UPDATE

News and Notes

Fee for Service in Maharashtra Hospitals

It is not surprising that the Government of Maharashtra has been the first to introduce fee-for-service medical care in all district and Government medical College hospitals from February 9 this year. The trend had started long back: the Municipal Corporation dispensaries and hospitals hiked the OPD case paper charges over a year ago with no significant resistance from any corner. But now the fee-for-service will be and is being charged at a higher rate not only for the OPD and indoor case papers, also for each component of the service availed of by the patient. The outdoor case paper now costs Rs.2 instead of 10 paise for seven days' treatment, and for indoor patients the charge is Rs.5 per day (in addition Rs. 3 per day are charged for diet). For laboratory investigations the charges are: Rs.5 for routine blood, Rs.10 for urine, stool, sputum, ESR, malaria and filaria, Rs.5 for MMR and screening, Rs.20 for standard X-ray. For operations, the charges are: Rs.120 for major operations, Rs.50 for minor operations done in minor OT., Rs.10 for minor operations done in the OPD without anaesthesia. For deliveries in these hospitals, family planning disincentives are applied: Rs.20 for third and subsequent deliveries.

The virtues of fee-for-service have been rigorously propagated in Maharashtra for the last one and a half decades. The political and economic crisis of the Indian rulers, which began to manifest itself from the late 1960s, was reflected acutely in the health-care sector. The experimentation primarily with the support of foreign funding agencies which led later to the formulation of international and national strategies for the primary health-care and the health for all had begun as early as the late 1960s and the early 1970s. All these experiments were meant to develop a strategy without radically changing the health-care structure and so also the social structure and without demanding any extra resources from the state to provide some basic health care to the people.

As these experiments grew under the 'care' of NGOs and voluntary agencies all over India, particularly in Maharashtra, they exerted a strong influence on government policy-making. Many of them attributed their success in people's participation to their policy of charging for services, albeit charging at low price. While attacking government policy of providing free services, it was argued that people do not appreciate services when provided free and there is a wastage of resources, as people misuse and overuse government services. They did not stop here. They even carried out some studies showing that the community is ready to pay for the services from the village health worker level to the hospital level. Thus evolved a strong case for the 'community financing' of health-care.

In this context, two points should be noted. Firstly, the majority of the NGO experiments were and are being carried out noy in the developed districts but in the underdeveloped areas (Jesani, Duggal, Gupte, 19). Therefore, in these areas the penetration of commodity relations is very pronounced. The NGOs' policy only took it further. Secondly, corruption and malpractices in the government sector are so rampant that they have already become institutionalised. The PHCs are no longer exclusive free service institutions nor were the district and the medical college hospitals before the February 1988 order. In a very significant number of them private practice by doctors both inside as well as outside the institution is the norm rather than the exception. In fact, about 25 per cent of PHCs and all rural hospitals and district hospitals officially allow doctors to do private practice, although not within the institution. Therefore, a fee-for-service atmosphere and value system has existed for long in the government sector. The health bureaucracy too believes in and encourages this state of affairs.

However, despite corruption and malpractice, poor were able to avail of some services, though it was second grade as doctors used to be more concerned about those patients who were either VIPs or used to fill their pockets. Now with the government becoming a 'private practitioner', even this second grade service is no longer available to the poor. The provision of providing free treatment to 40 per cent of patients is an eyewash, as it is at the discretion of the civil surgeon and the superintendent, who neither have inclination nor time to indentify such needy patients. Undoubtedly the government has in one stroke thrown overboard the fundamental recommendation of the Bhore Committee (1946) that health care should be available to people irrespective of their ability to pay.

Ironically enough privatisation of health

financing has take place in the context of the much lauded primary health-care and health for all. Certainly, privatisation does not necessarily and logically flow from the basic principles of primary health care. But when the PHC approach is articulated within backward capitalism which has historically, in our country, encouraged private sector through public sector resources, and at a time when the private health sector is attempting to expand its sphere of operation, it could generate a dynamic towards privatisation unless the PHC approach is combined with a vociferous demand for complete nationalisation of health-care services and allied drug and instruments industry.

Moreover the demand for low cost health-care must be made secondary to the demand for a National Health Service. In a climate where the private sector is allowed and given concessions to establish hi-tech medical care and the government hospitals in the urban areas—especially those also catering to the VVIPs—following the same line, people's expectation and aspiration to be treated with the best of medical tools will naturally increase. This is irrespective of whether the so-called best is really the best or not, rational or not and even appropriate or not. This climate decisively undermines the basis of primary health-care approach and it will be regarded as a second grade service by the people. Thus while one must continue to work for rational medical practice—even show to the government how resources could be saved by having rational medical practices in our hospitals (as against charging for services to meet demands)—unless low-cost medical care is propagated with a demand for an NHS, the PHS approach may well turn out to be self-defeating do late

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