

PRIVATE HEALTH EXPENDITURE

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HEALTH CARE SERVICE SCENARIO

India has a wide variety of health care services available to its population. On the one extreme there are the high-technology hospitals and diagnostic centres (both private and public) in metropolitan cities, and on the other, one has village health guides, folkhealers, faith healers and quacks in remote village. Between these two extremes there are district general hospitals (civil hospitals), private hospitals, 'trust' hospitals consulting and general private practitioner dispensaries and clinics (allopathic, ayurvedic and homeopathic...) rural/cottage hospitals, primary health centres and sub-centres.

Are there an adequate number of health care providers in India to meet the health care needs of the population? This is a difficult question to answer. If one looks at the official/published data then the aggregate ratios that emerge (doctor: population, bed: population etc..) reveal that there is a large shortfall when one considers any adequate minimum standard. For instance, in 1988 in India there was one allopathic doctor per 2300 population and one hospital bed per 1300 population (CBHI, 1989). As per the standards set by the Bhore committee in 1946 these ratios should have been 1:1600 and 1:175, respectively, distributed evenly all over the country (Bhore, 1946, III.3,4). For the figure of doctors if we consider the non-allopathic registered practitioners then we are well ahead of the Bhore Committee's recommendation today, the ratio being 1 doctor per 975 population. Ofcourse, this is not evenly distributed all over the country.

If we disaggregate the 1988 figures for India on the basis of their location we find that the urban areas are nearer the Bhore Committee standards whereas the rural areas are embarrassingly far behind. In rural India the (allopathic) doctor population ration is 1:7900 and the bed population ratio 1:5440 whereas in the urban areas it is 1:790 and 1:400, respectively! (CBHI, 1989). The ratio for the rural areas would improve considerably if we include the non-allopathic and the non-qualified practitioners.

Like hospital beds, the number of hospitals, dispensaries, health centres, nurses and other paramedics are far from adequate, especially in the rural areas. As for medical practitioners if we consider practitioners of all systems of medicine and add the non-qualified practitioners (quacks) then their number for the country becomes more than adequate. The same is true for pharmacists also. The reason for the large number of medical practitioners and pharmacists is very obvious - a thriving for-profit private health sector (private medical practice and the pharmaceutical industry).

This scenario thus reveals that the for-profit private health sector exists in India in an adequate quantum but this (the qualified lot) is not available to the entire population easily because of its urban-metropolitan concentration; and secondly the quality of a large proportion of this sector is questionable.

The Bhore Committee's recommendations of the minimum decent standards was for the public health sector but in the last 45 years this sectors performance has been very poor. Over three-fourths of the investment of the public health sector has taken place in urban areas, where less than one-fourth of the country's population resides. When we consider medical care specifically, the public health sectors performance in the rural and other peripheral areas is even worse.

In contrast, the private health sector has grown rapidly in the post colonial period with State support. The State's health sector policies have encouraged the growth of the private health sector in medical care-specifically curative services-by investing resources in medical education, providing subsidies and soft loans to set up hospitals and private practice, by giving tax and duty waivers to the hospital sector and for import of medical equipment, and by allowing graduates of medical colleges (who have been trained at public expenses) to set up private practice freely or to migrate abroad in large numbers.

Given the above scenario private health expenditure assumes a great significance because to support such a huge private health sector (including the non-qualified) the quantum of household resources being expended must be phenomenal.

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Information about health expenditure in India is very scanty. Public Health Expenditure is fairly well documented (officially only) because of the sheer fact of accountability of expenditure to the office of the Comptroller and Auditor General of India (see Table 1). In contrast to this, expenditure of private health care is very poorly documented. The National sample Survey's (NSS) earlier rounds (nineteen fifties) have recorded fairly reliable information but later rounds have not paid any heed to this category of consumer expenditure. The Central statistical Organisation (CSO) has been making estimates, partially based on NSS data (see Table 1). But when one compares their data with similar empirical studies then CSO estimates appear to be grossly under-estimated and are contrary to the growth of the private health sector. In the seventies and eighties, when the private health sector was rapidly expanding (see Amar Jesani's paper) the CSOs estimates of private health expenditure were declining with respect to public health expenditure. That is, over the years the share of expenditure of the state sector has enlarged in comparison to private health expenditure as well as in terms of proportion of GDP. (Table 1). This is difficult proposition to swallow when we consider the rapid growth rate of the private health sector in the past 15 years. We will not go into further details of Table 1 because it is self-revealing.

A review of known studies on private health expenditure is presented here. This will be followed by a concluding section on issues emerging out of the existing scenario.

When the Bhole Committee set out to examine the state of the health sector in India it had only one estimate of private household expenditure. This was R.B. Lal's Singur study which showed that in 1944 private household expenditure on health care was Rs. 2 1/2 per capita. In comparison the State health expenditure in the same year was only 36 paise per capita. (Bhole, 1946) This totalled upto 4% of the GDP with private health expenditure having a share of 87%.

The third round of the NSS in 1951 recorded a private health expenditure of Rs.5.77 per capita per year (NSS, 1952). Together with State health expenditure in the same year it worked out of 2.53% of GDP with private health expenditure having share of 87%.

In the fifties and early sixties Prof. S.C. Seal and his colleagues conducted pioneering general health surveys in districts from nine States. In these surveys private health expenditures were also recorded. The average was Rs.3.34 per capita and these varied in different districts from between Rs.0.40 to Rs.7.20 per capita (Seal et.al; 1961, 1962, 1963) but what was remarkable was that this health expenditure worked out to between 3% to 4% of the respective SDP and the private health expenditure share was between 83% and 88%.

Similar smaller studies were done in the sixties and seventies which also recorded household health expenditure R.L. Parker in Narangwal in 1966-69 and 1973-74 recorded a private health expenditure of Rs.7.65 and Rs.21.30, respectively, per capita per year. Sunder Rao in North Srcot in 1973 recorded Rs.80 per family per year. NIHAIE in 1973 recorded Rs.72 per family in rural Delhi. (qwuoted in Banerjee, 1980). These private health expenditures again amounted to a share of over 80% of total health expenditure. The NSS results of the 278th round (1973-74) also corroborates this.

In studies undertaken by FRCH in the eighties similar results were obtained. An exploratory survey in Bombay of a middle class and working class population revealed private health expenditure to be as high as 6.9% and 12.5%, respectively, of their aerage income in 1984(Duggal, 1986). In a fairly large study in 1987 in Jalgaon district private health expenditure was recorded as 5.2% of income,, (Duggal and Amin 1989). The results of all these studies are in sharp contrast to the CSOs estimates of private health expenditure. They may be small studies but they show a definite pattern and that too over a long time period.

What is evident from the above review is that the financial burden of households in meeting their health care needs in substantial. Households spend between 4 to 7 times of what the State spends on health care services. This is not a very happy state of affairs considering the fact that more than half the country's population has resources that barely meet their food requirements. When illness strikes it necessarily eats into food consumption, and worse still the capacity to earn if the patient happens to be a breadwinner.

This it is important to understand the consequences of such a high private health expenditure in the context of the socio-economic scenario of widespread poverty.

We will now briefly look into some analytic issues that emerge out of the Jalgaon study (Duggal & Amin 1989) referred to above. This will help in raising relevant issues vis-à-vis the consequences of a burdensome private health expenditure.

The Jalgaon study made an effort at revealing class differentials of morbidity, treatment and health expenditure. This kind of an analysis has not been attempted in the past except by the studies conducted by Prof. Seal. NSS probably has this kind of data but it has never published it - there is hope that they will be doing it for the 42nd round (1987) results.

Through the data of Seal's studies and the Jalgaon study are not strictly comparable, we nevertheless give in Table 2 the two sets of data just to indicate the similarities that were evident in classwise disaggregation of private health expenditure.

Given the socio-economic conditions in India the distribution in Table 2 is not surprising. When health care services have to be purchased most often as commodities such a distribution is bound to emerge because purchasing power (P-Power) becomes a crucial factor.

The Jalgaon study threw up a serendipitous finding. Contrary to expectation we found that morbidity prevalence increased with rise in class status. After a careful analysis of all associated variables we hypothesize that definition of illness is closely linked with the availability of P-power to buy health care services in a market economy. This hypothesis is strongly supported by class differentials of health care utilisation and health expenditure also. To summarise these interrelationships with rise in class status: Morbidity prevalence increases (Pearson's $r = + 0.81$), non-utilisation if any health care facilities declines (Pearson's $r = - 0.90$), use of private health facilities increase (Pearson's $r = -0.89$) and per capita health expenditure increases (Pearson's $r = +0.94$) (Duggal & Amin, 1989)

Thus, the poorer classes, due to their impoverished conditions and lack of P-power, perceive a lower morbidity rate because they cannot afford to spend on every small illness or chronic ailment that may afflict them. Even of the morbidity that they perceive a fairly large proportion stays unattended because they feel it is an expenditure that can be avoided; and when they decide to use a facility, they prefer public health services because they cost the least.

These findings then clearly provide a basis to question the commodification of health care, the existence of the private health sector and as a consequence expending of vast sums of personal health expenditures by households.

Another important related issue that emerges, especially in the context of increased private sector expansion, is that of user charges. Results of studies like the Jalgaon study have a tendency to be misused because they supposedly show that people have the capacity to pay. Hence they conclude that people can also pay user charges at public health care institutions. This is a highly dangerous conclusion because most people spend on health care not out of choice but forced by circumstances, especially the non-availability and inadequacy of public health care services.

In conclusion, we would like to emphasize that the large volume of private health expenditure in India is probably one of the largest in the world when viewed as a proportion to total health expenditure. Even in the USA about half the expenditure on health care is incurred by the State. In the European capitalist countries the States share is now over 80% (Scieber & Poullier, 1988). These facts thus indicate that even under capitalism private health expenditures are on their way out. This situation has arisen in these countries for two reasons. Firstly, a demand for universal and relatively equitable health care, and secondly the need to curb rising cost of health care. In both cases only increased State intervention has helped sort out matters. Thus in India one needs to look at the private health sector and private health expenditure in this context also.

(This paper is partially based on my Ph.d dissertation, which I am currently pursuing on a ICSSR National fellowship and partly based on the ICMR sponsored on Health Expenditure in India)

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Table 1: Health Expenditure In India by Plan Period

(Including Plan and Non-plan Expenditure)

	Plan I	Plan II	Plan III	Non-Plan	Plan IV	Plan V	Plan VI	Plan VII	Paln VIII@	
	1951-56	1956-61	1961-66	1966-69	1969-74	1974-79	1979-80	1980-85	1985-90	1990-95
1. State Health Expenditure (Rs.Crores)	197.30	393.74	712.59	723.59	2238.48	4728.32	1439.88	12970.53	28,000	65,000
2. Of which Medical Services (Rs.Crores)(n)	85.59	161.23	265.62	261.98	720.09	1553.49	433.93	3517.73	6,800	15,000
3. 1 as % of GDP	0.41	0.60	0.71	0.77	1.00	1.19	1.41	1.59		
4. 2 as % of GDP	0.18	0.25	0.27	0.28	0.32	0.39	0.42	0.43		
5. CSO's estimate of pvt. Health Expenditure (Rs. crores) (b)	536.00	796.00	1503.00	1513.00	3768.00	8331.00	2577.00	13821.00		
6. 5 as % of GDP	1.11	1.21	1.51	1.62	1.69	2.10	2.52	1.69		
7. 2 as ration of 5	016	0.20	0.18	0.17	0.19	0.19	0.17	0.25		

(a) This includes only medical care provided for the general population and hence excludes medical expenditures on schemes like ESIS, CGHS and others, which are benefits only for employees of the state sector/public sector.

(b) CSO's estimates refer only to medical services and medicines and hence are comparable with row(2).

(*) estimated (@) projected

Source:CAG, various years, CSO, 1989.

Table 2:Classwise Distribution of Privat eHealth Expenditure
Seal et.al (1957) and Duggal & Amin (1987)
(Figures are relative (%) expenditure when Mean=100)

Study (Ref year)	Poorest			Richest		
	I	II	III	IV	V	Mean
Seal (1957)	33	51	101	194	765	100
Duggal(1987)	29	83	140	228	202	10

Source: Seal et.al. 1961,1962,1963

Duggal & Amin 1989.

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