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Privatization of Health Care and Increasing Burden of Health Expenditure on Household: A Challenge for Universal Health Courage in India

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Abstract—*Health is the basic requirement for socio-economic, political and cultural development of any society. The government wants to make certain effort for enhancing the well-being of the individual. But due to certain reason it becomes unsuccessful. The most predominant reason is the introduction of privatisation which excludes the role of government in every spare. The services which earlier provided by government now its trends become change. Privatizations touch every aspect but among them the health care got much affected. The main aim of privatization is surplus value. It equates quality with cost. The privatization of health care creates inequalities in healthcare between the countries and within the countries. Privatisation leads to steep hike in health expenditures, increased medical cost, and cost of drugs, medical consultations, medical tests and hospitalisation. It also enlarged the inappropriate competition in the market, this is not because to earn but how to earn more than others. These steep hikes in health expenditure create hindrance among the low-income groups and push them in a vicious circle of poverty. The main aim of this paper was to examine the privatization of healthcare and burden of health expenditure on households. It also Explore the impact of privatization on the quality of care. This paper is primarily based on secondary data. The existing literature revealed that India ranks third in out-of-pocket expenditure on health and almost 60% of total expenditure is paid by the common man and about 3.2% Indians fall below the poverty line due to huge medical bills with about 70% spending their entire saving on healthcare and purchasing drugs. The reviewed data showed that medicines account for 20–30% of global health spending, slightly more in low- and middle-income countries, and, therefore, constitute a major part of the budget of whoever is paying for health services. The finding of this paper exposed that out of the total private medical expenditure, around 72 per cent in rural and 68 per cent in urban areas was made for purchasing 'medicine' for non-hospitalised treatment. Rural households primarily depended on their 'household income/savings' (68%) and on 'borrowings' (25%), the urban households relied much more on their 'income/saving' (75%) for financing expenditure on hospitalisation, than on 'borrowings' (only 18%) The pivotal problem in healthcare sector is high cost of drugs/medicine and recommending high prized non-generic medicine (NSSO, 2O14).*

Keywords*: Out-of-pocket health expenditure, Health, Privatization, Preventions.*

Introduction

Human life is a very valuable asset and each individual has an ultimate right to live with respect and dignity. It is the responsibility of the government to enhance the quality of health care for every citizen and to uplift his right to health and health service. Health service is vital for every society as other basic needs like food, water, shelter and clothing. Each nation has its own procedures & the vital objective of these rules and procedures is to design a just health care system which provides equal and efficient health services to all. These enhance overall productivity of the country (Nagla, 2018).In any society the value of human capital is very precious, if it is not appropriate then physical capital and natural resources cannot be appropriately utilized. So the health is basically the prime components of human capital. The good health status of a nation promotes quality of productivity and elevates the social and economic development.

But in the contemporary time due to the introduction of privatization of health care, it creates various agonies and issues for the people, particularly for the down trodden section of the society. The health care becomes the business in the hand of health professional their motive is only to profit maximization and not quality of care. They want only to gains profit by any fair and foul means. The medic has forgotten their obligations toward their patients and doing their job without inculcating ethics. The trust of patients on doctor is totally vanishes by medic (Nagla, 2018).The draft National Health Policy (NHP 2015) acknowledges about the fact that the slow increase in GDP on health is a matter of great concern. The document gives more emphasis on the relationship between economic growth and well-being. The draft also accepted that because of the increasing medical cost the catastrophic health expenditure touch to the sky which push poor household into the poverty (Ghoshal et al, 2015, p.21). Now the new National Health Policy 2017 (NHP 2017) has also considered the same subject. The policy (NHP 2017) aim to find an appropriate way to touch everybody in an inclusive unified approach for promoting well-being and aims

at attaining universal health coverage and improving quality health care services to all at inexpensive cost. (Motkuri et al, 2018.pp.1).

Defining Health Right

Health is acknowledge as the socio-medical concept which indicates that whatsoever is possible must be done for enhancing the social, spiritual, physical, and mental health of the individual. Article 21has discussed about the right to health and health care which is the most fundamental right under the Indian constitution. The Supreme Court of Indian too has given more focus on the health on its citizen and claims that the government come forward and take every initiative for promoting and protecting the health of its indigenous people without discrimination.

Objectives

- To examine the privatization of healthcare and burden of health expenditure on households.
- To analyse the impact of privatization on the quality of care.
- To study the attitudes of government toward the regulation of private sectors.

Methodology

This paper is mainly based on secondary date. Researcher have reviewed various Books, Journals, Research Articles, New Papers, National and International Reports like WHO Report 2018, World Factbook 2018, World Health Statistic 2018,Global Health Observatory2018 (GHO), National Health Account 2018 (NHA), National Health Profile 2015, NFHS 4 Round, NSSO 71^{th} $_{2014}$ and other existing data.

Privatization of Health Care

The growing concept of privatization may not be appropriate for the developing nations as it is appropriate for developed countries. There are various reasons behind the acceptance of privatization in developing countries like India, but the most dominant among them is the financial crisis which compels them to choose privatisation. The private sector is not new in India health care system. It was prevailed in the British period. But the corporate sector was limited to individual consultants, during the pre-independence era. A survey conducted by the Bhore committee on the health institution in which they claimed that 92 per cent of the institutions were sustained by public funds and 8 per cent were fully sustained by private funds. So this depicts that the prevalence of private health institutions were very minor (Nagla, 2018). p. 304). However after 1991 India adopted LPG policy for enhancing the economic growth and development. Aftermath the private sector become more dominant means of healing. According to Nadkarni, 2010 and Chatterjee, 2008, they argued that the unrefined inefficiencies in the public sectors invites and pull to the private sectors growth in the health care system in Indian (Nagla, 2018, p. 302).

Policy of Liberalization and Commercialization of Health Care

There was a conspiracy of west behind the idea of Liberalization and Globalization. Through these concepts they introduced certain kinds of profit organization in low-income countries like international Monetary Fund, World Bank and the World Trade Organisation. They generate pressure on the third world countries for adopting or accepting these economic policies for the growth and development purpose. The World Bank is the main supporter of privatization of goods and services particularly the health service. All benefits directly and indirectly from disease to other sources goes in the bally of west especially from the developing countries. So they are touching to the sky and we remained on the bottom. On the name of development and change all components of society got affected by privatization but healthcare system got much affected. Due to this the establishment of Apollo and entry of foreign doctors into health care, is the depiction of commercialization of healthcare. According to Baru (2010) there are many business groups in India like Tata, Hinduja, Modis and Escorts have floated multi-speciality hospital and are primarily registered as Trust. The groups actually promote business and enjoy subsidies on the name of Trust. In these hospitals there are non-resident Indian doctors (Nagla, 2018).

Concept of Essential Medicine, Medicine Cost and Out-of-Pocket Expenditure

The concept of essential medicine was very limited in the earlier time because people were using certain kinds of healing methods. As India was famous for spiritual healing and people across the globe elect to travel for spiritual healing. But now in the contemporary era drugs becomes a vital feature of modern health care service throughout the world. As much as people become depends on modern medicine, its demand increase. World Health Organization (WHO) defines essential drugs or medicines as “those drugs that satisfy the healthcare needs of majority of the population, they should therefore be available at all times in adequate amounts and in appropriate dosage forms, at a price the community can afford”(WHO, 2004).

According to World Health Organization 2004, 1.3 to 2.1 billion people remain without access to medicine despite making certain efforts (Nagla, 2018). This demonstrated that the improvement is very low. Medicines account for 20–30% of global health spending, slightly more in low- and middle-income countries, and, therefore, constitute a major part of the budget of whosoever is paying for health services (WHO, 2010). In many low-income countries, government health expenditure as a percentage of GDP has also been in decline in recent year (Access to Medicine Index, 2018).

In developing countries 40 million deaths happened and among them one-third are children under 5age. These deaths can be treated with cost-effective essential drugs. In developing countries one-fifth of the public and private health spending on pharmaceutical companies, it signifies up to 66% in developing countries. In most low income countries people spent huge share of their income on facsimile drugs rather than essential medicine. These huge amounts spent on medicine push household in vicious circle of poverty. But due to privatization the price of drugs rise very high because of lesser fair policy (Maiti et al, 2015.p.1).

The increasing dependency on medicine and the raising prices of medicine have vigorous impact on both the public and private out-of-pocket expenditure. National Health Accounts of 2014-15 have revealed that more than one-fourth (29%) of total health expenditure (private and public together) is spent on pharmacies/ medicines. A huge part of the out-patient medical expenses are associated with medicines. NSSO 71th report demonstrated that out of the total private medical expenditure, around 72 per cent in rural and 68 per cent in urban areas was made for purchasing 'medicine' for non-hospitalised treatment (NSSO, 2014). The pivotal problem in healthcare sector is high cost of drugs/medicine and recommending high prized non-generic medicine. There is no matter for consumers if these medicines are essential but they prescribed non-essential drugs which are the main source of income loss of poor household. So from the above fact we can say that India does not have a solid drug regulatory mechanism. In recently the Supreme Court of India, the National Human Rights Commission and the Members of Parliament have given more emphasis on these issues (Motkuri et al, 2018, p.17). So the increasing cost of medical treatment and inaccessibility and unaffordability is a great challenge for universal health coverage in India.

Expenditure on Health

According to Roy (2004-05: p.242) "health expenditures are defined on the basis of their primary or predominant purpose of improving health, regardless of the primary function or activity of the entity providing or paying for the associated health services. Health expenditures consist of all expenditures or outlays for medical care, prevention, promotion and rehabilitation, community health activities, heath administration and regulation and capital formation with the predominant objective of improving health".

India ranks third in out-of-pocket expenditure on health and almost 60% of total expenditure is paid by common man and about 3.2% Indians fall below the poverty line due to huge medical bills with about 70% people spending their entire saving on healthcare and purchasing drugs (WHO's World Health Statistics, 2012).

As we know that financing healthcare cost is a major challenge. Figure 1 showed that 40% of inpatient spending is met through borrowing (33% and sale of assets (6%). The rest is financed through household income/saving (48%) and from friends(12%) while a high amount (80%) of outpatient spending is financed through households own income /saving (Hooda,2015.p,68).

Trends and Patterns of Health Expenditure India

In India health care system is primarily provided by Public sector, private sector and through external agencies. In public health expenditure there are three main players such as Centre, State and local bodies. Among these three funding agencies, State plays an important role in the health care financing. There are three major components in private health expenditure in India such as out of pocket expenditure, health insurance and NGOs. Among all these components, out of pocket expenditure has very dominant share in the total health expenditure of the country.

As per National Health Accounts Report 2010, out of the total health expenditure, the share of private sector was the highest at 71.62 per cent, 26.70 per cent by public sector and 1.68 per cent by external flows.

Table 1, revealed that there is no significant change seen in the public expenditure on health as a percentage of GDP. It depicts that in 2009-10 the public health expenditure as a percentage of GDP was 1.12 and instead of upsurge it has decline 0.10 and seen a slight increase in 2016-17. These data demonstrated the attitude of the Government towards the health status of its citizens.

The Figure2,showed that the centre share in total health expenditure is inappropriate and low. We can see that in 2009-10 the centre share in total health expenditure was 36% and the state was 64%, which was almost double and in 2016-17 it was 29%, and the State share was again more than double. These date depicted that the centre share was decline since 2009-10 to 2016-1as 7 percent.

Table 2, showed that financial constrain is the most important reason behind treatment delay. Majority of the people rural male (55%) and female (59%) and (75 %) urban male and (62%) female delayed medical advice due to financial reason. The second reason to delay medical treatment is lack of medical facility, 18% rural male and 13.5% female delay treatment due to unavailability of health care service.

Table 3, depicted that majority of the people as 52% rural male and 49% female and 48% urban male and 50% female takes treatment from private doctors/clinic. This table also presents that private sectors is the major source of treatment for both sectors (rural & urban).

Table 4, demonstrated that an average total expenditure for non-hospitalised treatment is higher in urban area Rs 639 per ailment for both gender and Rs 509 for both gender in rural area.

Table 5, showed that average total medical expenditure per hospitalisation caseis higher in rural female(Rs122955) than rural male(Rs17528). It is also higher than urban male (Rs 28165) and female (Rs 20754). So we can say that total medical expenditure on hospitalisation is higher than non-hospitalisation

Table 6, depicted that on an average total direct medical expenditureis higher in urban (Rs24436) then rural Rs1435. The indirect total expenditure is higher in rural area(Rs2021) than urban (Rs2019). This reveals that urban household spent more on direct medical treatment and rural more on indirect. The reason is obvious.

Figure 3, depicted that in all India level around 72% in rural sector and 68% in urban sector of the total medical expenditure spent for purchasing 'medicine'. Second in this list for both for rural (15%) and urban sector (16%) was 'Diagnostic test and other expenditure', followed by 'doctor's fee'.

Findings

- Treatment without any medical advice was primarily attributed to 'financial constraints' (57% in rural, 68% in urban).
- More than 70% (72% in rural and 79% in urban) spells of ailment were treated in the private sector (consisting of private doctors, nursing homes, private hospitals, charitable institutions, etc.).
- Higher preference towards allopathic treatment was prevalent (around 90%) in both the sectors.
- In treating the in-patients, private institutions dominated both the rural 58% and urban areas 68%.
- Higher amount was spent for non-hospitalised treatment of an ailment by the urban population (`Rs639) than the rural population (Rs509).
- Out of the total medical expenditure, around 72% in rural and 68% in urban areas was made for purchasing 'medicine' for non-hospitalised treatment.
- The rural population spent, on an average, Rs.5636 for a hospitalised treatment in a public sector hospital and Rs.21726 for that in a private sector hospital.
- As high as 86% of rural population and 82% of urban population were not covered under any scheme of health expenditure support.
- Rural households primarily depended on their 'household income/savings' 68% and on 'borrowings' 25%, the urban households relied much more on their 'income/saving' 75% for financing expenditure on hospitalisation, than on 'borrowings'18% (NSS 71 st Round, 2014).

Conclusion

The growing cost of non-essential medicine is the vital reason of delay of treatment and high out-of-pocket expenditure. From above fact we can say it is very complicated for India to reach on the path of UHC. If India wants to productive future then she must inculcate the worth of human health. Government should formulate stringent laws for pharmaceutical companies and private sectors and implement them with fair strategy. Then there is a possibility of equal access of health. Burden of health care cost decimate the life of poor people. Government designed various health protection policies but still 86% of rural and 82% urban are not covered under any health care protection scheme. So government must come forward and takes appropriate steps for promoting the health and well-being of common people. This is only the solid solution for attaining UHC. In India it is estimated that 20 million people fall below the poverty due to indebtedness, borrowing for meeting healthcare cost.

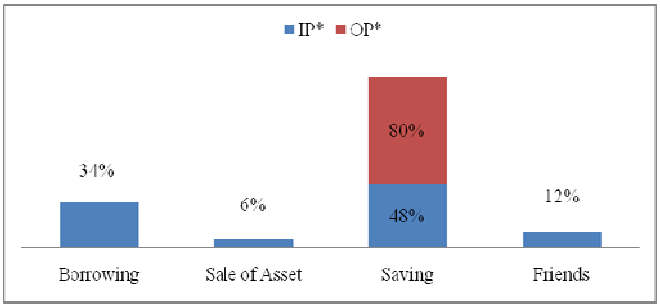


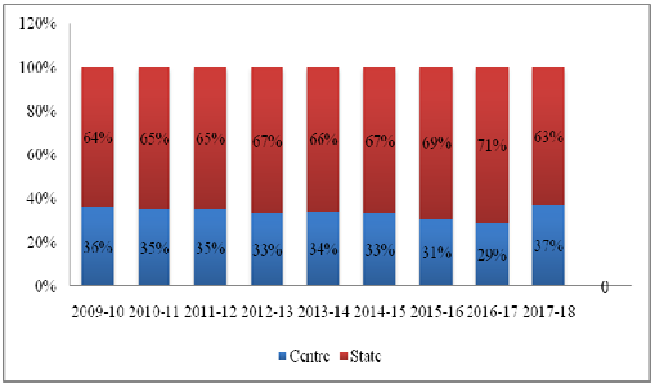
Figure 1: Source of Meeting Medical Cost by Households
Source: (Hooda, 2015)
Notes: OP*-Out-Patients. IP*- Inpatients

Table 1: Trends in Public Spending on Health in 2009-10 to 2017-18.

Year	Public Expenditure on health (In RsCrores)	Population (In Crores)$	GDP	Per Capita Public Expenditure on Health (In Rs)	Public Expenditure on Health as Percentage of GDP (%)
2009-10	72536	117	6477827	621	1.12
2010-11	83101	118	7784115	701	1.07
2011-12	96221	120	8736039	802	1.10
2012-13	108236	122	9951344	890	1.09
2013-14	112270	123	11272764	913	1.00

2014-15	121600.23	125	12433749	973	0.98
2015-16	140054.55	126	13764037	1112	1.02
2016-17	178875.63	128	15253714	1397	1.17
2017-18	213719.58	129	16751688	1657	1.28

***Source*:** National Health Accounts Cell, Ministry of Health & Family Welfare, Government of India 2018.



Source: National Health Accounts Cell, Ministry of Health & Family Welfare, Government of India 2018.

Figure 2: Trends in Centre-State share (%) in Total Public Expenditure on Health

Table 2: Percentage distribution of treated ailments without medical advice by reason for not seeking medical advice for each gender

Reason for treatment delayed		% of delayed treatment without medical advice				
		Rural		Urban		
	Male	Female	All	Male	Female	All
1	2	3	4	5	6	7
Lack of medical facility	17.7	13.5	15.4	2	0.8	1.3
Quality of care not available	3.4	3.9	3.7	2.4	2.1	2.2
Good care more expensive	8.7	3.9	6.2	3.1	7.2	5.3
Quality care need long waiting	2.9	3.7	3.3	1	3.3	2.3
Lack of money	55.4	59.1	57.4	75	62.8	68.3
Other	11.9	15.8	14.0	16.6	23.9	20.6
Total	100	100	100	100	100	100

Source: NSS 71 st Round, Ministry of Statistics and Programme Implementation, Government of India, 2014.

Table 3: Percentage of Taking Treatment from Different Level of Care on the Basis of Gender during Last 15 Days

Level of care		% of taking treatment from different level of care					
		Rural			Urban		
	Male	Female	All		Male	Female	All
1	2	3	4		5	6	7
Public hospital	15.9	17.5	16.8		17.4	17.3	17.3
Private doctor /clinic	52.7	48.9	50.7		48.9	50.8	50.0
Private hospital	20.8	21.3	21.0		30.2	27.7	28.8
Total	100	100	100		100	100	100

Source: NSS 71 st Round, Ministry of Statistics and Programme Implementation, Government of India, 2014.

Table 4: Average Total Expenditure (`Rs) for Non-Hospitalised Treatment per Ailment

Gender	Average total expenditure (Rs) for	
	Rural	Urban
1	2	3
Male	502	683
Female	515	604
Total	509	639

Source: NSS 71 st Round, Ministry of Statistics and Programme Implementation, Government of India, 2014.

Table 5: Average Total Medical Expenditure (Rs) for per Hospitalisation Case (EC) During Stay at Hospital

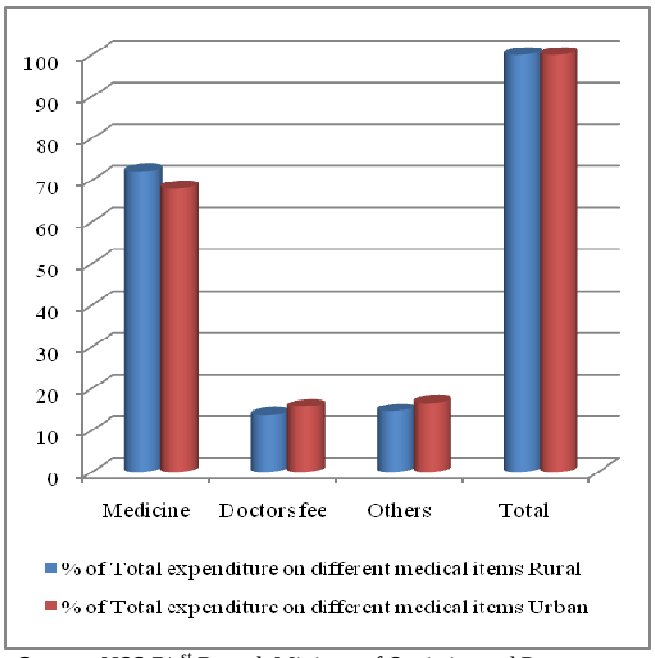
Gender	Average total medical expenditure (Rs)per hospitalisation case		
	Rural	Urban	All
1	2	3	4
Male	17528	28165	21113
Female	12295	20754	15292
All	14935	24436	18268

Source: NSS 71 st Round, Ministry of Statistics and Programme Implementation, Government of India, 2014.

Table 6: Average Total Medical & Non-Medical Expenditure during Stay at Hospital

Quintileclass of UMPCE	Average total medical & Non-medical expenditure during stay at hospital					
	Medical		Other		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
All	14935	24436	2021	2019	16956	26455

Source: NSS 71 st Round, Ministry of Statistics and Programme Implementation, Government of India, 2014



Source: NSS 71 st Round, Ministry of Statistics and Programme Implementation, Government of India, 2014.

Figure 3: Total expenditure on different medical items; All India

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