health was transferred to the provincial governments and the latter began to take some interest in rural health care. In fact, a rural health care expansion in a limited way began in India first from 1920 onwards when the Rockefeller Foundation entered India and started preventive health programs in the Madras Presidency in collaboration with the government and gradually extended its support for such activities in Mysore, Travancore, United Provinces and Delhi. The focus of their activities was on developing health unit organisations in rural and semi-rural areas, in addition to support for malaria research and medical education (Bradfield, 1938, 274-275).

This intervention of the Rockefeller Foundation is historically very important for development of health care services and health policy in India, especially for rural areas. It may be considered a watershed that paved the path for the ideology that rural areas need only preventive health care and not hospitals and medical clinics, that is they need "public health" and not medical care. There was a romance attached to leaving the rural areas to their folk traditions and practices for their medical care but intervention was needed to maintain public health so that epidemics could be controlled! The result of this was that medical care activities of the State were developed mainly in the urban areas and rural areas were deprived the devolution of medical care within their reach. This is an important historical fact to note because this same differential treatment for urban and rural areas have continued even in the post-colonial period, and the international actors, now many more in number and more aggresive at that, provide for its continuity both financially and ideologically.

This dualism underlies the history of development and underdevelopment and without keeping this in context the analysis of the health sector will have little meaning.

The imperial government in India adopted measures that were totally inadequate to deal with the problems at hand. Apart from the racial and urban bias in developing public health infrastructure they also ignored the way the private health sector was developing. No concern whatsoever was shown at regulating the private health sector as a consequence of which the number of unqualified practitioners kept increasing. While those concerned with colonial administration and living in the enclaves had access to the modern health care services which were evolving, the remaining ("natives") were left to the mercy of these private practitioners most of whom were either "traditional" practitioners trying to integrate with modern medicine or outright quacks. This is an important fact to note because the generally accepted view is that private practitioners became a significant segment of the health sector only after independence. In fact as early as 1881 there were 84,187 male medical practitioners (Census-1881, 1883 - female occupations were not recorded in the 1881 census), of which only 16% were qualified allopaths and the remaining were either Indian system practitioners or unqualified practitioners; and of the allopathic practitioners only one-fifth were in state service, the remaining being in private practice This reveals not only the large size of the private health sector but also shows early commodification of health care provision and a lack of control and regulation of the medical profession. By Independence the qualified allopaths had reached 50,000 and others 150,000.

During the colonial period hospitals and dispensaries were owned mostly by the State as also financed by it but as stated earlier they were located in urban areas or district headquarters and hence its access was fairly restricted for the general population.

In Table 1 we can see the growth of the health sector and its financing during the colonial period.

Post-colonial Era

Independent India has not as yet seen a radical transformation in provision of health care services for its majority population, especially the masses in the rural areas. This inspite of a National Health Plan being available on the eve of Independence. The detailed plan set out by the Bhore Committee was both well studied and comprehensive and designed to suit Indian conditions. It sough to construct a health infrastructure which would require an increase in resource allocation by the state of about three time that existing then. These state health services would be available universally to all free of cost and would be run by a whole time salaried staff. The Bhore Committee plan was biased in favour of rural areas with the intention of correcting the wide rural-urban disparities in the shortest possible time. When implemented fully in 25-30 years the level of health services would improve ten-fold(of that existing in the early forties) to 567 hospital beds per 100,000 population, 62.3 doctors per 100,000 population and 150.8 nurses per 100,000 population spread proportionately all over the country. This development would make the private health sector dispensable. This level of health services would have been about three-fifths of World War II Britain.

The First and Second Health Ministers Conference after Independence accepted the Bhore Committee recommendations in principle but maintained that lack of resources was the major obstacle to implement this plan. The First Five Year Plan also pursued this same line of argument but subsequent Five Year Plans even stopped mentioning the Bhore Committee Report.

Viewed historically the post-Independence state health financing and health services development was not very different from the colonial period. The same enclave pattern continued (ofcourse the residents of enclaves were now indigenous!) - urban concentration, class-caste bias etc.. What changed was the

proportion of medical institutions and facilities in the private sector - the last two decades have witnessed a very high growth rate of private hospitals and dispensaries (Jesani and Ananthram, 1993).

The First Five Year Plan had clearly set out the purpose of planned development vis-a-vis the private sector - "The distinction between the public and the private sector is it will be observed one of relative emphasis; private enterprise should have a public purpose and there is no such thing under present conditions as completely unregulated and free enterprise. Private enterprise functions within the conditions created 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 way of tariffs, fiscal concessions and other direct assistance, the incidence of which is on the community at large. Infact as the experience of recent years has shown, major extensions of private enterprise can rarely be undertaken except through the assistance of the state in one form or another" (Planning Commission,1952:p33).

The influence of the Bombay Plan (also called Tata-Birla Plan) is evident in the above passage and this was again reflected in the First Industrial Policy Resolution that was set out during the Second Five Year Plan. This policy of the State supporting the growth of the private sector is also reflected in the health sector.

For instance right from the beginning medical education has been financed almost entirely by the State. Yet, more than three-fourths of medical graduates each year either set up private practice, join private institutions or worse still migrate to developed countries. As a consequence the private health sector has grown rapidly with clear evidence of support from State resources. Not only medical education but also setting up of private practice, hospitals, diagnostic centres, pharmaceutical manufacture etc.. receive state assistance in the form of soft loans, subsidies, tax and custom duty waivers, income tax benefits etc.. All this has helped the private health sector to grow from strength to strength. However, the State has not made efforts at regulating the private health sector as is implied in the above Planning Commission statement and as a result the private health sector, apart from being unregulated has also become highly exploitative given the 'supply-induced demand' nature of the health sector. For a country having the largest number of poor in the world this is not good for its health !

On the other hand State health services which were to be created to serve the underprivileged majority have not even reached half the level which the Bhore Committee had envisaged way back in 1946. Even that which has developed is in urban areas with an increasing share of the private sector. The only target of the Bhore Committee which has been realised is the production of doctors but most of these doctors are in the private sector and in urban areas.

Table 2 highlights these disparities very clearly. Rural areas continue to be highly uderserved and the urban private health sector is burgeoning.

2. The Character of the Private Health Sector and Related Issues

The health sector world-wide is perhaps the largest subsector of the economy. No other sector of the larger economy has a reach as much as the health sector, its market being assured, whatever the odds. Given this

basic feature, modern medicine under capitalism has exploited fully the opportunities for appropriating surplus through provision of health care.

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. While such commodification of health care is nearly complete in the developed countries, in a country like India the large rural - urban gap in availability of modern health care makes for a slower process. However, in the west the existence of welfare states under which near universal access to health care is guaranteed has prevented health care from being a commodity for the user because of the existence of a monopoly buyer of health care and a standardised system of payment to providers.

Provision of routine medical care for a wide range of diseases and symptoms 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 fairly 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 sector health expenditure today is Rs.20,000 crores (1999-2000), being spent on 5000 hospitals and 550,000 beds, 11,100 dispensaries, 23,000 PHCs, 140,000 subcentres and various preventive and promotive programs, including family planning. The State employs 140,000 doctors and also runs 108 medical colleges. But the services provided by the state do not meet the expectations of people and as a consequence the latter are forced to use private health care 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 12,00,000 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), and if we accept this estimate then the total medical practitioners active becomes about 14,00,000, that is one such practitioner per 700 population!

Another study done in Ahmednagar district by FRCH showed that the district in 1992 had 3056 active medical practitioners (FRCH 1999). Ahmednagar being an economically average developed 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.

Urban concentration of health care providers is a well known fact - 59% of the country's practitioners as per 1981 census (73% 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) 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 location policy which 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.. We have also stated that there are a very large number of practitioners who do not have any qualification from the recognised systems. 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 and those with non-allopathic qualifications are located in equal numbers in both urban and rural areas as indicated by the 1981 Census - 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 in 1992 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,1999).

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 - this is discussed in a subsequent section. Thus, a major question which 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 today and hence it should become 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 and those who

wish to acquire knowledge and skills of other systems should have the necessary facilities to pursue those as electives or specialisations.

We strongly feel that this is an important issue of concern for policy makers. If some steps in the direction suggested are not undertaken with due seriousness then the existing system hierarchies (with allopathy as dominant and homoeopathy and ayurveda qualifications serving as a legitimacy to practice modern medicine or as alternate to allopathy for the patient when the latter fails to cure) will continue and quality care or care with basic minimum standards will never be achieved.

Related to having an accredited qualification is the question of registration with the appropriate authority and 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 of such health care 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 registrations 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. As a consequence 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 and 1998; Duggal and Amin, 1989; George et. al. 1993; Jesani et.al., 1996; Kanan et. al, 1991; NCAER, 1992 and 1995; Madhiwala et.al., 2000; Nandraj et.al., 2000). 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.

As suggested in the preceding section something needs to be done at the policy level about this wild crosspractice 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 location restriction in overserved areas and location encouragement in underserved 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 location policy for setting up medical practice becomes essential. Along with this regulation, standards and quality care are necessary features.

3. Patterns of Growth

In section 1 we have discussed briefly the growth of the health sector in the historical context. Here we will look at recent trends, especially during the last decade or so which is characterised by liberalisation of the Indian economy and followed by a structural adjustment in the more recent years.

Planned health care development was confined to what the Planning Commission did. The Ministries of Health have shown little concern for planned development of the health sector in India. The Planning Commission's concern was with only the public sector inspite of knowing that the private health sector is the dominant one and such planning has no meaning if the private sector is left out of the ambit. As a consequence of this the availability of data on the private health sector is a major problem. The only definitive set of private sector data is on the number of hospitals and beds and that too is an underestimate as various micro studies have revealed. Another set of data on the private health sector which is somewhat definitive is pharmaceutical production where 90-95% of formulations are manufactured in the private sector.

Tables 1 and 2 give a broad overview of health sector development in the country, including whatever data is available for the private sector. This data reveals that the private health sector has been dominant since even before independence but since details are not available on the private health sector as is evident from the tables a critical analysis becomes difficult and restricted to anecdotal evidences or results of small studies and enquiries and investigations. Hence the analysis presented in the following paragraphs must be viewed in this context of limited information.

Production and Growth of Medical Humanpower

The training and education of doctors of the modern system is predominantly in the public sector. Until the last decade the private sector showed little interest in medical education and the entire burden of producing doctors and nurses was on the state. But in recent years private medical colleges are increasing in numbers rapidly, many without getting the necessary permission of the Medical Council of India because they lack the necessary facilities essential for imparting such education and training. This trend has been largely due to lack of any regulation on the growth of the private sector, the states unwillingness, and rightly so, to increase the number of medical seats in the public sphere and the large demand of doctors in mid-east and western countries. It must be noted that inspite of various restrictions outmigration of allopathic doctors remains very high with about 4000 to 5000 doctors leaving the country every year which at today's prices means a loss of atleast Rs.4000 - 5000 million (US$ 100 - 125 million), assuming a minimum of Rs.10 lakhs as the cost of production of a doctor. Given this situation it has become very profitable to run private medical colleges but since such a nature of production doesn't help the health sector in the country it needs to be questioned. Why should the state continue to subsidise the production of doctors for private practice or to meet demands of global markets? When only one-fifth of doctors produced in state medical schools join the public health system it makes little economic, social or even political sense to produce such a large number of doctors for the private sector with such a fantastic subsisdy! And those doctors who come out of private medical schools after spending about Rs.10 lakhs of their personal money will not only not work in the public system but will hasten the process of destruction of any sense of professional ethics which may exist today.

In contrast, production of doctors under ayurved, homoeopathy, unani, siddha etc.. is largely in the private sector with very limited subsidies from the state. Even these doctors are largely produced for the private market. And with lack of any regulation of medical practice most of them indulge in whole-scale crosspractice, especially allopathy. Infact it is an open secret that non-allopathic qualification is a via media for setting up the more profitable practice of modern medicine. Ofcourse doctors with such qualifications have little scope for migration to other countries and hence they don't contribute to the drain of the nation’s wealth and resources. However, data on doctors of non-allopathic systems is even more scarce. Further, in India there are practitioners providing medical care privately without having any medical or health qualification at all and this we have seen in an earlier section is a number equivalent to all those having an accepted qualification and registration.

The story about nurses is a little different from that of doctors. Firstly, we do not produce enough nurses and what is produced is either absorbed by the state or more often by outmigration. It is funny but we produce more doctors than nurses in India! Secondly, the demand for qualified nurses in the private sector in India is very small because the private hospitals and nursing homes do not follow any standard practices and prefer to employ nursing personnel who are trained only as auxiliaries or worse still are trained on the job. Neither the Nursing Council or Medical Council or the State have shown any interest in regulating this aspect of private care.

Today with an estimated 700,000 qualified practitioners of various systems and an equal number of unqualified practitioners in individual private practice we have the largest private health sector in the world and one which is completely unregulated. This segment of the private health sector is providing only curative services on a fee-for-service basis.

Health Care Facilities

Apart from individual practitioners (general practice and consultants) there are dispensaries, nursing homes and hospitals. While dispensaries as a concept is from the public sector those reported in official statistics as private dispensaries are usually one or two bedded day care centres (usually rural), or even without beds registered as clinics of private practitioners who are affiliated to insurance medical systems (usually urban).

Hospitals and nursing homes constitute the more significant part institutional care. There is no accepted definition differentiating the two but as a rule the small private hospitals (5-10 bedded) are referred to as nursing homes. Historically the private hospital sector has been small in India as elsewhere in the world because state and charity (including religious missions) were regarded as the most appropriate providers of such care. But as such care got commodified under capitalism aided by technological developments which facilitated profiteering private interest in running hospitals increased rapidly. In India the limited data we have shows that this process of rapid increase in the number of private hospitals and their capacity began in the mid-seventies and has advanced progressively, increasing from a mere 14% of hospitals in 1974 to 68% in 1995. This period of rapid private sector expansion in the hospital segment also coincides with newer medical technologies being made available as well as large scale increases in the number of specialists being churned out from medical schools.

Whether private or public the hospital segment expanded mostly in the urban areas and the rural populations access to such care got worse over the years. Even today 84% of hospital beds are in urban areas when 75% of the population resides in villages!

The private hospital sector is presently in the process of making another transition in its rapid growth. This is the increased participation of the organised corporate sector. The new medical technologies have made possible the concentration of capital possible in the medical sector. These new technologies are increasingly reducing the importance of the health care professional. S/he is no longer the central core of health care decision making and corporate managers are increasingly gaining control of the health care sector. New medical technologies have opened new avenues of corporate investment that is going to bring about far reaching changes in the structure of health care delivery. With private insurance also threatening to arrive on the scene health care too will soon make its way into the big league of monopoly capital.

Production of Drugs and Medical Equipment

The pharmaceutical industry in India is very large and is able to cater to not only almost the entire demand for drugs in the country but is also emerging as a major exporter at the global level. While the public sector had played a larger role in the production of bulk or basic drugs in the past its role has declined in this segment of drug production over the last decade and a half. With a turnover of nearly Rs.160 billion (in 1999) and more than 90% of this being in the private sector the private pharmaceutical industry is the engine of the private health sector in India. It has penetrated the remotest of rural areas and has not deterred from using even the large unqualified segment of practitioners to expand its market. If someone has any information on private medical practice it is the pharmaceutical industry. Its well organised network of medical representatives know the private medical sector in and out. In many districts they have even organised the information on the private and public health care sectors, ofcourse for their own use. Our experience in carrying out micro studies of the private health sector shows that medical representatives and drug stores are the best source of information on the private health sector, much better than the local Indian Medical Association.

The nonallopathic drug industry, mainly ayurveda and homoeopathy, is also fairly large but organised information on it is not available. Also there are no known estimates of turnover or drug production. However, there are a number of ayurvedic drug manufacturers whose turnover is in hundreds of crores, and again mostly in the private sector.

For the consumer the major concern is the rapid increase in drug prices. During the last two to three years prices of many essential drugs have doubled and this makes seeking of health care more expensive not only in the private health sector but also in the public health sector because the latter's drug budgets have not increased with the increase in drug prices.

The medical equipment industry in India is much smaller than the pharmaceutical industry and India still has to rely heavily on imports, especially of hitech equipment. But there is every indication that it is on the verge of growing very rapidly. The 7th Five Year Plan had estimated a demand of Rs.9000 million for the period in this sector and in 1986-87 the imports were valued at Rs.650 million.

Health Care Utilisation and Expenditures

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. As a consequence 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.600 to 800 billion private health care market in the country at 1999 market prices. This includes the hospital sector where the private sector has about 50% of the market share.

Concluding Remarks : In conclusion it is important to reemphasise the role of the state in contributing to the growth of the private health sector. Direct and indirect support to the private health sector by the state is the main form which privatisation takes in India. Some instances are as under :

- medical education as indicated above is overwhelmingly state financed and its major beneficiary is the doctor who sets up private practice after his/her training; three-fourths of medical college graduates from public medical schools work in the private sector. Though they are trained at public expense their contribution to society is negligible because they engage in 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, 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 technology.
- 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, but by being inefficient 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 and 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 todays liberalised scenario and with World Banks advice of state's role being restricted 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.

Note : See Appendix II for Tables relevant to the discussion presented above.

4. Organising The Private Health Sector: Towards A Public-Private Mix

As discussed in the preceding sections the private health sector is responsible for nearly three-fourths of all health care in the country and yet it is not regulated in any significant manner by any authority even when there are Acts established for that purpose. For instance the Councils of the various systems of medicine are supposed to assure that only those having the appropriate qualifications and those registered with them may practice the particular form of medicine. But evidence presented above shows that this does not happen in practice and hence unqualified persons set up practice, there is rampant crosspractice, irrational and other malpractices are common, there are no fixed schedules of charges for various services being rendered, hospitals and nursing homes do not follow any minimum standards in provision of services, practice may be set up in any place etc... Whereas the public health sector due to bureaucratic procedures is forced to maintain atleast some minimum requirements, for instance they will not employ nonqualified technical staff, will carry out tasks only if minimum conditions or basic facilities are available, will follow certain set procedures of use of equipment or purchase of stores etc.. and is subject to public audit, the private health sector doesn't pay heed to any such thing (see mfc bulletins nos.173 and 174, july/august 1991, for a detailed discussion on this issue).

Private medical practice has now existed too long without any controls and regulation. In the last decade or so an increasing pressure is being exerted on the private health sector to put its house in order. Patients,

consumer bodies and other public interest groups are targetting malpractices and negligence in the private health sector and demanding compensation, accountability, setting up of minimum standards etc..

Apart from getting the concerned authorities to implement existing Acts, laws etc... there is a need to bring in an entirely new range of comprehensive regulations as existing in countries which have near universal health care provision with predominantly privately managed care. This means drastic changes in health policy and reorganisation of the entire health care system. We recognise that privately provided health care has come to stay but we also believe that it needs to be organised in an appropriate manner to evolve a public-private mix which provides universal health care coverage. Appendix I gives an indicative list of action necessary for comprehensive regulation of the private health sector.

The new strategy should thus focus both on strengthening the state-sector and at the same time also plan for a regulated growth and involvement of the private health sector. There is a need to recognise that the private health sector is huge and has cast its nets, irrespective of quality, far wider than the state-sector health services. Through regulation and involvement of the private health sector an organised public-private mix could be set up which can be used to provide universal and comprehensive care to all. What we are trying to say is that the need of the hour is to look at the entire health care system in unison to evolve some sort of a national system. The private and public health care services need to be organised under a common umbrella to serve one and all. A framework for basic minimum level of care needs to be spelt out in clear terms and this should be accessible to all without direct cost to the patient at the time of receiving care.

Today we are at the threshold of another transition which will probably bring about some of the changes like regulation, price control, quality assurance, rationality in practice etc.. This is the coming of private health insurance that will lay rules of the game for providers to suit its own for-profit motives. While this may improve quality and accountability to some extent it will be of very little help to the poor and the underserved who will anyway not have access to this kind of a system. Worldwide experience shows that private insurance only pushes up costs and serves the interests of the have. If equity in access to basic health care must remain the goal then the State cannot abdicate its responsibility in the social sectors. The state need not become the primary provider of health care services but this does not mean that it has no stake in the health sector. As long as there are poor the state will have to remain a significant player, and interestingly enough, as the experience of most developed countries show, the state becomes an even stronger player when the number of poor becomes very small![1]

While reorganisation of the health sector will take its own time, certain positive changes are possible within the existing setup through macro policy initiatives - the medical councils should be directed at putting their house in order by being strict and vigilant about assuring that only those qualified and registered should practice medicine, continuing medical education (CME) should be compulsory and renewal of registration must be linked to it, medical graduates passing out of public medical schools must put in compulsory public service of atleast five years of which three years must be at PHCs and rural hospitals (this should be assured not through bonds or payments but by providing only a provisional license to do supervised practice in state health care institutions and also by giving the right to pursue postgraduate studies only to those who have completed their three years of rural medical service), regulating the spread of private clinics and hospitals through a strict locational policy whereby the local authority should be given the right to determine how many doctors or how many hospital beds they need in their area (norms for family

[1] Data from OECD countries clearly shows that the State is a major player in health financing and over three-fourths of the resources for the health sector in these countries, except USA, comes from the public exchequer; even in the USA it is over 40% but in India the State contributes only about one-fifth the balance coming out of pocket of households

practice, practitioner : population and bed : population ratios, fiscal incentives for remote and underserved areas and strong disincentives and higher taxes for urban and overserved areas etc.. can be used), regulating the quality of care provided by hospitals and practitioners by setting up minimum standards to be followed, putting in place compulsory health insurance for the organised sector employees (restructuring the existing ESIS and merging it with the common national health care system where each employee has equal rights and cover but contributes as per earning capacity, for example if each employee contributes 2% of their earnings and the employer adds another 3% then nearly Rs.100 billion could be raised through this alone), special taxes and cesses for health can be charged to generate additional resources (alcohol, cigarettes, property owners, vehicle owners etc.. are well known targets and something like one percent of sales turnover for the products and a value tax on the asset could bring in substantial resources), allocation of existing resources can be rationalised better through preserving acceptable ratios of salary : nonsalary spending and setting up a referral system for secondary and tertiary care. These are only some examples of what can be done through macro policy initiatives.

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Appendix I

What should a Comprehensive Legislation seeking Regulation include?

The following suggestions on regulation encompass the entire health sector. However, they are not an exhaustive list but only some major important areas needing regulation.

1.Nursing Homes and Hospitals :

- Setting up minimum decent standards and requirements for each type of unit; general specifications for general hospitals and nursing homes and special requirements for specialist care, example maternity homes, cardiac units, intensive care units etc.. This should include physical standards of space requirements and hygiene, equipment requirements, humanpower requirements (adequate nurse:doctor and doctor:beds ratios) and their proper qualifications etc...
- Maintenance of proper medical and other records which should be made available statutorily to patients and on demand to inspecting authorities.
- Setting up of a strict referral system for hospitalisation and secondary and tertiary care
- Fixing reasonable and standard hospital, professional and service charges.
- Filing of minimum data returns to the appropriate authorities for example data on notifiable diseases, detailed death and birth records, patient and treatment data, financial returns etc..
- Regular medical and prescription audits which must be reported to the appropriate authority
- Regular inspection of the facility by the appropriate authority with stringent provisions for flouting norms and requirements
- Periodical renewal of registration after a thorough audit of the facility

2. Private Practitioners :

- Ensuring that only properly qualified persons set up practice
- Compulsory maintenance of patient records, including prescriptions, with regular audit by concerned authorities
- Fixing of standard reasonable charges for fees and services
- Regulating a proper geographical distribution
- Filing appropriate data returns about patients and their treatment
- Provision for continuing medical education on a periodic basis with licence renewal dependent on its completion

3. Diagnostic Facilities :

- Ensuring quality standards and qualified personnel
- Standard reasonable charges for various diagnostic tests and procedures
- Audit of tests and procedures to check their unnecessary use
- Proper geographical distribution to prevent over concentration in certain areas

4. Pharmaceutical industry and pharmacies :

- Allowing manufacture of only essential and rational drugs
- Regulation of this industry must be switched to the Health Ministry from the Chemicals Ministry
- Formulation of a National Formulary of generic drugs which must be used for prescribing by doctors and hospitals
- Ensuring that pharmacies are run by pharmacists through regular inspection by the authorities
- Pharmacies should accept only generic drug prescriptions and must retain a copy of the prescription for audit purposes

Appendix II : Tables

TABLE 1: HEALTH CARE INFRASTRUCTURE AND FINANCING 1880 - 1940

	1880	1890	1900	1910	1920	1930	1940
1.Hospitals & Disps.	1212 (only state financed)	1736	2313	4262	5067	6448	7441
i)Percent State Owned	na	na	na	68.5	72.2	72.0	87.3
ii)Percent State Financed	na	na	na	74.5	78.0	81.9	92.4
iii)Total Beds	na	na	na	45639	55772	67245	74111
iv)No. of Patients Treated (millions)	na	12.98	20.49	35.06	45.53	67.87	na
v)% treated in state financed institutions	na	na	na	80.4	82.7	84.6	na
2.Total Public Health Expenditure, includes local govt.(Rs.million annual avg. of last decade)	18.5	23.3	38.8	53.5	76.3	143.4	145.3
-percent spent by local govts.	43.8	45.1	51.8	58.3	61.6	63.7	60.8
-percent public health expenditure to total govt. expenditure	3.14	2.92	3.78	4.23	4.54	5.35	5.47
3.Medical Practitioners as per census	91607					304544	
-percent qualified (only allopathy)	14.51					25.58	

Sources : **Expenditure Data** - Roger Jeffery: The Politics of Health in India, Univ. of California Press, Berkely, 1988
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Practitioner data - Census of India 1881 vol.III, GOI and 1931 vol.I Part II, GOI, includes Burma etc...

Table 2: HEALTH INFRASTRUCTURE DEVELOPMENT IN INDIA 1951-1998

			1951	1961	1971	1981	1991	1995	1996	1997	1998
1	Hospitals	Total	2694	3054	3862	6805	11174	15097			
		% Rural	39	34	32	27		31			
		%Private				43	57	68			
2	Hospital & dispensary beds	Total	117000	229634	348655	504538	664135	870161			
		% Rural	23	22	21	17		20			
		%Private				28	32	36			
3	Dispensaries		6600	9406	12180	16745	27431	28225			
		% Rural	79	80	78	69		43			
		% Private				13	60	61			
4	PHCs		725	2695	5131	5568	22243	21693	21917	22446	
5	Sub-centres				27929	51192	131098	131900	134931	136379	
6	Doctors	Allopaths	60840	83070	153000	266140	395600	459670	475780	503950	522634
		All Systems	156000	184606	450000	665340	920000			1100000	1155000
7	Nurses		16550	35584	80620	150399	311235	562966	565700		
8	Medical colleges	Allopathy	30	60	98	111	128		165	165	
9	Out turn	Grads	1600	3400	10400	12170	12086				
		P. Grads		397	1396	3833	3139				
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	79.4	91.3	104.9	120.7
11	Health outcomes	IMR/000	134	146	138	110	80	74/69	72	71	
		CBR/000	41.7	41.2	37.2	33.9	29.5	29	25	24	
		CDR/000	22.8	19	15	12.5	9.8	10	9	9	
		Life Expectancy years	32.08	41.22	45.55	54.4	59.4	62	62.4	63.5	
	Births attended by trained practitioners	Per 1000 live births				18.5	21.9		28.5		
12	Health Expenditure Rs. Billion	Public	0.22	1.08	3.35	12.86	50.78	82.17	101.65	113.13	126.27
		Private@	1.05	3.04	8.15	43.82					
		CSO estimate of pvt.		2.05	6.18	29.70	82.61				

@ Data from - 1951:NSS 1st Round 1949-50; 1961: SC Seals All India District Surveys,1958; 1971: NSS 28th Round 1973-74; 1981: NSS 42nd Round 1987; 1991 and 1995: NCAER – 1990 and 1994.

Source : 1. Health Statistics / Information of India, CBHI, GOI, various years
2. Census of India Economic Tables, 1961, 1971, 1981, GOI
3. OPPI Bulletins and Annual reports of Min. of Chemicals and Fertilisers for data on Pharmaceutical Production
4. Budget Papers of Central and State Governments, various years
5. National Accounts Statistics, CSO, GOI, various years

TABLE 3 : PUBLIC AND PRIVATE DISTRIBUTION OF HEALTH INFRASTRUCTURE

(percentages)

	HOSPITALS		DISPENSARIES		HOSP BEDS		ALLOPATHS	
	Pub	Pvt	Pub	Pvt	Pub	Pvt	Pub	Pvt
1964	*	*	*	*	*	*	39.6	60.4
1974	81.4	18.6	*	*	78.5	21.5	*	*
1981	56.2	43.8	86.2	13.8	71.6	28.4	29.4	70.6
1986	54.7	45.3	*	*	73.9	26.1	26.6	73.4
1988	44.1	55.9	50.6	49.4	70.1	29.9	*	*
1991	42.6	57.4	40.4	59.6	67.8	32.2	*	*
1993	33.4	66.6	37.0	63.0	64.6	35.4	*	*
1996	31.9	68.1	39.0	61.0	63.4	36.6	*	*

Note : * Not Available

TABLE 4 : MEDICAL AND NURSING HUMANPOWER IN INDIA 1952 - 1987

REFERENCE YEARS	DOCTORS									
	Allopaths	Homeopaths	Ayurveds	Sidha	Unani	Total	Dentists	Nurses	Midwives	Total
1952	65370	-	-	-	-	-	3291	17989	-	-
1956	76904	-	-	-	-	-	3003	24724	-	-
1961	83756	27468	73382	-	-	184606	3582	35584	51194[$]	86778
1966	103184	-	-	-	-	-	4374	57621	-	-
1969	128584	110514	155828	1543	24530	420999	5182	69937	-	-
1971	151129	-	-	-	-	-	5512	80620	80159	160779
1974	190838	145434	223109	18128	30400	607909	6647	98403	100554	139930
1979	249752	112638	225477	18093	25988	631948	7518	139825	130382	198957
1981	268712	115710	233824	18357	28737	665340	8648	154230	144820	270207
1984	297228	123852	251071	11352	28382	711885	8725	170888	168493	339381
1985	306966	123852	251071	11352	28382	721623	9598	197735	171590	369325
1986	319254	131091	272800	11581	28711	763437	9725	207430	185240	392670
1987	330755	-	-	-	-	-	9750	-	-	-
1990	381978						11011			
1992	-	-	-	-	-	-	-	385410	-	-
1993	405224	-	-	-	-	-	21720	-	-	-
1995	459670	-	-	-	-	-	-	559896	-	-
1996	475780	-	-	-	-	-	-	565696	-	-
1997	503950	172910	350561	12528	41374	1081323	-	-	-	-
1998	522634	180733	352328	12528	41630	1109853	-	-	-	-

Source : Health Statistics of India, CBHI, GOI relevant years; Annual Reports of MoHFW

Notes : - = Not available.

$ = Includes both midwives and health visitors.

TABLE 5 : RURAL-URBAN DISTRIBUTION OF MEDICAL HUMANPOWER IN INDIA

REFERENCE YEARS		TOTAL	ALLOPATHS	DENTISTS	HOMEOPATHS	AYURVEDS	UNANI	ALL OTHERS
1961	R	119969	19187	1122	16185	45112	-	38363
		(49.6)	(29.5)	(20.3)	(52.4)	(61.8)	-	(54.3)
	U	121533	45837	4407	11075	27875	-	32339
		(50.3)	(70.5)	(99.7)	(40.6)	(38.2)	-	(45.7)
	T	241502	65024	5529	27260	72987	-	70702
		(100)	(100)	(100)	(100)	(100)	-	(100)
1971	R	129896	49846	1333	23527	36871	4110	14209
		(48.8)	(39.4)	(22.8)	(61.2)	(62.6)	(52.4)	(49.6)
	U	136083	76507	4507	14917	21994	3736	14420
		(51.2)	(60.6)	(77.2)	(38.8)	(37.4)	(47.6)	(50.4)
	T	265979	126353	5842	38444	58865	7846	28629
		(100)	(100)	(100)	(100)	(100)	(100)	(100)
1981	R	152047	53407	1471	31916	36503	2600	26145
		(41.2)	(27.2)	(18.5)	(63.7)	(57.3)	(38.8)	(59.7)
	U	216818	143147	6493	18188	27211	4097	17682
		(58.8)	(72.8)	(81.5)	(36.3)	(42.7)	(61.2)	(40.3)
	T	368860	196554	7964	50104	63714	6697	43827
		(100)	(100)	(100)	(100)	(100)	(100)	(100)

Source : Census 1961, 1971, 1981, GOI.
Notes : All others denotes data on Physicians and Surgeons (Other categories not covered separately). R = Rural; U = Urban; T = Total; Figures in parentheses are percentages. Unani practitioners were not covered separately by the 1961 Census. Sidha medical practitioners were not covered by the census.

TABLE 6 : RURAL-URBAN DISTRIBUTION OF NURSES AND OTHER PARAMEDICAL HUMANPOWER IN INDIA

REFERENCE YEARS		TOTAL	NURSES	MIDWIVES & HEALTH VISITORS	OTHER HEALTH WORKERS*
1961	R	11657	29098	33980	48579
		(47.5)	(38.2)	(66.4)	(45.2)
	U	123141	47111	17214	58816
		(52.5)	(61.8)	(33.6)	(54.8)
	T	234798	76209	51194	107395
		(100)	(100)	(100)	(100)
1971	R	109181	31711	23714	53756
		(39.3)	(30.6)	(65.3)	(39.0)
	U	168569	71899	12606	84064
		(60.7)	(69.4)	(34.7)	(61.0)
	T	277750	103610	36320	137820
		(100)	(100)	(100)	(100)
1981	R	193049	52275	29705	111069
		(43.1)	(31.3)	(59.9)	(48.1)
	U	254956	114913	19874	120169
		(56.9)	(68.7)	(40.1)	(51.9)
	T	448005	167188	49579	231238

	(100)	(100)	(100)	(100)

Source : Census 1961, 1971, 1981. Figures in parentheses are percentages
Notes : R = Rural; U = Urban; T = Total. ***** Includes other nursing, sanitary and medical and health technicians.

TABLE 7 : SECTORAL EMPLOYMENT OF ALLOPATH DOCTORS IN INDIA

YEARS	GOVERNMENT SERVICE	PRIVATE SECTOR	TOTAL
1942-43	13000 (27.4)	34400 (72.6)	47400[a] (100)
1963-64	39687 (39.6)	60502 (60.4)	100189[b] (100)
1978-79	69137 (29.3)	166494 (70.6)	235631[c] (100)
1984-85	81030 (27.4)	214799 (72.6)	295829[c] (100)
1986-87	88105 (26.6)	242650 (73.4)	330755[c] (100)
1997-98	120000 (22.9)@	402634 (77.1)	522634[c] (100)

Sources : a) Report of the Health Survey and Development Committee (Bhore Committee), 1943, Vol. I, pg. 13.
b)IAMR-NIHAE "Stock of Allopathic doctors in India", 1966, pg. 71-72.
c)Health Statistics of India - 1979, CBHI, GOI. Health Information of India - 1985, 1988, CBHI, GOI.
@ estimated by author

TABLE 8 : OWNERSHIP STATUS OF HOSPITALS AND HOSPITAL BEDS

YEAR	HOSPITALS			HOSPITAL BEDS		
	Government	Private	Total	Government	Private	Total
1974	2832	644	3476	211335	57550	268885
	(81.4)	(18.6)	(100)	(78.5)	(21.5)	(100)
1979	3735	2031	5766	331233	115372	446605
	(64.7)	(35.3)	(100)	(74.2)	(25.8)	(100)
1981	3747	2923	6670	334049	132628	466677
	(56.2)	(43.8)	(100)	(71.5)	(28.4)	(100)
1984	3925	3256	7181	362966	137662	500628
	(54.6)	(45.4)	(100)	(72.5)	(27.5)	(100)
1986	4093	3381	7474	394553	141182	533735
	(54.7)	(45.3)	(100)	(73.9)	(26.1)	(100)
1987	4215	3549	7764	411255	144009	555264
	(54.3)	(45.7)	(100)	(74.1)	(25.9)	(100)
1988	4334	5497	9831	410772	175117	585889
	(44.1)	(55.9)	(100)	(70.1)	(29.9)	(100)
1993	4597	9113	13710	385216	210987	596203
	(33.5)	(66.5)	(100)	(64.6)	(35.4)	(100)
1996	4808	10289	15097	395664	228155	623819
	(31.9)	(68.1)	(100)	(63.4)	(36.6)	(100)

Source : Health Information of India, CBHI, GOI, various years.
Directory of Hospitals in India, CBHI, DGHS, GOI, 1981.
Notes : Figures in parentheses denote percentages.
Government figures include ownership by local bodies.
Data on the number and ownership status of hospitals and

beds were not reported by 6 states in 1974, 5 in 1979,
1 in 1981, 1984, 1986, 1987 and 1988.
Madhya Pradesh has not reported its data since 1979.

TABLE 9 : SECTORWISE PRODUCTION OF BULK DRUGS AND FORMULATIONS

(Rs. in Crores)

YEARS	BULK DRUGS			FORMULATION		
	Public Sector	Private Sector	Total	Public Sector	Private Sector	Total
1974-75	33	61	94	25	475	500
	(35.1)	(64.9)	(100)	(5.0)	(95.0)	(100)
1977-78	47	117	164	53	847	900
	(28.7)	(71.3)	(100)	(5.9)	(94.1)	(100)
1980-81	63	177	240	80	1120	1200
	(26.3)	(73.8)	(100)	(6.7)	(93.3)	(100)
1983-84	67	258	325	-	-	1760
	(20.7)	(79.4)	(100)			
1987-88	-	-	480	-	-	2350
1990-91	-	-	730	-	-	3840
1994-95	-	-	1518	-	-	7935
1995-96	-	-	1822	-	-	9125
1996-97	-	-	2168	-	-	10494
1997-98	-	-	2623	-	-	12068
1998-99@	-	-	3000	-	-	16000

@ **rough estimate**.

Source : Dinesh Abrol & Amitava Guha, "Production and Price Controls. The Achilles Heel of National Drug Policy" in "Drug Industry and the Indian People", ed. Dr. Amit Sengupta, Delhi, Science Forum, 1986, p 140; and Ministry of Chemicals and Fertilisers Annual Reports

TABLE 10 : INDIA'S EXPORTS AND IMPORTS OF MEDICAL EQUIPMENT

(Value in Rs. Lakhs)

YEARS	EXPORTS	% CHANGE	IMPORTS	% CHANGE	BALANCE
1977-78	NK	-	941.20	-	-
1978-79	NK	-	1253.90	+ 33.2	-
1979-80	128.90	-	1547.70	+ 23.4	- 1418.80
1980-81	204.73	+ 58.8	1972.10	+ 27.4	- 1767.37
1981-82	708.89	+ 0.3	2399.00	+ 21.6	- 1690.11
1982-83	688.00	- 2.9	2869.00	+ 19.6	- 2181.00
1983-84	600.00	- 12.7	3268.04	+ 13.9	- 2668.04
1984-85	650.00	+ 8.3	2894.57	+ 11.4	- 2244.57
1985-86	400.00	- 38.5	5857.26	+ 102.4	- 5457.26
1986-87	700.00	+ 75.0	6500.00	+ 10.9	- 5800.00
1987-88	1300.00	+ 85.7	NK	-	-

Source : CEI, "Handbook of Statistics", 1988.

Notes : NK = Not Known.

TABLE 11: UTILISATION OF HEALTH CARE FACILITIES FROM SELECTED STUDIES

(*Percentages*)

Study	Area	SOURCE OF CARE								
		Public Hospital	PHC/ Public Disp.	Private Hospital	Pvt. Practi-tioner	Drug Store	Tradi-tional	Self Care	Other	Total
NSS - 1986-87										
(All India)										
(OPD cases)	Rural	17.7	7.9	16.2	53.0	-	-	-	5.2	100
	Urban	22.6	4.6	18.1	51.8	-	-	-	2.9	100
(Inpatients)	Rural	55.4	4.3	38.6	-	-	-	-	1.7	100
	Urban	59.5	0.8	38.5	-	-	-	-	1.2	100
NCAER- 1990										
(All India)	Rural	28.0	9.9		(44.4)	10.8	-	-	6.9	100
	Urban	31.2	7.9		(44.8)	13.6	-	-	2.5	100
KSSP - 1987										
(Kerala)	Rural		(23.0)		(53.0)	-	-	12.0	12.0	100
FRCH- 1984										
(Maharashtra 4 districts)										
	Rural		(33.1)		(58.4)	-	1.6	6.9	-	100
FRCH - 1987										
(Jalgaon District)										
	Rural		(11.1)		(84.6)	-	1.7	2.6	-	100
	Urban		(16.9)		(77.5)	-	3.7	1.9	-	100
FRCH- 1990										
(Madhya Pradesh 2 dist)										
	Rural	2.8	14.8		(73.9)	1.3	1.0	6.2	-	100
	Urban	14.8	0.3		(71.9)	3.2	0.8	9.4	-	100
NCAER 1993										
(All India)										
OPD Cases	Rural	17.4	20.4	5.6	46.3	3.1	0.5	2.0	4.7	100
	Urban	25.5	8.5	10.2	48.6	5.2	0.2	0.8	1.0	100
Inpatients	Rural		(62.0)		(38.0)	-	-	-	-	100
	Urban		(60.1)		(39.9)	-	-	-	-	100
NSS 1995-96										
OPD Cases	Rural	11.0	8.0	15.0	55.0	-	-	-	10.0	100
	Urban	15.0	3.0	19.0	55.0	-	-	-	7.0	100
Inpatients	Rural	39.9	5.3	53.9	-	-	-	-	0.8	100
	Urban	41.8	1.3	56.3	-	-	-	-	0.6	100
CEHAT 1997										
Mumbai	City		(10.0)		(84.0)	-	-	5.0	1.0	100
CEHAT 1998										
Nashik District	Rural	2.0	20.6	3.3	52.9	7.3	4.0	8.6	0.1	100
	Urban	5.1	5.2	1.8	48.9	21.0	2.9	14.7	0.1	100

SOURCES : 1) NSSO, 1989 and 1998 2) NCAER, 1992 and 1995 3) Kanan, Thankappan, et.al, 1991 4) Duggal.R S. Amin, 1989 6) George.A et.al, 1993 7) CEHAT, 2000 (a) and (b) (see citations in Table 12)

Table 12 : Household Health Expenditures from Selected Studies *(in Rupees)*

Study	Area	Expenditure Rs.	Expenditure Rs. per ailment or episode by sector		
		Percapita/year	Public	Private	Total
1. NSSO – 1987 all India: NSSO – Report No. 364 42nd Round, NSSO, New Delhi, 1990	Rural Urban (OPD) Rural Urban (Inpat.)		114.75 103.39 320.00 385.00	84.93 91.30 733.00 1206.00	144.00 175.00 853.00 1183.00
2. FRCH – 1987 (Jalgaon): Duggal & Amin – Cost of Health Care, FRCH, Mumbai, 1989	Rural Urban Total	192.19 170.97 182.49	 76.84	 116.31	103.56 100.44 102.14
3. FRCH – 1984 (Maharashtra 4 districts): Jesani,Duggal,Gupte – NGOs in Rural Health Care, FRCH, Pune 1996	Rural	135.00	28.00	87.08	56.99
4. KSSP – 1989 (rural Kerala); Kanan, Thankappan,..	Rural (OPD)	178.00			
5. NCAER – 1990- all India: NCAER – Household survey of Medical Care, NCAER, New Delhi, 1992	Rural Urban Total	 204.00	169.00 126.00	147.00 164.00	152.00 143.00
6. FRCH – 1990 – MP 2 districts: George, Shah& Nandraj, Household health expenditure in M P, FRCH, Mumbai, 1993	Rural Urban Total	294.00 308.00 298.00	 146.00	 173.00	138.00 129.00 134.00
7. NCAER 1993 – all India: ….	Rural Urban (OPD) Rural Urban (inpat.)		49.00 63.00	130.00 152.00	91.00 114.00 1045.00 1197.00
8. NSSO 1996 – all india: NSSO, Report No. 441 – 52nd Round, NSSO, New Delhi ,1998	Rural Urban (OPD) Rural Urban (Inpat.)		129.00 126.00 2080.00 2195.00	186.00 200.00 4300.00 5344.00	176.00 194.00 3202.00 3921.00
9. CEHAT 1996 – Mumbai: Nandraj et.al., ….., CEHAT, Mumbai, 2000	Urban	415.68			95.45
10. CEHAT 1996 – Nashik district Madhiwala et.al., Health, Households and Women's Lives, CEHAT, Mumbai, 2000	Rural Urban Total (OPD) Rural Urban Total (Inpat.)	660.00 528.00 624.00 (opd+inpatient)	16.00 12.00 16.00 332.00 1938.00 974.00	118.00 128.00 121.00 2188.00 3129.00 2255.00	97.00 98.00 92.00