Publisher's Note

Voluntary Health Association of India (VHAI) was watching with considerable consternation the gradual but steady decline in health services and facilities all over the country. Keeping this deep concern in mind, it was felt that we should facilitate setting up of an Independent Commission on Development & Health in India (ICDHI) as an initiative of leaders of health movement, well known health scientists, respected civil servants as well as pioneers of voluntary sector. During the year 1995, Independent Commission on Development & Health in India did the first report on State of Health in India. Besides analysis of existing data and indepth studies, the Commission identified the maladies affecting the present health care system and developed a clear recommendations for future actions. This exercise was supplemented through a series of public hearings, roundtables with the stakeholders and health professionals as well as reviewing the successful national and international efforts.

The Report of the Commission was released by Shri Atal Behari Vajpayee, the then Hon'ble Prime Minister of India on 13th May 1998, in the presence of Union Secretary (Health) and senior officials. The Prime Minister during his discussion assured that the Report will receive due attention of the Government in the framing of subsequent health policies and plans.

It is heart-warming that the ICDHI Report was very widely distributed, discussed and debated at different forums including the Parliament, the Ministry of Health & Family Welfare and the Planning Commission. In many ways, the report has influenced current thinking of the Government on various issues of Public Health including framing of the National Health Policy and the Population Policy. This eventually led to the formation of National Rural Health Mission.

In the last one and a half decade, ICDHI has come out with similar reports on various aspects of health care with clear evidence based recommendations for the future, which are accepted as serious input to the health programmes of the country.

The present issue of 'Health for the Millions' on 'Political Economy of Health Care in India', particularly looks at the state of Private Health Sector in India. It provides detailed analysis of sensitive issue in the health care sector of the country. Due to the depressing state of the public sector in health care, there has been an unprecedented growth of the private sector, in primary and secondary and tertiary health care all over the country. This growth of unregulated private practice has shaken the very objective of equity and social justice in the provision of health care. Due to the falling ethical standards of the medical profession and totally free market technology-driven operational principles, the private sector generally falls short of providing quality health care at a reasonable cost. Through a detailed analysis of the nature and trend of this unwanted development in the country's health care scenario, the authors have built up a sound critique of the existing situation. The issue is replete with valuable suggestions for organizing the private health sector through a public-private mix and introductions of participatory regulatory norms.

We thank Ravi Duggal, Oommen Kurian, Padma Bhate-Deosthali and Suchitra Wagle for this painstaking and penetrating analysis of the private sector in health care and coming up with clear evidence based recommendations for the sector.

Alok Mukhopadhyay

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Political Economy of Health Care in India

The Indian State has been a minor player in the financing of ambulatory health care while private providers -modern and traditional - as well as informal providers have had a dominant role. The private health care sector now accounts for around 80 per cent of all OP care in the country (NSSO, 2006). While pre-colonial health care was still largely within the jajmani[1] realm of transactions, the establishment of modern medicine during the colonial period gradually moved it in the direction of commodification. Today, health care is dominated by modern medicine and is available largely as a commodity. Even traditional and non-formal providers, including practitioners of quackery, use some aspects of modern medicine in their practice and operate within the market context.

This transition has been very different in the case of hospital care. Right from pre-colonial times, through the colonial period, the post-Independence period up to the mid-seventies, the State and its agencies were the main providers of hospital care. There were also significant non-state players who set up large charitable hospitals. By the 1970s, medical education made a major transition; post-graduation, specialisation and super-specialisation in medicine became much sought after, bringing in a dramatic change in medical practice. Specialists, on the one hand, began setting up private nursing homes and the corporate sector on the other, began showing an interest in entering the hospital sector. Development in medical technology also hastened the process of commercialization of health care and made "for-profit" hospitals, a lucrative proposition. By the later part of the 80s, the State was already decelerating investments in the hospital sector. This was a clarion call for the private sector to increase its presence. By the turn of the millennium, the "for-profit" hospital sector had become dominant and within the state sector, privatization via user-charges as well as through contracts and leasing had become the order of the day.

Today, the largest source of financing health care in India is out-of-pocket or self-financing, which is both regressive and iniquitous. Latest estimates based on National Accounts Statistics indicate that private expenditures on health care in India are about Rs 2750 billion; 98 per cent of this is out-of-pocket. Public expenditures on health care are about Rs 600 billion, additionally. Together this adds up to 5.7 per cent of GDP with out-of-pocket expenses accounting for 78 per cent of the share in total health expenditures or 4.3 per cent of GDP. This is a substantial burden, especially for the poorer households in the bottom three quintiles, which are either

1 The jajmani system was a set of economic interrelations across caste groups in the local community which had social sanction and, linked to it, mandatory social obligations. While at one level it facilitated economic organisation of the local community and assured livelihoods within both productive and service sectors, at another level it also restricted occupational mobility because occupational assignment under such a system was caste based, especially for service occupational categories. Hence, the jajmani system also kept intact the economic basis of the caste system. Today, it is largely destroyed but may be found in pockets in most states, but especially the Hindi heartland.

Table 1: Key Data Pertaining to Out-of-Pocket Expenditures, Source of Finance and For Not Seeking Care Across Expenditure Quintiles and Social Groups, NSS 52nd Round, 1995-96

	I Poorest	II	III	IV	V Richest	SC/ST	Other Caste	All
Outpatient								
Rural								
Rs. per episode	77	94	124	130	174	92	138	128
Urban								
Rs. per episode	95	141	139	164	225	122	166	160
Inpatient								
Rural								
Rs. per Hosp.	1020	1197	1495	1931	4595	2789	3133	3102
Urban								
Rs. per Hosp.	835	1499	1964	2765	7470	2046	4303	3921
Debt and sale of assets (%)	47	45	42	42	32			43
Did not seek care (%)	24	21	18	18	9			17
Cost as factor in not seeking care (%)	33	23	21	22	15			24

Source: Compiled from NSS 52nd Round data files, NSSO, New Delhi, GOI, 1998

below the poverty line or at the threshold of subsistence; when illness strikes, such households collapse, completely. In fact, for the poorer quintiles, the ratio of their income financing health expenditures is 2 to 4 times more than the average mentioned above. Further, while this burden is largely self-financed by households, a very large proportion of this does not come from current incomes. Especially for hospitalisations, this large proportion comes from debt and sale of assets (Duggal 2007). In fact, the impoverishing effect of OOPS is well documented. Garg and Karan calculate that during 1999-2000, approximately 32 million people in India were pushed below poverty line due to high OOP payments for health care (Garg and Karan 2009). This number could only have gone up as the utilisation as well as the cost of health care in the private sector has increased substantially since 2000. This was also the time when user fees were charged in public hospitals.

Data from the 52nd Round of NSS 1995-96 (Table 1) reveals that over 40 per cent households borrow or sell assets to finance hospitalisation expenditures, and there are very clear class gradients to this – nearly half the bottom two quintiles get into debt and/or sell assets in contrast to one-third of the top quintile. As per latest available information, a recent review which used data from the latest NSSO morbidity survey (2004) found out that close to a fifth of the health expenses for outpatient care in rural areas is financed through borrowing; the corresponding percentage for hospitalisation is much higher at around 40 per cent. This recourse to borrowing and sale of assets,

while being substantial even in urban areas, is greater in the rural areas. The reliance on borrowing is significantly higher for the poorer sections of the population compared to the better-off with sharp differentials, especially in urban areas (Baru et al 2010). In fact, in the top quintile, this difference is supported by employer reimbursements and insurance. When we combine this data with the ratio of "not seeking care when ill because of financial reasons", it becomes amply evident that dependence on self-financing has drastic limits. It is also, in itself, the prime cause of most ill health, especially amongst the large majority for whom out-of-pocket mode of financing strains their basic survival.[2]

2 Duggal, Ravi (2007), Poverty and Health: Criticality of Public Financing, Indian Journal of Medical Research, Vol. 126, pp 309-317.

Table 2: Distribution of Untreated Illness

Expenditure Quintile	Reason for Not Seeking Treatment						
	No Medical Facility Nearby	Lack of Faith	Long Wait at the Facility	Financial Reasons	Ailment Not Serious	Others	Total
Very Poor	2.17	0.49	0.15	7.41	5.04	3.96	19.22
Poor	1.77	0.81	0.07	7.25	6.51	4.41	20.81
Middle	1.75	0.57	0.21	6.00	6.99	3.54	19.06
Richer	2.47	0.47	0.20	4.01	8.20	5.75	21.10
Richest	1.36	0.47	0.39	2.10	8.98	6.51	19.80
Total	9.52	2.81	1.02	26.77	35.73	24.16	100.00

Source: Mukherjee and Karmakar (2008)

Table 3: Distribution of Untreated Illness Across NSSO Rounds

Reason for No Treatment	Rural			Urban		
	2004	1995-96	1986-87	2004	1995-96	1986-87
No medical facility	12	9	3	1	1	0
Lack of faith	3	4	2	2	5	2
Long Waiting	1	1	0	2	1	1
Financial problem	28	24	15	20	21	10
Ailment not serious	32	52	75	50	60	81
Others	24	10	5	25	12	6
All	100	100	100	100	100	100

Source Sakthivel and Karan 2010

In sharp contrast, in countries where near universal access to health care is available with relative equity, the major mechanism of financing is usually a single-payer system from tax revenues, social or national insurance or a combination of these, administered by an autonomous health authority, mandated by law and provided through a public-private mix organised under a strictly regulated system. Canada, Sweden, United Kingdom, Germany, Costa Rica, South Korea, Australia, Japan, Brazil, Venezuela, Mexico, Sri Lanka and Thailand are a few examples. Experiences from these countries indicate that the key factor in establishing equity in access to health care and health outcomes is the high proportion of public finance in total health expenditures. Most of these countries have public expenditures averaging 80 per cent of total health expenditures.[3]The greater the proportion of public finances, the better the access and health outcomes. Thus India, where public finance accounts for only 20 per cent of total health expenditures, has poor equity in access to health care and health outcomes. In comparison, public finance accounts for between 30 and 60 per cent of total health expenditures[4] in China, Malaysia, South Korea, Thailand and even Sri Lanka.

Health Care Utilisation and Expenditure

Since public health infrastructure in the country is limited and grossly inadequate to meet the health care demand, private health care has taken a dominant position — often with active state support — especially with regard to treatment of routine illnesses. Private general practice is presently the most commonly used health care service by patients in both rural and urban areas . When India became independent in 1947, the private health sector provided only 5-10 per cent of total patient care (Sengupta 2005). In the next few decades however, things changed drastically and by 2004, a large proportion of total ailments were treated from private sources — 78 per cent in the rural areas and 81 per cent in the urban areas (MoHFW 2007).

India's public spending on health, after increasing between 1950–51 and 1985–86, stagnated during 1995–2005. It was down to 0·95 per cent of the GDP in 2005, comparing poorly with countries such as China and Sri Lanka. Our public spending per person on health is a reflection of this. The per capita government spending on health in India was just about 22 per cent of that in Sri Lanka, 16 per cent of that in China, and less than 10 per cent of that in Thailand. Low share of public funding has severe adverse impact on human welfare, as access to health care is linked, then, to the ability to pay. In 2004–05, government expenditure (including external support) accounted for 22 per cent of total health spending — slightly reduced from 22·6 per cent in 2001–02. Consequently, private spending in 2004–05 accounted for 78 per cent of the total spending on health — slightly increased from 77·4 per cent in 2001–02 (Shivakumar 2011).

Understandably, when it comes to utilisation of facilities, private institutions dominate — in 2004, about 58 and 62 per cent of the hospitalised cases in the rural and urban areas, respectively, were treated by the private institutions. The proportion of government and private institutions in the provision of care has shown a stark reversal between 1986-87 to 2004, from a situation

3 http://www.oecd.org/document/39/0,2340,en_2649_201185_2789735_1_1_1_1,00.html , Accessed on 2 August, 2005. l

4 WHO (2004).World Health Report -2004, Geneva, WHO.

where about 60 per cent of the hospitalised cases were treated by the government institutions. A steady decline in the use of government sources and a corresponding increase in the use of private sources over the last three NSS rounds can be seen from Table 4. The changes were, however, sharper during the period between 1986-87 and 1995-96 rather than between 1995-96 and 2004. Between 1986-87 and 1995-96, rural hospitalisation cases accessing private facilities increased from 40.3 per cent to 56.2 per cent — an increase of 15.9 percentile points — but between 1995-96 and 2004, the increase was only by another 2.1 percentile points. A similar deceleration occurred in urban areas too (MoHFW 2007). However, this need not be indicative of a trend as lately the government policy shows a marked tilt towards increased private sector participation in provisioning.

In India, public health expenditures had peaked around mid-1980s at about 1.6 per cent of GDP and 4 per cent of the government budget. Thereafter, a declining trend was visible, especially in the immediate post-structural adjustment period.[5] The decade of eighties was a critical period in India's health development. Public health infrastructure, especially rural, expanded substantially, with major improvements being recorded in health outcomes. But soon after, public investment in health declined sharply; public expenditures showed a declining trend both as a proportion to GDP as well as in total government spending. This impacted health outcomes, which show a slower improvement if not stagnation.[6]There has indeed been some improvement following the recent implementation of NRHM which boosted public health expenditure as a proportion of GDP, though not as much as it was in the 1980s or at par with goals set at the beginning of the Eleventh plan. Simultaneously, private health sector expansion has accelerated, as evidenced from the utilisation data from three NSS Rounds 42nd (Pre-SAP) and 52nd and 60th (Post-SAP) Rounds.

Table 4: Trends in Hospitalisation Cases - Govt/Private (Percentage)

NSSO Rounds	Rural		Urban	
	Govt	Private	Govt	Private
42nd	59.7	40.3	60.3	39.7
52nd	43.8	56.2	43.1	56.9
60th	41.7	58.3	38.2	61.8

Source: (MoFHW 2007 NSSO)

A comparison of the average medical expenditure incurred per hospitalised case for rural and urban areas for all the three NSS rounds shows an increase in the overall expenditure, over the three rounds. The increase has been steeper in the private sector even after adjusting for the general price rise (MoHFW 2007). This is laid out in detail in Table 5.

Another comparison of the hospitalisation expenditure of the two recent NSSO rounds, after adjusting price rise by CPI, shows a rise in relative expenditure by nine percentage points in rural private hospitals in a period of nine years as compared to rural government hospitals where it more or less remained the same. In urban areas, the government hospitalisation cost was 12 per cent more as compared to the earlier period

5 Deolikar, Anil B et al. (2008) Financing Health Improvements in India, Health Affairs, Vol. 27, pp. 978-990.

6 Duggal, Ravi (2007), Poverty and Health: Criticality of Public Financing, Indian Journal of Medical Research, Vol. 126, pp 309-317.

of 1995- 96 in 2004. Correspondingly, a steep 37 per cent relative increase in urban private sector cost for hospitalisation was seen (MoHFW 2007).

Comparative analysis of different NSS rounds compiled by WHO and the Health Ministry reveal that about 47 per cent of the total rural hospitalisation cases in the country were financed by the sale of assets or loans. This proportion ranges from 37 to 63 percent across different income class of households. The high expenditure for hospitalised treatment in the private sector is a major reason for this. This was aggravated by the decline in the proportion of hospitalisation in the comparatively cheaper public sector. In urban India, about 31 per cent of the hospitalisation cases were financed by loans and sale of assets, with the proportion ranging from 13 to 55 percent for different class of households. Both rural and urban areas show a steep rise in the financial burden of inpatient treatment. Alarmingly, the number of untreated ailments due to financial reasons has risen steadily. In 1986-87, the financial reason cited for not accessing health care by 15 per cent and 10 per cent in rural and urban areas respectively rose sharply to 28 per cent in rural and 20 per cent in urban areas in 2004 (MoHFW 2007).

Table 5: Comparative Average Total Expenditure per Hospitalised Case during Last 365 days by Type of Hospital – Rural and Urban

Sector	Government Hospital			Private Hospital		
	42nd	52nd	60th	42nd	52nd	60th
Rural	1,120	3,307	3,238	2,566	5,091	7,408
Urban	1,348	3,490	3,877	4,221	6,234	11,553

The Private Sector Takeover of Health Care

The decade of the nineties was a watershed for private capital accumulation and consolidation in India; it was also a period of steady decline as far as public investments in health care is concerned. The fiscal crisis precipitated at the beginning of the decade which subjected India's economy to the SAP doctrine of the Bretton Woods Institutions changed the character of both the private sector as well as the government in India. Liberalisation, privatisation and globalization (LPG) was the new mantra and the fulcrum for shaping economic policies and planning. Macro-economic reforms opened up India's economy to the world market, and with remarkable swiftness, the Indian corporate sector came of age. Indian MNCs shone invitingly on the global horizon, with the pharmaceutical industry quickly emerging as one of the front runners. It soon became the 4th largest producer by volume and a major exporter globally of medicines, especially in the generics segment. This development had the combined effect of reducing drug prices globally and increasing prices in India. It must be noted that the strength of the Indian pharmaceutical companies came from huge subsidies that it received from the state. India's production of doctors and nurses using public resources was already contributing to global private accumulation in the health sector for many decades.

Economic reforms also opened up the insurance sector, bringing in private players. Health insurance, hitherto available only through public sector insurance companies, began to expand rapidly to support the growing private and corporate hospital sector. The third engine — apart from the pharmaceutical industry and the insurance industry — of the private

Box 1: Government Subsidies to the Private Sector

A large number of hospitals in India are registered under the Trust and/or Societies Act; laws which are meant to register and regulate charitable institutions. Historically, hospitals were an important arena for charitable actions and individuals or institutions set them up to provide free and/or concessional medical care. In India too this was well entrenched since late 19th century. Some of the earliest non-government hospitals were charitable hospitals and hence their registration under the Trust and Societies Acts was justifiable. The situation in the last 3 or 4 decades has changed and many hospitals registered under these laws are in reality elite institutions which don't indulge in any charity whatsoever. We do still have many genuine charitable hospitals run by various missionaries, NGOs in rural areas or small towns and cities but there are also a large number of corporates who have misused the provisions of these laws and set up hospitals which in reality do not cater to any form of charity even though the law mandates that. To take Maharashtra's example, the law says that such hospitals should provide 10 per cent of inpatient and outpatient care in their hospitals free to poor patients and another 10 per cent at concessional rates to economically weaker sections.

Many elite hospitals in Mumbai city for instance are registered under the Bombay Public Trust Act but they are hospitals which have charges that only the rich or insured patients can afford. Well-known hospitals such as Bombay Hospital, Jaslok Hospital, Breach Candy Hospital, Lilawati Hospital, Hinduja Hospital, Kokilaben Dhirubai Ambani Hospital, Nanavati Hospital among others which are owned by corporate are operating as Trust hospitals. They get all the tax benefits that the law provides but they do not treat genuinely poor patients as mandated by law, citing that such treatment (10 per cent free beds) causes losses. Some among these hospitals, very recently, approached the court and got an order that they need not cater to the poor as mandated, albeit for a short period.

Civil society advocacy on this to pressurise the government to demand accountability from these hospitals has been met with strong resistance and even court orders demanding adherence to provision of the Act have not been respected. Rough estimates indicate that such kind of hospitals (excluding the genuine charitable ones) own nearly 200000 hospital beds and given current costs the cost of running one bed in such a hospital is about Rs 2 million per year. Twenty percent of these beds or 40000 should be providing free or concessional care. Translated into money value this is Rs 8000 crores per year which we can consider as a public resource invested in these private hospitals which fail to accrue to the poor beneficiaries. If these hospitals were to function as for profit private hospitals then (profitability rate of Apollo group of hospitals is 40 per cent – despite being public trusts their financial data is not available in public domain) the tax that would accrue to the state would be many times over this figure. So the loss to the state exchequer due to such non-compliance is huge. Apart from this, hospitals which have received land and other tax concessions are also huge in number. They too have neglected their binding social obligations and defrauded the state of huge amounts of money.

Recently, the CSO carried out a survey of non-profit institutions in the country for the first time in 2008-09 and found that 59507 Trusts/Societies were involved in health care delivery. What was significant was that their biggest growth was post-1990s as evidenced by the following data on year of registration: 1970 and before: 1683; 1971-1980: 2311; 1981-1990: 6014; 1991-2000:16614; 2001 -2008-09: 32718. This is indicative of the fact that the growth of such hospitals in the private sector has been phenomenal in recent years to take advantage of tax concessions. (Report on Non-Profit Institutions in India, CSO, Govt. of India, 2011, New Delhi) In fact, registering as a charitable trust or having an unequal partnership with an existing charitable institution is a tested strategy of corporate expansion in health care.

health sector boom was the opening up of medical education to private players. The proliferation of private medical colleges in the late nineties and the new millennium completed the circle for consolidation of private health business in India.

Almost as a parallel development, public investment in public health facilities declined; under-financing and poor human resource policies led to the near-collapse of the public health system. Increasingly, the middle classes migrated away from public facilities and patronised health insurance, either directly or through employers, to pay for their health care in the private health sector. Introduction of user fees by the state governments within the public health system further alienated the poor from the public health facilities. At present, states other than Andhra Pradesh, Jharkhand and Kerala have user fees in place in most of the public hospitals. Several ill-conceived privatisation initiatives in the public health system also led to the weakening of public health facilities. Large amounts of public funds were directed into the private health sector both directly through schemes such as "Chiranjeevi" in Gujarat, "Aarogyashri" in Andhra Pradesh, the "RSBY" across the country etc. (refer section on PPPs) and indirectly through subsidies and concessions to corporate hospitals.

Production of Drugs and Medical Equipment

For decades now, the pharmaceutical industry has been the most powerful arm of the private health sector. It has grown over the years with extensive support and subsidies from the state. The allopathic pharmaceutical business, worth over Rs 1000 billion in 2008-09,has grown multi-fold since then. The turnover, expected to reach $55 billion by 2020,will push India into the big league with countries such as US, Japan and China.[7] From the sixties until the late eighties, the public sector pharmaceutical giants such as IDPL, HAL, Bengal Chemicals, etc. contributed bulk drugs at subsidised rates to private formulation units. The government backed this initiative with a policy that refused to recognise product patents, thus facilitating the private pharmaceutical industry to compete with MNCs from the developed countries. As a quid pro quo, the government regulated drug prices, resulting in India having the lowest drug prices in the world. Helped and supported by such a policy, the Indian pharmaceutical industry grew strong enough to compete globally on its own by the 1980s. Not surprisingly, public sector drug giants which provided subsidy to private pharmaceutical companies eventually weakened and died by the end of the 1980s. Medicine prices in India began to soar as India became a major exporter of drugs and a key global player by the turn of the new millennium.

India's pharmaceutical export in 2008 was in the range of $5.9 billion to $8.4 billion. In the domestic export basket as well, the share of the pharmaceutical sector increased from 2.8 per cent in 2005 to 3.3 per cent in 2009. The Indian pharmaceutical sector showed a steadily growing positive trade balance. The surplus had been contributed by formulations, which accounted for 78 per cent of the exports in 2009. However, in bulk drugs, the country has had a negative trade balance during many years. India's pharmaceutical industry has increasingly become export-oriented and the share of exports in sales has steadily grown from

7 Sardana, MMK (2010) Competition Issues in Health Sector, ISID Discussion Notes, Institute for Studies in Industrial Development.

Table 6: Sectorwise Production of Bulk Drugs and Formulations (` in Crores)

YEARS	BULK DRUGS			FORMULATION		
	PUBLIC	PRIVATE	TOTAL	PUBLIC	PRIVATE	**TOTAL**
1974-75	**33**	**61**	**94**	**25**	**475**	**500**
	35.1	**64.9**	**100**	**5**	**95**	**(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**
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**
the 2000-2005 data is available for individual bulk drug and not a yearly total						

@ 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

15 per cent in 1993-94 to 41 per cent in 2009-10. Two major changes in trends are seen when one looks at the trends of growth of exports of both bulk drugs and formulations. Firstly, while the rate of growth of exports of bulk drugs was higher than that of formulations during the 1990s, the opposite is true now. Secondly, bulk drugs which showed a steady decline in the growth of exports between 2001 and 2005 reversed the trend in the post-2005 period. Formulations, on the other hand, exhibited a steady growth in exports, throughout. On the whole, it may be concluded that exports of bulk drugs and formulations have been growing at higher rates in the post-2005 period than in the 10 years of the post-1994 period[8] (Joseph, 2012).

8 Joseph, Reji K (2012) Policy Reforms in the Indian Pharmaceutical Sector since 1994: Impact on Exports and Imports, Economic and Political Weekly. Vol.47No. 18, pp. 62 – 73.

Table 7: Growth of Select Indian Pharmaceutical Companies (Rs Crores)

	1996-97	2008-09
Ranbaxy Laboratories	1146	4755.76
Glaxo smithkline Pharmaceuticals	699.63	1668.08
Cipla	451.88	4807.67
Aventis Pharma	382.69	-
Piramal Healthcare	319.28	1665.42
Alembic	282.38	-
Torrent Pharmaceuticals	258.85	-
Cadila Healthcare	255.48	1765.40
Ipca Laboratories	251.15	-
Dr. Reddy's Laboratories	244.99	4394.90
Lupin	-	2934.25
Sun Pharma	-	2830.86
Aurobindo Pharma	-	2730.75
Wockhardt		1448.87

Source CMIE: Economic Intelligence Service (EIS) cited in DIPP (2010)

Table 7 provides clear evidence of the phenomenal growth of private pharmaceutical business in India as well as its exploits, globally. With the growth of exports being much higher than domestic consumption, drug prices within the country are under pressure. A huge increase in the prices of essential drugs is visible even as its availability declines in the country. A discussion paper prepared by the Department of Industrial Policy and Promotion (DIPP) of GoI in 2010[9] maintained that this is despite the fact that India itself has a large unmet domestic demand for critical medicines. Around 65 per cent of the Indian population still lacks access to essential medicines. The share of drugs in OPD expenses were estimated at 63 per cent by NSSO 60th Round (January 2004). NSSO, in their report on the 61st Round indicated that this expenditure had increased to 82 per cent, though by the 66th round in 2010, a slight decline to 77 per cent[10]was seen. As per the National Health Accounts, medicines accounted for 38-62 per cent of inpatient expenditure in rural and urban areas.

According to the DIPP discussion paper, the need for affordable and high quality medicines is critical for the sustainable growth of the Indian economy. In this context, three developments in the pharmaceutical sector in India have heightened the concerns being expressed.

1. **The enactment of the Patent Amendment Act in 2005** allowed for the grant of product patents in the pharmaceutical sector. The first pharmaceutical product patent under the amended act was granted in 2006. While the bulk of essential drugs are still under the process patent regime, new formulations will steadily be issued product patents resulting in focusing of monopoly power among the patent holders.
2. **Recent restructuring of ownership in the sector:** Six reported cases where foreign companies have taken over Indian companies are provided in Table 7, given below.
3. **Strategic alliances being forged by some large Indian players**: Most of these companies are export-oriented, heightening the concern that their takeover by multinationals will further orient them away from the Indian market. In such a scenario, domestic availability of the drugs being produced by them will reduce. The result: weak

9 GoI (2010) Discussion Paper on Compulsory Licensing, DIPP, New Delhi.

10 NSSO 2011: Key Indicators of Household Consumer Expenditure 66th Round 2009-10, NSSO, New Delhi.

Table 7: Foreign Companies Take over

Year	Indian Co. Taken Over	Foreign Company which Took Over	Country of Origin	Take Over Amount US$ mill
Aug 2006	Matrix Lab	Mylan Inc	USA	736
April 2008	Dabur Pharma	Fresenius Kabi	Singapore	219
June 2008	Ranbaxy Laboratories	Daiichi Sankyo	Japan	4600
July 2008	Shanta Biotech	Sanofi Aventis	France	783
Dec 2009	Orchid Chemicals	Hospira	US	400
May 2010	Piramal Health Care	Abbot Laboratories	US	3720

Source: Press Report Cited in DIPP (2010)

competition, leading to an increase in domestic drug prices. Database from the Centre for Monitoring Indian Economy indicates that while the rate of growth of sales of the pharmaceutical companies declined during 2001-2009 (14.2 per cent annual) compared to their growth during 1988-2000 (19.5 per cent annual), their ratio of profit after tax to total income increased to 9.7 per cent (average of 2001-2009) from 4.9 per cent (average of 1988-2000). This indicated the worsening in both the availability and affordability of pharmaceutical products. Additionally, the strategic alliances being forged by other foreign companies with Indian drug manufacturers for licensing and supply also alter the pharmaceutical landscape. These include alliances of GSK with Dr Reddys; Pfizer with three companies — Aurobindo, Strides Arcolab and Claris Life Sciences; Abbot with Cadilla Health Care and Astra Zeneca with Torrent.[11]

The non-allopathic drug industry, mainly Ayurveda and Homoeopathy, is also fairly large but organised information on it is not available. No known estimates of turnover or drug production are available on them. However, there are a number of Ayurvedic drug manufacturers whose turnover runs into hundreds of crores, again mostly in the private sector. In 2008, Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy(AYUSH) production put together in the registered sector was estimated at about Rs 9000 crores, with international trade grossing nearly Rs 2500 crores.[12]

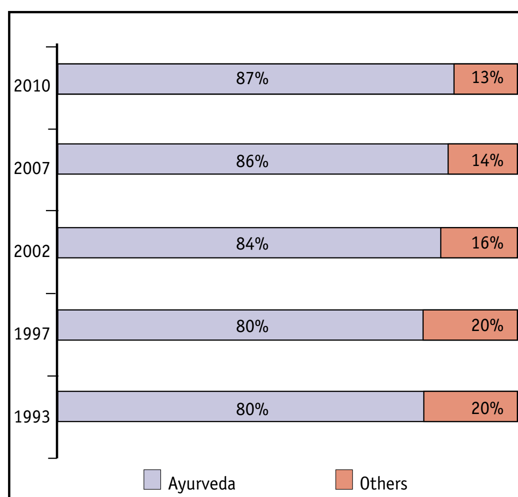
The latest report by the Department of AYUSH titled AYUSH in India 2010 reveals that 8644 manufacturing units in the country are engaged in the manufacturing of various AYUSH drugs. A maximum of 7494 manufacturing units manufacture Ayurvedic drugs, whereas, 414, 338 and 398 manufacturing units were involved in the manufacturing of Unani, Siddha

11 This section borrows from the DIPP Discussion Paper (2010).

12 Joshi, Kirti (2008) Indian Herbal Sector, NIstads, New Delhi (Accessed at http://www.nistads.res.in/indiasnt2008/ t4industry/t4ind19.htm) , accessed on 5 March 2012.

and Homoeopathy drugs, respectively. A marginal declining trend of 0.2 per cent per annum was realised in total AYUSH drug manufacturing units during 1992-2010. As clear from Diagram 1, Ayurveda and Unani Drug manufacturing units have grown annually at the rate of 0.3 per cent and 0.1 per cent, respectively while drug manufacturing units of Siddha and Homoeopathy have annually come down by 2.4 per cent and 4.5 per cent, respectively during 1993-2010 (Dept of AYUSH, 2011).

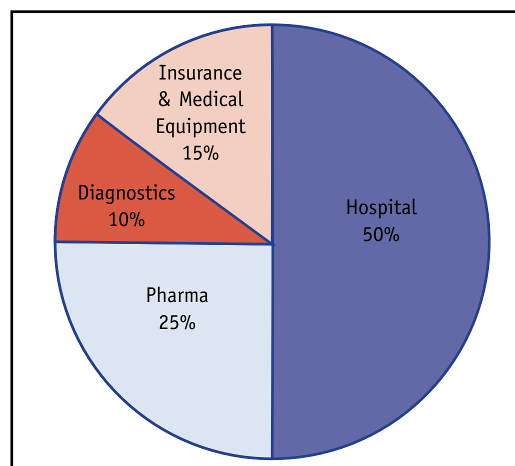
Diagram 1: Per cent Distribution of Licensed Pharmacies under Ayurveda & Other Systems of AYUSH



Source: Dept of AYUSH (2011)

The global medical devices market was estimated at $260 billion in 2006. The Indian medical devices and equipment market was at $1318 million in 2005,with an expected growth rate of 9 per cent per annum, which would help it touch USD 2028 million by 2010[13]. More recent estimates suggest that the Indian health care industry is estimated at $35 billion and is expected to reach over $75 billion by 2012. Estimates by ASSOCHAM (2011) suggest that Indian health care sector currently represents a $40 billion industry.[14] It was seen that while the market for medical supplies and disposables is dominated by the domestic manufacturers, importers dominate the costly and high end medical equipments. The medical equipment market is currently growing at a rate of 15 percent per annum; demand for equipments is expected to reach $5 billion by 2012 .[15] The composition of the industry is given in Diagram 2. Diagram 3 shows both exports as well as imports of medical equipment, rising steadily from INR 28 billion in 2004-05 to around INR 56.7 billion in 2008-09.[16]

Diagram 2: Healthcare Industry Break-up



Source: ASSOCHAM (2011)

As data from the Ministry of External Affairs shows, the pharmaceutical industry has grown from mere US$0.3 billion turnover in 1980 to about US$21.73 billion in 2009-

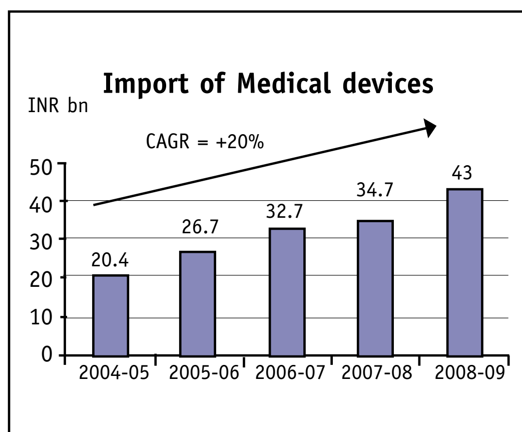
13 GoI (2009) Medical Devices: Sector Analysis, Department of Pharmaceuticals, Ministry of Chemicals and Fertilizers, New Delhi.

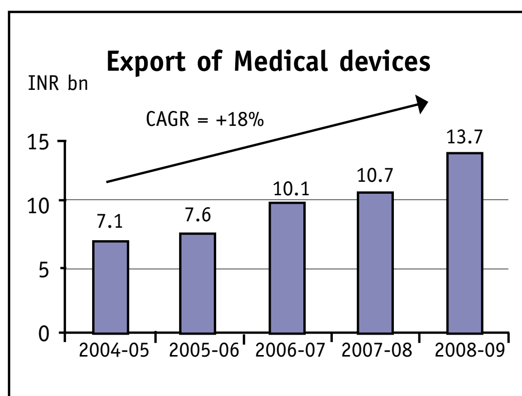
14 ASSOCHAM (2011), Emerging Trends in Health care , KPMG, New Delhi.

15 IVG Partners (2010) Indian Medical Equipment Industry Opportunities for US Companies, Report, New York.

16 IVG Partners (2010) Indian Medical Equipment Industry Opportunities for US Companies, Report, New York.

Diagram 10: Import and Export of Medical Devices





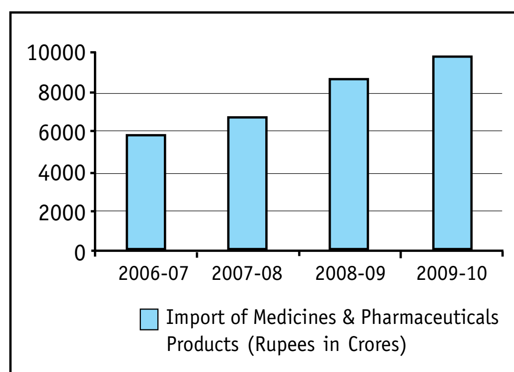
Source: IVG Partners (2010)

10. The country now ranks third in terms of volume of production (10 per cent of global share) and 14th largest by value (1.5 per cent of global share). One reason for lower value share is the lowest cost of drugs in India ranging from 5 per cent to 50 per cent less as compared to developed countries. The Indian pharmaceutical industry growth has been fuelled by exports. Its products are exported to a large number of countries with a sizeable share in the advanced regulated markets of the US and Western Europe. India currently exports drug intermediates, Active Pharmaceutical Ingredients (APIs), Finished Dosage Formulations (FDFs), Bio-Pharmaceuticals, Clinical Services to various parts of the world.[17]Export of Drugs and pharmaceuticals from 2006-07 to 2009-10 are given below in Diagram 4. The tremendous growth in exports over the last decade is given in Diagram 5.

Diagram 2: Imports

Year	Import of Medicines & Pharmaceuticals Products (`in Crores)
2006-7	`5866.37 Crores
2007-08	`6734.15 crores
2008-09	`8648.90 crores
2009-10*	`9828.00 crores

*Provisional



Source: Directorate General of Commercial Intelligence and Statistics (DGCIS) Kolkata taken from http://pharmaceuticals.gov.in/AnnualReport1011/ch_2.pdf

The Indian generic industry is for a variety of reasons, known as the "Pharmacy of the Developing Countries". As AIDAN (2011) estimates suggest it was India's generics that brought prices down from $15000 per person per year to $350 for first-line AIDS medicines. Around eighty per cent of people living with HIV in developing countries depend on Indian generic medicines for their survival. Indian generics

17 Accessed at http://www.indiainbusiness.nic.in/industry-infrastructure/industrial-sectors/drug-pharma1.htm , accessed on 5 March 2012.

supply more than 90 per cent of paediatric AIDS medicines. For millions of people in the developing world, access to essential medicines is often a question of life and death. Backed by the big multinational pharmaceutical companies, US, European Union and European Free Trade Association are pushing for aggressive trade policies to restrict the supply and production of the generic medicines (AIDAN 2011).

As regards AYUSH drugs, the report, AYUSH in India 2010, shows that during the last four plan periods total trade of AYUSH-related items increased from Rs 580.98 crores in 1995-96 to Rs 2540.79 crores in 2009-10 — a growth rate of 13.08 per cent per annum. During the Eleventh Five Year Plan, export of AYUSH products increased from Rs 2275.64 crores in 2007-08 to Rs 2887.01 crores in 2009-10 at an average annual growth rate of 12.63 per cent. On an average, the import of AYUSH products has increased by 14.99 per cent annually, from 261.82 crores in 2007-08 to 346.22 crores in 2009-10. Thus, during this plan, the total trade of AYUSH products increased substantially from 2537.46 crores in 2007-08 to 3233.24 crores in 2009-10 at an average annual growth rate of 12.88 per cent, as compared to 5.63 per cent average annual growth rate in total trade during the 10th Five Year Plan (Department of AYUSH 2011).

The draft National Pharmaceuticals Pricing Policy declared that all 348 essential medicines as per National List of Essential Medicines (NLEM) 2011 will be under price regulation, marking a shift from market-share based methodology to that based on need. However, it was observed that the proposals of market-based pricing can legitimise higher prices, since in the pharmaceutical market doctors as well as

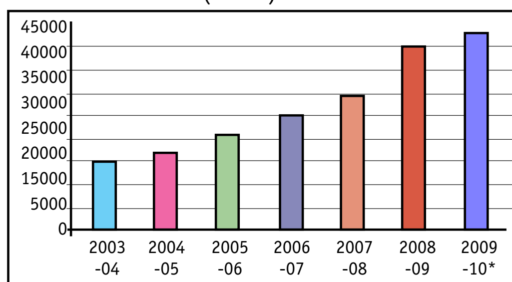
Diagram 5: Export Growth

('in Crores, %)

Year	Exports	Growth %
2003-04	15213	18.61
2004-05	17228	13.25
2005-06	21230	23.23
2006-07	25666	20.89
2007-08	29354	14.37
2008-09	39821	35.66
2009-10*	42154	5.86

* Provisional

Source: Directorate General of Commercial Intelligence and Statistics (DGCIS) Kolkata



Source: *http://pharmaceuticals.gov.in/AnnualReport1011/ch_2.pdf*

patients tend to favour costlier brands of the same formulation (Srinivasan, S. 2011). It was also observed that the proposal of National Pharmaceutical Pricing Policy (NPPP) 2011 to regulate prices of all the 348 drugs in the NLEM 2011, though well-intended, has inbuilt ways to escape from price regulation (Srinivasan, S. 2012).[18] A pricing policy that has some linkage to the cost of production will be a welcome alternative.

Parallel to this, the Indian government is under immense pressure from EU trade negotiators to accept stricter intellectual property rules. If accepted, this can have a disastrous effect on the health of the poor with its inevitable upward impact on drug prices.

18 Srinivasan, S (2012) Loopholes in pharma pricing policy, Hindu Business line (Accessed at http://www.thehindubusinessline.com/opinion/article3449400.ece on 24 May, 2012).

Private Medical Education

Until the nineties, medical education in India was a public monopoly; adequate numbers of doctors were being produced to meet the needs of the country. Unfortunately, most doctors graduating from these medical colleges either went into private practice or migrated abroad causing a perpetual deficit of doctors in the public sector. Instead of addressing the issue of non-availability of doctors for the public sector, the government changed its policy in the nineties to allow the setting up of private medical colleges. This changed completely the political economy of medical education in India. Like the Gold Rush of the 19th century, private medical colleges started mushrooming all over the country. The last two decades has seen a three-fold increase in private medical colleges — from about 114 medical colleges to 314 presently. For nursing schools, the increase was even higher — from just 739 in 2000 to 2028 in 2010. Most of this expansion in nursing education caters to the global demand of nurses while much of the private sector in India still employs unqualified nurses. This prolific growth in the private sector helped consolidate the strength of the private health sector in India; more significantly, it changed the character of health care by further commercialising it. Such commercialisation of medical and nursing education has further distorted the public good character of health care. This can only hasten greater expansion of private health care! More on this aspect is discussed in the next chapter.

Health Insurance

Health insurance is a contentious business. The recent spat amongst insurance companies regarding Third Party Administrators (TPA) and hospitals was all about the share in the booty collected from patients. This booty is growing at the rate of over 40 percent annually and is worth Rs 115 billion in premiums as shown in Table 9 and 10. Policies cover 268 million individuals (as on March 31, 2011, 189 million being under various Govt. schemes), as much as 22 per cent of the population (a sharp increase from a mere 5 per cent population coverage only 2 years ago). This is growing rapidly amongst not only middle classes but also amongst the poor who are covered through various government health insurance schemes.

Table 9: Health Insurance Premiums (Rs billions) by Type of Company

Company	2010-11	2009-10	2008-09	2007-08
Public	69.13	48.83	38.24	31.36
Private	45.67	34.21	28.01	19.88
Total	114.80	83.04	66.25	51.24

Source: IRDA Annual Report 2010-11, IRDA, Nov 2011, pg. 47

Table 10: Health Insurance Premium 2006-2011 Public and Private Companies

(Rupees Billion)

Insurer	2006-07	2007-08	2008-09	2009-10	2010-11
Public	19.74	31.37	38.24	48.83	69.13
Private	12.35	19.88	28.01	34.22	45.67
Total	32.09	51.25	66.26	83.05	114.80

Source: IRDA Annual Report 2010-11, IRDA, Nov. 2011

For many years, the public sector insurance companies dominated and pioneered health insurance this business with an approach of "do-good" towards this very small component of their overall general insurance business. Since the last few years though, the trend has shifted leading

to an increase in the share of the private sector. Consequently, there has been a shift in business ethics. As the private sector increasingly dominates this business, the rules of the game are changing. Profiteering has taken centre stage. Premiums are rapidly increasing, more and more conditionalities/ exclusions are being added, and claim reimbursements are being delayed and/or short-paid. On the other hand, the private health care provision remains unregulated as well as unethical in practice. Given such an environment, the current fracas was bound to happen. The only people who suffer as a result are the patients who despite paying heavy premiums for years end up being short-changed when they seek the benefits of their policy. The hospital gets its money even if they have overcharged, the TPA makes deals with both hospitals and insurance companies and facilitates reduced cashless payments, transferring the burden to patients. Amidst this rigmarole, the insurance companies gain by reimbursing a lower claim.

The above notwithstanding, health insurance has come to stay — for the middle classes and those working in the organised sector it is a tool to access high-end private health care. For the latter, health insurance is a great boon as it helps boost occupancy rates of private hospitals. The private hospital sector today cannot survive without health insurance and the latter requires the former to stay in business and make profits. In recent years, the health insurance business,with a view to expanding their market, has been developing public-private partnerships (PPPs). This allows it access to public resources under government-mandated health insurance schemes for the poor (see section on PPPs for details). The government-sponsored health insurance market has boomed in the last two years, taking the insured population coverage from 5 per cent in 2008-09 to a whopping 22 per cent in 2010-11. This is a huge bonanza for the health insurance business with premiums under government schemes totalling Rs 1699.61 crores (of which Rs 1201 crores was private sector insurance companies) in 2010-11 with around 189 million individuals being covered. The total premium has substantially gone up from Rs 1077.18 crores (private sector Rs 887 crores) covering 167 million people in 2009-10. The health insurance companies which were largely dependent on the organised sector employees and the rich for their business now have the public exchequer making huge contributions to their growth for financing select hospitalisations of the poor. The government's entry through health insurance schemes and consequent promotion of the private hospital sector has caused further harm to the already collapsing public health system.

Corporate Hospitals

Expansion of the pharmaceutical industry, explosive growth of private insurance and mushrooming of private medical education have transformed the political economy of health care in India. The entry of private corporations in the hospital sector is a significant fourth factor in this transformation. Corporate investment in the health sector is not new. It has been around since the 19th century; only the character of this investment has changed. During the 19th century and the first half of the 20th century, private investment in health was dominated by the merchant capitalist class who donated money, land, building, equipment etc. to public agencies to provide health care benefits to the poor and working classes. Mumbai is a classic example of such philanthropy from

Box 2: Medical Tourism in India

The National Health Policy visualised urban medical institutions as service production units at par with production units, and therefore, important sources of foreign exchange earnings. India has, over time, become a major destination in Asia for global medical tourists which offers treatment at only 20 per cent of the cost of treatment in the West. The hitech hospitals in India attract patients from The Middle East as well as the West by offering them "First World Quality at Third World Rates". It is estimated that medical tourism in Asia will be worth $4 billion by the year 2012(Confederation of Indian Industries-McKinsey 2002). The four main countries involved in this trade are India, Singapore, Thailand and Malaysia. However, health tourism can concentrate resources to facilities and services that cater to the diseases of the rich. Hence, the services these institutions promote are not necessarily in accord with the epidemiological priorities in the country. Only the upper crust gains through this skewed priority in the service structure (from Reddy and Qadeer, 2010).

business. Thus, all major public hospitals in Mumbai such as JJ Hospital, GT Hospital, Cama Hospital, KEM hospital, Nair Hospital etc. received huge grants and endowments to set up these institutions from merchant capitalist and the early bourgeois capitalists. However, post-1950s with the dominance of bourgeois capitalism, the strategy changed. Corporates began direct investments in hospitals using the Public Charitable Trust Acts to keep such investments and surpluses tax free. Thus, some of the large private hospitals in Mumbai such as Breach Candy, Bombay hospital, Jaslok Hospital, Lilawati, Hinduja, Ambani, Nanavati etc. are the elite hospitals set up by different business houses which operate as Trusts and, as discussed above, defraud the state of huge revenues.

In the nineties, under the LPG reforms, a new opportunity for the corporate sector in health care emerged — setting up public limited companies. The Apollo Hospital group was the front runner;subsequently others such as Max, Fortis, Wockhardt etc. joined the party. Apollo and Fortis (after acquiring Escorts and Wockhardt) are a huge chain of hospitals and other medical services. Apollo group presently has 8700 hospital beds with a turnover of Rs 26 billion; the Fortis group with 9700 beds has a turnover of Rs 19 billion. They have all received various subsidies from the Central and State governments, enjoy various tax exemptions and concessions, rake in huge profits and are of no benefit to the common person despite mandatory free services as per various laws/regulations and agreements in lieu of the concessions awarded to them.

The corporate and other large private hospitals are direct beneficiaries of health insurance business, including the government sponsored health insurance schemes. Apart from this, they gross huge foreign exchange earnings through medical

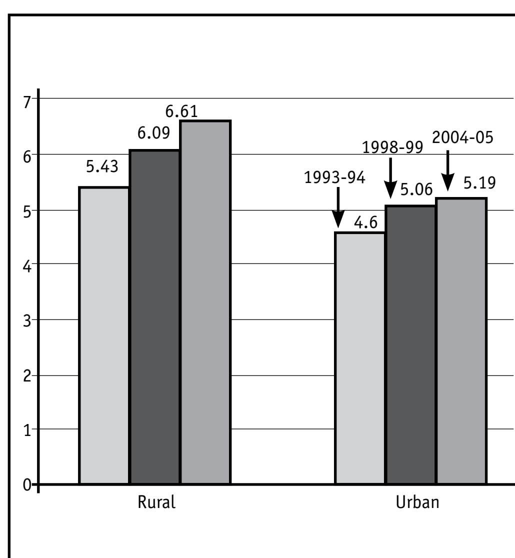
tourism estimated to be around 500,000 patients per year each averaging a spending of about $5000 — a whopping Rs 12,500 crores! The corporate sector has been the main mover of advanced medical technology in the country. Technological transformation in health care which is increasingly demanding more capital-intensive inputs has facilitated the corporatisation of health care and further commercialisation. This has spawned an independent business within the private health sector of diagnostic centres for sonography, CT Scan, MRIs etc. as well as for pathology laboratories. Though data on this industry is scanty, it is estimated to be an over Rs 25,000 crore industry (75 per cent imports based). The industry is growing rapidly, especially with corporatisation of health care and the support which comes from insurance. In fact, following on the footsteps of corporate hospitals and insurance, the medical devices industry is also pursuing the PPP route getting government hospitals to outsource diagnostics, lab tests, dialysis etc.

Impact on Out of Pocket Expenditures

The above four factors that helped consolidate and strengthen the private health sector have had direct consequences for households by impacting their out-of-pocket spending (OOPS) on health care. OOPS have been consistently on the rise, post-SAP as evident from NSSO surveys. Recent countrywide research studies have also demonstrated a continuous rise in OOPS despite the huge investment under NRHM. Such a rise is directly responsible for large scale pauperisation/indebtedness in the country. The growing OOP burden in the country is a key indicator of private health sector growth in India. The latest consumer expenditure data from the 66th NSS Round 2009-10 shows that the mean per capita monthly expenditure out-of-pocket on health care (OPD and IPD) in India is Rs 99.06 in urban areas and Rs 56.91 in rural areas. Of this, medicines account for over two-thirds of the OOPS.[19] As a proportion of household consumption expenditure too, health expenditure has been rising over time, as Diagram 6 clearly demonstrates.

The above review shows that the private health sector is now in complete command. Owing to lax government policies on public health, it is making further inroads into the already weakened public health sector through the vehicle of public-private partnerships. The next chapter will look at the growth pattern of health human power and health institutions including teaching facilities, with a focus on the past decade.

Diagram 6: Health Spending as Percentage of Household Consumption Expenditure Across NSS Rounds



Source: Baru et al. (2010)

19 NSSO ,2011op.cit.

The Changing Growth Trajectory

In chapter 1, the changing political economy was briefly discussed, with focus on the growth of the health sector in the historical context. Here we will look at recent trends, especially during the last couple of decades. These years were characterised by liberalisation of the Indian economy and the structural adjustment policies that followed. The new direction to health policy is towards reducing the role of the government while increasing that of the private sector. According to the Eleventh Plan document itself, the growth of private hospitals and diagnostic centres was also encouraged by the Central and State Governments by offering tax exemptions and land at concessional rates. These concessions were offered in return for provision of free treatment for the poor as a certain proportion of outpatients and inpatients. Apart from direct and indirect subsidies, the larger private corporate hospitals receive huge amounts of public funds in the form of reimbursements from the public sector undertakings, the Central and the State Governments for treating their employees (Planning Commission 2007).

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 primary concern has been only the public sector. Such a planning was skewed right at the outset with the dominant private sector being left out of the ambit.[20]Consequently, the availability of data on the private health sector is a major problem. Although 80 per cent of outpatient visits and 60 per cent of hospital admissions are in the private sector, the

20 Jan Swasthya Sabha (2000), Confronting Commercialisation of Health Care, Towards the Peoples Health Assembly Book – 5 (Accessed at http://www.communityhealth.in/~commun26/wiki/images/2/21/NHA1_Confronting_Commercialization_of_Health_Care.pdf.), accessed on 5 March 2012.

Table 11: Health Human Power Across Years

	Government Allopathic Doctors	Government Dental Doctors	Total Government Doctors (Allopathic and Dental)	Number of Allopathic Doctors TOTAL (Registration Data)	Number of Allopathic Doctors in the Private Sector	Percentage Private
2004	67576	2148	69724	643964	574240	89.17%
2005	NA	NA	NA	675375	NA	NA
2006	73549	3233	76782	700699	623917	89.04%
2007	76542	2993	79535	731439	651904	89.13%
2008	84852	3233	88085	761429	673344	88.43%
2009	84569	3076	87645	793305	705660	88.95%
2010	85254	3421	88675	816629	727954	89.14%

Source: CBHI Various Years

only definitive set of private sector data is on the number of hospitals and beds; that too is an underestimate as various micro studies have revealed. Unfortunately, even this data is available only up to 2002. Another set of data on the private health sector which is somewhat definitive is pharmaceutical production where 90-95 per cent of formulations are manufactured in the private sector.

Tables 12 to 16 give a broad overview of health sector development in the country. These include whatever data is available for the private sector. The data reveals that the private health sector has been significantly big even before Independence. (Please refer to Table 12 in the annexure for data). Since details were not available on the private health sector during that period, a critical analysis becomes difficult and restricted largely to anecdotal evidences or results of small studies and investigations. Hence, the analysis presented in the following paragraphs must be viewed in this context of limited information.

Production and Growth of Medical Human Power

Training and education of doctors of the modern system was predominantly the domain of the public sector. Until a couple of decades back, the private sector showed little interest in medical education. The responsibility of producing doctors and nurses was almost entirely on the state. This, however, was to change in the last two decades.

India had 19 functioning medical colleges at the time of Independence, with 1200

Table 13: Public and Private Distribution of Health Infrastructure

	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	63	64.6	35.4	*	*
1996	31.9	68.1	39	61	63.4	36.6	*	*
1997	31.72	68.28	43.28	56.72	61.49	38.51	*	*
1998	30.02	69.98	43.32	56.68	67.2	37.2	*	*
1999	25.35	74.65	47.63	53.37	61.74	38.26	*	*
2000	28.78	71.22	47.67	52.33	62.34	37.66	*	*
2001	27.48	72.52	45.9	54.1	61.83	38.17	*	*
2002	26.31	73.69	46.71	53.29	61.67	38.33	*	*
2003 onwards segregated data not updated								
* Not available								

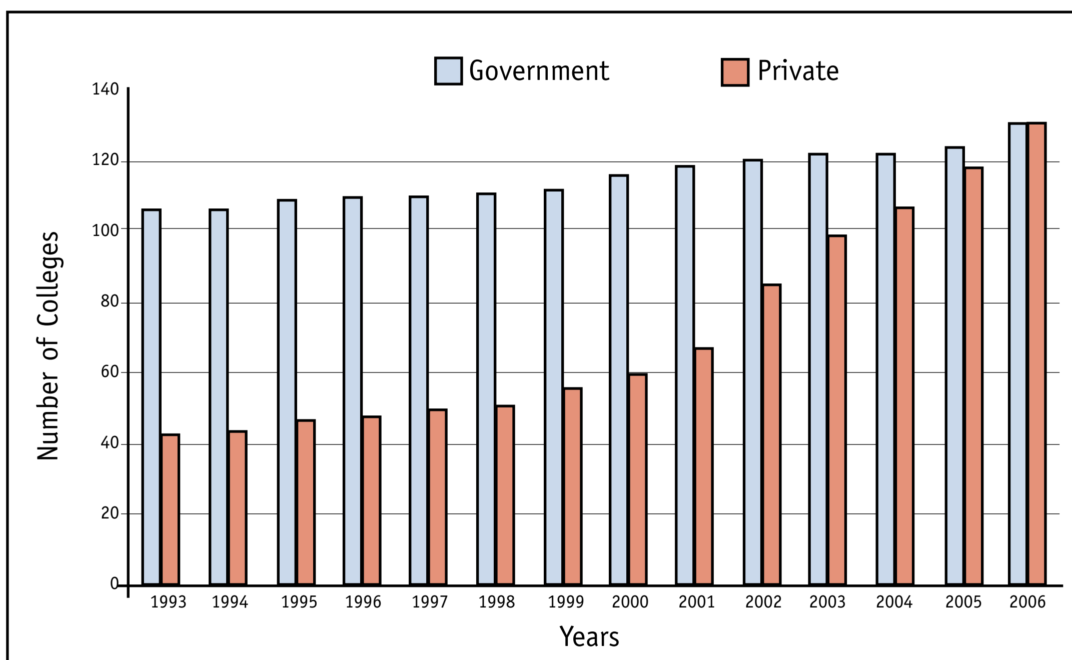
doctors graduating each year. According to the latest data from the Medical Council of India, India now has roughly 270 medical schools, from which 28,158 doctors graduate each year. This rapid increase in medical education has been a result of proliferation of private institutions. While in 1990, only about 33 per cent of the medical schools were privately operated, the proportion has now doubled to about 57 per cent (Rao et al. 2011).

In recent years, private medical colleges have been rapidly increasing in number (see Diagram 7). Many of such institutions, lacking basic necessary facilities for imparting such education, are coming up without the permission of the Medical Council of India. This unhealthy trend owes much to the lack of any regulation on the private sector's growth and the state's unwillingness- rightly so- to increase the number of medical seats in the public sphere to cater to the large demand for doctors in the mid-east and western countries.

Out migration of health human power greatly contributes to the country's shortage of health workers. Indian doctors constitute the largest number of foreign-trained physicians in the USA (4·9 per cent) and the UK (10·9 per cent), the second largest in Australia (4·0 per cent), and third largest in Canada (2·1 per cent). It was estimated that about 100,000 Indian doctors work in the USA and the UK. The results of a study at India's premier medical college showed that in the 1990s, 54 per cent of graduates left the country for a career in the USA (Rao et al. 2011).

As the latest figures published by the Department of AYUSH indicate, there were 7,87,564 AYUSH registered practitioners throughout the country as reported by State Boards/Councils of Indian Systems

Diagram 5: Growth of Medical Colleges in Recent Years (Public and Private) based on MCI Data



Source: http://www.hrhindia.org/Paper2/Appendix/Appendix.html

of Medicine and Homoeopathy (ISM&H) as on 1.4.2010. A maximum of 4, 78,750 practitioners have been registered under Ayurveda System, whereas 2,46,772 practitioners are registered under the Homoeopathy System. Only 51,067, 9,217 and 1,758 practitioners have been registered under Unani, Siddha and Naturopathy systems, respectively. On an average, registered practitioners under AYUSH systems have grown at the rate of 1.9 per cent per annum during 1993-2010, as shown in the next figure. The number of Ayurvedic practitioners registered observed a growth of 1.8 per cent per annum only, whereas average annual growth rates of 1.5 per cent and 2.5 per cent has been registered in Unani and Homoeopathic practitioners, respectively during 1993-2010. However, on an average, the number of registered practitioners of Naturopathy has increased by 13.4 per cent per annum during the period 1988-2010. Similarly, there is a 6.6 per cent average annual growth rate of Siddha practitioners during the period 2004-2010(Dept of AYUSH 2011).

In contrast, the production of doctors under Ayurveda, 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. In the absence of any regulation of the medical practice, most of them indulge in whole-scale cross-practice, especially under Allopathy. It is an open secret that non-allopathic qualification is often a via media for setting up the more profitable practice of modern medicine.[21] Of course, doctors with such qualifications have little scope for migration to other countries and so, do not contribute to the drain of the nation's wealth and resources. Presently, an estimated 3,193 hospitals and 23,750 dispensaries provide only AYUSH services. These hospitals together have 56,842 beds. While 90.6 per cent of hospitals and 96.5 per cent of dispensaries are in the public sectors, it is interesting to note that ashigh as 45.4 per cent of these beds happen to be in the private sector. The proportion of the total 7,12,121 registered AYUSH doctors who are in active practice, however, is not known. Around 3,83,986 of those doctors are male and 98,650 are female. [22] Added to these registered doctors, many informal practitioners also provide AYUSH services.

Government estimates published by CBHI based on doctor's registration data indicate that of all the Allopathic doctors, about ninety per cent work in the private sector (Table 14). Interestingly, this proportion has not improved even marginally over the past decade despite large scale government schemes. One reason could be that all these schemes substantially depend on mechanisms such as private partnerships, contracting in etc. to address human resource constraints.

The story about nurses is a little different from that of doctors. India produces more number of doctors than nurses, according to government data! According to a recent estimate based on the Census data from 2001, the relative shares indicate that there are approximately 1.2 nurses and midwifes per Allopathic physician. If only nurses are considered, then there are approximately 0.81 nurses per Allopathic physician in India, suggesting that there

21 Jan Swasthya Sabha (2000), Confronting Commercialisation of Health Care, Towards the Peoples Health Assembly Book – 5 (Accessed at http://www.communityhealth.in/~commun26/wiki /images/2/21/NHA1_Confronting_Commercialization_of_Health_Care.pdf) , accessed on 5 March 2012..

22 GoI (2012) Ayush in India 2011, New Delhi

Table 14: Sectoral Employment of Allopathic Doctors in India

YEARS	GOVERNMENT SERVICE	PRIVATE SECTOR	TOTAL
1942-43	13000 (27.4)	34400 (72.6)	47400a (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)
1998-99			
1999-00			
2000-01			555550
2001-02			577094
2002-03			607075
2003-04			625423
2004-05			643964
2005-06			675375
2006-07			700699
2007-08			731439
2008-09			761429
2009-10			793305
2010-11			816629

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**

are more doctors than nurses (http://www.hrhindia.org/assets/images/Paper-I.pdf). Secondly, the demand for qualified nurses in the private sector in India is very small.This is because the private hospitals and nursing homes do not follow any standard practices.They prefer to employ nursing personnel who are trained only as auxiliaries or worse still, are trained on the job. According to a recent CEHAT study, the proportion of private hospitals without qualified nurses is alarmingly high (CEHAT 2010). Neither the Nursing Council or Medical Council or the State has shown any interest in regulating the human resources aspect of private care.

As per recent PHFI and World Bank research, the distribution of health work force across states shows high inequities. There is high variance in doctor as well as nurse densities across states, as is clear from Diagram 8.

Another matter of concern is the remarkably low proportion of female health workers in India, evident from Diagram 9. The presence of female health workers including female doctors is an important contributing factor for enhanced women's access to health services. Barring the category,"Nurse and Midwife" perceived in India to be a largely female vocation, the proportion of women in all other categories is exceptionally low. The data on participation in health profession collected by WHO's World Health Survey in Maharashtra revealed sharp class, gender and rural-urban inequities in distribution of doctors, nurses and other health professionals across the population. For instance, measured as per 1,00,000 population, the bottom three quintiles did not have a single person as a doctor; there were 16 per cent more

Diagram 8: Doctor and Nurse Density

Figure 4: Doctor Density
(Per 10,000 Population)

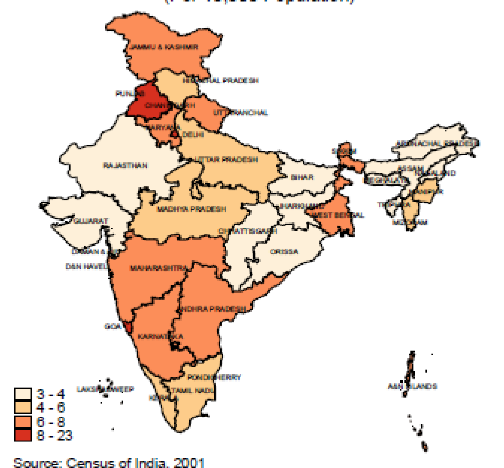
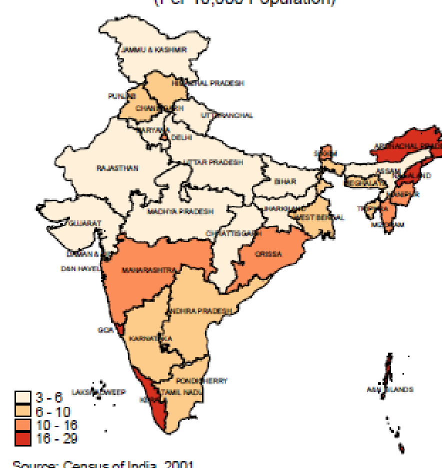


Figure 5: Nurse & Midwife Density
(Per 10,000 Population)



Source: *www.hrhindia.org/assets/images/Paper-I.pdf*

male physicians than female and 188 per cent more physicians in urban areas than in rural areas. Such disproportionate distribution of doctors results in the sharp class and gender differentials in access to health care. The nursing profession was generally class neutral with relative equity across classes, though rural areas had 179 per cent less nurses than urban areas.[23]

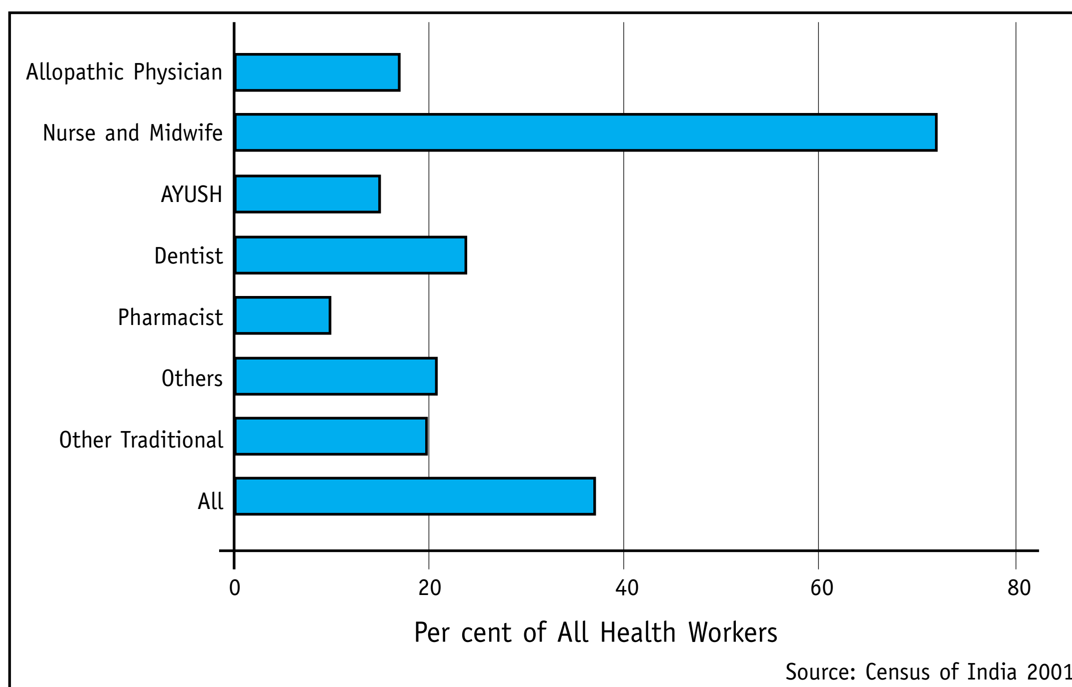
Data presented in a recent Lancet article shows that in 2006, there were 271 teaching institutions for auxiliary nurse midwives, 1,312 offering the general nurse midwifery degree, 580 offering bachelors degree in nursing, and 77 offering Master's degrees in nursing. Private nursing institutions have added primarily to the increase in nursing education; of colleges offering courses in general nurse midwifery, 88 per cent were private sector institutions. However, little is known about several unrecognised and unregistered nursing schools, especially in southern states, as lack of regulation continues to be a major issue (Rao et al. 2011).

Geographical imbalances are sharper than the public-private one. Southern states account for account for 63 per cent of the general nursing colleges in the country, 95 per cent of which are private. The distribution of nursing institutions that offer higher education is even more disproportionately distributed — 78 per cent are located in the four southern states, all of which have higher numbers of nurses and midwifes per 10,000 population than the national average (7·4 per 10,000 population). States such as Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh offer a stark contrast and have much fewer numbers of nurses per 10,000 populations than the national average. However, they account for only 9 per cent of nursing schools in the country (Rao et al. 2011).

Running parallel to this development, the presence of Indian nurses in developed countries is substantial and shows an increasing trend. Available data suggests

23 Duggal, Ravi (2008), Inequities in Access to Health Care, in SATHI (2008) A Report on the Health Inequities in Maharashtra.

Diagram 9: Proportion of Female Health Workers in India



Source: PHFI 2008, HRH Technical Report # 1

substantial emigration from India. For instance, the number of new Indian nurse registrants in the UK grew from 30 in 1998 to 3551 in 2005. The National Council Licensure Examination for Registered Nurses, a qualification needed to become a registered nurse in the USA, had 417 Indian first-time examinees in 2000.The numbers rose to 5,281 in 2007 (Rao et al. 2011). A study based in one of the recruiting hubs in India noted that that up to one-fifth of the nursing labour force may be lost to wealthier states through circular migration.[24]Khadria (2007) noted that India is faced with the double challenge of producing more nurses for emigration and, at the same time, filling vacancies within India. The enormous enthusiasm on the part of the private commercial agencies that engage in BPO — including nurse supply and the resultant massive growth in recruitment activities — is causing serious risk of selective depletion of the most qualified nurses in the country.[25]

In 2005, with an estimated 2.2 million health workers (a density of approximately 20 health workers per 10,000 population, 70 per cent of whom work in the private sector according to NSSO estimates (http://www.hrhindia.org/ assets/images / Paper-I.pdf),India arguably has the largest and completely unregulated private health sector in the world. This segment of the private health sector provides only curative services on a fee-for-service basis.

Healthcare Facilities

Apart from individual practitioners (general practice and consultants), dispensaries, nursing homes and hospitals are also to be taken into account. While dispensaries as

24 Hawked, Michael et al (2009) Nursing brain drain from India, Human Resources for Health 2009, 7:5.

25 Khadria, Binod (2007) International Nurse Recruitment in India, Health Serv Res. 2007 June; 42(3 Pt 2): 1429–1436.

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).Some run even without beds registered as clinics of private practitioners, affiliated to insurance medical systems (usually urban). No official data is available for dispensaries after 2004.

Hospitals and nursing homes constitute the more significant part of institutional care. There is no accepted definition differentiating the two. As a rule,though, the small private hospitals (normally less than 30-bedded) are referred to as nursing homes.

Historically, the private hospital sector has been small in India as elsewhere in the world. This is because state and charity (including religious missions) were regarded as the most appropriate providers of such care. With changing times, such care was commercialised under capitalism with technological developments facilitating profiteering.With rising profits, private interest in running hospitals increased rapidly. In India, the limited data available shows that this process of rapid increase in the number of private hospitals and their capacity began in the mid-seventies. It has advanced progressively, increasing from a mere 14 per cent of hospitals in 1974 to about 74 per cent in 2002 (Table 15). In 2002, the country had 11,345 private/NGO hospitals (Allopathic) with a capacity of 2,62,256 beds (http://planningcommission.nic.in/plans/planrel/fiveyr/11th/11_v2/11th_vol2.pdf).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 increase in the number of specialists being churned out from medical schools.

Whether private or public, the hospital segment expanded mostly in the urban areas; the rural population's access to such care worsened, over the years. Even today 74.05 per cent of hospital beds are in urban areas when 69 per cent of the population resides in villages! The achievements of the public health sector made during the eighties in improving health outcomes weakened with the economic crises of 1991.The subsequent economic reforms which followed under the Structural Adjustment Program (SAP) strategy commandeered by the World Bank depleted it further. As mentioned earlier, during the 5th to 7th Plan period, public health services and public health investment were relatively robust. This was reflected in faster improvements in health outcomes, to begin with developed states, and soon followed by the underdeveloped. This approach received a setback at the turn of the nineties when resource commitments in the public health sector declined, especially so in the developed states (Duggal 2007).

At one level, this is reflected in slowing down of improvements in health outcomes and the widening rural-urban gap of these outcomes. At yet another level, public health care facilities are worsening with little or no inputs being provided to run these facilities. The 2002 National Health Policy unashamedly acknowledged that the public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continues to be unacceptably high, and resource allocations generally insufficient. Between mid-eighties and mid-nineties, upto 30 per cent decline in use of public health care facilities could be seen in both rural and urban areas, over the decade. Why so? Partly, the answer lies within the same data set. The cost of seeking treatment,

Table 15: Ownership Status of Hospitals and Hospital Beds

Year		Hospitals			Hospital Beds	
	Government	Private	Total	Government	Private	Total
1974	2832 (81.4)	644 (18.6)	3476 (100)	211335 (78.5)	57550 (21.5)	268885 (100)
1979	3735 (64.7)	2031 (35.3)	5766 (100)	331233 (74.2)	115372 (25.8)	446605 (100)
1981	3747 (56.2)	2923 (43.8)	6670 (100)	334049 (71.5)	132628 (28.4)	466677 (100)
1984	3925 (54.6)	3256 (45.4)	7181 (100)	362966 (72.5)	137662 (27.5)	500628 (100)
1986	4093 (54.7)	3381 (45.3)	7474 (100)	394553 (73.9)	141182 (26.1)	533735 (100)
1987	4215 (54.3)	3549 (45.7)	7764 (100)	411255 (74.1)	144009 (25.9)	555264 (100)
1988	4334 (44.1)	5497 (55.9)	9831 (100)	410772 (70.1)	175117 (29.9)	585889 (100)
1993	4597 (33.5)	9113 (66.5)	13710 (100)	385216 (64.6)	210987 (35.4)	596203 (100)
1996	4808 (31.9)	10289 (68.1)	15097 (100)	395664 (63.4)	228155 (36.6)	623819 (100)
1997						
1998						
1999			18281 (100)			
2000	4111 (25.87)	11317 (71.22)	15888 (100)	398043 (57.63)	260184 (37.66)	690723 (100)
2001	3836 (24.56)	11330 (72.52)	15622 (100)	389441 (57.03)	260669 (38.17)	682886 (100)
2002	3579 (23.25)	11345(73.69)	15393 (100)	387895 (56.75)	262067 (38.33)	683545 (100)
2003	3593		__	389141		__
2004*	5479			380993		
2005	7008			469672		
2006	7663			492698		
2007	9976			482522		
2008	11289			494510		
2009	11613			540328		
2010	12760			576793		

* 2004 onwards segregated data is not available for private secctor.

Source : CBHI 2000-2010

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.

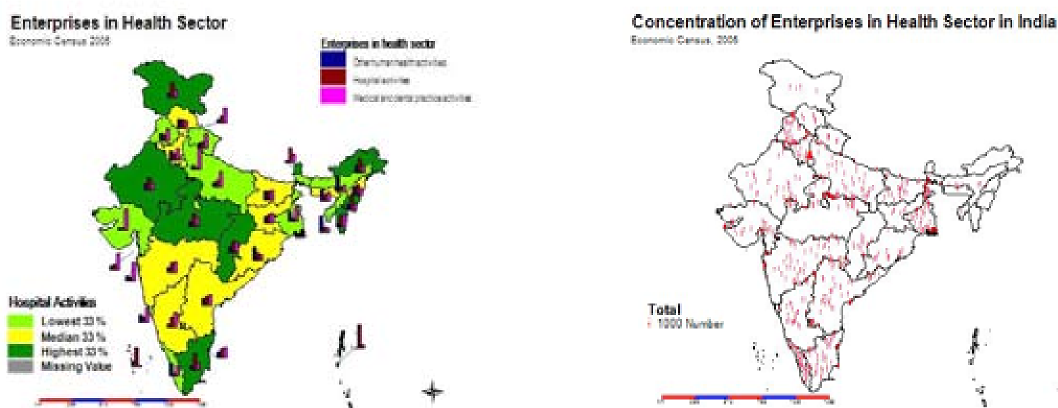
even in public hospitals, has increased over five-fold (in private hospitals, it is nearly seven-times more). During the same period, the purchasing power of the poorer classes has not changed in any substantial way. Consequently, the 52nd Round showed higher levels of untreated morbidity, especially amongst the poorer groups. The other part of the answer is the declining investment and expenditures in the public health sector. It can be argued that these trends are closely linked with a wide spectrum of changes in the economy since the mid-1980s. It is these changes which have led to privatisation of services, deregulation of drug prices, heightened reliance on market mechanisms to address welfare needs, and weakening of public health systems (Duggal 2005).

The issue of quality of care that plagues a large part of the public sector is not unique to it. The private sector, given its large size and dominant position, provides the lead and sets norms for a culture of medicalisation that the public sector is often forced to emulate. Yet, the systemic factors that ail the public sector are often not taken into account. Efforts at reforms in the health sector mostly prove to be facile, and involve increasing public subsidies to the private sector. While the private sector has, thus, grown with implicit state support, its quality, outcomes and cost have not been issues covered under a strong regulatory mechanism(Rao 2007).

Even while no official data is available regarding the size or nature of the private health sector in India, some indicative assessment of the same could be achieved using national surveys. The latest dataset that one could refer to for such an exercise is the Economic Census of India 2005. It provides the complete count of all entrepreneurial units within geographical boundaries of the country and lists the basic entrepreneurial data on the number of enterprises and employment, therein. Diagram 10 provides an idea of the distribution of enterprises in the health sector.

The establishment is defined as an enterprise or part of an enterprise that is situated in a single location, in which one or predominantly one kind of economic activity is carried out. It is an economic unit under a single legal entity. It is further divided into Own Account Establishment (OAE)and Establishments with hired worker. An establishment without any hired worker, on a fairly regular basis, is termed as an Own Account Establishment. It

Diagram 10: Enterprises in Health Sector



Source: Economic Census 2005

is normally run by members of the household. An establishment with a hired worker is self-explanatory.

Table 16 gives the distribution of Establishments and Workers of the activity group Health and Social Work across categories. It is assumed that the general trend of this broad group will hold for private health institutions, which is the major subset of this group. According to this data, about 39.88 per cent units and about 14.47 per cent workers come under the category, which can be termed as a proxy for home-based private care providers. About 60.12 per cent units (4,69,000 in numbers) and about 85.53 per cent workers (2,27,5000 in numbers) fall under establishments with hired workers. However, a large majority of this category happens to be small establishments employing a small number of staff. It is revealing that only 8.92 per cent of these institutions employ more than five-staff members. The data also shows that around two-thirds of all institutions which employ more than five people, and almost three-fourths of all the health human-power employed in such institutions, are concentrated in the urban areas. As discussed earlier, care across all these categories would be of questionable quality; it cannot be clearly established that quality is a function of size in a situation of no regulation. However, this data clearly establishes that private sector in India is highly varied in size and dominated by small players, at least in number. The data also supports the hypothesis of stark rural-urban disparities and the resultant spatial access barriers that act in addition to price barriers.

A study conducted by CEHAT on the growth of health care facilities in four cities of Maharashtra found a lopsided geographical distribution of the facilities in four cities in Maharashtra. While the private sector grew rapidly in part responding to the increasing population rate and high economic development in certain pockets, the growth rate of the public health facilities remained abysmally low. An overburdened system was impacting people's access. Geographical placing of the public facilities is very important. An undue concentration of public facilities was found in certain pockets, defeating the logic of a hierarchical referral system. The study also points at the non-availability of both public as well as private health facilities for the urban poor living on the periphery of the city as observed in Aurangabad and Nashik. A recent study conducted in Nashik found a total of 13,000 beds in the district; almost 70 per cent were in the two cities of Nashik and Malegaon alone (Ashtekar 2010).

In situations such as this, there is an urgent need to consider geographical norms for private hospitals within the cities to facilitate a more equitable distribution of health services.

Table 16: Health and Social Work: Distribution of Establishments and Workers by Type (2005) (Number in Thousand**)**

	Combined		
	OAE	**Establishments. with Hired Workers**	**Total**
Establishments	311	469	781
%	39.88%	60.12%	100.00%
Workers	385	2275	2660
%	14.47%	85.53%	100.00%

Source: Economic Census 2005

Although no official data at the national level is available for the private sector after 2002, 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. New medical technologies have made possible the concentration of capital 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; corporate managers are taking over the control of the health care sector. New medical technologies have opened new avenues of corporate investment, promising far-reaching changes in the structure of health care delivery.

Latest figures published by the Department of AYUSH indicate that of the total 3,277 hospitals across India, 2904 or 88.6 per cent are run by the government. A mere 373 hospitals or 11.4 per cent are being run by the private sector. Conversely, the private sector that runs just 11.4 per cent hospitals have 52.7 per cent of all the AYUSH beds available in the country! There were 62,649 beds under AYUSH hospitals in the country in2010. The maximum number of beds (44,820) has been reported in Ayurveda hospitals. On an average, beds of AYUSH hospitals have grown at the rate of 3.4 per cent per annum since 1993. Average annual growth rates of 3.5 per cent, 3.2 per cent, 4.4 per cent, 2.2 per cent and 1.5 per cent have been registered in the bed strengths of Ayurveda, Unani, Siddha, Homoeopathy and Sowa-Rigpa (Amchi), respectively, during 1993-2010, whereas, bed strength of Yoga and Naturopathy hospitals have declined by 17.6 per cent and 1.5 per cent per annum, respectively(Department of AYUSH 2011).

Concluding Remarks

In conclusion, it is important to reemphasize 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:

- The character of medical education has considerably changed over the years with an increasing participation of private medical colleges in this sector. However, the major beneficiary of the public medical school continues to be 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, and subsidies to private pharmaceutical and medical equipment industry. It manufactures and supplies raw materials (bulk drugs) to private formulation units at subsidised rate/low cost. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially the highly expensive new medical technology.
- The government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes. Hence, they do not contribute to the state exchequer even when they charge patients exorbitantly.
- The government is shifting from its role as a provider to being a purchaser of care largely provided by the private sector. The government has also been

contracting out its programmes 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 greater privatisation.

- 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, 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. Despite repeated calls to abolish such user fees, no action has been forthcoming.
- 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. Even registration is not required for a hospital to function, unlike other institutions for instance, shops. Standards of care such as the ones related to minimum human resources (qualification and number), record keeping, and treatment protocols etc show complete neglect by the state.

The above are a few illustrations of how the state has helped strengthen the private health sector in India. In today's liberalised scenario where the state is willingly becoming a purchaser rather than a provider, the private health sector is ready for another leap in its growth. This will mean further appropriation of people's health and a worsening health care scenario for the majority population. Access to health care will become a direct function of purchasing power, or the probability of the poor to be included in the ever shrinking Below Poverty List, which in no way represents the health insecure population of India. In a country where a significant percentage of population falls under poverty line because of health-related spending, financing and provisioning needs to be more universal in nature with a clear focus on the public sector

Broadly, we may conclude that the private health sector in India has grown with the support of crutches from the state, with the latter hoping its contribution to private sector's growth will contribute to public good. While this did not happen, the private health sector has witnessed an unprecedented boom. It has taken complete control of health care in India. It is believed that competition will regulate markets but in reality this does not happen. The health sector is characterised as being pushed by supply-induced-demand whose reins are in the hands of the providers.There is no evidence that increased supply will depress prices. Capital-intensive MRIs and CT Scans keep getting costlier, despite a rise in such tests. With increasing domination and control of the private health sector, a further reduction in access to health care seems imminent. The consequence: the heightening of inequities.

Note: See Annexure for tables relevant to the discussion presented above.

Regulation and Public Private Partnerships

The lack of regulation in the Indian health sector may be explained by the historically low levels of public investments in health, and health sector reforms that further reduced government investments. Encouraging the private health care providers to play a greater role in health care provision and to exponentially expand has been a policy goal. Such a weak policy regime has resulted in a largely urban-centric expansion. In the given situation, it would be good to discuss, briefly, various regulatory options at hand.

Information asymmetries inherent in the health care market which result in low quality, price distortion, over medication etc necessitate strict government intervention in regulation. Globally, the medical profession has been largely self-regulated. In the present scenario, though, such complacent approach has been challenged, particularly in the context of rampant commercialization of health and the information asymmetries that favour providers in the sector. In order to find the best ways to ensure better and safer health care, countries have their own regulatory authorities. Some instances are the Health Care Commission in UK, the National Quality Forum in the United States of America, the Canadian Patient Safety Institute in Canada and the Australian Council for Safety and Quality in Health Care in Australia.

Theoretically, the minimisation or control of risks in the society remains the core objective of regulation. Many ways ranging from persuasion to punishment may be used. Regulatory strategies cover a range of options rather than being just about enforcing law. The options could be categorised under five types of policy instruments:

- **Voluntarism**- is based on an individual or organisational undertaking to do the right thing without coercion.
- **Self-regulation**- is where an organised group regulates the behaviour of its members (e.g. by establishing an industry-level code of practice).
- **Economic instruments**- involve supply-side funding sanctions or incentives for health care providers, and also demand-side measures that give more power to consumers.
- **Meta-regulation-** involves an external regulatory body ensuring that health care providers implement safety and quality programs and practices.
- **Command and control-** involves enforcement by government (e.g. ensuring compliance with rules for licensing facilities).

Mechanisms of Health Sector Regulation

Health sector regulation is aimed at two aspects of health policy — the policy objectives and managerial mechanisms to achieve them, each with specific functions, yet closely connected in order to achieve national health goals. The first dimension of regulatory activity may be termed social and economic policy objectives. It is normative and value-driven in nature, concerned with specific policy goals — with ends and objectives — and with the broad public interest. Social and economic policy objectives could be listed as follows:

- Equity and justice: to provide equitable and need-based access to health care

for the whole population, including poor, rural, elderly, disabled and other vulnerable groups.

- Social cohesion: to provide health care through a national health care service or to install a social health insurance system.
- Economic efficiency: to contain aggregate health expenditures within financially sustainable boundaries.
- Health and safety: to protect workers, to ensure water safety and to monitor food hygiene.
- Informed and educated citizens: to educate citizens about clinical services, pharmaceuticals and healthy behavior.
- Individual choice: to ensure choice of provider, and in some cases insurer, as much as possible, within the limits of the other objectives.

The second dimension of regulatory activity may be termed the health sector management mechanisms. This level is practical and operational; it is concerned with specific regulatory mechanisms through which decision-makers seek to attain the type of policy objectives set out in the following list:

- Regulating quality and effectiveness: assessing cost-effectiveness of clinical interventions; training health professionals; accrediting providers.
- Regulating patient access: gate-keeping; co-payments; general practitioner lists; rules for subscriber choice among third-party payers; tax policy; tax subsidies.
- Regulating provider behaviour: transforming hospitals into public firms; regulating capital borrowing by hospitals; rationalising hospital and primary care/home care interactions.
- Regulating payers: setting rules for contracting; constructing planned markets for hospital services; developing prices for public-sector health care services; introducing case-based provider payment systems (e.g. diagnostic-related groups); regulating reserve requirements and capital investment patterns of private insurance companies; retrospective risk-based adjustment of sickness fund revenues.
- Regulating pharmaceuticals: generic substitution; reference prices; profit controls; basket-based pricing; positive and negative lists.
- Regulating physicians: setting salary and reimbursement levels; licensing requirements; setting malpractice insurance coverage.

As mentioned already, the methods available for regulation in the health sector range from "soft" ones to "hard" ones. Regulation in the health sector, however, has traditionally been "soft" —largely a matter of voluntary compliance by individual doctors, backed up by professional self-regulation in instances of glaring incompetence. The exceptions are the licensing of health professionals, a "hard" instrument of command and control, and the licensing of facilities through standards inspection, a common approach to improving quality. In a vast country such as India beset by an unorganised health care system, a market characterised by supply-induced demand and poor ethics, a judicious and customized mix of all instruments under the state's command is an imperative.

Existing Regulations in India

The private health sector consisting of general practitioners, nursing homes and hospitals involving 80 per cent of doctors, 26 per cent of nurses, 49 per cent of beds, 78 per cent of ambulatory services and 60 per cent of in-patient care constitutes a huge majority of the medical human power

in the country. Despite this, there is hardly any regulation of the practice of this sector of health. This is indeed surprising as such activity cannot be carried out without registration. The medical professional has to be registered with the Medical Council. The doctors who decide to set up their own clinics as well as hospitals, nursing homes, polyclinics etc. have to register with the respective local body. The problem with the above is that the controlling bodies are virtually non-functioning. The reason for this is a lack of interest on the government's part and weak provisions in various acts, heavily influenced by the private health sector.

Another agent in the private health sector which requires enhanced regulation is the pharmaceutical industry. As a chemical industry, it is regulated to some extent but as a participant in the health sector, it operates virtually unregulated. Whereas the public health sector due to bureaucratic procedures is forced to maintain at least some minimum requirements (e.g. they will not employ non-qualified technical staff, follow certain set procedures of use of equipment or purchase of stores etc) and is subject to public audit, the private health sector operates without any significant controls and restrictions.

As per existing laws in the health sector, the following are some authorities which have provision for regulation:

The Medical Council of India and the respective State Councils are authorized to regulate medical education and professional practice. Presently, beyond providing recognition to medical colleges the Medical Council does not concern itself with the practitioner. It steps in only when a complaint is made and a *prima facie* case established. Even the list of registered practitioners is not regularly updated by the Medical Councils. The national body, at present, concerns itself with only recognising and de-recognising medical colleges whereas the State bodies function only as registers for issuing a license for practicing medicine. (The State Councils also facilitate recognition of private medical colleges which the National Council has de-recognised!).

The Local Bodies (Muncipalities, Zilla Parishads, Panchayat Samitis etc.) have the authority to provide a license to set up a nursing home or hospital and regulate its functions. However, besides providing the certificate to set up a hospital or nursing home the local bodies do not perform any other function, despite a provision in the Act.

The Food and Drug administration (FDA) has the jurisdiction to control and regulate the manufacture, trading sale of all pharmaceutical products. This is one authority which has been provided some teeth by the law, but so ridden is it by corruption that its performance is most embarrassing. Inspite of the ridicule it had to face due to the Lentin commission inquiry, its behaviour remains, more or less, unchanged.

In addition to these, the **Clinical Establishment Act, the National Accreditation Board for Hospitals and Health Care Providers (NABH) and the Indian Public Health Standards (IPHS**) under National Rural Health Mission are attempts to define standards for health care facilities.

However, it was observed that such compartmentalised initiatives may have

led to further fragmentation of an already segmented industry. The problem lies in not having a single, unified system to establish standards in varied areas such as structures, processes about quality, rationality and costs of care, treatment protocols and ethical behaviour applicable to both the public and the private sector. It is necessary also to monitor the functioning of health facilities and ensure compliance with established standards. Such a system is essential for ensuring accountability of these institutions and organizations (HLEG 2012).

For these very reasons, the HLEG made the following recommendations to rein in the private sector and pave the way for the upcoming Universal Health Coverage initiative:

- **Establish a National Health Regulatory and Development Authority (NHRDA)** statutorily empowered to regulate and monitor/audit both the public and the private sectors, and ensure enforcement and redressal.
- **Mandate the accreditation of all health care providers (public and private, Allopathic and AYUSH);** registration of all clinical establishments by the National Health and Medical Facilities Accreditation Unit (NHMFAU) of the NHRDA.
- **Establish a system to independently evaluate the performance of both public and private health services.**
- **Establish a health system portal to strengthen the use of information technology** for better performance by both public and private sectors.
- **Strengthen the Drugs and Medical Devices Regulatory Authority** and expand its scope to include the development function to ensure better regulation of the pharmaceuticals and medical devices sector.
- **Engage the private sector for provision of health care through a well-defined "contracting in" mechanism.** Such a mechanism would help to harness the power of the formal private sector but with adequate checks and balances.

In line with the HLEG's recommendation of utilising private sector capacities via a "contracting-in" mechanism, albeit within a strict regulatory framework, the Steering Committee on Health for the Twelfth Five-Year-Plan too recommends leveraging the strengths of the private sector, subject to strict checks and balances. It also states that in a system of cashless access to an "essential" package, public health care facilities should be provided financial and operational autonomy to enable them to compete with private and non-governmental organisation (NGO) providers (Planning Commission 2012). It has not, however, made clear how a historically-starved public sector will be able to "compete" with private and NGO providers. Obviously, a level playing field does not exist, as of now.

In view of the existing health situation and health problems and the context of commercialised practice, regulation of those who provide the nations health care is an urgent necessity. The entire process of regulation must have the end user (patient) represented on the regulating bodies.

As discussed earlier, the private health sector is responsible for nearly three-fourths of all health care in the country. Though Acts have been established, it is not yet regulated in any significant manner by authorities. 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, in practice, this does not happen. The result: unqualified persons set up practice, there is rampant cross-practice, irrational and other malpractices abound, 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. Bureaucratic procedures force the public health sector to maintain, at least, 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. While the public sector is subject to public audit, the private health sector doesn't pay heed to any such thing.

Ideally, regulation of the health sector must aim at improving clinical performance in terms of safety and quality, target risk mitigation, promote ethics and social justice and protect professional standards. However, as seen in the previous chapter, even while private health care dominates the health care scene in India, there is insufficient information regarding the number of private establishments, human resources employed, standards of care etc. Irrational and inappropriate treatment is rampant and care of questionable quality is often rendered to patients. Overcharging, excessive use of technology, enrolment of patients in illegal clinical trials, unnecessary surgeries and other unethical practices are widespread, impacting well being and inflating costs (Nandaraj 2012).

It is in the context of such wide variations in the availability of health care facilities in the private sector that regulation of the private sector by the government becomes significant. As the International Federation of Health and Human Rights Organisations puts it, health care is a right, not just a service and definitely not a charity, commodity or a privilege. Recognising this right implies that governments have obligations and the regulation of non-state actors such as the private health sector falls within this domain. The large private sector operates without any standards of care or regulation of cost. It runs parallel to the public sector with no obligation to fulfil public health goals. It is, therefore, necessary that this sector be regulated and made accountable. In doing so, the plurality that exists in the sector needs to be kept in mind. The Constitution of India, in the Seventh Schedule, states that health which includes public health and sanitation, hospitals and dispensaries is a state subject. This includes the regulation of clinical establishments. Most states have failed in their obligation to enact legislation for regulating private providers of health care.

While some state level efforts at regulation of private hospitals do exist, these are rendered ineffective for all practical purpose as the clauses, rules and by-laws are dated. These efforts have failed to take into consideration the growing and changing profile in terms of the size and scale of complex operations. The rate and quantum of change was so rapid that most of these laws remain irrelevant. In addition, the penalties for non-compliance are mild and fail to provide any deterrent effect on the provider (Nandraj 2012). However, patients, consumer bodies and other public interest groups have been long targeting malpractices and negligence in the private health sector and demanding compensation, accountability, setting up of minimum standards etc.

For example, as part of the National Abortion Assessment study done by CEHAT and Healthwatch (2004), a facility survey conducted across six states revealed that 80 per cent of abortion care was being provided by private facilities. Of these private facilities offering abortion, only 25 per cent were certified under the MTP Act. Certification under MTP act is mandatory. The fact that so many operate without complying is indicative of the apathetic attitude of private providers to any regulatory mechanism.

The Bombay Nursing Home Registration Act (BNHRA) governs the registration of private hospitals in Maharashtra. The Act, made in 1949, was applicable only to the Mumbai city. It was later amended and made applicable to four districts of the state namely Mumbai, Nagpur, Pune and Solapur. A further amendment in 2005 extended its ambit to the entire state of Maharashtra. A recent CEHAT study of 261 nursing homes (less than 30 beds) from 11 districts of the state found that 25 per cent hospital owners in Maharashtra were not aware about the law, a telling comment on the apathetic attitude of the medical profession. This was borne out in the workshops that CEHAT organised where several doctors said that the BNHRA was not implemented in their districts; they were still registered simply under Shops and Establishment Act. The fact that hospitals could actually function and flourish without even being legally registered as hospitals is a cause for concern. A serious issue, it points to the poor implementation of the law by the state health department.

The need for central level legislation was long felt by various stakeholders. A majority of the states had no proper regulation of the clinical establishments. Addressing this need, on May 3, 2010, Parliament passed the Clinical Establishments (Registration and Regulation) Act, 2010. The central government is now in the process of formulating the rules for the states. Where rules are in place, they were notified only in the recent past. In many states such as Maharashtra the registration rates are very low. In Tamil Nadu, for instance, the Act came into force in April 1997, but the Act could not be enforced because of lack of rules. In Karnataka, even though there are around 15,000 medical establishments in Bangalore alone, only 5,080 applied for registration under the Act, enforced in 2007. None of the unregistered providers were punished or fined (Nandraj 2012).

Taking Maharashtra as a case study, even the presence of the BNHRA 2005 could not implement proper registration of facilities. The SHSRC 2009 puts the total number of private facilities registered under BNHRA at approximately 7648. Even in districts where studies have established the dominance of the private sector, the numbers on the BNHRA register do not reflect this reality. For example, a study in 2009 listed 368 private hospitals with 30 or less beds within the limits of Nashik city itself. However, the BNHRA list has only 56 private hospitals in Nashik district as a whole. The same study listed private hospitals with 30 or less beds in Amaravati City and Aurangabad city and came up with estimates of 232 and 174, respectively.

For the respective districts, where logically the numbers should be higher, BNHRA list has a much lesser number.

A CEHAT study found that most hospitals did not fulfil the minimum requirements under law. The study further revealed that 56 per cent of the hospitals under study did not have a single qualified nurse, more

than 50 per cent hospitals did not have a resident doctor (24*7), and only 14 of 114 maternity homes had a midwife (CEHAT, 2010). The same study also found that though registration under the BNHRA was high (89 per cent), it was considered mere paper work. Basic minimum requirements under the law such as display of certification, presence of qualified doctor and nurse, maintenance of case records was not complied with by most hospitals.

A recent study by PHFI in Madhya Pradesh revealed a very slow process of registration under Clinical Establishment Act. Although the Act was introduced as early as 1973, the state was unable to frame the rules until 1992. After 15 long years, the implementation process began, partly due to opposition against its strict rules by various strong interest groups in the court. The original act was put into motion only after 28 amendments were made to it. However, only about 50 percent of the registered facilities complied with the standards that were mandated (PHFI 2011).

The government is engaging the private sector more and more; most of such partnerships share the logic of insurance where the state plays the role of the purchaser. The regulatory role of the state stays as weak as ever. However, the fact that the current initiatives towards universal coverage seem to favour insurance-based solutions demands that effective systems of regulation be put in place.

In the context of the recent recommendations by the HLEG on Universal Health Coverage, regulation of private institutional providers assumes greater relevance. The direction of the policy seems to be towards a national health package, implemented by public and private providers. Such a system necessitates that the government has sufficient information to engage with the private clinical establishments. Regulation, thus, becomes inevitable. Regulation also assumes significance with the rolling out of RSBY in a large number of states. Under this, the states are tying up with private providers, in the absence of adequate regulations and enforcement machinery in place at the local level. Contracting with private providers in such an environment would be a sure recipe for fraud, increase in costs and failure (Nandraj 2012).

The recently published HLEG Report on UHC observes that the Clinical Establishment Act, the NABH and the IPHS under National Rural Health Mission are compartmentalised initiatives. This may have led to further fragmentation of an already segmented industry. It accepts that these were efforts to define standards for health care facilities. However, the problem according to HLEG lies in not having a single, unified system. Such a system is needed to establish standards applicable to both the public and the private sector and to monitor the functioning of health facilities and compliance with established standards, while ensuring complete accountability. The HLEG report recommended the establishment of a National Health and Medical Facilities Accreditation Unit (HLEG 2011).

Public Private Partnerships

Public-Private-Partnerships (PPPs) were introduced as part of health sector reforms as a solution to an overburdened public health system, marked by constraints. Government started involving the private sector through such partnerships. They were roped in to participate in various national health programs such as polio eradication, RCH and RNTCP. Since the start of these partnerships, right from the First Five Year

Plan to the Eleventh Plan, the PPPs has evolved to a great extent. Today, they are not just limited to the national level but also involve international NGOs for various programs (Baru, R. 2008).

Table 17 provides the various forms of partnership that the government of India has promoted over the years.

Table 17: Forms of PPPs and Possible Actions

Form of Partnership	Criteria for initiation
1. Franchising	• The effort to revitalize the complete govt. infrastructure is time consuming and a slow process • Resources required to expand public health infrastructure is enormous • Need for services is enormous and the government health institutions are not in a position to cater to needs • Availability of vast network of private hospitals in places needed • When objective is to improve access to services on immediate basis • Improve quality standards of private sector and provide high quality care at affordable prices
2. Branded Clinics	• Need to expand services rapidly • Provide high visibility to clinics • Offer a package of services selected for the purpose • High quality services at affordable prices
3. Contracting-Out	• Difficult to manage government health units in remote and inaccessible areas • Utilization of services and performance levels are consistently low due to non-availability of staff • Aim is to put government health facilities to optimum use • Increase responsiveness of government health facilities to local needs through community involvement
4. Contracting-In	• Improve efficiency levels of services provided • Make management of services more effective • Conserve scarce resources by cutting costs • Try out innovative approaches to improve efficiency and effectiveness
5. Social Marketing	• Combine service delivery with demand creation • Availability of products in a vast network of easily accessible retail outlets • Encourage brand choices and competition to improve penetration levels • Perceived value attached to priced products than products distributed free of cost

6. Build Operate Transfer (BOT)/ Joint Ventures	• An enormous number of service delivery points whether hospitals, labs or diagnostic centres have to be constructed within a short span of time • When the cost of building and maintaining a unit is prohibitive for the Govt to bear alone. When returns on investment are guaranteed • Government treats health as infrastructure industry.
7. Voucher System	• Improve access to services and provide choice • Costs act as a major barrier to services • Existing service delivery points do not have provision to all types of services • Inadequate knowledge about the value of service (e.g. importance of antenatal care) • Generate demand for services particularly among poor and disadvantaged sections
8. Donations from Individuals	• Presence of affluent families, philanthropic organisations • Identified needs to improve quality of services • Clear procedures and guidelines to accept donations • Transparent and accountable systems that enhance image of institutions
9. Partnerships with Social Clubs and Groups (eg. Rotary Club)	• Partnerships to popularise revitalized service points, communication campaigns and logistics management • Organisation of camps on a large scale • Need for additional resources and also management and technical expertise • Need to step up advocacy efforts
10. Involvement of Corporate Sector	• Resources to outreach services through NGOs in remote areas • Effective services to employees in organised sector • Policy advocacy efforts • Adoption of villages or CHCs/PHCs by corporate health sector to improve services
11. Partnership with Professional Associations	• Presence of active professional associations with clear guidelines • Internal committees to promote ethical practices • Management expertise to implement projects • Need to prepare standard protocols, quality assurance system by building consensus • Improvement of technical skills of professionals in both private and public sectors • Improve professional response to programme needs
12. Capacity Building of Private Providers, Pharmacists and Informal Providers (RMPs	• High dependence of people on private sector for services • Technical knowledge and skill levels are not to a desirable standard • Improve quality standards of providers and increase access to quality services • Put in place an effective referral system • Involve services providers in social marketing efforts

13.Special Category "Campaigns with the Private Sector to Improve Health	• When the need to promote a service or health care product is established • Multiple partner involvement is required to promote a product • Advocacy efforts to make product acceptable at all levels
14.Autonomous Institutions	• Need to upgrade quality of services and initiate use of state-of-the-art technology in health care delivery • Provide enough flexibility to health units • Improve efficiency and effective levels of management • Reduce costs and facilitate quicker decision-making • Allow institutions to generate alternate sources of funding
15. Partnering with NGOs/ CBOs	• Encourage community involvement • Improve community ownership of programme • Test innovative and cost-effective approaches to service delivery • Cover inaccessible and remote areas
16. Mobile Clinics	• Provide access to services people living in inaccessible terrain • Make services available at central location to reduce travel time and costs of clients • Improve utilisation of services in remote areas
17. Insurance Schemes	• Focus on poor and disadvantaged • Provide services at affordable costs • Long term solution to health problems • Improved choice of health units • Reduce indebtedness among poor due to health costs

Source: MoHFW 2005

The result is a complex mix of various types of PPPs operating at different levels. In such models, ideally, both the parties should work together in implementing a programme. Each one is expected to have a clear role and say in how that implementation happens (Blagescu and Young 2005, WHO 1999).

In spite of such clear definitions, the nature of contract between the two has always been asymmetric and skewed towards the private sector (Datta, A.2009).

Services were contracted without any clear deliverables. There was no provision or plan for management of contracts which requires personnel with requisite skills. Most of them had no clauses for exit or penalty, no standard treatment protocols, no provision for grievance redressal. There was no transparency in these processes, as absolutely no criteria had been set out. Such a level of arbitrariness has had its implications on the effectiveness of the programmes and the nature and quality of services provided through such partnerships as the following discussion would show.

Box 3: The Seven Hills Hospital Partnership

The case of Seven Hills Hospital in Mumbai reveals another set of serious problems with these partnerships, nature of contracts, shared goals and so on. This is being promoted as a PPP by the BMC. It was inaugurated by none other than the President of India when the ward for the "poor" patients was not even ready. It was earlier reported that one floor of the hospital was dedicated to the BMC for treatment of its patients. However, later it came to light that a separate building was being constructed for the BMC. As part of PPP, the BMC has given 17 acres of land to the Seven Hills for construction of a hospital where its patients will also be provided care. The ToR does not include details of how these services will be administered and managed.

At present, the private hospital is already functional on government land that it has received free-of-cost and the proposed "public ward" is not yet functional. In fact the management has raised concerns over "high" cost of running these services for the BMC now as cost of drugs and other expenses are not clearly stated. While the ToR is not in public domain, it is apparent that this is hardly a partnership as the government has actually given land for setting up of a private hospital. There are no clear returns to the public sector or the public, at large. Recently, there has been news about the hospital charging hefty sums and refusing to provide free medicines to the poor. The case is in court and a decision is pending. The court case has, of course, not affected the functioning of the hospital. It continues to flourish, for over a year now, with celebrity patients, and zero services for the poor.

A Review of some PPPs in Health

Private sector engagement has been a stated policy objective of the government. In line with such a policy, the last decade has seen a proliferation of various PPPs in the area of health. Most of these partnerships had poor populations in focus. They were amply supported by funds, even in a situation where public sector recruitment and infrastructure creation have been often postponed for paucity of funds. In the following section, some of the existing Public-Private Partnership arrangements in health are critically looked at and policy gaps identified.

Rashtriya Swasthya Bima Yojana (RSBY) is an insurance scheme for the poor, administered by nodal agencies under the aegis of the Ministry of Labour and Employment in different states. RSBY contracts the task of beneficiary enrolment to insurance companies. There are 11 different insurance companies in 24 states. After the insurance company is selected, they need to empanel both public and private health care providers in the project and nearby districts. The empanelment of the hospitals is done based on prescribed criteria. Empanelment of hospitals shall be done as soon as the insurer gets the contract; it can continue simultaneously with the enrolment of the beneficiaries. The insurer shall empanel enough hospitals in the district so that beneficiaries need not travel very far to get the health care services. For empanelment of the public hospitals, the insurer needs to coordinate with respective health department of the state (rsby.org.in2011).

Although enrolment has shown an increasing trend in RSBY, it is nowhere near the target of covering all the BPL families in the countries by 2012. More importantly, a flawed targeting system being used to

generate the list of people living below the poverty line (BPL) has emerged as a key problem. It has resulted in both inclusion and exclusion errors as with other targeted programmes run by the government. The slow progress of enrolment has, in fact, exacerbated the existing problem, related to targeting per se.

According to Dercon (2011), while enrolment appears to be high and rather successful, early evidence on its functioning is more damning about its success. Rajasekhar et al. (2011) report that in Karnataka, 85 per cent of the eligible households knew about the system; 68 per cent were enrolled. But in practice, six months on, utilisation rates were virtually zero, with beneficiaries not receiving cards or information on where to access care. Enrolled hospitals were reportedly not honouring their commitments, asking for cash or turning away patients with RSBY cards.

In one of the earliest and one of the few independent reviews of the scheme, Narayana (2010) observed that the state governments — with the exception of Kerala — are neither too keen nor have the administrative apparatus to get the poor enrolled. In Kerala, it was largely the keenness of the state government and the effort by the gram panchayats which led to better coverage. The author observed that Panchayats need to be strengthened to reach basic services. The study also found that hospitalisation rates vary a great deal across the districts of each state. The variation is high in Gujarat from 9.07 to 196.41 and Uttar Pradesh from 0.77 to 64.00 while it is relatively low in Bihar. The study observed that the proportion of private hospitals empanelled in a district plays a role in boosting the hospitalisation rate. The RSBY guidelines do talk about de-empanelment and blacklisting of hospitals that are corrupt, but till date, data indicates that only three (out of 29) states have reported de-empanelment of hospitals.

Citing the case of Kerala, it was observed that to achieve even the NSSO level of hospitalisation rates, the premium will have to be pushed four times the current levels. Since the central contribution is capped at Rs750, it will have to be substantially financed by the states. As was seen, since a couple of districts could influence the state average with high private sector-induced hospitalisations, it was recommended that governments not wash their hands off major investments in health infrastructure in poorer regions by brandishing RSBY.

Similarly, **Rajiv Aarogyasri Scheme**[26] was introduced in the state of Andhra Pradesh to address the complete lack of adequate health care for the poor. This situation was paralleled by the burgeoning of a large corporate hospital and diagnostic sector with players such as Vijaya Diagnostics, Medinova, Apollo, Care, Medwin and Yashoda. The scheme run by a PPP aimed to provide tertiary surgical and medical treatment of serious ailments for BPL families up to a value of Rs 2 lakh per year. The scheme is implemented through a network of corporate hospitals, 50 plus bedded private hospitals, and large government hospitals by an insurance company selected through a competitive bidding process.

The scheme was not designed to address primary or secondary level health care requirements. PHC had almost no role in it as it was assumed that the public sector has a mandate to provide these services. Although public hospitals were part of the network, there was anecdotal evidence of the scheme staff — employed by the

26 Based on Shukla, Rajan et al. (2011) Aarogyasri Health Care Model: Advantage Private Sector, EPW,Vol46No. 49.

insurance company — who are supposed to assist the beneficiary and guide them through referral and treatment. In fact, they diverted cases from government hospitals (and even medical colleges) to private hospitals. This is somewhat corroborated by scheme data which showed that the corporate hospitals accounted for around four times more volume as well as value of surgeries/treatments.

The review of the scheme had noted that the scheme's focus on corporate tertiary care leads to sub-optimal use of health care funds. Medicine costs are inadequately covered in the scheme and its focus on procedures sometimes impedes clinical competence, resulting in inappropriate care. It was also observed that guaranteed returns have removed incentives for the insurance company to monitor inflated bills. While access to tertiary health care may increase, it was often just a by-product of a cash-rich, no-risk enterprise for the health care industry. Corporate hospitals have increased in size and number, at the cost of the governmental health care network, carrying with it all the risks of unnecessary, undefined and excessive medicalisation. The authors conclude that while Aarogyasri scheme has been revolutionary in placing health on the political map in the state, its current design and operation can intensify structural flaws of the system instead of rectifying those (Shukla et al. 2011).

Analysing various existing PPP models, a persistent ambiguity about the MoUs between the two parties was pointed to as responsible for many of the existing problems with this mechanism (Baru R., Nundy 2008). There is no evidence, to date, on whether or how these partnerships are increasing access to services, affecting out-of-pocket payments by patients, reducing or increasing equity or improving quality of care.[27]Most of the proposed partnerships transfer public funds to private providers, with the aim of ensuring access for poorer patients. The private sector doctors who are part of the PPP, offering free service to poor mothers, only take "safe" cases of normal delivery and divert complicated cases to the public hospitals. There were also cases of doctors demanding extra money from BPL patients. It was observed that essentially, the scheme may only end up shifting the problem — the management of complications requiring Emergency Obstetric Care (EmOC) — to public providers. [28]

Since July 2008, the second phase of Aarogyasri, the state government has received claims of more than 11,000 hysterectomy cases from hospitals and nursing homes. A 2009 study by a non-profit organisastion, AP Mahila Samatha Society, found hysterectomy cases in women between 25 and 40 increased by 20 per cent since "Aarogyasri" was launched. Their study on 1,097 women in five districts also found that doctors told 30 per cent women that they would die if they did not get operated.[29] Following public outrage, many hospitals have been removed from the empanelled list of Arogyasri Health Care Trust forthwith and blacklisted.[30]

Evidence from Maharashtra indicates several problems in these partnerships. A rapid

27 National Conference Report. Emerging Health Care Models: Engaging the Private Sector. Mumbai, 25–26 September 2009. At: <www.cehat.org/go/uploads/PPP/reportfinal.pdf>.

28 AkashAcharya and Paul McNamee, (2009) Can Public Private Partnership Reduce Maternal Mortality?Assessing efforts made by the "Chiranjeevi" scheme in Gujarat , PPP Conference, CEHAT Mumbai.

29 Moyna (2010) Menopaused 20-somethings , Down to Earth, at http://old.downtoearth.org.in/full.asp?foldername=20100615&filename=news&sid=5 also see, http://timesofindia.indiatimes.com/india/The-uterus-snatchers-of-Andhra-/articleshow/6239344.cms

30 http://www.hindu.com/2010/01/26/stories/2010012653230400.htm.

assessment study was done in Ahmednagar district pointing out a dysfunctional PPP model for maternal health developed to provide the EmOC facilities.The study comments strongly on its stability, unorganized referrals, fund flows and other strategy issues. From the point of view of maternal mortality this is a crucial issue. While PPPs for EmOC under the Janani Suraksha Yojana JSY) scheme was perceived as a solution to solve the severe shortage of the specialists in rural area, it was seen that the services were limited to the deliveries by Caesareans excluding other complications (Chaturvedi, S. Randive B 2011).[31]

In a review which covered 30 public-private interactions in reproductive health services in India being implemented in 50 different sites across the country, (Ravindran, Sundari 2011) observed that barring a handful, there exist very few assessments of the contribution of such partnerships. This is especially true of partnerships that do not involve the government of India or state governments. Being completely private initiatives, it is not clear who the projects are accountable to. A comprehensive assessment of these initiatives is a crying need (Ravindran 2011).[32]

The question of regulation of Public-Private Partnerships becomes important and urgent as most of the governmental efforts to enhance access are by means of such partnerships with the private sector. A strong regulatory framework becomes a mandatory condition if such partnerships are to serve public health goals and enhance equity. The state needs to play a stronger role in regulation not just of quality of care but also by setting, monitoring and enforcing minimum standards and determining the scope of the private sector. Information should be collected on health outcomes and quality of care before the state involves these hospitals further in provision of maternity care. Until this is done, including this sector in partnerships with the state for providing services such as maternity care, and particularly emergency obstetric care, may be putting patients at risk. Such partnerships could, unfortunately, even end up regularising the poor functioning of this sector. Lastly, the state's own managerial capacity for monitoring Public-Private partnerships needs to be improved (Bhate-Deosthali et al. 2011).

Health policymakers have embraced PPPs as a mainstay of health policy and have embarked on several initiatives. The monitoring mechanisms need to be made more effective and powerful. Verifiable sets of performance indicators have to be prepared for PPPs and reports routinely made. Health care services provided by such PPPs have to be, as a rule, an entitlement, and a service guarantee, as discussed before. The ownership of partnership should be with the public sector. Continuous monitoring and evaluation of the partnership is required to address equity concerns. Mechanisms for reviewing contracts and making changes should be put in place, at the earliest. The state needs to upgrade its management skills to be able to play the role of a monitor. As per laws existing in many states, the private charitable trust hospitals who have been beneficiaries of tax exemptions and direct/ indirect subsidies from the state are required to provide free treatment to a stipulated number of BPL patients. Nevertheless, as seen in the case of Delhi and Maharashtra, they have been flouting this for long. Stringent

31 Public-Private Partnerships for Emergency Obstetric Care: Lessons from Maharashtra, Indian Journal of Community Medicine, January-March 2011 http://www.ncbi.nlm.nih.gov/pmc /articles/PMC3104703/.

32 Ravindran, T. K.Sundari (2011) Public-Private Interactions in Reproductive Health Services in India: A Mapping, CEHAT, Mumbai.

action against them is a must. The number of beds that each of these hospitals must make available for BPL patients should be labelled as public bed and a strong referral network with the public health services established to operationalise this.

Community-based monitoring of NRHM, which has proved successful in some districts of a few states, needs to be introduced in all districts. Maharashtra is one of the very few states that have successfully implemented this programme. It has contributed extensively to improving the public health services in terms of its availability and utilisation. Such effective use of CBM to raise concerns also regarding the private sector would be extremely beneficial.

Urban health needs to be brought into focus with rapid urbanisation all around. The disease load needs to be addressed using well-organised referral systems that have sufficient staff. Patients ought not feel the need to visit tertiary hospitals even for minor ailments. Such a well-developed referral system with focus on primary health care should take care of crowded tertiary hospitals. It is an immediate imperative to address lack of basic health care services in urban areas rather than depending on insurance schemes such as RSBY. In such schemes problems such as induced demand, cost escalation, moral hazard, and exclusion of the poor are severe. In many states, the manner in which RSBY being run, at present, with minimal public hospital enrolment, makes it appear to be an absolutely private sector scheme.

In addition to the above, different laws governing public and private health care need to be gathered under one umbrella. All laws governing private sector such as the MTP, PCPNDT and Bio Medical Waste Disposal Act should be put under one body to increase efficiency and effectiveness. This would ensure simplified procedures, better compliance, and stricter monitoring. Declining sex ratio, a shame, is possible only with the connivance of doctors. Medical associations should be made answerable for taking action against such erring doctors. Gujarat has taken the initiative on this. A Gujarat Public Health Act has been drafted through a large consultative process. Other states must consider such a step so that issues of health care as entitlements, standards of care, patient's rights and grievance redressal mechanism, are legislated. The states must work towards such an Act through a consultative process, involving various stakeholders.

The regulation of private health care sector assumes greater significance in the context of the recommendations by the HLEG on Universal Health Coverage as well as the Steering Committee on Health for the Twelfth Five Year Plan favouring a national health package to be implemented by public and private providers. Regulation of the sector would provide an objective information basis and also assist the government in engaging more effectively with the private clinical establishments. It is getting increasingly clear that any effort by the government towards universalisation will be through mechanisms similar to RSBY, running across the country. Looking at the RSBYs functioning over the last three years shows the pitfalls of tying up with private providers. In the absence of adequate regulations and enforcement machinery in place such a tie-up has had adverse impacts on the scheme. If Universal Health Coverage means such contracting with private providers on an even larger scale without reining them in, it would inevitably result in cost-escalation, large scale corruption, and eventual failure.

Universal Access to Health Care – Reining in the Private Sector

Universal Access to Health Care implies equitable access for all to health care. There is no discrimination whatsoever, especially discrimination based on the capacity to pay. Worldwide, countries which have established universal or near universal access have clearly demonstrated that public financing of health care is critical to realise this. However, delivery of health services need not be only in the public domain. For instance Canada, which has the best and most equitable health care system in the world, assures full access to everyone without the need to make any payment at the point of care. Health Canada, a public corporation pools all resources.It is a single payer for all health care services. While most hospitals are run by governments in Canada, private hospitals are also given access to these resources when citizens access them. For out-patient care, most providers in Canada are private providers contracted-in by Health Canada on pre-agreed fee for services. The NHS in UK is very similar though it uses a different financing model — capitation payments for GPs contracted in under NHS and hospitals run directly by NHS. Brazil, Venezuela, Mexico are close to emulating these models. On the other hand there are examples such as Sweden, Sri Lanka, and Cuba which are completely state-run systems, providing universal access to health care. Thailand is the most recent entrant into this club. India will have a lot to learn from the Thai experience as the structure of the health care system in India and Thailand has been very similar. Today, the debate on the Twelfth Plan is talking about universal coverage, with the HLEG committee being appointed to make recommendations.

The HLEG report defines Universal Health Coverage as "ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services" (HLEG Report 2012). It visualizes making a choice between public sector facilities and contracted-in private providers available to patients. Two different options are being suggested:

In the first option, private providers opting for inclusion in the UHC system would have to ensure that at least 75 per cent of outpatient care and 50 per cent of in-patient services are offered to citizens under the NHP. For these services, they would be reimbursed at standard rates as per levels of services offered. Their activities would be appropriately regulated and monitored to ensure that services guaranteed under the NHP are delivered cashless with equity and quality. For the remainder of the out-patient (up to 25 per cent) and in-patient (up to 50 per cent) coverage, service providers would be permitted to offer additional non-NHP services over and beyond the NHP package. For this they could accept additional payments from individuals or through privately purchased insurance policies. The second alternative entails that institutions participating in UHC would commit to

provide only the cashless services related to the NHP and not any other services which require private insurance coverage or out-of-pocket payment. The HLEG report envisages bringing down private health spending to about 30 per cent in ten years. Indeed, the success of this plan is directly dependant on how forcefully the government intervenes in the sector. The intervention would be both in terms of direct investments in improving its own provisioning, and also facilitating smooth contracting-in through strong regulatory mechanisms already mentioned. [33]

In the light of the submission of the recent HLEG report and the resultant negotiations within the state agencies in the run-up to the Twelfth Five Year Plan, one thing is clear: any future effort towards expansion of government-funded health care in India will have a major role for the private sector health care providers and various other stakeholders. However, the trends visible in the health sector development in India and the ever-increasing dominance of the private health sector is not in keeping with global trends in countries experiencing economic growth. All countries which have transited from underdevelopment towards development have transformed their health sector in the direction of universal access and equity. In India, even after two decades of rapid economic growth, the Indian state has failed to reorient the health sector towards a universal access to health care approach. The NRHM, as part of the flagship programmes of the UPA government, promised to achieve architectural corrections but has failed to achieve its goals. It certainly cannot be a model as it stands today since it broadly follows the old approach of selective care and targeted outreach. Additionally, the Centre's attempt to increase spending on public health by hiking allocations to NRHM failed in many states as states responded by reducing their expenditure. Instead of decentralising expenditure on health, the Centre has taken control of a larger share of resources for the sector, which have not been adequately utilized, even for the priority programmes (Duggal 2009).[34]

The problem with the NRHM's financing approach lies in bypassing the state governments by allocating resources directly to state and district societies. The states have not taken this move well. This is because a substantial chunk of health resources which would otherwise come as grants to state health ministries are now outside their control and decision-making. The NRHM fund flows also bypasses the treasury, resulting in expenditures going off-budget and showing state health allocations in a poor light. That apart, this funding strategy designed to give greater autonomy to the public health system in planning their programmes and making their own decisions does not work in practice for several reasons. Managers and line staff working in the public health system do not have the capacity to do such planning, budgeting and independent decision-making. Thus, while the funds may be flowing in more smoothly under NRHM, the health bureaucracy still controls the reins of decision-making. These bring to naught the "innovative" financing strategy.

What learning accrues from the above: that the state will not allow the Union Government to tread roughshod on what is the turf of the state government by

33 HLEG (2012).

34 Duggal, Ravi (2009), Sinking Flagships and Health Budgets in India, Economic and Political Weekly, Vol46No. 33.

constitutional mandate. So, solutions that look at reforming the health care system have to be developed under the oversight of the state government. Unfortunately, the HLEG has made the same error in developing its strategy. Let alone the state governments, even the Union Ministry of Health has had a marginal role in the analysis and development of the recommendations. So, expecting the ministries of health to own and have confidence in the HLEG proposed strategy is rather facile. Now, the most likely thing to happen, as evidenced through the history of health policy making in India, is that bits and pieces of the suggestions will be picked up. What is presently being talked about in the national (and a few state) policy-making circles for shaping the final contours of the Twelfth Plan are a few populist interventions drawn from the HLEG report — access to free medicines for all in public facilities, push for the National Clinical Establishment Act in the states as a start to strengthen private health sector regulation, up scaling of the RSBY type of schemes for secondary and tertiary care for the poor which will further private hospital growth and some experimentation in contracting in private health care services in one district in each state for moving towards universal coverage (the last two drawn from the Report of the Steering Group on Health of the Planning Commission).

The HLEG report has, however, been criticised for not spelling out the programmatic implications of how the government might control, contain, engage or utilise the private sector to achieve public health goals (Rao, 2012). It was also observed that HLEG report has chosen not to address many aspects that have transformed the mandated role of public hospitals. These aspects include private practice by government doctors, their close relationship with private hospitals and diagnostic centres and the contracting-out of clinical and diagnostic facilities in government hospitals to private players etc (Baru, 2012). The report has also been termed a "missed opportunity" in that it addressed gender issues in an ad hoc and uneven fashion (Ravindran, 2012).

The limitations of the HLEG report apart, it must be acknowledged that after the Bhore Committee Report of 1946, HLEG is the first attempt to discuss the health sector in India in a holistic way; the recommendations are, indeed, comprehensive, realistic and bold. For the first time an officially constituted group (though without key officials as its members) has looked at the private health sector and suggested a strategy to involve it centrally in the achievement of public health goals. It must be added here that the HLEG has built its strategy, arguments and recommendations on the wide ranging debates on universal access to health care fostered by the Right to Health Care campaigns by the Medico Friend Circle (MFC) (See MFC bulletins and background papers on UHC on the website www.mfcindia.org) and the Jan Swasthya Abhiyaan (http://www.phmovement.org/). These debates have occurred over the last three to four years. They have engaged vast sections of civil society across the country, including regional consultations in collaboration with the National Human Rights Commission. There is an increasing consensus that Universal Access to Health Care is a logical direction in which any health care system has to move towards. To realize this, the private health sector has to be reined in under a public mandate.

So what is the range of actions needed to shape the Twelfth Plan in the context

of the above debate to realize universal access to health care? To begin with:

- Equating directive principles with fundamental rights through a constitutional amendment.
- Incorporating a National Health Act (similar to Canada Health Act) which will organise the present health care system under a common umbrella organization as a public-private mix governed by an autonomous national health authority which will also be responsible for bringing together all resources under a single-payer mechanism. The National Health Bill in its present form is grossly inadequate in putting forth a framework for universal access.
- Generating a political commitment through consensus building on right to health care in the civil society.
- Developing a strategy for pooling all financial resources deployed in the health sector and redistribution of existing health resources, public and private, on the basis of standard norms (these would have to be specified) to assure physical (spatial) equity.
- The above suggestions are most essential to establish that there is a political will to move in the direction of universal access. Health being a state subject as an immediate step, within its own domain, the states should additionally undertake to accomplish the following to demonstrate their seriousness of intent and political will:
- Allocation of health budgets as block funding, that is on a per capita basis for each population unit of entitlement as per existing norms. This will create redistribution of current expenditures and substantially reduce inequities based on residence. Local governments should be given the autonomy to use these resources as per local needs. Where necessary contracting-in private health care services could be done in a regulated way, but within a broadly defined policy framework of public health goals.
- Strictly implementing the policy of compulsory public service by medical graduates from public medical schools. Public service of a limited duration should be made mandatory before seeking admission for post-graduate education. This will increase human resources with the public health system substantially and have a dramatic impact on the improvement of the credibility of public health services.
- Essential drugs as per the WHO list should be brought back under price control (90 per cent of them are off-patent). As required, volumes needed for domestic consumption must be compulsorily produced so that availability of such drugs is assured at affordable prices, within the public health system.
- Local governments must adopt location policies for setting up of hospitals and clinics both public and private, as per standard acceptable ratios. For instance, one hospital bed per 500 populations and one general practitioner per 1000 persons. To restrict unnecessary concentration of such resources in areas, fiscal measures to discourage such concentration should be instituted.
- The medical councils must be made accountable to assure that only licensed doctors are practicing what they are trained for. Such monitoring is the core responsibility of the Council by law which they are not fulfilling. As

a consequence, the Council is failing in its duty to protect the patients who seek care from unqualified and untrained doctors. Further, continuing medical education must be implemented strictly by the various medical councils. Licenses should not be renewed (as per existing law) if the required hours and certification is not accomplished.

- ESIS, CGHS and other such employee-based health schemes need to be integrated with the general public health system so that discrimination based on employment status is removed. Such integration will help more efficient use of resources. For instance, ESIS is a cash-rich organisation sitting on funds collected from employees. ESIS has total invested funds amounting to Rs 195,832 million in 2008-09 parked in debentures, deposits and shares of companies. Their hospitals and dispensaries are grossly under-utilised. The latter could be made open to the general public.
- Strict regulation of the private health sector must be done, as per existing laws. Also an effort should be made towards changes in these laws to make them more effective. This will contribute towards improvement of quality of care in the private sector as well as create some accountability.
- Strengthening the health information system is another important requirement. Databases need to be beefed up and updated to facilitate better planning as well as audit and accountability.

The above are suggestions that states could immediately implement within the existing framework and without the bigger reforms which the HLEG report talks about. However, to achieve this, they must display a minimal political will for change. If these are implemented with some seriousness it would impact substantially both the public and private health sectors in a positive way and prepare the ground for big tickets reforms as suggested by the HLEG report.

Further restructuring as per HLEG or similar strategies which states may involve will be possible only if the health care system, both public and private, is organised under a common umbrella and framework as discussed above. Under this,, finances for health care are pooled and coordinated by a single-payer system. Access to health care must be organised under a common system which all are able to access without any barriers; public funds should be the predominant source of financing. The providers of health care services, including the contracted-in private providers have to have reasonable autonomy in managing the provision of services. Decision-making and planning of health services should be decentralised within a local governance framework with multi-stakeholder representation, including associations of providers and civil society. In such an arrangement, the health care system must be subject to continuous public/ community monitoring and social audit under a regulated mechanism which leads to accountability across all stakeholders involved.

In order to accomplish the restructuring that we are talking about, the following modalities, among others, would need to be in place:

- All resources, financial and human, should be transferred to the local authority of the Health District (Block Panchayats) though the treasury route.

Box 4: National Health Bill 2009 and Related Issues

The Constitution of India recognises the right to life and liberty of every individual. However, the government drafted the first National Health Bill in 2009, six decades after India adopted its Constitution. This was done partly in response to civil society activism, with a view to "provide for protection and fulfilment of rights in relation to health and well-being, health equity and justice. It also included those rights related to all the underlying determinants of health as well as health care, for achieving the goal of health for all and for matters connected therewith or incidental thereto". The proposed health legislation goes beyond delivery of health care services to endorsing health care rights of every individual. It brings about a change towards a realisation that individuals have an equitable right to health and well-being. The draft of the proposed National Health Bill is di erent from all other health legislations because it is based on the understanding that health care and sound public health are public goods. It encompasses all the tenets of health and health care, including the determinants, and aspires to the goal of health for all. This proposed legislation delineates all rights of an individual with respect to health and health care, while regulating the services provided by health institutions and health care providers through adequate health care information and systems for redress. It gives emphasis to the Panchayati Raj institutions and local organisations. The bill addresses the needs of people in society who are marginalised and vulnerable through not just health care but by also addressing the determinants of health. It mandates an assessment of the impact on health of every proposed law, policy, programme, project, technology, or a potentially damaging activity, in relation to health, before decisions. The bill envisions protecting the right to affordable, inclusive, and portable health care that is accessible, available, acceptable, good quality. It also envisions that such health care ought to be delivered in a non-discriminatory way through transparent and accountable processes by government and private institutions.

However, criticism has been raised by researchers that there is a clear shift in sight. So far, all policy documents have accepted that the state is responsible for the provisioning of Primary Health Care to all even though the definition of PHC has been changed from "comprehensive" to "selective" PHC then, "primary level" and lastly "essential" health care. However, now when it comes to state obligations, the emphasis has shifted from providing service to ensuring economic access to services. The state takes on stewardship of the private sector — a role of overseeing the transition. Thus, even though the scope (field level, out patient or indoor care), and the levels (primary, secondary and tertiary) of services are articulated, the division of responsibility between public and private providers is not. In other words, there is no clarity on the state's provisioning obligations.

Concerns regarding infringement of the states' autonomy were also raised where the Centre has the prerogative to legally interfere with the working of the State in many more areas of health and welfare than what was possible earlier. Earlier the Centre manipulated through resource control; now there is an explicit appropriation of the constitutional prerogatives of the State. It was concluded that in this milieu today, the draft National Health Bill is full of welfare concerns but lacks legal teeth. However, it was also suggested that if the bill has to move beyond a restricted NRHM, it must address the challenge of providing, "Comprehensive Primary Health Care" for all as defined in the Alma Ata declaration. It must also address the issue of resource mobilisation for reviving state-funded institutions. It will have to address these aspects through a systemic perspective wherein the shared objectives of the public and private sector, their specific roles, responsibilities and freedoms, if any, will have to be specified. Otherwise, it will remain yet another legislative measure on the road to anti-people health sector reforms.

Source: Extracts from K S Reddy et al. (2011) and Qadeer, Imrana & Chakravarthi, Indira (2010).

- The health district will work out a detailed plan based on local needs and aspirations and is evidence-based within the framework already worked out under NRHM with appropriate modifications.
- The private health sector of the district will have to be brought on board as they will form an integral part of restructuring of the health care system.
- An appropriate regulatory and accreditation mechanism which will facilitate the inclusion of the private health sector under the universal access health care mechanism needs to be worked out.
- Private health services, wherever needed, both ambulatory and hospital, will have to be contracted in and appropriate norms and modalities, including payment mechanisms and protocols for practice, will have to be worked out.
- Undertaking detailed bottom-up planning and budgeting and allocating resources appropriately to different institutions/providers (current budget levels being inadequate new resources as suggested in the paper also needs to be raised).
- Training of all stakeholders to understand and become part of the restructuring process is essential.
- Developing a monitoring and audit mechanism and training key players to do it is again a necessity.

The above draws from the current debates and the HLEG (though not an exhaustive list), listing some critical issues to be addressed under the Twelfth Plan strategy if there is seriousness in moving towards universal access to health care. Further, the most important challenge would be reining in the completely as yet unregulated private

health sector, as discussed in a preceding section. An unregulated private sector will be dominated by profit motive.It will function completely on supply-induced demand given the special nature of the market which fuels unnecessary procedures, prescriptions, surgeries, referrals etc. leading to its characterisation as an unethical and malpractice-oriented provisioning of health care. This has huge financial implications on poor and middle class households, inflating costs of health care, spiralling indebtedness and being responsible for the largest OOPs anywhere in the world. This, in fact, is exacerbated by the fact that even patients who depend on the public sector for care — where costs are lower — depend on the private sector for medicines and diagnostic care.

The challenges across the country differ due to different levels of development of the public and private health sectors in the states. For instance, a state such as Mizoram, a small and hilly state, already has an excellent primary health care system functioning with one PHC per 7000 population and one CHC per 50000 populations. Since it has virtually no private health sector, the demand side pressures are huge. Hence, the public health system delivers. Each PHC has two or three doctors on campus available round the clock with 15–20 beds which are more or less fully occupied. Around 95 per cent of deliveries happen in public institutions. Mizoram has indeed realized the Bhore dream. The problem in Mizoram is that there are very few specialists available. Hence, higher levels of care become problematic. The CHCs are, however, run by MBBS doctors who have received some additional training. Mizoram does not have a medical college but it does have reservations in other state medical colleges. While the state cannot provide tertiary care, it has a budget to send people elsewhere to seek such care. Mizoram does this with 2.7 per cent of its NSDP and has the best health outcomes in India. In some sense Mizoram is like Sri Lanka — a statist model. There are a few other states in India which can do a Mizoram because they too do not have a significant private health sector. But to do that they have to demonstrate the political will of Mizoram.

Even though extremely successful, Mizoram cannot be the national model because the reality across most other states is very different — the reality of an entrenched private health sector which is unethical and unregulated. The private health sector has to be reined in. This can only happen with a strong political will which declares health care to be a merit good, access of which for citizens is a responsibility of the state. The state must also take on the private sector to get organised under public mandate. Under NRHM, sporadic efforts towards this end are being undertaken in the name of public-private-partnerships such as “Chiranjeevi” in Gujarat, “Yeshasvani” in Karnataka, “Arogya Rakshak” in Andhra Pradesh, Rajiv Gandhi Hospital in Raichur (Karnataka Govt and Apollo Hospitals) etc. They may have achieved limited success but then health care systems cannot be built by segmenting it into programmes and one-off initiatives such as PPPs. There have to be serious efforts at building a comprehensive health care system; it goes without saying that given India’s political economy of health care the private sector will have to be a significant partner in this process rather than being the main beneficiary. Hence, states have to think beyond the Chiranjeevis and Yeshasvanis which misdirect public resources and often subsidise private provision without any significant public benefit. The states must learn from the recent experiences of Thailand, Mexico and Brazil to invest in

an organised health care system. With a booming economy, resources ought not to be a constraint.

As mentioned earlier, the Thailand experience is most relevant to India. A decade ago Thailand's health care system was as segmented as India's and the issues relating to the private sector were also of a similar nature. The Thai government exerted adequate political will to turn around the health care system, including reining in the private health sector to work under public mandate and oversight. Brazil and Venezuela have also shown that a strong political can make the desired changes happen quickly and that the private health sector can be reined in for public benefit.

Given the deteriorating situation of the public health system in a scenario of private health sector expansion during the last decade, there has been a considerable ferment in civil society as well as academia in putting universal access to health care on the national agenda. As discussed above, the People's Health Movement (Jan Swasthya Abhiyaan) has been consistently campaigning for right to health care over the last decade. In the last three years along with the Medico Friend Circle, substantive debate has taken place on the concern for universal access to health care.[35] The academia debated this issue in a special Lancet edition (February 2011, Vol: 377 Issue 9765).The Planning Commission appointed the HLEG on Universal Health Coverage which also submitted its report towards the end of 2011 as discussed earlier.

The debate throws up a clear consensus on the manner in which India can provide universal access to health care: by strengthening the tax-based financing of health care, strong regulation of the private health sector, strengthening public health facilities — both infrastructure and human resources — and contracting-in private health care under strictly regulated agreements to deliver health care where public systems are inadequate. However, researchers have already noted that the HLEG report pays inadequate attention to regulating the deeply entrenched private health sector, other than merely stating the need for regulation of for-profit health care that privileges individual responsibility and choice over social solidarity.[36]

All the above inputs are available for the Twelfth Five Year Plan to change the political economy of health care in India, and there are indeed customary talks about allocations of massive resources for the social sector, especially health. There are two clear challenges that the Twelfth Plan has to deal with if it is serious about pushing for universal access to health care. First is the challenge of tripling health budget allocations from 1 per cent of GDP to at least 3 per cent as promised in the UPA manifesto. With the current tax: GDP ratio of 17 per cent, this is just not possible. The tax:GDP ratio has to be pushed in the region of 25 per cent if adequate resources for the social sectors have to be made available. One does not need drastic changes in tax laws to do this. Simple steps such as better tax compliance and discipline (collecting all that is due), getting rid of most corporate tax expenditures (revenues forgone) will nearly double the tax:GDP ratio. The second challenge is the more difficult one — the reining in of the private health sector. An exceptional political will is needed to accomplish this.

Global experience shows that reining in

35 See www.mfcindia.org for the relevant MFC bulletins.

36 Baru, Rama V. (2012) , A Limiting Perspective on Universal Coverage, EPW, Vol.47No. 8.

of the private sector is crucial to realize universal access to health care under capitalism. What do we mean by reining in? Firstly, as discussed above, appropriate regulatory mechanisms have to be put in place to regulate the functioning of the private health sector. These include ethics in medical practice, standard treatment guidelines, quality benchmarks/ accreditation, price regulation, registration, licensing and location policies, continuing medical education etc. Secondly, the entire health care system has to be organised under a public mandate, for instance the NHS in UK, which will give private providers an opportunity to contract-in their services as needed under the defined public mandate. This will require appropriate legislation, setting up rules and regulations of business and contracting-in, effective monitoring and audit mechanisms to maintain oversight and probity etc. Thirdly, the political management of private health sector associations lobbies to prevent them from subverting and corrupting the processes of public engagement of private providers is imperative.

The challenge for the Twelfth Plan is enormous. It requires huge restructuring of the health care system in the country through strong regulatory mechanisms both for the public and private sectors, education of professionals in ethics of practice, pushing the politicians for creating a strong political will to make health care a public good as well as generate and commit adequate resources to realise universal access. The restructuring of the health care system and its financing strategy, given the price advantage of India and economies of scale it offers, will actually reduce nearly by half the health care spending in India. It will also substantially reduce the household burden to access health care.[37] Calculations done for Medico Friend Circle debates show that for universal access to health care across India we need less than 4 per cent of GDP[38] provided we show the political will to shift health care from the domain of the market to the category of a universally provided merit good. This will indeed do a lot of public good.

37 Duggal, Ravi (2010) Unhealthy Planning, The India Economy Review, 30Sept 2010 (Accessed at http://theindiaeconomyreview.org/MagazineIssue.aspx?id=2) , accessed on 5 March 2012..

38 Duggal, Ravi2011: Financing the Cost of Universal Access to Health Care, MFC bulletin 348-350, August 2011 – January 2012.

Note from Contributors of this issue

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Annexure

Table 12: Health Infrastructure Development In India 1951-1998

			1951	1961	1971	1981	1991	1995	1996	1997	1998	1999
1	Hospitals	Total	2694	3054	3862	6805	11174	15097				18281
			% Rural	39	34	32	27		31			
			%Private				43	57	68			13647
2	Hospital & Dispensary Beds	Total	117000	229634	348655	504538	664135	870161				74.651
			% 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	535590
		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					7586
		P. Grads		397	1396	3833	3139					1711
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		70
		CBR/000	41.7	41.2	37.2	33.9	29.5	29	25	24		26.1
		CDR/000	22.8	19	15	12.5	9.8	10	9	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	Public	0.22	1.08	3.35	12.86	50.78	82.17	101.65	113.13	134.08	172.16
	Rs Billion	Private@	1.05	3.04	8.15	43.82	173.6	233.47		590.93		835.17
		CSO estimate of pvt.		2.05	6.18	29.7	82.61					

Contd.. Health Infrastructure Development In India 2000-2010

			2000	2001	2002	2003	2004	2005	2006	2007	2008 RE	2009 BE	2010 BE
1	Allopathic Hospitals	Total	15888	15622	15393	—	5479	7008	7663	9976	11289	1 613	12760
		% Rural	18.52	17.17	15.91		68.49	56.56	55.53	69.71	55.78	54.08	53.25
		%Private & Vol. org	71.22	72.52	73.69	—							
2	Allopathic Hospital	Total	690723	682886	683545	—	380993	469672	492698	482522	494510	540328	576793
	Beds	% Rural	9.28	8.41	8.64	—	31.23	23.81	26.88	31.92	28.79	26.47	25.95
		%Private	37.66	38.17	38.33	—							
3	Ayush Hospitals	Total	3880	3943	3909	3224	3136	3158	3340	3360	3371		
4	Ayush Hospital Beds	Total	74611	69476	69049	70336	63816	64869	66125	68155	66272		
5	Allopathic Dispensaries	Total	23065	22306	22638	—	22291						
		% Rural	51.12	49.6	50.32	—	49.54						
		%Private	52.33	54.1	53.29	—	54.12						
6	Allopathic Dispensaries Beds	Total	29138	29181	29662	—	29662						
		% Rural	53.12	53.2	52.83	—	52.83						
		%Private	50.07	49.99	49.8	—	49.8						
7	Dispensaries under Ayush	Total	20707	20627	20239	20974	21246	21138	21476	21769	22014		

8	Primary Health care	CHCs	3043	__	__	__	3222	__	3910	4045	4276	4510	
		PHCs	22842	__	__	__	23109	__	22669	22370	23458	23391	
		Sub-centres	137311	__	__	__	142655	__	144988	145272	146036	145894	
9	Doctors	Allopaths	555550	577094	607075	625423	643964	675375	700699	731439	761429	793305	816629
		All Systems	1236674	1265896	1298545	1320447	1338988	1393235	1425522	1456777	1513355	1555377	1568883
10	Nurses		1231322	1270299	1382901		865135*	1481270	1509196	1572363	1652161	1702555	__
11	Medical	Allopaths	189	__	__	__	229	242	262	266	289	300	314 **
	Colleges	All Systems	368	403	406	_	431	450	_	479	477	492	492
12	Out turn	Grads	7586	21544	__	__	__	__	25324	30740	29990	31876	23324
		P. Grads	4497	__	__	__	__	__	__				
13	Dental Colleges		135	149	164	185	189	205	240	268*	282	290	289
14	Pharmaceutical												
	Production												
15	Health Outcomes	IMR/000	68	66	63	60	58	58	57	55	53	50	__
		CBR/000	25.8	25.4	25	24.8	24.1	23.8	23.5	23.1	22.8	22.5	__
		CDR/000	8.5	8.4	8.1	8	7.5	7.6	7.5	7.4	7.4	__	__
	Life Expectancy	Male	61	61.3	61.6	61.8	62.1	63.3	62.6	__	__	__	__
	Years	Female	62.7	63	63.3	63.5	63.7	63.9	64.2	__	__	__	__
	Births Attended by	Per 1000 live births					48.00%		48.8% (NFHS)		52.70%		
	Trained												
16	Practitioners												
17	Health Expenditure***	Public	186.13	194.54	197.32	NA	258	NA	365	431	516	590	650
	Rs Billion	Private	981.68	1100	1250	NA	1700.00#	NA	2100.00#	2400.00#	2600.00#	2750#	

AIDS Awareness

National AIDS Control Organization (NACO) has developed a communication strategy to create awareness about HIV/AIDS and promote safe behaviors. Campaigns are conducted regularly on mass media supported by outdoor media such as hoardings, bus panels, information kiosks, folk theatre, and exhibition vans. At the inter-personal level, training and sensitization programmes for Self-Help Groups, Anganwadi Workers, ASHA, members of Panchayati Raj Institutions and other key stakeholders are carried out. Vulnerabilities of High Risk Groups including commercial sex workers (CSW), men having sex with men (MSM), injecting drug users (IDU) and also truck drivers and migrants are specifically addressed through behavior change communication programmes implemented as part of Targeted Intervention (TI) projects. In addition, Integrated Counselling & Testing Centres (ICTC), STI clinics and Antiretroviral Therapy (ART) centres have provision of counseling and provide necessary information to clients approaching them.

The amount spent at NACO level during the last three years and in the current year in 2012 so far is Rs. 117.48 Crores.

The programme succeeded in reducing the number of annual new HIV infections by 56% during the last decade through scaled up prevention activities.

The estimated adult HIV prevalence also has come down from 0.41% in 2000 through 0.36% in 2006 and 0.31% in 2009.

NACO had launched two phases of Red Ribbon Express project, in 2007-08 and 2009-2010 to generate awareness about HIV/AIDS. The third phase of RRE has been launched from Jan, 2012. During the third phase, the special exhibition train with messages on HIV/ AIDS and other health issues and a training coach for providing Counseling, testing and other health services will traverse through 23 states halting at 162 stations.

Source: Loksabha, Unstarred Question No. 1157, 17th August, 2012

High Prices of Life Saving Drugs

National Pharmaceutical Pricing Authority (NPPA) fixes or revises price of scheduled drugs / formulations as per the provisions of Drugs (Prices Control) Order, 1995 (DPCO, 1995). No one can sell any scheduled drugs / formulation at a price higher than the price fixed by the NPPA. The life saving drugs are not defined in the DPCO, 1995.

A number of drug companies have been found to be selling medicines at a higher price to consumers. In such cases, NPPA initiates action of overcharging against the companies as per the provisions of the DPCO, 1995 and the Essential Commodities Act, 1955.

Based on detection of overcharging cases since its inception and till 29th February 2012, NPPA has issued demand notices in 816 no of cases involving an amount of Rs. 2456-89 crore

Overcharging along with interest for selling the medicines at a price higher than the prices fixed under DPCO, 1995. Of this, Rs. 217.67 crore has been realized till 29th February 2012 leaving a balance of Rs. 2239.22 crore to be realized. Out of this, an amount of Rs. 2126.72 crore is under litigation & pending in various courts and Rs. 44.18 crore is pending for recovery with Collectors of various States and the balance is under process.

The NPPA monitors the shortage and availability of the drugs in the country through State Drug Control Administration. Whenever shortage is reported by the State Drug Controller, NPPA takes remedial steps for ensuring availability of drugs by impressing upon manufacturers to rush the stocks to the places of shortage. The shortages reported are the brand specific and in most cases equivalent substitutes are available in the market.

Apart from various efforts being done by Ministry of Science & Technology, Department of Biotechnology and the Council of Scientific and Industrial Research the Faculty and researchers of National Institute of Pharmaceutical Education & Research (NIPER), under the administrative control of Department of Pharmaceuticals are also working in the area of most neglected diseases.

Source: Loksabha, Unstarred Question No. 2708, 29th March, 2012

Maternal Death Audits

As per the periodic survey reports of Registrar General of India-Sample Registration System (RGI-SRS), Maternal Mortality Ratio (MMR) in the country has declined from 254 per 100,000 Live Births in 2004-06 to 212 per 100,000 Live Births in 2007-09 which translates into a decline in absolute numbers of maternal deaths from approximately 67,000 to 56,000.

Under the National Rural Health Mission (NRHM), one of the key interventions under Maternal Health is implementation of "Maternal Death Review (MDR)" at the health facilities and in the community and formation of MDR Committees at district level and a task force at State Level. The process of Maternal Death Review has been initiated by the states for which guidelines and tools have been disseminated to the states by Government of India.

Source: Loksabha, Unstarred Question No. 4803, 4th May, 2012

Malnutrition

The Government has accorded high priority to the issue of malnutrition. The approach to dealing with the nutrition challenges has been two pronged: First is the Multi-sectoral approach for accelerated action on the determinants of malnutrition in targeting nutrition in schemes/programmes of all the sectors. The second approach is the direct and specific interventions targeted towards the vulnerable groups such as children below 6 years, adolescent girls, pregnant and lactating mothers.

The Government is implementing several schemes/programmes of different Ministries/ Departments through State Governments/UT Administrations. The schemes/programmes include the Integrated Child Development Services (ICDS), National Rural Health Mission (NRHM), Mid-Day Meal Scheme, Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) namely SABLA, Indira Gandhi Matritva Sahyog Yojna (IGMSY) as Direct targeted interventions. Besides, indirect Multi-sectoral interventions include Targeted Public Distribution System (TPDS), National Horticulture Mission, National Food Security Mission, Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), Total Sanitation Campaign, National Rural Drinking Water Programme etc. All these schemes have potential to address one or other aspect of Nutrition.

Several of the existing schemes/programmes including ICDS have been expanded / universalized just before or during the Eleventh Five Year Plan. Government has recently decided to strengthen and

restructure ICDS with special focus on pregnant and lactating mothers and children under three and to launch an effective information, education and communication campaign against malnutrition.

The World Bank assisted "ICDS Systems Strengthening and Nutrition Improvement Project" (ISSNIP) is yet to be approved by the competent authority and hence question of fund utilization and its impact on malnutrition does not arise at this stage.

Source: Loksabha, Unstarred Question No. 196, 24th August, 2012

Communicable Diseases

The Planning Commission's document " Faster, Sustainable and More Inclusive Growth - An Approach to the Twelfth Five Year Plan" has inter- alia addressed the issues of gender sensitivity in healthcare and also communica ble diseases in a holistic manner. It emphasises the need to break the vicious cycle of multiple deprivations faced by girls and women because of gender discri mination and under-nutrition.

Approved outlay during the Eleventh Five Year Plan period for National AIDS Control was Rs. 6150 crores, for National Vector Borne Disease Control Programme (NVBDCP) Rs. 2251.75 crore, for Revised National Tuberculosis Control Programme (RNTCP) Rs. 1604.25 crore and for National Leprosy Eradication Programme (NLEP) Rs. 218.84 crore.

Under the National Vector Borne Disease Control Programme (NVBDCP) subsumed under National Rural Health Mission (NRHM), focussed attention is given to high endemic areas. The approach to the Twelfth Plan envisages that infectious diseases such as tuberculosis, malaria, also need focused attention and a contin ued commitment to prevention and control.

Source: Loksabha, Unstarred Question No. 4678, 4th May, 2012

Upgradation of Maternity and Childcare Facilities

The Government of India launched the National Rural Health Mission (NRHM) in the year 2005 with the objective to provide accessible, affordable and quality health care services to the rural population across the country. Under the Mission, States including the State of Madhya Pradesh project thick requirement for upgradation of health facilities in the State Programme Implementation Plan which is approved by the NPCC and funds are released for approved activities.

Besides, to provide basic medical facilities especially to pregnant women and newborns, the mission envisages the following provisions:-

- JananiSurakshaYojana (JSY) – Conditional Cash Transfer Scheme for promoting institutional deliveries.

- JananiShishuSurakshaKaryakaram (JSSK)- entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. The initiative stipulates free drugs, diagnostics, blood and diet, besides free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put up in place for all sick newborns accessing public health institutions for treatment till 30 days after birth

- Strengthening facility based new born care through sick new born care units in District Hospital, New Born Stabilizing unit in Sub District Hospital with new born corner in every functional delivery point.

- Nutritional Rehabilitation Centres for management of severely malnourished children.

Source: Loksabha, Unstarred Question No. 3821, 27th April, 2012

Restructuring of ICDS

The scheme of ICDS was initiated in 1975 with 33 projects and 4891 Anganwadi centres (AWCs). The scheme was gradually universalized, in phases, and finally in 2008-09 with approved 7076 projects and 14 lakh AWCs. The universalisation of the scheme led to increased outreach which necessitated operational, programmatic and other reforms.

In order to address various programmatic, manage mental and Institutional reforms as well as to meet administrative and operational challenges, the Ministry of Women and Child Development has formulated a comprehensive proposal on ICDS Strengthening and Restructuring which inter-alia include addressing the gaps and challenges with (a) special focus on children under 3 years and pregnant and lactating mothers (b) strengthening and repackaging of service including , care and nutrition counseling services and care of severely underweight children (c) a provision for an additional Anganwadi Worker cum Nutrition Counselor for focus on children under 3 years of age and to improve the family contact, care and nutrition counseling for P&L Mothers in the selected 200 high-burden districts across the country, besides having pilots on link worker, 5% crèche cum Anganwadi centre (d) focus on Early Childhood Care and Education (ECCE) (e) forging strong institutional and programmatic convergence particularly, at the district, block and village levels (f) models providing flexibility at local levels for community participation (g) improving Supplementary Nutrition Programme including cost indexation, (h) provision for the construction and improvement of Anganwadi centres (i) allocating adequate financial resources for other components including Monitoring and Management and Information System(MIS), Training and use of Information and communication technology (ICT) and (j) to put ICDS in a mission mode etc.

The Scheme of ICDS is a Centrally Sponsored Programme implemented through the State Governments/UT Administrations. The Scheme, since inception, envisages involvement of voluntary organizations, Central Social Welfare Boards, Local bodies, Panchayati Raj Institutions etc. wherever they are functional, to be actively involved in this Programme for implementation, soliciting community support etc. The States have been given the autonomy, within the overall framework of the ICDS, to entrust whole or part of the ICDS projects to a voluntary organization including NGOs for which grants to them would be provided by the concerned State Government/UT Administration. The responsibility for deciding eligibility criterion, job responsibilities, wages etc. of NGO appointees, therefore, rests with the State Governments/UT Administrations.

Source: Rajya Sabha, Starred Question No. 499, 10th May, 2012

NATIONAL NEWS

India's healthcare: It's a privatized system anyway

India has in effect, one of the most privatized healthcare systems in the world. World Bank data for 2010, the latest available, shows that public expenditure on health in India was just 29.2% of total health spending, against the global average of 62.8%.

The only countries for which data was available with a lower proportion of public spending to total spending on health were Guinea Bissau, Guinea, Sierra Leone, Afghanistan, Myanmar, Azerbaijan, Haiti, Ivory Coast, Uganda, Georgia, Yemen, Chad and Tajikstan.

Not only was India's proportion of public expenditure to total spending on health considerably lower than the global average, it did not even come close to matching the average for "low income" countries, which was 38.8%. Even sub-Saharan Africa, with 45.3%, was doing significantly better.

Taken along with the data on how much of the GDP total health expenditure accounts for, India's figures make for even more dismal reading, with the global average being 10.4% of GDP.

The figure for OECD, a club of the world's most economically developed countries, was 12.9%. Middle-income countries, a group that includes India, averaged 5.7% and even low-income ones registered 5.3%. Against this, India spent a measly 4.1% from all sources of health.

Put the two sets of numbers together and what it tells us is that India's public expenditure on health was equivalent to a mere 1.2%. That's against a global average of 6.5%, an OECD average of 8.4%, a middle-income countries level of 3.0% and 2.1% for low-income countries as a whole. Once again, sub-Saharan Africa with public health expenditure equivalent to 2.9% of GDP does considerably better than India.

In short, not only does India spend less on healthcare than most of the world, including countries which are significantly worse off economically, even what little is spent comes largely from private sources.

It is hardly surprising under the circumstances that studies have shown that spending on healthcare is, along with spending on rituals like death rites and marriages, among the major reasons for indebtedness in Indian households.

Source: The Times of India, New Delhi, 8th August 2012

Ministry opposes plan to overhaul healthcare

The health ministry has opposed the Planning Commission's proposal for a radical overhaul of the public healthcare system, saying it deviates from the government's primary goal of providing health coverage to all.

The ministry has asked the apex planning body to rewrite its chapter on health in the 12th five-year Plan document that covers FY12-17, a top ministry official said.

Several of the commission's suggestions contradict recommendations of the high level expert group (HLEG) on universal health coverage, or UHC, set up by Prime Minister Manmohan Singh in October 2010

with the mandate of developing a framework on affordable healthcare for Indians, this official said. The bone of contention is the Planning Commission's proposal to switch to a "managed healthcare network" model in which public and private hospitals may have to compete with each other for patients.

Also, under the plan, the government's primary healthcare function will be limited to essential interventions such as immunization, antenatal care and disease-control programmes, leaving clinical services to the managed-care model. The government's role will in effect diminish from providing health services to managing the network.

Under the managed-care model, while networks of largely private hospitals will be paid per patient registered, doctors will be paid per prescription, according to the Plan document. The transition to this model is proposed to happen over two Plan periods (2012-17 and 2017-22).

China is now revising its health policy because of growing inequity. It is important to ensure the public sector remains committed to providing quality healthcare without chasing money in any and every manner and to develop a model of Universal Health Care (UHC) wherein the private sector will assist the public sector in serving a public purpose rather than privatizing the delivery of public sector healthcare.

Source: Live Mint, New Delhi, 6th August, 2012

India to give free medicine to hundreds of millions

India has put in place a $5.4 billion policy to provide free medicine to its people, a decision that could change the lives of hundreds of millions, but a ban on branded drugs stands to cut Big Pharma out of the windfall. From city hospitals to tiny rural clinics, India's public doctors will soon be able to prescribe free generic drugs to all comers, vastly expanding access to medicine in a country where public spending on health was just $4.50 per person last year.

The plan was quietly adopted last year but not publicized. Initial funding has been allocated in recent weeks. Under the plan, doctors will be limited to a generics-only drug list and face punishment for prescribing branded medicines, a major disadvantage for pharmaceutical giants in one of the world's fastest-growing drug markets.

"Without a doubt, it is a considerable blow to an already beleaguered industry, recently the subject of several disadvantageous decisions in India," said KPMG partner Chris Stirling, who is European head of Chemicals and Pharmaceuticals.

"Pharmaceutical firms will likely rethink their emerging markets strategies carefully to take account of this development, and any similar copycat moves across other geographies," he added.

But the initiative would overhaul a system where healthcare is often a luxury and private clinics account for four times as much spending as state hospitals, despite 40 percent of the people living below the poverty line, or $1.25 a day or less.

Within five years, up to half of India's 1.2 billion people are likely to take advantage of the scheme, the government says. Others are likely to continue visiting private

hospitals and clinics, where the scheme will not operate.

"The policy of the government is to promote greater and rational use of generic medicines that are of standard quality," said L.C. Goyal, additional secretary at the Ministry of Health and Family Welfare and a key proponent of the policy.

"They are much, much cheaper than the branded ones."

Global drugmakers like Pfizer (PFE.N), GlaxoSmithKline (GSK.L) and Merck (MRK.N) will be hit. They spend billions of dollars a year researching new treatments and target huge growth for branded medicine in emerging economies such as India, where generics account for around 90 percent of drug sales by value, far more than in developed countries.

U.S.-based Abbott Laboratories (ABT.N), which bought an Indian generics maker in 2010, is the biggest seller of drugs, both branded and generic, in India, followed by GlaxoSmithKline.

In March, India granted its first ever compulsory license, allowing a domestic drugmaker to manufacture a copy-cat version of Nexavar, a cancer drug developed by Germany's Bayer (BAYGn.DE), unnerving foreign drugmakers that fear a lack of intellectual property protection in emerging markets. That enabled India's Natco Pharma (NATP.NS) to sell its generic version of Nexavar at 8,800 rupees per monthly dose, a fraction of the 280,000 rupees Bayer's version cost.

In another blow to Big Pharma's emerging market ambitions, China recently overhauled regulations to grant authorities the power to allow domestic drugmakers to produce cheap copies of medicines protected by patents.

Emerging markets are on track to make up 28 percent of global pharmaceuticals sales by 2015, up from 12 percent in 2005, according to IMS Health, a healthcare information and services company.

Most sales in emerging markets come from branded generics, which are off-patent drugs priced at a premium to those made by local manufacturers.

The Organisation of Pharmaceutical Producers of India (OPPI), a lobby group for multinational drugmakers in the country, argues that the price of drugs is just one factor in access to healthcare and that the scheme need not be detrimental to manufacturers of branded drugs.

"I think this will hasten overall growth of the pharmaceutical industry, as poor patients who could not afford will now have access to essential medicines," said Tapan Ray, director general of OPPI.

About 600 billion rupees in drugs are sold each year in India, or 482 billion at wholesale. Drugs covered under the new policy account for about 60 percent of existing sales, or 290 billion rupees at wholesale cost.

The government's annual cost is likely to be lower due to bulk purchasing and because patients at private clinics would still pay for their own drugs. States will pay for 25 percent of the free drugs and the central government will cover the rest.

Under various existing programmes, around 250 million people or less than a quarter of India's population, now receive free medicines, according to the health ministry.

India's new policy, to be implemented by the end of 2012 and rolled out nationwide within two years, is expected to provide 52 percent of the population with free drugs by April 2017, at a cumulative cost of 300 billion rupees.

That requires a major funding ramp-up from a deficit-strapped government. The scheme has been granted just 1 billion rupees thus far from central government coffers.

Public doctors will be able to spend 5 percent of the budget, equivalent to around $50 million a year, on drugs outside of the government's list, on branded drugs or on medicines that are not on the list. Beyond that, they can be punished.

If doctors are found to be prescribing medicines which are not on the list, or which are branded, then disciplinary action will be initiated.

Free medicine is just one solution to better healthcare in India, where just getting to a state clinic can require a long journey.

Source: Reuters, Mumbai, 5th July, 2012

India spends least on Healthcare

India showed 29.2 percent expenditure on health in 2010, according to data World Bank India. India being one of the most privatized healthcare systems in the world. Analysing GDP total health expenditure, India's figures make for even more dismal reading, with the global average being 10.4 percent of GDP. The only countries for which data was available with a lower proportion of public spending to total spending on health were Guinea Bissau, Guinea, Sierra Leone, Afghanistan, Myanmar, Azerbaijan, Haiti, Ivory Coast, Uganda, Georgia, Yemen, Chad and Tajikstan.

Not only was India's proportion of public expenditure to total spending on health considerably lower than the global average, it did not even come close to matching the average for "low income" countries, which was 38.8 percent. Even sub-Saharan Africa, with 45.3 percent, was doing significantly better. It is also observed that India's public expenditure on health was equivalent to a mere 1.2 percent. This is against a global average of 6.5 percent, an OECD average of 8.4 percent, a middle-income countries level of 3.0 percent and 2.1 percent for low-income countries as a whole. Once again, sub-saharan Africa with public health expenditure equivalent to 2.9 percent of GDP does considerably better than India.

In short, not only does India spend less on healthcare than most of the world, including countries which are significantly worse off economically, even what little is spent comes largely from private sources. It is hardly surprising under the circumstances that studies have shown that spending on healthcare is, along with spending on rituals like death rites and marriages, among the major reasons for indebtedness in Indian households.

Source: E – Health Magazine, New Delhi, 13th August 2012