

Health Care System – The Public Vs Private Debate



Hospital Administration

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ABSTRACT

Health management debate centers on the involvement system in the delivery of health care for the population. India is a pluralist society with strong democratic foundations however of late commercial interests and economic order is challenging the system. Since independence the country's health system has not risen to the challenges of multitude of communicable and non-communicable diseases. The country continues to be at the lower scale of critical health indicators in the world. The public health system has been inefficient in delivery of services and the space has been taken by private sector. This has led to certain adverse effects in the form of public debt due to medical care, questionable practices & individualized care. The paper analyses the public and private health system in relation to the dimensions of health and the strengths and weaknesses of the two systems. The responsibilities of the health system towards populations and health are elaborated alongwith important mechanisms for a unified approach.

INTRODUCTION

Health management for the population is a much-discussed issue in the current context. The debate centers on the involvement or non-involvement of the government in funding health care for the population and treating the right to health as a fundamental right. Governments across the globe are grappling with the issue of increasing costs on account of health care.

Globalisation and trade practices have changed the realities of yesterday and thrown in new possibilities, opportunities and associated problems. Human rights have taken a new meaning where issues on ethics, exploitation and rights of an individual are important in the global context. It is thus relevant to visualize health as a part of the economic, social and political policy and factor in the roles that the public and private domains face in this century.

HEALTH AND THE STATE

During the medieval period religious monasticism undertook the prime responsibility for providing health care to the sick. The religious orders were insulated institutions, which professed their values and beliefs and were largely left independent by the civil societies during the period. They occupied positions of high respect and acted as arbiters in moral disputes. The actions undertaken by the monasteries were rarely questioned. With new developments taking place on the industrial front and economic issues coming in the forefront the monasteries largely lost their predominance. At the same time there was a rise of scientific thought in the health field. Macro economic issues, new inventions and discoveries and the industrial revolution guided the directions of the involvement of the state in the health field¹.

The state encouraged professional practices, provided the legal framework, regulated social policies, financed the health care system and gave infrastructural support. The monarchy went in a decline the last century the state itself came to be guided by various theories and concepts largely influenced by Karl Marx entreaties. The major three predominant views of the theories of states are the Marxist, Pluralist and New right. The Table 1 below summaries the three theories¹:-

TABLE 1 : THEORIES OF THE STATE

Marxist	Pluralist	New Right
Beholden to and acts on behalf of dominant economic interests (classes) in society	A neutral body balancing competing interests in service of the public to which it is responsible	A self serving entity intent on its own expansion and aggrandizement
Medical care should help eliminate inequalities and protect health of disadvantaged groups	Medical care system should be balanced and protect the interests of all groups and individuals. The state is a weather vane blown in whatever direction the public dictates	Medical care should be pre-dominantly private and health an individual responsibility. Government should have minimal involvement

The Marxist theories espouse a concept of class system where certain groups and classes are subordinate to the other. The state is society driven by a concentration of powerful individuals and institutions. Medical care provided is to distribute the wealth amongst all classes of the society.

The Pluralist view arbitrates between the competing interests of the society. The government remains neutral and pluralist embrace a constant sum concept. Two assumptions underlying the pluralist theory are

- The state is effectively subordinate to the Government but subject to legitimate authority of the political leadership and
- The democratic process is effective and meaningful

The medical care in such states is increasingly influenced by the reaction of the public and policies take the shape according to public points of view and the prevalent economic and social situation. India is an example of the pluralist state.

The New Right perspective is self-serving wherein it espouses that the expansion of itself (primarily economic with political clout) should be the aim of the state. The state should not be dealing in health issues of the individual, which should their own responsibility.

The pluralist state encouraged the development of the medical profession in the last century. Medical professionals were part of the apparatus for making policy decisions besides providing the health care to the population. The medical profession was placed at a pedestal by the society in general and a respect for medical professionals was created amongst the population.

However similar to the decline of the monastic order, economic issue started creeping in the medical profession. As new technologies were discovered and advancements in the pharmaceutical industry took place corporate interests started prevailing over the hereto medical professionals view point. State power declined and multi national corporations gained more influence in the health management stakes. Power also moved from the clinics of the medical professionals to the boardrooms of the corporates and insurance companies. New right perspective seems to be asserting itself over the older pluralistic order.

HEALTH UNDER THE INDIAN CONSTITUTION

India has a federal set up with 29 states and 7 union territories. The primary responsibility for providing health care to the citizens of the country lies with the States. The Seventh Schedule, Article 246 of the Indian constitution provides the details of the Union, State and the Concurrent lists². The constitutional provisions related to health are as follows³:

(a) Union List: International Health relations and port quarantine, administration of central Institutes, promotion of research, census, collection and publication of statistical data, etc.

(b) Concurrent List: Vital Statistics (including registration of births and Deaths), prevention of food adulteration, drug Control, labour welfare, etc.

(c) State list: Public Health, sanitation and medical care, hospitals and dispensaries etc.

ROAD MAPPING THE DEVELOPMENTS IN THE PUBLIC AND PRIVATE SECTORS

Health is politics and Politics is Health as if people matter – has been a common refrain from the health scholars Rudolf Virchow, Halfdan Mahler and BC Roy.

Colonial India

The colonial India and post independence policies in India present as interesting facet. The British imperial policies promoted westernized medicine over the indigenous systems. Colonial exploitation ensured that while the metropolises developed not much attention was given to the rural India population. Health accessibility was limited to the Europeans and rich Indians in the cities. The majority of the population was out of the purview of the health system and relied on the indigenous systems. However the state sponsorship of the indigenous systems declined resulting in diminishing quality⁴.

To encourage imports the British Indian Govt levied back-breaking land revenues, taxes on the Indian industries. A combination of all factors created adverse environmental conditions, which augmented the health problems. Famines, Communicable diseases, epidemics and hunger took hold. At the time of Indian independence the life expectancy at birth was only 26 years.

The only bright light during the era were initiatives coming from the leadership of Mahatma Gandhi and visionar-

ies like Dr BC Roy who understood that there were intricate links between the health and environment conditions. In 1938 the National Health (Sokhey) sub committee of National Planning Committee of the Indian National congress advocated a community approach by having 1 community health worker for 1000 population. With the pro independence movement gathering momentum and the pressures of post war reconstruction the British Indian Govt established the Health survey and development (Bhore) committee. The report is considered an authoritative document and is regarded as a seed of hope⁴.

Post Independence

Early Years. A start was made in 1952 to set up Primary health centres, medical colleges and national institutes. There was a rapid expansion of the primary health care facilities and Govt medical institutions in the next two decades. However there continued to be gaps between the policy commitments and their implementation. The developments in the initial phase were a springboard. However the seeds of retreat were sown in 1967 when health programmes became overtly focused on family planning issues. At the same time vertical programmes were launched which met with initial successes. However over a period of time the vertical programmes became increasingly cost ineffective⁵. International initiatives were also launched during the period.

Turmoil in the 1990s. The early 1990s were the defining years for the direction in which the health movement moved. IMF bailed out the Indian government from the financial crises in 1991. Thus the IMF came to influence major budgetary allocations. The health budget was scaled down by 20% in 1992-93. There was a steady decline in public health initiatives, which was on the contrary led by an expansion of private sector. States started providing duty exceptions and incentives to private medical facilities. Governments also instituted cost recovery mechanisms from the patients in Government hospitals Private enterprises increasingly took the space of the public institutions. The number of hospitals grew from 11,174 hospitals in 1991 (57% private) to 18,218 (75% private) in 2000⁶.

Globalisation, opening of the economy and liberal policies led to setting up of new medical colleges and corporate hospitals. Political leaders, businessmen and multinationals jumped in the bandwagon to generate profits. In 2000, the country had 1.25 million doctors and 0.8 million nurses. That translates into one doctor for every 1800 people.

Though the spending on healthcare is 6% of gross domestic product (GDP), the state expenditure is only 1.4% of the total spending. People using their own resources spend rest of it. Thus only 17% of all health expenditure in the country is borne by the state, and 82% comes as 'out of pocket payments' by the people⁷.

The development of the health care in India has become skewed to the urban populace. The point of concern for the country is the inequitable distribution of the health resources. The ratio of hospital bed to the population is 15 times lower in the rural areas. The proportion of doctors is 6 times less in rural areas as compared to urban regions. Even the Govt spending was concentrated more in the urban than the rural areas by as much as 7 times. Health delivery in the rural areas remains challenge even more than 50 years after independence⁶.

TABLE 2: THE RURAL URBAN DIVIDE⁵

Sector	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mortality per 1000 (NFHS II)	Weight For Age-% of Children Under 3 years (<2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 population	Malaria +ve Cases in year 2000 (in thousands)
India	26.1	70	94.9	47	408	3.7	2200
Rural	27.09	75	103.7	49.6	-	-	-
Urban	23.62	44	63.1	38.4	-	-	-
Sector	Population BPL (%)	IMR/ Per 1000 Live Births (1999-SRS)	<5Mortality per 1000 (NFHS II)	Weight For Age-% of Children Under 3 years (<2SD)	MMR/ Lakh (Annual Report 2000)	Leprosy cases per 10000 population	Malaria +ve Cases in year 2000 (in thousands)
Better Performing States							
Kerala	12.72	14	18.8	27	87	0.9	5.1
Maharashtra	25.02	48	58.1	50	135	3.1	138
TN	21.12	52	63.3	37	79	4.1	56
Low Performing States							
Orissa	47.15	97	104.4	54	498	7.05	483
Bihar	42.60	63	105.1	54	707	11.83	132
Rajasthan	15.28	81	114.9	51	607	0.8	53
UP	31.15	84	122.5	52	707	4.3	99
MP	37.43	90	137.6	55	498	3.83	528

The pharmaceutical industry expanded rapidly and became a major influence on the practices of the medical profession. The country has an annual pharmaceutical production of about 260 billion (INR) and a large proportion of these medicines are exported. The imposition of the TRIPS regime escalated the cost of medicines⁶.

In a study carried out by Phadke et al⁸ it was observed that the drug supply to the public sector in Satara District was a mere Rs. 5.6 million, as compared to the most minimum, reliable estimate of a drug sale of Rs. 212.8 m in the private sector during 1991-92. Unnecessary, irrational, hazardous drugs and injections were prescribed especially in the private sector. Public Sector prescriptions were found to be more rational. Continuing Medical Education of doctors was limited and the influence of the medical Representatives, increasing prices of drugs and competition amongst doctors influenced the prescription of doctors in the private sector. In the public sector drugs were prescribed on account of chronic shortages. 69% and 55% of the money spent on prescriptions in the private and public sector, respectively, was wasted, with an average of 63%. Patients visiting government clinics in Satara district had to buy 15% of the drugs prescribed to them, instead of getting all drugs free.

Patients became a commodity. A systematization of medicine has taken place where the medical professionals became cogs in the wheel. A Marie Antoinette syndrome was defined where in a large number of populace are unable to pay for the rates charged by the private institutions. A survey undertaken by the National Council of Applied Economic research found that expenditure on medical needs was the second most important cause of rural indepthness⁶.

Public health organisation has virtually ceased to perform. A study report presented to the Prime Minister in 1997 pointed out that the health services were in an advanced stage of decay. A study on the community centres showed that virtually none of the centres was running at an opti-

mal level. 38% of all PHCs have all the essential manpower and only 31% have the entire essential supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs⁶.

India continues to have one of the highest rates of maternal mortality. The Maternal Mortality ratio for India is 190 maternal deaths per 100,000 live births as per Baseline data. IMR is still significantly high in India⁶. India has an under five mortality rate of 53 per 1000 live births.

About 0.5 million people die from tuberculosis every year in India and this number has hardly changed in last five decades²⁵. Other communicable diseases like Malaria, Encephalitis, Kala Azar, Dengue and Leptospirosis to name a few, are far from being eradicated. The number of reported cases of Malaria has remained at a high level of around 2 million cases annually since the mid eighties. The outbreak of Dengue in India in 1996-97 saw 16,517 cases and claimed 545 lives²⁶. Around 0.6 million children die each year from an ordinary illness like diarrhea. Oral Re-hydration Solution (ORS), which is presently administered in only 27% of cases. Cancer claims over 0.3 million lives per year and tobacco related cancers contribute to 50% of the overall cancer burden⁷.

Private health sector was and in some quarters is seen as a boon for the Indian Health system. Patients from the public sector reported lower levels of satisfaction with the care received than the level of satisfaction of the patients from the private sector facilities. Suresh Balakrishnan and Anjana Iyer⁹ observed that 31% of patients from government hospitals gave clear positive ratings, while only 20% from Corporation hospitals did so. In contrast 57% of the users in Mission and private hospitals gave positive ratings. The hidden cost of care associated with care in public hospitals was greater for the poor. Even at the secondary level, the out of pocket expenses was 42% in public sector and 71% in private sector¹⁰.

Surinder Jindal ¹¹ observed that it is largely curative and rehabilitative medicine which is getting privatised, and rightly so. Such services are not only costly but highly individualised and time-consuming as well. Individualised care is obviously easier in private than in government institutions. One can choose both the treating doctor and the time and place of treatment. Privatisation has helped improve health services – their type, scope, quality and consequences.

However some other studies brought out the other side of the story in the Private sector. In a study carried out for the diagnostic facilities by Tomar, et al ¹² in Agra it has been found that the services provided by the labs are generally below average. Rick K Homan⁹ conducted a study comparing the private and public facilities in Trivandrum and observed that on the average private hospitals performed three times the number of caesarean deliveries in the public hospitals. 25% of lab tests in public sector were referred to private laboratories. Private sector hospitals tended to order more x-rays per patient (on average 55% more) than the public sector.

Besides increasing the social dichotomy the focus of the private sector is only on the profit generating tertiary care facilities, which are urban, based. The private sector is not willing to carry out social obligations. The proportion of people unable to afford basic healthcare has doubled in last decade. The World Bank in a report has acknowledged that doctors over-prescribe drugs, recommend unnecessary investigations and treatment and fail to provide appropriate information for patients in private healthcare sector. The private sector commercially driven as it is has brought on socio-economic inequality in healthcare delivery system⁶.

The public sector hospitals are experiencing “x-efficiencies” in that they are producing services beyond their intended capacity. For private sector hospitals, the low occupancy levels create the opposite problem (of under-utilization). The momentum of the system overwhelms the ability to focus on long-term goals and the result is a series of short-term crises. The government must improve documentation of the medical records and additional control to monitor performance of providers⁹.

Yesudian et al ¹³ carried out a detailed study on the behaviour of the private sector towards health care delivery in Bombay. Overuse of equipment was present; the justification given being lack of improvement of technology in the public sector hospitals, the poor get the benefits of the public health system since the rich take treatment from pvt centres and the sector being highly competitive, modern technology is necessary to improve its’ performance. Questions were raised on the overuse of the diagnosis, high costs of treatment and unethical medical practices and commercialization of the sector.

Yesudian et al¹³ further observed that skilled manpower to operate the modern equipment was lacking and there was a deficiency of nursing staff. Non-allopathic doctor were appointed who were not trained in emergencies. Public hospitals were used by these consultants as means of getting clients who could afford private treatment. Private practitioners were involved in large-scale malpractices. Including ‘cut’ practice where the percentage of cuts being given was as high as 40%. Unnecessary investigations and even surgeries were carried out by the doctors.

Despite the deficiencies, the Tenth Plan Report¹⁴ acknowledged that the private sector is playing an important role in the health system of India. The private sector accounts

for 82% of all outpatient visits and 52% of all hospitalization. This is primarily through small nursing homes of less than 25 beds accounting for 82% of total private facilities. The tertiary care facilities were just 1-2% of the total pvt facilities. The same was also stated in the National Health Policy 2002⁵.

Developments Internationally

Europe¹⁵ : To a large extent the health systems in Europe were influenced by the Soviet Union model. The soviet health care system and the social security system appealed to the workers in the European countries. The European countries partly to counter the influence of the communist modified their own systems to meet the needs of the workers. There were two streams, which were generated

Public model of the National Health Service where the whole population was got under the ambit of the NHS which provide the health care.

Social Security system in countries like the France and Germany, which increased the benefits of social security to include all employees and their families as also the unemployed.

38. US¹⁶ : The US system was not influenced by communism and its labour policies. As a result the system developed in three streams. The employers took the responsibility for providing health care to their employees through insurance or other mechanisms. The State did not play a role in this. There were private institutions established for people who could pay. The Govt stepped in to provide cover as part of social security system to the most needy through the Affordable Care Act. Charlene Harrington et al analysed data from over 13000 nursing homes in the US. The study observed that investor owned nursing homes provide worse care and less nursing care than non profit or public centres¹⁷.

ANALYSING THE PUBLIC AND PRIVATE HEALTH SYSTEMS

Analysis and critique of a Health system should be based on the principles and practices developed over the years. In 1988 ‘The US National Institute of Medicine’ issued a report ‘The Future of Public Health’ ¹⁹ highlighted the following issues; public complacency about advances against health problems as public health issues are taken for granted, political leadership pushed for short-term solutions rather than a long-term plan, general public is confused, in adequacy to carry out the function, in equity in distribution of the resources, effective leadership is limited, poor relations in the medical profession & organization fragmentation and redundancy.

The World Health Organisation in 1946 adopted a visionary document, which affirmed¹⁸

“The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, social or economic condition”

One of the strategies adopted at the Alma Ata conference in 1978 was defining Primary Health Care and its elements¹⁹

“Essential health care universally accessible to individuals and families in the community through their full participation and at a cost the country and the community can afford”

Primary health care espouses 4 principles¹⁹; universal accessibility and coverage in relation to need, community and individual involvement and self-reliance, intersectoral action for health & appropriate technology and cost effectiveness. Universal health coverage has come to occupy centre stage. The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them.

Any health system should address the following dimensions: Equity, Accessibility, Acceptability, Accountability, Affordability, Ethics & Fiscal issues. The table below examines the public sector and the private sector in India as per above issues:-

TABLE 3 : HEALTH SYSTEM AND ITS DIMENSIONS

Health System Issue	Public Sector	Private Sector
Equity	Policies and plans well intended however facilities have an urban skew Poor infrastructure means that certain pockets of populace have to be dependent on the private sector resulting in inequity	Poor left out.
Accessibility	Large number of centres have been established accessible to populace Disabled by lack of manpower, equipment and resources	Generally situated in urban areas and profit making centres Not accessible easily for the major population
Acceptability	Population and communities do not generally have the confidence in public health services	Acceptable to the patients however increasing suspicion on account of rising malpractices
Accountability	Increased bureaucracy and rules and regulations have meant that direct accountability is lacking in the system	Absence of adequate regulatory mechanisms and legal framework means accountability is lacking
Affordability	Supposedly free of cost however most drugs have to be purchased and large numbers of investigations are done in private sources. Still caters for the poor in the country Certain tertiary care facilities charge nominal fees	High fees, irrational prescriptions, unnecessary diagnostics means that the cost of treatment is high. No fixed fees for procedures rather dependent on the patients capacity to pay.
Ethics	Professional norms are followed though unethical practices exist	Commerce driven. Ethical practice is lacking
Fiscal	Limited budget Financial accountability is lacking	Profit motives are present hence only procedures which fulfill the commercial aim are conducted.

Peter Crampton and Barbara Starfield²⁰ commented on the government ownership of the primary care services. A summary of strength and weaknesses of the private and public sectors in primary care for primary care is given below:-

TABLE 4 : HEALTH SYSTEM STRENGTH & WEAKNESSES

Characteristics	Ownership		
	Private Non profit	Private for Profit	Government
Direct accountability to Government	+	+	+++
Willingness to cater to diversity	+++	+	+
Likelihood of producing public goods	+++	+	+++
Able to experiment with policy options	+++	++	+
Likelihood of exploiting information symmetries	+	+++	+
Likelihood of disguised profit distribution	+++	+	+
Responsiveness to increase in demand	+	+++	+
Likelihood of blunting more extensive policy development	+++	+++	+

HEALTH SYSTEM: RESPONSIBILITIES

The Functions of the health system can be viewed in the following three categories¹⁹:-

Health system management (maintenance and development functions) - Formulation of Health Policy, Planning of programs, Mobilization and allocation of resources, Implementation and monitoring, Development of human resources & Health research

Public Health (essential public health functions)- Information systems, Protection of environment, Prevention of disease, Essential public health functions

Health care (function of individual care at the critical contact and referral levels) - Primary care, Secondary care, Tertiary care & Specialised care

The table below suggests an approach for involvement of both the public and private sectors in the domain of health:-

TABLE 5: APPROACH TO HEALTH SYSTEM

Functions	Public Sector	Private Sector
Health System Management		
Legislation	Develop legislation	Public private partnerships formalised
Regulatory Bodies	An autonomous strong regulatory body for control of the private sector and regulating quality control in the Govt sector	Professional bodies to administer and regulate the profession
Policies on Health, Sanitation and Environment	Intersectoral cooperation with civic agencies	Consultancy from University groups NGOs and experts
Public Health		
Preventing Epidemics	Primarily should be responsibility of the district and state health authorities	NGOs, community volunteers and groups
Protecting population against environmental hazards	Appropriate legislation and inspections	Citizen group interaction with civic authorities, Labour unions
Preventing injuries	Civic agencies	NGOs, community leaders
Encouraging healthy behavior	Health institutions at all levels	Health institutions at all levels, NGOs

Disaster response	Establishing Disaster command posts, first response to disaster	Augmenting the public resources
Health Care		
Community level	Community Health Centres, Primary Health Centres, Sub centres – close interaction with community	General practitioners, Practicing indigenous systems of medicines
Secondary	District Hospitals – need to be augmented and require to provide leadership in the district	Private nursing homes and hospitals – ethical practices and record keeping
Tertiary & Specialised care	Medical Colleges – infrastructure needs to be updated. Require to develop as learning organization in the area. Leadership in continuing medical education	Linkages and interaction with regulatory bodies

There is case for having a strong regulatory mechanism for the private sector. The National Health Policy 2002⁵ seeks to address the issues of a statutory regulation of private health facilities, developing standards, proper conduct of clinical practises and establishing an information system. This has been taken forward in the new National Health Policy 2015.

Bhat R²¹ feels that the challenge for the future will be to ensure the quality and efficiency of health services in both the public and private sectors through regulatory mechanisms while seeking to promote national health objectives.

Yesudian et al¹³ states that policy related to the private sector should be directed towards two main issues 1) Development of the primary health services 2) regulation and monitoring of the private health services. Private participation in some of the primary facilities in the non-poor areas should be encouraged. Regulatory norms for various aspects such as physical standards, qualified manpower, etc. should be evolved and be made compulsory.

Surinder Jindal¹¹ stated that there are three main elements of health care: prevention, treatment and rehabilitation. Prevention of disease is both a personal and a state obligation. In fact, the state has enormous stakes in the maintenance of healthy and relatively disease-free society. Private sector should principally be involved in the curative and rehabilitative fields. However if the system has to be redefined certain benchmarks will have to be made.

Norman Daniels¹⁵ proposed the following Benchmarks of fairness for National Health Care Reforms which includes universal access- coverage and participation, universal access – minimizing non-financial barriers, comprehensive and uniform benefits, equitable financing, equitable financing – by ability to pay, value for money – financial efficiency, public accountability, comparability and degree of consumer choice.

Summary & Conclusion

The reality of the health system of today in India is that private health system should be incorporated in the health policy and delivery mechanisms. A regulatory body needs to be established to develop standards and assess standards of care in public and private hospitals and outsourcing facilities. The professional bodies need to be strengthened. There is a strong case for providing technical and managerial inputs to doctors in public health system to develop as

'leader/manager physicians'. Para medic professionals will be the answer for the future.

Standard treatment protocols starting for the primary care and secondary care level need to be established. Public Health requires to be augmented pro actively in a way that leadership provided in the field continues. Policies for response to disasters and epidemics need to be streamlined at operational levels.

Information Technology should be introduced in a major way at all health systems and facilities. An integrated HIS networking with strong information systems backbone is required for the country and the states.

Health financing mechanisms require to be strengthened. The Govt both at the Centre and State require to finance the public health system to make it competitive to the private sector. Investments in public health system will enable a quality delivery of care. Insurance mechanisms for the vulnerable population require to be in place to ensure financial protection. The insurance mechanisms should consider private public partnership arrangements to provide universal access to the population. In partnership of the public and private health systems lies the answer to meeting our health goals.

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