

Health Reforms and Utilization of Health Care in three states of India: Public health Prospects

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Abstract

Health sector reforms were introduced in several states of India in 1991. The rationale was to increase choice and competition, to improve quality and access to health care. Such demand-led incentives were integral to macro-economic stabilization programs world-wide during the 1990s. For a majority of the population of India, health care costs linked to commercialisation of health services were forcing households into serious debt. Using primary data on patterns of utilisation of health services (2002), this paper reports from a systematically collected empirical evidence base, to explore the preliminary impact of changes to the health sector from 1991 to 2000 in West Bengal (WB), Tamil Nadu (TN), and the hospital sector of Andhra Pradesh (AP). The overall aim is to provide historical context to the experience of reforms for

poor and vulnerable groups and to understand current discourses on the health system in India, focused on “managed care” through a universal health insurance programme. We explore linkages between the past and present on disinvestment in public provision and its long-term consequences for equity of access to health care in the three states, and elsewhere in the country.

Introduction

The role of the state has historically been essential to public health and disease eradication programs in India. Evidence from the past two decades suggests that this has radically altered in the face of multiple pressures including those initiated by donor driven structural adjustment programs. This paper summarizes findings of a major study set in the context of profound shifts in the health sector in the 1990's. Its findings are described and set in the current policy context with regard to access to and the financing of health services.

The aim of the study was to compare and contrast effects of health sector reforms in three states: Andhra Pradesh (AP), Tamil Nadu (TN) and West Bengal (WB), at different stages of development, to explore the impact of changes in the organization and financing of health care on vulnerable populations. It also intended to obtain insights into the quality of care from users and providers of health care under reforms. TN and WB states provided cross sectional population studies whilst AP provided an important institutional focus on secondary care at both public and private sector institutions.

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Study design

Selection of sites

Study sites were drawn from West Bengal (WB), Tamil Nadu (TN) and Andhra Pradesh (AP), wherein WB and TN at that time were at a relatively advanced stage in demographic and epidemiologic transition while AP had a higher ratio of health facilities to population than the other states but it also had lower health status and development indicators such as education and access to basic facilities such as water and sanitation.

There were two major phases to the study; a quantitative household survey and a qualitative survey.

The selection of districts for the quantitative phase was based on the Relative Index of Development (RID) from the Centre for Monitoring Indian Economy (CMIE) as opposed to per-capita income, to ensure a balanced representation of developed and less developed districts in the sample. A multistage stratified sampling procedure was adopted in both rural and urban areas. The 1991 population census and the Urban Frame Survey (UFS) blocks prepared by the National Sample Survey Organization (NSSO) formed the sampling frame for the urban and rural areas, respectively.

All households in a selected village were categorized into four socio-economic classes and a suitable number of households were selected in a ratio as shown in **Table 1**.

In West Bengal the 6 sample districts selected were Kochbehar, Maldah, North 24 Parganas, Burdwan, Midnapore, and Bankura. In Tamil Nadu the five sample districts were Chengalpattu, Tiruvanamallai, Tiruchirapalli, Dindigal Anna, and Coimbatore. In addition, the metropolitan cities of Calcutta and Chennai were also included. The distribution of the different stages of sampling units (e.g., district, villages/blocks and households) is shown in **Table 2**.

For the metropolitan cities of Kolkata and Chennai, 50 blocks (each containing around 600 population) from the former and 30 blocks from the latter were randomly selected. From each

Economic	Social Origin	
	Backward	Others
Low	a=6	b=2
Others	c=1	d=1

Note: Official terminology to classify scheduled caste and scheduled tribes of India

selected block, 20 households were selected; 1000 households for Calcutta City and 600 households for Chennai City were randomly chosen for the survey. Other than the Household listing, the two schedules used were i) the village/block schedule and ii) the Household Interview Schedule

The study trained interviewers to interview each adult (15 years and above) in the household. If no adult was present, information was collected through proxy reporting. For children, the (biological) mothers were the informants.

The qualitative survey included in-depth interviews (with providers) and focus group discussions (from the sampled population), which were conducted to gauge perceptions of the quality of care by sector, its impact on health outcomes and on household expenditures. More than 300 in depth interviews were conducted in WB and TN. About 500 hospital patients were surveyed in addition to a sample of providers (doctors) at both outpatient and inpatient facilities in the towns, Eluru (West Godavari district in Coastal Andhra) and Mahbubnagar (Mahbubnagar district in Telangana) in AP as illustrated in **Table 3**.

Key Findings: General

Socio economic background (West Bengal and Tamil Nadu)

The low socioeconomic status of the overall sample in WB and TN was reinforced by the fact that more than 93% in WB and 97% in TN were

States	Number of Districts	Rural		Urban			Total # of households
		Number of Villages	Number of households	Number of towns	Number of blocks	Number of households	
West Bengal	6	108	3240	12	96	2536	5776
Tamilnadu	5	80	1600	10	80	1880	3480

Notes: Since some very small villages had less than our quota of 30 households (per selected Village), the total number of households was actually 5685.

State	Vulnerable Household	Non-vulnerable Households	Total
West Bengal	52	57	109
Tamil Nadu	102	68	170
Andhra Pradesh (Hospitals % Outpatient clinics)	Public 252	Private 228 (110 from clinics% 118 outpatients)	480

eligible for PDS (a public subsidy to families below poverty line), which at the time of the survey (2000) had a ceiling of Rs. 15,000 as an average Annual Per Capita expenditure (APCE).¹

Extended families were predominant in both states. However joint families more prevalent in WB than in TN; literacy levels were marginally higher in TN (70% of the sample having completed secondary education or higher), but only 62.6% were in the same category in WB. Female literacy

was particularly low in WB with 43% of women without schooling, while in TN this proportion was 28%. The levels of literacy and APCE play an important role in the nature and patterns of sector utilization of health care.

Andhra Pradesh

In the hospital study in two towns (Eluru in West Godavari and Mahbubnagar in Telangana districts), the two government hospitals were used mostly by the very poor. 85% reported their annual family income was Rs. 30,000 or less. In contrast, 50% of patients in private hospitals had a family income above Rs. 30,000 per annum. Similarly, the percentage of outpatients with an income above Rs. 30,000 per annum was relatively high in the private hospitals.²

More than half of those interviewed in public hospitals were non-literate: 60.9% in Mahbubnagar and 52% in Eluru. 74% of the literate patients had only a primary education.

Vulnerable	Non-Vulnerable			Total		
	V	NV	Total	V	NV	Total
Fever	41.3	38.4	40.1	31.2	34.8	32.9
Diarrhoea, Gastroenteritis	21.4	18.8	20.3	7.2	5.5	6.4
Gout/joint pain	4.9	6.0	5.3	9.2	11.6	10.3
ENT, (eye,dental)	4.7	5.9	5.2	3.3	3.0	3.2
Respiratory troubles	4.8	5.5	5.1	6.0	5.8	5.9
Blood pressure	3.8	6.2	4.8	4.4	2.8	3.7
Skin disease	4.7	4.2	4.5	0.7	1.8	1.3
Communicable diseases*	2.6	1.6	2.2	0.1	0.3	0.2
Diabetes	0.2	1.4	0.7	1.8	3.1	2.4
Heart troubles	0.7	1.4	0.9	-	-	-
Pregnancy Complications	-	-	-	12.0	16.0	14.0
Others	10.9	10.6	10.9	18.9	24.1	19.7
Total	100	100	100	100	100	100

Notes: Note; V=Vulnerable ; NV=Non-vulnerable ; *includes Tuberculosis, Chickenpox, Malaria, and Measles

¹ The classification of vulnerable status depended on a variety of attributes which are identified at the end of this paper.

² Survey data from 1999I

Sector/Source	West Bengal			Tamil Nadu		
	V	NV	Total	V	NV	Total
Public	19.8	12.8	17.0	40.1	67.4	50.8
Private	67.8	83.3	74.2	58.9	30.7	47.8
Traditional	2.3	1.0	1.7	0.1	0.2	0.2
Others	10.1	2.9	7.1	0.9	1.7	1.2
Total	100	100	100	100	100	100

Note; V=Vulnerable Source: compiled from Analysis of Study; NV = Non-Vulnerable

Table 4 highlights the incidence of self-reported morbidity in the previous month³ among vulnerable and non-vulnerable groups.

Morbidity pattern (previous month): West Bengal and Tamil Nadu

Diseases of poverty reinforced by poor nutrition, a lack of access to running water, and poor sanitation were significant features contributing to morbidity in WB and TN. Almost half of the sample in WB (40%) suffered from non-specific fevers. By contrast in TN only 33% complained of fevers. Gastric conditions were more than three-fold greater in WB (20.3%) compared to the sample in TN (6%), highlighting differences between the two states in sanitation conditions and education levels particularly among women. The non-vulnerable groups in both states complained of chronic joint conditions; 10.3% and 5.3% in TN and WB respectively.

Andhra Pradesh Morbidity

In AP the proportion of acute conditions and the need for emergency care was high especially for the public sector; meningitis, accidents and injury, and obstetric complications were the most commonly reported whereas women's health problems – hysterectomy, abortions, surgery – accounted for the largest share of admissions to private hospitals (67%) with surgery for cataracts and appendicitis coming next. Chronic conditions such as hypertension and TB were admitted to the long stay wards of the district public hospital.

Utilization: Overview

The two states differed with respect to culture, behavior, awareness, and socio-economic/demographic characteristics. There were sectorial

differences between public and private utilization of health care.

What is surprising is that despite having a wider network of private health care facilities than WB, in TN over half of ill persons used public sector health facilities (50.2%) including government hospitals (both OPD and IP), Primary Health Centers (PHCs), Community Health Centers (CHC), and public dispensaries. The better off (non-vulnerable) utilize the public sector the most (67%). In contrast, only 17% utilize public health facilities in WB, and 74.2% used private providers, 62% of whom were physicians. (**Table 5**).

When disaggregated for inpatients, the opposite is the case in WB with the vulnerable using more public facilities (18.5%) compared with non-vulnerable (11.5%) but in relatively low proportions. In TN, the only cases where vulnerable groups utilized public facilities more were for antenatal care and for delivery where almost twice as many of vulnerable used public facilities compared to non-vulnerable groups. The use of public facilities for delivery was 63.2% (urban) vs. 37.5% (rural) and 66.% vs. 50% in Chennai.

Usage of health care among all segments of the sample was determined by availability. **Focus group discussions** suggested distance, cost, and availability of medicines were key factors in the selection of sectoral health services. However, among the non-vulnerable groups, additional factors such as personal attention, quality of environment, and easy access to medicines influenced selection; this was particularly the case in the samples from AP and TN. An emphasis on preference for institutional care in urban areas among vulnerable and non-vulnerable groups in TN highlights falling demand for outreach programs of preventive care in maternal and reproductive services (antenatal care) due to the experience of uneven quality, lack of

³ Self-reporting can underestimate conditions of morbidity for chronic conditions and other ailments that are uncommon and rarely diagnosed. The least educated are particularly vulnerable in these cases.

continuity, and poor PHC availability during this period (1991-1999). This was also noted by a number of other studies covering this period (MacArthur Foundation 2006, JSA 2006).

The use of public facilities among vulnerable groups in both states was related to the relative cost of public over private sector as well as familiarity with and confidence in diagnosis. Where non-vulnerable groups accessed public provision (TN in particular but also in AP) it related mostly to cost in comparison to private health (for inpatient care), and fear of an escalation of costs due to frequency of usage among this group.

Utilization of inpatient services in Andhra Pradesh

AP has been a state with the fastest growth rate of private beds in the country since 1991-1992 with almost two thirds of hospital beds under private provider category (59%) and only 35% under the public provider. In both towns despite the shrinkage in the size of public sector, both the better off and poorer populations relied on public providers.

Table 6a shows that in more than two-thirds of inpatients in both towns were white ration card holders (65.3%) utilizing public sector facilities, but this sectoral share was reduced to less than half when it came to Outpatients (45.7%). The overstretching of services both in the wards and OPDs often forced the population from deprived areas into private hospitals. There also exists a historical nexus between providers of public and private sector in the poorest district (Mahbubnagar). More than one third of those with low incomes (less than 20,000 pa) were forced to use “private” facilities. (32.9% and 35.6% for IP and OP, respectively). Table 6b below also highlights the overwhelming dependence of low income groups (less than Rs 20,000 pa) on public provision in both districts.

Some 15% of patients in Eluru and 30% in Mahbubnagar were unable to prove their BPL (below the poverty line) status highlighting the futility of targeting and the ration card method of proof, among the most deprived. See **Tables 6a & 6b**.

Indebtedness and cost of care (WB, TN, AP)

In all three states the cost of health care was a major factor in household indebtedness and particularly among daily wage laborers from rural areas. In TN and WB, the APCE for health care among vulnerable and non-vulnerable groups as a proportion of total household expenditure (HHE) was 4 and 6% respectively, excluding deliveries and hospitalization. But when charges for hospitalization are included, costs increased to 20% of annual income for the most vulnerable in WB and TN.

The greatest share of costs was spent purchasing medicines, followed by consultations and diagnostic tests. This applies mainly to the private consultations but is also the case for public hospitals where doctors prescribe medicines unavailable at the hospital. In the public sector, the costs of food, transport, lodging, and informal payments (tips) were an issue for users. Whilst these could not be accurately gauged, they were said to contribute to the hidden costs of public sector usage among the most vulnerable, especially in AP and TN.

Inpatient costs were several fold greater in the private sector than in the public sector where the main conditions treated were chronic ones, although deliveries at private nursing homes were still common in AP and TN. Women in AP claimed that they were often advised to undergo caesarean sections without medical indication in both public and private institutions. The cost difference was more than double between a normal delivery (Rs. 2921) and a caesarean delivery (Rs. 7241) in a private hospital. Charges for a normal delivery at the

Table 6a: Ration card status of patients at public and private clinics (AP)

	Inpatients				Outpatients			
	White	Pink	None	Total	White	Pink	None	Total
Eluru								
Government Hospitals	62.32	8.70	28.99	100	54.88	11.59	33.54	100
Private Hospitals	30.87	46.31	22.82	100	35.20	42.40	22.40	100
Total	51.29	21.88	26.82	100	46.37	24.91	28.72	100
Mahbunadar								
Government Hospitals	73.37	13.02	13.61	100	54.55	21.59	23.86	100
Private Hospitals	48.10	31.65	20.25	100	40.41	48.63	10.96	100
Total	65.32	18.95	15.73	100	45.73	38.46	15.81	100

Source : compiled by Narayan K.V.(2000) Impact of Health Sector Reforms on Hospital Services in A.P

Table 6b: Hospital services utilization among those earning less than Rs. 20,000 per annum (1999)

District/ Sector	Inpatient %	Outpatient %
Eluru		
Public	76.5	72.5
Private	29.7	37.5
Mahbubnagar		
Public	78.7	73.8
Private	32.9	35.6

Source: compiled by Narayan K.V.(2000) Impact of Health Sector Reforms on Hospital Services in A.P. Indebtedness and Cost of care (WB, TN and AP)

public hospital were significantly less (Rs.203 to Rs. 403). Caesarean deliveries were encouraged at a rate four times higher (68%) than that recommended by the WHO (15%) at the time of the study (2000). Doctors in the public sector claimed that such interventions were undertaken to help poor pregnant women (exempt from payments) avoid readmissions from “repeat infection” following delivery and to prevent returns to the hospital with long distances to travel and resulting opportunity-costs.

Debt due to illness and Household Index

For all three states, some 20% fell into debt attempting to meet their health expenses over the preceding thirty days. **Figure 1** highlights an inverse relationship between the extent of indebtedness due to health expenditure and the household index (HI), which was constructed from our data as a representative indicator of all possible socio-economic parameters affecting health and health awareness relevant for WB and TN. In WB, rural, poor households were almost five times more likely (29.4%) to fall into debt than the better off in both rural and in urban areas (5.4%) based on an assessment of their respective household index.⁴

Meeting health expenses

Table 7 highlights the distribution of indebted ill persons. 60-70% sought assistance from non-institutional sources. In-depth interviews suggested that whilst friends and relatives were the primary source for borrowing, there was always pressure to repay to ensure that kin relations were sustained.

The loans highlight the difficulties and challenges for access to institutional credit among both sections of the population (vulnerable and non-vulnerable). The rural poor were twice as likely

Table 7: Distribution of ill persons indebted by different sources of loans or financial Assistance Received and vulnerability status (%)

Source of loan/financial assistance	V	NV
Friends/ Relatives	64.3	70.0
Office/ Financial Institution	3.9	4.9
Money Lender	14.9	5.5
Sale/ Mortgage of property	8.3	4.1
Other	8.6	15.5
Total	100	100

Source: Compiled from Study data (1999)

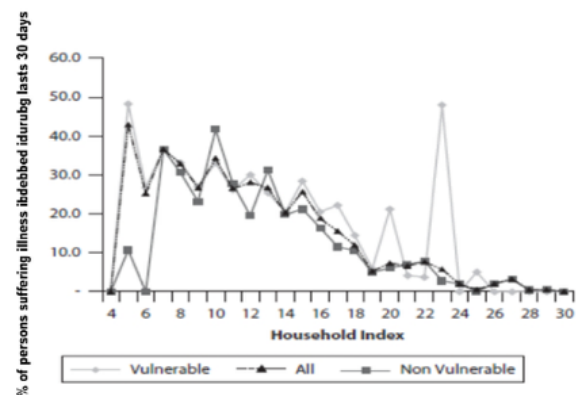
V= Vulnerable (Patients below poverty line in 1999); NV= Non-Vulnerable patients above poverty line in 1999.

(8.3%) than the better off in WB (4.1%) to sell their property and assets and almost three times as likely to go to a money lender (14.9% v 5.4%) to pay for medical costs.

In AP, overall some 60% of hospital patients in Mahbubnagar and 35% in Eluru were forced to take out loans to meet their medical expenses. In both towns the age of patients who had fallen into debt appeared higher for public hospitals because the majority of those attending were very poor.

In all three states there were complaints about reduced access to public facilities forcing people to travel long distances and pay for private providers, whether individual physicians or institutions. The

Figure 1: Extent of indebtedness for medical treatment in relationship to HHI (source: World Bank)



⁴ Household index sample provided in the Annex

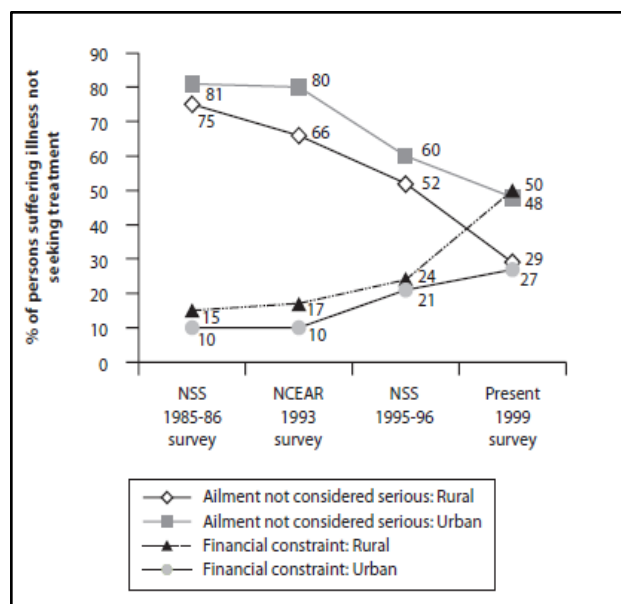


Figure 2: Temporal Variation in Proportion of Persons suffering Illness and two key reasons for not seeking treatment compared with earlier studies(1985, 1993 and 1995) better off group noticed improved facilities in private factors clinics and hospitals particularly in terms of diagnostic equipment and staff-to-patient ratios which were attracting them to use these facilities.

rural vulnerable group stated an urgent need for a functioning public sector, where costs were lower and confidence in the quality of care greater.

These sentiments were most clearly expressed in AP but also in WB where this view was spread across the urban sample. In TN and AP the urban vulnerable group felt obliged to use private sector physicians due to lack of alternatives and convenience related to opening times and the availability of medicines.

Where costs were prohibitive people would forego treatment or describe the ailment as not serious. The highest share of this nearly half of the

Table 7: Distribution of ill persons indebted by different sources of loans or financial assistance received and vulnerability status. (%)

Source of loan / Assistance	Vulnerable (%)	Non-vulnerable (%)
Financial Assistance		
Relatives / Family	64.3	70.0
Office / Financial Institution	3.9	4.9
Money Lender	14.9	5.5
Sale/Mortgage of Property	8.3	4.1
Other reasons	8.6	15.5
Totals	100	100

Notes: Compiled from Study data (1999); V= Vulnerable (Patients below poverty line in 1999); NV= Non-Vulnerable patients above poverty line in 1999.

vulnerable group (48.5%) and one third (30%) were deprived of needed treatment due to cost as illustrated in Table 8.

When probed further about an ailment “being minor,” financial constraint was the true reason and overlapped with “not considering the ailment as serious enough” to seek care. For vulnerable and non-vulnerable groups in WB and TN, self-medication was often the option for minor ailments among adults. Particular care was taken however for pregnant women and children to ensure access to health care when needed despite the costs involved.

Figure 2 highlights time trends for lack of access and compares the findings of this study with that of NCAER in 1985. It shows that whilst the proportion of the population considering ailments as not serious was reduced in all cases (v and non v) during this period, financial constraints increased 3 fold for non-vulnerable and 5 fold for vulnerable groups between 1985 and 1999.

Table 8. Proportionate distribution of ill persons not seeking treatment by reasons and vulnerability status

Reasons for no medical attention	West Bengal		Tamil Nadu	
	V	NV	V	NV
Financial Constraint	48.5	28.3	30.0	36.1
Ailment not considered serious	26.3	51.5	28.0	41.0
No facility available	2.5	0.8	x	x
Other	22.7	19.4	42.0	22.9
Total	100	100	100	100

Notes: Source: Compiled from study data (1999); V= Vulnerable; NV= Non Vulnerable

Quality of Care

Views on the quality of care varied and depended on income and social origin. The better-off patients in TN and AP complained of waiting times in public hospitals and clinics, the lack of personal attention, the absence of needed medicine, and lack of cleanliness. Forced to use private facilities, the better off complained about rising costs and called for regulation to control prices.

The well-off groups who frequented private clinics and OPDs but opted for public facilities for inpatient care in both states (AP and TN) claimed that while the environment at the OPDs and wards of public hospitals had improved over the previous years there remained a lack of attention from doctors and long waits for cursory appointments.

Evidence from in-depth interviews with providers suggests that public hospitals, outpatient departments and primary health care facilities were forced to operate under huge stresses from serious under-resourcing, often leading to daily humiliation for those doctors and nurses working on the front lines. Further, the overall difficulties of obtaining public health services due to the distance to a functioning facility, poor transport linkages in rural areas, inconvenient opening times in cases of accidents and emergencies, the absence of medicines onsite, waiting times once one had reached a facility, and the cursory time spent with doctors for diagnosis in appointments contributed to the declining reputation of public health services whilst encouraging a rush of private providers to fill in the gaps.

Table 9; Private hospital bed availability at the time of Survey in AP (1999)				
Bed availability	PHI's (#)	%	Beds (#)	%
0	471	14.9	0	0
1-10	1,298	41.2	8891	19.1
11-20	842	26.7	16,543	29.1
21-30	307	9.7	8,231	17.7
31-50	140	4.4	5,855	12.6
51-99	52	1.7	3,553	7.6
100-249	37	1.2	5,319	11.4
> 250	4	0.1	1,158	2.5
Total	3,151	100*	46,550	100

Note: Source: Andhra Pradesh Health Information Board(1994),Narayana(2000)
Notes: PHI :Private Health Institution.
Figures may not add up to 100 as they have been rounded off.

Size of private sector and the issue of choice (TN, WB, AP)

Despite growing investment (as with the APVVP), the size of private sector institutions remained small in all three states. Most clinics and nursing homes had bed availability of less than 30 and were concentrated in better off urban areas. Nursing homes and clinics were usually owned by an individual doctor or pairs of doctors, whilst diagnostic centers were few and far between at the time of the study; these centers had experienced exponential growth during the past decade and a half. In the better off districts (coastal Eluru) in AP private sector doctors were mostly hospital based and specialist oriented, whilst in the poorer districts (inland: Mahbubnagar) they were located in clinics; doctors were aware that most patients would seek out public hospitals for inpatient treatment. The majority of doctors (85%) in the public sector also maintained private clinics which allowed them to self refer patients to their private facilities. **Table 9** highlights bed availability in the private sector and shows that at the time of the survey more than 2/3rds of hospitals had less than 30 beds in AP.

In all three states the major advantage of the private provider over the public one was immediate access to personnel and medicines; this was particularly important in emergencies. People use the private system – despite the cost – because they have no other choice.

This was an important finding of the study. Other studies of health sector reforms interpret utilization of the private system as a stated “preference” (Newbrander 1997; Sen and Koivusalo 1998). Interpreting the utilization of private provision as a *preference* is a misleading justification for privatization.

This is illustrated in a series of utilization and sectoral performance studies commissioned by the World Bank during the 1990s and in 2004 (Devarajan and Shah 2004; Gopakumar 2004). These studies argued that the poor quality of public provision and a failure to “deliver basic services to the poor” were key factors in the growing use of private health care. However this approach excludes key facts about the rationale for utilization, which in our study, among others cited here (Ghosh 2014; Narayana 2003; Qadeer et.al. 2001) shows a clear preference among the poor (and many non-poor) for a well-resourced public system, rather than privatization. However the lack of availability of adequate public provision at OPD and inpatient levels combined with uneven quality do have an important influence on decision making (Baru and

Bisht 2010; Dilip and Duggal 2002; Ergler et.al. 2013; Pollock 2004; Sen 2003; Unger et.al. 2006) .

However, the analysis provided by those supporting an increase in private health provision has been unable to address the impact on quality and access of disinvestment in the public sector in most states of India post-1990's. During this period, out of pocket expenditure increased in tandem with reductions in both central and state level contributions for health care (NSSO, 52nd and 60th rounds; Economic Research Foundation, New Delhi 2006). One may conclude that financial factors such as cost, distance and time (all of which are related to opportunity cost) affected the "perception" among vulnerable groups of whether an episode of sickness was serious or not. If this is taken into account, then the majority of those without access to health care were affected by economic factors rather than by any "choice" over quality; this refutes the neoliberal discourse on the utilization of health care among vulnerable groups.

Discussion

Current Scenario- the lost decade?

A decade of changes to the financing and delivery of services created major impediments to accessible public provision in all three states surveyed. Whilst the nature and scale of changes varied from one state to another, the underlying trend of commercialization of health care prevails. This is characterized by rising costs, reduced access to public health care, continued rural/urban disparities in availability of health care, and an uncontrolled rise in the price of medicines and diagnostics. All this is combined with aggressive marketing by corporate providers.

There has been a major shift towards private providers for inpatient care for the first time since Independence; this is evidenced by the 60th round of the NSS on morbidity and utilization of health services (from 1995/96 to 2004). In all three states we studied, commercialization has reduced the functional capacity of the public provider. The only exception was in primary care facilities where NRHM inputs averted a total collapse. The discussion below follows the thread of the study, to explore prospects for public health provision in India.

Between 1987 and 1996, there was a 30 per-cent decline in the overall use of public health facilities

in rural and urban areas with a concurrent increase in the use of private facilities. This contributed to an exponential rise in out-of-pocket expenditure and household indebtedness (Gangoli et. al. 2005; Mondal 2013; Srinivasan 2005). An analysis of the aforementioned NSS data complemented by a household survey in 2007 showed that among those using OPD during the NSS survey period some 34% of the population lost all savings, some 30% borrowed with high interest, and 2% were forced to sell assets to pay for OPD care. (Mondal 2013) To date, the imbalance continues to grow in favor of private providers, particularly for OPD care.

Three factors may be identified that continue to challenge public provision in both the country as a whole and in the three states studied here.

First and foremost is **prolonged under-investment in affordable, quality public provision** during the period 1991 and 2003-4. This led to a proliferation of private providers mostly for secondary and tertiary care as well as an explosion in OPD, diagnostic clinics, and pharmacies which mushroomed to fill in the gaps left by the state. These entrants, in particular the corporate ones, have been aggressively marketed by generous state subsidies ranging from lowered land prices, reduced interest rates on loans for capital and infrastructure, lowered duties on medical equipment, and other benefits normally conferred to fledgling industries. Incentives such as the ability for 100% FDIs (Foreign Direct Investment) allowed by several states for tertiary hospitals strengthened the insurance market for foreign companies which was opened up in 2008. (Bhat 2006; Butala and Northbridge 2010; Narayana 2003; Sen 2003; Bannerjee and Sen under review, 2017).

The second major factor is the **financing of private providers** through the Rashtriya, Swasthya Bima Yojana, (RSBY) system of universal health coverage implemented by the Government of India in 2008. Intended to support BPL (below the poverty line) families for *inpatient care* (up to Rs. 30,000 for a family of five persons⁵) it has been lauded worldwide and has in reality supported millions of families. However, it has also provided a major boost for the expanding private sector through the indirect linking of hospital treatment covered by the scheme to private providers (Basu 2010; Dror and Vellakkal 2012; The Economist 2010).

In theory, those covered by the scheme (RSBY) are entitled to choose between private and other

⁵ In 2016-2017 the amount of cover increased to one Rs.1 Lakh, covered a wider section of the BPL (below the poverty line) population in the informal sector and also included some pilot studies for coverage of OPD in a number of states.

Table 10: Empanelment of private and public hospitals in some States of India: 2010

State	Selected districts	Private Hospitals	Public Hospitals	Total
Andhra Pradesh	1	3 (43%)	4	7
Bihar	38	865 (89%)	100	965
Delhi	1	35 (100%)	n/a	35
Karnataka	30	546 (2%)	328	874
Tamil Nadu	2	n/a	n/a	n/a
West Bengal	19	544 (89%)	62	606
Kerala	14	146 (47%)	161	307
Punjab	22	175 (53%)	161	336

Source: Government of India RSBY Empanelment Data: Source: <http://www.rsby.in/Hospitals.aspx?id=1>

providers. However, in practice, the majority of empaneled hospitals providing RSBY are in the private sector. Thus, the problem afflicting the public provider at inception of this 3 states study remains largely unchanged a decade on. For example, RSBY data from 2010 demonstrates that the empanelment hospitals accredited to provide inpatient care within RSBY – with the exception of Kerala and Punjab – were predominantly in the private sector (85%) for a majority of states.

In West Bengal, until 2014, the private share was more than 89%, whilst in the poorest districts of the state such as Murshidabad and Birbhum empanelment of private providers was almost 100% (Ministry of Labour and Employment of the Government of India 2014). In Karnataka, out of 91 hospitals receiving accreditation by 2013, 77% (70) were in the private sector and only 10% were public providers. Since RSBY empanelment is in favor of private providers there is little choice for the patient but to opt for a bewildering variety of private providers.

Table 10 highlights the imbalance in empanelment in most states; some states have simply not reported on the public-private balance. A recent exploratory study in a number of districts of West Bengal suggests that the BPL population is not accepting treatment in private clinics, which has had an impact on the whole managed care system. (Bandyopadhyay and Sen 2017). While to date there has been no comprehensive evaluation of RSBY, the few reports from individual states indicate low levels of utilization of inpatient care where private providers are in a majority of empaneled hospitals under this scheme (Selveraj and Karan 2012, Sinha and Chatterjee 2014; Ghosh 2014; Thakur 2016). In Districts surveyed in West Bengal however, a clear

preference is stated among BPL for the public provider, thus reinforcing a long tradition of preference for public provision despite the lure of free health care in private hospitals and clinics.⁶

Implementation issues related to targeting also remain. Many states are still using BPL lists from 2002 to identify beneficiaries; this often leads to the exclusion and exploitation of those who have fallen into poverty since. Despite the enrolment of 37 million individuals by 2013, in many states less than half of those classified as BPL are listed. Moreover, tribal and scheduled castes in several states remained among the most vulnerable groups. (Dasgupta et al. 2013). There is also growing awareness that simply providing coverage for “inpatient services” is insufficient when the purchase of medicines (the greatest cost to patients), and OPD attendance, are key factors in ongoing impoverishment. (Basu 2010; Shahrawat and Rao 2012).

Hence the fragile and uneven quality of public provision is highlighted in the recent FICCI report on UHC (Ernst and Young Partners (India) 2012). The report shows the extremely limited capability of the public provider to compete with private hospitals, clinics, and (more recently) contracted primary health care as in other countries. (Jacobs 2010; Liu et al. 2014). This, despite continued demands from the public for improved accessible public services and to reductions in the growing disparities in access to health services among different segments of the population. This has been shown by our study and by the earlier work of Dilip and Duggal (Dilip & Duggal 2002) and more recently by several others (Ghosh 2014; Leone et al. 2012; Levesque et al. 2006; Mondal 2013). The outcome of such disinvestment will be a further

⁶ There is strong tendency to consult individual physicians but the same does not apply to institutional care in West Bengal where there is a tradition and a preference for public provision.

marginalization of the public provider with risk of ongoing cost escalation with private providers competing with each other for hi--tech facilities to lure patients.

The third major factors are **the lack of regulatory controls** over cost and quality and the adhoc expansion of private hospitals. Private providers in India face few controls with regard to cost and can provide uneven quality of care with limited patient redress. As in the case of women being forced to undergo caesarean sections in our study, the absence of controls worsens underlying problems of uneven quality, externalities, and the asymmetry of knowledge. These reinforce health inequities to the detriment of the population at large (Economic Research Foundation 2006; Rao 2012). Between 2004 and 2008 for example, the cost of deliveries in private health centers increased more than three-fold in Tamil Nadu, Andhra Pradesh and by twofold in West Bengal (Mohanty and Srivastava 2013).

Asymmetries of knowledge are evidenced in our utilization study (2000) and they work against patient interests leading to expensive and often unnecessary treatment.

In one of few studies of the financial health of 128 private hospitals across several states, Bhat (2006) raised serious concerns about poor financial management, poor quality of care, and the cost of care. Bhat questions the viability of the existing system. The study highlighted hospital debt arising among other factors from excessive spending on technology and medical equipment; these factors create medical inflation. The study showed expenditure on equipment in the selected hospitals more than doubled between 2001 and 2003 alone from Rs. 65.32 billion to Rs. 150 billion, accounting for some 12% of total private health expenditure. These expenditures could only be recouped from fees and charges. The author emphasized the inefficiencies of private hospitals, the fragmentation of care, and the near total absence of monitoring and regulation. (Bhat 2006)

The experience of “managed care” includes the lure of insurance funding for private providers and the inability of the federal state to control prices. This applies whether or not there is a ceiling or capping attached to a treatment episode: costs are likely to escalate. Experience suggests that multiple pressures from private providers often refusing to treat at the capped level is likely to challenge any set rate. Moreover since the bulk of empanelment in most states (bar a minority) falls under the private provider category, it can only further undermine public provision through substantial public subsidies

to private providers, without any recourse to the gatekeeping function of primary care and prevention; Primary Health Care has been long established as one of the most effective means for promoting population health, reducing health risk and health inequities, lowering longer term health care costs and most of all reducing the harmful effects of the asymmetry of knowledge between patients and providers (Abhiyan 2006; Qadeer, Sen & Nayar 2001; Yeravedkar et al. 2013). Current support for the expansion of hospital care further medicalizes people’s health by undermining public health and prevention.

Conclusion

After Independence, India never invested more than 3% of its GDP in health services. The initial National Plans were an effort to develop an infrastructure that could reach out to the population. The precedent for the gradual dismantling of public provision was embedded in the sixth Plan (1980) when it opened up the health sector to non-governmental institutions. Policy directives derived from the 1993 World Bank report “Investing in Health Care” were reflected in the National Health Policy (NHP 2002) which declared the inability of the state to fully meet population health care needs. (Gangoli, Duggal, Shukhla 2005; Nigam 2005). The NHP made a rallying call for private providers to fill the gap in public provision without any analysis of the root cause for the decline of the public sector. It lacked scrutiny of potential costs or quality of replacing public with private providers, in a country with no effective regulation of health care by private providers and a large vulnerable populace unable to challenge malpractice.

Disinvestment and the on-going subsidy of the private sector by the state are keys to declining public health services. This experience is widely recognized as a global phenomenon and includes the experiences of high, low, and middle-income countries. It is viewed as a phenomenon to boost and guarantee profits in a turbulent global market where public finance remains the most secure profit base for private providers (Pollock and Price 2002; Sen 2003). Also evident from the experience of India and elsewhere is that having a parallel system of provision where one sector is well placed to accrue profit whilst the other receives little, contributes to the chronic demise of public provision. It is also destructive of building a democratic social space, premised on less inequities across sectors but especially so in the health sector a root cause of fear and debt.

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Acronyms

APCE- Annual per capita expenditure
APVVP-
CHC - Community Health Care
CMIE -Centre for the Monitoring of Indian Economy
FICCI- Federation of Indian Chambers of Commerce% Industry
GDP- Gross Domestic Product
HHI – Household Index
IP- Inpatient
NCAER- National Council for Applied Economic Research
NHP- National Health Policy
PDS- Public Distribution System
RID- Relative Index for Development
RSBY- Rashtriya Swasthya Bima Yojana
UHC- Universal Health Coverage
UFS - Urban Frame Sample
V% Non- V

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Notes

1..BPL People living at or below the poverty line (1999).

2 The classification of vulnerable status depended on a variety of attributes. Definition of Vulnerability status was attributed to a household rather than an individual. The definition for Vulnerable and Non-vulnerable was attributed to the sample in West Bengal and Tamil Nadu only and had to include two of the

following criteria: Vulnerable: Per capita monthly household expenditure < Rs 500 for rural areas, < Rs 750 for urban areas, and < Rs 1000 for Kolkata and Chennai city. That the dwelling is Kutcha (not brick built) or thatched. That the Social Group is SC, ST, or OBC.

Non-vulnerable: Households which did not fit into the above criteria.

3. Survey date: 1999.

4. Self-reporting can underestimate conditions of morbidity for chronic conditions and other ailments not commonly known or diagnosed, especially among the least educated and most vulnerable.

5. Household Index: Household characteristics were combined into a single Household Index which includes composite values of poverty, high fertility, low income, low educational level, larger household size, higher dependency ratios, and predominantly rural residence and agricultural employment provided those households with a low score. Each of these attributes were given scores which then created the categories of high, medium, and low indices. These were used in the analyses to examine in particular, medical expenditure and indebtedness.

