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PRIVATISATION OF HEALTH CARE IN INDIA : A COMPARATIVE ANALYSIS OF ORISSA, KARNATAKA AND MAHARASHTRA STATES.*

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PRIVATISATION OF HEALTH CARE IN INDIA : A COMPARATIVE ANALYSIS OF ORISSA, KARNATAKA AND MAHARASHTRA STATES.

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The mix of private and public health care provision has always been a major topic in health policy debate. The changing trend has invited attention of both the government and academia. The term privatisation refers to the growth of the 'for profit' sector and its inter relationship with the public sector. It also includes the introduction of market principles in the public sector viz. user fees, contracting out and private insurance schemes. While the private sector existed even at the time of independence, it has grown and diversified over the years. The study explores the characteristics, trends and the social basis of private sector growth. This part of the study is based on available studies and data of the Ministry of Health and Family Welfare. The trends in privatization are analyzed in terms of increase in private institutions and beds relative to public provisioning across rural and urban areas and states.

It further explores the manner in which this sector has grown during the nineties after the introduction of Structural Adjustment Programme (SAP). During this period there was not only growth of 'for profit' health care but the public sector was being increasingly restructured with the introduction of market principles. This kind of a trend has been promoted in the context of states facing a fiscal crisis and therefore opting for loans and grants from multilateral and bilateral agencies who have advocated policies for making the public sector generate its own resources. The net effect of such a restructuring process on the utilization patterns for out patient and in patient care across states and income fractiles are analyzed in relation to the structures of provisioning.

The organization of the sections in this paper is as follows :

Section two locates the privatization debate in a global context. Section three examines the phases in the growth of the private sector in India through an analysis of various Committee reports and other

relevant studies. Section four examines studies and available data to capture the trends, characteristics and social basis of the private sector at the primary, secondary and tertiary levels of care across the three states namely, Orissa, Karnataka and Maharashtra. The last section examines the utilisation patterns for outpatient and in patient care across rural / urban and the selected states.

2. Globalisation and Health Services: An Overview

The most significant and widespread global trend in health care over the past decade and more has been the increasing share of 'for profit' health care and its marketization across societies. This process in the health care sector has paralleled the process of economic globalization and is intrinsically linked to it.

While private medical practice and the dispensation of medical care for a price have been known for a long time, the commercialisation, corporatisation and marketisation of health care are a phenomenon of the last quarter of the 20th century. The process received a boost during the late seventies and early eighties due to global recession, which enveloped both developed and developing countries, imposing a fiscal constraint on government budgets and encouraging them to cut back on public expenditure in the social sectors. This increased the space for the growth of the private sector in provisioning of health care, which was accelerated during the eighties and nineties with the growth of the pharmaceutical and medical equipment industries and their seeking out markets for their products.

In this process of globalization multinational corporations have systematically targeted them for policy influence, defining priorities for disease control programmes, provisioning of health care, and medical research at the national level. Typically these MNCs have influenced national policies in key areas as provisioning and research in health care through multilateral agencies like the World Bank, World Health Organisation and the World Trade Organisation. They have influenced development funding in the social sectors, securing focus for programmes with a higher curative content. Rather than focus on public health and preventive programmes they have

encouraged funding of curative and drug-based programmes. Through the WHO they have not only pursued this strategy but have also sought to promote policy awareness in areas where the pharmaceutical industry has greater interests. Once again preventive programmes and public health have taken a back seat. Through the WTO the policy framework for intellectual property protection aimed at protecting pharmaceutical company bottomlines and helping them generate super profits have been put in place. Such policy interventionism has ensured the funding of specific programmes, the creation of a market for drugs and equipment and the freeing of state controls on the market. During the nineties, the WHO has increasingly gone in for partnerships with industry especially for the tropical disease research programmes. (Brundtland:2000)

The increased influence of global drug multinationals in the nineties has been facilitated by the recent trend towards mergers and the increased concentration of selling power within the pharmaceutical industry. As a result of these mergers a few corporations account for the bulk of pharmaceutical sales in the world. Many of these companies export drugs, vaccines and biological instruments to developed and developing countries. The major pharmaceutical, equipment and insurance related multinational companies are based in the United States. During the nineties they have expanded their markets across several developing and developed countries. This process has also been accompanied by the increased importance given to the growth of 'for-profit' healthcare.

2.1: International Experience with Marketization of Health Care

The trend towards marketisation of healthcare cuts across the developed and developing countries. While the United States has been a leader of the 'market model', the phenomenon is spreading even to "socialist" societies. Market forces have largely controlled financing, provisioning and research in the healthcare sector in the U.S. Financing has been largely managed through insurance companies, provisioning by large hospital corporations and research by pharmaceutical and medical equipment companies. The government's role has been minimal which includes providing public insurance to the elderly and poor, regulatory

guidelines for the private sector and giving subsidies for private medical care. (Brown, 1984). The marketised model of American medical care came under severe criticism during the Eighties which essentially focussed on the rising costs of medical care, excessive emphasis on curative and high technology care, the dominance of the medical technology and pharmaceutical industries in medical care. The critics further argued that these trends marginalised sections of the middle and working classes from access to health care which was corroborated by the increase in both the uninsured and under insured persons during the eighties and the nineties. The uninsured consumers of health services were largely drawn from the working class and even some sections of the middle class. (Carrasquillo et al:1999) Given the high cost of medical care the uninsured were effectively denied access to health care. However, efforts to introduce universal public insurance and other progressive reforms were resisted both by the pharmaceutical companies and the for-profit healthcare providers.

Despite the problems faced by the US health care system, most countries have been moving towards the American model of care where the private sector plays a dominant role. This undoubtedly is a consequence of globalization and the influence of the U.S. experience on other countries, an influence which has been partly communicated through the media and public perceptions of what is acceptable, and partly imposed by multilateral lending agencies like the World Bank. These agencies have strongly advocated privatisation measures in health care as part of the structural adjustment programmes. This position was well articulated in the World Development Report 1998, that was entitled, 'Investing in Health'.(Rao:1999)

Countries in Europe, Africa, Latin America and Asia that had built state supported health services during the sixties and seventies, have now encouraged privatisation both as a response to the fiscal crisis of the public sector and to fulfill conditionalities linked to multilateral lending programmes (Jara &Bossert:1995). The erstwhile Soviet Union and several central and eastern European countries have gone through a process of marketisation and the subsequent weakening and in some cases even dismantling of state services. Similarly, China has also been marketising its health

services and is encouraging MNCs to enter the health care market. Studies show that increasing marketisation of health care has pushed up cost of medical care and has contributed to increased inequality in access to services across regions and classes in China. (Acharya et al:2001)

Similar trends are visible in UK, several West European countries and in East Asia. In UK, several American hospital and insurance companies have entered the market during the eighties. During the same period efforts were made to restructure the National Health Service in order to reduce government spending. Several other countries in Africa and Asia have followed similar paths, with reduction in government spending on health care and an increased push for privatization. This has meant shifting of responsibility to individual households to pay for care (Price:1989). The consequences of marketization have been well documented for Latin America and Africa as in the case of some Asian countries. These studies show that access to care has reduced for the poor, costs of drugs are high and the private sector serves only those who can pay.

2.2 : Consequences of Marketization: Some Global Trends

What have been some of the consequences of marketisation in terms of cost, equity and universal access? Available data from both developed and developing countries show that marketisation has had serious consequences for equity. It has resulted in those who are poor being denied access or often getting poor quality of care. In many third world countries, paying for care has meant indebtedness for the household. During the decade of the eighties, in the US, the percentage of uninsured had risen by 30 percent and during the nineties the number of uninsured rose by 15.6 %. In 1998 approximately 44 million young persons were uninsured in the US and these included ethnic minorities, poor, elderly and women.(Carrasquillo et al:1999) Lack of insurance meant that these people could not access preventive services and treatment for chronic illnesses was also beyond their reach. As a result, very often they had to delay seeking medical care and hospitalization. If this is the situation in an affluent country then it is bound to be much worse in poorer countries where a larger

proportion of the population are poor. The nature of privatization has varied across countries in terms of the extent and nature of private sector growth.

Across the world the process of privatization share some common features specially due to the influence of the pharmaceutical and technology industries coupled with the policies of multilateral organizations. However the extent and nature of privatization varies across countries which is influenced by the specific socio-political context.

3. Private Health Services in India : An Overview

In the following section we attempt to trace the evolution of the private sector and explore its characteristics for India and the specific states under study. It is well known that the private sector in health care in India is represented by plurality in terms of systems of medicine and the forms of practice. Even before independence the single largest category of providers consisted of private practitioners across allopathic, ayurveda, unani, siddha and homeopathy. (Baru: 1994) The private sector in all these systems are dominated by individual practitioners and the growth of nursing homes and hospitals was largely confined to allopathic system of medicine from the seventies. Other indigenous systems of medicine did not witness a similar kind of growth at the secondary and tertiary level health care. Clearly the growth of the private secondary and tertiary levels of care were confined largely to urban areas and rural areas where there was agrarian prosperity. The relationship between economic development and growth of private services is obvious and this has been empirically shown in a study of a comparison of poorer and richer districts in Andhra Pradesh (Baru:1994). This study empirically showed that the number of private institutions at the secondary level of care was skewed in favour of the developed districts as compared to the poorer ones. This kind of a trend has been observed across other states as well.

The three states under study represent varying levels of development, private medical care and public health services. Maharashtra represents a developed state, Karnataka, a middle level and Orissa a poorly developed state. Given

these variations, one would like to examine the growth of the public sector and the private sector in these three states. Given the paucity of data on the private sector we are relying on published sources to discern the broad trends for essentially secondary and tertiary levels of care. The data on primary level care is not available but we have made use of published and unpublished studies that give us some insight into the numbers and characteristics of the providers in the private sector at this level. Utilisation of services for both out patient and in patient care is examined in the context of the structures of provisioning. This analysis will be done to study the variations across selected states, across income groups and also the vulnerable social groups, namely, the schedule caste and schedule tribes. Since NSS data is available for the mid eighties and the nineties, it is possible to study if there has been any shift in utilization patterns. All these three states have opted to go for reforming health systems project as a part of the World Bank financed project, which is part of 'soft loans' that several states have opted for.

If one examines the trends in death and infant mortality rates (IMR) for these three states one finds that the latter reflects the levels of development. In 1995, Maharashtra, which falls in the category of well-developed state, has an infant mortality of 55 per 1000 live births, followed by Karnataka with 62 and Orissa with 103. Interestingly the rural-urban differential is not very much in the infant mortality rates. It is also important to note that both Maharashtra and Karnataka have IMR lower than the All India average while Orissa is significantly above it. (Table 1). The death rates show a similar trend with both Maharashtra and Karnataka having Crude death rates of 7.4 and 7.6 per 1000 population, respectively while Orissa has 11.2. While Maharashtra and Karnataka have death rates below the All India average, Orissa's rates are higher than the All India average. (Table 2). Thus one can see that the overall socio-economic development seems to show variation in health status indicators as well as the provision of health services. The objectives of this section, specifically are:

1. To examine the trends in health services development in the private sectors relative to the public sector in terms of bed strength at the primary, secondary and tertiary levels.

2. To examine the utilisation patterns for outpatient and inpatient care in these states – across income and social groups.

In order to address the first objective relevant data on macro picture put forth by the Central Bureau of Health Intelligence (CBHI) and other available studies on the private sector are made use. For the second objective the 42nd and 52nd Rounds of the NSS and the latest NFHS data are utilized. This analysis is possible for poorer socio-economic groups.

3.1 : Evolution of Health Services in India from the Forties to the late Nineties

Health services development in India can broadly be divided into three phases. The first phase of development was the post independence period which upto the seventies witnessed growth of health services in the public sector. Investments in the health sector were meagre but there was an effort to build a network of services in both rural and urban areas. This phase was followed by the period from the late seventies to the late eighties when there were cutbacks on public spending and concessions given to private sector, and during the third phase India went in for loans from the IMF and World Bank. This was the period when several state governments received loans for reforming the publicly provided health services.

Like many of the newly liberated countries during the 20th century, the leadership of the Indian nationalist movement had committed itself to principles of universality and a nationalized health service system to ensure that all sections of the population get access to services. The vision at that point in time was to build self-reliance in the economy and social sectors and hence in health care the emphasis was on the development of institutions, manpower, research, pharmaceuticals and technology.

A number of actors have played an important role in shaping the health service system in India. The nationalist movement and its commitment to democratic politics played a very important role in ensuring that the needs of the majority were represented (Bhargava:2000). These various actors included the political parties, big business groups, professional bodies and other civil society bodies. It is indeed interesting to

note that the different sections of the political spectrum had clearly articulated the need for a state supported health service system. These sections included the national bourgeoisie, the left parties and the Indian National Congress. Each of them had articulated their respective positions through well-articulated plan documents.

Given the poor health of majority of Indians the thrust was to invest in preventive and curative care along with improving the overall living conditions of the population. The Bhore Committee report was an attempt at designing a health service system based on the needs of the majority who belonged to the deprived sections of the population. As the Bhore Committee observed, majority of the Indian population was suffering from malnutrition and anaemias. The major killers were a host of communicable diseases or commonly referred to as diseases of the poor. Therefore, the political leadership had to take cognisance of the extent of the problem and realised that it had to be tackled only through state investment since the market was restricted to individual private practitioners-both allopathic and other systems of medicine. Whether it was provisioning, or education private capital was limited and therefore even the representatives of big business relied on the state investing in education and health.

Within the health services, the professional organisations supported state investment but did not want it to interfere with their autonomy to continue private practice. It is indeed interesting that while the 'left' parties called for the abolishment of private interests within the medical and pharmaceutical sectors, the professional bodies wanted the doctors to be allowed to continue their private practice. The Bhore committee accommodated the interests of the professional bodies by not taking measures to eliminate private interests both within and outside the public health service system. Thus even at the time of independence a substantial percentage of government doctors were practicing in the private sector as individual practitioners but the number of institutions was very small. Private interests were also present in the pharmaceutical industry during this period (Jesani and Anantharam:1993; Baru:1998).

A survey of the health status of the population during the late forties revealed that death rates, infant mortality and maternal

mortality rates were very high and the major causes of death were a host of communicable diseases. Keeping in view the poor health conditions of the majority, the report emphasized the need for strong primary health care services supported by secondary and tertiary levels of care. They had estimated that around 12 percent of the GNP would need to be invested in the health sector in order to provide health services across the country. In addition it also recommended the need to invest in the pharmaceutical sector in order to develop indigenous capabilities and reduce excessive reliance on the multinational corporations. The Bhore Committee in 1946 symbolized the effort of the Indian State to plan and deliver health services, which would be accessible to all its citizens. The real growth period for health services was during the sixties but even at that time the investments were far from adequate. Thus the vision of the Bhore committee suffered a setback during the sixties with inadequate levels of investment which resulted in a weakly developed primary health services with most of the investment going into the secondary and tertiary levels of care (Banerji:1985 ; Qadeer: 1985).

In terms of structure, the Bhore committee had envisioned a three-tier with a strong primary health service network as a base and supported by secondary and tertiary levels of care. In order to build an extensive network of services the committee had suggested fairly high levels of investment of up to 12% of GDP. Despite the rhetoric of primary health care the structure of provisioning was largely curative, biased towards urban areas and in the secondary and tertiary levels of care. The structures of provisioning largely reflected the needs and aspirations of the middle classes from both urban and rural areas.

As in the other social sectors, in health too the low levels of investments resulted in incremental planning rather than an integrated one. Very often these meagre resources built infrastructure that reflected the middle and upper classes while the needs of the majority were largely neglected. Several scholars have often criticized this and some have even questioned whether India can be characterised as having a 'welfare state' at all (Jayal: 1999). Despite the incremental nature of health service planning, India did manage to build a fairly extensive

network of services, created indigenous capacity for training personnel for various levels of care, and invested in research and pharmaceutical capability. However, the low levels of investments in health services affected the growth of the public sector and this was an important reason for the expansion of the private sector during the seventies and eighties.

Given the nature of democratic politics wherein the interests of different sections were being accommodated, it was the needs and aspirations of the urban and rural middle classes that was reflected in the growth of health services in India. The services were largely urban and curative based with emphasis on technological solutions to a number of health problems. This matched the interests of the professionals who were also largely drawn from the upper and middle classes. Once again there was ideological pressure from opposition parties and civil society, which questioned the directions of health service development. Interestingly this kind of questioning occurred only during those phases of Indian politics when there was a progressive political regime, which expressed concern about inequalities and conditions of the poor and vulnerable sections of the population. This resulted in the setting up of committees that called for re-orientation of health services to rural areas and also investing in preventive care. Apart from progressive regimes there were socio-economic changes occurring in the agrarian sector in several parts of the country which resulted in the rise of the rich and middle peasant classes. These classes started putting pressure on the state to invest more in infrastructure inputs, education and health care. The growing demands from the middle and rich peasant classes in rural areas resulted in some investments being diverted to rural areas (Kamat :1985; Nambissan,G. & Batra, P:1989). These pressures had a marginal impact for service provisioning in rural areas since the state did not increase investments substantially. As a result, the rural-urban inequalities in service provisioning remained largely unaltered through the seventies.

The seventies were marked by a number of debates concerning the problems of health services development and suggestions for change within the country. Some of them were seriously reviewed by national bodies and they were extremely

critical but also offered alternatives to remedy some of the problems (ICSSR/ICMR Committee report: 1981). The reviews discussed the underfunding of the health sector and the structural inequalities within it. The critiques emphasised the need for reorienting health services to rural areas and also to make medical education more relevant to the needs of rural areas. However, the oil shock of the late seventies had a negative impact on the financial condition and India along with several other developing countries found themselves caught in the world recession. Due to the financial crunch most third world governments during the eighties were in no position to increase investments in health. Inadequate investments in health services meant a stagnation in the growth of public services, and this was an important reason for the growth of market forces in the health sector (Baru:1998).

The growth of the private sector and the gradual neglect of the public sector have to be seen in terms of the changes in the social structure after independence in the rural/urban areas and across regions in India. The growth of the middle classes after independence was not merely restricted to urban areas. With agrarian prosperity as a result of the green revolution, there was a rise in the rich and middle peasantry who were largely drawn from the backward castes. This was mainly seen in some northern, western and southern states in the country (Kamat: 1985). These sections had made use of public investment in education as a vehicle for social mobility in order to challenge traditional social hierarchies. As a result, these upwardly mobile sections invested heavily in the education of their children for social mobility and from some of the more prosperous areas of the country they immigrated to the UK and USA as qualified professionals during the late sixties and seventies (Baru:1998; Omvedt:1981 ; Khadria:1999). Thus a globalised middle class of professionals, who had both urban and rural roots, was beginning to emerge. The aspirations of these classes were clearly at a divergence from the large section of the poor. Typically the 'new middle class' found the public system inadequate to meet their needs and in those states where there was a vibrant private sector they started moving out of the public sector. This is seen in the case of health service utilisation during the mid eighties wherein the urban and rural middle income

groups utilised private health services depending on their ability to pay. Here it is important to underscore that there are regional variations and this kind of a trend is seen in the richer states as compared to the poorer ones (Baru:1998). The moving out of upper and middle sections of the population from public provisioning had serious consequences for financing, provisioning and quality of services. These sections really provide the constituency for support of health sector reforms and support the neo liberal position that public services are for the poor and those who can afford to pay should use private services. With the middle class giving up ownership of the public sector there is a further weakening of the state's commitment towards public provisioning.

The growth of the private sector has been largely a phenomenon of the late seventies and eighties as was seen in the rest of the developed and developing world. In India even prior to independence, the proportion of individual private practitioners was as much as 73 percent and the remaining 27 percent were employed in government service (Bhore Committee: 1946; pp.42-43). The committee recognised that private practice by government doctors would go against the principles of equity but did not address how the large proportion of private practitioners would affect the public health services (Baru:1998). Infact there was no real debate about either nationalising or defining a role for the private practitioners as was the case in some Latin American countries (Jara & Bossert: 1995). The growth of individual practitioners at the primary level of care continued through the sixties but at this point in time there was little growth of private institutions at the secondary level care.

In his analysis of privatisation in health care, McKinlay has observed that for any substantive analysis there needs to be recognition of the role played by large finance capital in the health sector. Large finance capital was largely confined to the pharmaceutical, medical equipment and insurance industries and these operated globally (McKinlay: 1980). The impact of these industries was very visible in the Indian case during the late eighties and nineties when there was a sharp increase in the import of medical equipments. The real peak was seen during the mid to late nineties with the government offering reduced import duties

for medical equipment (Baru:1998). Apart from imports, many multinational equipment companies like Siemens, Philips, Becaton and Dickinson and General Electric started setting up assembling plants in the central and southern parts of India. As an executive of Phillips international remarked "The health care business is a $3000 billion industry worldwide. If even we attract 1 percent of the market in India, the potential for the medical equipment industry is tremendous" (Baru: 1998).

India with its fairly significant middle class provides a good market for these multinationals. Computer software industries tie up with the medical sector and American insurance companies looking for tie-ups will further consolidate the position of global capital in the private health sector. This would definitely redefine and alter the spaces for the states to plan their health services. These trends are not restricted to the private sector but with the restructuring of the public hospitals under the health sector reforms the interests of some of these industries especially the medical equipment industry would grow.

4. Structure and Characteristics of Private Health Care Providers in India

The Indian private sector is characterized by a heterogeneous structure consisting of institutions of varying sizes and patterns of ownership (Bhat: 1993; Baru:1998). Bulk of the private sector still consists of individual practitioners, both qualified and unqualified, who essentially provide primary level, out patient care and are located in both rural and urban areas. These practitioners provide primary level curative services of extremely variable quality across urban and rural areas in the country (Jesani:1993, Yesudian:1994; Baru:1998).

The secondary level of care in the private sector are provided by nursing homes with a bed strength ranging from 5-50 and are promoted by single owners or partners.(Jesani:1993; Bhat: 1993; Yesudian: 1994;Baru:1998). While in most states they are largely an urban phenomenon, in other states, where private sector growth (relative to public sector) is high, they have spread to even peri urban and rural areas. Studies conducted in Hyderabad and Chennai reveal that most of these nursing homes offer

general and maternity services and are managed by doctor entrepreneurs (Baru:1998; Muraleedharan:1999). Within this category there is a further division between small and large nursing homes, which differ widely in terms of investments, equipment and facilities, range of services offered and quality of care. Most of these promoters are qualified doctors who have located these enterprises in urban and semi urban areas. The tertiary level care consists of multi specialty hospitals that are promoted by partners or as private limited or public limited enterprises. These are mostly located in the larger cities and have a strong Non Resident Indian connection with doctors based in the United States. (Baru:1998)

Private sector institutions providing tertiary care constitute roughly 1-2 per cent of the total number of medical care institutions and bed strength. This figure is arrived at through available studies in some of the metropolitan centres where the tertiary sector is present. They are mainly the large hospital run by trusts; private or public limited enterprises.(2) The private and public limited hospitals are only an urban phenomenon and have been the largest beneficiaries of subsidies given by the government in terms of land and loans.

4.1 Characteristics of Primary Level Care Private Providers

Available studies on private sector in India suggest that a considerable section of the population in both rural and urban areas and across states, access the services of individual private practitioners for primary level care (Sunder,R: 1992; Krishnan:1994). Micro-level studies from Delhi, Hyderabad and rural Uttar Pradesh show that people from different sections of the population, both rural and urban areas, use these practitioners as a first resort for acute conditions but also use government facilities (Nanda and Baru: 1994;Vishwanthan and Rhode:1994). These utilisation studies show that the private practitioners are resorted to for a variety of minor illnesses for curative care. These studies also show that there is much heterogeneity among providers in terms of qualifications, systems of medicine, and practices. They include herbalists, indigenous and folk practitioners, compounders and others (Vishwanathan and Rhode: 1994; Uplekar: ; Baru:1998). These practitioners being easily available and

accessible locally, are utilised extensively. Studies conducted in urban slums and rural areas from Uttar Pradesh, West Bengal. Orissa. Kerala, Tamilnadu and Maharashtra indicate that the middle and better off sections in these communities use services both qualified and unqualified private practitioners. The really poor are unable to afford the doctor's charges and hence, either opt for the government hospitals or often go without care (Bisht: 1993; Soman: 1992; Vijaya: 1997; Kakade: 1998).

Chemist shops and pharmaceutical representatives influence the prescribing patterns of both qualified and unqualified practitioners. In addition, the former also dispense medicines for a variety of ailments and act as providers of primary level care. Studies by Phadke and Greenhalgh in Maharashtra have amply demonstrated the nexus between the marketing network of the pharmaceutical industry and prescribing patterns of doctors, both qualified and unqualified (Greenhalgh: 1986; Phadke: 1998; Shah: 1997). Phadke's study on the supply and use of pharmceuticals in Satara district of Maharashtra shows that a high proportion of prescriptions of both government and private doctors is irrational and often very costly. The influence of pharmaceutical representatives is significant and they are the single most important source of continuing medical education of doctors (Phadke et al:1995). Samantaray while examining the utilisation of health services in Kandhamal district of Orissa shows that women utilise the services of the pharmacist in both rural and urban areas without consulting health professionals (Samantaray: 2000).

Given the poor knowledge base of these practitioners it is not surprising that their treatment of even common ailments are often irrational, ineffective, and sometimes harmful. Studies that have looked into provider behaviour with respect to specific diseases like tuberculosis and diarrhoea in Maharashtra, Delhi slums and Tamilnadu support the findings from elsewhere (Uplekar: 1991; Bhandari: 1994; Balambal et al:1997).

4.2 Characteristics of Private Providers at the Secondary and Tertiary Levels Care

A few studies on the secondary level of care show that it consists of institutions

that provide both outpatient and in-patient with 5 to over 100 beds. These studies provide insight into the heterogeneity of these institutions in terms of scale of operation, services offered, technology employed, and the social background of patients using these facilities (Bhat:1993, Jesani: 1993; Nanda and Baru:1994, Baru:1998; Muraleedharan:1999). They have further shown that these institutions are largely promoted by single owners or partners, who are mostly doctors. Typically these institutions are located in towns and cities but in some states like Andhra Pradesh, Maharahtra, Gujarat and parts of Karnataka and Tamilnadu they have spread to peri urban and rural areas, specially in those areas which are economically well developed. Given the variability in the size and characteristics of the institutions at this level of care there is much plurality in type, quality and costs of services provided by such institutions.

Nandraj and others have explored the variability in the physical infrastructure , qualifications of personnel and their practices at the secondary level of care in Mumbai. The studies from Delhi, Chennai and Hyderabad show similar trends and this lack of some basic and uniform standards for service provisioning has implications for the quality of care provided (Baru:1998; Muraleedharan:1999). It is important to point out here that there is a dearth of studies looking at the quality of the private sector in some detail.

The tertiary level forms only 1-2 percent of the total private sector and is located in the large cities. Typically these are promoted as trusts, public or private limited enterprises and most of these are located in the southern cities of Chennai, Bangalore and Hyderabad. These hospitals have a strong NRI link and provide a range of super specialist care.

4.3 Regional Variations in the Growth of Private Health Care

The growth of the private sector is related to the level of economic and infrastructural development. As mentioned in the earlier section, the primary level care consisting of private practitioners is widespread in both rural/urban areas and across states. However when it comes to secondary and tertiary levels of care there is a distinct variation across states. A study across developed and backward districts in Andhra Pradesh demonstrated this amply.

The private sector bed strength was much higher in the better-developed districts when compared to the backward ones (Jessani:1993;Baru:1994). This kind of a pattern is seen across states as well. There is a paucity of data on individual practitioners since the only source of information available is based on the registration data from the various medical councils. This data is limited because not all practitioners are registered with these councils and there is also a great deal of cross practice across systems of medicine (Baru:1994; Duggal: 2001). Duggal estimates that the number of practitioners is around 12 lakhs in the country and are concentrated in states like Maharashtra, Gujarat and the southern states. The allopathic doctors constitute about 45 percent of total registered practitioners and are located mostly in urban areas, whereas non allopathic are mostly located in the smaller towns and rural areas (Duggal:2001).

At the secondary level of care which consists of nursing homes, the economically developed states like Maharashtra, Punjab, Tamilnadu and Gujarat have a higher proportion of beds in the private sector when compared to the public sector (Table 3). That are relatively poorer states such as Orissa, Madhya Pradesh, Uttar Pradesh and Rajasthan have low private sector growth. The growth of corporate hospitals is largely a phenomenon in those states, which have agrarian prosperity and also have strong NRI links. For the three states under study the trends are clear; Maharashtra is the high private sector growth state, Karnataka falls in the middle range and Orissa is a poor state with very little private sector growth. The trend in growth of private beds relative to public from the seventies to the nineties indicates that in Karnataka there has been a doubling of private beds over the twenty year period, for Maharashtra the private beds have increased four and a half times during the same period. While for Orissa there has been no growth and infact shows a negative growth of private beds during this period (Table:3).

A survey done by the Karnataka government in 1996 on non government facilities shows that there are a large number of institutions in this sector at the secondary and tertiary levels of care. It showed that 89 percent of these institutions were general hospitals with bed strength of 36,042, followed by those that provided only

maternal and child health services (10.04%) and the remaining provided specialist services like opthalmology and oncology (Govt. of Karnataka:2000, pp.29-30). In terms of ownership 83.38 percent of these institutions were promoted by individuals, 7.49 percent were partnerships, 3.98 percent were charitable trusts 2.46 percent were registered societies, 1.58 % were religious missions and 1.11 % were limited companies. Nearly 52% of the total beds were in the category of institutions promoted by individuals.

This data does not provide us information on the distribution of these institutions within Karnataka but the general pattern is that they are mostly located in urban and peri urban areas. Karnataka does have a sizeable private sector but there is no system for registration hence there is an incomplete picture of the private sector. In recent years there has been an increase in the number of nursing homes and corporate hospitals especially in urban areas (Govt. of Karnataka: 2000). In terms of accessibility of services there is considerable regional variations in both the private and public sectors. North Karnataka has poor infrastructure in terms of roads, communications and transport facilities while southern Karnataka has better infrastructural facilities which has an impact on accessibility and utilisation.

In Maharashtra a few studies have focussed on the public sector and the regional variations in terms of its distribution. More developed regions of Marathwada and Konkan have better facilities and access as compared to poorer region of Vidarbha (Budhkar:1996). Budhkar observes that there has been a strong tradition of local bodies in the provisioning of health services in Maharashtra. During the late seventies those regions that experienced agrarian prosperity viz. Marathwada and parts of Konkan, also witnessed a spurt in the growth of the private sector at the secondary level of care. She also shows that dispensaries and small nursing homes, which are skewed in favour of urban areas, dominate the private sector. This kind of a trend was observed in a study of distribution of NGOs in Maharashtra where there was a greater concentration in the better developed districts than the poorer ones (Jessani: 1986).

When it comes to Orissa there are no studies available on the growth of private sector. However studies that have looked at the health care services show that the public services are skewed towards urban areas and the private sector's contribution is not more than 10 percent of the government beds. Therefore there is very little interface between the public and private sectors. An analysis of bed strength in the private sector in relation to the public sector shows that the presence of the private sector in Orissa is very low (As shown in Table4) (Padhi,S. & Mishra,S.:2000).

4.4 ; Micro Studies on the Private Sector: Maharashtra, Karnataka and Orissa

A survey of available literature on the private sector in these three states reveals that there is a paucity of both published and unpublished studies in this area (CEHAT, IIT & JNU: 2001). Maximum number of studies have been done in Maharashtra, followed by Karnataka and lastly, Orissa. For Maharashtra most of the studies have been conducted in Bombay and focus on the utilisation of the private sector, the private practitioners and their practices.

A few studies have looked at the practices of private practitioner, both allopathic and non-allopathic, with respect to communicable diseases like malaria, tuberculosis and leprosy (Uplekar and Shepherd: 1991; Uplekar and Rangan:1996). Study of private practitioners in Bombay with respect to the treatment of tuberculosis showed that both allopathic and non-allopathic doctors were treating this disease. A survey of these practitioners revealed that there was a lack of awareness among them about the standard regimen for treatment of tuberculosis. These practitioners were found using expensive regimens and providing incomplete treatment as well (Uplekar and Shepherd:1991). A similar study tried to examine the knowledge, attitude, practice and beliefs about leprosy. It showed that while these practitioners had knowledge about the disease their attitudes were infact very negative towards the patient suffering from the disease. This kind of an attitude is bound to affect patient care.

A study conducted in the rural and urban areas of Pune district showed that people who had developed symptoms of tuberculosis generally went to a private clinic. These private practitioners tend to

use X rays as a diagnostic tool rather than the technique of sputum examination. It has been well known that the latter is not only cheaper but also effective for the diagnosis of tuberculosis. People from both rural and urban areas preferred the private practitioners because they had to wait for less time and that the clinic timings were more convenient. The study also showed that the cost of treatment was much higher in the private sector as compared to the public sector. As a result about a third of the patients who were treated in the private sector had incurred debts in order to bear the expenses of the treatment. Rural patients had spent almost double the amount of money for treatment as compared to their urban counterparts. For the case of malaria, private practitioners were the first levels of resort, as a study from the urban slums of Bombay reveals. This study showed that these practitioners use a number of irrational formulations for treating malaria and infact had little or no interaction with the public health care system (Kamat:2001).

As far as Karnataka is concerned the review shows that there are very few studies on the private sector. An advocacy group based in Bangalore has looked into the utilisation of government, private and charitable hospitals by households earning less than Rs 3500 per month. This study revealed that the costs for medical treatment were high in the case of private hospitals when compared to the government or charitable hospitals (Balakrishnan & Iyer:1997).

5. Utilisation of Private Health Services

The structure of provisioning of health services will largely determine the patterns of utilisation and the expenditures incurred at the household level. Based on an analysis of the 42nd and 52nd Rounds of the NSS, the household survey conducted by the National Council of Applied Economic Research (NCAER) and the National Family Health Survey, trends in health services utilisation in the three states have been analysed. The analysis has been disaggregated for out patient and in patient care, states; rural/urban and income levels depending on the availability of the data for such analysis.

5.1 : Utilisation of Health Care for Out patient Services

Analysis of the 42nd round of the NSS data, pertaining to 1985-86 period shows that in both rural and urban areas at the all India level more than 50 percent of out patient services were provided by private doctors. In rural areas only 18 percent of the cases requiring out patient care sought treatment in a public hospitals, 5 percent at a primary health centre and a mere 3 percent in public dispensaries. In urban areas the proportion of those who used public hospitals was higher than in rural areas. In Maharashtra 49.94 percent used private doctors and 23 percent used private hospitals for out patient care in urban areas. Only 19 percent of the households had used public hospitals and the remaining had used a public dispensary or primary health centres. In rural areas 51 percent of the households had resorted to private doctors and 19.5 percent to a private hospitals. Only 14 percent had used public hospitals, 10.4 percent primary health centres and mere one- percent the public dispensaries for treatment.

In Karnataka 43 percent of outpatients had used the private doctors and 22 percent a private hospitals for out patient care in urban areas. Moreover, 27 percent had used public hospitals and mere 1.71 and 1.23 percent used primary health centres and public dispensaries respectively.

In rural areas 41.5 percent had used private doctors and 18.5 percent private hospitals. 25 percent of the households had used public hospitals, 8.5 percent primary health centres and a mere 1.2 percent public dispensaries.

Orissa shows a different trend from Karnataka and Maharashtra. In urban areas 38.7 percent used private doctors and a mere 4 percent private hospitals. Nearly 42 percent of the households had used public hospitals while only 1 percent had used a PHC and 3.5 percent the public dispensaries for treatment. In rural areas 31 percent used the private doctors and there was no reported utilisation of private hospitals at all. 34 percent of the population used the public hospitals, nearly 12 percent the PHC and 6 percent the public dispensaries (Tables 5 &6).

The 52nd round of the NSS data pertaining to 1995-96 period shows that there has been an increase in the utilisation

of private sources for in patient and out patient care across rural and urban areas. At the all India level, 64 percent of rural and 72 percent of urban outpatient care was sought through the private sector. In Maharashtra 73 percent in rural and 77 percent in urban areas had resorted to the private sector. In Karnataka 51 percent in rural and 74 percent in urban areas resorted to the private sector for care. In Orissa 31 percent in rural and 53 percent in urban areas had resorted to the private sector for out patient care (Duggal:2001).

The NCAER survey of 1993 shows that around 55 percent of the households had sought outpatient care with private doctors in rural areas while around 64 percent had gone to private sources in urban areas. In Maharashtra around 53 percent are using private sources in rural and around 66 percent are using the same in urban areas. In Karnataka around 40 percent are using private sources in rural and around 50 percent are using the same in urban areas. In Orissa around 17 percent are using private sources in rural and 55 percent are using the same in urban areas (Sundar,R. :1995).

Analysis of the NFHS of 1993 has provided information on utilization of maternal health services and also for certain diseases suffered by children. This data has been analysed for schedule castes, schedule tribes and other groups separately. The data has also been analysed across major states. For antenatal care which comes under out patient consultations, at the all India level for the SC and ST categories, 42 per cent and 28 per cent, respectively received antenatal care from trained personnel, while only 14 per cent and 18.5 per cent received care from trained personnel. It is important to note that 42.2 % of SC and 52.3 % of ST households did not receive ante natal care at all. The states of Maharashtra, Karnataka and Orissa presented a picture of variations. In Maharashtra 10.3% of SC households, 29.6 % of ST households and a 11.1% belonging to 'others' received antenatal care from health personnel at their homes ; 65.5 % of SCs, 44.4 % of STs and 44.5% of 'others' received antenatal care from trained personnel. In Karnataka, 24.7% of SCs, 20.5% of STs and 17.5% of others received antenatal care at home. While 56.8% of SCs, 58.1% STs and 66.4% of 'others' received antenatal care from trained

personnel. In Orissa, 30.6% of SCs, 30 % of STs and 18.9% of 'others' received antenatal care from a health worker at home. While 35.3% of SCs, 22 % of STs and 44.5% of 'others' used the services of trained personnel for antenatal care. There is clearly a variation in utilisation of services across these three states. In all three states the percentage of households receiving care at home from a trained personnel is low and in general the access to these services by STs is lower than the SCs. Across the three states the levels of utilisation for antenatal care is extremely poor (Ram et al:1998;Table.9).

In the case of children suffering from fever a fairly high proportion of households go to a nearby provider or health facility. At the all India level 66.7% of SCs, 55% of STs and 68.2% of 'others' used the facility nearby. Across states the proportion of utilisation is high. It is found that in Karnataka, 72.3 % of SCs, 84% of STs and 76.7% of 'others' used the nearby health facility. In Maharashtra 60 % of SCs, 68% of STs and 77.5% of 'others' used the providers and in Orissa 51.7% of 'SCs, 41.6% of STs and 57.4% of 'others' used the provider for treating their children. This data suggests that people from all the three categories use the services ; But there is variation across states. While the percentage utilising the services is fairly high for all the three categories in Maharashtra and Karnataka it is quite low in the case of Orissa (Table 11).

5.2 : Utilisation of In-patient Services

When it comes to in-patient services the picture is somewhat different. An analysis of the 42nd round of the NSS data at the All India level reveals that only around 36 percent of the hospitalisations were in private hospitals in urban and around 35 percent in rural areas. In Maharashtra around 48 percent of the households had used a private hospital in urban areas while in rural areas the figure was around 54 percent. In Karnataka around 50 percent in urban areas and around 38 percent in rural areas had used private sources for treatment. In Orissa, around 15 percent in urban and 7 percent in rural areas had been treated in a private hospital (Tables 7&8).

The 52nd round of the NSS data shows that at the all India level 54.7 percent of households in rural and 56.9 percent urban areas had utilised private hospitals

for their hospitalization. There has definitely been an increase in the proportion of persons utilising the private sector between the 42nd and 52nd Rounds of the NSS, which is roughly over a decade.

In Maharashtra 68.8 percent in rural areas and 68.2 in urban areas had utilised private sources . In Karnataka 54.2 percent in rural and 70.2 in urban areas had utilised private sources. In Orissa 9.4 percent in rural and 19 percent in urban areas had utilised private sources. Apart from the inter state differences in utilisation of the private sector there is also a difference between the poorest and richest quintiles. An analysis of the 52nd round of the NSS shows an interesting picture that at the All India level 39 % of the poorest quintile were using the private sector for hospitalisation while 77 % of the richest quintile were utilising the private sector. Among the three states, the poorest in Orissa relied mostly on the public sector than either Karnataka or Maharashtra states. In many states the middle and lower middle sections have started using the private sector while the poor still continue to rely on the public hospitals. Therefore there is a clear indication that the utilisation of the private sector increases as the income gradient increases. As far as the vulnerable sections viz. schedule castes and tribes are concerned, utilisation by schedule tribes is very low in both the public and private sectors while in the case of schedule castes it is marginally higher and the dependence is greater on the public than the private sector.

The NCAER survey on utilisation of inpatient care shows that 38 percent in rural and 40 percent in urban areas resort to private sources at the all India level. In Maharashtra 69.5 percent in rural and 41.2 percent in urban areas resort to private sources. In Karnataka 38.9 percent in rural and 42.2 percent in urban areas resort to private sources. In Orissa a mere 1.9 percent in rural and 31.3 in urban areas resort to private source (Sundar,R:1995).

While there is some variability between the findings from NSS and NCAER surveys they both show the variation in utilisation patterns across the three states. It also broadly reflects the structures of provisioning in terms of private and public sectors in these three states. Maharashtra has a higher proportion of private beds, followed by Karnataka and lastly Orissa,

which is being clearly reflected in the utilization patterns as well. The important issue to be underscored is that in all three states there is dependence on the public sector especially for in patient care but the degree of dependence however varies across these states.

The NFHS also provides data on the proportion of deliveries taking place in institutions. Invariably, they are quite low among the vulnerable sections. At the All India level 10.9 per cent of the SCs used public hospitals while a mere 5.1% used the private hospital. Among the STs 6.7% used public hospitals and 2.4% private hospitals. Among the category of 'others' 16.3% used the public sector while 12.9 % used the private sector. Non institutional or home deliveries formed a high proportion with 82.7%, 89.6% and 69.9% of SCs, STs and 'others' respectively (Table.10). The proportion of Schedule castes accessing private facilities was only 4.4 % while for STs it was 4.5% in Karnataka. In Orissa a mere 0.7% of SCs and 1.3% of STs were using private facilities. However in Maharashtra 16.6% of SCs and 6.1% of STs were using the private facilities for deliveries. The proportion of home deliveries is high in Orissa with 86.1% for SCs and 92.4% for STs and 80.6% for others. In Karnataka 77.8% of SCs, 73.2% of STs and 58.2% of others had deliveries at home. In Maharashtra 55.2% of SCs, 82.2% and 51.7% of others had home deliveries (Table 10).

5.3 ; Trends in Immunisation

The 52nd Round of the NSS data contains information on the immunization status of children aged 0-4 years for polio, DPT, BCG and measles vaccine. Analysis of this data shows that at the All India level that there are rural-urban differences in immunisation coverage. The coverage of doses is higher for urban as compared to rural areas and the immunisation status is positively associated with the socio-economic status measured by per capita expenditure. Immunisation rates were somewhat higher among non-SC/ST children as compared to SC/ST children (Mahal et al:2001). The data reveals that there are regional variations across states of children who received immunisations. Kerala, Karnataka, Maharashtra, Andhra Pradesh , Tamilnadu, Punjab, Haryana received high average doses per child compared to the

All India doses. Even Orissa, which is a poor state, had the average number of doses higher than the All India figure. The analysis also revealed that the government is the major provider of immunisation services and it is higher for urban compared to rural areas. Across states the analysis shows that the share of private sector immunization increases with the socio-economic status at the All India level in urban areas. The only two states where the private sector plays a higher role in immunization services are Kerala and Maharashtra (Mahal et al:2001).

5.4 : Expenditure Incurred on Private Sector in Relation to Public Sector

Three important messages emerge from the two NSS surveys. First, the average medical expenditure per ailment episode is higher for both in patient and out patient care in the private sector. Second, the expenditure in the private sector is higher for urban compared to rural areas. Third, there is also an increase in expenditure on medical care between the 42nd and 52nd rounds, which have a gap of a decade between them, for both the public and private sectors. The NCAER's survey also shows that the average expenditure is higher for the private compared to the public sectors for both rural and urban areas. Krishnan has analysed the 42nd round of the NSS data for expenditure on medical care across states. He shows that the average total expenditure for hospitalisation is higher than the all India mean in nine out of 15 states and these include rural Delhi, Punjab, Haryana, Uttar Pradesh and Bihar. The same trend holds true for the urban sector (Krishnan:1999). A few household level studies have shown that around 7-9% of household consumption expenditure is spent on health care, of which 85% is spent in the private sector. The 52nd round of the NSS data shows that per capita out-of-pocket expenditure per year on private facilities ranges from over Rs 500 among the richest, to Rs. 75 among the poorest (Mahal et al: 2000).

Analysis of the 52nd round of the NSS data shows that the expenditure on both inpatient and out patient care has increased between 1986 and 1996. Between 1986 and 1996 costs of medical care in both the public and private sectors have risen sharply . The costs in the public sector rose by 549 % in rural areas and 470% in urban areas while for the private sector it rose by 486%

in rural and 343% for urban areas. The major reason for the rise in costs of medical care in the public sector has been the increased prices of drugs. This rise in costs of medical care is bound to affect accessibility and utilisation of health services, which would result in those requiring care but not getting it. This would also explain why the rates of untreated illnesses are very high among the poorer groups and when they do seek care they have to borrow to pay for care (Iyer & Sen: 2000). The 52nd round estimates that 45 % of the country's poor had to borrow money or sell their assets to meet increasing cost of medical care.

6. Conclusion

This study has explored the evolution of the private sector and its characteristics for India and also across states, more specifically in Maharashtra, Karnataka and Orissa. The three states under study represent varying levels of socio-economic development and this is reflected in the health outcomes as well as the growth of the private sector. In terms of health outcomes, Maharashtra has lower infant mortality rates as compared to either Karnataka and Orissa. The available data clearly shows that Orissa has the poorest health indicators among these three states. The private sector is a heterogeneous structure consisting of a substantial number of individual practitioners who have either formally or informally trained. They are distributed across rural and urban areas and offer primary level curative care. The secondary level of care consists of institutions which deliver both in patient and out patient care. There is great variability in the size of operations at this level and it is mostly an urban and peri-urban phenomenon. The tertiary level of care is an urban phenomenon and cities like Delhi, Hyderabad, Mumbai, Chennai, Bangalore have a substantial presence of these hospitals.

In terms of provisioning, Maharashtra has both a strong public and private presence, followed by Karnataka and then Orissa. These structures of provisioning then get reflected in the patterns of utilisation. In general available data suggest that the utillisation of private services is higher in Maharashtra and Karnataka when compared to Orissa and this holds for the vulnerable groups as well.

The patterns in private utilization of health services has been quite different for out patient and in patient care. Across all

the three states there is a greater dependency on the private practitioners for out patient care. However, when it comes to hospitalisation there is variation in utilisation patterns across the three states. This variation needs to be explained with respect to the structures of provisioning. The states that have experienced higher private sector growth are the ones which are economically better off. There is a higher utilisation of the private sector for hospitalisation in Maharashtra and Karnataka. In these states it is the upper and middle income groups that use these services whereas in Orissa the percentage of those using the private sector among the middle and upper middle sections is very low (Krishnan:1994).

The NSS, NCAER and NFHS data show that there are variations in the patterns of utilisation of the private sector across states, income groups and vulnerable social groups. The 52nd Round of the NSS data has shown a tremendous increase in the costs of medical care in both the public and private sectors. For out patient care all the three states have shown an increased use of the private sector. Of the three states, urban Orissa has shown the highest increase from 42.4% in the mid eighties to 53% in the mid nineties (Table 12). For Inpatient care there has been a bigger increase in urban compared to rural areas. Maharashtra and Karnataka show similar trends in increased use of private sectors whereas Orissa shows only a small increase.(Table: 13). This kind of a trend needs to be analysed in the context of increase in the growth of private services but also in terms of what has been happening in the public sector is analyzed further. The issues concerning rising costs in the public sector, the quality of care provided and increase in the costs of drugs have acted as push factors for utilising the private sector. What is indeed worrying is that the levels of utilisation among the schedule tribes across states has shown very low levels of utilisation. This would mean that those who need care are not seeking care because they cannot afford it and therefore may not be seeking care when they need it the most (Iyer & Sen: 2001). In a sense while the middle and upper middle classes can choose to use either the public or private sectors, the poor may not be in a position to access either of them because of rising costs of medical care. Where the public sector is weak this will clearly affect utilization by the poorer sections of the population. Clearly there are important questions regarding

equity in this context. At the state level this calls for a rational use of available resources and also for a policy that will strengthen public provisioning and regulating the private sector. In addition, other mechanisms like public insurance schemes could be given a serious thought to address some of these inequities and its consequences.

Footnotes

1. This was articulated by Bruntland in her inaugural address to the WHO where she welcomed the partnership between the pharmaceutical companies and the WHO for its disease control programmes.

2. Based on empirical studies of the secondary and tertiary levels of care in Hyderabad it was found that only 1 % of them were corporately managed (Baru:1998). Similarly in Chennai, only 1.2% were corporately managed (Muraleedharan:1999).

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Table - 1

Infant Mortality Rates - 1993-95

(Per 1000 live births)

States	1990			1993			1994			1995		
	Rural	Urban	Combine	Rural	Urban	Combine	Rural	Urban	Combine	Rural	Urban	Combine
Karnataka	80	39	70	79	73	69	42	45	43	63	65	62
Maharashtra	64	44	58	67	67	66	32	36	36	50	54	55
Orissa	127	68	122	115	108	107	69	65	65	110	103	103
All India	86	50	80	82	79	80	45	51	51	74	73	74

Source : CBHI - 94, 95-96

Table -2

State wise Death Rates in India during 1986-1995 :

(Per 1000 Population)

States	Area	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Karnataka	Combined	8.7	8.7	8.8	8.8	8.1	9.0	8.5	8.0	8.1	7.6
	Rural	9.4	9.7	9.5	9.6	8.8	9.8	9.4	9.5	9.3	8.5
	Urban	6.8	6.1	7.0	6.5	6.1	6.9	6.0	5.2	5.5	5.6
Maharashtra	Combined	8.4	8.3	8.9	8.0	7.4	8.2	7.9	7.3	7.4	7.4
	Rural	9.7	9.5	10.1	8.9	8.5	9.3	9.1	9.3	9.2	8.9
	Urban	6.1	6.1	6.7	6.3	5.4	6.2	5.6	4.8	5.4	5.3
Orissa	Combined	13.0	13.1	12.3	12.7	11.7	12.8	11.7	12.2	11.1	10.8
	Rural	13.5	13.7	12.8	13.2	12.2	13.5	12.1	13.1	11.7	11.2
	Urban	8.1	7.8	7.1	8.1	6.9	6.6	7.8	5.8	7.2	7.4
All India	Combined	11.1	10.9	11.0	10.3	9.7	9.8	10.1	9.3	9.2	9.0
	Rural	12.2	12.0	12.0	11.1	10.5	10.6	10.9	10.6	10.1	9.7
	Urban	7.6	7.7	7.7	7.2	6.8	7.1	7.0	5.8	6.5	6.5

Source : CBHI - 95 - 96

TABLE – 3 GROWTH OF PRIVATE & VOLUNTARY HOSPITALS AND BEDS IN MAJOR STATES

SL. No.	STATE	1973			1983		1985		1987		1989	1991		1993		1996	
1	Andhra Pradesh	113	9,213	266	11,103	266	11,103	266	11,103	266	11,103	841	19,784	N.A.	26,791	2802	42192
2	Bihar	N.A.	N.A.	125	8,447	125	8,447	90	8,519	55	5,536	55	5,536	N.A.	8,519	90	8519
3	Gujarat	41	1,219	669	16,929	733	16,339	1,211	21,128	1,319	25,093	1,319	25,093	N.A.	83,487	-	-
4	Haryana	17	1,877	18	2,566	18	2,566	17	2,558	20	2,772	20	2,232	N.A.	2,232	20	2232
5	Karnataka	38	5,106	53	6,894	44	6,702	51	7,339	51	7,339	51	7,339	N.A.	9,999	56	9999
6	Kerala	N.A.	N.A.	606	18,203	606	18,203	173	14,309	1,899	44,321	1,899	49,169	N.A.	49,169	1899	49169
7	Madhya Pradesh	8	1,601	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	0	0
8	Maharashtra	68	8,300	682	26,024	945	32,033	1,121	35,296	1,319	35,849	1,319	37,781	N.A.	37,758	2583	37758
9	Orissa	35	1,741	34	1,408	31	1,227	31	1,227	29	1,306	29	1,301	N.A.	1,306	14	201
10	Punjab	20	2,070	35	2,913	35	2,913	43	3,466	39	3,781	39	3,782	N.A.	3,782	39	3782
11	Tamil Nadu	69	9,618	61	8,562	61	8,562	73	9,505	119	10,366	119	10,366	N.A.	10,366	119	10366
12	Uttar Pradesh	151	19,897	160	12,083	159	12,026	159	12,026	159	12,026	159	12,026	N.A.	12,026	159	12026
13	West Bengal	78	8,452	126	6,424	126	6,610	126	6,463	129	6,511	129	6,912	N.A.	6,912	134	6759
14	All-India	718	66,926	3,022	134,266	3,549	139,442	3,549	144,009	6,522	177,034	6,522	180,386	N.A.	210,987	10289	228155

Source : Government of India, Ministry of Health & Family Welfare Health Information of India, Central Bureau of Health Intelligence, New Delhi : Government of India, Various Years.

TABLE – 4 GROWTH OF PRIVATE BEDS RELATIVE TO PUBLIC BEDS IN MAJOR STATES

Sl.No.	State	1973		1983		1993		1996	
		Public Beds	Private Beds	Public Beds	Private Beds	Public Beds	Private Beds	Public Beds	Private Beds
1	Andhra Pradesh	19,356	9,213	22,722	11,103	22,776	26,761	3640	42192
2	Bihar	11,722	N.A.	14,078	8,447	20,522	8,519	20522	8519
3	Gujarat	10,150	1,219	11,502	16,929	20,708	33,487	-	-
4	Haryana	3,767	1,877	4,744	2,566	4,796	3,232	4948	2232
5	Karnataka	18,485	5,106	21,267	7,779	27,216	9,999	27736	9999
6	Kerala	19,623	N.A.	24,875	18,203	28,030	49,169	28030	46169
7	Madhya Pradesh	12,551	1,601	16,827	N.A.	25,310	N.A.	18141	0
8	Maharashtra	23,653	8,300	37,790	26,024	34,261	37,758	34261	37758
9	Orissa	7,235	1,741	9,988	1,408	13,077	1,306	14572	201
10	Punjab	5,918	2,070	11,316	2,913	10,786	3,782	10936	3782
11	Tamil Nadu	13,287	9,618	31,574	8,562	37,935	10,366	37935	10366
12	Uttar Pradesh	23,326	10,897	33,125	12,083	34,267	12,026	34267	12026
13	West Bengal	25,106	8,452	42,319	6,424	47,252	6,912	47825	6759
14	All-India	230,161	66,926	329,245	134,266	365,696	210,987	375987	228155

Source : Government of India, Ministry of Health & Family Welfare Health Information of India, Central Bureau of Health Intelligence, New Delhi : Government of India, Various Years.

TABLE - 5 Distribution of Out-Patient Treatment Over Sources of Treatment for States/U.T. –Urban

		Type of Hospitals									
S.No.	States/UTs	Public Hospital Centre	Primary Health Centre	Public Dispen	Private Hospital	Nursing Home	Charitable Hospital	ESI Doctor	Private Doctor	Other	All
1	Andhra Pradesh	18.42	0.66	1.43	41	3.23	1.05	1.45	26.62	6.1	100
2	Assam	26.03	2.09	1.48	6.58	0.81	0.03	-	51.07	11.97	100
3	Bihar	15.62	1.2	0.81	20.95	0.66	0.18	0.37	56.45	3.76	100
4	Gujarat	14	0.45	1.41	39.28	-	1.05	2.7	38.13	2.98	100
5	Haryana	11.3	2.18	3.52	6.12	2.05	0.31	4.69	68.6	1.23	100
6	Himachal Pradesh	40.77	4.69	2.25	2.07	-	-	-	50.22	-	100
7	Jammu & Kashmir	40.39	4.3	2.35	0.81	-	2.86	0.38	44.84	4.07	100
8	Karnataka	27	1.71	1.23	22.07	1.01	0.24	1.36	43.19	2.09	100
9	Kerala	32.83	2.43	0.43	40.21	0.66	0.12	0.63	19.87	2.82	100
10	Madhya Pradesh	28.77	1.01	0.63	12.48	0.34	0.72	1.59	51.65	2.81	100
11	Maharshtra	19.39	1.66	3.1	23.01	0.3	0.92	0.87	49.94	0.81	100
12	Manipur	40.1	18.16	3.18	9.83	-	-	-	17.8	10.93	100
13	Meghalaya	23.42	0.06	1.54	6.07	-	-	2.75	49.23	15.95	100
14	Nagaland	30.6	-	-	1	-	-	-	68.25	-	100
15	Orissa	41.8	1.11	3.54	4.07	0.67	1.05	1.42	38.78	7.56	100
16	Punjab	8.72	0.84	0.59	9.14	0.25	0.4	0.77	79	0.29	100
17	Rajasthan	51.36	3.54	2.31	12.15	0.33	0.24	0.3	24.3	5.45	100
18	Sikkim	83.3	3.9	-	-	0.84	-	-	11.96	-	100
19	Tamil Nadu	29.94	1.11	1.52	17.28	3.94	0.49	2.5	40.91	2.31	100
20	Tripura	17.72	6018	1.28	-	-	-	-	50.9	23.92	100
21	Uttar Pradesh	13.63	0.82	1.48	6.32	0.66	1	0.27	73.93	1.92	100
22	West Bengal	19.52	0.58	0.74	1.95	0.34	2.03	2.39	69.6	2.85	100
23	Chandigarh	20.9	-	3	1.59	-	-	3.94	70	0.57	100
24	Delhi	32.14	0.29	6.95	7.3	1.41	0.89	3.28	45026	2.48	100
25	Goa, Daman & Diu	42.12	-	10.6	21.18	-	-	-	23.93	5.17	100
26	Mizoram	63.85	3.13	5.24	7.12	-	-	-	14.67	5.99	100
27	Pondicherry	67.6	1.42	-	2.16	-	-	-	26.52	2.3	100
28	Andaman & Nicobar	74.81	1.41	3.96	7.23	-	-	-	7.4	5.19	100
29	Lakshadeep	73.01	19.78	-	3.97	2.44	-	-	0.8	-	100
30	All India	22.6	1.19	1.75	16.18	1.15	0.81	1.61	51.83	2.88	100

Note: Percentages may not add up to 100 due to rounding off figures.

Source : Government of India, Central Statistical Organisation, Morbidity and Utilisation of Medical Services, 42nd Round of the National Sample Survey. No. 364 (New Delhi : Government of India, 1989.)

E – 6 Distribution of Out-Patient Treatment Over Sources of Treatment for States/U.T

S.No.	States/Uts	Public Hospital Centre	Primary Health Centre	Public Dispen	Private Hospital	Nursing Home	Charitable Hospital	Esi Doctor	Private Doctor	Other	All
1	Andhra Pradesh	14.38	3.15	1.39	32.12	2.52	0.22	1.09	40.05	5.08	100
2	Assam	20.01	16.24	16.76	7.21	0.01	-	-	28.17	11.6	100
3	Bihar	13.04	2.05	1.75	9.86	0.58	0.26	0.03	59.04	13.39	100
4	Gujarat	25.28	4.64	2.5	20.89	0.1	2.8	0.08	40.77	2.94	100
5	Haryana	11.94	3.28	1.68	8.52	0.8	0.35	-	68.79	4.64	100
6	Himachal Pradesh	48.7	6.23	5.74	1.84	0.7	-	-	35.79	1	100
7	Jammu & Kashmir	37.78	5.33	15.68	0.24	-	0.07	0.99	2.37	7.54	100
8	Karnataka	25.72	8.47	1.27	18.48	1016	0.17	0.94	41.51	21.28	100
9	Kerala	27.5	4.32	2.32	41.64	1.04	0.11	0.38	20.57	2.12	100
10	Madhya Pradesh	20	8.49	2.4	12.39	0.62	0.23	1.87	49.62	4.38	100
11	Maharshtra	14.03	10.42	1.44	19.54	0.16	0.78	0.43	51.04	2.16	100
12	Manipur	20.61	31.08	8.53	1.91	-	-	-	8.5	19.37	100
13	Meghalaya	10.22	24.63	8.15	0.22	-	1.19	-	34.54	21.07	100
14	Orissa	34.01	11.93	6	**	-	0.51	0.71	31.39	19.35	100
15	Punjab	9.72	1.3	1.52	9.53	0.06	0.22	0.23	76.58	0.84	100
16	Rajasthan	38.23	6017	11.04	7.84	0.72	0.07	0.68	27.39	7.86	100
17	Sikkim	72.68	7.57	2.95	2.23	-	-	-	14.57	-	100
18	Tamil Nadu	30.41	4.93	0.85	20.32	3.04	1.63	0.85	33.13	4.84	100
19	Tripura	19.48	10.41	7.35	1.62	-	0.73	-	31.72	28.69	100
20	West Bengal	12.48	6	0.89	0.93	0.17	0.18	0.04	74.74	4.49	100
21	Chandigarh	10.95	-	-	-	-	-	10.95	78.09	-	100
22	Dadar & Nagar Haveli	65.34	7.96	-	5.65	-	-	-	19.06	1.99	100
23	New Delhi	30.73	3.23	-	14.69	-	-	-	51.35	-	100
24	Goa, Daman & Diu	30.8	24.72	-	15.79		-	-	28.69	-	100
25	Mizoram	24.68	42.6	18.18	-	1.19	-	-	0.48	12.87	100
26	Pondicherry	46.51	8.63	1.84	9.62	-	-	1.18	32.22	-	100
27	Andaman & Nicobar	77.74	8.17	8.08	-	-	-	-	1.57	4.44	100
28	Lakshadeep	41.23	43.39	-	15.38	-	-	-	-	-	100
29	All India	17.67	4.94	2.59	1.03	0.75	0.35	0.38	53.01	5.18	100

Note: Percentages may not add up to 100 due to rounding off figures.

Source : Government of India, Central Statistical Organisation, Morbidity and Utilisation of Medical Services, 42nd Round of the National Sample Survey. No. 364 (New Delhi : Government of India, 1989.)

TABLE – 7 Percentage Distribution of In-Patient Treatment Cases Over Type of Hospital for States/U.T. –Urban

S.No.	States/UTs	TYPE OF Hospital						
		Public Hospital	Primary Health Centre	Private Hospital	Charitable Instt.run by Public Trust	Nursing Home	Others	All
1	Andhra Pradesh	37.98	-	55.15	3.75	2.74	0.38	100
2	Assam	79.88	2.45	10.14	0.11	7.42	-	100
3	Bihar	44.69	1.02	32.98	1.56	12.43	7.32	100
4	Gujarat	59.21	-	34.25	3.13	0.26	0.39	100
5	Haryana	55.31	-	34.25	1.8	8.64	-	100
6	Himachal Pradesh	77.13	3.85	19.02	-	-	-	100
7	Jammu & Kashmir	93.23	2.73	3.44	0.11	0.49	-	100
8	Karnataka	48.51	0.39	40.49	1.26	9.06	0.29	100
9	Kerala	54.77	0.88	41.79	0.64	1.92	-	100
10	Madhya Pradesh	76.01	0.97	15.24	1.98	5.01	0.79	100
11	Maharshtra	45.74	0.49	47.63	3.41	1.81	0.92	100
12	Manipur	91.66	1.16	1.02	-	1.3	4.86	100
13	Meghalaya	51.68	1.74	44.29	2.29	-	-	100
14	Orissa	78.94	2.54	13.9	1.15	1.28	2.19	100
15	Punjab	48.37	0.4	43.21	3.22	2.01	2.79	100
16	Rajasthan	84.98	0.64	7.92	1.24	3.05	2.17	100
17	Sikkim	91.75	4.12	3.12	-	1.01	-	100
18	Tamil Nadu	57.74	0.3	34.14	0.41	5.61	1.8	100
19	Tripura	94.4	5.6	-	-	-	-	100
20	Uttar Pradesh	57.97	1.28	19.43	2.04	15.53	3.75	100
21	West Bengal	72.64	1.26	10.06	2.45	13.48	0.11	100
22	Chandigarh	92.89	-	7.11	-	-	-	100
23	Dadra & Nagar Haveli	-	-	-	-	-	-	100
24	New Delhi	70.15	0.92	15.17	1.48	11.29	0.99	100
25	Goa, Daman & Diu	61.71	-	38.29	-	-	-	100
26	Mizoram	91.39	-	6.79	1.82	-	-	100
27	Pondicherry	85.68	-	12.9	-	1.42	-	100
28	Andaman & Nicobar	93.74	-	.6.26	-	-	-	100
29	Lakshadeep	70.29	10.78	18.93	-	-	-	100
30	All India	59.51	0.75	29.55	1.91	7.04	1.24	100

Note: Percentages may not add up to 100 due to rounding off figures.

Utilisation of Medical Services, 42nd Round of the National Sample Survey. No. 364 (New Delhi : Government of India, 1989.)

TABLE – 8 Percentage Distribution of In-Patient Treatment Cases Over Type of Hospital for States/U.T. –Rural

S.No.	States/UTs	TYPE OF Hospital						
		Public Hospital	Primary Health Centre	Private Hospital	Charitable Instt.run by Public Trust	Nursing Home	Others	All
1	Andhra Pradesh	28.9	1.01	65.22	1.04	3.36	0.47	100
2	Assam	82.51	7.51	7.56	0.59	0.73	1.1	100
3	Bihar	47.19	2.67	27	0.88	13.82	8.44	100
4	Gujarat	48.66	0.3	42.8	7.31	0.62	0.31	100
5	Haryana	50.96	-	31.95	3.45	11.62	2.02	100
6	Himachal Pradesh	80.09	7.84	8.89	-	1.2	1.98	100
7	Jammu & Kashmir	91.17	4.98	2.6	0.88	-	0.45	100
8	Karnataka	55.31	2.71	32.94	2.59	5.62	0.91	100
9	Kerala	41.02	2.36	53.4	0.26	2.96	-	100
10	Madhya Pradesh	72.62	6.61	14.8	1.64	3.29	1.04	100
11	Maharshtra	40.67	2.9	53.38	2.18	0.11	0.76	100
12	Manipur	69.07	9.66	17.72	0.19	0.19	3.17	100
13	Meghalaya	80.2	2.22	17.58	-	-	-	100
14	Orissa	80.25	7.81	6.36	2.62	0.89	2.07	100
15	Punjab	45.46	2.03	47.14	1.97	1.66	1.74	100
16	Rajasthan	77.03	2.98	13.16	1	3.11	2.72	100
17	Sikkim	100	-	-	-	-	-	100
18	Tamil Nadu	55.53	0.62	39.11	0.97	2.71	1.06	100
19	Tripura	87.89	11.76	-	0.35	-	-	100
20	Uttar Pradesh	52.61	2.76	27.26	3.46	10.1	3.81	100
21	West Bengal	76.77	14.85	1.43	0.66	6.05	0.24	100
22	Chandigarh	91.21	-	8379	-	-	-	100
23	Dadra & Nagar Haveli	68.34	2.15	26.24	-	-	3.27	100
24	New Delhi	81.16	-	18.84	-	-	-	100
25	Goa, Daman & Diu	82.3	-	17.7	-	-	-	100
26	Mizoram	65.79	33.36	0.85	-	-	-	100
27	Pondicherry	81.03	-	15.56	-	-	3.41	100
28	Andaman & Nicobar	94.73	5.27	-	-	-	-	100
29	Lakshadeep	33.04	30.01	36.95	-	-	-	100
30	All India	55.4	4.34	31.99	1.71	4.86	1.7	100

Note: Percentages may not add up to 100 due to rounding off figures.

Medical Services, 42nd Round of the National Sample Survey. No. 364 (New Delhi : Government of India, 1989.)

Table 9

Percentage distribution of women who gave live births during the four years preceeding the survey by source of antenatal care during pregnancy according to SC & ST categories, India and States, 1992-93

India /States	ANC only at home from health			Trained Personnel			No ANC		
	SC	ST	Others	SC	ST	Others	SC	ST	Others
India	14	18.5	11.9	42.4	28.3	53	42.2	52.3	34
A.P.	24.1	29.8	18.3	61.9	32.4	65.9	11.5	35.5	12.2
Assam	NA	0.8	3	63.6	30.3	49.3	36.4	68.9	47.2
Bihar	13.4	6.4	9.7	21.2	14.8	28.3	63.6	78.8	60.8
Goa	NA	7.1	1.3	87.5	88.1	94	12.5	4.8	3.8
Gujrat	19	39.4	22.6	62	28.3	54.2	15	31.5	22.6
Haryana	5.6	NA	5.2	61.5	NA	69.4	32.8	NA	25
H.P.	2.1	3.8	1.5	70.3	54.5	76.6	27.6	41.6	21
Jammu	1.3	NA	0.6	74.7	NA	79.7	24	NA	18.5
Karnataka	24.7	20.5	17.5	56.8	58.1	66.4	18.6	20.5	15.1
Kerala	NA	2.9	0.6	96.9	82.9	97	3.1	8.6	1.7
M.P.	13.5	20.2	14	41.2	19.3	44	43.4	59.2	41.1
Maharashtra	10.3	29.6	11.1	65.5	44.4	73	22.8	26.1	15.5
Orissa	30.6	30	18.9	35.3	22.2	44.5	32.2	46.1	35.5
Punjab	2	NA	1.7	85.3	NA	86.1	12.8	NA	11.8
Rajasthan	4.2	14.3	7.1	17.2	16.9	27.7	76.7	68.5	63.1
T.N.	25.9		13.6	65.5		81.3	8.3	NA	4.7
U.P.	14.9	3.9	14.4	21.9	11.4	32.4	62.9	84.6	52
W.B.	6.1	6.7	6.7	60.6	61	69.6	33.3	32.3	23.1

Source : Cited in Ram.F, Pathak K.B. & Annamma K. I, Utilization of Health Care Services by the Under Previleged Section of Population in India : Results from NFHS, IASSI Quaterly, Vol. 16, Nos. 3&4, 1997 PP. 133.

Table 10

Percentage distribution of women who gave live births during the four years preceeding the survey by source of antenatal care during pregnancy according to SC & ST categories, India and States, 1992-93

India /States	Health Facility Institutions						Home (Own Parents)		
	Public			Private					
	SC	ST	Others	SC	ST	Others	SC	ST	Others
India	10.9	6.7	16.3	5.1	2.4	12.9	82.7	89.6	69.9
A.P.	15.1	2.4	14.3	10.8	4.8	22	72.7	90.3	54.7
Assam	9.6	5.4	8.4	3.3	1.4	3.6	84.9	93.2	87.6
Bihar	4.1	2.5	6.4	3.3	1.4	7.1	91.5	96.1	85.6
Goa	50	52.4	41	15	11.9	47.5	35	35.7	10.9
Gujarat	24	6.4	16.7	15	6.4	23.9	61	86.3	59
Haryana	4.2	NA	11.3	3.6	NA	9.3	91.5		78.9
H.P.	12.6	3.2	16.1	0.4	NA	2.2	86	90.5	80.8
Jammu	11.7	NA	19.5	1.8	NA	6.6	85.7		73.3
Karnataka	16.9	22.3	22.4	4.4	4.5	18.3	77.8	73.2	58.2
Kerala	68.8	68.6	37.4	28.1	2.9	50.8	3.1	22.9	11.3
M.P.	12.2	3.1	16	3.3	0.9	5.6	81.3	93.9	77.3
Maharashtra	25.5	10	24.1	16.6	6.1	23.6	55.2	82.2	51.7
Orissa	10.8	3.3	15	0.7	1.3	2.7	86.1	92.4	80.6
Punjab	8.9	NA	10.1	10.1	NA	17	80.8		72.4
Rajasthan	5.7	5.6	12.1	1.5	0.6	2.8	90.7	93.4	84.3
T.N.	29.3	NA	34.8	14.9	NA	33.8	24.8		30.2
U.P.	1.6	NA	8.2	1.6	NA	4.9	94.5	99	86
W.B.	21.3	16.6	27.5	0.6	NA	6.2	78	83	65.9

Source : Cited in Ram.F, Pathak K.B. & Annamma K. I, Utilization of Health Care Services by the Under Previleged Section of Population in India : Results from NFHS, IASSI Quaterly, Vol. 16, Nos. 3&4, 1997 PP. 137.

Table 11 Among all children under four years of age who are suffering from fever during two weeks before survey, the percentages taken to a health facility or provider and the type of treatment given by SC/ST population, India & States 1992-93

India /States	% taken to a health facility or provider	Percentage treatment with Antimalarial or Syrup	Antibiotic Pills	Injection	Home remedy/ herbal medicine	Other	None
India							
SC	67.7	7.8	35	27	5.7	36.2	20.5
ST	55	6.4	31.2	21.2	5.6	31.8	27.2
Others	68.2	8.4	34.8	21.8	5.3	39.7	18.8
A.P.							
SC	77.5	5	50	50	2.5	30	20
ST	54.3	11.4	28.6	42.9	_	14.3	34.3
Others	70.9	10.7	45.6	47.6	_	32	19.9
Assam							
SC	25	3.1	25	5	2.5	15.6	56.3
Others	32.8	4.7	17.2	2.8	5.3	28.8	47.5
Bihar							
SC	68.1	16.1	52.3	20.9	_	22.8	23.9
ST	53.5	5.6	47.9	5.6	8.5	26.7	31
Others	59.3	10.7	47.7	19	2.3	26.2	23.7
Gujrat							
SC	63.1	9.2	30.8	21.5	1.5	23.1	30.8
Others	78.7	8.7	47.4	20.2	2.4	32.8	11.5
Haryana							
SC	89.5	_	2.5	38.1	_	90.8	8
Others	84.6	1.5	3.6	27.7	6.3	85.2	7.9
H.P.							
SC	77.7	1.8	25.9	16.4	1.8	58.2	13.2
Others	82.7	1.6	22.2	15.1	4.4	66.2	6.7
Jammu							
SC	64.2	6.1	14.6	7.8	8.5	70.1	9.7
Others	73.7	8.1	7.1	12.3	6.2	73.8	12
Karnataka							
SC	72.3	8.5	25.5	38.3	2.1	51.1	14.9
ST	84	12	60	56	_	28	4
Others	76.7	7.5	28.8	48.6	1.4	54.8	11.6
M.P.							
SC	68.4	21.2	67	31	6.6	17.4	9.7
ST	57.4	1.5	33.6	35.6	9.3	37.6	21.5
Others	67.8	6	39.7	35.8	3.2	35	21.1
Maharashtra							
SC	60	8	20	4	4	44	32
ST	68	4	30	2	2	38	20
Others	77.5	8.4	30.9	28.7	1.7	52	17.1
Orissa							
SC	51.7	2.1	23.5	2.8	6.2	45.5	28.3
ST	41.6	5.4	18.7	9	9.3	35.8	35.5
Others	57.4	5.1	20.6	4.9	6.2	48.5	25.6
Punjab							
SC	86.7	9.3	6.7	29.3	1.3	78.7	6.7
Others	93.4	13.2	7.1	27.9	1	78.7	2.5
Rajasthan							
SC	51.4	12.9	21.4	31.4	11.4	24.3	24.3
ST	61.4	13	38.9	29.6	5.6	20.4	20.4
Others	66.9	14.6	42.7	24.8	7.6	26.8	13.4
T.N.							
SC	67.8	3.4	39	44.1	3.4	27.1	27.1
Others	74.4	4.1	48.9	38.8	2.3	32.9	20.1
U.P.							
SC	70.1	6.5	48.5	30.1	7.9	26.1	15.5
Others	70.8	9	46.2	24.6	6	28.2	14.5
W.B.							
SC	49.2	8.8	6.4	2.3	14.3	33.3	41.7
Others	60.4	8.7	18.2	1.6	16.8	37.8	25.4

Source : Cited in Ram.F, Pathak K.B. & Annamma K. I, Utilization of Health Care Services by the Under Previleged Section of Population in India : Results from NFHS, IASSI Quaterly, Vol. 16, Nos. 3&4, 1997 PP. 143.

Table 12 Trend in Utilisation of Out Patient Services in the Private Sector Between 42nd and 52nd Rounds of the NSS

(Figures are in percentages)

Sl.No.	States	42nd (Urban)	42nd (Rural)	52nd (urban)	52nd (rural)	% urban	change rural
1	Maharashtra	72.4	70.5	77	73	4.6	2.5
2	Karnataka	0.65	60	74	51	9	-9
3	Orissa	42.4	31	53	31	10.6	No change
4	All India	50	50	72	64	22	14

Source: Government of India, CSO, 42nd and 52nd Rounds of the NSS

Note Private Sector Includes both private doctors and hospitals.

Table 13 Trends in Utilisation of Inpatient Services in the Private Sector Between 42nd and 52nd Round of the NSS

Sl.No.	States	42nd (Urban)	42nd (Rural)	52nd (urban)	52nd (rural)	CHANGE urban	change rural
1	Maharashtra	48	54	68.2	68.8	20.2	+14..8
2	Karnataka	50	38	78.2	54.2	20.2	16.2
3	Orissa	15	7	19	9.4	4	2.4
4	All India	36	35	56.9	54.7	20.9	19.7

Source: Government of India, CSO, 42nd and 52nd Rounds of the NSS.