PRICING PROCEDURE FOLLOWED BY THE HOSPITAL SECTORS TO COST THEIR SERVICES IN KERALA, INDIA

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ABSTRACT

In India the health care systems is experiencing dramatic changes from what it was a few decades ago. Health is a basic fundamental right of all citizens and health promotion forms an intrinsic part of health care. Like in any other public financed economy health competes for resources with other sectors of the economy although health can be treated as a ‘commodity’ or not is widely debated several movements through have made deep inroads into several sectors of the Indian economy, their presence in social sectors like health is notably low. An exception is Kerala where hospitals have come to play a significant role. A hospital is a crucial organization that stands unique and incomparable to any other business enterprise. It is unique and special because it deals with life of mankind. Patients are not just attracted by high-tech hospitals rather the demand for devoted doctors, accurate diagnostic facilities, qualified nurses and supporting services are important. Being a voluntary and charitable institution, the view of hospital pricing is that hospitals desire to obtain as much net revenue as possible in order to expand hospital size and obtain extensive specialized equipment. This may occur because the hospital administrator attempts to maximize his utility (which depends up on having a large hospital equipped with all the latest equipment) or simply because physicians on the hospital staff place pressure on the administrator to increase hospital size and acquire the most modern facilities. If this view is correct, prices will be higher relative to costs in areas where it is possible for hospitals to make excess profits. Therefore the study aims to analyse the pricing procedure followed by the hospitals to cost their services in Kerala state and do the hospital in these sectors such as co-operative and private hospitals witness any significant change in the pricing procedure while making a comparison? To find the answer the researcher proposes to make a detailed study of the selected co-operative and private hospitals in Kerala and the study found out that pricing of services are comparatively lesser in co-operative hospitals than the private ones. So the study concluded that the nonprofit hospital as an organization aiming in its pricing policy to recover its costs. The typical short term hospital is not interested in making a profit as such, being a voluntary and charitable institution; it is content to cover its costs and sets its charges accordingly.

Keywords: Pricing; Healthcare; Hospitals

INTRODUCTION

A hospital is a crucial organization that stands unique and incomparable to any other business enterprise. It is unique and special because it deals with life of mankind. Patients are not just attracted by high-tech hospitals rather the demand for devoted doctors, accurate diagnostic facilities, qualified nurses and supporting services are important. Establishment of a hospital requires careful planning. The human factor is very essential unlike in other industries since a hospital involves care of the physical, clinical and psychological aspects of patients. Facilities should be appropriate according to the needs and affordability of the community. The doctors, nurses and technicians are more important than the equipment and building. Great care therefore should be taken to recruit qualified staff, and there should be continuous training and motivation (Suha,1997).Kerala has to its credit a fairly
developed healthcare infrastructure and Kerala has a long history of organized health care. When the State was founded in 1956, the foundation for a sound health care system had already been laid. Thereafter, there was remarkable growth and expansion of government health services. The number of beds in government hospitals rose from 13,000 in 1960 to 38,000 in 1996. The annual compound rate of government expenditure on health during that period was higher than the compound rate of total government expenditure and higher than the annual compound rate of growth of the state domestic product. The easy accessibility and coverage of medical care facilities has played a dominant role in shaping the health status of Kerala. Some of the hospitals in Kerala are more than 50 years old. Health had been a major area of spending in the budget from early years in Kerala. (Gangadaharan, 2005).

The growth of health facilities in Kerala offers many lessons in development. The active role of the state government has seen a key factor in the expansion of health care facilities. The initial period of rapid growth in health facilities was dominated by the public sector up to the 1980s. By the mid 1980s because of fiscal and other problems, there was a slow down in the growth of government health institutions. This affected not only the growth in absolute number of beds, but probably the maintenance of quality as well. However, by this time, the private sector was paired for growth and it took the lead in the growth of health care facilities in Kerala. The growth of the private sector in Kerala should not be seen as independent phenomena. The public sector paved the way for its development by sensitizing the population to the need for sophisticated care and creating demand. The government continues to play leadership role in the training of all strata of health professionals, who are then largely absorbed by the private sector. Factors outside the health field, such as a growing income, improvement of literacy and population ageing all contributed to this trend. Kerala knows for its model of ‘Good Health at Low cost’ achieved through universal availability, accessibility and performance of government healthcare delivery system to even poorer sections of the society. Competition from govt. facilities often serves as an important factor in determining treatment cost in private hospitals (Aravindan, 2000).

The annual growth rate of government health care expenditure has been showing a steady increase. India’s first ever Human Development Report published in 2002, placed the southern State of Kerala on top of all other states in India, because of easy accessibility and coverage of medical care facilities. Kerala is one state where private health sector, both indigenous and western systems of medicine, has played a crucial role. The Ayurvedic system of treatment practiced in Kerala dates back to centuries. In the field of modern medicine system, missionary hospitals have contributed profusely by even going into the interiors of the state. High level of education especially among Women and greater health consciousness has played a key role in the attainment of good health standards in Kerala. Today with the mushrooming of private hospitals that offer quality services, matching international standards and with the tie up of the health care industry with the tourism sector, health care in Kerala is growing by leaps and bounds (Soman, 2007). As such the present study aims to investigate the pricing procedure followed by the selected private and co-operative hospitals in Kerala in order to understand the healthcare sector in Kerala in detail.

LITERATURE REVIEW

Chattarjee (2002) argued that there are large numbers of factors which promote the growth of the health care institutions in private sectors in India; there are equally a large number of factors, which frustrate the growth of the private health care institutions in India. Hence efforts are being made to see reasons and allow the private sector health care institutions to grow in the interest of the community. The rate at which the current population is being affected by diverse diseases, it will be essential that the total load of treatment be shared both by public and private sector health institutions in future.

The most prevalent view of pricing in the nonprofit hospital industry is that prices are set equal to average cost of providing hospital care i.e. the hospital attempts to break even. This view of hospital pricing is based up on the assumption that nonprofit organizations are interested only in serving the public and have no desire to make any profits. With this purpose in mind Davis & Karen (1971) examine the ratio of hospital prices to average cost. Empirical evidence presented in this paper
contradicts the prevailing view that hospitals merely attempt to recover costs in their pricing policy. In addition the view that the excess of price over average cost is merely an attempt on the part of the hospital to accumulate sufficient revenue to make needed investment is not substantiated. Instead, price-average cost ratios are found to be sensitive to certain demand and supply conditions. Although the conclusions of this study must be viewed as tentative until additional empirical investigation based up on better measures of various variables can be undertaken, the findings do indicate the need for more detailed theoretical analysis of the pricing of hospital services.

Finch & Rajesh (2000) have examined the distribution pattern and to present the profile of the private health care services in Rajasthan, evaluation of the changing pattern of the hospitals and the economic burden on the families due to health care expenses, assessment of the people’s perception about private health care services in Rajasthan and the assessment of socio-economic background of the people visiting private hospital for treatment. Through this study it becomes clear that the private health sector is more accessible and popular with those who can afford it. However, it is found that the private health sector in its present unregulated form does not favour the low-income groups since they suffer from a heavy economic burden due to high treatment costs. The reason the poor are forced to go to the private hospitals is the non-availability of government medical services, better quality of services and easy access. Unless certain minimum reforms are undertaken to ensure good service by the Government, the poor will be forced to go to the private hospitals and get exploited, thus leading to the increase in their economic burden.

Karin et al. (2005) made an attempt to analyze and to evaluate the organization and cost of hospital management. In Germany so far, there exists no evaluation of the relationship between the organization and costs of hospital administrations and hospital characteristics. In a survey of hospital administration costs, structure, and salary level 126 hospitals participated for the years 1998 and 1999. The study finds out that hospital of medium size and non-profit ownership show the smallest expenditures for personnel in the administration per treated case. However, salary level was not uniformly linked to hospital size. Hospital ownership appeared to be a strong indicator for the level of personnel salaries. For the planned introduction of prospective payment via Diagnosis Related Groups (DRG) starting 2003 in Germany has substantial implications for their study. Publicly owned hospitals, in particular, are likely to have their administrations most severely affected by the change.

SIGNIFICANCE OF THE STUDY
Kerala has a long history of organized health care. When the State was founded in 1956, the foundation for a sound health care system had already been laid. Kerala has a vast health care infrastructure under Allopathy, Ayurveda and Homoeopathy system of medicine. In the health sector the role of Allopathy stream is very important and the major participation is focused in the Allopathic sector which has hospitals both in the private and public sector. Therefore the paper proposed to conduct a detailed study on the pricing procedure followed by this sectors in the health care scenario of Kerala.

OBJECTIVES OF THE STUDY
1. To ascertain the pricing procedures and practices followed by the hospitals in different sectors in Kerala
2. To identify the various components and major cost centers in a hospital industry for inpatient and outpatient customers.

RESEARCH METHODOLOGY
The research is designed as both explorative and descriptive. So the major data source is primary in character. However secondary data from print media (books, reports, monographs) and the official record of the government are also made used. The sample units for the study is selected by multi stage stratified random sampling. First of all the total population is divided into three strata based on region, based on ownership and based on bed strength of each selected hospitals. After the stratification the
Datas are collected from the hospitals according to their bed strength of each private and co-operative hospital. The bed strength ranging below 50, between 51-150, and above 150 forms the group. For the purpose of analyzing the data suitable mathematical tool like percentage was used.

RESULTS AND DISCUSSIONS

In this section an attempt is made to assess the pricing procedure followed by the hospitals to cost their services. Collection of cost data from sample unit establishes that there are some commonalities in the cost structure in the various components sector wise(private, co-operative and government). Based on the common features the overall cost structure is subdivided into 3 major heads for clarity in analysis. This type of segmentation is done both in the case of inpatient services and outpatient services. But while making a comparative study the government hospitals are excluded from the analysis. The major cost centers in a hospital industry for inpatient customers are

1. Rent charges (Room and ward)
2. Operation theater charges
3. Charges on consumables
4. Service charge for doctors and paramedical staff
5. Sundry Charges

Rent Charges

Rent charges for a hospital comprises of room charge for general ward, ordinary room, deluxe room and AC room. The above data is classified sector wise and presented in the table given below.

<table>
<thead>
<tr>
<th>Type of room</th>
<th>Private hospital</th>
<th>Co-op hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Ward</td>
<td>180 to 200</td>
<td>160 to 180</td>
</tr>
<tr>
<td>Ordinary room</td>
<td>250 to 300</td>
<td>240 to 270</td>
</tr>
<tr>
<td>Delux Room</td>
<td>350 to 400</td>
<td>320 to 350</td>
</tr>
<tr>
<td>AC Room</td>
<td>1200 to 1700</td>
<td>1000 to 1500</td>
</tr>
</tbody>
</table>

Source: Compiled from field survey

Table 1 reveals that the rent collected from patients for general ward vary from Rs 180 to 200 in the case of private hospitals and it is Rs 160 to 180 in co-operative hospitals. The charges for ordinary room in private hospitals and co-operative hospitals vary from Rs 250 to 300 and Rs 240 to 270 respectively. Table further reveals that charges for deluxe room vary from Rs 350 to 400 in private hospitals and it is Rs 320 to 350 in co-operative hospitals and charges for AC room for private and co-operative hospitals vary from Rs 1200 to 1700 and Rs Rs1000 to 1500 respectively. From the table it is clear that charges in respect of rent are comparatively lesser in co-operative hospitals.

Surgery Charges

Surgery charges for both private and co-operative hospitals includes components such as doctors fee, charges for OT consumables, in plant charge, doppler charge, dressing charge, operation theatre charge etc.

Table 2 reveals that there is only slight variation in the surgery charges levied by private and co-operative hospitals. The major component of operation charge is doctor’s fee, it varies from Rs 2500 to 6300 in private hospitals and it is Rs 2000 to 5000 in co-operative hospitals. Charges for OT consumables vary from Rs 300 to 400 and Rs 200 to 250 in private and co-operative hospitals respectively. The table further reveals that in-plant charge is another major component of surgery bill and it vary from Rs 5000 to 5500 in private hospitals and it is Rs 4000 to 4500 in co-operative hospitals. Doppler charge in private hospitals and co-operative hospitals vary from Rs 300 to 400 and
Rs 200 to 250 respectively. In addition to this dressing charge for private hospitals varies from Rs 150 to 200 and it varies Rs 125 to 150 in co-operative hospitals.

Table 2. Surgery Charges levied in Hospitals (Figures in rupees)

<table>
<thead>
<tr>
<th>Items of Charges</th>
<th>Private hospital</th>
<th>Co-op hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors fee</td>
<td>2500 to 6300</td>
<td>2000 to 5000</td>
</tr>
<tr>
<td>OT consumables</td>
<td>300 to 400</td>
<td>200 to 250</td>
</tr>
<tr>
<td>In-plant charge</td>
<td>5000 to 5500</td>
<td>4000 to 4500</td>
</tr>
<tr>
<td>Doppler Charge</td>
<td>300 to 400</td>
<td>200 to 250</td>
</tr>
<tr>
<td>Dressing Charge</td>
<td>150 to 200</td>
<td>125 to 150</td>
</tr>
</tbody>
</table>

Source: Compiled from field survey

Charges on Consumables

Charges on consumables includes, water and electricity, oxygen, pulse charges, ECG and inhalation and associated charges. The data is classified sector wise and presented in the table given below.

Table 3. Charges on Consumables levied from patients (Figures in rupees)

<table>
<thead>
<tr>
<th>Type of Charges</th>
<th>Private hospital</th>
<th>Co-op hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water &amp; Electricity</td>
<td>115 to 120</td>
<td>80 to 100</td>
</tr>
<tr>
<td>Others</td>
<td>800 to 1000</td>
<td>600 to 750</td>
</tr>
</tbody>
</table>

Source: Compiled from field survey

Table 3 describes the charges levied on consumables and from the table it is clear that the levy for water and electricity vary from Rs 115 to 120 in private hospitals and it is Rs 80 to 100 in co-operative hospitals. The table further reveals the other charges on consumables also. It varies from Rs 800 to 1000 and Rs 600 to 750 in private and co-operative hospitals respectively.

Fee for Doctor’s Services

The service charge for doctors in both private and co-operative hospitals includes fee for rounds consultancy and fee for operation. The details are given below.

Table 4. Fee for doctor’s services (Figures in rupees)

<table>
<thead>
<tr>
<th>Fee for consultancy</th>
<th>Private hospital</th>
<th>Co-op hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rounds</td>
<td>125 to 175</td>
<td>100 to 150</td>
</tr>
<tr>
<td>Operation</td>
<td>2500 to 6300</td>
<td>2000 to 5000</td>
</tr>
</tbody>
</table>

Source: Compiled from field survey

Table 5.4 reveals the fee levied for doctors’ services and it is clear that the co-operative sector fix a fee levied a fee at least 25 percentage less than the private hospitals.

Other Charges

The other amount levied from inpatient customer includes admission fee, establishment charge, miscellaneous charge, medical service charge, post-operative charge and monitoring charge etc. as given below.

Table 5 describes the other charge levied as admission fee varies between Rs 50 to 75 in private hospitals where it is Rs 40 to 50 in co-operative hospitals. The establishment charge and miscellaneous charge in private hospitals varies from Rs 110 to 150 and Rs 500 to 600 respectively. The table further reveals that medical service charge of both private hospitals and co-operative hospital varies from Rs 100 to 150 and the post-operative charge varies between 500 to 600 and 200 to 300 rupees in private hospitals and co-operative hospitals respectively. The monitoring charge for private hospitals varies
from Rs 150 to 175 and Rs 125 to 135 in co-operative hospitals. From the table it is clear that there is only a slight difference in the charges levied by both private and co-operative hospitals.

Table 5. Other Charges levied from inpatients (Figures in rupees)

<table>
<thead>
<tr>
<th>Head of Expense</th>
<th>Private hospital</th>
<th>Co-op hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission fee</td>
<td>50 to 75</td>
<td>40 to 50</td>
</tr>
<tr>
<td>Establishment charge</td>
<td>110 to 150</td>
<td>100 to 150</td>
</tr>
<tr>
<td>Miscellaneous charge</td>
<td>500 to 600</td>
<td>350 to 400</td>
</tr>
<tr>
<td>Medical service charge</td>
<td>100 to 150</td>
<td>100 to 150</td>
</tr>
<tr>
<td>Post-operative charge</td>
<td>500 to 600</td>
<td>200 to 300</td>
</tr>
<tr>
<td>Monitoring charge</td>
<td>150 to 175</td>
<td>125 to 135</td>
</tr>
</tbody>
</table>

Source: Compiled from field survey

The major cost centers in hospital industry for outpatient customers are –

1. Consulting fee for permanent doctors
2. Consulting fee for visiting doctors
3. Dressing charge and
4. Injection Charge

The above data is classified sector wise and presented in the table 5.6.

Table 6. Charges for outpatient services (Figures in rupees)

<table>
<thead>
<tr>
<th>Head of expense</th>
<th>Private hospital</th>
<th>Co-op hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consulting fee</td>
<td>50 to 100</td>
<td>50 to 175</td>
</tr>
<tr>
<td>Consulting fee for visiting doctors</td>
<td>150 to 200</td>
<td>100 to 150</td>
</tr>
<tr>
<td>Dressing charge</td>
<td>50 to 200</td>
<td>50 to 150</td>
</tr>
<tr>
<td>Injection Charge</td>
<td>30 to 50</td>
<td>25 to 40</td>
</tr>
</tbody>
</table>

Source: Compiled from field survey

Table 6 reveals that the general cost charge collected from outpatient in respect of consulting fee vary from Rs 50 to 100 in the case of private hospitals and it is Rs 50 to 175 in co-operative hospitals. The consulting fee for visiting doctors in private hospitals and co-operative hospitals vary from Rs 150 to 200 and Rs 100 to 150 respectively. Table further reveals that charges for wound dressing vary from Rs 50 to 200 in private hospitals and it is 50 to 150 rupees in co-operative hospitals. Charges for injection in private and co-operative hospitals vary from Rs 30 to 50 and Rs 25 to 40 respectively. From the table it is clear that charges in respect of outpatient services are comparatively lesser in co-operative hospitals.

The most prevalent view of pricing in the hospital industry is that prices are set equal to average cost of providing hospital care, i.e. the hospital attempts to break even. This view of hospital pricing is based upon the assumption that nonprofit organizations are interested only in serving the public and have no desire to make any profits. This is validated in the book written by Ingbar and Taylor, in their book the nonprofit hospital as an organization aiming in its pricing policy to recover its costs. The typical short term hospital is not interested in making a profit as such, being a voluntary and charitable institution; it is content to cover its costs and sets its charges accordingly.

CONCLUSION AND LIMITATIONS

An important view of hospital pricing is that hospitals desire to obtain as much net revenue as possible in order to expand hospital size and obtain extensive specialized equipment. This may occur because the hospital administrator attempts to maximize his utility (which depends up on having a large hospital equipped with all the latest equipment) or simply because physicians on the hospital staff
place pressure on the administrator to increase hospital size and acquire the most modern facilities. If
this view is correct, prices will be higher relative to costs in areas where it is possible for hospitals to
make excess profits. Such areas might be characterized by high incomes and extensive coverage on the
demand side as well as limited supply conditions such as a shortage of beds or unavailability of
alternatives to private hospital. Thus the study concluded that the enquiry about pricing of services
shows that charges in respect of pricing are comparatively lesser in co-operative hospitals than the
private one. The major limitation for this study is that it has not covered the other types of institutions
in the health sector such as Ayurvedic, Homeopathic, and Unani etc and it has become difficult for the
researcher to collect data from different hospitals. Perceptions of the respondents are measured through
observation, personal interview, questionnaire and schedules. The power structure in India may cause
respondents to answer with partially frank acknowledgement of feelings. It became very difficult to
meet and elicit opinion of administrators due to their busy schedules. Majority of administrators are
under the impression that research on management means probing in to their internal affairs especially
in health care sector . With this opinion they hesitated in providing required data. Another limitation is
that the above analyzed data is not sufficient to study about the pricing procedure followed by the
healthcare sector in Kerala.

REFERENCES

    Sahithya Parishad.
    Centre For Development Studies.
    Economic and Political weekly, 145-152.
    Thiruvananthapuram: Centre for Development Studies.
    Rajasthan: Voluntary Health Association of India & Rajasthan Voluntary Health Association of
    Inida.
    Distributions.
    Economic And Political Weekly, 14, 85-92.
    Welfare.