

Private providers of Healthcare in India: A policy analysis.

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Abstract

This paper aims to critically analyze the role of private providers of healthcare in India, especially the unqualified medical practitioners. Due to the critical shortage of human resource for health, unqualified practitioners play an important role in the delivery of healthcare to a large section of society. But their role is often ignored in policy decisions. This paper also makes some practical recommendations on the inclusion of this semi skilled health manpower in the areas which are underserved by the conventional health care infrastructure. We tried to address the issues of cost and quality of care by private providers. We also examined the increasing role of corporate multispecialty hospitals in large metropolitan urban areas.

BACKGROUND

The debate on the role of private providers in the health sector started after the end of cold war era and change in economic and political philosophy in late 1980s and 1990s. Under the influence of neo liberalism developing countries were persuaded by donor agencies and Bretton Woods institutions to reduce the government expenditures and encourage competition by private providers. Health sector is also influenced by these reforms and World Bank came with its much cited World Development report 1993 which clearly advocates for fundamental change in the role of Government from providing health care to financing health care by encouraging competition among private providers (1). Before that governments were assumed to be responsible for the universal provision of health care. The Alma Ata declaration which was adopted by WHO in 1978 also viewed governments responsible for the provision of equitable access to basic health services through "Primary health care" model, which involved universal, community-based preventive and curative services, with substantial community involvement (2). Even after decades of efforts governments in most of the developing countries were not able to achieve universal health care for various reasons like lack of funds, inefficiency, and scarcity of human resource of health. To bridge this gap between the demand and the supply a massive private sector has emerged.

For profit providers of health care (PPs) is huge area including providers of both clinical as well as non clinical services (like pharmaceuticals, catering, laundry, security etc.) but for the simplicity only clinical for profit providers

are considered in this policy document.

HEALTH CARE DELIVERY SYSTEM IN INDIA

Despite being the second fastest growing major economy in the world, (with a GDP growth rate of 9.4% for the fiscal year 2006–2007) public spending on health care is among the lowest in the world. According to National Health Accounts total expenditure on health care is only 4.63% of Gross Domestic Product (GDP) out of which only 20% is public financed and rest 80% is private expenditure mostly out of pocket expenses (3). India ranks among the top 20 in its private spending on health care out of which 82% is from personal out of pocket money, employers pay for 9% of spending on private care and health insurance share is only 5-10% (4). Lack of public provision has resulted in the emergence of a large unregulated and urban centric curative private health sector which serves about 80% of health needs (5). In the absence of any comprehensive health insurance coverage and increasing cost of health care more than 40% of all patients admitted to hospital have to borrow money or sell assets, including inherited property and farmland, to cover expenses, and 25% of farmers are driven below the poverty line by the costs of their medical care (4). According to the National Family Health Survey II (6), only 23.5% of urban residents and 30.6% of rural residents choose to visit a government health facility as their main source of health care services.

The reason why Indians prefer private providers over public providers is the lack of quality care in public facilities. At primary care level the unavailability of doctors and/or drugs

at the government health centers force the patients to choose the private practitioners. In secondary and tertiary centers overcrowding and lack of quality care in public hospitals are the main reason for choosing the private hospitals. In a recent survey carried out by Transparency International, 30% of patients in government hospitals claimed that they had had to pay bribes or use influence to jump queues for treatment and for outpatient appointments with senior doctors, and to get clean bed sheets and better food in hospital(7)

ECONOMICAL RATIONALE OF FOR PROFIT PROVIDERS

Competition among private providers will bring out efficiency in health care and decrease the welfare loss.

Expanding services to the areas and the groups where public system is not able to cover.

It will bring more resources in health care sector.

Encourage rich and well off people to use private health care will decrease burden the public sector so that resources can be directed to the poor and unprivileged section of the society

New Public Management argues decreasing role of government from provider to stewardship (8).

CHARACTERISTICS OF PRIVATE HEALTH CARE PROVIDERS

Private Health care providers in India can be divided in to the following 4 sub types,

Unregistered quacks: The exact number of quacks is unknown but it is estimated to be more than one million (9). These are ubiquitous in rural areas as well as in urban slums where they are the only sources of health care to the people living on the margins of the society. These quacks described by media as 'Jhola Chhaps' are without any medical qualification and most of them not even completed their basic education. At the most they have assisted some doctor or RMP at the beginning of there 'career' and this is the only source of their information. Because of lack of proper training they usually indulged in many harmful practices like misdiagnosis, misuse of steroids and antibiotics, illegal and unsafe abortions, excessive use of injections and delayed referrals. India does not have a comprehensive law against the quackery many states have different legislation in place but they are seldom get implemented.

Registered Medical s (RMP) and Practitioners of Indian System of Medicine: These are the main health care providers in rural and small towns. RMP have received some basic training and but not the full curriculum. Practitioners of Indian systems of medicine include practitioners of Ayurveda, Yoga, Unani, Sidhha as well as Homeopathy (AYUSH). Current legislation does not allow AYUSH practionner to prescribe allopathic treatment to the patient but it is a wide spread practice. The main source of their information is medical representatives of pharmaceutical companies who frequently brief them about the current medicines(10). They usually run their solo clinics and usually charge patient a consultation fees some times this is only a margin on the price of medicines.

Qualified Medical Practitioners running their solo clinics or nursing homes: They are the main source of health care in urban and semi urban areas they are qualified and provide ambulatory and in patient care in their clinics and nursing homes.

Tertiary care Multi specialty corporate hospitals: These are relatively recent phenomena of big cities and metropolitans. With the favorable policy of providing prime land at a subsidized rate and tax exemptions large corporations, such as drug and information technology companies, and wealthy individuals often from the Indian Diaspora have started venturing in health care market. They now dominate the upper end of the market, with five star hospitals manned by foreign trained doctors who provide services at prices that only foreigners and the richest Indians can afford (11). These hospitals are largely unregulated, with no standardization of quality or costs. Although they have been provided the land and tax exemptions in return of the promise to provide free treatment to poor patients it is not really the case. Media reports often suggest that it is very difficult for poor to get treatment in these facilities. There main contribution is to provide a choice to the persons with ability and willingness to pay a better care and consequently reduction in the burden and waiting list in the publicly funded tertiary centers.

EVALUATION OF ROLE OF FOR PROFIT PROVIDERS

Although private health care providers include all the above mentioned groups but due to the numeric dominance of unqualified practitioners they have been included for the evaluation of for profit providers in terms of efficiency, sustainability, equity and their impact.

Allocative Efficiency: Private health care providers are able

to provide felt needs and expressed demands to the majority of the population. They are able to fill the gap left by inefficient public health care delivery system in ambulatory care as well in in-patient care. Inappropriate treatment due to poor quality which may be potentially harmful in case of unqualified practitioners is a major concern.

Technical efficiency: It is usually relatively lower when direct and indirect costs of patient are included again poor quality of treatment may reduce the technical efficiency driving cost per output higher.

Sustainability: It is evident that private health care providers able to sustain because of their responsiveness to the health care needs of the population and dependency on the willingness to pay of the community.

Equity: Penetration of the unqualified providers to lower income groups and underserved areas (progressive distribution) makes them a potential vehicle for delivering the targeted services to those groups (12). Financial burden are also maximum on those group due to total out of pocket payment.

Health Impact: They over all health impact of profit providers is a debatable topic currently there is no empirical evidence to reach on any robust conclusion but the simple fact that they are the only available help to a large section of population at the time of crisis (ill health) makes argument in their favor.

WHAT ARE THE EVIDENCES

Malaysia: in an empirical study on the role of private s in rural areas authors concluded for profit providers are able to play a significant role in curative care in the rural areas because of their knowledge and contact with the local families and longer flexible operating hours. The excessive use of high cost diagnostic procedures like ultra sound and X-ray were also noted (13). A study by Stop TB department of WHO regarding involvement of private practitioners (PPs) in providing DOTS in DR Congo, Egypt, India, Kenya, The Netherlands and the Philippines concluded an effective role of Private practitioners in combating the TB in low, moderate and high prevalence countries (14). A study on Private practitioners of Karachi suggests that PPs are eager to learn new and rational procedures and provide preventive services (13)

The competition between private providers of health is not always about the optimum clinical care or lower price but

high cost diagnostic technologies and hotel facilities which are responsible for escalation of cost of medical care, the study on the private hospitals of Bengkok has concluded (13).

RECOMMENDATIONS

It is not possible to replace for profit Providers of health by a universal public health care system. The attention should be focused on making their role more defined and complementary to public system in achieving the universal coverage of essential health services. The integration of private health care providers in to existing public programs is the need of hour. For this some initial steps would be

Identification & Resource Mapping: They first thing to do is to maintain and regular updation of a list of all clinical care provider in the area at PHC level with their education, experience and type of services they provide.

Rehabilitation of Unqualified Practitioners with training, capacity building and accreditation to diagnose, treat and refer the specified common health problems with standard protocols.

Monitoring & Quality control is essential to adherence to the code of conduct.

Strict enforcement of anti quackery legislation against those practitioners who do not adhere to the rules.

Incentives for the provision of socially desirable services like notification of communicable diseases, referrals, provision of DOTS for tuberculosis and family planning services, etc may be in the lines of ASHAs under NRHM (15).

Public awareness campaigns to educate consumers about the appropriate treatment and cost of common diseases, quality of care and standard clinical behaviors and encouragement of feed back to public authorities. (They same type of interventions should be adopted for practitioners of Indian Systems of Medicine who wish to practice the modern medicine.)

For dealing with the qualified medical practitioners doing private practice it is important to reduce the cost and incorporation of best medical ethical care in them. Provision of compulsory continued medical education and change in the method of payment is essential. The current method of payment (fee for service) is some how responsible for escalation of cost due to supplier induced demands. These

problems can not be addressed until a strong health insurance market emerges and provider payment method is changed to case payment like DRGs (diagnostic related groups). Government should encourage risk pooling by community based health insurance scheme and private providers of insurance.

Another concern is the uneven standard of quality of these providers which usually never addressed seriously. Professional bodies like Medical Council of India (MCI) has been reported to be extremely slow in processing negligence cases against the doctors (13). With the increasing role of private health care, the implementation of statutory regulation, and the monitoring of minimum standards of private nursing homes and diagnostic centers becomes essential. The judgment of Supreme Court bringing doctors under the preview of consumer protection Act in 1995 is a welcome sign but there is a need of greater awareness of this at ground level.

Contracting out of the areas where public infrastructure is weak to PPs by encouraging them with soft loans and tax exemptions. Critical shortage of doctors in public system can be addressed with contractual agreement with leading PPs of the area to practice in public setting with a monthly payment.

Corporate hospitals should be made to respect their commitment of providing subsidized care to the poor otherwise their no point in giving them tax exemptions and subsidized public lands and facilities. Current method is very ambiguous it can be made transparent by transferring the agreed number of patients from the waiting list of public tertiary care institutions to these hospitals every month.

CONCLUSION

India's large unregulated private for profit market of

ambulatory and inpatient care is largely ignored in public policy. It is not in the interest of the nation to ignore significance of this massive supply of health care resource rather to turn it into advantage of public health. New innovative strategies should be adopted to use these resources for accelerated, technically optimal and financially viable health care delivery to the underserved section of the population.

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