PRIVATE SECTOR IN HEALTHCARE DELIVERY MARKET IN INDIA: Structure, Growth and Implications

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Private Sector in Healthcare Delivery Market in India: Structure, Growth and Implications

Shailender Kumar Hooda*

[***Abstract***: *This study analyses the extent, growth and regional distribution of private healthcare providers in India and draws some implications. Evidence shows that, presently, nearly 10.4 lakh private health enterprises consisting of hospitals/clinics, medical/dental/diagnostics centres, homeopathy/unani/ayurveda centres, nursing homes and social service centres, are providing a wide range of healthcare services in the country. While the private sector has grown since independence, it picked up pace in the 2000s—the liberalised phase of Indian healthcare sector. However, growth has largely been urban-centric, developed regions, and/or areas/districts where existence of public facility is already high. Private sector has failed in mending the deficiency gaps in health services provision across states, districts and rural-urban regions. The number of small informal practitioners has declined over the years, while that of large formal providers have increased. The Indian private hospital sector is shifting towards corporatisation, with the majority currently concentrated in only a few districts of some states. The number of allopathic providers is growing rapidly as compared to AYUSH providers. A large number of practitioners are unskilled (without formal degree) and are not registered under any act/legislation. Over the years, the private sector has overtaken the healthcare provision and delivery market; however, services are not cost-effective. This has resulted in high healthcare cost and high out-of-pocket health payment burden in the country.*]

Introduction

The growing size of private providers in health service delivery system has attracted considerable debate amongst scholars, civil society organisations and policymakers, both in the developed and developing countries. The growth phenomenon of the private sector, particularly in the developed countries that have followed a pro-market approach, is different from that of the others. Financing in these economies is largely managed through insurance companies, service provisioning by large hospital corporations and research by pharmaceutical and medical equipment companies. The government plays a minimal role, which includes giving subsidies for private medical care, providing public insurance to the

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elderly and the poor, but drawing up strong regulatory guidelines for the private sector (Baru, 2006). The experiences of these developed nations reveal that the market model has several shortcomings, despite that the pro-market model is widening even in Socialist countries like Russia and China and emerging economies like South Africa, Latin America and Asia including India (Lefebvre, 2010). The extent and nature of privatisation of the healthcare delivery market, however, vary widely across the globe.

India has been experiencing with private sector in healthcare delivery market since independence. But, little evidence is in place of how it has grown and diversified (in size, ownership pattern and structure) during the pre- and post-liberalised periods; how has its composition and distribution changed across rural-urban regions, districts and states; what is its role in meeting the requirement of deficient areas; whether private entities/ practitioners provide cost-effective services; and, so on. Against this backdrop, the present study attempts to provide evidences on the structure, trends and heterogeneous/diversified growth of private sector in healthcare delivery market in the pre- and post-liberalisation phases in India. The growth of the private sector is analysed by type of service providers like allopathic practitioners (not just physicians, but also those providing allopathic treatment like hospitals, medical and diagnostic labs/centres, etc.), Indian Systems of Medicine (ayurveda, yoga and naturopathy, unani, sidha and homeopathy, collectively referred to as AYUSH), and other nursing and social welfare services. The results are presented across states, districts and rural-urban regions of India. The study also draws upon evidence on how the hospital sector has been reshaped—from informal to formal and to corporatisation of healthcare, and lists the reasons behind its growth and how it has overtaken the healthcare delivery market. Based on these findings, some emerging challenges and implications for health sector are reported.

Methods and Materials

The study largely explores data from 57th (Unorganised Services excluding Trade & Finance), 63rd (Service Sector Enterprises excluding Trade) and 67th (Unincorporated Non-agricultural Enterprises excluding Constructions) rounds of National Sample Survey Organisation (NSSO) provided by the Ministry of Statistics and Programme Implementation, Government of India. These are the most recent rounds of NSSO which were conducted during 2001–02, 2006–07 and 2010–11 respectively. These include the Unorganised Service Sector Enterprises of India. These rounds have been chosen to help analyse the growth and structure of the unorganised health service enterprises of India. They include information on all kinds of health practitioners/providers—from individual practitioners to large allopathic hospitals, medical and nursing homes, dental practice, physiotherapists, para-medical practitioners, diagnostic and pathological laboratories, blood banks and others which include independent ambulatory care; Indian Systems of Medicine including ayurveda, unani and homeopathy; formal and informal practitioners; and, qualified and unqualified practitioners. In addition, health services are also classified as residential and non-residential cares. Residential care includes nursing facilities for the

elderly and rest homes for the mentally challenged, including for those suffering from other mental health disorders and substance abuse. Since social work activities—with and without accommodation for the elderly/disabled—are also part of healthcare activities, they have been included in these rounds.

The health service sector enterprises in these rounds are referred to as Own Account Enterprises (OAEs) or Establishments and define the ownership pattern as "for-profit" and "not-for-profit" enterprises. An OAE is, typically, run by an individual health practitioner or a household providing health services, but without employing additional workers on a "fairly regular basis". Thus, an OAE can be classified as an enterprise which employs temporary workers on an irregular basis. In most cases, OAEs are run by individual health practitioners and are therefore referred to as small health enterprises. The establishments, on the other side, hire at least one worker (along with temporary workers, if any) on a regular basis. Thus, establishments are generally referred to as large-sized enterprises. However, considering the fact that these enterprises can hire contract/temporary workers and can be of small, medium or large size, the results therefore are presented by classifying enterprises on the basis of the number of workers, including the owners of the enterprises.

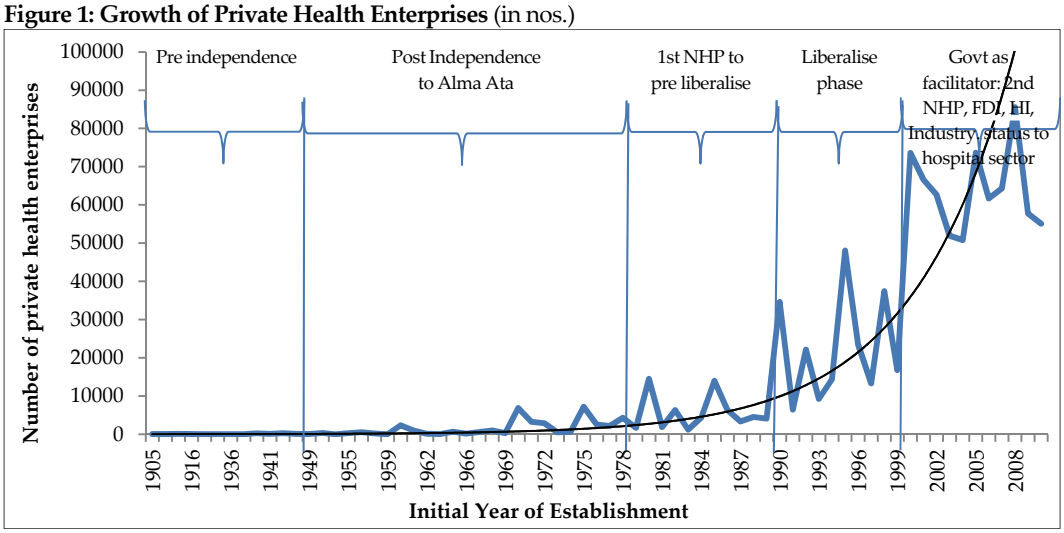
Note that the NSS data on service sector enterprises captures the health enterprises in informal or unorganised sector. In addition, the study also gathers information on organised health enterprises, especially on the hospital sector from Prowess database of the Centre for Monitoring Indian Economy (CMIE), Hospital and Dispensary Directory prepared Ministry of Health and Family Welfare, and through field survey investigations. Information has also been collected from some relevant published materials, including policy documents/reports.

Growth of Private Healthcare Sector

The existence of private sector in Indian healthcare can be traced at the time of independence. As per NSS 2010–11 survey, taking all practitioners and facilities together, around 10.4 lakh private health enterprises were providing health services in the country. Since independence, India's policy framework has undergone various changes on the macroeconomic front as well as within the health sector. If one goes by the initial year of establishment of the enterprises, it can be seen that the growth rate of private providers in healthcare picked up slightly during the 1980s, and rose sharply during the 1990s (*Figure 1*). This was a phase when a considerable amount of literature**,** especially from World Bank, International Monetary Fund and other pro-market thinkers, questioned the economic efficiency of the public sector as compared to the private sector. This literature, however, ignored its welfare effect on society; to top it off, resource constraints, measured through fiscal capacity, were cited as the main reason for the limited role of public sector in healthcare.

The growth rate of private healthcare providers seems to have risen sharply after 1990–91, that is, the liberalisation phase of the Indian economy. Growth, however, turned sharper after 2000 when a considerable amount of liberalisation policies were rolled out in the Indian healthcare sector. During the period, state was largely seen as a facilitator of private sector, with limited or no role as a regulator. Cross-country experiences, however, reveal that in countries which follow a pro-market approach claims to draw up strong regulatory guidelines for the private sector. But, in the context of the private sector in India, state has largely been a facilitator rather than a strong regulator.

Figure 1: Growth of Private Health Enterprises (in nos.)



Source: Unit level record of 67th round of NSS.

Low and inadequate public spending in health sector has been a generic problem of India. In a recent period, the spending level is noticed to be lower than the required level of resources; in fact, it cannot even meet the minimum level of basic healthcare facilities in the country. The current health spending level is noticed to be very low at 1.2 per cent of Gross Domestic Product (GDP), which is significantly lower than the global average of five per cent of GDP. Public spending on health in India is not only lower than the global average, it is recorded to be even lower than some of the low and middle income countries, including those whose per capita GDP is lower than that of India. Despite an ambitious commitment under National Rural Health Mission in 2005 and High Level Expert Group meeting in 2011 to increase public spending by two to three per cent of GDP, it could not be increased. Even if one adds indirect health spending (like water supply and sanitation expenditure) to the health spending component, it will reach only half of the committed two to three per cent benchmark (Hooda, 2015a). Low public spending on health confirms little intervention from the state in the health sector, which leads to inadequacy of services and provides leverage to the private sector to exploit the healthcare market.

Recently, there is an indication of state withdraw from the health sector, but seems to be as a facilitator of private sector. For instance, in the 2003–04 budget, the hospital sector was

accorded the status of an industry, following which long-term cheap loans were granted to private healthcare institutions (Shah and Mohanty, 2011). With this move, the health sector, especially hospitals, received various benefits such as reduced custom duty on medical equipment (from 100 per cent to 40 per cent during the late 80s and further to 15 per cent in 2000s and 7.5 per cent in 2016), subsidised land, cheap loans, and income tax exemption.

In the year 2000, Government of India allowed 100 per cent foreign direct investment (FDI) in hospital sector through automatic route. This was a major initiative to invite/attract foreign private players in the hospital sector. The foreign players made significant strides through foreign direct investment. Foreign investment in hospital sector increased to Rs 3995 crore in 2013–14 from a meagre Rs 31 crore in 2001–02 (Hooda, 2015b). While some foreign players pursued independent ventures, others entered into joint ventures with domestic players. The share of FDI equity inflow into hospital sector in the total health sector FDI inflow increased from 12.8 per cent in 2000 to 25.5 per cent in 2013 (Hooda, 2015b).

The national health policy landscape has recently undergone changes, especially on the health financing front. Government's approach to finance healthcare has shifted from its traditional way of tax-based health financing for comprehensive provisioning of healthcare services to financial protection through health insurance. Health insurance is seen as a means to finance household healthcare expenses. In addition to employer-based health insurance schemes like CGHS and ESIC, India threw open its health insurance sector to private domestic insurers in 1999. The insurance sector further opened up for foreign players through FDI in health insurance. The FDI cap in health insurance increased from 26 per cent to 49 per cent in 2014. Note that these private health insurers generally target the middle and upper-middle income groups, especially those who can pay a premium. These schemes generally allow people to avail healthcare facilities both from the public and the private providers, especially for hospitalisation care. Taking into consideration the low level of per capita income of majority of the population**,** penetration of private health insurance remained low. It is because majority of the population is unwilling to accept a premium-based health insurance policy. Low income levels also lead to low-paying capacity for high-priced (costly) private healthcare facilities, which, in turn, render health services inaccessible for a majority of the population. In order to increase the paying capacity, the private sector persuaded the central and state governments to cover the poor and informal community under the government-funded health insurance schemes. Following this, states like Karnataka, Andhra Pradesh and Tamil Nadu introduced the central government’s pro-poor health insurance scheme called Rashtriya Swasthya Bima Yojna (RSBY) to provide financial protection to poor communities for availing the services from the public as well as private healthcare providers. Considering that a person enrolled in an insurance plan will generally avail services of a private facility, it will only indirectly promote private healthcare providers in the long run.

Health is essentially a *state subject* in India. It is the state’s prerogative to make appropriate regulations and legislations for the private sector to perform uniformly. Considering that

the health sector is critical to saving lives, there is need for stronger regulatory governance for private practitioners/providers. Evidence shows that nearly 66 per cent of the health enterprises are registered under various Acts and only 43 per cent are registered under Medical Practitioners Act (MPA). Regulation status of private practitioners at state level shows that out of 29 states, about 16 do not have any legislation, which makes it mandatory for private establishments to have a licence to function. The remaining 13 states have also adopted various Clinical Establishment Acts[1], but they are either out-dated or lack appropriate guidelines and rules. The Act, therefore, could not be enforced properly in many of these states. For instance, minimum standards related to infrastructure, human resources, patient safety and display of information have not been developed, nor are the issues relating to accountability with respect to quality and price been addressed in states that have enforced these legislations (Phadke, 2016). The service provision and quality norms in many formal facilities are reported to be inadequate. For instance, in West Bengal, around 94 people died in a state-of-the-art corporate hospital on 9 December 2011 simply because the hospital did not follow proper quality and safety rules. The mushrooming of the private health sector with or without appropriate regulations leads to unhealthy and unethical health practices in the country which is a serious cause of concern.

On May 3, 2010, the Parliament passed the Clinical Establishments (Registration and Regulation) Act, 2010 which is applicable to all types of healthcare providers. It covers all clinical establishments owned, controlled or managed by private or government providers, society/trust (public or private), dental clinics, corporations and private practitioners; services of practitioners of recognised systems of medicine (ayurveda, unani, siddha, etc.), all types of laboratories, diagnostic institutions and therapy centres, and so on. This is important for infrastructure, human resources, availability of medicines and equipment, including their maintenance for improving the quality of healthcare services (Phadke, 2016). Till date, the Clinical Establishment Act 2010 (CEA, 2010) has only been enforced by a few states like Bihar, Jharkhand, Uttrakhand, Himachal Pradesh, Arunachal Pradesh, Sikkim, Pondicherry, Uttar Pradesh, Rajasthan, and Mizoram despite its inadequate form.

Coupled with various pro-market health sector reform initiatives, population dynamics, people's awareness and perception about health, change in treatment-seeking behaviour, double burden of disease, changing nature of life style diseases, global integration and

[1] Namely Bombay Nursing Homes Registration Act 1949; West Bengal Clinical Establishment Act, 1950; Delhi Nursing Homes Registration Act, 1953; Jammu and Kashmir Nursing Homes and Clinical Establishments (Registration and Licensing) Act, 1963; Madhya Pradesh Upcharya Griha Tatha Rujopchar Sambandhi Sthampamaue (Registrikaran Tatha Anugyapan) Adhiniyam, 1973; Punjab State Nursing Home Registration Act, 1991; Orissa Clinical Establishments (Control and Regulation) Act, 1991; Manipur Nursing Home and Clinic Registration Act, 1992; Sikkim Clinical Establishments (Licensing and Registration) Act, 1995; Nagaland Health Care Establishments Act, 1997; Tamil Nadu Private Clinical Establishments Regulation Act, 1997; Andhra Pradesh Private Medical Care Establishments (Regulation and Registration) Act, 2002, Rules 2005 and 2007; Karnataka Private Medical Establishments Act, 2007.

medical tourism are other possible factors that have encouraged private providers/enterprises and foreign investors to exploit the hospital market in India. All these factors together have resulted in the growth of private health practitioners in the country. Though the private sector has grown over the period, but growth is noticed to be faster during the period when such pro-market initiations were followed, especially after the nineties.

Changing Landscape of Private Sector Growth

The growth of the private sector has been highly heterogeneous in India. Various providers *viz*. formal and informal, for-profit and not-for-profit, national and multinational for-profit corporation, and small, medium and large corporate entities have come up. Of the total 10.4 lakh healthcare enterprises, the share of Own Account Enterprises (OAEs) which function without hiring workers on a regular basis is recorded to be around 71.3 per cent in 2010–11, which amounted to 7.38 lakh in number. The number of registered establishments was recorded at around 2.97 lakh (28.7 per cent). A higher number and share of OAEs reflects that small enterprises, especially run by individual practitioners, dominate the healthcare delivery market. Such a practitioner is referred to as a traditional healer or barefoot doctor or *ghola chhap* doctor who generally provides outpatient care services.

Health enterprises in India have grown and diversified over a period of time. Its diversity can be reflected in the following classifications viz. hospitals, medical and nursing homes, dental care practice, nurses, masseurs, physiotherapists, para-medical practitioners, diagnostic and pathological laboratories, blood banks and others which include independent ambulatory care, ayurveda, unani and homeopathy practitioners. In addition, services are also classified as residential and non-residential cares. Residential care includes nursing care facilities for the elderly, rest homes for the mentally challenged, including those suffering from other mental health disorders and substance abuse. Social work, with and without accommodation for the elderly/disabled, is also part of the healthcare activities in the country.

The private healthcare sector is dominated by service providers of allopathic medicines. In 2010–11, the share of allopathic facilities was around 76 per cent, consisting of hospitals (7.8 per cent), medical (55.6 per cent), dental (4.1 per cent), nursing (4.1 per cent) and diagnostic (4.4 per cent) labs/centres, whereas the shares of service providers of homeopathy and ayurveda medicines were recorded to be around 11.2 per cent and 7.4 per cent respectively. It is interesting to note that after independence, roughly 1352 private health enterprises were recorded in 1950, which cumulatively increased to 10.4 lakh in 2010–11 (*Table 1*). In 1950, Ayurveda service providers dominated the healthcare delivery market as against allopathic providers. However, over a period of time, allopathic health enterprises grew at a much faster rate than ayurvedic and others (*Table 1*). The high growth in allopathic services may be attributed to the several pro-market reform initiatives undertaken over

time, which favour allopathic providers the most. The initiatives include the introduction of public-private partnership, accordance of industry status to hospital sector, FDI in hospital sector, and promotion of private, social and pro-poor health insurance schemes to avail hospitalisation services that suit the allopathic service providers.

Table 1: Heterogeneous Growth and Structure of Private Healthcare Sector in India

	1905–1950	*1951–1960*	*1961–1970*	*1971–1980*	*1981–1990*	*1991–2000*	*2001–2010*	*Total*	*GR*
Hospital	187	11	1284	4332	8123	13973	52240	80265	1.13
Medical	331	2342	2539	19630	42847	137144	368517	576027	1.12
Dental	42	0	201	73	1747	7841	31805	42052	1.16
Ayurvedic	504	449	1796	6866	9812	29662	27767	76891	1.08
Unani	0	512	477	202	61	6187	9346	16837	1.06
Homo	0	23	765	4709	11150	34000	64748	115760	1.16
Nursing	0	0	2366	1360	1130	13712	23663	42231	1.07
Diagnostic	0	0	32	707	2342	13215	29056	45805	1.18
Others	0	0	1239	1053	2591	5688	12931	23856	1.07
Residential	289	90	42	429	127	1233	4232	6521	1.05
Social	0	1	0	388	800	2270	5783	9252	1.10
Total	1353	3428	10741	39749	80730	264925	630088	1035497	1.11

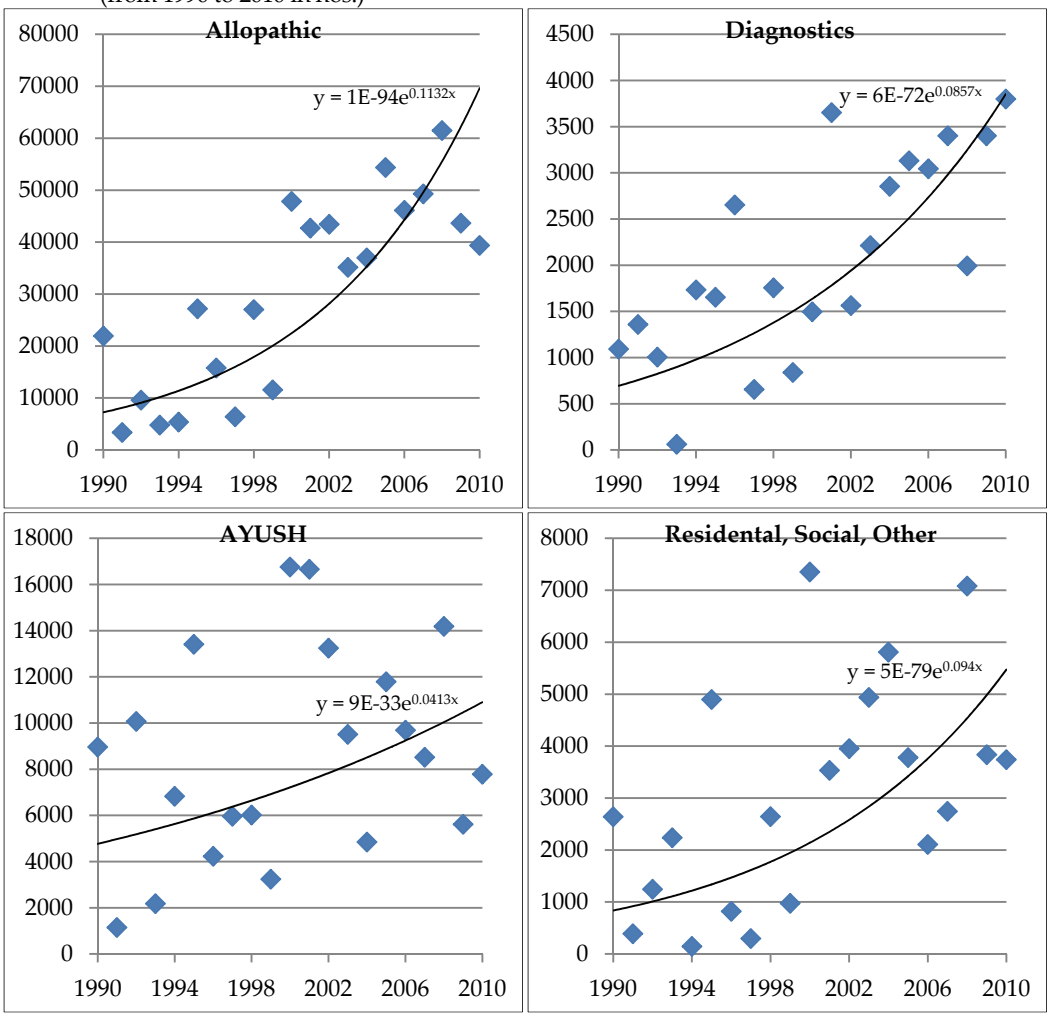
Note: Total enterprises are higher than the cumulative add up, as it represents the year 2010–11.
Source: 67th round of NSS.

Based on the foregoing, allopathic providers can be classified as hospital, medical, dental and diagnostic labs, and blood bank service providers. Within the overall classification of healthcare providers (presented in *Table 1*), medical service providers constitute the largest share of around 55.6 per cent. Only 21.7 per cent of these medical care enterprises are establishments and the rest 78.3 per cent are OAEs, indicating that a majority of medical care providers are small/independent practitioners. A large number of hospitals and dental and diagnostic enterprises are of the nature of an establishment (about 66.8 per cent, 65.1 per cent and 61.6 per cent respectively), but their share in total allopathic enterprises is low. This reflects that the Indian healthcare market is dominated by small-sized private enterprises. Under the Indian Systems of Medicine, homeopathy practitioners constitute a large share (about 11.2 per cent) in the total private health enterprises (*Table 1*). As far as the rate of growth of these enterprises is concerned, allopathic service providers (hospital, medical and dental) and diagnostic labs/centres grew at a faster rate as compared to the Indian Systems of Medicine (AYUSH) and other providers (*Figure 2*).

On an average, 64 per cent of the health enterprises, OAEs and establishments taken together are run by individual practitioners. The medical/clinic, ayurvedic, unani, homeopathic and nursing cares in most cases are operated by individual practitioners. Hospital and residential/social care centres absorb more workers per enterprises as

compared to other service providers. Most of the medical care institutions (70 per cent) are run by individual practitioners (*Table 2*).

Figure 2: Heterogeneous Growth: Rise of Allopathic and Diagnostic Establishments, Post 1990s
(from 1990 to 2010 in nos.)



Source: 67th round of NSS.

The classification of private health enterprises by type, nature and size shows that the share of establishments in 1950 was 53.7 per cent, which declined to 28.7 per cent in 2010–11. At the time of independence, around 21.4 per cent private health enterprises registered themselves as not-for-profit entities (NPE). The NPE share, however, was recorded to be very low, around 1.6 per cent in 2010–11. Today, most of the enterprises (about 98.4 per cent) are for-profit (FPE) in nature (*Table 3*).

Table 2: Size of Private Health Enterprises by Number of Workers, 2010–11

	Comp.Distribution (in %)			*Distribution by Providers (in %)*			*Aggregate (% and no.)*		*Nature and registration status of enterprises*		
	Small (1)	*Mediu m (2-5)*	*Large (≥6)*	*Small (1)*	*Mediu m (2-5)*	*Large (≥6)*	*Total (%)*	*Total (no.)*	*% of Est*	*% of FPE*	*Not regd. under any act (%)*
Hospital	33.5	34.4	32.2	4.1	8.4	53.0	7.8	80265	66.8	97.7	15.4
Medical	69.9	28.5	1.6	61.1	50.2	18.4	55.6	576027	21.7	99.6	35.4
Dental	27.9	71.5	0.6	1.8	9.2	0.5	4.1	42052	65.1	99.9	18.9
Ayurveda	68.7	30.5	0.8	8.0	7.2	1.2	7.4	76891	17.2	99.7	32.9
Unani	63.4	36.6	0.0	1.6	1.9	0.0	1.6	16837	30.3	100.0	37.7
Homeopathic	75.2	24.5	0.3	13.2	8.7	0.7	11.2	115760	18.8	99.2	33.2
Nursing	80.8	19.1	0.0	5.2	2.5	0.0	4.1	42231	12.0	99.8	59.1
Diagnostic	31.0	58.7	10.3	2.2	8.2	9.7	4.4	45805	61.6	99.3	29.2
Blood Bank	69.2	14.8	16.0	0.0	0.0	0.1	0.0	318			
Other	69.8	27.4	2.8	2.5	2.0	1.3	2.3	23538	21.8	97.0	56.7
Residential	22.2	37.1	40.7	0.2	0.7	5.4	0.6	6521	76.9	51.2	33.1
Social	12.8	37.0	50.1	0.2	1.0	9.5	0.9	9252	77.1	19.3	18.7
Total	63.7	31.6	4.7	100.0	100.0	100.0	100.0	1035497	28.7	98.4	33.8

Source: Unit level record of 67th round of NSS.

NSSO data on Service Sector Enterprises provides interesting insight into the type, nature, size and growth of private health enterprises. The total number of enterprises decreased from 13.2 lakh in 2001–02 to 10.4 lakh in 2010–11, which comprises both NPE and FPE enterprises. The share of NPE in the total number of health enterprises is significantly lower than that of FPE. The share of NPEs in the first two rounds (57th and 63rd) shows an increasing trend. A closer examination of data reveals that most of the NPEs are registered under a co-operative society, charitable or trust Acts. These NPEs are basically large-sized establishments, which generally employ a large number of workers in order to function properly. As far as the type of enterprises (OAE or establishment) is concerned, both the number and the share of the establishments increased during different rounds of data between 2001 and 2011. All enterprises taken together by size of workers reflect a true picture of the size (small or large) of the enterprises. For the purpose, enterprises are classified as very small having individual/single worker/owner, small (two to five workers), medium (five to 10 workers) and large (more than 10 workers). The analysis of different rounds of data shows an increasing trend in small-, medium- and large-sized enterprises and a declining trend in single/individual run enterprises. Large-sized enterprises are increasing at a much faster rate as compared to medium- and small-sized health enterprises. About 89 per cent of OAEs are run by individual/single practitioners. Though OAEs dominate the healthcare market, they witnessed a decline in shares between

2001–02 and 2010–11 (*Table 3*). This reflects that large-sized enterprises are mushrooming at faster rate in the country.

Table 3: Ownership Pattern and Changing Nature of Private Health Enterprises

	Type of Enterprises		*Nature of Enterprises*		*Size of Enterprises (by no. of workers)*				
	OAE	*Est.*	*NPE*	*FPE*	*Single (1)*	*Small (2–5)*	*Medium (6–10)*	*Large (>10)*	*Total*
2001–02 (57th)	1081325	241106	25422	1297009	1009064	276690	25777	10900	1322431
	(81.8)	(18.2)	(1.9)	(98.1)	(76.3)	(20.9)	(1.9)	(0.8)	(100)
2005–06 (63rd)	793032	280469	31408	1042093	757227	287611	28629	16819	1090286
	(72.7)	(25.7)	(2.9)	(95.6)	(69.5)	(26.4)	(2.6)	(1.5)	(100)
2010–11 (67th)	738647	296850	16982	1018515	659475	327344	30246	18432	1035497
	(71.3)	(28.7)	(1.6)	(98.4)	(63.7)	(31.6)	92.9)	(1.8)	(100)
CAGR (2001–11)	**-0.041**	**0.023**	**-0.044**	**-0.026**	**-0.046**	**0.019**	**0.018**	**0.060**	**-0.027**
Decadal Growth of Health Enterprises (using establishment year from 67th round of NSS)									
1905–1950	46.3	53.7	21.4	78.6	13.2	55.3	16.9	14.6	1353
1951–1960	76.5	23.5	2.9	97.1	75.2	21.8	0.0	2.9	3428
1961–1970	65.4	34.6	3.8	96.2	35.4	55.6	4.5	4.6	10741
1971–1980	70.2	29.8	2.5	97.5	56.3	31.4	6.8	5.5	39749
1981–1990	71.3	28.7	2.1	97.9	62.5	32.8	2.6	2.1	80730
1991–2000	71.2	28.8	1.6	98.4	64.8	30.3	2.8	2.1	264925
2001–2010	71.6	28.4	1.5	98.5	64.3	31.7	2.3	1.7	630088
Up to 2010–11 (67th round)	738647	296850	16982	1018515	659475	327344	30246	18432	1035497

Source: Unit level records of 57th, 63rd and 67th rounds of NSS.

The above-given figures, worked out on the basis of year of establishment of an enterprise from 2010–11 NSS dataset, also show that up to the 2000s, the number/share of OAEs grew at much faster than that of the establishments. The trend, however, reversed thereafter (*Table 3*). It may be because some of the Indian states had introduced health insurance schemes, which led to an increase in insurance penetration in the country. Health insurance generally provides reimbursement for medical expenses incurred during hospitalisation. Hospitalisation services are provided by the large/formal establishments/ hospitals/ enterprises. Therefore, formal establishments/enterprises show an increasing trend as compared to OAE/informal/small practitioners. The share of OAE/informal enterprises, however, is still very high. The notion that emerges from the declining number of small providers and the increase in the number of large and middle providers is that India's healthcare sector is shifting from informal/unorganised to the formal/organised providers. In this process, the big fish (large enterprises) eats the small fish (small clinics/individual providers). How this changing trend will help in providing healthcare services to the poor and general population needs to be evaluated separately.

In 2010–11, there were around 10.4 lakh private health enterprises, which roughly employed 21 lakh workers in the healthcare sector. This accounts for 1.9 per cent of the total workforce (manufacturing, trade and services excluding agriculture) in India and 5.4 per cent of total workforce engaged in the services sector. Engagement of workers in OAEs (835375 in number) is slightly higher than in enterprises per se (738647 in number). This reflects that around 89 per cent of the OAEs are run by individual practitioners and the rest 11 per cent sometimes employ workers on a temporary basis. The OAEs roughly engage 40 per cent of the total workforce in healthcare enterprises, while the rest 60 per cent are in establishments. Within OAEs, the clinics/medical care enterprises engage the highest number (60.4 per cent) of workers of the total workforce engagement in private health enterprises (*Table 4*). It is interesting to note that a large proportion of these workers, including working owners, are without formal degree/education. The private health enterprises, therefore, comprise unskilled, semi-skilled and skilled health practitioners.

Table 4: Workforce Engagement in Private Health Enterprises, 2010–11

	Comp. Distribution (%)		*Distribution by Providers (%)*		*Aggregate (in % and no.)*	
	OAEs	*Est.*	*OAEs*	*Est.*	*Total (%)*	*Total (no.)*
Hospital	6.2	93.8	3.6	36.2	23.2	485564
Medical	57.2	42.8	60.4	29.9	42.1	879581
Dental	19.2	80.8	2.1	5.9	4.4	91705
Ayurveda	65.1	34.9	9.0	3.2	5.5	115381
Unani	54.8	45.2	1.5	0.8	1.1	23323
Homo	65.9	34.1	12.1	4.1	7.3	153033
Nurse	74.3	25.7	4.8	1.1	2.6	54121
Diagnostic	17.0	83.0	2.6	8.4	6.1	127839
Blood	37.5	62.5	0.0	0.0	0.0	773
other	48.0	52.0	2.5	1.8	2.1	44046
Residential	6.2	93.8	0.3	2.6	1.7	34741
Social	8.9	91.1	0.9	5.8	3.8	80415
Total	39.8	60.2	100.0	100.0	100.0	2090522

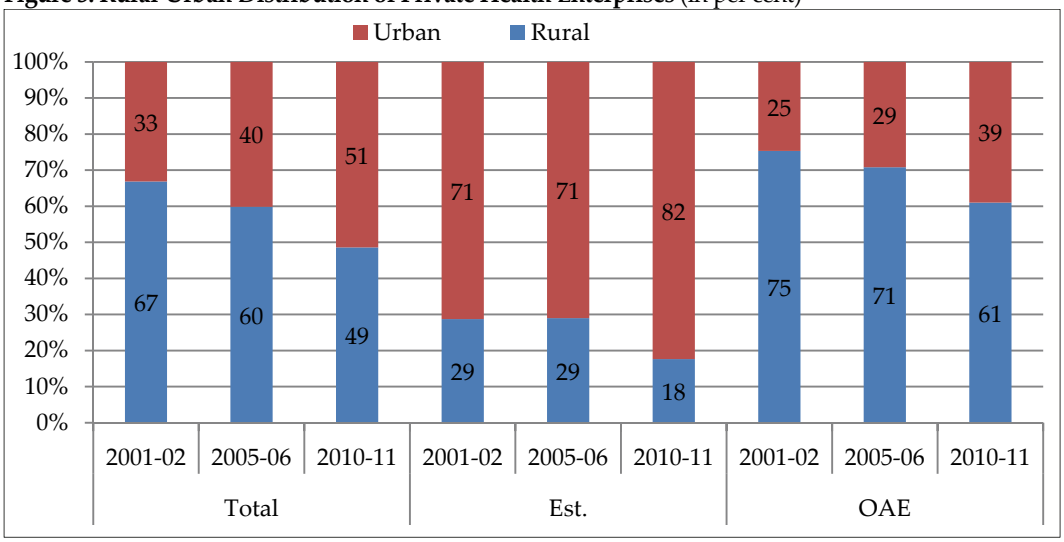
Source: Unit level record of 67th round of NSS.

Regional Distribution of Private Entities

The regional distribution of private facilities shows that the presence of OAEs is greater in rural areas. In 2010–11, OAEs held around 61 per cent of the shares in rural areas. In 2010–11, only a marginal 18 per cent of the establishments were reported to be present in rural areas, while the rest 82 per cent were reported to be present in urban areas (*Figure 3*). This reflects that rural areas have a greater number of small/individual practitioners but lack in formal organised and large facilities as compared to urban areas (*Figure 3*). Presence of a high number of OAEs/individual practitioners in rural areas may be attributed to the poor

implementation of the Clinical Establishment Act, which also reveals an unsatisfactory level of compliance with guidelines/regulations that pertain to healthcare practices. A closer examination of NSS data reveals that a majority of these enterprises are not registered under any act; but those registered, get approval certificate from village Pradhan/Panchayat rather than upon formal registration of the clinical practice. NSS data also reflects that a majority of the healthcare practitioners in rural areas have no formal education/degree. These conditions certainly affect the quality of health services in rural areas. It can be said that rural areas lack in formal organised and adequate quality healthcare facilities.

Figure 3: Rural-Urban Distribution of Private Health Enterprises (in per cent)



Source: 57th, 63rd and 67th rounds of NSSO.

Distribution of private health enterprises per 100 thousand population across states in India shows that a high number of private health enterprises (PHE) and private allopathic enterprises (PAE) are reported (in ascending order) to be present in Himachal Pradesh, Gujarat, Pondicherry, Chhattisgarh, Karnataka, Kerala, Maharashtra, Andhra Pradesh, Chandigarh, West Bengal, Uttaranchal, Uttar Pradesh, Punjab, Haryana and Delhi (*Table 5*). Barring a few, these happen to be high-income and economically prosperous states, indicating the presence of a large number of private enterprises. The presence of public (government) allopathic hospitals per 100 thousand population, however, does not reflect the same trend. A simple correlation between private allopathic enterprises (PAE) and public allopathic hospitals (PAH) at state level turned out to be negative with coefficient value -0.56. This indicates that the number of private allopathic enterprises per 100 thousand population is lower in states where public allopathic hospitals are more in number and vice-versa. That is, if a state ensures the provision of a vast range of government healthcare facilities to its population, the probability of having private facilities will be low. However, it would be interesting to observe whether the private sector will

Table 5: Public and Private Healthcare Facilities at State level – A Comparison

	Govt hospitals and private health enterprises (in nos.)#			*Per 100,000 Population (in nos.)*			*Healthcare use from private facility: 2014## (in per cent)*		
	PHE	*PAE*	*PAH*	*PHE*	*PAE*	*PAH*	*OPV: Male*	*OPV: Female*	*IPD: Person*
Manipur	139	34	725	5	1	27	57	40	11
Nagaland	34	31	575	2	2	29	9	58	27
Arunachal Pradesh	66	41	767	5	3	55	3	1	11
Sikkim	18	18	204	3	3	34	23	21	27
Assam	7109	2010	6599	23	6	21	25	21	11
Meghalaya	1058	239	546	36	8	18	4	52	11
Mizoram	128	128	449	12	12	41	32	49	14
A & N Islands	66	62	173	17	16	46	41	19	6
Daman & Diu	50	38	33	21	16	14	88	98	75
Tripura	4155	713	837	113	19	23	69	30	7
Orissa	19782	8819	9664	47	21	23	32	25	19
D & N Haveli	89	89	58	26	26	17	30	69	30
Bihar	59937	33164	12230	58	32	12	98	47	57
Goa	483	483	235	33	33	16	70	80	49
Jammu & Kashmir	4953	4283	4272	39	34	34	52	53	6
Jharkhand	19385	12267	4837	59	37	15	68	84	60
Tamil Nadu	43605	29812	11928	60	41	17	69	65	60
Rajasthan	40490	31853	15527	59	46	23	64	61	46
Madhya Pradesh	48740	34799	11564	67	48	16	73	74	47
Himachal Pradesh	4302	3411	2688	63	50	39	43	60	24
Gujarat	46111	31328	9985	76	52	17	82	82	77
Pondicherry	822	652	125	66	52	10	63	65	68
Chhattisgarh	17039	13861	7889	67	54	31	87	53	51
Karnataka	48178	36069	11946	79	59	20	82	78	73
Kerala	34846	21577	6639	104	65	20	72	64	65
Maharashtra	95684	73505	13564	85	65	12	87	81	81
Andhra Pradesh	74603	57300	14606	88	68	17	89	85	78
Chandigarh	951	790	21	90	75	2	69	50	23
West Bengal	112470	73245	12831	123	80	14	82	80	23
Uttaranchal	11836	9083	2966	117	90	29	60	47	49
Uttar Pradesh	233826	189168	24908	117	95	12	87	84	70
Punjab	40489	28163	3643	146	102	13	79	83	71
Haryana	36312	26311	3121	143	104	12	89	92	67
Delhi	27741	21121	155	166	126	1	88	71	37
Total/Average	**1035497**	**744467**	**196331**	**86**	**62**	**16**	**76**	**74**	**58**

Note: PHE: all types of private health enterprises; PAE: private allopathic enterprises consisting of medical and dental hospitals, diagnostic centres/labs and blood banks; PAH: all types of govt/public allopathic hospitals including SCs, PHCs and CHCs during March 2012.

Source: #- 67th (2010–11) round of NSS for PAE and Rural Health Statistics 2012 for PAH; ##- utilisation status from 71st (2014) round of NSS.

serve the underserved (where government facilities are low) area/state. This will be possible only if one analyses data of both the public and the private healthcare facilities at the disaggregate level, say the district level.

District-level information on private health enterprises shows that out of 568 districts, only 29 per cent (166 in number) districts have large (more than 10 workers) private allopathic facilities (*Table 6*). The remaining 71 per cent districts have only small providers, of which a majority are informal providers with very low level of education and also involved in unethical practices. Interestingly, in states like Himachal Pradesh, Tamil Nadu, Andhra Pradesh and Kerala, nearly 50 per cent, 60 per cent, 70 per cent and 86 per cent districts have large private allopathic healthcare facilities. The coverage of districts with large private allopathic facilities in high-income states like Gujarat, Haryana, Punjab and Maharashtra is noticed to be lower than in the above-mentioned four states, namely Himachal Pradesh, Tamil Nadu, Andhra Pradesh and Kerala. It may be because health insurance penetration in Himachal Pradesh, Tamil Nadu, Andhra Pradesh and Kerala is much higher than the all-India average. As discussed, health insurance generally encourages the private sector to exploit the healthcare delivery market. So, it can be interpreted that it is not the aggregate income but the paying capacity protected through health insurance which matters more as far as the location of the private sector enterprise/establishment is concerned. The notion that high-income states can attract a high percentage of private facilities does not hold true.

The status of public healthcare facilities at district level measured through an all-India Index, which includes information on sub-centres, primary health centres, community health centres, sub-divisional and district hospitals (per 100 thousand population) shows high variation across districts. The value of Index turned out to be very high, i.e. 21.11 in one district, while it was as low as 0.0000184 in another district. This indicates that there exists high inequality in public provisioning of healthcare facilities across districts in India.

Now, we shall evaluate whether the notion—if a state ensures high number of government healthcare facilities, the probability of having private facilities would be low—holds true at district level. For the purpose, correlation between public healthcare facilities (represented through index value) and private allopathic enterprises using district level information is estimated. The correlation coefficient between these two turned out to be positive. This means that private large allopathic enterprises can also be found in districts where a large number of public facilities already exist. So, the state-level notion breaks down if one looks at the district-level information on public and private healthcare facilities. From this analysis one can conclude that the private sector does not exist just for the sake of filling the health service deficiency gap; rather, it perceives the health service cluster as an opportunity to expand the market. Thus, there is dearth of both public and private facilities in many of the districts. While there is no one to serve people in these districts, others are abounding in both public and private healthcare facilities. This reflects that the private sector is not inclined towards filling the

regional gap in health infrastructure in the country, but considers it as a profit-making business. Private healthcare facility is an urban-centric phenomenon; in other words, an area where a healthcare market already exists.

Table 6: District-level Status of Large/Charitable/Trust Enterprises, 2010–11

	Number of districts having private allopathic enterprises (PAE)					*%age of Establishment*
	Total no. of NSS districts	*Large PAE (>10 workers)*	*% of district covered with large PAE*	*PAE regd. under CPT*	*PAE regd. Under CPTS*	
Andhra Pradesh	23	16	70	3	6	25
Assam	24	4	17	1	1	25
Bihar	38	4	11	1	1	16
Chhattisgarh	18	1	6			11
Delhi	7	3	43	2	3	60
Gujarat	25	7	28	5	7	46
Haryana	20	7	35	2	2	32
Himachal Pradesh	12	6	50	1	3	24
Jammu & Kashmir	11	1	9			57
Jharkhand	22	2	9	1	1	28
Karnataka	28	9	32	1	1	49
Kerala	14	12	86	3	9	39
Madhya Pradesh	48	6	13	1	2	19
Maharashtra	34	12	35	2	4	52
NE states	21	5	24		1	
Orissa	29	5	17	2	4	15
Punjab	19	9	47	1	3	21
Rajasthan	31	3	10	3	6	19
Tamil Nadu	30	18	60	6	13	65
Uttar Pradesh	71	19	27	5	8	16
Uttaranchal	14	5	36	2	2	18
West Bengal	19	9	47	1	4	15
Total/Average	**568**	**166**	**29**	**43**	**81**	**29**

Note: CPT: hospitals registered under Charitable and Public Trust Acts; CPTS: hospitals registered under Charitable, Public Trust and Societies Acts; Large PAE: having worker >10.

Note that the NSS data on health service sector enterprises does not capture information on organised corporate hospitals. In order to show the distribution of these corporate

hospitals across states and districts, data has been extracted from the National Hospital Directory prepared by the Ministry of Health and Family Welfare. National hospital directory is reported to contain information on 1048 large public and private corporate hospitals in India for the year 2015. Of these, 175 are public and 873 are private corporate hospitals, which include medical institutions. Similar to the localisation pattern of informal unorganised health enterprises, most of the private corporate hospitals (around 77 per cent) are located in 15 states, covering only 33 districts of the total 640 districts in India (*Appendix 1*). Even most of the large size hospitals are also concentrated in some of the districts. For instance, around 76 per cent of the large hospitals are located in only 26 per cent (155 in number) districts out of total 585 districts of India (*Appendix 2*). In India, on average, 20 per cent (865 in number per district) of the hospitals are located in seven districts, namely Mumbai, Ahmedabad, Bengaluru Urban, Thane, Hyderabad, Pune and Chennai (*Appendix 2*). Concentration of healthcare facilities in only a few districts is a matter of grave concern, especially because it highlights the inequality in availability of healthcare facilities in the country.

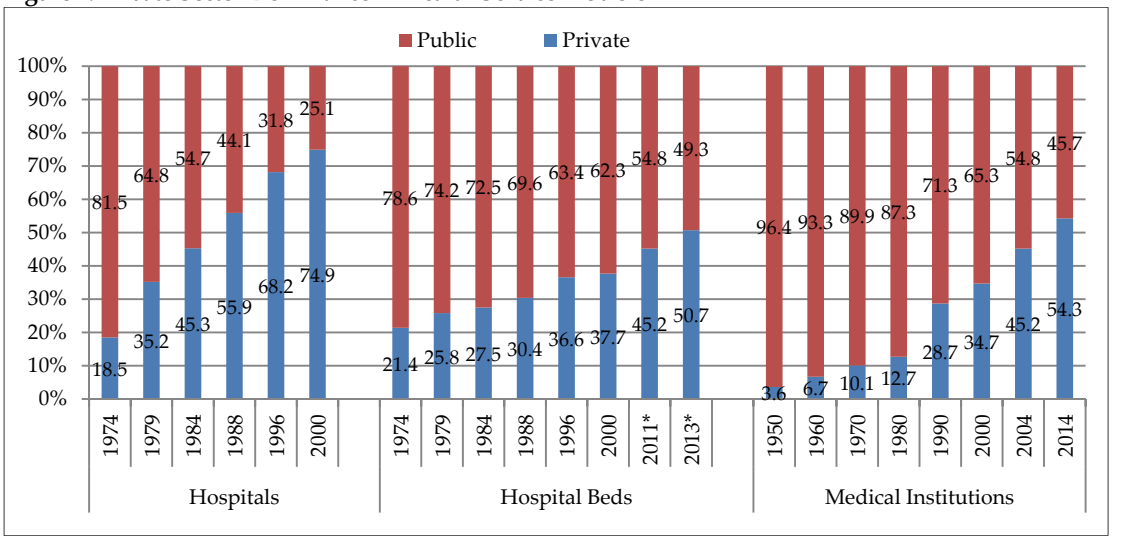
Outcome and Implications

Dominance in Service Provision

Growth in the private health sector has resulted in an increase in the number of hospitals and hospital beds as compared to the public sector. The share of private hospitals was only 18.5 per cent in 1974, which increased to 74.9 per cent in 2000. Similarly, the share of hospital beds increased to 50.7 per cent in 2013 from a low of 21.4 per cent in 1974. Medical institutions are essential for the development of human resources for health[2]. The share of private medical institutions at the time of independence was only 3.6 per cent, whereas it crossed the half-way mark and reached 54.3 per cent in 2014 (*Figure 4*). The share of government hospitals, hospital beds and medical institutions has declined over the period. Coupled with other pro-market health sector reform initiatives, the low level of government spending on health sector has encouraged the private sector to exploit and overtake the healthcare delivery market in India.

[2] The World Health Organisation's *World Health Report 2006* defines human resources for health (also health workforce) as 'all people engaged in actions whose primary intent is to enhance health.'

Figure 4: Private Sector Dominance in Health Service Provision



Note: Data on hospitals and hospital beds is not available after 2000; information for the years 2011* and 2013* represent hospital beds in medical institutions.

Dominance in Service Delivery

The private sector has not only overtaken the service provision market, but also has assumed the dominant position in service delivery. As per 71st round of NSSO, conducted in 2014, private sector roughly provides around 2/3 of inpatient and 3/4 of outpatient care treatments in the country. The outpatient care treatment received from private sector, however, has been nearly constant since 1986–87, but its share in inpatient care treatments increased to 68 per cent in urban areas and 58 per cent in rural areas in 2014 from a low of 40 per cent in 1986–87 (*Table 7*).

Table 7: Inpatient and Outpatient Care Treatments by Type of Facilities (in per cent)

NSS rounds	*Description*	*Inpatient*		*Outpatient*	
		Public	*Private*	*Public*	*Private*
42nd 1986–87	Total	60.0	40.0	22.5	77.5
52nd 1995–96	Total	43.5	56.6	19.5	80.5
60th 2004–05	Total	40.0	60.1	20.5	79.5
71st 2014	Rural	41.9	58.1	28.9	71.1
	Urban	32.0	68.0	21.2	78.8

Source: Various rounds of NSS.

Increase in Healthcare Cost

The dominion of the private sector over health service delivery market has resulted in higher healthcare costs in the country. The cost of care has increased manifold. With the

rising cost of healthcare, services have become unaffordable for the general population. *Table 8* shows that the cost of hospitalisation in a private facility as compared to a public facility was around 2.3 times higher in rural areas and 3.1 times higher in urban areas in 1986–87. In 2014, the cost of hospitalisation in a private facility increased by 4.2 times as compared to that in a public facility (*Table 8*). The disease-wise cost analysis shows that the cost of some of the diseases in a private facility is around 8 times higher than in a public facility (*Table 9*).

Table 8: Cost of Per Hospitalisation Case in Public/Private Facility (in Rs)

Years/ Rounds		*Public (Rs)*	*Private (Rs)*	*Pvt/Pub (ratio/times)*
42nd 1986–87	Rural	1120	2566	2.3
	Urban	1348	4221	3.1
52nd 1995–96	Rural	3307	5091	1.5
	Urban	3490	6234	1.8
60th 2004–05	Rural	3238	7408	2.3
	Urban	3877	11553	3.0
71st 2014	Total	6120	25850	4.2

Source: Various rounds of NSS.

Table 9: Average Medical Expenditure per Hospitalisation Case by different Ailment Category (in Rs): **2014**

	Public Hospital	*Private Hospital*	*Pvt/Pub (Ratio/times)*
Cancers	24526	78050	3.18
Other	14030	35572	2.54
Cardio-vascular	11549	43262	3.75
Genito-urinary	9295	29608	3.19
Musculo-skeletal	8165	28396	3.48
Psychiatric & neurologica	7482	34561	4.62
Injuries	6729	36255	5.39
Ear	6626	19158	2.89
Gastro-intestinal	5281	23933	4.53
Respiratory	4811	18705	3.89
Blood diseases (including anaemia)	4752	17607	3.71
Endocrine, metabolic & nutrition	4625	19206	4.15
Skin	3142	14664	4.67
Infections	3007	11810	3.93
Obstetric and neonatal	2651	21626	8.16
Eye	1778	13374	7.52
All	**6120**	**25850**	**4.22**

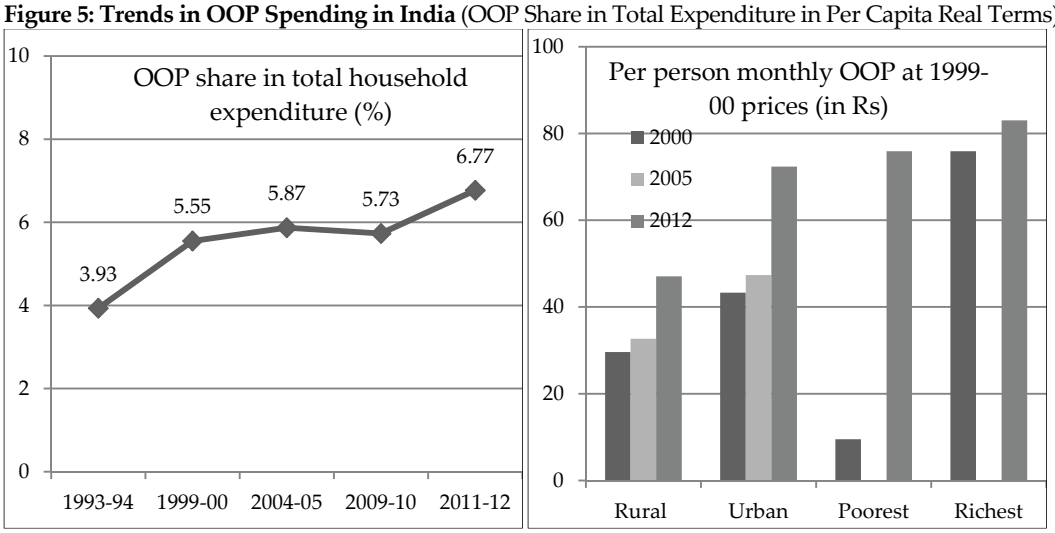
Source: 71st round of NSS.

This reflects that the cost of hospitalisation in private facilities has increased over the period than in public facilities; and, in some cases, private sector costs are significantly high. The private sector is not cost-effective. With the increase in private sector service provision, not only have healthcare costs increased, but also services have become unaffordable for the general population. In order to reverse this trend, public sector spending on health service provision is urgently warranted.

Increase in Health Payment Burden

A majority of the people choose to go to a private facility for both inpatient and outpatient treatment programmes, which costs nearly four to eight times more than in a public facility. It has not only resulted in high per capita spending on health, but also led to an increase in the out-of-pocket (OOP) expenditure. For instance, the share of OOP spending in total household spending increased to 6.77 per cent in 2011–12 from a low of 3.93 per cent in 1993–94 (*Figure 5*). The real per capita monthly OOP spending (at 1999–200 prices) also shows a sharp rise across rural-urban residents and poor-rich households between 2000 and 2012. The increment in per capita monthly OOP spending is noticed to be much higher amongst the poorest households than the richest. Amongst the poor, it increased from a meagre share of Rs 9.5 in 2000 to Rs 75.9 per person in 2012 (*Figure 5*), but in case of the rich, there was only a marginal increase.

Figure 5: Trends in OOP Spending in India (OOP Share in Total Expenditure in Per Capita Real Terms)



Source: Designed using published documents (Selvaraj *et al*., 2015,p. 169; Karan *et al*., 2014, Pp. 4 *&* 5).

How Effective are the Pro-Market Initiatives: An Illustration

Private healthcare has gained special attention with the approval of 100 per cent foreign direct investment (FDI) through automatic route in hospital sector in 2000. Post 2000, long-term cheap loans were also granted to private healthcare institutions, especially after the

hospital sector was accorded industry status in 2003–04 budget. Provisioning of health insurance schemes—private, social and target-oriented (pro-poor)—is another way to promote privatisation in the hospital sector. With these pro-market reform initiatives, the hospital sector, especially the large corporate hospitals, get various benefits like land subsidy, low-interest loans, income tax and tariff rate exemption, etc. However, these benefits are subject to certain conditions, which include serving the poor/EWS people free of cost, providing affordable care services, locating their entities in rural/semi-urban areas and filling the gap of health service provision in deficient areas. The quantum of benefits and subsidies generally get enhanced once a hospital registers itself under the Charitable Trusts Act or the Societies Registration Act as a non-profit entity. In order to receive these benefits, a large number of hospitals have registered themselves under these Acts; and, the number is increasing. However, it will be interesting to know whether these entities serve their stated purpose.

Some studies have pointed out that these hospitals were found to be violating the aforementioned conditions. While these hospitals provided free or low-cost care to the general population during early independence years, they do not fall under the charitable category any longer (Kurian, 2012). Today, they provide medical services at market prices. *Table 10* shows a comparative picture of the price of one-day hospital stay in Delhi. They charge almost equal to what the corporate hospitals charge for one-day stay. This reflects that these charitable hospitals are no longer charitable. They provide services at market prices. To top it off, some of them avoid tax compliance. For instance, in Delhi, Max hospital has run into tax trouble and was also found flouting charity clause.[3] Our regulatory system is so weak that the punishment for violating a rule is not adequate in itself. For instance, according to Delhi Nursing Homes Registration Act, 1953 'whoever contravenes any of the provision of the Act will be punished with a fine which may extent to Rs. 100 and in case of continuing offence to a further fine of Rs. 25 in respect of each day on which the offence continues after such conviction,' reflecting lack of adequate and ineffective provision of regulation. Similarly, on December 09, 2011, around 94 people died in a state-of-the-art corporate hospital in West Bengal simply because the hospital did not follow appropriate quality and safety rules. This happened because of inadequate and ineffective regulations in the State. It can be argued that the pro-market reform initiatives are not so effective from the point of view of the society and the country.

The locational preference of these charitable/trust hospitals is generally found to be urban-centric. As shown earlier in *Table 6*, a close examination of NSS 2010–11 data reveals that the existence of these entities in rural/semi-urban areas and districts with inadequate service provision is negligible. It also reflects that charitable and trust hospitals taken together are located only in 43 districts of India out of the total 568 NSS districts. If one

[3] Mehta, Avantika (2015), 'Delhi: Max Hospital in Trouble; Found Flouting Charity Clause,' *Hindustan Times*, April 05.

includes hospitals registered under the Society Act, the coverage reaches just 81 districts. This reflects that these entities are not inclined to serve the deficient or underserved areas or fill the regional gap in health service provision.

Table 10: Charitable and Trust Hospitals: Charity are Market Prices
(Price in Delhi for One-day Hospital Stay, in Rs)

Hospitals	*Type of Management*	*Price of General Ward*	*Price of Shared Room*	*Single Room*
Max Devki Devi DDF (in 2008)	Corporate	13,000	16,000	21,000
Indraprastha Apollo (in 2008)	Corporate	14,000	15,500	19,000
Sri Ganga Ram Hospital (in 2008)	Trust	13,000	13,500	19,000
AIIMS (in 2008)	Public	---	---	5,000
Forties (in 2015)	Corporate	10,000	11,000	12,000
Sant Parmanand Hospital (in 2015)	Charitable			13,000

Source: Data for 2008 taken from Lefebvre (2008) and for 2015 through phone calls to hospitals.

These hospitals not only manage to get large areas of land at subsidised rates, but also get big loans at low interest rates along with several tax exemptions. This allows them to reap the benefits of economies of scale. As a result, per worker and per enterprise high value of gross value added (GVA) can be easily calculated as compared to the per unit GVA of for-profit enterprises. Per worker and per enterprise GVA in Rupee term for non-profit enterprises, charitable/trusts hospitals registered under the Society Act are reported to be much higher as compared to the for-profit enterprises (*Table 11*). Thus, the hospital sector has become a profit-making business for these entities or, in other words, it has turned out to be a profit-maximising sector in the country. Probably, for this reason, one can see a significant increase in the number of allopathic hospitals and diagnostic labs/centres after the liberalisation phase in India.

Table 11: GVA per Worker and per Enterprise – A Comparison (Rs in '000')

GVA per workers	*OAE*	*Est.*	*NPE*	*FPE*	*Charitable*	*Society*	*Public Trust*	*Total*
Allopathic	79	125	115	108	163	126	111	108
AYUSH	66	94	22	77	20	86	49	76
Other	123	93	56	122	40	65	45	102
Social	15	79	77	39	143	21	305	74
Total	76	118	83	103	110	71	185	101
GVA per enterprise								
Allopathic	89	539	1173	225	1115	2526	735	231
AYUSH	73	244	96	104	41	257	133	104
Other	144	511	334	258	251	481	131	268
Social	51	815	759	143	1126	281	2867	640
Total	86	500	721	196	708	984	1204	205

Source: 67th round.

Owing to the high cost of care in charitable/trust hospitals, including other non-profit entities and not-for-profit enterprises, healthcare services have become costly which has further resulted in high OOP burden and household impoverishment due to health payments. Therefore, there is an urgent need to devise and implement effective regulations in order to deliver cost-effective services through private sector.

Is the Private Sector Better?

As discussed, pro-market scholars generally raise two major points. One, public sector in a broader sense is ineffective in delivering services as people have less faith in it because of the low quality of services and the long queue/waiting time. Two, private sector can fill the gap and provide cost-effective services to the general population. These arguments do not hold true once we analyse data on related variables in the Indian context.

Table 12 presents an association between the provisioning of healthcare facilities by private health enterprises, private allopathic enterprises and the public sector with two outcome variables—utilisation status (both for inpatient and outpatient care) and cost of cares. The results show that high availability of public facilities in a state reduces both the consumption of inpatient and outpatient care services at private facilities and the overall medical care (per case) cost for households. This reflects that there will be less utilisation of private facilities if the government ensures provision of more public facilities in the states. The argument that people have less faith in public facilities does not hold true in the Indian context. Besides, public facility is more cost-effective than private facility; according to a few cases, hospitalisation cost is reported to be high in states with a large number of private health/allopathic practitioners. On the other side, cost of hospitalisation reduces with the increase in public healthcare facilities in the states.

Table 12: Association of Public/Private Facility with Cost/Utilisation Parameters

	a	*b*	*c*	*d*	*e*	*f*	*g*	*h*
a. Private health enterprises (PHE)	1.00							
b. Government allopathic hospital (GAH)	-0.58	1.00						
c. Private allopathic hospital (PAH)	0.93	-0.56	1.00					
d. Share of establishment in total PHE	-0.48	0.36	-0.47	1.00				
e. % of OPV in private facility: Male	0.67	-0.62	0.68	-0.40	1.00			
f. % of OPV in private facility: Female	0.48	-0.65	0.58	-0.27	0.67	1.00		
g. % of IPD in private facility: Persons	0.44	-0.54	0.54	-0.29	0.71	0.76	1.00	
h. Cost of hospitalisation: per case	0.69	-0.61	0.79	-0.32	0.55	0.46	0.41	1

Source: Table 5.

Thus, in order to reduce hospitalisation cost and OOP burden, state governments needs to allocate adequate funds to the health sector in order to ensure high availability of public healthcare facilities. With high availability of public health services, states can ensure

greater utilisation of inpatient and outpatient services at government facilities. However, if the states fail to provide adequate public healthcare facilities, the private sector will capture the healthcare delivery market and lead to high healthcare costs.

One interesting observation from *Table 12* is that the association between availability of government allopathic hospitals (GAH) and share of private health enterprises is found to be positive. However, correlation coefficient turned negative between GAH and total private enterprises. This reflects that with the increase in government hospitals/facilities, the share of establishment (large formal/organised hospitals) will also increase. On the other side, informal/OAE enterprise will decrease. Decrease in informal small providers can be a healthy indication as majority of these providers practice without formal education/degree, leading to unhealthy practices and low quality services. However, access to services will be undermined. Only one study has held this argument to be true**,** but it is beyond the scope of the present study. Overall, these evidences suggest that the public sector is better than the private sector in terms of providing cost-effective services in the country.

Conclusion

This study has analysed the trends and structure of the growth of private sector in healthcare delivery market in India and how it has diversified over the years. The study has also listed factors that are responsible for its growth. In order to provide a comprehensive picture of the role of private sector in healthcare delivery market, the study has closely looked at the role of the private sector in health service provision and coverage, provision of inpatient and outpatient care treatments and corporatisation of the hospital sector, including the emerging issues.

Evidence shows that the private sector is distinguished by the presence of a vast number of health enterprises—around 10.4 lakh as compared to a low of 1.96 lakh public healthcare facilities. The private sector provides a wide range of healthcare services ranging from hospitalisation, medical, dental, diagnostics, homoeopathic, unani, ayurvedic, residential nursing to social services. Over the period, there has been a rapid increase in the number of private allopathic healthcare providers as compared to AYUSH providers. Indian private allopathic health sector is shifting from informal to formal organised and gradually to corporate structure**.** Majority of allopathic providers are unskilled practitioners (without formal degree). A large number of private health enterprises are not registered under any act/legislation, leading to unhealthy and unethical practices in the country. Over the period, the private sector has assumed dominance over both the healthcare provision and the healthcare delivery market. This has resulted in high healthcare cost and high OOP burden in the country. Most of the Indian districts and rural areas are suffering because of the deficiency of healthcare facilities. The growth of private sector has largely been urban-centric; as a result, regional gaps or deficiencies remain.

While India has been experimenting with the private healthcare delivery market since independence, from the above analysis it can be concluded that the private sector's presence has only strengthened through diversification over the period. The role of the private sector in healthcare delivery market, however, attracted special attention in the year 2000 when the Government of India approved 100 per cent foreign direct investment through automatic route in the hospital sector. Further, cheap and long-term loans were also granted to private healthcare institutions and the hospital sector was accorded the industry status in 2003–04 budget. These pro-market reform initiatives along with factors like population dynamics, people's awareness and perception of health, change in treatment-seeking behaviour, double burden of disease, changing nature of lifestyle diseases, global integration, and medical tourism have encouraged private providers/enterprises including foreign investors to exploit the hospital market in India. National- and state-level social and pro-poor health insurance schemes are other factors that motivate growth in the private sector. With the growth of the private sector, services have become costly, which, in turn, has increased the OOP burden in the country.

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Appendix

Appendix 1: Concentration of Corporate Hospitals in India (as on September 17, 2015)

	Public	*Private*	*Total*	*Concentration of hospitals (≥2digits in no.) across districts*
Andhra Pradesh	1	31	32	Hyderabad(27)
Assam	6	0	6	
Bihar	8	11	19	Patna(16)
Chhattisgarh	4	3	7	
Delhi	61	272	333	South (67), West (55), Central(42), South West(41), North West(39), New Delhi(34), East (32), North(15)
Goa	1	5	6	
Gujarat	12	23	35	Vadodara (8), Surat(6)
Haryana	5	192	197	Gurgaon (58), faridabad(29), Sirsa(16), Hisar(15), Ambala(11), Rohtak(11)
Himachal Pradesh	2	0	2	
Jammu and Kashmir	7	8	15	Jammu (13)
Jharkhand	3	0	3	
Karnataka	2	24	26	Bengaluru(22)
Kerala	26	6	32	Kollam (8), Kochi (7)
Madhya Pradesh	0	32	32	Indore(32)
Maharashtra	0	42	42	Mumbai(23), Pune(18)
Odisha	5	3	8	
Punjab	2	87	89	(Ludhiana(41), Amritsar(25), Mohali(10)
Rajasthan	3	4	7	
Tamil Nadu	3	30	33	Chennai(20)
Uttar Pradesh	1	65	66	Kanpur(20), Noida(13), Ghaziabad(10)
Uttarakhand	3	4	7	
West Bengal	0	21	21	Kolkata(21)
NE-states	7	5	12	
UTs	13	5	18	
Total	175	873	1048	806 (76.9%): covering only 33 districts

Source: https://data.gov.in/catalog/hospital-directory-national-health-portal

Appendix 2: Distribution of Large-sized Public and Private Hospitals in India, September 2015

States/ Hospitals range	*Number of Districts with hospitals range (in Number)*							*Total no of districts covered*	*Total no of hospitals*
	>500	*251–500*	*101–250*	*51–100*	*21–50*	*6–20*	*≤ 5*		
Andhra Pradesh			Krishna (193), Guntur (184), Hyderabad (165), East Godavari (163), Chittoor, Visakhapatnam	5	3			14	1,380
Assam				1		9	12	22	183
Bihar			Patna (248)		13	22	3	39	1,039
Chhattisgarh			Raipur (170)	2	1	11	4	19	445
Goa					2			2	84
Gujarat	Ahmedabad (1130)	Surat (241), Vadodara (482)	Mahesana (199), Rajkot (172), Anand (145), Kheda, Sabar, kantha	11	4	2	1	26	3,807
Haryana		Faridabad (281), Gurgaon (262)	Hisar (120)	10	7	1		21	1,669
Himachal Pradesh				4	5	3		12	485
Jammu and Kashmir				1	1		7	9	96
Jharkhand			Ranchi		4	15	5	25	478
Karnataka	Bengaluru Urban (993)		Belagavi, Dakshina Kannada	6	12	7	2	30	2,226
Kerala			Ernakulam (180), Thiruvananthapuram	6	5	1	1	15	890
Madhya Pradesh			Indore (244), Bhopal (146)	2	2	20	23	49	899
Maharashtra	Mumbai (1308), Pune (660), Thane (725)	Nagpur (290)	Kolhapur (178), Nashik (176), Raigarh (167), Solapur (167), Satara (160), Ahmednagar, Aurangabad, Jalgaon	3	8	10	2	34	4,807
Odisha			Cuttack	3	7	15	5	31	718
Punjab			Ludhiana (211), Amritsar (185), Jalandhar	5	8	3	1	20	1,201
Rajasthan		Jaipur (408)		5	6	17	3	32	1,209
Tamil Nadu	Chennai (552)	Coimbatore (262)	Madurai (167), Erode, Kanchipuram (151), Kanniyakumari, Salem, Tiruchirappalli	5	13	4	1	31	2,399
Telangana	Hyderabad (687)			4	4	1		10	1,175

States/ Hospitals range	*Number of Districts with hospitals range (in Number)*							*Total no of districts covered*	*Total no of hospitals*
	>500	*251–500*	*101–250*	*51–100*	*21–50*	*6–20*	*≤ 5*		
Uttar Pradesh		Ghaziabad (660), Lucknow (272)	Agra (199), Gautam Buddha Nagar (188), Kanpur Nagar (175), Meerut (189), Varanasi (169), Allahabad (145), Bareilly, Gorakhpur	7	16	33	5	71	3,158
Uttarakhand			Dehradun	2	1	4	5	13	390
West Bengal		Kolkata (415)	Bardhaman	5	7	4	1	19	1,165
NE-States					2	11	21	34	234
UTs			Chandigarh	1		1	4	7	136
Total no of districts	7	10	50	88	131	194	106	585	
Total no & (%) of hospitals	6055 (20.0)	3273 (10.8)	7579 (25.0)	6173 (20.4)	4429 (14.6)	2460 (8.1)	304 (1.0)		30,273 (100.0)
Hospitals per district (in no)	865	327	152	70	34	13	3	52	

Source: data.gov.in. Districts having around or more than 150 hospitals are reported in parenthesis.

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