Private Health Care System in India: A Critical System Review

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Abstract

Health care as a public right is the government's responsibility. The Indian public health care system is lacking in fulfilling the health needs of the community at large. The Indian public health care delivery system is weak, and this situation persists even after seven decades of democratic health planning and development. Public health care centers are primarily concentrated in state capitals and district headquarters. This gap is filled by the emergence and expansion of the private health care system. Poor quality of care, no availability of hospital and health personnel, and long waiting times are the main reasons behind the boom of the private health sector in India. Long, low public health expenditure and investment in the health sector and legitimization of the private health sector after the 1990's, are behind the boom of the private sector in India. At present, the private health sector is the main source of health care for both rural and urban households, with seven-tenths of urban and two-thirds of rural households using this sector. People are more likely to visit private doctors or clinics than private hospitals. Serving mainly urban and economically well-off populations; services are not organized and regulated properly; much emphasis on diagnostic tests, surgeries, and hospitals; and focus on medical care, especially curative health services are major reasons of criticism of private health care system in India. Private health providers are diverse in nature. They differ in education and training, their location, medical field, and services provided by them. Private health care system provides more personalized care and are updated with new technology. The Patient's positive perception towards private hospitals is due to quality health services, but they also complain about long waiting hours and too much cost of services. Improving the quality of medical and paramedical education, capacity building, encouraging accreditation or measures to improve quality of care is the need of the hour for country's goals on universal health coverage.

Key Words:

Public health care, Private health care, Health care system, Health rights, Health for all, Quality of care, Accessibility of health care.

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Introduction

The health services are delivered through health system which constitutes management and organizational matter. Health care should be appropriate, comprehensive, adequate, accessible, affordable and feasible (Park, 2015). Since Independence, health care in India has been challenged by the issue of the accessibility and affordability. Health services should be organized to meet the entire population and not merely selected groups. Health services should cover the full range of pramotive, preventative, curative and rehabilitative services. Health care is a public right and it is the responsibility of government to provide this care to all people in equal measure. Comprehensive health care as recommended by Bhore Committee (1946) formed the basis of national health planning in India and led to the development of primary health centers and sub centers. But this health care system is inadequate to fulfill the health need of community at large. This gap is fulfilled by emergence and expansion of private health care system. The shift of private health sector as welfare service to business industry was marked by emergence of big super specialty and corporate hospital.

Private health care system: current scenario

At the time of Independence, private health care system accounts total 5 to 10 percent of total patient care (Rao, 2012). A recent survey report of NFHS-IV (2015-16) in Uttar Pradesh shows that private health sector is main source of health care for both rural and urban households where seven tenth urban and 67 percent rural households is user of this sector (IIPS & ICF-2017). Peoples are more likely visiting to private doctors or clinics 57% than to private hospitals (8%). Similarly, more than 55% households in India do not seek health care from public health care. According to NSS-75th round survey in 2017-18 on household social consumption related to health shows that maximum percentage share of treated major ailments was of private health sector (62 %) alone in which private doctors/private clinic share 41%, and private hospitals share was 21% (MoHFW-2020). Opposite to this, Govt/public hospital share in treatment is only one third (33%) of total type of health care service providers. NSS-75th data also evident that hospitalization for major ailments was more in private hospitals (55.3%) than Govt/public hospitals (42%). Further Private hospitals share in hospitalization was more in both rural (45.7%) and urban (61.4%) areas.

A study of six states confirmed that the proportion of people who went to private health facilities was high, varying between 63 and 83 per cent in three North Indian states (Iyengar and Dholakia, 2011). Private practice of medicine provides a large share of the health services available. The General Practitioners constitute nearly

70% of the medical profession. Public Private Partnership (PPP), privatisation, corporatisation and medical tourism are common new trends in development of modern Indian health care system (Baru,1988). Corporatization of hospitals in country led to the inflationary pressures on the cost of health care. This increases inequalities among different sections of community in access to health care (Baru, 2000).

Factors behind private health sector boom

Indian public health care delivery system is weak even after seven decades of democratic health planning and development. According to rural health statistics in India 2018-2019, average rural population covered by health facilities like SCs (5616), PHCs (35567), CHCs (165702) are below the population norm of 5000, 30,000 & 1, 20,000 respectively (MoHFW-2020). In 2005, against sanctioned post 0f 24,476 doctors at PHCs in rural areas 17.5 % are vacant. This shortage is persisting and becoming less in 2019 when against sanction post of 32,824 doctors this tally reached at 23.5%. This shortage is more or less continued in urban PHCs where vacant position of doctors is 19% in year 2019. Medical colleges, Super specialty hospitals and tertiary health care centers are primarily concentrated in state capitals, district headquarters.

Poor Quality of care is the most important contributing issue to growth of the private health care system. When people are asked why they are not using public health care services, they generally attributed it (i) due to poor quality of care (48%), (ii) no government health facility is nearby (45%) and (iii) waiting time at public health centers are too long (41%) as major reasons for not using public health facilities. While facilities time is not convenient(26.4%), health personnel are often absent(14.8%), no drugs available, no female health provider are other reasons for not using government health facilities (IIPS&ICF-2017). Experience and perceptions of quality of health care positively affect the utilisation of health care services they received. Women and men recently visited a health facility reported overall same satisfaction with quality of care. However, median time for public health sector is just double than private sector (15.2 minutes) and furthermore, only 45.5% men visitors reported public health facility was very clean than public health facility (74.7%). So, it is clear that private care providers compete with private providers in context of quality of care and private sector is perceived as better quality health service provider by many more.

Low public health expenditure and investment in health sector resulted in inadequate and outdated infrastructure, severe shortage of human resources and high out of pocket of expenditure by households. The Total Health Expenditure (THE) constitutes current and capital expenditures by public and private sectors

providing health care in India. According to National Health Accounts (NHA, 2016-17), the total health expenditure as percentage of GDP has been decreasing from 4.2% in 2004-05 to 3.8% in 2016 -17 (MoHFW-2020). The per capita THE was highest in Kerala at Rs.8083 while lowest in Bihar at Rs.2358. Government Health Expenditure is always disappointing in country. It was only 1.2% of GDP and 32% of the total health expenditure. In 2016-17 Per capita Total health expenditure was Rs. 4,381and Government health Expenditure was Rs.1418 only. The maximum government spending on health is highest in Uttar Pradesh then Maharashtra and Tamilnaadu. Household Out of Pocket Expenditure – OOPE- (amount directly spent by households at the time of receiving health care) was 2.2% of GDP and Rs. 2570 per capita. There were prominent interstate differences in out of pocket expenditure on health. Further, the share of OOPE against the Total Health Expenditure was highest In Bihar (77.6%) then Punjab (77.3%) against national average at 58.7%.

Government policies are legitimizing privatization on the name of health care reform. After 1990's with the implementation of structural adjustment policies health care expenditure is under attack and government is withdrawing away from the responsibility to provide health care to all. National Population Policy (2000) advocates partnership between NGOs and private sector organizations including corporate houses. National Health Policy (2002) encourages private investment in health sector to increase availability and coverage especially super specialties. National Rural Health Mission (2005) and National Urban Health Mission (2013) were planned to achieve its goal through public private partnerships with NGOs & health providers to make full use of health care resources. PPP are now part of execution of various national health programmes like Directly Observed Therapy Short Course (DOTS), Revised National Tuberculosis Control Programme (RNTCP), private gynecologist in Reproductive and Child Health (RCH) Programme/Janani Suraksha Yojana (JSY). The National Health Policy (2017) advocates a "positive and proactive engagement with the private sector for critical gap filling towards achieving National goals". In this policy private sector engagements goes beyond contracting and purchasing and even more.

Public-Private Partnerships (PPP) are flourishing in health insurance sector in India. Private health insurance as percent of THE is increasing at 1.6% in 2005-06 to 4.7% In the same period, health Insurance coverage in India is increasing at 5% to 29% (IIPS&ICF-2017). In Uttar Pradesh only 6% of household have any kind of health insurance that covers at least one member of household which is 8% in urban UP & 5% in rural UP (IIPS&ICF-2017). *Ayushman Bharat*-a national health protection scheme-which will cover over 10 crore poor families will, allowed taking

cashless coverage up to 5 lakh rupees per family per year for secondary and tertiary care hospitalization from both public and empanelled private hospitals. But only few private institutions joined the scheme because of the low reimbursement rates, it is less beneficial and also a high risk business.

The Government of India directly-indirectly providing support and concessions to corporate hospitals in the form of subsidized sale of land, reduced import duties and tax concessions for medical research (Baru, 2000). Other benefits received by the private sector include reduced utility charges, discounted or free land, and low-interest loans (Chakraborty, 2003). In Andhra Pradesh Private corporate hospitals receive large amounts of public funds in the form of reimbursements from public sector undertaking, state and central governments (e.g., the Central Government Health Scheme CGHS) for treating their employees (Narayana, 2003). Private hospitals are replacing rather than complementing public hospitals by weaning away resources from government hospitals,

Current criticism of private health care system

Private health care services are located mainly in urban areas. Accessibility and availability of health care is important for ensuring its people health status and use of health care services. Private health care providers are mainly concentrated in (both bigger and smaller) urban centers like states capitals, metropolitan cities, district headquarters, tehsils and towns (Kumar, 2002).

Private health care services are available to those who can pay. Cost of treatment in private sector is too much higher than any health care system. According to Health and Family Welfare Statistics In India 2019-20, doctor's /surgeon's fees is more than thirty times higher in private hospitals (Rs.5,812) than public hospitals (Rs. 185) .Similarly, average bed charge of hospitalization in private hospitals is twenty eight times higher (Rs.3,777) than that of public hospital (Rs.135) (HFWS, India 2019-20:136). According to NFHS-IV Survey, average out-of-pocket cost paid for delivery in a health center was Rs.7,935. However, in private health facilities it was five times as high as in public health facilities (HFWS, India 2019-20:111). This difference further continued in average medical expenditure per case hospitalization of (non childbirth hospitalization) of major ailments. The average medical expenditure per hospitalisation case is Rs.31,845 in private hospitals which is more than seven times expenditure per hospitalisation in govt/public hospitals (Rs.4,452). Private-public difference is not only high in hospitlisation but also in expenditure on treatment of ailments not involving hospitalization. Expenditure on treatment of ailments not involving admission in hospital is highest in private hospital (Rs.1062) then trust/NGO run hospitals and private doctor/clinics and lowest in Govt./ public hospitals (Rs.331) .

Private health services are accessible only to a small part of population. Percentage share of the class in total number of hospitalization (excluding child birth) shows that hospitalization share increase with the increase in class of households and rural-urban divide clearly evident in hospitalization of all class of population. Highest 20% of population has nearly two times more share in hospitalization in comparison of lowest 20% population. NSS-75th round data on major sources of financing of hospitalization expenditure categories them in household income/savings, borrowings, contribution from friends and relatives, sale of physical assets and others sources mainly. When the hospital expenses of low income group and rural people are not met from their household income/savings they borrowed it from outside or sell their physical assets more than the high income group which took help from friends and relatives mainly. In all these sources of financing poor, rural and marginalized people are low that's why private health services are limited to well off family more and out of reach from poor's.

The Health care services are not organized and regulated properly. Medical Council of India (MCI) and Indian Medical Association (IMA), Nursing Council of India (NCI), and the Pharmacy Council of India (PCI) regulate some of the actions and functions of large body of their related health professionals. However, these regulatory bodies are not much effective in maintaining educational standards and monitoring the competencies of those registered with them. The report of Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure for the 11th Five-Year raised the serious concerns relating to enforcement, effectiveness and implementation of the Clinical Establishment Act, 2010 (Planning Commission, 2007: 11–12).

Private doctors/hospitals give *much emphasis on Diagnostic tests, surgeries and hospitalization*. These are the major components of expenditure in private medical care. In urban areas of country, two-third caesarean childbirth took place in private hospitals. Similarly, in rural areas caesarean and other complicated institution deliveries took place more in private hospitals than public hospitals (HFWS, India 2019-20:111).

Private health care provides mainly medical care and mainly curative health services. Medical care refers to those personal services that are provided directly by physicians or rendered as a result of the physician instruction. Health care is implies more than medical care. This includes the all health services available to people for promoting, maintaining, monitoring or restoring their health. So it is clear that health extends beyond the narrow limits of medical care.

Private health Sector: Type & Quality of Care (QoC)

Private Health Care System is vast and diverse in nature. Private health care providers differ very much in education and training, their location, medical field they belong and services provided by them (Kumar,2002). These can be broadly categorized into two parts as follow:

***i) Individual Practitioners*:** They are from both modern and traditional medical system known as Registered Medical Practitioner (RMP). This includes private doctors, private clinic, private paramedic, AYUSH, traditional healer, pharmacy/drug store & others (NFHS-IV).

***Strength*:** High on access and often are the first choice of contact of locals. Private Medical Practitioner (PMP) is patient centric offer acceptable services. They enjoy the confidence and trust of the patients, therefore get their loyalty and mouth publicity in the local community (Kumar,2002).

***Weakness*:** Greater part of PMP is unqualified and lack appropriate training, particularly those in rural or urban slum areas (Rao, 2005). Competency of PMP is highly questionable and variable. Safety is often at risk due to irrational practices. Money for nothing i.e. lots of expenditure on unnecessary things is common component of their practices.

***ii) Institutions* (*Nursing Homes and Hospitals*):** On the basis of profit motive, these can be further divided in two parts as follows:

***For profit hospitals*:** Nursing Homes, General & superspeciality Hospitals, Corporate or Mega Hospitals. During the last three decades, the number of private hospitals has significantly increased especially corporate chains like Apollo, Fortis, Indira IVF and Max among others (Baru, 2000). However, the majority of private sector hospitals are small establishments.

***Not for profit hospitals*:** NGOs, Missionaries/Charity Hospitals and Nursing Homes.

***Strength*:** Highly qualified and better-trained physicians and Para-medical staff possessing good technical skills are supposed to be the main strengths of private sector hospital. Patient satisfaction is more in comparison to public hospitals. Due to better accessibility in distance, and timing responsiveness to patient's particularly in emergency, private hospital are more approached (Kumar,2002).

***Weakness*:** Most private hospitals lack in land area and space per bed; lack of qualified and trained nurses and paramedical staff; located mainly in cities towns and developed areas. Unnecessary surgeries and deliveries through sygerian, delay in referral and discharge are common practices for monetary gain. Safety is a

matter of worry in private hospitals. The high cost of impatient treatment in the private sector raises the issue of affordability and also equity.

WHO (2006) recommends that "a health system should strive to make improvements in six dimensions—namely, (a) effective (adherence to evidence base and results in improved health outcome), (b) efficient (maximize resource use and avoid waste), (c) accessible (timely and geographically reasonable), (d) acceptable/ patient-centered (takes into account individual preferences), (e) equitable (does not vary in quality due to factors such as gender and socioeconomic status) and (f) safe (minimizes risk and harm)—in order to improve the quality of care" (Rao, 2012:16). Encouraging and supporting private hospitals in India to get accreditation is an important enabling mechanism to improve the quality of care. Accreditation works better than legislation and self-regulation (Dogra, 2004).

The private health sector is generally assumed to be more efficient, effective, quality conscious and patient centered. Private sector hospitals claim also this. However, trust, superspeciality and corporate hospitals that provide true quality of medical care are small in number. It seems to be compromised many times. In private health care, due to a business unit, patient pay the price of this quality of care. Studies revealed the patient positive perception towards private hospitals due to qualitative health services, but also complain about long waiting hour and increase cost of services. It is a paradox. Peoples from urban areas, highly educated and upper socioeconomic strata are closest and rural areas and marginalized people are the remote ends of it. Private health care system provides more personalized care and update with new technology. Private health care due to their smaller size and patient centric approach, are more equipped to offer personalized care. Instead of being responsible for many dozens of patients, nurses and paramedic staffs have only a few to care for at a time. Waiting times tend to be short and certain, and doctor-to-patient ratios are generally better.

Conclusion

The private health care sector is fairly large and growing continuously in 21st century capitalistic India. The private health care has improved accessed to medical and health care one side and also raise challenges to public health system-universal health care for all - another side. Hospitals and nursing homes need to be set up in such a way that their location is not concentrated in urban and developed regions only. Instead of political pressure, use GIS for arriving at decisions regarding the appropriate location of new health facilities in the city so as to improve accessibility. Improving the quality of medical and paramedical education, capacity building encouraging accreditation or measures to improve quality of care is the

need of the hour. Both central and state government needs to develop centralized system and mechanism to monitor Quality of Care and standard and guidelines. The complexity and diversity of the private health systems is another important challenge. The specific policy approaches are needed to engage and manage vast and diverse private health sector so that it will work as crucial resource for country's goals on universal health coverage.

References

1. Baru, V. (1998): *Private Health Care in India: Social Characteristics and Trends*, Sage Publication, New Delhi.
2. Baru, R.V.(2000).*Privatization and Corporatization*. Seminar 489 May. Available online at: http://www.india-seminar.com/2000/489/489percent20baru.htm.
3. Chakraborty, S. (2003): "*Private Health Provision in Uttar Pradesh, India*." In A. S. Yazbeck and D. H. Peters, eds., Health Policy Research in South Asia: Building Capacity for Reform, 257–77. Washington, DC: World Bank.
4. Dogra, S. (2004): "*Delhi Houses 1,600 Unregistered Nursing Homes: Survey*."

a. Express Healthcare Management 5 (4): 1–8. Available online at: http://www.

b. express pharmapulse.com/20040304/healthnews03.shtml

5. International Institute for Population Sciences (IIPS) and ICF (2017): "Morbidity and Health Care." In *National Family Health Survey (NFHS-4), 2015-16: India.* Ch. 11. Mumbai: IIPS
6. International Institute for Population Sciences (IIPS) and ICF (2017): *National Family Health Survey (NFHS-4), India, 2015-16: Uttar Pradesh*. Pg. **24&145-146**, Mumbai: IIPS
7. Iyengar S. and R. H. Dholakia. (2011): "*Access of the Rural Poor to Primary Healthcare in India.*" Working Paper No. 2011-05-03, May. Indian Institute of Management, Ahmadabad.
8. K. Park. (2015): *Park's Text Book of Prventive and Social Medicine*. Jabalpur : M/s Banarsidas Bhanot,. 23rd Edition.
9. Kumar, S. (2002): *Socioeconomic Status and Health: A Study of a Village in Eastern UP*. An Unpublished MPhil dissertation submitted to CSMCH,SSS, JNU, New Delhi.
10. MoHFW (2000): *National Population Policy, 2000*: Department of Family welfare, Ministry of Health and Family Welfare, New Delhi.

11. MoHFW (2002): *National Health Policy 2002*: Ministry of Health & Family Welfare. New Delhi.
13. MoHFW (2005): *National Rural Health Mission: Meeting People's Health Needs in Rural Areas. Framework for Implementation, 2005–2012*: Ministry of Health & Family Welfare, New Delhi.
14. MoHFW (2017): *National Health Policy 2017*: Ministry of Health & Family Welfare, Government of India, New Delhi.
15. MoHFW (2020): Major Findings of *NSS-75th Round (2017-18):* Household Social Consumption in India: Health, In *Health and Family Welfare Statistics* in *India 2015-16:* Section D*,* Ministry of Health & Family Welfare, Government of India, New Delhi.
16. MoHFW (2020): National Health Accounts *(NHA, 2016-17):* Health Financing Indictor, In *Health and Family Welfare Statistics In India 2015-16:* Section F*,* Ministry of Health & Family Welfare, Government of India, New Delhi.
17. MoHFW (2020): *Rural Health Statistics in India (2018-2019):* Health Infrastructure from Different Sources, In *Health and Family Welfare Statistics In India 2015-16:* Section E*,* Ministry of Health & Family Welfare, Government of India, New Delhi.
18. Narayana, K. V. (2003): "*Changing Health Care System*" Economic and Political Weekly, 22 March–28 March and 29 March–4 April (double issue), Pg. **1230–41.**
19. Planning Commission (2007): *"Report of the Working Group on Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure for the 11th Five-Year Plan*." New Delhi: Planning Commission, Govt. of India.
20. Rao, P. H. (2005): *"Private Medical Practitioners in Rural India: A Profile*." Health and Population Perspectives 28 (1): Pg. **40–49**
21. Rao, P. H. (2012): "*The Private Health Sector in India: A Framework for Improving the Quality of Care*." ASCI Journal of Management 41 (2): Pg. **14-39**
22. World Bank (2001): *"Raising the Sights: Better Health Systems for India's Poor."* Health, Nutrition, Population Sector Unit India, South Asia Region. Washington, DC: World Bank.
23. World Health Organization (WHO, 2006*): "Quality of Care: A Process for Making Strategic Choices in Health Systems.*" In Basic Concepts of Quality, Ch. 2. Geneva: WHO