

Unhealthy Prescriptions : The Need for Health Sector Reform in India

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India's health care system is characterized by a pattern of mixed ownership and with different systems of medicine - Allopathy, Ayurvedic, Unnani, Sidda and Homeopathy. Three major groups in health care in the country, the public health sector, the private health sector and the households who utilize health services. The public health sector consists of the central government, state government, municipal & local level bodies. Health is a state responsibility, however the central government does contribute in a substantial manner through grants and centrally sponsored health programs/schemes. There are other ministries and departments of the government such as defense, railways, police, ports and mines who have their own health services institutions for their personnel. For the organized sector employees (public & private) provision for health services is through the Employee's State Insurance Scheme (ESIS).

The private health sector consists of the 'not-for-profit' and the 'for-profit' health sectors. The not-for-profit health sector includes various health services provided by Non Government Organisations (NGO's), charitable institutions, missions, trusts, etc. Health care in the for-profit health sector consists of various types of practitioners and institutions. The licensed practitioners range from general practitioners (GPs) to the super specialists, various types of consultants, nurses and paramedics, licentiates, and rural medical practitioners (RMPs). The health care practitioners with no formal qualifications constitute the 'informal' sector which consists of faith healers, local medicine men / women, traditional birth attendants priests and a variety of unqualified persons (quacks). The private health subsector institutions are heterogeneous in the services they provide, their size and quality.

Public Financing Limitations

In India health sector reforms are taking place under the broad umbrella of Structural Adjustment Programs (SAP) which is termed as the new Economic Policy (NEP). The two major aspects of the SAP are privatisation and liberalisation.

The major problem historically and more so presently under SAP is the issue of under-funding of health services. The investment by the government in health care has been inadequate to meet the demands of the people. The government has over the years committed not more than 3.5% of its resources to the health sector. The budgeted expenditure for 1994-95 was 2.63% of total or \$ 2 per capita, which is the lowest ever. **(Duggal., Nandraj & Vadair 1995)**. As a percentage to Gross Domestic Product (GDP) it has been around 1 %, woefully

short of the World Health Organization's recommendation 5%. Due to the SAP there has been further compression in Government spending in an effort to bring down the fiscal deficit. The grants from central government to the state governments declined drastically from 19.9% in 1974-82 to 3.3% in 1992-93. Central programs or centrally sponsored programs are the most severely affected. The Share of central grants for public health declined from 28% in 1984-85 to 17% in 1992-93 and for diseases control programs from 41% in 1984-85 to 18% in 1992-93 (**NIPFP, 1993**). Financing of the health needs to be substantially strengthened because ultimately it is these provisions that become the foundation for improvement in the quality of life.

Within this meager amount available, the government's prioritization and allocation of health expenditures are misplaced. From among its various developmental efforts, the population control program stands as the highest priority activity. The under development and poverty of the country is blamed entirely on its population growth rate. The Family Planning and Welfare program is the single largest consuming more than half the plan resources for the health sector. Over the years, expenditure on family welfare program has increased rapidly. From an annual average expenditure of \$0.13 million during the second plan (1956-61) it increased to \$ 1.42 million in the 3rd plan period (1961-66) and further to \$ 6.71 million during 1966-69. It continued to increase at a rapid pace in the consecutive plan periods. Family planning expenditures are spent mostly in rural areas through the Primary health center's and Sub Centers. Besides the allocation of resources the Family Planning program uses the entire local health infrastructure and human power to meet the targets. This has resulted not only in a neglect of other health programs but also the discrediting of the rural health services as a population control service. In spite of such large quantum of funding the family welfare programme it has been a marked failure. Thus the total fertility rate continues to remain around 4.5 per women and the population growth rate has remained near constant for the past three decades at around 2.2 % per annum.

The policies and priorities to various diseases control programs continue to shift. At present there are around 15 national diseases control programs functioning. These are for diseases and illness such as TB, malaria, filaria, leprosy, diarrhea, blindness, sexually transmitted diseases, mental health, cancer, etc. The latest addition is AIDS. Every plan period brought out a new national diseases control program. The shifting priorities to various diseases program has been more due to the international pressure than the diseases profile of the country. Low priority, under-funding and shifting priorities for diseases control programs persist in spite of an increase in morbidity and mortality.

Though the reach of the public health services is very limited it supports a very large bureaucracy from the nation's capital down to the primary health center level. The support for this elaborate bureaucracy and line workers forms a major chunk of the health expenditure. The Central Ministry of Health employs over 30,000 persons. Analysis of the expenditure on health in one of the major states in India during 1990-91 shows that 43% of the total expenditure on

public health was incurred on salaries. This is in addition to the expenditure on salaries under each program head. **(Govt. of Maharashtra, 1992)**. Consequently salaries absorb an exceptionally large proportion of expenditure leaving very little for drugs and supplies.

There is utter neglect of rural areas in provision of medical care services. The government conveniently took up the responsibility of preventive and promotive health services and left the curative care largely in the hands of the private health sector. It has been clearly shown time and again by various studies the rural-urban disparities in terms of health infrastructure is very wide. Analysis of total state expenditures on health reveals that between 70% to 80% of the investment and expenditure reaches 30% of the population in urban areas. For instance, in 1991 of all hospitals and beds in the country only 32%, and 20% respectively were in the rural areas i.e., 20 beds per 100,000 population in rural areas as compared to 238 beds per 100,000 population in urban areas. **(CBHI, 1992)** The poor in the villages were given inferior health services in the name of Primary Health Care, National Programs . For the rural population there is very little provision of state funded curative care though these services are most demanded. Studies conducted reveal the fact that Primary Health Center's are grossly under-utilized primarily because they have inadequate resources (staff, medicine, equipment, transport,) and because the entire focus of the health program is in completing family planning targets **(ICMR 1991, Gupta JP, et.al 1992, Ghosh B 1991)**. The loss of faith in the public health sector has provided the private health sector an opportunity to thrive and make its presence felt as the sole provider of curative care in the rural areas.

Alternative Financing

Instead of increasing the outlay on the health sector the government is adopting alternative means of financing through various methods under the policy prescriptions of the SAP. Traditionally the finances of the health sector were being met from the revenues collected by the government to a smaller extent as aid from bilateral and multilateral sources. The present policy is to take loans from the World Bank and other international agencies to upgrade and run the health programs in the country. Another method of financing of health services favoured by the government is through the levy of user charges. This brings out the fact that the government is abdicating its role of providing free health services, especially those with the greatest need. In the present socio economic conditions the poor would be the most affected.

Public support for Private Services

The government directly or indirectly supports the growth of the private health sector at the cost of public resources through the provision of financial assistance for setting up private practice, hospitals, and diagnostic centers. Pharmaceutical manufacture is benefiting from soft loans, subsidies, tax and customs duty waivers.

Government support is clearly evident is the production of doctors for the private health sector. Nearly 16,000 doctors are being produced every year from around 140 medical colleges in the country. At today's prices on an average training of each doctor costs the government around \$ 142.85. However, the government health services are unable to fill in the vacant position in their own facilities. Between two thirds and three fourths of those qualifying from public funded medical colleges practice in the private sector. That means for every 3 doctors the government trains for its own health services it also trains 7 doctors for the private sector at public cost. A further distressing fact is that out of every 100 doctors who go into the private sector 40 migrate out of the country. This is a gross injustice to the poor people in the country who have contributed their mite in training these doctors.

The government is also handing over the public health services and programs to the private health sector, more specifically the non-government organisations (NGO) It can be argued that the major role the NGO's should be creating awareness rather than taking over services which the government is duty bound to provide. In addition certain services in the hospitals and health centers are being contracted out for the purpose of efficiency and quality.

The Private Health Sector

The private health sector in India is the most dominant sector in terms of financing and utilization of health services. There has been a tremendous amount of growth in physical size, investments, expenditures and utilization. Recent studies reveal that 50% of people utilise private inpatient health facilities, figure that goes up to 80% for ambulatory care (NSSo, 1989: Duggal and Amin, 1989: Kannan et. al; 1991 NCAER, 1992: George et al , 1994) .The share of the private health sector is around 4 % of the Gross Domestic Product as compared to the government spending which is around 1 %. The share of the private health sector at today's prices works out to between \$ 4,571 millions and \$ 5,714 millions per year **(Duggal, Nandraj 1991)**.

Abuse in Private Practice

Health planners and policy makers among others have failed to take a holistic assessment of the private health services in the country. There are very few studies conducted on the role, functioning, size and quality. Data presented by official agencies are has been found to be grossly underestimates **(Nandraj, 1994)**.

Private health facilities tend to perform unnecessary investigations, tests, consultations and surgeries, as well as overcharge and overprescribe. Due to the fact that surgeries are profitable, many are conducted without any regard for the patients well being. A study revealed that 31% of deliveries were by cesarean section. More significantly 70% of the hospitals where cesareans were routine were privately owned. A committee in Maharashtra found that the average rate of cesarean childbirth in private hospital was 30 % as compared to government which was only 5 %. Ultrasound investigations, amniocentesis, epidural anesthesia etc. are also done unnecessarily more frequently in order to recover investment costs. The rising costs of health care are also due to the irrational and unethical practices resorted to by the private health sector.

For specialized treatment like hospitalization and investigations, for each referral made, a part of the fee charged to the patient is given to the referring doctor. In Bombay, the profit-ratio is as high as 30% to 40 % of the fees charged. In some towns of Maharashtra informal associations of doctors have standardized the ratios of profits to be given to referring doctors. **(Nandraj , 1994)**

In many private hospitals there is pressure on the doctors to ensure that the beds are occupied and the hospital equipment is fully utilised. Many hospitals fix the amount of 'business' a physician or surgeon must generate. Many of the private hospitals refuse admission to patients unless a certain deposit is paid before hand, regardless of the severity of the patient's health status. This is inspite of the fact that the patient may be seriously ill or an accident victim.

Corporate Hospitals

A new feature in the private health care delivery system is the participation of corporate hospitals. During the last one and half decades the growth of corporate hospitals has been notably fast. In 1983, the first corporate hospital in India was set up in Madras. It was established by Apollo Hospitals Enterprise Ltd. (AHEL), which recorded a turnover of \$ 3.2 millions and a net profit of \$ 0.30 in 1988. These hospitals cater to only the rich and the cost of treatment in them is far beyond the reach of the common people. Several large firms in addition to their regular business have diversified into the field of health. This is due to the realization that health could also be transformed into an industry with such desirable features as: a large and available market of illness, access to a ready qualified and trained labour, and the new miraculous state of the art medical technology. They also boast of the latest diagnostic and therapeutic facilities. For example today Bombay has 13 body scanners, Delhi has 11, Madras 8, Calcutta has 3, Hyderabad 2, Pune 3 and Ahmedabad 3. **(Jesani. A & Ananthraman S. 1993)**. Suffice to say that with the rise of the corporate sector, the cycle in health care does not start with a trained medical person and a sick person in search of each other, but with an investor in search of profitable investment **(Phadke A, 1993)**.

Regulatory Deficiency

In India the private health sector functions practically unregulated and unaccountable to the people or any authority. There are no standards of medical practice prescribed for private hospitals in terms of qualification of staff employed, equipment needed, administration, treatment offered. Only recently the private hospitals in terms of qualification of staff employed, equipment needed, administration, or treatment offered. Only recently the private practitioners and hospitals were brought under the purview of the Consumer Protection Act, a policy which was met with great resistance from the medical fraternity.

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Except for the states of Maharashtra, Delhi and Karnataka there are no rules, laws, or regulations for private hospitals functioning. The practitioners are supposed to function broadly under various medical councils set-up for various systems by law. However, the functioning of the medical councils in the country leaves much to be desired. The registers are not updated, elections to the council are rigged, the trails are held in camera, and in many state medical councils action has not been taken against a single doctor in spite of complaints. The existing regulations which are few and far too few are outdated, inadequate and not being implemented. It will not be an overstatement to say that due to the predominance of the private health sector the Indian health care market has become a largely supply-determined market. This is because the state did not take seriously the responsibility of regulating, monitoring and making the private health sector accountable. It has become all the more important in the current context where the private sector is being encouraged to actively involve itself in almost all sectors of the economy. Despite having one of the largest private health sectors in the world, providing 70% of care in India, the fact that it should function practically unregulated is a matter of grave concern. Majority of the people utilize the services of the private health sector but have, little or no control on the quality or pricing.

Household Expenditure on Health

The various studies conducted have revealed that households spend a substantial amount on health care and the poorer class spends more on health care in terms of their proportion to consumption expenditure and income. A study conducted in two backward districts of Madhya Pradesh, in 1991 showed that the per capita expenditure incurred by the household on health worked is approximately \$ 9 per year with 74% of the expenditure going into doctors fees and medicines. Household health expenditure works out to 8.4%. The upper class spends only 4% of their consumption expenditure, while the lowest and lower middle classes spend as much as 8% and 10% respectively on health care. **(George, Shah, & Nandraj, 1993)**. A study in rural Kerala in 1987 found

that the per capita cost per year incurred by the household on health was \$ 5. The percentage of the reported income spent on health was found to be around 7%. Comparing it across class it found that the lowest class spends as high as 14% of their income on health as compared to the highest class which spent only 4.4% s. **(Kannan, Thankappan, Raman Kutty , and Aravindan, 1991).**

Findings from various studies make it evident that a substantial financial burden of the household is borne for meeting health care needs. Compared to government expenditure on health the private household expenditure is nearly 4 to 5 times more. A substantial portion of their income and consumption expenditure is spent on health. This certainly is not a happy state of affairs, since such expenditure on health care would mean cutting down on the household food consumption. This gains significance when we realize that nearly half of the country's population does not have enough resources to meet their food requirements, and worse still the capacity to earn if the patient happens to be the sole earning member. Given this socio economic situation in the country the purchasing power becomes a crucial factor. As we have seen above the accessibility of the public health service is poor especially in rural areas of the country. The private health sector becomes unaffordable for the vast majority of the poor. There is impoverishment of the lower class or middle class due to illness which could be of a chronic nature or that involving hospitalization or surgery. The high cost of health care makes the poor more marginalised. There is a need to question the dominant role of the private health sector and the consequently high health care expenditure.

Conclusions

The issues raised above need to be addressed by the planners, policy makers, funders, NGO's, researchers among others. In the new lexicography of Indian economics privatisation and liberalization are the new panacea for ills in the economy. Privatisation and liberalization being undertaken in the country has to be viewed in the broad context of majority of the Indian people living under extreme poverty conditions, non-availability of basic amenities for the majority of the people, poor nutritional status, impoverishment due to health, poor availability of public services, presence of a dominant and unregulated, unaccountable private health sector along with strengthening of market forces and helplessness of the consumer against various odds. In India no single system can work. The health sector reforms that are undertaken in India are diametrically opposite to the people's needs . What we need is a combination of social insurance, employment related insurance for the organised sector employees, voluntary insurance for other categories who can afford to pay and finally, tax and related revenues.

Issues that need to be questioned in India's health policy

Priorities within the health sector need to be changed.

More funds need to be made available for the rural areas especially with regard to curative services.

Additional resources, especially for non-salary expenditures.

Greater decentralisation on a priority basis.
Questioning of increasing support for population control.
Wastage reduction and improving efficiency by better management practices.
Establishment of proper referral systems. Regulatory intervention and monitoring of the government in the private sector and market.
Geographical distribution of physicians through licensing and other means.
Legislation should be enacted where there is no legislation.
Standardisation of fees charged by the practitioners and fixation of reasonable charges.
Trend favouring user charges should be countered.
Additional revenues earmarked for the health sector could be generated through taxing health degrading products.
Those with a capacity to pay should be mandated to contribute to health care through insurance and other pre-payment programs.

Notes

1) Ruppes have been converted into US dollars at the rate of 35 Rs. per US\$).

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