Title:

Changing Landscape of Private Health Care Providers in India: implications for National Level Health Policy

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Introduction:

The debate regarding private sector engagement has evolved significantly in the last four decades. The three National Health Policies (1983; 2002 and draft 2015) initiated so far reflect the changing nature of private provisioning and increasing might of the private sector in shaping policy discourses. For instance in the first National Health Policy of 1983 (NHP 1983), reference to private sector figure as an issue of private practice by government doctors and possible ways to motivate government providers to give up the same. Within a span of two decades, expansion of private sector was seen as a welcome development (NHP 2002). The underlying premise was supposed supremacy of market mechanisms over state in providing health care- reflecting the ascent of neo-liberal thinking in health policy discourse. Thus public private partnerships in various forms, providing various incentives for growth of private sector were recognized as essential instruments for health sector development. The draft NHP of 2015 takes the pro-private sector argument further and proposes to engage private sector in public provisioning and financing through purchasing mechanisms, giving it a permanent place in health care delivery (GoI 2015). Furthermore, the growth of private sector is glorified and celebrated in NHP 2015, it is seen as a driver of economic growth.

Barring few studies, evidence on size, location, structure and composition of private sector is really limited, whereas evidence on quality of care and efficiency are also inadequate to say the least. On the other hand, from household surveys conducted by National Sample Survey (42^{nd}, 52^{nd} and 60^{th} rounds) increasing dependence of people on private sector for curative health services is clear. By now the consequences of private provisioning and lack of financial protection in seeking care in terms of increasing impoverishment, enhancing economic hardship and untreated ailments and avoidable mortality are well-known (KS Rao 2005; Sakthivel 2009; Charu 2009). Lack of data and information on private provider is evident from the fact that there is no reliable estimate of the size of private sector in India. The objective of the study is to create a broad estimate of the size, structure and composition of private providers in India, using two important data sources namely, the IMS Hospital Census and NSSO survey.

Private sector health care in India is characterized by plurality in terms of systems of medicine and the forms of practice (Baru 1998). The private sector encompasses all and sundry- from for-profit large corporate entities, not-for-profit trusts (private and religious), to general practitioners of all hues – qualified specialists, unqualified rural medical practitioners – chemists and diagnostic laboratories, etc. It is interesting to note that most of these health providers are involved in providing curative care addressing various market segments. Even before Independence, the single largest category of providers consisted of private practitioners across allopathic, *ayurveda*, *unani*, *siddha* and homeopathy. These individual practitioners, both qualified and unqualified, essentially provide primary level, outpatient care and are located in both rural and urban areas. These practitioners provide primary level curative services of extremely variable quality across urban and rural areas in the country (ibid).

The secondary level of care in the private sector is provided by nursing homes with a bed strength ranging from 5 to 50 and is promoted by single owners or partners. While in most states they are largely an urban phenomenon, in other states, where private sector

growth (relative to public sector) is high, they have spread to even urban peripheries and rural areas. Studies conducted in Hyderabad and Chennai reveal that most of these nursing homes offer general and maternity services and are managed by doctor entrepreneurs (Baru 1993; Muraleedharan 1999). Within this category there is a further division between small and large nursing homes, which differ widely in terms of investments, equipment and facilities, range of services offered and quality of care. Most of these promoters are qualified doctors who have located these enterprises in urban and semi-urban areas. The tertiary level of care consists of multi-specialty hospitals that are promoted by partners or as private limited or public limited enterprises. These are mostly located in the metropolitan cities. The dominance of the private sector is felt almost in every sphere of the health system – be it in financing, provision, medical education & training, medical technology & diagnostics, manufacture and sale of medicines, etc. (Rao et. al 2005).

Materials and methods:

In terms of its organization, private sector can be divided into three broad categories- the unorganized sector providers, organized sector providers and corporate sector. In

order to capture the diversity, magnitude and structure of private health care sector in India we have used different data sources, because no single data source exists for capturing both organized and unorganized sector providers. Survey of unorganised enterprises conducted by the National Sample Survey Organisation (NSSO) covers enterprises operating in service sector including health sector (GoI 2000-01, 2006-07 and 2010-11). There are three rounds of surveys which provide data for the years 2000-01, 2006-07 and 2010-11. Some of the salient aspect of the survey are it collected information/data on number of enterprises and workers, in addition to operational features of the service sector enterprises, such as, the location of the enterprise, ownership pattern, registration details of enterprises, number of working hours, etc. A multi-stage stratified random sampling framework was adopted to collect enterprises in the service sector. The number of enterprises surveyed in the health sector was 11,931 out of a total of 190,282 units in the service sector in 2006-07. This accounted for roughly 6.27% of the total service sector enterprises. The survey included all health sector enterprises which were involved in health and medical services but excluded government-owned, public sector undertakings, local bodies, irrespective of the systems of medicine (whether allopathy or non-allopathy). The survey covered a broad spectrum of enterprises from private dispensaries, clinics and consultation chambers run by doctors.. Interestingly, the survey collected information/data on units engaged in veterinary activities.

The other data source which lists corporate hospitals in the country is the Centre for Monitoring Indian Economy data source, though its coverage is limited and does not provide the depth of health care related information on these incorporated entities. However, neither NSSO nor the CMIE estimates include the majority of organized private sector in the country. Census of hospitals both public and private for 62 cities of the country conducted by IMS Health India for the year 2012 was used in this study. This is the first census of any kind that has enumerated organized private hospitals in the country and it covered all the registered health facilities that provide inpatient care under government, private not-for-profit and private for-profit. Altogether 14121 hospitals were surveyed with detail information on available facilities within the hospitals with special focus on number of beds, number of nurses and doctors working in the hospitals. Population figure for the cities was taken from census of India for the year 2011.

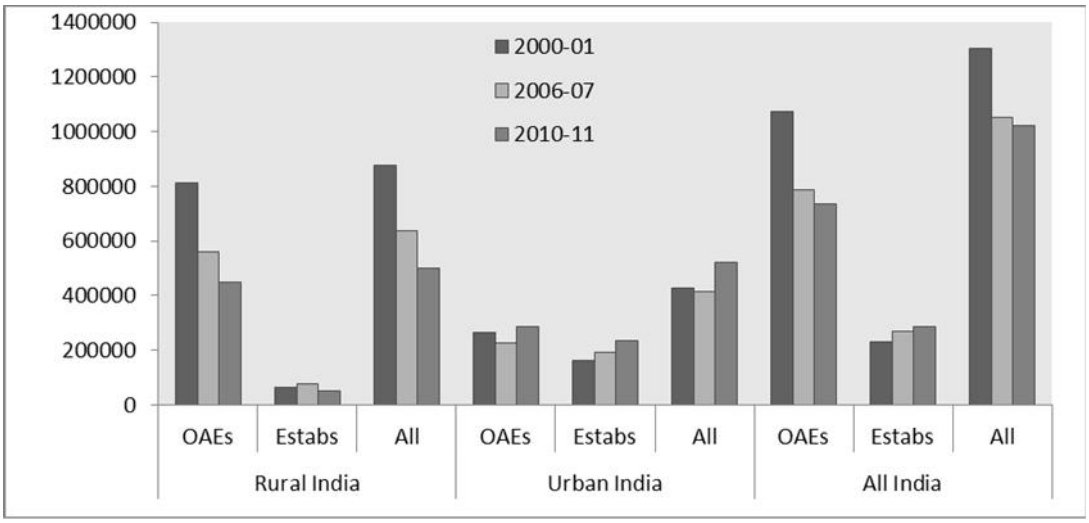
Results: the unorganized health sector in India

Recent evidence from surveys of the informal sector by the National Sample Survey Organisation (NSSO) shows that there were an estimated one million private health care providers employing about 1.99 million workers during 2010-11. Seventy two percent of all enterprises are micro in nature, called the Own-Account-Enterprises (OAEs), while the rest are composed of medical establishments. OAEs are individual or household run business providing out-patient services without hiring a worker on a fairly regular basis. Of the one million enterprises, less than half of the enterprises are found in rural areas while the rest are present in urban India.

According to the NSSO survey estimates, in 2001-02, all thepractitioners and facilities put together were approximately 1.3million unincorporated enterprises providing health services in the country, excluding public facilities. Four out of every five enterprises (1.1 million) were Own Account Enterprises (OAEs) and the rest were (0.23million) establishments (figure 1)[i]. An overwhelming majority (eighty per cent) of the OAEs were located at the villages where as most of the establishments are in the urban areas. As per the 2006-07 survey, number of unorganized enterprises had declined to 1.05million. This decline is mainly on account of a decline in OAEs (0.78 million), whereas number of establishments has increased (0.27 million). Thus between 2000-01 and 2006-07 more than 40,000 new establishments had come up, largely in the urban areas. At the same time OAEs have gone down by almost 0.3 million.

Similarly, 2010-11 survey shows further decline in total number of enterprises to 1.02 million. Number of enterprises declines significantly in rural areas compared to the previous round. Between 2006-07 and 2010-11, enterprises in rural areas declined by 0.14 million, majority of which are OAEs. On the other hand, number of enterprises in urban areas has increased by 0.11 million, with additional 45355 new establishments being added. By 2010-11 less than half of the total enterprises (49%) are located in rural areas, down from more than two third (67%) a decade back. These clearly point out that rapid transformation towards organised forms of production taking place in urban areas of the country, while the OAEs declining in number.

Figure 1: Number of enterprises by type and location: 2000-01, 2006-07 and 2010-11



Source: Unit records, various rounds of NSSO: 57th Round, 63rd round and 67th round.

Health care providers have been categorized into six sub-categories as per the National Industrial Classification (NIC 2008) based on largely one activities, but it also includes individual practitioners. out of the 1.5 million medical institutions, little less than two third (64 percent) of these enterprises are either hospitals[ii] or medical care facilities practicing Allopathic systems of medicine[iii]: while over one-fifth of all enterprises are engaged in practicing AYUSH (Table 1). AYUSH practitioners included Homoeopathy practitioners (11 percent), followed by Ayurveda (8 percent) and Unani Practitioners (2 percent). The other major providers are nursing and physio-therapy institutions, which accounted for about four percent of all providers.

Table 1: Distribution of Health Care Providers by main activity (%)

	OAEs			Eshtablishments		
	2000-01	2006-07	2010-11	2000-01	2006-07	2010-11
Hospital activities	0.6	1.2	3.6	15.5	14.9	18.8
Medical and Dental practices	50.5	47.2	63.3	58.8	47.1	53.4
AYUSH practitioners	27.8	24.2	23.0	13.3	18.1	14.1
Nursing and physio-therapy[iv]	14.9	14.4	5.0	1.6	7.3	1.8
diagnostics/ pathology[v]	1.3	2.3	2.4	9.3	11.3	9.9
Others	4.9	10.7	2.5	1.6	1.3	1.8

Total	100	100	100	100	100	100

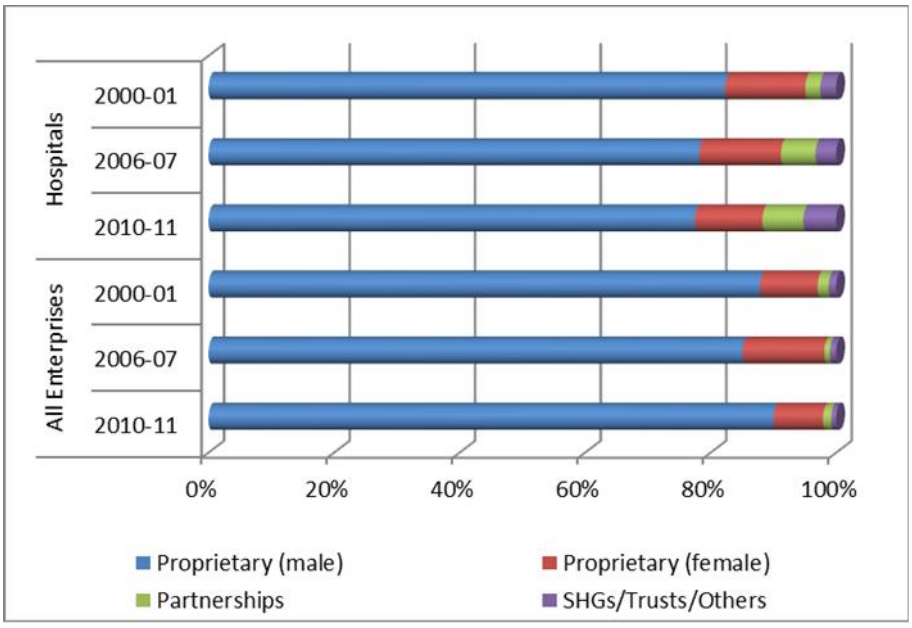
Source: Unit records, various rounds of NSSO: 57th Round, 63rd round and 67th round.

Between 2000-01 and 2010-11, share of enterprises engaged in hospital activities has increased significantly. Almost a fifth of all establishments are now engaged in hospital activities compared to 15.5 percent in 2000-01 and number of establishments engaged in hospital activities has more than doubled during the same period. Share of enterprises engaged in medical and dental practices have gone down among establishments whereas it has increased in OAEs (Table 1).

Share of AYUSH practitioners in OAEs have gone down from 27.8 percent to 23 percent between 2000-01 and 2010-11, so has the number of OAEs engaged in AYUSH have also gone down significantly. Similarly share of Nursing and physio-therapy centres have gone down considerably among OAEs. Two clear trends emerge from the above data- number and share of establishments engaged in hospital activities has increased and similarly OAEs engaged in AYUSH have decreased. This clearly suggests that health care sector is transforming towards more formal structures from the erstwhile predominance of informal providers.

The predominant ownership pattern in India's unorganized private health care delivery system is proprietorship. As health enterprises are dominated by the presence of huge number of OAEs in the private health care system in India, solo private health providers usually run by a single physician accounted for 98 percent of all health enterprises put together. Partnership and private limited company accounted for a paltry one percent and 0.2 percent respectively. Overwhelmingly large majority of the individual proprietors are men and very few of them are women.

Figure 2: Ownership Pattern of Health Enterprises in India (2000-01, 2006-07 & 2010-11) (% share)

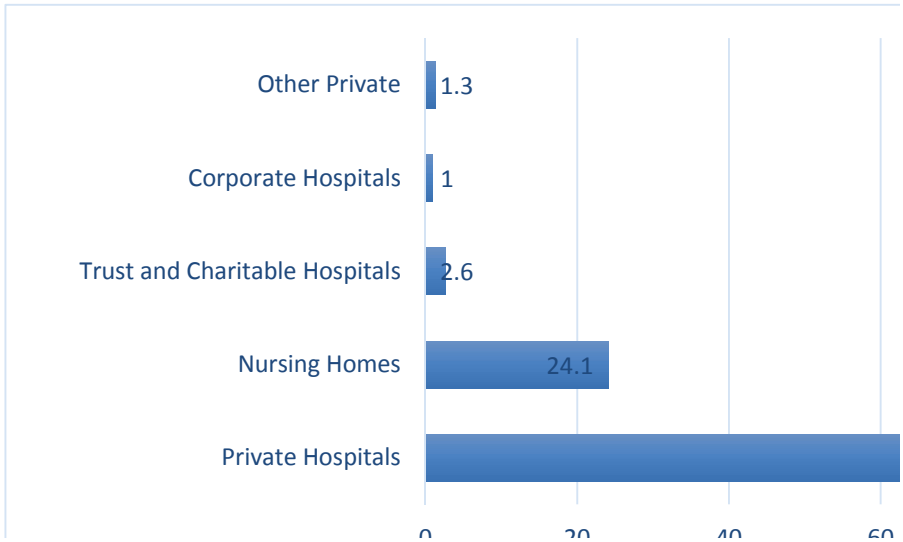


In the case of hospitals, the ownership pattern exhibits slightly different scenario, where proprietorship mode accounted for roughly 88 percent in 2010-11, partnership and private limited company taken together took a share of around 6.5 percent and trust hospitals 5.2 percent. It is interesting to observe that nearly all of ISM (Indian System of Medicine consisting of Ayurveda, Unani and Homeopath practitioners) enterprises are predominantly owned and operated by solo-proprietorship. Furthermore we observe an increasing share of partnership and limited companies among hospitals.

Organised private health care sector:

IMS census conducted in 62 major cities of the country during 2012 reveals that there were 14121 hospitals and out of which around 13413 hospitals fell under private sector contributing to almost 95 percent of the total hospital facilities in these cities. These Private facilities were not homogeneous in nature and it ranges from small nursing home to a big corporate hospitals. Among the different types of hospitals, private hospitals were in majority with the share of around 71 percent followed by the nursing homes with 24 percent. Trusts and charitable hospitals contributed to around 3 percent and corporate hospitals 1 percent.

Figure 3: Types of private hospitals (In %)



Source: Authors' calculation based on unit records of IMS hospital census

Private hospitals have shown variation in terms of in house facilities such as bed facilities as well as human resources that they have. In case of bed facilities across the health institution private hospitals had highest number of hospital beds followed by nursing homes. The average number of beds on the other hand was highest in corporate hospitals as compared to other type of hospitals. Corporate hospitals at an average had 177 beds much higher than trust and charitable hospitals which is placed second with average of 68 beds followed by private hospitals with 35 beds and nursing homes with 17 beds (table 2). Corporate hospitals not only had the highest bed strength but it also had very high variations ($\sigma = \pm 47$) compared to other health institutions where the variation was relatively lower.

Table 2: Beds across different types of private hospitals

	Total No of Beds	Std. Deviation	Mean	*(95 % confidence Interval)*
Private Hospitals	333352	17.761	35.0	*33.2-36.7*
Nursing Homes	44344	2.506	13.7	*13.3-14.2*
Trust and Charitable Hospitals	23884	22.831	67.9	*58.0-77.7*
Corporate Hospitals	22998	47.446	176.9	*148.7-205.1*

Other Private	1026	0.602	6.1	*5.3-6.8*

Source: Authors' calculation based on unit records of IMS hospital census

Number of nurses also varied across the health facilities. Highest number of nurses were present in private hospitals where 64874 nurse were working followed by nursing homes with 6998 nurses. But in case of average availability of nurses it was the corporate hospitals with 54 nurses at an average leading the pack followed by trust and charitable hospital with 22 nurses at an average. Private hospitals had 12 nurses on an average and it was lowest in case of nursing homes with 5 nurses (table 3). Corporate hospitals not only had highest number of nurse per facility but it also had highest variation across the facilities ($\sigma = \pm 64.6$) as compared to other hospitals.

Table 3. Nurses Across different types of Private hospitals

	No.	Std. Deviation	Mean	*(95 % Confidence Interval)*
Private Hospitals	64874	30.2	12.0	*11.2- 12.8*
Nursing Homes	6998	6.3	5.5	*5.1-5.8*
Trust and Charitable Hospitals	5273	40.9	22.4	*17.2-27.7*
Corporate Hospitals	6491	64.6	53.6	*42.0-65.3*
Other Private	63	3.2	3.3	*1.8-4.9*

Source: Authors' calculation based on unit records of IMS hospital census

Private hospitals with 34498 doctors had the highest number of doctors across different facilities. The corporate hospitals, even though contributed to merely one percent of total hospitals, was second in terms of number of doctors. There were 3413 doctors in corporate hospitals with average availability of 29 doctors per facility which was highest across the facility. Average availability of doctors in corporate hospitals was more than double of average of 10 doctors that was available in trust and charitable hospitals which were placed second (table 4). In terms of variability in number of doctors across the facilities corporate hospitals have shown highest variation ($\sigma = \pm 47.4$).

Table 4. Doctors Across different types of Private hospitals

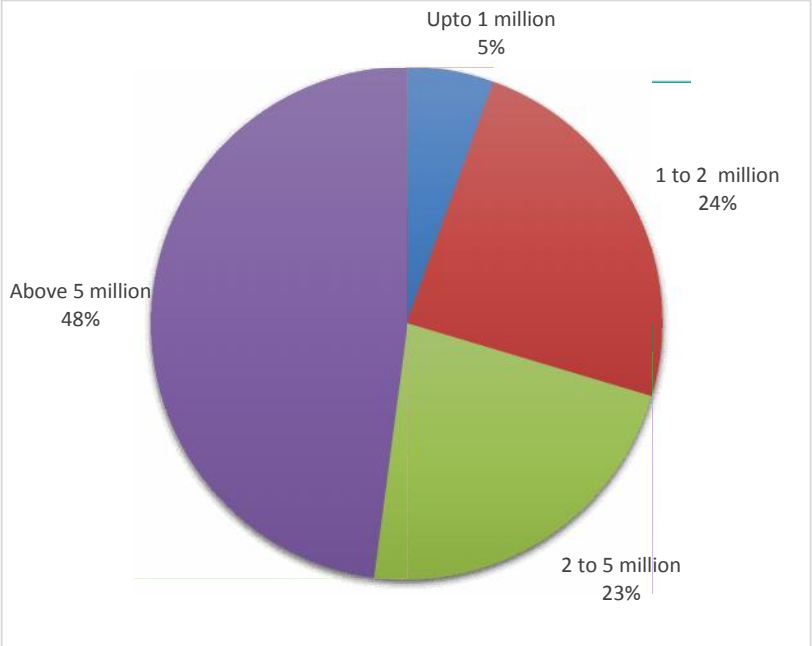
	No.	Std. Deviation	Mean	*(95 % Confidence Interval)*
Private Hospitals	34498	17.8	6.5	*6.0-7.0*
Nursing Homes	2984	2.5	2.4	*2.2-2.5*
Trust and Charitable Hospitals	2455	22.8	10.4	*7.5-13.3*
Corporate Hospitals	3413	47.4	28.9	*20.3-37.6*
Other Private	25	0.6	1.2	*0.9-1.5*

Source: Authors' calculation based on unit records of IMS hospital census

Location of Private Hospitals

Cities in India are not homogenous in nature. They vary in size as well as in the nature of development. Division of cities on the basis of population is a common practice in India that is adopted to show the extend of growth of cities. In our samples we have range of cities that represent the upcoming urban space to big metro cities that has more than 5 million of population. In order to see the availability of private hospitals, cities were divided into four categories on the basis of population. Majority of private hospitals services are located in the bigger urban centres, around 48 percent of these facilities are located in big cities that has population more than 5 million. Presence of private facilities is least in relatively small urban space where population is less than 1000000. It is the million plus cities or the big cities that has most of the private health services. The detail list of cities and total number of hospitals under private sector is given in appendix1.

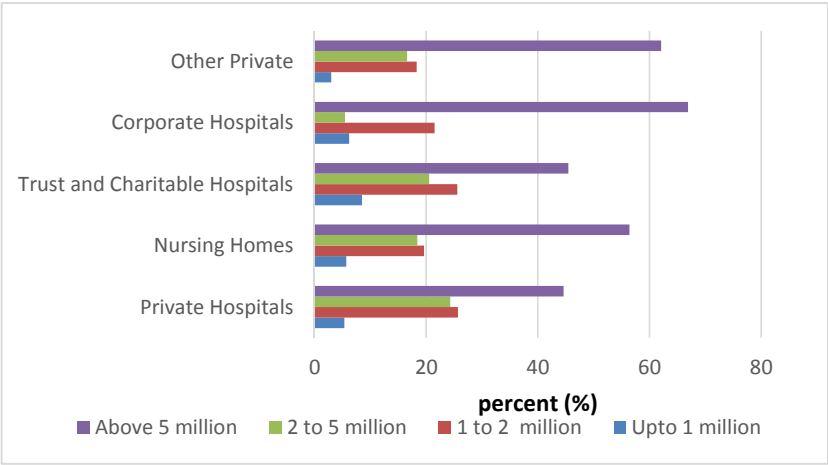
Fig 4. Concentration of Hospitals in Cities



Source: Unit records IMS Hospital Census

Among the different health facilities again the concentration is highest in big cities or the cities with more than 5 million population. The distribution is most skewed in case of corporate hospitals as around 67 percent of them are located in the big cities. Some of the notable big cities include the four metros, ie Mumbai, Kolkata, Delhi and Chennai and upcoming metros such as Ahmedabad, Bangalore and Pune. Mumbai had shown highest presence of health facilities among all the big cities. Mumbai alone has 2119 facilities out of 13413 private facilities across the cities contributing to around 16 percent of total health facilities.

Figure 5: Hospital types and size of the Cities (% distribution)



Source: Authors' calculation based on unit records of IMS hospital census

Discussion:

The paper clearly brings out the diversities in private health care sector in India as well as provides a reasonable estimate of providers in the country. The 62 cities covered in the census are major cities of the country covering more than forty percent of the population. At the same time these are also the cities with higher penetration of organized private sector. On the other hand the unorganized sector data complements the census data, covering the major part of the smaller providers in urban locations and entire rural private sector. It can be safely assumed that the penetration of organized private health care sector would be limited in the rural areas. While the urban metropolitan areas are endowed with corporate hospitals and organized private sector, in rural areas large part of the providers are individual practitioners in unorganized sector. Corporate hospitals consist of only one percent of total establishments, but they have five percent of beds and employ as much as eight percent of doctors. More than two third of these corporate hospitals and almost half of the private hospitals were located in few five-million-plus cities. If we take cities with more than two million population, more than ninety percent corporate hospitals and three quarter of the private hospitals could be found there. This leaves behind large part of the urban population living in smaller cities.

Decline in number of individual practitioners, especially in rural areas over the last decade is noteworthy. Rise in establishments in urban areas have failed to compensate the decline in individual practitioners in rural areas and as a result the size of the unorganized sector has declined overall. These clearly point out that rapid transformation towards organised forms of production taking place in urban areas of the country. Disappearance of general practitioners from metros like Delhi clearly point out to such tendencies. Further insights are required on the process through which these practitioners are being included in the medico industrial complex.

In the late 1980s, when medical care was gradually opened up to private sector and public private partnerships (PPPs) were made part of national strategy, the idea was to help market grow. Introduction of neo-liberal reforms in the 1990s accelerated the process. Continuous cutbacks in expenditure halted the process of expansion of government health services and reduced quality of care in the 1990s and thereafter.

The implication on the health system was severe; there was complete stagnation of growth in public health infrastructure in 1990s and early 2000s. Many public facilities (especially at primary levels) became non-functional, thus forcing a larger number of people to move out of the public system. During the three decades public sector facilities merely doubled whereas the private sector grew eight times (NCMH 2005). Characteristics of private sector have also undergone rapid change with the gradual shift of ownership from individual practitioners to entrepreneurs. One crucial implication of such a shift could be surrender of medical ethics which is supposed to be the binding principle for medical professionals to rules of profit maximization. Introduction of state sponsored health insurance programs in several states as well as at the national level is also expected to stimulate private sector growth.

The draft National Health Policy 2015 has made favorable pronouncement to provide further impetus to the booming for-profit health sector. It proposes that secondary and tertiary level care would remain targeted and would be provided free only for poor and vulnerable populations, such care would be "strategically" purchased from the private sector, quite likely through insurance mechanisms, in-sourcing and out-sourcing. Hence, rather than an integrated Health system approach, this is a fragmented and dualistic approach – where the logic of public health is compromised by an ideologically driven, poorly evidenced market logic. Continuing and expanding insurance mechanisms for purchase of care from the private sector at secondary and tertiary levels will add a level of profiteering, fail to ensure rationality in the provision of care, may remain unaccountable, and is likely to inflate costs.

Regarding regulation of private medical sector, the direction of the NHP draft is a dilution even of the basic regulatory measures proposed through the existing national Clinical Establishments Act (CEA). The NHP finds the existing modest CEA proposals to be 'intrusive', outdated. While ignoring key components of regulation such as patient rights, regulation of rates, standard treatment guidelines, multi-stakeholder bodies to oversee regulation, it proposes a watered down accreditation, a non-binding voluntary mechanism is proposed as a 'first step'.

Conclusions:

The approach of draft NHP 2015 towards private sector engagement is more or less positivist in nature- since there exists a large private sector providing majority of

clinical care in the country; hence it is imperative that private sector be made an essential part of public financed health care delivery model. The NHP 2015 further proposes to engage private sector in secondary and tertiary care services. In this paper we have seen that majority of the private sector in India is fragmented small and individual practitioners engaged in provisioning of primary care services in rural areas. If the design of private sector engagement is based on the existing structure of private sector it should focus on individual practitioners based in rural areas rather than depend on an urban centric hospital based model. Such a design is not likely to improve access to health care for the vast majority of the people living in smaller towns and rural areas.

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[i] **Enterprise**: According to the service sector survey conducted during 2006-07, it considered an institution as a unit involved in the production and/or distribution of some goods and/or services (mainly health services) which is provided for the purpose of sale, whether fully or partly. In terms of ownership of the enterprises, it may be owned and operated by a single household or by several households jointly, or by an institutional body (registered under any act of the local or state level agencies).

Own-account Enterprise: An Own-Account Enterprise (OAE) is defined as a unit which is engaged in the provision of health service on a fairly regular basis but without employing any hired worker.

Establishment: An enterprise, on the other hand, is defined as a unit that employs at least one hired worker on a fairly regular basis. A hired employee is one who is a paid or unpaid apprentices, paid household member/servant/resident worker in an enterprise.

[ii] NIC division 86100: This class includes the activities of general and specialized hospitals, sanatoria, asylums, rehabilitation centres, dental centres and other health institutions that have accommodation facilities, including military base and prison hospitals

[iii] NIC division 8620: This class includes activities that can be carried out in private practice, group practices and in hospital outpatient clinics, and in clinics such as those attached to firms, schools, homes for the aged, labour organizations and fraternal organizations, as well as in patients' homes

[iv] NIC division 86904: Activities of nurses, masseurs, physiotherapists or other para-medical practitioners

[v] NIC 86905 Activities of independent diagnostic/pathological laboratories