PUBLIC PRIVATE PARTNERSHIP TOWARDS UNIVERSAL HEALTH CARE IN INDIA

A Roadmap for achieving UHC

NATIONAL LAW SCHOOL
OF INDIA UNIVERSITY BENGALURU
THINK TANK ON HEALTH

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Executive summary

Private healthcare sector holds overall 60% Inpatient department (IPD) beds and 85% tertiary care beds today. This is in contrast to 92% beds being provisioned by the public sector in 1946. Providing health care to the ever increasing population is just not possible without public and private sectors coming together. Therefore, government policies taking the private sector in to confidence, not limiting to reimbursement rates is the key; and determines realising of Universal Health Care (UHC) initiatives in India. Achieving 3.5 beds and 1 doctor per 1000 population is the key towards realisation of UHC. This will need enormous financial resources. Government intends to increase the healthcare spending to 2.5% from 1.2% of GDP, which will be too short an amount to meet the quantum of needs. Private sector has to inevitably play a significant role by partnering with Government by investing more by way of setting up of facilities in deficient regions. Preferably we need encouraging policy initiatives to enhance private investment in health sector so that this partnership can become robust. This is the only pragmatic approach to ensure the dream of UHC of the government in the days to come.

Preface

This document examines quickly two much debated aspects in India viz., (i) the present status of health delivery systems; and (ii) how the constitutional goal of right to health (of an individual) can effectively be realised, without losing any further time. India ambitiously prepares to provide free healthcare services to approximately 70% of its population, through various schemes, making us almost to meet up with the criteria meant for Universal Health Coverage (UHC). Without careful planning and enabling policy environment these efforts of UHC might get derailed. There are many policy documents, articulating these aspirations of India. But scattered around in several places. Hence, the present effort is to consolidate all these in one place, to enable clearer macro picture.

Introduction

The right to health and health care is long been declared as a human right. The Constitution of India guarantees everyone's right to the highest attainable standard of physical and mental health. The Supreme Court had interpreted Art. 21 (right to life) to include, among many things, the right to health as a fundamental right to everyone. It has also been held that the right to health is integral to right to life and the government has a constitutional obligation to provide health facilities to all. The jurisprudential basis of this discourse is overall benefit that can be achieved as a society. An intrinsic value of adequate health security is to reduce the vulnerability of societies to health threats. Hard fact, however, is that majority of our population is excluded from getting a quality healthcare — making the constitutional recognition as a mere theoretical framework. Although we could not provide complete justiciability to the right to health, as aspired by our Constitution; the articulation resonates the legitimate expectation of 'we the people' in this regard. Undoubtedly the COVID-19 situation has brought out the fact that everyone responsible has ignored to put in place an effective health care delivery system. Poor healthcare system in India is a legacy issue. Five year plans are known to have ignored investment in development of social sectors. Health among the social sectors never figured prominently at all. Otherwise also in the State's development strategy the health sector has always been a neglected sphere. The political class probably invested where they could maximise their immediate political returns. Unfortunately health sector till now was made to wait as if its turn is next to come. Health, education and housing are key social indicators. Except some lip-sympathy for housing, in India, other two never become part of political agenda. However, thanks to present pandemic, for the first time health has emerged as the prime political agenda, which will determine the future of Indian politics. This is the most opportune time for everyone to revisit all our efforts to ensure right to health for all.

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Indian health care system

The long and short story of Indian healthcare sector is that — the State shouldering the sole constitutional responsibility of providing healthcare to everyone, has shrunk from 92% in 1946 (as estimated by Bhore Committee) to mear 30% today. On the contrary the private healthcare has grown enormously from 8% in 1946 to 70% today. It is estimated that, private health care sector todays holds 60% of IPD beds, and 85% of tertiary care beds. During the pandemic days the private sector has provided 76.4% of total care, with Government facilities having contributed the remaining, shows how dominant the private sector to respond to emergency situation as well (Annexure I). It's not only in quantity, the private sector has brought in the unprecedented quality in to the health care too. All this occurrence is inspite of the Bhore Committee's strong prescription that, healthcare service should be delivered by the State alone to be effective and affordable. With population escalating three-folds now, the State to discharge its constitutional duty of health care has inevitably partnered with the private sector, making it not only a provider of healthcare services, but also as a strategic purchaser of healthcare services (from private service providers) with enormous regulatory powers.

Healthcare was not on our planning agenda till government came up with the new health policy in the year 2017, which inter alia proposed hike in healthcare spending, National Health Assurance Mission and followed up by launch of its flagship scheme; AYUSHMAN BHARAT, with two components. The first being setting up of 1.5 lakh health & wellness centres[1] and second, cashless healthcare cover up to 5-lakhs for India's 40% of underprivileged population in its PRADHAN MANTRI JAN AROGYA YOJANA (PMJAY)[2] towards secondary and tertiary care. Coupled with existing government run welfare insurance schemes by some of the states for BPL population and Central Government schemes like CGHS, ECHS and ESI, an estimate of 65-70% of India's population will be covered under cashless health cover, once PMJAY gets implemented in totality leading to UHC. This would mean 87.92 to 94.63 crores of people (as per 2018 estimates). By 2036 it may swell up to 98.93 to 106.54 crores of people (at the estimated total of 152.2 crores of population). Not only people are going to be added, the age group which require medical care would also increase from the current state. This is due to population under 15 years and 60 years and above are set to increase considerably by 2036. The Ministry of Health

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[1] These centres seek to promote individuals and communities to a healthy lifestyle and take control of their health by brining services closer to the community. They provide free services to the users and provide wide variety of services, like maternal and child health services, care for non-communicable diseases, palliative and rehabilitative care, oral care, eye and ENT care, mental health etc. To start with 1,50,000 health and wellness centres will be set up with reasonable infrastructure and community linkages. Many sub-health centres (SHCs), primary health centres (PHCs), and urban health centres will be converted into Health Wellness Centres by 2022. In July 2020 — 42,291 wellness centres were commissioned.

[2] This package covers 24 specialities and 1578 procedures through a network of public and empanelled private health care providers to cater to over 10.74 crore facilities, with no limit on family size and benefits that can be availed in any part of the country. Those already included under the Rashtriya Swasthiya Bima Yojana (RSBY), which is a pre-existing scheme, presently subsumed into PMJAY. The Central Government shares the cost of implementation in the ratio of 60:40 with the State Governments, while between the Center and the North-east the ratio of 90:10. In Union Territories, the Central Government will sponsor 100% of the cost. The State Governments that have already enrolled their own schemes similar to the PMJAY, have been given the flexibility to top the list of beneficiaries with households from their own respective databases and can also use state funds to cover those not eligible under the eligibility criteria of the SECC database or the RSBY criteria.

and Family Welfare document states that 'with declining fertility, along with the increase in life expectancy, the number of older persons in the population is expected to increase by more than double from 10 crores in 2011 to 23 crores in 2036 — an increase in their share to the total population from 8.4 to 14.9 per cent'. Making it more critical as to how medical services are provided to them.

Universal Health Coverage (UHC) according to WHO is about "ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services". The incidence of catastrophic spending on health in India is reported on the basis of out-of-pocket expenditure touching up to 25% of household's total income or consumption (this is the approach adopted for the SDG monitoring framework). As per WHO, in Asia 80 million people experience financial catastrophe and 50 million are impoverished due to healthcare payments. Sizeable public spending much beyond 5% of GDP needs to be directed to achieve the golden goal of UHC. The mantra, therefore to effectively achieve the goal of UHC, is to embrace the WHO proposed three interrelated healthcare financing strategic options viz. — (i) more money for health; (ii) reduce out of pocket healthcare expenses; and (iii) reduce and eliminate inefficient use of resources. Some early ball-park estimates for India peg health goal implementation at 55 lakh crores till 2030 (2.36 lakh crores per annum) estimeated at total of 152.2 crores of population.

The UHC should focus on all aspects of health (referred to by WHO as breadth, depth and height) and address all the dimensions of coverage, services covered and financial protection offered, as indicated in the following diagram.

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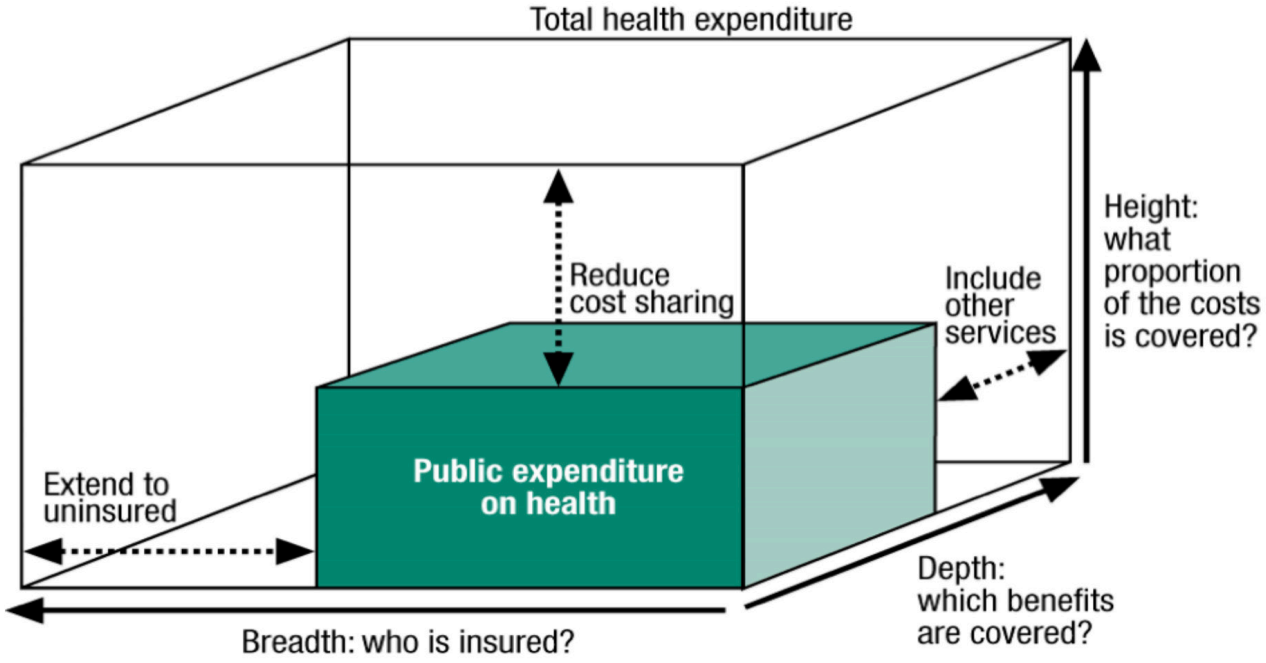
Dimensions of Universal Health Coverage



The global experience proves that UHC is not only affordable but also feasible, if strategised correctly. India faces distinct challenges in reaching UHC. They are high disease prevalence, issues of gender equality, unregulated and fragmented health-care delivery system, non-availability of adequate skilled human resources, vast social determinants of health, inadequate finances, lack of inter-sectoral coordination and various political pull and push of different forces and interests. Therefore it's inevitable that India can't afford to roll out UHC in one go, but in a phased manner. It should be remembered that "if services are to be provided for all, then not all services can be provided. The most cost-effective services should be provided first".

The NHP, 2017 aims to "ensure healthy lives and promoting well-being for all at all ages". It's by any scale a claim of high order. In this background the Ayushman Bharat Scheme is to be seen, which targets to immediately cover 40% of the most vulnerable population. To meet our international obligation towards Sustainable Development Goals (SDG), it is critical that India implements effectively the UHC programme. UHC is an explicit target under SDG-3 and can act as the anchor to guide and inform SDG goals in health.

while India is preparing to secure healthcare to 65-70% of its population mediately (through various schemes) a vibrant private sector is absolutely an imperative. This is in addition to government continuing to increase its spending on health

Inevitability of partnership

Government does not have adequate secondary care and very little of tertiary care infrastructure, it is logical that government will depend heavily upon private healthcare sector in delivering health services under various schemes. It's only through Public-Private Partnership (PPP) the target of UHC can be achieved, wherein government procures health services from private sector and deliver to its population. The rates at which Government purchases the healthcare services will determine further developments, as Government being the monolithic purchaser, endowed with sufficient sovereign state authority, may force private players to agree for unscientific rates. This will endanger the entire private healthcare sector in the long-run. This has now become serious bone of contention, threatening to push private healthcare industry towards unviability. While India is preparing to secure healthcare to 65-70% of its population mediately (through various schemes) a vibrant private sector is absolutely an imperative. This is in

the greatest Indian challenge is unequal distribution of healthcare infrastructure favouring urban settlements. Urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 1,00,000 population. This is in sharp contrast to 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 1,00,000 of population in rural India. Curative care in the rural health infrastructure is the weakest component in spite of high demand for such services

addition to government continuing to increase its spending on health. Four independent and interdependent elements viz., availability, accessibility, affordability and acceptability (quality), determine the achievability of UHC.

Availability — India has close to 1.6 million beds currently. This will be 1.3 beds per 1000 population in contrast to WHO norm of 3.5 beds per 1000 (for developing nations). This means we need to add more than double the present figure, which is certainly an uphill task. The Government intends to spend 2.5% of GDP on health by 2025. Even if it happens as estimated would not help the cause. To achieve the WHO norm, we need to take the private sector into confidence to invest and develop further.

Quality Health Care Workforce (HCWs) will determine the 'availability' further. HCW include doctors, nurses and allied health staff. India faces huge shortage of doctors. As against WHO's ideal of 1 doctor per 1000 population; currently we have 0.65 doctors per 1000. India has good number of Indian System of Medicine (ISM) doctors if they are added in the count — we will reach a figure of 1.3 doctors per 1000 population. This integration to realise needs proper policy planning, which is languishing for a long time. The shortage of specialist doctors is much more acute than one can imagine. We have a shortage of 80% of specialist doctors in 5600 Community Health Centres, as per the Government estimate itself, making the services non-functional, although brick-and-mortar infrastructure is in place. This shortage burdens the seeking population to travel long distances to district hospitals and other urban centres. The medical seats have now been increased to about 75,000 in MBBS and 35,000 in Post Graduate level. At this pace, it will take another decade

to have adequate number of specialists unless we come out with other additional innovative means, which shall necessarily include use of medical technology.

Similar is the case with nurses and healthcare workers. There are about 1.3 nurses per 1000 population as against the norm of 2.5 nurses per 1000 population. Here again we witness a huge variation from region to region. For example, state of Kerala has 6.7 trained nurses per 1000 population, where as Karnataka has 3.75, Tamil Nadu has 3.25, West Bengal has 0.75, Uttar Pradesh has 0.3 and Bihar has 0.2. With such a poor score and distribution, it will just not be possible to meet the availability criteria. Same is the case for allied healthcare professionals as well. India does not has regulatory council like ones for doctors and nursing staff. Due to this, training such workers is completely un-structured and lacks uniformity. We need to quickly adopt Allied Healthcare Professional Council Bill lying in the Parliament and aggressively train HCWs to meet domestic demand. In fact, India with young population profile can be in a position to export trained allied healthcare work force to other countries and boost the employment opportunities.

Accessibility — Making available of health services in the closer geographical range is critical. The greatest Indian challenge is unequal distribution of healthcare infrastructure favouring urban settlements. Urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 1,00,000 population. This is in sharp contrast to 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 1,00,000 of population in rural India. Curative care in the rural health infrastructure is the weakest component in spite of high

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demand for such services. Naturally, this demand is met either by the city hospitals or nearest urban centres. Lack of professional men, the rural infrastructure is to a great extent non-functional. Due to non-functioning of rural hospitals (CHCs), the rural population has to travel long distances to reach to the nearest district level hospital or a government medical college hospital. Situation is no different in private sector, which is largely catering to the needs of tertiary care and which requires services of specialists. The shortage of specialists and super specialists has forced the private sector not to go beyond tier-I or tier-II cities. State of Tamil Nadu for example has close to 200-such hospitals, out of which 100 are in just 2-cities of Chennai and Coimbatore. State of Telangana has close to 125 such hospitals, out of which more than 100 are in just in the city of Hyderabad. This exhibits great geographical disparity and thereby very poor state of accessibility. There are close to 2500 private hospitals with bed size of 100 and above, which largely cater to tertiary care needs.

Affordability — WHO explains affordability means that the population gets healthcare services at a cost which it can afford. It's indeed a tall claim as it only looks at affordability from the point of view of people or population. So low income countries, unless government or insurance pitches in, this approach

compromises on quality of healthcare and restricts private investment into the health sector. Substantial Indian population is still forced to buy healthcare services out-of-pocket. Reports indicate that many families got pushed in to poverty by incurring huge expenditure on their healthcare needs. States like Andhra Pradesh, Telangana, Tamil Nadu, Maharashtra, Karnataka, Gujarat run welfare health schemes for BPL population, approximately catering to 40% of their population. With launch of PM-JAY, India ambitiously inching towards covering 65-70% of population for free healthcare services to achieve the target of affordability. However, the million dollar question is — with meagre 1.2% of GDP being spent on healthcare how government will augment the financial resources. Other challenges like doctors, beds, other facilities etc., still remain to be addressed.

Acceptability — It is important that healthcare services meet the requirement of appropriate standards. The acceptability relates to hospitals follow the quality and patient safety protocols. NABH accreditation launched in 2006 has introduced the framework for quality and patient safety. Close to 1000 hospitals/nursing homes have attained full accreditation, whereas there are about 4000 hospitals/nursing homes having basic NABH entry level certification. Considering that there are more than 60,000 hospitals/nursing homes, we have long way to go. Various government/private insurance schemes are incentivising hospitals having some kind of accreditation or certification. This needs to be pursued more vigorously for the simple reason that millions of medical errors are being reported across the globe in general and developing nations in particular. This has huge impact on increased morbidity/mortality, which invariably go unnoticed. Here it may be relevant to mention that affordability and acceptability have very close relationship. If hospitals are pushed beyond a point to provide affordable services, the hospitals will be constrained to cutting the corners, not adhering to standard protocols and that will affect the patient safety adversely. This point is largely not discussed in open but has huge ramification in terms of increased morbidity/mortality. There is a saying that 'Quality healthcare will cost but absence of quality (patient safety) may cost life'.

typical short-sighted buyer (of products and services) seldom thinks of seller's welfare and sustainability. He attempts to benefit himself even if it is at the cost of sellers sustainability. The State has to realise that it can't afford to behave like typical consumer, as the basic obligation of provisioning healthcare facilities is on its shoulders alone

Re emphasising promotive & preventive health care

Prevention is better than cure, more so in case of health. The present Pandemic has forced us to reorient towards this simple yet fundamental truth of life. Value for money analysis (VFM) of health care dynamics, indicates that a rupee spent in curative care would help the individual suffering with morbidity; whereas a same rupee spent towards preventive and promotive care will help the community itself. Moreover the preventive

and promotive health care initiatives are cost effective. For instance wearing a face-mask in public places would cost minimally, but prevents curative spending on several communicable diseases. Maintaining social distance, exercising regularly etc., might not even cost anything in terms of money but are capable of reducing the need for curative investment by several times. A multi pronged approach needs to be adopted to mainstream preventive and promotive health strategies.

Government needs to reorient its focus on; prevention, detection, control and management of health of its people. Safe drinking water, sanitation and nutrition need to be treated as foundational block for building robust health systems. Health & Wellness centres envisaged under AYUSHMAN BHARAT have to be given high priority in this regard by deploying competent professionals.

The way through

To realise the constitutional obligation, and also to meet India's global commitment of SDG, there is no alternative than to effectively implement UHC in a phased manner. Strategic consolidation of existing schemes and rolling out of additional schemes is the way through. Government has to have the support of private sector to implement its goal of UHC. Recently the Government has announced its ambition of adding 3000 new hospitals in different regions, especially in tier II/III cities. Without proper professional workforce and team of people to man, these hospitals will not cater to the required goal. Equal attention is to be paid to enhance the competency skills of manpower required. An aggressive planing to have more specialists through — normal PG route, through medical colleges, DNB courses and fellowship programs, as without adequate

number of specialists, any amount of financial investment will not help in achieving 'Health for all' goal. Even after addition of 3000 hospitals government has to have the support of private sector to cater to the ever growing need to cover everyone. A pro-active support and incentivising the private sector hospitals can alone realise this goal, as running the hospitals efficiently after they are established is equally important.

As partnering with private sector is inevitable; it is equally important to have favourable policy environment created. True spirit of partnership needs to resonate through these policy initiatives. However, unfortunately it is consistently seen that Government is typically acting as mere purchaser of the healthcare services. Like an ordinary buying customer Government is bargaining hard with the private players, to make then unviable in the long run. Typical short-sighted buyer (of products and services) seldom thinks of seller's welfare and sustainability. He attempts to benefit himself even if it is at the cost of sellers sustainability. The State has to realise that it can't afford to behave like a typical consumer, as the basic obligation of provisioning healthcare facilities is primarily on its shoulders alone. Much worst is the situation where the Government is using its sovereign authority to push the private sector around, thinking instinctively that all private player intend to make unreasonable profits. The 'package rates' fixed by the government to buy the healthcare services stand good testimony to the above

averments. The healthcare service package rates are arrived typically by bargain or thumb-rule, than being fixed scientifically. Annexure II, appended to this document shows comparison of CGHS rates in 2007 and 2014. A cursory glance of the same would show how rates of several procedures are reduced 30 to 70%, although there was consistent inflatory trends around. Therefore, health of health delivery system needs to be addressed simultaneously with 'health for all' mission. Otherwise in long run the situation would grow from bad to worse — leaving healthcare to shambles.

The market has responded naturally by withdrawing additional investments in the health sector. The current sentiment is not encouraging any new investments in the health sector. In spite of cent percent Foreign Direct Investment (FDI), vide automatic route in health (hospital) sector and manufacture of medical devices, the investments into India is not very encouraging.

Thailand, Singapore and India have emerged as most preferred destinations for medical tourism in the past. Low cost of treatment, quality healthcare infrastructure and availability of highly skilled professionals have helped to this effect. In 2020 the medical tourism is estimated to be approximately $ 158.2 billion, without adding the growing market in yoga and Ayurveda. If effectively encouraged medical tourism will also stimulate improved air travel, domestic travel, hospitality facilities, language interpreters etc., leading to subsidiary job creation options. Without further investment into the healthcare sector, we would lose the plausible advantage to Thailand and Singapore. Even the new government infrastructure of healthcare should aim to leverage medical tourism. The overall Indian strategy, shall not only attempt to cater UHC to its population, but simultaneously aim at growing much beyond to the region (like SAARC, ASEAN regions).

Recently quite a few private establishments in India have catastrophically closed down due to unviability. The government needs to come forward immediately in addressing the concerns of private sector in paving way for fresh incentives. Providing soft loans, electricity at concessional tariffs, single window clearance etc., are few steps in this regard. Issues of 'availability' and 'accessibility' will take time to yield, it will be prudent to embrace technology to compliment the initiative. The concept of home health similarly can be promoted in conjunction with hospitals to augment the bed capacity.

Financial viability

Since long healthcare industry is passing through a difficult times. Financial sustainability has emerged as the single most concern in healthcare sector. Hospitals till recently were getting majority of patients paying from out of pocket at the rack rates fixed by the hospitals. Even in the regions, having sizeable population of CGHS/ECHS beneficiaries, the hospitals were managing through partial cross subsidising for lower CGHS tariffs. Similar was the case in the states having state insurance schemes. This situation is rapidly changing. CGHS tariffs fixed in the year 2014 have not been revised, whereas expenditure due to normal inflation, rise in salary etc., has gone up considerably. The margins from pharmacy and consumables has drastically

been reduced. All this has telling impact on financial sustainability of hospitals. Over and above, we have PMJAY, where rates for various medical procedures are much lower & do not meet even the minimum operational cost. The Earnings before Interest Taxes and Depreciation and Amortisation (EBITDA) which was about 20% till recently, is going down to single digit, pushing hospitals to imminent financial un-sustainability. Unviable and static rates fixed in the government run schemes including CGHS and PMJAY, without following any scientific basis is the prime contributing factor. Private insurance companies including GIPSA are trying to follow rates specified under PMJAY. Inflation index has increased 43% in past 10 years. Salary component is a major part of overall operating budget in a tertiary care hospital and it has gone up manifold; to cite an example, the salary even in government sector has gone up by 90% from 6th Pay Commission to 7th Pay Commission over a period of 10 years and private sector cannot be far away from it. Electricity, which is another major component, its tariff is more than doubled over past 10 years. All these issues are virtually sounding death knell for private healthcare industry. Private industry also needs to re-engineer delivery of care by sharing/optimizing of resources and cutting down on waste as appropriate.

The paper has brought out the current status of health systems in the country and broadly identified the gaps in the infrastructure to meet the goal of 'Health for All' as envisaged in the constitution. The COVID-19 pandemic has made us to realise that healthcare needs far greater attention, almost aimed at re-building of current health systems in the country. Public health structure which is supposed to be first line of defence in pandemics, has been found wanting with shortage of critical care beds, doctors and nursing staff. The enormous contribution from private sector in extending treatment for COVID patients is shown in at Annexure II. We need to evaluate strengths and weaknesses of private & public systems and create a synergy as 'win-win' situation.

SUGGESTED REFORMS

Strengthening public health systems and making it accountable in terms of delivery of value based services to the community at large

Incentivise private sector to establish hospitals in deficient areas especially in tier-III cities. Such investments may be even from CSR

Formalise 'home-health-services' as a viable option to augment hospital beds

Increase number of PG seats to make good the shortage of specialist doctors

Establish 'Allied Healthcare Professional Council' for credentialing of healthcare workforce (HCWs)

Constitution of professional 'Healthcare Regulatory Body' to address issues of patient safety, outcomes, cost and service delivery covering patient's rights

Restructure government health schemes including CGHS, PMJAY etc., with scientific study on costing to fix prices of medical procedures for reimbursement to private empaneled hospitals, and introduce co-payment as appropriate

Fast track implementation of National Digital Health Mission and promote use of technology

Promotion and integration of AYUSH systems with the present health care delivery systems

ANNEXURE ONE

Private Participation in COVID 19 Management

S. No	Component	Maharashtra & Goa	Tamil Nadu	Karnataka	Total Contribution from Private Hospitals
1	Number of Private Hospitals & Medical Colleges involved in COVID care covered in this exercise	1,031	352	NA	1,383
2	Total Number of earmarked beds in Covid Care	1,08,940	16,367	NA	1,25,307
3	Total number of patients treated as on date in the private sector	3,10,109	3,50,000	50,059	7,10,168
4	Number of testing (Rapid+ PCR) done by private sector laboratories	21,55,157	58,83,240	NA	80,38,397
5	Fatality rate as percentage of patients in private hospitals	2.77%	1.57%	NA	
6	Number of known VIP's treated in private hospitals	NA	NA	NA	
	76.4 % of all COVID care facilities are in the Private Sector				
	64.58% of COVID patients have been treated in the private healthcare set up in Tamil Nadu				
	56.81% of COVID patients have been treated in the private healthcare set up in Karnataka				

ANNEXURE TWO

Comparison of CGHS Rates - 2007 and 2014: Non NABH

Sl. No	Sr. No. Yr. 2014	PROCEDURE/INVESTIGATION LIST	2007 Amount	2014 Amount	Percentage
		TREATMENT PROCEDURE FOR HEAD AND NECK			
1	**476**	Total Amputation & Excision of External Auditory Meatus	7300	1500	-79.45
2	**479**	Excision of Cystic Hygroma Extensive	8750	6707	-23.35
3	**483**	Excision of Carotid Body-Tumours	17500	11615	-33.63
4	**486**	Pharyngectomy & Reconstruction	20000	15000	-25.00
5	**515**	Laryngectomy	20000	16043	-19.79
		TREATMENT PROCEDURE ICU/CCU PROCEDURES (SPECIAL CARE CASES)			
6	**379**	Neonatal ICU charges (Per day)	975	340	-65.13
7	**383**	Exchange Transfusion	810	265	-67.28
		TREATMENT PROCEDURE ABDOMEN / GI SURGERY			
8	**449**	Appendicectomy	12000	8108	-32.43
9	**667**	Jejunostomy	10400	5750	-44.71
		TREATMENT PROCEDURE OBSTETRICS AND GYNAECOLOGY			
10	**1068**	Vulvectomy -Simple	13500	9200	-31.85
		TREATMENT PROCEDURE NEURO-SURGERY			
11	**954**	Twist Drill Craniostomy	10000	4250	-57.50
12	**981**	Brain Biopsy	11900	5808	-51.19
13	**943**	Brain Mapping	2000	837	-58.15
		TREATMENT PROCEDURE PAEDIATRIC SURGERY			
14	**1022**	Meckels Diverticulectomy	10500	3347	-68.12
		TREATMENT PROCEDURE BURNS AND PLASTIC SURGERY			
15	**1063**	Free Grafts - Wolfe Grafts	3000	1725	-42.50
16	**1078**	Reduction of Facial Fractures of Nose	4000	1380	-65.50
		TREATMENT PROCEDURE ORTHOPEDICS			
17	**1150**	Excision of Bone Tumours	8000	6900	-13.75
18	**1159**	Open Reduction of Dislocations	4660	3439	-26.20
19	**1165**	Tendon Transfer	6000	3105	-48.25
20	**1166**	Laminectomy Excision Disc and Tumours	15000	4830	-67.80
21	**1168**	Anterolateral decompression for tuberculosis/ Costo-Transversectomy	16000	3450	-78.44
22	**1194**	Removal of Wires & Screw	4000	1760	-56.00
		MRI			
23	**1664**	MRI Orbits – With Contrast	5000	2000	-60.00
24	**1671**	MRI Shoulder – With contrast	5000	2550	-49.00
25	**1685**	MRI Ankle both joints - Without contrast	5000	2500	-50.00

NATIONAL LAW SCHOOL
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THINK THANK ON HEALTH

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10/2020 Designed by -Basavaraj Halyal