Details of Module and its Structure

Module Detail	
Subject Name	Sociology
Paper Name	Sociology of Health
Module Name/Title	Privatization of Health Services in India
Pre-requisites	No pre requisites
Objectives	To explain the concept of Privatization of health Services in India To examine the role of Indian state in promoting private health care. To analyse the reasons underlying high cost, unregulated health care in India.
Keywords	Private Health Care, State Regulatory Mechanism, Privte Practice, Bhore Committee.

Structure of Module / Syllabus of a module (Define Topic / Sub-topic of module)	
Privatization of Health Services in India	Introduction, State and health Care, Origins of private Practice during the Pre-Independence Period, Privtisation of health in the post-Independence period, Growth of Private health Sector in the 197s & 1980s, Priate interests within the Public sector, Bhore Committee and Private Practice, State Policy towards Private health care, healthrvice devemnt after Indepenence, Need for Regulation of Private Sector, Conclusion.

Role	Name	Affiliation
Principal Investigator	Prof Sujata Patel	Dept. of Sociology, University of Hyderabad
Paper Coordinator	Prof. N Purendra Prasad	Dept. of Sociology University of Hyderabad
Content Writer/Author (CW)	Pro N Purendra Prasad	University of Hyderabad
Content Reviewer (CR)	Prof Sujata Patel	Dept. of Sociology University of Hyderabad
Language Editor (LE)	Prof Sujata Patel	Dept. of Sociology University of Hyderabad

Module 10- Privatization of Health Services in India

Introduction:

Prior to growth of allopathic medicine, during the 19th C, medical care was largely a private activity in the household and the community. During this period, in most developed and developing countries, healers who had some formal training, either philosophical or empirical, dealt with wealthy patrons while treatment of ordinary people remained in the hands of a number of lay practitioners who used traditional and magical remedies. In India, indigenous systems like Ayurveda, Unani and Siddha were largely the domain of individual practitioners who provided services for a price which was paid mostly in kind.

State and Health Care:

Accounts of Ayurvedic practice during the 19th C indicate that the kings patronised Ayurvedic practitioners by offering large sums of money. The rest of the population depended on a variety of healers and paid for their services. The state played a minimal role in assuming responsibility in providing services to the people. It was not until the end of the 19th C that efforts were made for some form of state intervention in health care anywhere in the world. The earliest effort was made by Bismark in Germany in 1883 when he introduced a health scheme for the working classes. Subsequently other western European countries introduced similar schemes. In 1911, Britain introduced national health insurance scheme which covered wage earners in industries but excluded women, children, the unemployed and self-employed. The scheme was introduced partly in response to political discontent of the working classes as well as to improve 'national efficiency'.

By the beginning of the 20th C, considerable developments had taken place in the field of medicine. However the high cost and poor organisation of medical care prevented it from being accessible to the majority of the population. Hence, the importance of state intervention in providing medical care was realised as early as 1911 bot consequent efforts covered only certain sections of the population. The 1950s and 1960s marked the most substantial growth period for the welfare state where in several developed and developing countries invested in social services. This was short lived due to the world-wide economic recession of the 1970s. The late 1970s saw a cut-back of investments in the social sectors and the debate on privatisation gained importance. These developments were by no means restricted to developed countries but had ramifications for developing ones as well.

In the Indian context, privatisation of healthcare is a complex phenomenon because the private sector has not grown independently of the public sector. Since independence, the Indian state has invested in infrastructure, training of medical and paramedical personnel and medical research. This has provided the base for the growth of the private sector and is therefore interrelated to the public sector at several levels.

Origins of Private Practice during the pre-Independence Period:

The origins of private practice can be traced to the 17th century with the establishment of the East India Company, following which European doctors were employed on a regular basis in India. Originally the company engaged the services of British doctors designated as `surgeons' mainly for ships which were bound for India. Later, some doctors were asked to remain in India on special request from the merchants. By the late 17th C, surgeons were hired and the east India company started employing medical men to treat their resident European employees. Many of the British surgeons found it an attractive proposition because one could derive income outside the formal job of surgeon to the company. In company hospital, surgeons were paid for each patient they treated over and above their salary.

The company surgeons had private medical practice probably treating mainly non-official Europeans and families of officials, but also including `native gentlemen' or members of the Moghul or Indian courts. Through the 18th and 19th C, the number of medical officers grew and a bureaucratic structure was established in India to organise recruitment and create a hierarchy of appointments.

Allopathic medicine was introduced by the British during the late 18th C, in order to protect and treat the employees of the east India Company. Over time they extended these services to the Indian population as well and therefore expanded the network of hospitals and dispensaries in the various presidencies. The expression of medical care facilities required trained personnel and this is what prompted the British to invest in medical education during the late 19th C to train subordinate staff who would work in the newly created facilities.

Many of these medical colleges not only recruited persons to be trained as subordinate staff but also admitted private students. Although the main objective of medical education was to supply subordinate staff, many of these colleges also admitted private students. As early as the 1880s, these private students had established private practice in major towns and were competing with European doctors for the private market. By 1900s, a substantial number of graduates had established themselves in private practice in the main towns.

Privatisation of Health in the Post-Independence Period:

A mixed provision of services existed even at the time of Independence and the state has not only accommodated but also protected private interests. Over the years, the private sector has grown and diversified its operations. Studies have shown that the bulk of the private sector consists of individual practitioners and that their services are used extensively in rural and urban areas. Of course, these private practitioners were both trained and untrained personnel. There was more reliance on the private practitioners for outpatient care.

Prior to Independence the British played a major role in introducing allopathic medicine. After Independence, the experience of the British in providing welfare services influenced the political leaders in India which actually shaped the structure of health care provisions. Like in Britain, health care delivery was financed and supported by the state. However, private interests in the form of practice by government doctors, private beds in government hospitals and supportive inputs like the pharmaceutical and medical equipment industries which are largely controlled by private capital, were also accommodated.

Growth of Private Health Sector in 1970s and 1980s:

Institutional growth started taking place during the seventies and continued through the 1980s and 1990s. Rama Baru (1998) says that it was during 1970s that there was a boom in the private sector which led to the growth of hospitals and insurance schemes across developed and developing countries. The philosophy which gained momentum was to roll back the welfare state and give more prominence to the market in the provisioning of medical services. The advocates of this philosophy argued that the welfare state consumed resources that would be better used for stimulating production rather than giving hand-outs. The solution was in cutting back on state interventions in the economy, reducing taxes, spending on welfare and privatising numerous state-owned enterprises.

The distribution of these private institutions in skewed towards urban areas and concentrated more in some states than others. The influence of developments in American medicine on the Indian scenario could be seen at three levels. First, the involvement of multinational pharmaceutical as well as medical equipment industries in health care sector. Second, the non-resident Indian (NRI) doctors who are also playing a prominent role in investing in tertiary level care, some of which is corporately managed and Third, the Indian governments' offer of 100 per cent equity to foreign hospital companies to invest.

Private interests within the public sector:

In the Indian context, apart from individual private practitioners owning enterprises, a fairly large number of doctors in the public sector practice privately. The research studies indicate that mixed provisioning of health care is not peculiar to India as many countries train personnel through state expenditure while the doctors opt to serve in the private sector. In addition, those who enter the private sector not just in India but in several countries, doctors employed in the public sector also practice privately. With privatisation, health care is being converted from a need to a commodity and since profit becomes the motive, it is bound to thwart efforts at health service planning. This the assumption based on which it is hypothesised that the growth of the private sector is not independent of the evolution of the public sector. Over the years, the private sector has used the public sector for its growth.

Bhore Committee and Private Practice:

The Bhore committee's survey of the sectoral employment of allopathic doctors in India during the 1940s revealed that 27 per cent of the doctors were in government while the remaining 73 per cent were in private practice. A survey of medical institutions by this committee revealed that 92 per cent were maintained on public funds and the remaining 8 per cent were wholly maintained by private agencies. The fairly high percentage of private practitioners ensured that their interests would not be jeopardised by the state health services.

Although the Bhore committee had categorically stated that the private practice by government doctors must be prohibited and did not visualize a role for independent private practitioners in government hospitals, a shift in policy could be seen as early as 1961 in the report of Mudaliar committee. The committee took note of the fact that nearly 40 to 70 per cent of doctors in different states were private practitioners.

The position the committee took vis-à-vis private practitioners was that since there was shortage of manpower, they should be encouraged to provide both curative and preventive services. It further stated that private practitioners should be "given opportunities to serve in government hospitals on a part-time or honorary basis and hospital authorities should encourage them to admit their patients needing in-patient care". This shows that as early as 1961, the demarcation between public and private sectors had become less clear, especially with the individual private practitioners being encouraged to use government hospitals to treat their patients.

State Policy towards Private Health Care:

A review of the planned documents as well as committee reports, indicate that there was no effort made at defining the role for private sector. By not defining its role, the private sector grew without any controls by using investments made by the state. In fact, when public expenditures on medical care did not increase, the state started visualizing more prominent role for the private sector in the provision of health care as a way of reducing its own involvement. Thus, the statement in the health policy document recommending utilisation of the yet untapped resources of the private sector is only a belated legitimization of the already proliferating private sector which has expanded considerably during the post-independence period.

The government also has offered a number of concessions for the growth of the private sector. First, the government has encouraged the growth of large private hospitals by reducing import duties on high technology medical equipment and special concessions are given for the non-resident Indians. Second, it has recognized medical care as an industry thereby making it eligible for loans from several public finance companies like the industrial development Bank of India (IDBI). Two measures together have definitely given a fillip to the private sector which has resulted in business groups entering the arena.

According to the World Bank's own data, with China spending 3.5 per cent its GDP on health, two-thirds on the decentralized public sector, has an IMR of 38 in 1991. While

India spends 6% of its GDP, three-quarters on the public sector, India had an IMR of 90. Why then does the Bank advocate the privatisation of health care in India? Instead of supporting and strengthening the decentralized concept of integrated people based health care as advocated by Bhore model and practice so effectively by China, Why does the world Bank advocate the policy of further promoting vertical programmes for selective primary health care (especially for family planning). The population control programmes have not only limited health benefits, but have destroyed the primary health care concept. In fact, Bhore committee visualized that any national health programme without its focus on primary health care would only alienate the people. Several studies in China, Sri Lanka, Kerala and Cuba have revealed that between Rs 100 to Rs 150 per capita per annum would enable a country to achieve effective health care right from the village to the super-specialty level. This is done by employing specifically trained village health and paramedical workers who can perform over 70 per cent in terms of preventive, promotive and curative health functions. Of course, this kind of health care system requires trained personnel, encouraged and supported by graded referral system.

Such a decentralized health care system can effectively deal with most of the major communicable diseases and family planning where the knowledge and technology is simple, safe, effective and cheap. The key to successful implementation lies in cultural affinity, constant availability and accountability of medical personnel to the people. This model is based within the community which knows its own local problems, people's health culture and uses all available types of health and medical care from herbal and folk remedies to indigenous systems – homeopathy and Allopathy as it deems best; not a single system imposed from above. Above all, it has interest in its own welfare. Then a socially enabling culture prevails which accepts unavoidable pain and suffering for which little can be done. Therefore high cost health care can be avoided as is done in Allopathy and in certain situations one accepts death as part of life. Prolonging life at any cost in an intensive care unit can be restricted.

If this assault on our body politic is not halted, it is inevitable that millions of the poorest representing 150 million population, will die in the next few years as a result of malnutrition due to increasing poverty and deteriorating living conditions. These deaths will then be ascribed to diseases like tuberculosis, malaria, cholera, gastroenteritis and plague. The fire fighting approach of the present health services will hardly be able to tackle the major debacle resulting from economic distress. To crown it all, the price of essential drugs and vaccines will rise manifold due to General Agreement for Trade and Tariff (GATT) and Intellectual Property Rights (IPR) agreements. Out of the total hospitals, 66% of the hospitals are private owned while 31% are government owned and 3% owned by local bodies. However, if you look at number of beds, 35% private owned, 62% government owned while the remaining 3% local bodies. Out-of-pocket expenditure is growing phenomenally in India particularly for the poor engaged in unorganised sector in getting health care services.

Health Service Development After Independence:

Although the class interests of India's new rulers came to the fore after independence, yet they had to adopt an egalitarian stance given the democratic urges kindled among the masses and their own egalitarian convictions. This impelled them to take such actions in health and other fields, in the first two decades of independence, which placed the country very high among the newly sovereign countries. An example is that of ensuring protection and promotion of health and nutrition of the people by placing it in the Directive Principles for the State policy in the Constitution of India.

According to Debabar Banerji, the motive force generated by the leadership's commitment and the experience gained by the health administrators from their work in the Indian Medical Service (IMS) enabled them to give concrete shape to the political vision of the rulers. This led to some far-reaching developments in the health services. Hence, Banerjee calls this period as the 'Golden Two Decades of Public Health in India'. Some of the landmarks requiring a mention are: Vertical programs, primary health centres, social orientation of medical education, indigenous systems of medicine, Family Planning/ Welfare Program, water supply and sanitation, nutrition, Minimum Needs Program, the Multi-Purpose Workers' scheme, the Community Health Volunteers (Guide) Scheme, and the Statement of National Policy. (Banerji, 2001: 44).

The political vision to establish a comprehensive health service system in the aftermath of independence was unfortunately short-lived. Despite this fact, a number of achievements or success stories are worth mentioning. These include the mass BCG campaign of the fifties, the National Malaria Eradication Program of the period 1958-63, and the setting up of the National Tuberculosis Institute and the National Institute of Health Administration and Education to train physicians to inculcate managerial, epidemiological, social, and political capabilities. Over the next three decades, there was a sharp decline in the quality of health services in the country. The year 1967 marked the beginning of a steep decline in the health services, culminating in the present state of its serious "sickness". The major forces contributing to this decline were:

1. Obsessive preoccupation with Family Planning Program at the cost of serious neglect of the health service needs of the people, particularly the poor.
2. The imposition of so-called "international initiatives in health", during the last two decades, by a formidable combination of "development aid" agencies of many Western countries and international organizations.
3. Considerable involvement of Western countries in shaping social (including health), economic, and political policies of the country in the form of pressures for privatization in the Structural Adjustment Program (SAP) from the late eighties onwards. (Ibid)

The declaration of self-reliance by the world at Alma-Ata (WHO 1978) brought swift and sharp responses from the major world powers, which were opposed to the principles of sharing power and the distribution of resources, and especially to moving away from a bio-medical model of health. According to Debabar Banerji, a swift invention of the idea of "Selective Primary Health Care" to nip the Alma-Ata Declaration in the bud took place. This led to the utilization of the very same health agendas advocated by World

Health Organization (WHO) and UNICEF as virtual barrage in implementing specific vertical programs selected by them. These included universal programs for immunization, oral rehydrartion and other child survival strategies, and social marketing of contraceptives. (Ibid)

Clearly, these programs were antithetical to the Alma-Ata Declaration. Considerable damage was inflicted upon the provision of comprehensive health services by according overriding priority to a single vertical program over the former. Not only were the vertical programs techno- centric, they were imposed on the people from above, their cost-effectiveness was not demonstrated; and worst of all, they made developing countries dependent upon the North for funds, supply of vaccines, and other logistic support. Despite the considerable weaknesses of these programs, in terms of their economic, administrative, and epidemiological sustainability in countries such as India, they were pushed through for political and ideological reasons rather than out of consideration for the real need for comprehensive programs. Thus, these programmes have paved the way for the growth of private health in India. (ibid: 46)

Growth of Private Health Sector in Hyderabad

The most significant and widespread global trend in health care over the past decade and more has been the increasing share of 'for profit' health care and its marketization across societies. This process in the health care sector has paralleled the process of economic globalization and it's intrinsically linked to it.

As Rama Baru observes, 'while private medical practice and the dispensation of medical care for a price have been known for a long time, the commercialization, corporatisation and marketisation of health care are a phenomenon of the last quarter of the 20th century. The process received a boost during the late 1970's and early 1980's thanks to global recession, which enveloped both developed and developing countries, imposed a fiscal constraint on government budgets and encouraged them to cut back on public expenditure in the social sectors. This increased the space for the growth of the private sector in provisioning health care. This process was accelerated during the 1980's and 1990's with the growth of the pharmaceutical and medical equipment industries and then seeking out markets for their products'. (Baru 2003)

In the Indian Subcontinent, which includes Pakistan, Bangladesh and India, the Bhore committee report provided the vision and influenced state policy in the financing, provisioning and administration of services.

In India at the time of independence there was a significant presence of the private sector, which was dominated by individual practitioners. According to the estimates of the Bhore committee, the proportion of allopathic doctors in private practice was 73% and remaining 23% were in government service (Baru: 1998). There was no effort by the government to curb the growth of the private sector. The proportion of private nursing homes and hospitals was insignificant at the time of independence. However, these institutions started growing during the 1970's and were restricted to urban areas and

states where there was capitalist growth in agriculture. The cutback in public spending coupled with government subsidies has resulted in the growth of the private sector at secondary and tertiary levels of care. Not only this, the impact of Muralidharan's committee (1962) recommendations have given green signal to the government doctors to practice private clinics, which would have resulted the growth of private clinics, hospitals and nursing homes. In India, it is mainly an urban phenomenon but in some states there has been a growth in services in peri-urban and even rural areas. This is seen in AP, Maharashtra, Kerala, Gujarat, Punjab and Haryana. In these states, the proportion of private beds is higher than public beds.(Baru, 1998)

Table 1: Percentage Share of Private and Public Hospital beds (India)

S.No.	Year	Private Sector	Public Sector
1.	1973	28.8	71.2
2.	1983	40.7	59.3
3.	1993	57.7	42.3
4.	1996	61.0	39.0

Source:GOI, Ministry of Health and Family Welfare, Health Information of India, Central Bureau of Health Intelligence (New Delhi: Govt of India, various years, Cited from (Baru:2003)

Need for Regulation of Private Sector:

Given the significant presence of the private sector, what are the mechanisms available to regulate its growth and the quality of services provided? In fact, there has been little effort to regulate the private sector at both the national and state levels. Some cities like Mumbai nd New Delhi have passed specific acts for regulating nursing homes and setting certain basic standards for their functioning (Duggal, 1991). However, evn in these ciites where some regulatory mechanisms exist, they have been criticised for being outdated and ineffective.

On the question of regulations, whenever state governments have tried to regulate the private sector, such efforts have met with tremendous resistance from the doctor-owners of these enterprises. As far as the central government is concerned, the only conditions laid down relate to the import of high-technology equipment. The government's condition is that all private hospitals importing medical equipment have to treat a certain percentage of in-patients and out-patients free of cost. However, having laid down these conditions there are no mechanisms by which the government can check whether they are being fulfilled. In a 1996 report, a survey of the larger private hospitals in new Delhi revelad that they had been established with a variety of state subsidies. Most of them had been set up by acquiring land at concessional rates from the Delhi Developemt Authority (DDA). The land was provided on the condition that at least 25 per cent of the total beds would be reserved for treatment of patiens from the weaker sections of society and the other 25 per cent subsidised for the poor. In addition to subsidised land, all these hospitals have also imported high-technology medical equipment without any duty. In 1996, the Delhi admiinsitration took a serious vew of the fact that none of these hospitals were abiding by the stipulated conditions. Howevr, what is ironic is that the

administration has not drawn up the parameters in case of non-compliance by these hospitals.

Apart from the government, the other avenues of control include the Indian Medical Association (IMA) and nascent consumer groups. The Indian medical association has generally represented the interests of private practitioners and therefore have rarely taken up issues for the regulation of privte hosptials. The few times it has taken a stand have always been when the interests of its numbers have been affected. For example, when the government introduced the village health guide schemes, the IMA protected against it on the grounds that the government was promoting quackery.

In the early 1970s, the action committee of the IMA drew attention to the problems of themedical profession in privte practice and wanted the government and health planners to take better cognisance of private practitioenrs and realise their potential in implementing health programmes. Howevr, beyond this there has been little effort by the IMA to raise issues concerning the privte sector. The privte nursing homes' association in Hyderabad in 1990s initiated proposals to standardise costs in nursing homes but this did not get implemented. In fact, in the last two decades, the regulatory mechanism has gone much weaker in all the states in India as corporate hospital culture prevails everywhere.

In regulating the private sector, efforts to ban private practice by government doctrs has also met with resistence. For example, in states of Uttar Pradesh, Bihar, Andhra Pradesh the state governments attempted to ban private practice but failed due to political pressure from doctors. The fact that the medical professionals are both socially and politically an important force and as a result they are able to ensure that their interests are protected.

The only avenue of public pressure is via certain consumer groups which have taken up issues of medical malpractice in both public and privte institutions (Duggal, 1991). However, these groups are few and they face an uphill task in dealing with professionals.

Conclusion:

The idea of private health care can be traced from the pre-independence period on wards. The ruling classes and the elite have patronised the privte doctors of all systems of medicine in Inda. In the post-Indepenence period, the first two decades witnessed growth of public health sector significantly and as a result there was substantial improvement in health standards. Therefore, researhers called the first two decades as golden phase in the health care services. Howevr, fromm 1970s, privte sector grew without any investment in medcal education or medical research in India. The trained manpower from the public sector was opportunistically used by the privte sector apart from seeking state subsidies for the establishment of private hospitals. By 1980s, there was mushrooming of nursing homes and medicum level hospitls. The decade of 1990s witnessed phenomental growth of corporate hosptials across India due to economic liberalization. However, the interests of the capital overtook the interests of sufferers and hence privte sector grew without any accountability . Paradoxically, higher the rate of growth in private sector, the weaker is

the state regulatory mechanism, thus compromising the health needs of the milllions of the poor people.