Mapping the Flow of User Fees in a Public Hospital

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Glossary / Abbreviations

AMO	Assistant Medical Officer
ANC	Antenatal Care
BPL	Below Poverty Line
CDO	Community Development officer
CRs	Corporation Resolutions
ECG	Electro cardiogram
GL	General Ledger
ICU	Intensive Care Unit
IPD	In Patient Department
LAMA	Leaving Against Medical Advice
MS	Medical Superintendent
MO	Medical Officer
MRO	Medical Records Officer
MLC	Medico Legal Case
NHP	National Health Programmes
OPD	Out Patient Department
PBCF	Poor Box Charity Fund
RA	Registration Assistant
RNTCP	Revised National Tuberculosis Control Programme
SCRs	Standing Committee Resolutions
USG	Ultra Sonography

Preface

User charges were introduced as part of health sector reforms as a financing strategy. The perception is that it is minimal and that the health facilities do provide exemptions for the poor. Despite global evidence that it is ineffective as a financing strategy, that it acts as a barrier for the poor and that is a regressive mechanism that incurs huge administrative costs, the Indian government has taken no steps whatsoever to review this. At CEHAT, we undertook a study to review existing evidence on the issue and then decided to track the implementation of user charges in a hospital to understand the processes better. The findings reveal the complete absence of any mechanism or specific guidelines to mitigate effects of user charges on those who cannot pay. What exists in the form of waivers and Poor Box Fund are arbitrary measures, and their implementation patently anti-poor. As the study found out, user fees have disastrous effects on the right to health care causing denial of treatment.

The findings underscore the need to evolve specific guidelines for use of the Poor Box Charity Fund (PBCF) so that those who cannot pay are able to access these funds to avail of medical care. The system of waivers needs to be streamlined too so that patients are not denied access to diagnostics and care. There is a need to establish systems of referral within the public health system so that patients are not shunted from one facility to the other.

In light of the report of the Prime Minister's High Level Expert Group for universal access to health care, it is important to note that countries that have ensure access and services to the poor are those where national policies stress universalism and do not target the poor. The HLEG too has strongly recommended the removal of user charges at public health facilities. We hope that the state and the Municipal Corporation of Mumbai take note of this and get rid of these charges.

Padma Bhate-Deosthali
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CEHAT

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The first draft of the study report was reviewed by PDC (Programme Development Committee) members Padma Deosthali, Sangeeta Rege, Sana Contractor, Dr. Padmini Swaminathan, Dr. Lakshmi Lingam, Dr. Vibhuti Patel, and Dr. Padma Prakash. We thank each one of them. This draft report was subsequently revised, adding new analysis, and rearranging chapters as well as the presentation of data. We have tried our best to incorporate all the feedback received and we are grateful for their invaluable comments. We also thank the Multi-Institutional Ethics Committee (IEC) comprising of Dr. Geeta Balakrishnan, Ms. Neha Madhiwalla, Ms. Arokia Mary, Ms. Neena Shah More, Dr. Pravesh Jung Golay, Dr. Shrey Desai, Mr. Vijay Hiremath and Ms. Zamrooda Khandey for their review and approval of the study design and final report.

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Executive Summary

User fees are payments made by patients to providers of government health services. Over the past two decades, there has been a radical change in the health financing systems of developing countries, where alternative methods of financing healthcare were adopted to supplement budgetary allocations. The burden of financing health care has been shifted from the government to the households through charging users of publicly provided health services/ facilities, especially for drugs and curative care.

The Maharashtra state government introduced user fees in hospitals in the nineteen eighties, and the scope and scale has been steadily increasing. In 2001, there was a substantial increase in the average user fee paid per patient at government facilities in Maharashtra). Recently, there have been proposals to increase substantially the fees charged for medical services at civic hospitals in Mumbai and also a decision to hike user fees across the state .This study was aimed at mapping the flow of user fees in a public hospital located in Mumbai. It also aimed to understand the provider's role in the process of giving waivers from user fees to the patients, and also, reimbursement of fees from Poor Box Funds to the 'needy'.

Key Findings:

- ✓ It was found that a large majority of the patients belonged to the underprivileged category, mostly coming from the nearby slum areas. Interviews with the doctors and other staff revealed that around 85-95% of the patients belong to low socio-economic categories. Non affordability of costlier care in the private sector is perceived to be the main criteria of the patients for coming to a public health facility.

- ✓ The study found that the amount collected as fees from patients has been going up every year. As evident from the following figure, it increased from 4.5 million in 2007-08 to 7.29 million rupees in 2010-11. Since there have not been any user fee hike in this time period, the increase, was primarily a result of the rise in the number of the patients who had to pay.

- ✓ As a percentage of the total expenditure, user fees collection was just 0.84% in 2010-11. It was also found that administrative costs are substantial and a rough estimate of the salary of the staff whose primary responsibility is related to user fees collection taken as a constant, amounted to 118.77%, 95.71%, 77.79% and 73.53% of the total user fees collected respectively for the years 2007, 2008, 2009 and 2010.

- ✓ It was found out that no data on free patient categories or quantum of free care is collected and compiled at the hospital level in a systematic manner, although such data exists at the fees collection/ service delivery levels.

- ✓ It was found that within the system, there are quick-fix solutions for estimating the amount of subsidy. In short, whatever money that is not collected according to the register is assumed - for official purposes- to be subsidy to patients who cannot pay. Actual numbers disaggregated to different waiver categories do not exist in the system.

- ✓ A survey of official documents found that most of the CRs talk about 'the ill who cannot bear the charges' being given reimbursements for the exact amount from Poor Box Charity Fund (PBCF). PBCF being a reimbursement mechanism, it has practically nothing to do with waivers or exemptions. Some CRs seemed to suggest that for certain services, only upto 20% of the total patients can be waived off the fees, and after that PBCF funds need to be used. Contradicting this, the circular sent to all the hospitals state very clearly that, the waived off fees has to go from the PBCF to the revenue account of the local government body, so that there is 'no deficit on the revenue'. To compound the confusion, it also says that 'total concessions' related to charges cannot exceed 20%. When combined to the fact that there are no clear guidelines as to how to identify those who will be exempt or waived of fees, it was found that all these factors lead to a situation where most of the fee concessions happen as a result of arbitrary decisions. In short, apart from a routine listing of groups like local government body employees, doctors and nurses who should be given free care, and a customary and vague mention of PBCF help for the poor (not crossing the 20% limit) no clear guidelines are ever given as to whose fees need to be waived and what criteria are to be used.

- ✓ Yet another tendency observed in the policy documents was the fact that it was revenue mobilisation which was being presented as the supreme objective of user fees. The equity objectives were being ignored and it was said that "in the city, compared to the charges at private hospitals these charges are minimal, fair and suitable"

- ✓ Barring a couple of instances, there is no clear mention of waivers in the CRs. Whenever waivers are mentioned it is made clear that for each waiver/exemption, money equivalent to the fees that is foregone has to go from the PBCF to the local government body's account. This is not being followed as of now, but the researchers found out from interviews with the senior administrators that this constant fear of the local government body actually choosing to demand money from the PBCF account -following the guidelines- for each waiver granted has a devastating effect on equity. On the one hand, there is pressure on the doctors to keep the number of waivers and exemptions to the minimum so that such claims are low, and also on the PBCF to keep reimbursements to a minimum so that there is ample money in the account just in case the local government body chooses to send a bill with retrospective effect.

- ✓ Analysis of hospital data reconfirmed the apprehensions from the analysis of interview data as well as policy documents. It was found that the poor is only a small sub-category among all the patients who receive user fees waivers, and access free care (not accounting for the drug costs and other indirect costs).

- ✓ The study found out that the scope of PBCF as an equity enhancing mechanism is very limited. As revealed by the interviews with many of the hospital staff, while either allowing for waivers or granting PBCF reimbursements, there is an insistence bordering on obsession to prevent inclusion errors. The glaring exclusion errors are not given the priority they merit. It follows that, only 10-20% of the total patients are referred for financial assistance through PBCF, and much less reimbursed as many cases are rejected.

- ✓ It was found that while only around 2 per cent of the user fees collected is deposited in PBCF, and the latter is seemingly assumed in the CRs to be a is a part of the user fees mechanism when it is not. Moreover, while the user fee collected have gone up, the proportion of the fees deposited in PBCF has in fact gone down from 2.56% in 2007 to 1.99% in 2009.

- ✓ It was found that only a very low percentage of the money available in the PBCF is used to reimburse the expenditures incurred by the poor and the needy. The percentage stood at a

mere 14.42 in 2009. As a result, over the five years between 2004 and 2009, the amount in the account -in which the local government body had invested seed money of Rs.1.61 Crores the interest of which was to be one of the main sources that finance PBCF-, has actually grown from Rs. 1.61 Crores to Rs. 2.37 Crores. This growth is solely because of accumulated interest earnings, primarily a result of money being unused to reimburse the needy patients.

- ✓ For a patient, the process of accessing free care -whether it is through waivers/exemptions or through PBCF arrangements or through direct contributions from external agencies or individuals- could prove to be very time consuming and result in much delayed care.

- ✓ It was found that the perceptions of the staff on user fees varied. Many seem to think that user fees are low and unavoidable. The apprehension of 'smart patients' taking advantage of the system figured in many interviews, along with the belief that user fees do not affect access. However, some even attempt helping the poor patients by trying out seemingly illegal/unethical methods, given the inadequacy of the existing mechanisms.

- ✓ It was found that the following factors -
  a) That there are large numbers of poor, who visit the hospital,
  b) That the number of poor who actually possess BPL cards is low,
  c) That BPL cards are used to identify poor who will access waivers and exemptions, and
  d) That the actual proportions of patients lucky enough to access waivers/exemptions are negligibly low

  -together mean that poor people in large numbers may not be able to realise their right to free health care, or may be getting burdened financially while accessing health care, with adverse equity implications. It is quite apparent that most of the poor who visit the hospital are made to pay.

Policy Recommendations

It is clear from the study findings that only a microscopic minority of the deserving poor who enter the hospital is able to access free care. When we examine the data on the status of reimbursements to the poor through PBCF , the situation is seen to be the same. It is evident from the findings that only a very small proportion of funds available are used to bring relief to the poor. The processes itself is marred by arbitrariness, and almost completely dependent on personal judgement of some key individuals in the absence of credible guidelines, that any limited equity improvements that it may be bringing about can almost be by accident. This, when added to the directly adverse effects user fees have on equity, proves that as part of state policy, cost recovery from public hospitals is not advisable

1. In view of the study findings, we maintain that user fees have a negative consequence on health equity and should be discontinued by the local government body, also taking into account the fact that the incremental income it offers is negligible; if not negative once the huge administrative and other costs are factored in. We hope that in the light of the recommendations of the Prime Minister's High Level Expert Group (HLEG), the local government body will soon take a favourable decision. The following measures are suggested in the interim period, to offer much needed relief to the patients.

2. The cap on the quantum of waivers which mandates that "the total concessions related to the charges cannot exceed 20%" must go. As discussed in the report, a baseline survey by MMRDA in 2002 found that income levels of more than 30 percent of households in Mumbai were below poverty line. Public hospitals like the one under study attract mostly the poor

from nearby slums -as evidenced in the report- and so, a cap of just 20% is blatantly iniquitous. It has to be borne in mind that the actual proportion of waivers now are much lower than even 20%, indicating the degree of existing inequity. Along with this, clear instructions need to be given to the hospitals that there are no upper limits set by the local government body to the amount that can be reimbursed by the PBCF.

3. The study brought forward the necessity of effective guidelines to exempt at least the needy from paying user charges at the public hospitals. The rules and guidelines that exist now are very sketchy and arbitrary. While the CRs and Circulars focus on the prompt collection of user fees, the mention of exempting the poor almost always limits to a statement of intention, rather than any concrete steps. Our study revealed that even people from those categories that are specifically mentioned in the Circular as being exempt from fees were denied subsidy at the hospital. The room for ad-hoc decision making at the level of hospitals needs to be curtailed, and for that the local government body needs to bring out clear guidelines as to how they plan to have a policy of user fees while protecting the poor and the needy. The objectives of the policy need to be articulated and the steps of operationalisation listed out. Plans to introduce BPL as a criterion would be self defeating for reasons mentioned in the report.

4. One of the rationales given by the local government body for the introduction of such fees in its hospitals is that "compared to the charges at private hospitals these charges are minimal, fair and suitable". The role of the public sector vis-à-vis the poor needs to be rearticulated and emphasised; particularly, when it is working alongside a large and unregulated private sector. It may be a laudable goal vis-à-vis the middle classes to offer the same quality services at a lower cost. But for the poor, it is imperative that the services are free at the point of delivery. For hospitals which predominantly serve the slum population, geographical/ targeting location may be tried as one of the criteria.

5. It was seen that no publicity is given to either the exemption/waiver schemes or the availability of funds from the PBCF to poor and needy patients. Notices regarding this need to be displayed prominently at different locations within the hospital in the local language.

6. Steps should be taken to ensure that patients who are referred within the public health system do not end up paying any charge twice. It must be ensured that patients are not referred to private facilities when cheaper public sector options are available. Awareness among the staff of user fees needs to be improved substantially. The focus should be on other objectives of user fees, besides that of revenue generation. A campaign to sensitise the staff to the needs of poor patients is advisable. As of now, the staff seems to focus on avoiding inclusion errors, even at the cost of having substantial exclusion errors- that is preventing the non-poor from accessing free care, even if it means that a number of poor people are denied access in the process. It has to be made clear to the staff that excluding the poor from accessing free care is unacceptable.

7. It is necessary to set up a mechanism to redress grievances. In the current setup, patients are expected to go to the Medical Superintendent with their complaints. It is highly unlikely that poor patients get easy access to the person who heads the hierarchy. As the administrative head, it is also very unlikely that the MS is available all the time to address patients' complaints. A staffed information kiosk may be set up to advice patients on user fee related procedures, which can also collect complaints.

8. Even in the ideal sense, 'free care for the poor' does not mean free access, because of shortage of medicines, travel costs and loss of wages. Given this situation, the practice of transferring money (equivalent to the amounts waived off) from the hospital PBCF account to the local government body's account so that 'there is no deficit in the revenue' should be stopped immediately. As discussed in the report, PBCF and user fees are completely different and separate mechanisms, and PBCF should offer needy patients relief over and above what they receive as exemptions or waivers. PBCF was constituted to enable the poor to access health care that was not free. It must not be used to reimburse the local government body for the minimal care it is bound to offer for free to poor people. Such medicines can be purchased by the hospital and supplied to the patients using PBCF money. Charges incurred on any private investigation can be paid by the hospital directly.

9. The tendency not to use PBCF interest income that accumulates over time needs to be checked. The committee responsible should see to it that funds are utilized every year. For all these reasons, strict guidelines need to be evolved guiding the operation of PBCF mechanism. The process of PBCF should be decentralized, and the decision cannot be confined to one person. Clinicians should also be included in the decision making at some point, and their role should not be limited.

10. There is a grave need to put in monitoring and supervision systems in place. Regular auditing across all the hospitals under the local government body should be done and the reports made available. The system should make sure that procedural guidelines are being followed strictly. For this, information systems in the hospital need to be overhauled. It was observed that data is entered into registers while fees are collected; no compiled data is available anywhere in the system. There is no record of how many have availed themselves of waivers, and a roundabout method[1] is used to estimate the amount that has to go from the PBCF to the local government body's account. This situation has to change and foolproof data systems have to be introduced so that separate estimates for waiver/exemptions and PBCF reimbursements exist across different categories. This will help supervision and monitoring substantially.

11. Increase funding: An increase in the overall public health budget is an immediate requirement. In fact, Maharashtra's public expenditure on health has declined from about 1% in the mid eighties to 0.59% in 2006-07 (Duggal 2007). 'Lack of funds' is given as the most important reason for the introduction and hike of user fees in public hospitals. Consistent fund flow to the hospital must come from general taxation. The increase in service use that follows fee removal is likely to be greatest in poorer areas, and so, these areas will need the largest injections of new funding. Along with this, the local government body must improve drug supply and procurement systems, and make provision for the increased demand for drugs which is likely to follow the removal of fees.

[1] According to a senior official, it is calculated by deducting the number of Paid patients from the number of total patients for each service. The difference is 'assumed' to have availed free care because they deserved it. An equivalent amount then has to be transferred. This is a very inefficient system with much room for corruption.

Chapter 1:

Introduction

User Charges in Health Care

Over the past two decades, there has been a radical change in the health financing systems of developing countries, where alternative methods of financing healthcare were adopted to supplement budgetary allocations. The burden of financing health care has been shifted from the government to the households through charging users of publicly provided health services/ facilities, especially for drugs and curative care (Akin et al, 1987) .

The practice of charging user fees in public hospitals of low income countries was given a boost as part of the structural adjustment policies, often as a condition of lending from the World Bank and International Monetary Fund (IMF). These policies in the health sector were eventually supported by many multilateral agencies. Apart from increasing revenue, user fees were introduced, according to these agencies, to achieve the objectives of reducing frivolous demand, improving quality and coverage, and increasing efficiency (Akin et al, 1987). Equity concerns related to user fees were to be addressed through a mechanism of fee waivers and exemptions which would protect the poor and make sure that cross subsidisation between the better off and the poor was made possible.

User fees have been in operation in many low income countries for more than twenty years. A survey conducted by the World Bank of 37 African countries in 1993 found that cost-recovery policies were practiced by 33 of them (Nolan and Turbat, 2005). Since then, however, many African and Asian countries have abolished user fees citing a variety of reasons- primarily the negative impact on poor peoples' access to health care services (Yates, 2009) . It is a mixed picture in India. Despite the growing concern that such fees may reduce access to essential services and adversely affect the achievement of the Millennium Development Goals (MDG), the practice continues in most states in India, also as part of the National Rural Health Mission (Shariff and Mondal, 2006). However, in Andhra Pradesh, the peoples' movement was successful in forcing the state to abolish user fees. The latest Common Review Mission of the National Rural Health Mission (NRHM) states that Kerala and Jharkhand also have stopped collecting user fees. Nevertheless, the proposed National Urban Health Mission (NUHM) in its draft mission document, calls for 'judicious' exercise of user fees as an effective mechanism for mobilization of resources.

User fees have been termed "the most visible indicator of the transfer in financing responsibility from governments to households" (UNICEF, 1999; p. 12). It was observed that in many low-income countries, cost recovery has directly resulted in households replacing the government as the main source of finance for basic social services, and that they have a disproportionate impact on the poor (UNICEF, 1999 and Sen et al 2002).

CEHAT conducted a study in Maharashtra to map the flow of user fees in a public hospital located in Mumbai. This report presents the findings of this study which aimed also to understand the provider's role in the process of giving waivers and exemptions from user fees, and reimbursement of fees from Poor Box Charity Funds to the needy patients. There is ample literature from various Asian and African nations on the implications of user fees, such as the decline in utilization of public healthcare services. However, literature capturing the processes involved in the implementation of user fees in India is

scarce and very little empirical evidence exists regarding the efficacy of the rules framed and implemented, and whether they actually facilitate the provisioning of free services to the poor and the needy. Literature on the extent of denial of subsidy and its reasons is not available. This study aims to address these gaps, at least partly.

Organisation of the report: This report is divided into four chapters. The first chapter introduces the study with the help of a literature survey. The second chapter states the objectives and methodology of the study. The third chapter discusses the findings of the study in the light of the literature surveyed, and the fourth chapter presents the conclusion and lays out recommendations.

User Fees in Maharashtra

The case of Maharashtra presents us with very interesting and contrasting statistics. The Economic Survey of 2009-10 states that with a per capita state income of Rs 49,058, Maharashtra is the second richest among all the Indian states. However, Maharashtra's poverty ratio at 30.7% is 3.2 percentage points worse than the all-India figure. In 2004-05, Maharashtra had around 32 million people under the poverty line, and along with Bihar and Uttar Pradesh, it brings up the rear of the states with a high BPL population (The Hindu, 2010). NFHS-3 found that more than sixty per cent of the children in Maharashtra are anaemic, with over 40% having moderate or severe anaemia. A recent report on nutrition observed that according to NSSO 61st round data, the calorie intake in 68% of the households in the rural areas and 74% households in the urban areas of Maharashtra is below the norm of below 2700 calories per day (SATHI 2009).

At the same time, the latest Economic Survey admits that the number of industries closed and workers affected has been going up in the recent past. The following table from Economic Survey 2009-10 illustrates that industrial employment is facing a crisis today. When coupled with the crisis in agriculture, it means that the poor population is much more than official estimates and is growing.

	Small Scale Indusries		Medium & Large Scale Industries	
Year	Closed down	Workers affected	Closed down	Workers affected
2007-08	26,220	1,43,381	474	67,355
2008-09	33,359	1,94,629	808	1,45,110
2009-10	44,997	1,97,798	845	1,53,786
(upto September, 2009)				

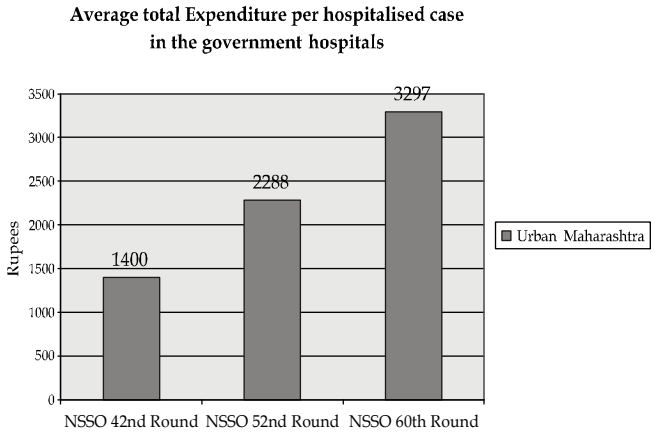
Source : Directorate of Industries, Government of Maharashtra.

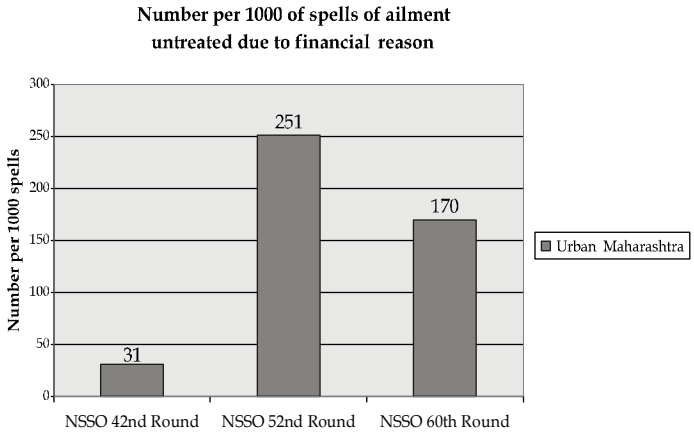
A study in 2009 observed that the three major factors responsible for the decline of village households into poverty were health expenses, high-interest private debt, and social and customary expenses. Health care expenses were a significant contributor in more than half of all cases of decline into poverty. It was also shown that Maharashtra has very high levels of out of pocket healthcare spending and is one state where there is significant increase in poverty due to such spending. It indicates that the burden of high spending is mostly in the lower quintiles of the expenditure distribution (Gupta 2009).

The Maharashtra state government introduced user fees in hospitals in the nineteen eighties, and the scope and scale has been steadily increasing while clear guidelines on exemptions have been largely absent (Thakur et al, 2005). In 2001, there was a substantial increase in the average user fee paid per patient at government facilities in Maharashtra (Mahal and Veerabhradraiah 2005). Recently, there have been proposals to increase substantially the fees charged for medical services at civil hospitals in

Mumbai and also a decision to hike user fees across the state (Asher 2010 and Shelar 2011). Though the officials maintain that the increase is very "nominal", in most of the cases, the increase has been substantial. The rate of a case paper, which is Rs. 5/- at present, has been increased to Rs. 10/-. The rate of an MRI has been increased to Rs. 2,500/- from Rs. 1,600/-; blood tests to Rs. 25/- from Rs. 20/-; X-ray to Rs. 40/- from Rs. 20/-. This is being done by a state whose capital itself has 1.2 million people who earn less that Rs. 20/- per day (Mumbai HDR, 2009).

Rules framed to give concessions to the poor were incorporated in the user fee mechanism to achieve the objective of equity (Thakur et al, 2005). However, as a broader study observed, 'the implementation of this rule has been the most serious area of neglect in the administration of the entire user fee structure." (Shariff and Mondal, 2006) Evidence from a study conducted by CEHAT has shown that the increased user fees introduced in 2000 had impacted the utilization of medical facilities at a public hospital in Maharashtra. In 1998-99, that is before user fees, this particular hospital had an annual OPD attendance of 170617 or 467 per day and after the introduction of user fees in 2001-02 it came down to 158811 or 435 per day and in 2005-06, it dropped further to 144804 or 402 per day (Duggal and Raymus 2007).





Shown above are trends for Urban Maharashtra for various NSSO rounds between 1986-87 and 2004, the period that roughly covers the two decades when such fees were in vogue. The first graph is the average total expenditure per hospitalised case in public hospitals from the mid-eighties. The second graph shows the number per 1000 of spells of ailment untreated due to financial reasons in urban Maharashtra, for the same period. There is a steady increase in the total expenditure per hospitalised case in public hospitals. During the pre-reform period, the proportion of patients whose access was denied because of financial reasons was much lower, just 31 per thousand spells as against 251 and 170 per thousand spells in the following rounds. While there may also be other factors at play, it is undeniable that direct hospital payments are a major deterrent.

User Fees-The International and Indian Experiences

In its influential study (Akin et al 1987) which presented User Fees as an innovative health financing mechanism, the World Bank suggested that charging patients would have three main benefits. First, it was said that fees would generate added revenue. Second, that fee would improve the efficiency of health care delivery by reducing frivolous demand. Third, that such fees would improve equitable health services access, because user fee revenues could be used to cross-subsidise the disadvantaged. Thus, user fees were initially seen to be "an appropriate financing mechanism because they would be effective (in raising additional funds), efficient (by encouraging an efficient use of services), and equitable (in benefiting poor people disproportionately"(Yates 2009). In the following section, evidence concerning these objectives from India and across the world is discussed briefly.

In the case of Mozambique, it was seen that even while the huge costs of administering were not taken into account, user fees contributed to only a small fraction of overall spending on health- as little as 0.7% (Oxfam 2009) . It was noted that scrapping user fees would result in a net increase in resources for health care services(Yates 2006). A study in 2004 which looked at 25 countries in Asia and Africa concluded that user fees generally raise very little money. According to the author, user fees do not normally account for more than 10% of recurrent costs and are "a far more inefficient revenue raising tool than general taxation due to high administration costs"(Pearson 2004). The following table taken from a 2004 review shows the low level of user fee collections in selected countries in sub Saharan Africa.

User Fee Collections in Selected Countries in sub Saharan Africa

	% of recurrent budget covered by user fees	**Year**
Benin	20	1993
Botswana	2	1983
Burkina Faso	14.8	1999
Burundi	4	1992
Cote d'Ivoire	7.2	1993
Ethiopia	9	1996/7
Ghana	6-May	1991
Guinea	20	1993
Guinea-Bissau	5	1995
Kenya	2	1984
Lesotho	7	1998
Malawi	3.3	1983
Mali	2.7	1986
Mauritania	9	1999
Mozambique	8	1996
Rwanda	7	1984
Senegal	4	1990
Swaziland	2.1	1984
Zimbabwe	3.5	1992
Unweighted Average	6.9	

Source: Pearson (2004)

While the revenues were meagre, the costs have been immense- both in terms of financial costs and more importantly, equity. A study from Zambia in 2005 showed that administrative costs were almost equal to the user fees revenue (Yates 2006). It was seen that 67% of the revenues collected in Honduras was absorbed by administrative costs (Xu et al 2006). Watskin observed that when a large section of the population is poor, the costs of administration rise and revenue-potential falls, reducing net returns (Watkins 1997).

Nevertheless, Yates notes that in the 1990s, there were a few studies which indicated that the introduction of user fees in some cases could actually increase the use of services. This was a result of increased demand arising out of quality improvements which were funded by the user fees collected.[2] However, most studies conducted since 2000 conclude that "user fees reduce usage and this effect is most pronounced in the suppression of demand for health care by poor people" (Yates 2009).

In health systems reeling under the pressure of severe staff shortage, collection of user fees placed yet another burden on the existing staff. After the removal of user fees in Nepal, a nurse at the Kathmandu Hospital observed: "When user fees were removed by the government in January, the number of women coming to give birth here almost doubled. It did not overwhelm our staff, because they no longer had to deal with the red tape of administering the fees"(Oxfam 2009). Citing a UN study, Ravindran (2005) observes that the argument that revenue generated could be used to improve services in such a way that it benefits the poor and vulnerable groups is misleading. She maintains that there is no evidence to suggest that this has indeed occurred in any country where user fees have been introduced as part of health sector reform (Ravindran 2005).

An early World Bank report noted that between 1975 and 1989, the average cost recovery rate in India was just 3.8% of the medical and public health budget (World Bank 1997). It was observed that in 1992-1993 the average hospital receipts were 1.4% of the total hospital expenditure (Bhat 1999). A study conducted later found that for the year 1996, of all states, only three had a cost-recovery ratio over 5 per cent (Mahal 2000). In short, user fees, wherever it was introduced, was not seen to contribute as expected. Although user fees are seen to be a failure in India in terms of revenue mobilised, they are still very much part of the official health policy.

The introduction of user fees was purportedly a measure also to improve equity. It was expected that the waiver and exemption system would work as an effective system of cross-subsidisation. Nevertheless, the overall experience has been quite to the contrary. It was seen in Sudan, for example, that scarcity of money was cited as the primary reason why 70 per cent of the sick people in disadvantaged areas chose not to seek care (Witter and Babiker 2005). Extensive reviews have shown that exemption systems rarely work and in the case of Zambia, it was observed that only 1% of exemptions were based on poverty status, indicating that either poor people did not access health care or were being forced to pay, either in the public sector or in the private sector (yates 2006). The principle of equity demands that the paying and non-paying patients be treated as equals. In practice, it was observed that the process of accessing systems of exemption is often stigmatising and de-humanising (Hutton 2004). Another related issue affecting equity is regarding the absence of well-defined guidelines on exemption policy. Thus, lower levels of administration who operationalise the rules may receive "conflicting signals from higher levels regarding the exemption policy". This will have negative implications for equity as it aggravates the "inherent conflict between attempting to recover costs and seeking to protect the poor"(Reddy and Vandemoortele 1996). In all this, from being an entitlement guaranteed as a matter of citizenship, free health care increasingly becomes a charity or a gift from individual staff to 'deserving' patients.

There is evidence that mechanisms like user fees actually amplify existing inequalities by excluding the poor from accessing health care facilities (O'Donnell et al, 2007). A simulation analysis of 20 African countries published in the British Medical Journal in 2005 calculated that abolition of user fees could prevent approximately 2, 33,000 deaths of under-five children annually. This amounted to 6.3% of all under-five child deaths in those countries (James et al, 2005). As per this estimate, over the last twenty years, about fifty lakh child deaths could have been avoided if user fees were not charged.

[2] According to Ravindran(2005), such successes were "only because the fees have been retained at local level and earmarked for specific items such as drugs".

It is often argued that the user fees charged are low. Nevertheless, as per evidence presented by Gilson and McIntyre, such fees can encourage patients to opt for inappropriate self treatment. It was also noted that as a direct result of user fees, patients tend to use partial drug doses, and often postpone or even forego the use of health facilities altogether. Impoverishment follows increased morbidity, and the patients who must pay fees may have to find money by selling key assets, cutting down on other necessary expenditure, or resort to borrowing at very high interest rates. At the same time, they must also endure loss of income (Gilson and McIntyre 2005).

Another study maintained that people were being forced to choose self-care. For every 10% increase user fees, reliance on self-care increased by 2.4 % (Asfaw et al, 2004). A study in Morocco showed that for every 10% increase in user fees, the access of the poorest 50% of women to a trained health care worker would drop by a high 6.2 %(Save the Children 2008). It was observed that user fees accentuated gender based barriers to accessing health services (Ravindran and De Pinho, 2005).

Evidence from across the country regarding the impact of user fees show that the poor get affected disproportionately. The Common Review Mission of NRHM observed that Chhattisgarh, a state with a large number of poor, charges user fees from 95% of its public health facility users(GoI 2009). In the case of Madhya Pradesh, only 2.47% patients were exempted charges for services on basis of BPL, lthough the official number of BPL population in the state is 37% (GoI 2007). A study in Punjab showed that BPL card holders treated free of cost made up only 0.4% of the patients treated in the outpatient department, and it declined further to 0.008% in two years (Ahmad 2006). Second Common Review Mission of NRHM observed that almost every state mission has noted the 'problem in the persistent user fees and the impact on access...' The team from Chhattisgarh reports,

> *"In the district hospital in Bilaspur, user charges for most of the services are found to be generally high and are even comparable with (those in) private hospitals. All BPL cardholders are excluded from user charges. However for those poor who do not carry a BPL card, the decision for exclusion is made at the level of civil surgeon on case-by-case basis. One would wonder how many poor could access civil surgeon's office to avail of such benefits. " (GoI 2008a)*

A study conducted in Bareilley, UP found that in 1999-2000, out of a total of 1,70,087 outpatients at MPDH hospital only 477 were treated free of cost. In 2000-01, out of 1, 41,852 outpatients, only 449 were treated free of cost. The study observed that the implementation of the waiver and exemption rules has been inadequate in the administration of the user fees structure (Sharif and Mondal 2006) .

While waivers and exemptions have been inadequate to protect the poor in India, BPL as a criterion is still being used to target the poor who receive free care. Though policy circles maintain that equity concerns are being addressed by waivers and exemptions, studies have shown that this claim does not hold. There are studies showing non-utilisation of funds collected. While there are studies that show the inadequacy of user fees as a tool of resource mobilisation and a mechanism to improve equity in India, there are no studies that track the operation of the mechanisms of various waivers and exemptions. Our study aims to fill this gap by trying to map the flow of user fees in a public hospital in Mumbai, and also to map the processes involved in poor patients' accessing various waivers and exemptions. The next chapter discusses the background, objectives and methodology of the study.

Chapter 2:

Background, Objectives and Methodology

Background of the Study

It is in the context explained in the previous chapter that the practice of User Fees in public hospitals in Mumbai has to be examined. Although on the average Mumbai has good population per hospital bed ratios, the distribution of beds within the city is quite unequal as is evident from the following table. The population per hospital bed in both the Eastern and Western suburbs are about five times greater than that of the city.

Hospital Beds and Number of People Per Bed in Mumbai

Area	Population	Municipal Hospitals		Other Hospital	
	(Mid-Year Estimates of 2007	Number of Beds	Population Per Bed	Number of Beds	Population Per Bed
City	3700098	6386	579	13577	273
Western Suburbs	5689012	2059	2763	8972	634
Eastern Suburbs	3888610	1702	2285	4723	823
Greater Mumbai	**13277720**	**10147**	**1309**	**27272**	**487**

Source : Public Health Department, MCGM (2006)

Mumbai's health budget, which was close to 30% of the municipal budget in the eighties, has declined to less than 15% at present (Duggal 2008). A baseline survey by MMRDA in 2002 found that income levels of 40 percent of households in Mumbai were below the poverty line. In the urban slums survey of the NSSO (2008-09), asked whether there have been any change in condition of medical facility during last 5 years, 74% of the respondents from Mumbai slums said no improvement, and 5.5% said that such facilities did not exist earlier or now. An earlier survey of 1035 households, which explored the need to strengthen public health care services had observed that hiking user charges could prove fatal, since 'low cost to user' was cited as the major advantage that made people prefer the public health care system (Dilip and Duggal 2003).

In Mumbai, user fees have been charged for a long time in hospitals run by the local government body. The act of 1888 in its Section 62A titled 'Fees to be charged by the corporations in public hospitals and dispensaries' which came into force on the 1st March 1909 (Bombay Government Gazette, 1909, p. 229)[3] says: "In public hospitals and dispensaries established and maintained, and in connection with other measures canted out, under clause (gg) of Section 61 such fees, if any, may be charged as may be prescribed by the corporation" (BMC 1888). The latest rates are based on a rate list published in the Circular 2000-2001 referring to Resolution dated 28/04/2000 and SC Resolution dated 02/03/2000.

[3] Section 62A and 62C came into force on the 1st March 1909, see Bombay Government Gazette, 1909, pt. I, p. 229.

Objectives of the Study

This study intends to provide a resource to cover the process of implementation of user fees in a public hospital of Mumbai run by the local government body and to look at the cost recovery over the past three years. The broad objective of this study is to map the flow of funds from collection, deposit to expenditure of the funds generated by levying user fees in the public hospital under study, and understand the health providers' role in the process of exemption/waiver from user fee and provision of Poor Box Funds to the needy.

The specific objectives of the study are

1. To examine the guidelines for the collection of user fees and implementation of waiver/exemption criteria in public hospitals run by the local government body in Mumbai.
2. To map the flow of funds collected through the user fees mechanism.
3. To understand the health providers' role in the provision of exemption, waivers and other subsidies (including provision of Poor Box Funds to the needy).
4. To examine the total revenue generated by the collection of user fees and its percentage contribution to total expenditure (of the selected facility) over the past three years.

Methodology

The study was conducted in one of the public hospitals run by a local government body in Mumbai. It was found that the process of implementation of user fees is similar in all such hospitals, as they follow the same broad guidelines and administrative structure. (This decision was taken after informal discussions with the staff in different hospitals) Hence, to capture the flow of user fees into a comprehensive map, an in-depth study at one facility was seen to be sufficient. At the same time, secondary data from that facility about fund collection and utilisation and the extent of waivers and exemptions was used to help contextualize the whole process.

The hospital under study is a public hospital situated in the suburbs of the city. Patients come from both nearby areas and the suburbs to visit this public hospital in order to avail themselves of a range of services. Information about the patients was sought from clinicians, administrators, social workers and other staff involved, wherein they were asked about the socioeconomic background of the patients and their capacity to pay. It also reflected the general perceptions of the hospital staff about the patients.

Primary data was collected by conducting semi-structured, in-depth interviews with the clinical and administrative staff involved in the implementation of user fees in the hospital. Interviews were conducted with the following personnel.

Administrative Staff	**No of Interviews**
MS (Medical Superintendent)	1
Cash counter staff	2
Office Superintendent	1
CDO/ Social worker	3
Accounts Office, Head Clerk, Administrative Officer, MRO[4]	4
Total Interviews	**11**

[4] The composition of the sample was changed from the original plan keeping in mind the fact that they involved with the user fee /PBCF processes to a significant extent.

Clinical Staff	No of Interviews
Honoraries	1
Lecturer	2
Registrars	1
MOs	2
AMO	1
Housemen	4
Head Nurse	1
Total Interviews	**12**[5]

A number of interviews were conducted with the clinical staff and transcribed for initial analysis. It was observed by the research team that no new information regarding the processes of either User Fees or Poor Box Charity Fund (PBCF) was forthcoming. During the course of interaction with the hospital staff, there was a simultaneous documentation of experiences and observations from the field by each of the researchers. These field observations included the day-to-day activities in the hospital including those of patients while accessing care, doctor-patient interaction and communication of the patients with the Community Development Officer (CDO). The research team noted the experiences of patients that emerged during the course of interviews with the staff, along with specific inputs from the staff concerned, and also from the patients themselves about the experiences and ordeals that they had to go through in order to access free care in various departments. This was done only after explaining to the patients the purpose of the visit and the study.

Wherever possible, the researchers directed the patients and guided them with information regarding waivers/exemptions and PBCF. All these field notes were compiled and certain cases of the patients were carved out from available information. The exercise helped to arrive at a holistic understanding of the flow of user fees and the equity-enhancing mechanism in the hospital.

Secondary data was collected from the Accounts and the Medical Records Departments of the selected facility and the proportion of patients accessing waivers and exemptions was studied. Paucity of systematic data about collection of user fees was a problem that the researchers faced. But they did get access to some data with which indicative trends could be arrived at.

A review of Resolutions (CRs), respective Standing Committee Resolutions (SCRs), Letters and Circulars from the Commissioner of local government body was conducted to look at existing guidelines. For this, a list of CRs and SCRs were accessed from the Commissioner's Letter No. TRV/2080 dated 24th February 2000 from the Health Profile 2001 and 2002, published by the Public Health Department. This letter contained the rate list that is still being followed, and interviews with the hospital staff revealed that no relevant CR/SCR regarding user fees emerged after 2000. Hence, we tried to access all those CR/SCRs mentioned in the said letter, as well as all those relevant CR/SCRs referred to in those respective documents. Permission was sought from the Secretary of the local government body to access these documents from the library of the local government body, which was granted after some delay. However, some of these references turned out to be wrong, and our search gathered nine CRs and six SCRs relevant to the current study. Signed copies of these were acquired from the authorities, translated and the content analysed to arrive at a broad idea of the current guidelines to be followed by the public hospitals run by the local government body.

[5] The number changed from the original plan since no new information regarding the processes was forthcoming in the interviews.

Tools

Informal discussions were used to collect preliminary information and to identify the stakeholders in the implementation of user fees. Interview guidelines were used to conduct in-depth interviews with the administrative and clinical staff.

A checklist was prepared for secondary data requirements from the facility, and data was collected from the office of the Medical Records Officer (MRO), different User Fees collection counters, and also from the office of the Community Development Officer. This study used both quantitative and qualitative methods to cover different aspects.

Data Analysis

The quantitative data was analyzed using MS Excel. The quantum and the proportion of waivers and exemptions, as well as PBCF reimbursements were analysed for a period of three years. Information such as the location of the facility and type of services rendered by the facility were used to contextualise the results. Trend analyses of the hospital health budget, user fees collected, and the PBCF account for the last three years were performed.

Qualitative data - Only those interviews where the participants gave explicit permission to record were electronically recorded. The data collected from the interviews were transcribed, and in some cases, translated. Transcription of the interviews was followed by content analysis, after the data had been arranged into different relevant themes. Analysis was carried out manually by the team.

Limitations

Data regarding the proportion of user fee revenue on the overall budget of the local government body remained unavailable, even after repeated efforts to access the same. This has limited the analysis of the macro situation, but with the availability of the hospital budget and the possibility of calculating the amount of user fees collected as a proportion to the total hospital budget for three years, we have been able to remedy it to some extent. Hospital data on user fees and the Poor Box Charity Fund for 3 years could be procured, while the original plan was to analyse data from the last 5 years. Data unavailability was the limiting factor in both instances.

Chapter 3:

Findings and Discussion

This chapter discusses the findings and observations from the study. For tracking the process of user fees collection, approval of waivers and exemptions and the reimbursement of the Poor Box Charity Funds, data collected through interviews have been used. While quantitative findings are based on data which was collected from Registration Assistants, office of the Medical Records Officer (MRO), office of the CDO and the Administrative Office (for budgetary data). The findings are presented under the following sections.

3.1 Hospital Profile

The first section in this chapter deals with the description of the hospital under study along with the profile of the patients who visit this hospital. This data was collected during the interviews and field visits and recorded as field notes and observations.

The hospital under study is situated in the suburbs. It is broadly partitioned into two sections - clinical and administrative. There is a casualty building that consists of the In Patient Department (IPD), Operation Theatre, Intensive Care Unit (ICU) and others, while the Out Patient Department (OPD) functions in a relatively older structure. There is a separate building for administrative activities that houses all the administrative offices and the Medical Superintendent's office.

This hospital represents a typical public hospital where hundreds of patients access a variety of medical services every day. The OPD timings are from 8 am to 1 pm and case papers are issued 8 am onwards until 11 am. There are three different case paper windows, for new patients, old patients and senior citizens. Adjacent to the case paper windows is a board displaying the list of available scheduled drugs. There are independent windows for dispensing medicines for general patients and for the employees of the local government body and a separate window for school children from schools run by the local government body.

The hospital executes the screening and treatment of patients suffering from diseases covered under the National Health Programmes (NHP). There is a health post and dispensary, which caters to the diagnosis and treatment of TB patients within the hospital premises. There is a fully functional blood bank with a blood collection of nearly 3000 bottles a year. The blood is collected from various sources such as blood donation camps, blood replacements and so on. The hospital has an Integrated Counseling and Testing Centre funded by the Mumbai Districts AIDS Control Society (MDACS) for pregnant women and the general population.

Clinical Department

The hospital has a bed-strength of over 500 and provides a range of services through various departments such as General Medicine, General Surgery, Pediatrics, Obstetrics and Gynecology, Dentistry, Psychiatry, Plastic Surgery and Orthopedics. All the departments in the hospital have OPD and IPD facilities barring the dentistry, psychiatry, pediatric and plastic surgery departments whose facilities are limited to the Outpatient Department. These departments have two units which alternate between the OPD and Operation Theatre on specific days the week.

The departments show a hierarchical structure of doctors starting from honoraries or Senior Consultants, Medical Officers (MO), lecturers, registrars and housemen. Honoraries are not full time employees and are not employed by the local government body; however, they receive an honorarium of Rs.1000/- per month. Next are the Medical Officers followed by lecturers who are employed by the local government body on a full time basis. Lecturers have the additional responsibility of teaching, where they have to deliver lectures to resident doctors every week. They are assisted by the registrars. On the last rung of this hierarchy are the housemen.

Though the hospital renders a range of services, it is unable to handle some emergency situations such as gynecological and neurological emergencies due to the absence of expert doctors.

Administrative Department

The administration is headed by the Medical Superintendent (MS) followed by the Administrative Officer. Next in hierarchy is the Office Superintendent who is in-charge of the overall supervision of the work done by the clerks and head clerks. The Accounts Officer looks into the verification, the salaries of the doctors, head clerk and the cash collection staff who consist of Registration Assistants. The Medical Records Officer works under the MS and takes care of the daily user fees collection from different departments. Below are the Registration Assistants who are engaged in actual cash collection at the windows. The details of each department could be found in ANNEXURE 1 at the end of the report.

3.2 User Fees and Poor Box Charity Fund (PBCF)[6] - Roles and Responsibilities of the Staff

The following section lists the roles and duties of all the staff employed in the hospital. The Medical Superintendent heads both the clinical and the administrative departments. The junior staff, such as housemen and registrars deals with the everyday patient load, whereas the senior staff including lecturers, Medical Officers and the Medical Superintendent have the added responsibility of teaching and maintenance of department and administration respectively.

While the hospital has a list of duties for the higher officials such as the Medical Officers and the Medical Superintendent, the responsibilities and duty hours of the junior doctors remain a grey area. While most of the housemen reported that they do not have specific work hours and they work 24/7, the lecturers said that after the OPD, they have to remain on call for the entire day. The exorbitant workload can be explained by the non availability of human resources at that level, which puts additional pressure on the staff. The following diagrams try to plot the roles of the medical and administrative staff vis-à-vis User Fees and the PBCF mechanism.

[6] PBCF is a fund which is used to reimburse poor patient's charges. Poor Box Charity Fund Committees were constituted in the hospitals run by the local government body in the year 1926 with the approval of the Standing Committee by Resolution No.6736 of 29.9.1926. The primary function of this committee was to provide medicines and surgical appliances unavailable for free in the hospital to the poor and needy patients.

Diagram 1: Roles & responsibilities- Clinical Department

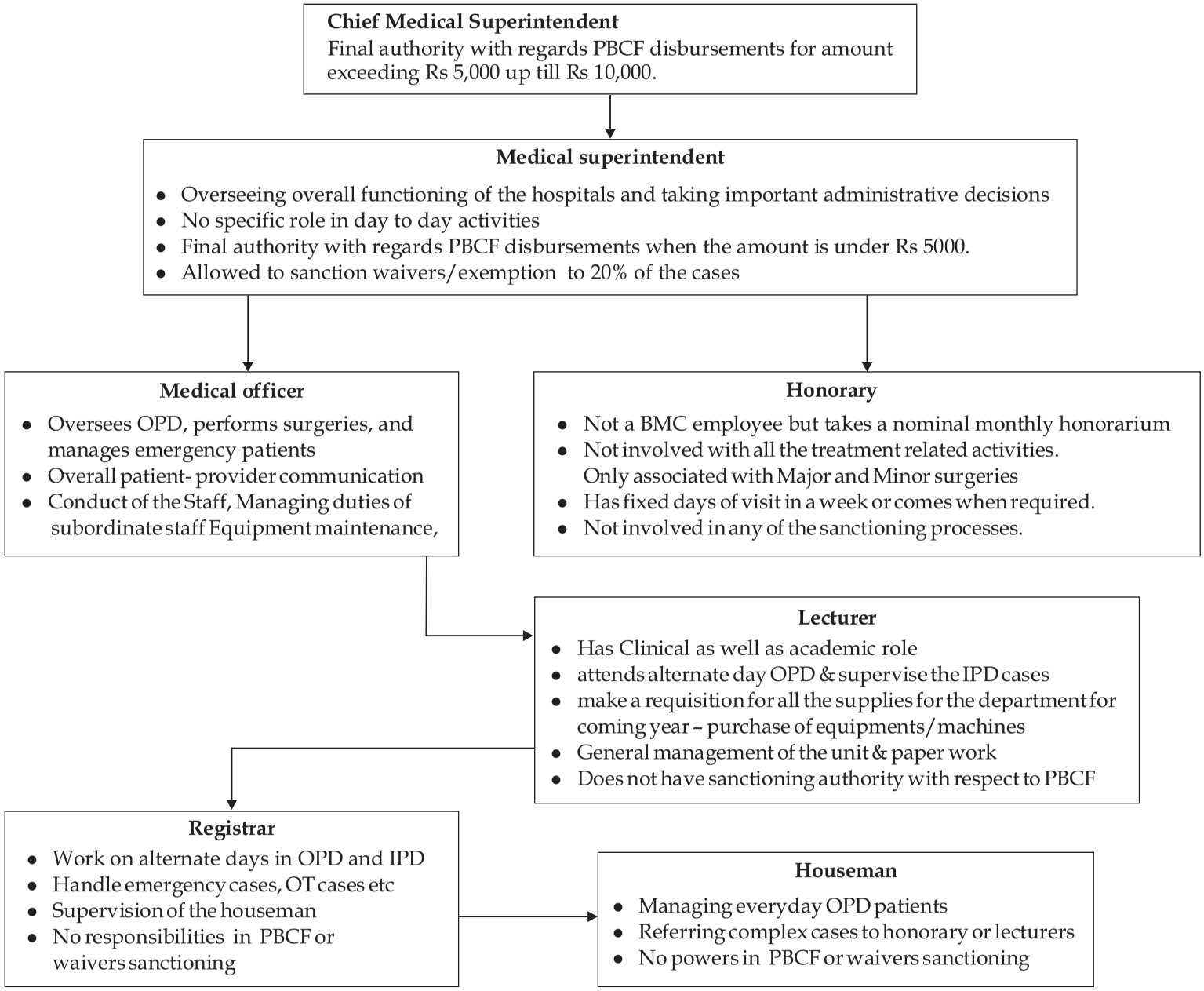
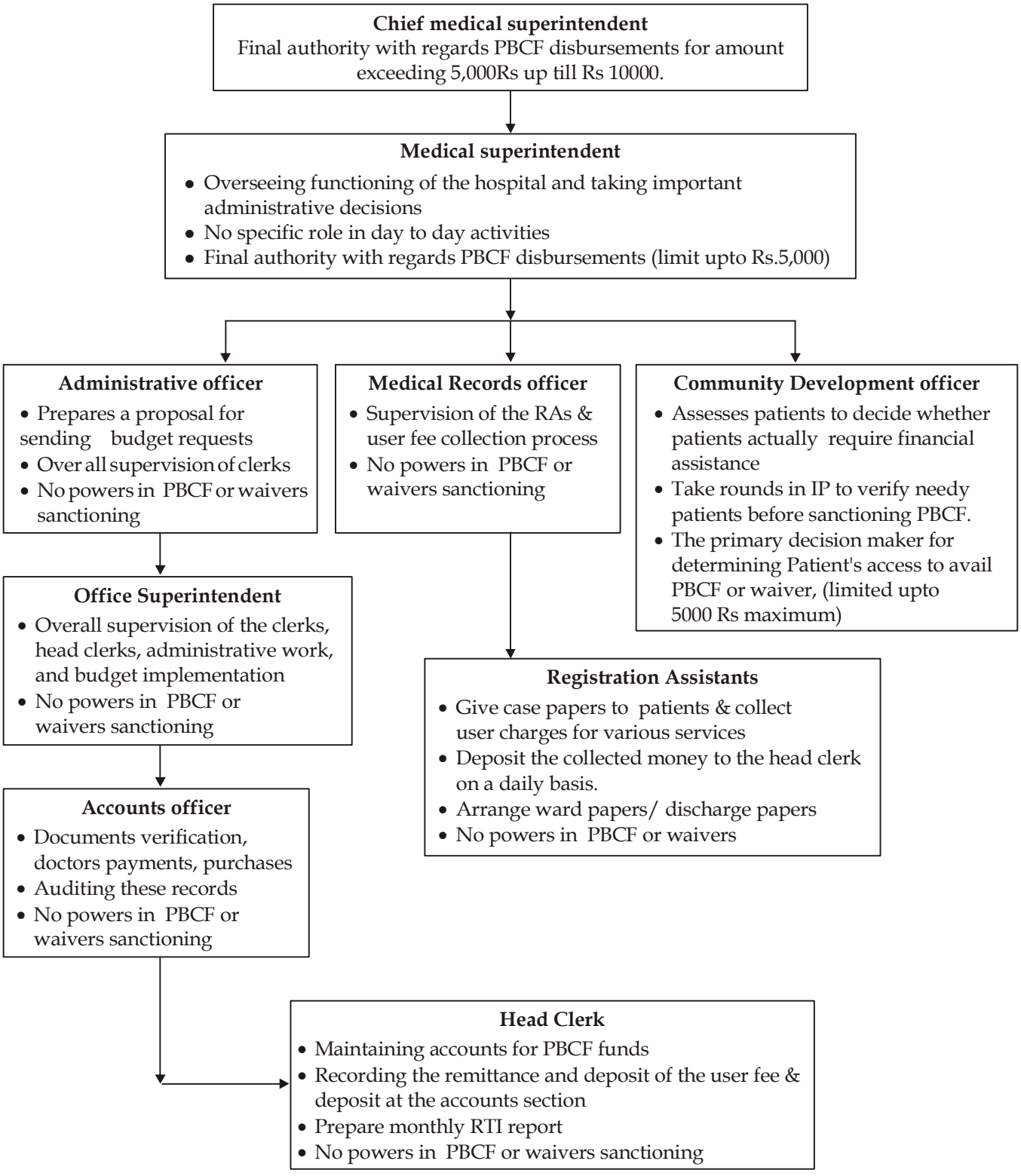


Diagram 2: Roles & responsibilities -Administrative Department



3.3 Patient Profile

Information about patients was sought from clinicians, social workers and other staff, wherein they were asked about the socioeconomic background of the patients and their paying capacity. It was helpful in understanding how and why the patients are categorized into different types.

Socioeconomic Profile

The doctors as well as the CDOs opined that 85%-95% of the patients belong to the underprivileged category, mostly from the nearby slum areas. A lecturer who has been working in the hospital for the last two years opined,

> *"Patients belonging to the lower classes come here. Nearly 90% belong to the extremely low class like beggars and slum population. Slum population is the highest".*

Patients not only come from nearby areas, but from across the city to avail themselves of services from this hospital. A CDO informed that the proportion of government employees availing services from this hospital is low.

The rush hours were in the first half of the day when long queues of patients could be seen in front of the case paper windows, in the diagnostic facilities, and the OPD till it closed at 1 o'clock. Though there were numbers assigned and written for different OPDs, new patients often got confused while searching for a department or a diagnostic facility; the support staff gave directions to such patients.

Treatment Seeking Behavior

The information given by doctors depicted how and why patients try to access health care in a public facility. Some of the housemen reported how the decision making is done by the patients while choosing a public health facility. One from Orthopedics Department shared,

> *"A patient who cannot afford comes to government hospital."*

Another houseman from Surgery said,

> *"If the condition is chronic, the patient won't come until the pain is unbearable as in the case of Hernia."*

Since housemen had the most contact with the patients, they were aware of the actual situation. These doctors opined that poverty is the main reason why patients hesitate to opt for surgery at an early stage of the illness and why about half of the patients they treat everyday need to be convinced. One of the senior doctors also acknowledged that as patients have more choices in terms of health care facilities, they tend to go to a private facility for minor ailments and come to the public hospital for operations, serious ailments and deliveries. All these insights underlined the fact that non affordability of expensive care in the private sector is perceived to be the main criterion for those patients who came to a public health facility.

Categorization of Patients

In addition to the general category of patients, the hospital has evolved a system of categorizing patients on the basis of situations in which they are admitted to the hospital. Although there are no specific written guidelines regarding this process, a considerable percentage accesses fee waivers. These categories are unknown patients, emergency cases and Medico Legal Cases (MLC). According to a doctor interviewed, if a patient is *"brought in by the police and the patient's whereabouts are untraceable, no identification- he/she is considered unknown".*

Similarly for Medico-legal cases, "In case of a train accident the patient is brought in by a police as a MLC and he/ she is categorized as unknown".

Unknown patients were mostly road-side patients, orphans and even the destitute, who have neither a proof of identification nor any relatives to look after them. It is the responsibility of the police (in case of an MLC) and the CDO to trace the patient's identity. The nursing staff and the aaya-bais (Ward Attendants) in the IPD keep an eye on such patients, look for visitors coming to meet them and inform the CDO accordingly, so that they can be charged fees. When an MLC patient is brought into the hospital by the police, the treatment of that patient is the responsibility of the police personnel accompanying him/her.

3.4 The User Fees Mechanism

Whenever a patient comes to the hospital he/she has to take/renew the case paper at the window. There is a separate window for senior citizens, where they can avail the paper free of charge only by showing their senior citizen card. Although on paper it offers free consultation and treatment for fifteen days, in many cases, it is only five days. A doctor observed,

> "*The OPD paper is valid for 5 days and some for 15 days. Once you take an OPD paper, you get free treatment for 5 days. If you come for treatment after 5 days of the first consultation, the treatment is charged again @ Re. 1/- per day. For example, dressings done after 5 days are charged Rs.5/- but if the patient comes within 5 days, it is free.*"

The window for collection of fees for the diagnostics is adjacent to the case paper window where charges for X-rays, Ultra Sonography (USG) and Electro cardiogram (ECG) are collected. The operation charges are collected at two different places. The minor operation fees and ICU charges are collected at the cash section window in the administrative office, while the major operation charges are collected at another cash collection window in the casualty section. This window also collects colour Doppler charges as well as morgue charges. The casualty window is open throughout the day and has Registration Assistants (RAs) working in shift duties.

Human Resources for User Fees Collection

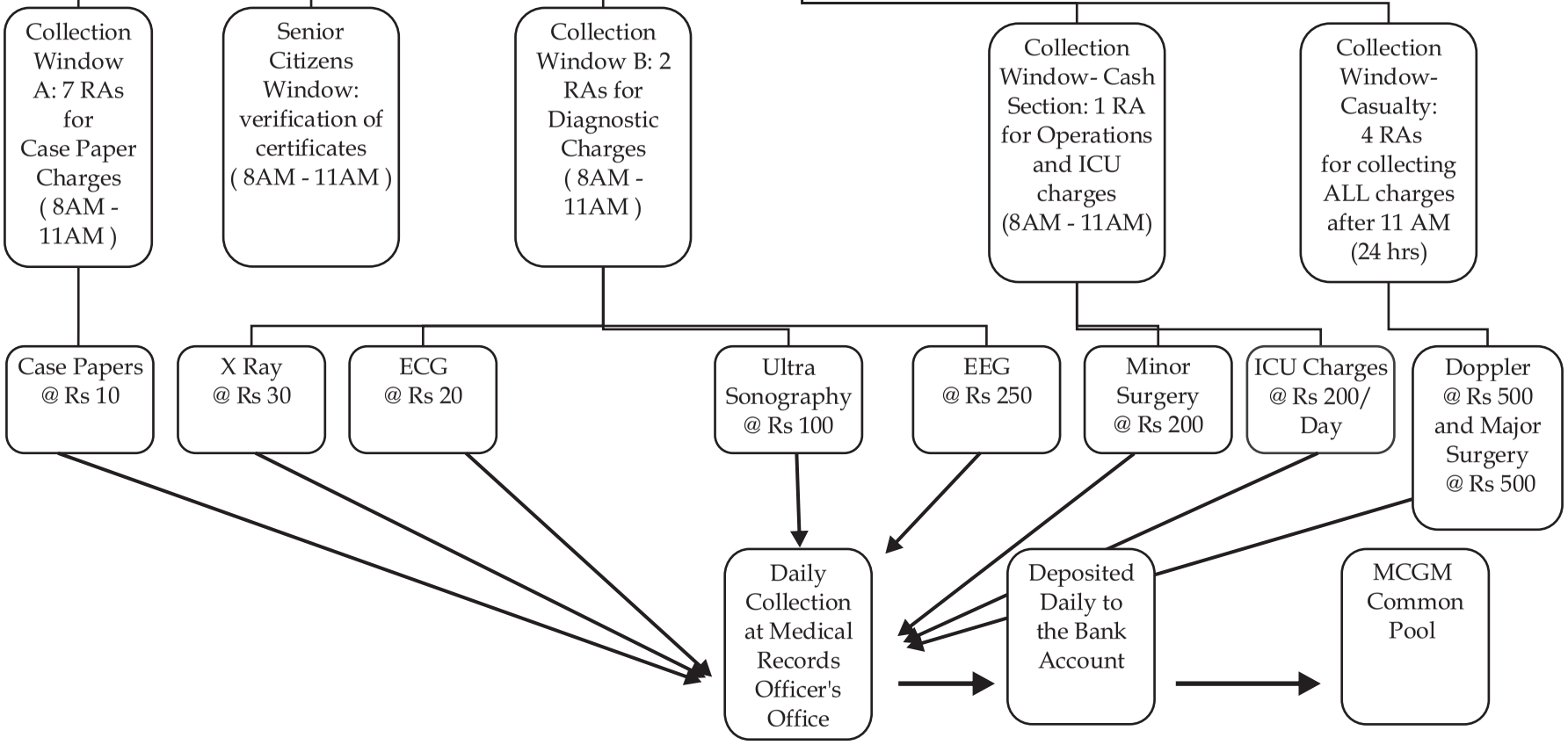
The MRO informed that there are total 15 full time RAs employed at the collection windows and additionally, 3 part time RAs. Full time RAs usually work from 8 am-to 4 pm and part time RAs, from 8 am to 12 noon or 12 noon to 4 pm.

Detailed information about the Registration Assistants

- There were 15 full time RAs and 3 part time RAs.
- Four served in the obstetrics and gynaecology department - three were on shift duty and one was on regular duty.
- Of the remaining RAs, 3 worked at the casualty section (7 pm -3 am, 3 am-11 am, 11 am - 7 pm) and 1 was a reliever who works in shifts.
- Six RAs worked at different OPD counters (8 am - 4 pm) and 1 at the office (No.65).
- Two Part time RAs (8 am-12 noon) and one full time RA worked at the Medical Records Department (12 noon - 4 pm)
- Full time RAs usually worked from (8 am - 4 pm) and Part time from (8 am-12 noon) or (12 noon - 4 pm).

The flow of user fees collected, as explored by the study is given in the following diagram (Diagram 3).

Diagram 3: User Fee Collection at the Municipal Hospital



Process of Collection

1. All the regular cash collection windows operate from 8 am-11.30 am (Other than the one at casualty)
2. RAs have to maintain a register, which has the details of the number and the type of patients for each day.
3. They also have to maintain a receipt book.
4. After 11.00 am the windows are closed and the registers along with the receipt book are handed over to the RA sitting at the casualty window.
5. He/she then continues in the same serial order of the receipt book in order to maintain regularity, and the process is continued till the next morning.
6. The cash collected at all the windows between 8.00am-11.00 am is deposited at the MRO's office and later taken to the cash section in the administration office by one of the RAs.
7. The cash collected is noted down and then it is deposited daily in the bank.

Deposit of Cash

- The money comes to the cash section, where the RA signs the remittance form and sends it to head clerk in the accounts department.
- The head clerk signs the form and the cash is sent to be deposited.
- The cash is deposited in the bank daily.
- The local government body gives a code number to the hospital, and according to the GL code (General Ledger code) the money goes into the treasury of the local government body.

Maintenance of Records

Though the daily cash collection is noted down in the MRO office, a record of free cases or waivers is not maintained, except for the RA registers which remain in the form of raw data. Common guidelines are not followed in such data entry, although over time, the Registration Assistants have evolved some coding/shorthand entry which is unintelligible even to co-workers in the same section. However, figures are never compiled into any sort of report of the scale and nature of waivers offered. How annual audits are conducted without this data remains unanswered.

Medicine and Bed Charges

No bed charges are levied on in patients in the general ward. Charges of Rs. 200/- per day are applicable only to the patients admitted in the ICU. That there are no bed charges is a major factor that encourages patients to come to the hospital.

The hospital has a list of scheduled drugs, which is determined by the hospital panel to be given free of cost to the patients. However, the board displaying the list of scheduled drugs shows non availability of at least one-third of the listed drugs. Of the list of more than a dozen ointments, only one was available, indicating that patients have to buy most of the medicines from nearby pharmacies, thus adding to their out of pocket expenditure.

Diagnostics and Operation Charges

According to information given by most of the doctors, pathology services including routine investigation are free for all the patients. Diagnostics, radiological investigations, operations, ambulance, blood bank

and ICU, are chargeable. The registrar mentioned that even dressings are chargeable, although it is not mentioned on the rate list.

Minor operations are charged Rs.200/- while major operations are charged Rs.500/-. There is a third category, supra-major operation, that is charged Rs. 1000/-. For more advanced operations, the patient is required to bring the implants from outside, while surgery charge is Rs. 5000/-. A detailed list of charges applicable in the hospital is available in ANNEXURE 3.

Differentiating Major from Minor Operations

From the interviews with the general surgeon, as well as with the orthopaedic doctor, it was clear that there were criteria which differentiated major and minor operations. The AMO reported that when the charges were implemented by the local government body, honoraries from each department had prepared a list of major and minor operations from a clinical viewpoint. A general surgeon informed that the categorization usually depends on the rule set by the local government body which has pre decided divisions of major and minor operations, which contradict part of the earlier statement, but confirm the existence of pre-determined criteria.

A prominent criterion that many mentioned is the length of operation. A senior doctor mentioned,

> *"It depends on the timing. Operations lasting longer than two hours are called supra major operations. If there is no need for an incision and stitches, then such operations are called minor operations."*

In many cases, segregation was by the length of operation or the need for incision. The Registrar clarified,

> *"If a major operation lasts longer than 2 hours it is a supra major operation. If the patient requires an incision, it is a major operation."*

The surgeon explained that the operations were also categorized depending on the use of anaesthesia, where if the patient was administered local anaesthesia, it was termed a minor operation; and if the patient was administered general anaesthesia, it was termed a major operation. Any operation that took longer than two hours was a supra major operation.

Special Cases
1. If a patient is weak and suffering from a chronic disease, wherein the operation needs to be carried out under general anaesthesia, such an operation is categorized as major. 2. Any operation on a child below the age of one falls under the category of major operations.

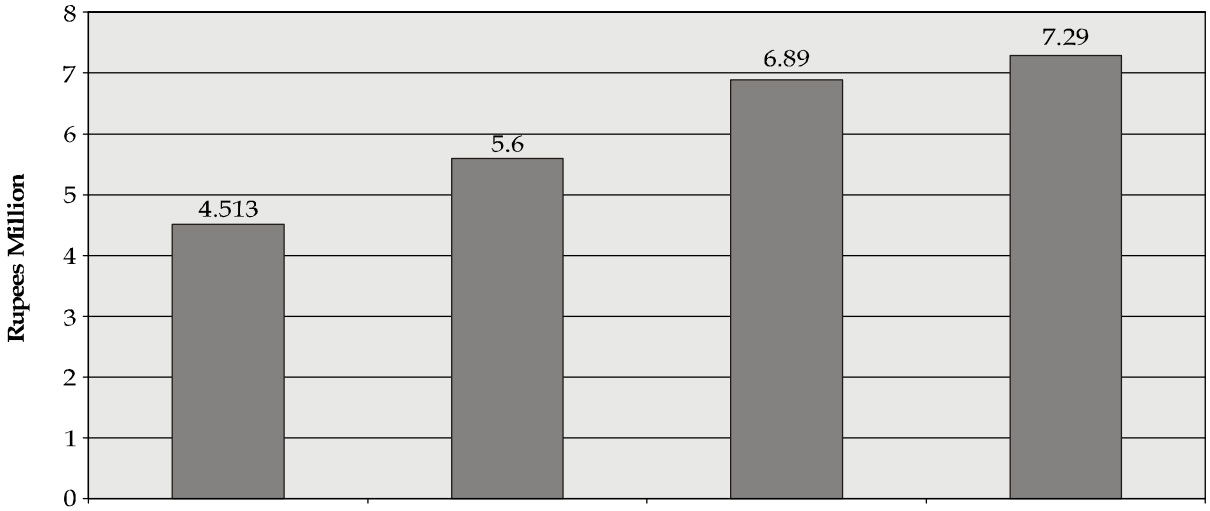
The information given by doctors about user fees for anaesthesia was contradictory. The registrar stated that anaesthesia was chargeable, while the AMO clearly mentioned that charges for anaesthesia were not borne by patients, but that the government paid it directly to the anaesthetist. He further said that for a major operation, the anaesthetists who are given a contract were paid Rs. 600/- and for a minor surgery, they were paid Rs. 400/-.

3.5 User Fees Collections

The study found that in this hospital, the amount collected as fees from patients has been going up every year. The following figure shows that it increased from Rs. 4.5 million in 2007-08 to Rs. 7.29 million rupees in 2010-11. Since there have not been any increase in user fees in this time period, the increase, was primarily a result of the rise in the number of the patients who had to pay. The annual OPD attendance in fact increased slightly between 2007 and 2009. Since we do not have sufficient data

on the annual turnover of patients in the pre-user fees era, this increase in itself does not say much. In fact, it reinforces the observation in earlier studies that after the stark fall during the initial years, hospital attendance marginally improves. Lastly and more importantly, one must keep in mind the fact that the fall in the number of free patients was much more than the actual increase in the OPD numbers within the same period. The section on waivers and exemptions discusses this.

Total User Fee Collections from the hospital (Rs Million)



Source : Data from Hospital Records

Fees collected under different heads are shown in the next table. As we can see, most of the money collected across the years comes from x-ray charges.

Case paper charges, operation charges, and ICU charges constitute other major components of the user fees collected in the hospital. It is also interesting that the amount collected from ICU charges nearly doubled between 2007 and 2009. Theoretically, in terms of equity, this increase in itself is not bad, provided poor and needy patients who cannot pay were exempt from payments.

User Fees Collections

	Actuals 2007-2008	**Actuals 2008-2009**	**Revised Estimates 2009-2010**	**Budget Estimates 2010-2011 as per new Fees**
Case Paper charges	1274000	1352000	1400000	1600000
Operation Charges	795000	1119000	1200000	1400000
EEG/ECG/USG/EMG	385000	740000	500000	500000
X-Ray Charges	1298000	1496000	1800000	1800000
Medical Opinion Certificate Charges	132000	128000	90000	90000
ICU Charges	629000	765000	1200000	1200000
2DEcho/Stress Test/Colour Doppler Charges			700000	700000
Total	4513000	5600000	6890000	7290000
Total (Rs Million)	**4.513**	**5.6**	**6.89**	**7.29**

Source : Data from Hospital Records

A the same time, as following table shows, user fees collected as a proportion to the total hospital expenditure has been coming down steadily. As a percentage of the total expenditure, user fees collection has decreased from 1.28% in 2007-08 to 0.84% in 2010-11. As a proportion of the total hospital expenditure, this is only a small amount, as other studies discussed in Chapter 2 have also shown. However, as none of these calculations take into account the substantial administrative costs that the user fees collection entails, we will proceed to calculate a rough indicative estimate of how much would be the costs of collecting user fees in the hospital under study.

User Fees Collected from the Hospital				
	BE 2007-2008	**BE 2008-2009**	**BE 2009-2010**	**Budget Provision 2010-2011**
% of the total Hospital Expenditure	1.28	1	1.17	0.84

Source : Data from Hospital Records

Any study of user fees has to take into account the administrative costs of the huge machinery that exists in the hospital just to collect the user fees, keep day to day accounts and facilitate waivers and exemptions. Most of the RAs are fully immersed in user fees related work and most of the CDOs' time is taken up in conducting socioeconomic assessments of patients trying to access waivers. Substantial time of the clinical staff gets spent on user fees related formalities too, and the delays that ensue can be seen as indirect costs. However, in the following calculation, we do not include the clinical staff. This is necessarily indicative, and is only a rough estimate of the salary of the staff whose primary responsibility is related to user fees collection. This estimate for different categories was reached by multiplying the mean salary scale by 3.35 (done in consultation with staff of the local government body). Salary scales were taken from the Hospital Manual.

Approximate salary bill of staff whose primary duties are related to User Fees Mechanism

Staff	**No of staff**	**Salary Scale**	**mean scale**	**Approximate monthly costs = mean salary scale *3.35**	**estimated annual salary bill**
Registration Assistants (Full Time)	15	4335-5915	5125	17168.75	3090375
Registration Assistants (Part time)	3	2160	2160	7236	260496
Community Development Officers	5	6040-8665	7352	24629.2	1477752
Collection Clerk	1	4495-7650	6072	20341.2	244094.4
Head Clerk	1	6040-8665	7352	24629.2	295550.4
TOTAL					**RS. 5368267.8**

Source : Data from Hospital Records

It must be reiterated here that doctors and administrators spend a considerable amount of time screening patients and doing paperwork regarding waivers, but the cost in terms of their efforts are not considered here. There are 26 Honoraries, 32 Registrars, 46 House Officers, 10 Medical Officers and 11 Lecturers in the hospital. Similarly, the efforts of nurses, paramedical and other staff who are asked to perform duties related to user fees, and also "to keep a strict watch" on the patients who have yet to pay, are not taken into consideration. (Yet, there is a considerable number of 'absconding' cases - that is, patients who leave secretly without paying the bills- possibly also because they cannot afford to pay. Leaving Against Medical Advice (LAMA) cases are three to four times that of 'absconding' cases as seen from

data available at the hospital)[7]. All this point to the high level of inefficiency in this highly iniquitous system.

This administrative cost estimate is quite revealing in the sense that it eats up a substantial part of whatever fees that are collected. One can put forth that if the indirect costs like clinical and paramedical staff's time, delays, infrastructural costs, foregone treatment etc are taken into account, the costs of user fees will far outweigh the revenue collection. The rough estimate of the salary of the staff whose primary responsibility is related to user fees collection taken as a constant, amounted to 118.77%, 95.71%, 77.79% and 73.53% of the total user fees collected respectively for the years 2007, 2008, 2009 and 2010. It is evident that substantial parts of the effort of the hospital's administrative apparatus are being spent on collecting user fees, and fulfilling the procedural requirements. Interestingly, there is no systematic collection of data regarding the user fee system per se, which would make evaluation much easier and address some concerns of accountability. On the whole, it is clear that the net revenue from user fees is very low, if not negative.

This situation may have parallels in various international experiences where the revenues have been low and the expenses have been high- both in terms of financial and more importantly of equity terms. A study from Zambia in 2005 had shown that administrative costs were almost equal to the user fees revenue (Yates 2009). It was seen that 67% of the revenues collected in Honduras was absorbed by administrative costs (Xu 2006). While it may not be very prudent to compare, we can observe here what Watkins concluded, that when a large section of the population is poor, the costs of administration are high and revenue-potential falls substantially, reducing net returns (Watkins 1997).

Documentation of Free Patient Data: Who is Accountable?

It has to be repeated here that the complete lack of any effort to record the number of free patients in a systematic manner is really surprising. With no real extra effort, monthly and annual reports can be prepared, with or without making use of advanced information technology. Unfortunately, at every level of the hierarchy, the palpable feeling is that such measures are unnecessary. For example, the Medical Records Officer who is responsible for managing the daily collection of user fees and monitoring the RAs expressed helplessness when asked about free patients: "It is very difficult to get details of the number of free patients and each RA has to look for the mention of free treatment done in the register". Some of the administrative staff argued that "records are kept as per their requirement". This means that even though there is daily maintenance of the registers of user fees, data about free patients does not get documented anywhere resulting in loss of the data from that point onwards. Within the system, there are quick-fix solutions. According to another senior administrator, "There is no record, but you can indirectly conclude, you can look at the X-rays and compare it with the amount collected, the rest is (assumed to be) 'waived'". In short, money that is not collected according to the register is assumed to be subsidy to patients who cannot pay. This lack of accountability opens the whole process up for the possibility of corruption that can surely be avoided.

[7] Between 2007 and 2009, LAMA cases have steadily been going up from 1011 to 1185, while 'absconding' cases have been around 300, annually. The doctors maintain that it is not because of the cost factor that patients run away, since there is help in the form of financial aid. A lecturer said, "They do not crib because they know they will not get a better deal in private facilities. It is less likely that they leave due to cost issues". Another doctor opined, "2%-3% people run away. Mostly, mentality is the reason for most of the patients absconding".

3.6 Official Resolutions and other Documents dealing with User Fees

We analysed the Resolutions that were collected from the local government body office along with a circular regarding the user fees mechanism that we could access from the office of the hospital under study. In this section, the content of the Resolutions, Standing Committee Resolutions (SCR) and other documents of the local government body which deal with the operation of user fees mechanism will be looked at briefly. These documents have been accessed from the main office of the local government body, and it was only after multiple requests and long delays that the research team was allowed to access these.

The research team tried to locate all the Resolutions that were referred to in the official letter No TRV/ 2080 dated 24th February 2000, that announced the revision of user fees. In the course of our search, we realised that many of these Resolutions (CRs) are untraceable, because the references given in the letter turned out to be wrong. The team tried to use the references from the later resolutions to locate the older ones so that the maximum number could be accessed. The relevant part of the Resolutions dealing with user fees thus acquired from the local government body office in the form of true signed copies, were then translated and used for content analysis. When analysed together, it is seen that there are two distinct themes in these documents.

First is the part that gives out charges - new or revised- for specific health care services in the hospital. This is the most straightforward part, where the rates for specific interventions are stated. There is hardly any scope for vagueness here, although sometimes some arbitrariness may creep in, as in the case of major vis-à-vis minor surgeries as will be discussed later.

The second part of these Resolutions deals with specifying the population groups that are to be excused from paying the fees. Here most of the resolutions repeat the same categories such as government employees, retired government employees and their dependants, government school children, public hospital nurses, and resident medical officers. The most comprehensive presentation is to be found in a circular that the Deputy Commissioner (Health) sent to all the hospitals on 24th February 2000, where these groups were listed:

From the proposed charges the following persons are allowed to access the services without paying charges:

1. *Government employees and their dependants, i.e. father/mother, husband/wife and dependant children.*
2. *Retired government employees and their spouse.*
3. *Medical College/Dental College/Nursing school students, students studying in the government School, Dispensary staff, school children and the Resident Medical Officer within the school.*
4. *In case of the poor patients who cannot afford to pay the above charges the exact amount will go from the Poor Box Charity Fund or any fund under the authority of the Dean/Deputy dean/Hospital Superintendent and deposited in the local government body's public revenue, so there is no deficit in the revenue. The Dean/Deputy Dean/Hospital Superintendent has the authority of making services free of charge or giving concessions to poor/needy patients. However, the total concessions related to the charges cannot exceed 20%.*
5. *The local government body employees and their dependant i.e. father/mother/husband/wife and dependant children, retired employees and their spouse, Medical College/Hospital/Dental College/Nursing school, students studying in the school run by the local government, dispensary staff and the resident medical officer are to be charged 50% of the rate for beds in a separate room and a separate section.*

This second part, which delineates how the waivers and exemptions are to be implemented, proves to be vaguer than the first part that dealt with the rates. This issue is explored in this section, in some detail. First, the categories under which the most number of waivers happen, do not find any mention

in the Resolutions or the circular, namely medico-legal cases, emergency cases and unknown patients. (This will be explored in detail with the help of quantitative data later on). There are no guidelines whatsoever regarding any relief to these categories, although in practice, a major part of the relief is accrued to them. Second, in the hospital, we observed that Senior Citizens are given waivers, both full and partial. Interestingly, there is no mention of senior citizens in the Resolutions. Although guidelines on this seem to be missing, those senior citizens who have an identity card, and who are aware of the concessions get partial or full waiver on certain services.

Regarding the poor, most of the Resolutions (CRs) talk about 'the ill who cannot bear the above charges' being given reimbursements for the exact amount from the Poor Box Charity Fund. PBCF being a reimbursement mechanism has practically nothing to do with waivers or exemptions. Some CRs seemed to suggest that for certain services, only up to 20% of the total patients can be given fee waivers, but after that, PBCF funds need to be used. Contradicting this, the circular sent to all the hospitals state very clearly that the amount equivalent to the fee waivers has to be taken from the PBCF to the local government's revenue, so that there is 'no deficit on the revenue'. To compound the confusion, it also says that 'total concessions' related to charges cannot exceed 20%. When combined with the fact that there are no clear guidelines to identify those who will be exempt or who are given waivers, all these factors lead to a situation where most of the fee concessions happen as a result of arbitrary decisions. This issue will be explored more in the discussion of PBCF as well as waiver/exemption sections.

Yet another tendency observed in the policy documents was the fact that revenue mobilisation was being presented as the supreme objective of user fees. That the equity objectives were being ignored will be somewhat clear from the following passages from the circulars sent to the hospitals:

> "*(It) is visible that, taking into account the amount spent on the public hospitals, the public revenue collected is negligible in comparison. In order to lessen the gap between collections and expenditure by a few percent it is very essential to increase the charges collected in the hospital (from the patients). Similarly, looking at the critical economic condition of (the) local government body, to undertake the costs incurred on the hospital and lessen the economic burden on the general budget to some extent, the attached appendix 'A' has the list of revised and new charges that have been proposed. In Mumbai, compared to the charges at private hospitals these charges are minimal, fair and suitable*".[8]

> "*Even though it is the statutory responsibility of the) local government body to establish and manage hospitals and dispensaries, to run and manage academic hospitals as per the parameters set by the Indian Medical Council would be additional burden on the local government body. Purchase of expensive and modern equipment for the hospital bearing the cost for their inspections and the increasing expenditures on the institutions, the hospital needs to increase the revenue to some extent. The revenue presently collected is negligible in comparison to the enormous expenditure of the hospital.*"[9]

A policy that starts by assuming that the charges are "*minimal, fair and suitable*" cannot be expected to pay much attention to equity goals. It was seen that resolutions that the research team had access to always deal exclusively with increasing or introducing user fees. Indeed, that may be one objective, but alleviating its effect on those who cannot pay did not come across as a priority. Apart from a routine listing of groups like government employees, doctors and nurses who should be given free care, and a vague mention of PBCF help for the poor (not crossing the 20% limit), no clear guidelines are given as to what are the criteria for fee waivers and who needs them. In fact, the CRs seem to assume that PBCF

[8] From Official documents such as Circular 2000-2001 , Standing Committee Resolution No. 611 and Resolution dated 28.4.2000, No. 67.
[9] Ibid.

is a part of the user fees mechanism when it is not. It is, in fact, a charity based mechanism that has been in operation in hospitals in Mumbai for decades. Putting around 2% fee collected in PBCF will not make it an extension of the user fees mechanism that can be used as an excuse to neglect waivers per se.

Barring a couple of instances, there is no clear mention of waivers in the CRs. Whenever waivers are mentioned it is made clear (as the senior administrators explained to us) that for each waiver/exemption, money equivalent to the fees that is foregone has to go from the PBCF to the local government body's account. This is not being followed as of now, but the researchers found out from interviews with the senior administrators that there was a constant fear of the local government body charging the hospital for waivers granted with 'retrospective effect'. That the government can legally do it, and that 'the hospital has to be ready for it', was given as an indirect reason for spending so little of the PBCF money, which in turn has had a devastating effect on equity. It has to be added however that PBCF money has never been transferred to the government account in the last eleven years.

On the one hand, there is pressure on the doctors to keep the number of waivers and exemptions to the minimum so that such claims are low, and also on the PBCF to keep reimbursements to a minimum so that there is ample money in the account just in case the local government body chooses to send a bill for eleven years. Together, these two see to it that only the smallest possible number of poor is able to access equity enhancing mechanisms and free care. These factors have in no small measure contributed to the view among the doctors and staff about user fees being just a revenue mobilisation tool.

The indirect impact of such documents on the attitude and perceptions of the hospital staff may not really help in the achievement of health equity goals. On the one hand, one is unclear in the guidelines of equity enhancing mechanisms that alleviate the adverse effects of user fees, and on the other, official documents put specific goals on the revenue to be mobilised using user fees. Illustrating from the circular that each hospital received, it was said that the proportion of collection to expenditure of the hospitals was expected to increase from 1:27 to 1:4. This work was to be treated as of 'extreme urgency'. The implications of such ambivalence on equity are only to be expected.

3.7 Patient Categories that have access to Waivers and Exemptions

Fee waivers at the public hospitals operate with an aim to address the equity for the people who cannot pay. A waiver is given to individuals or pre-defined groups, who are charged less or not charged at all. It was found that the hospital was providing two types of waivers - full and partial. Full waiver implied that there were no service charges at all, whereas in the case of partial waivers, some amount of the service charges was waived. At the same time, exemptions are certain medical services made free for everyone who access them.

In the hospital studied, most of the services offered are paid services, and the poor are supposed to access free care through individual or group waivers. The patient has to produce proof that he/she is poor, or from one of the categories for whom services are rendered free by the local government body, and the Community Development Officer (CDO) conducts a socioeconomic assessment after which it is decided whether or not a partial or a full waiver is to be given. The Medical officers also can waive the fees of poor patients in consultation with the CDO. This study also tracks the processes that patients entering the hospital need to undergo to access waivers and exemptions. The following diagram attempts to present the process from the point where the patient enters the system.

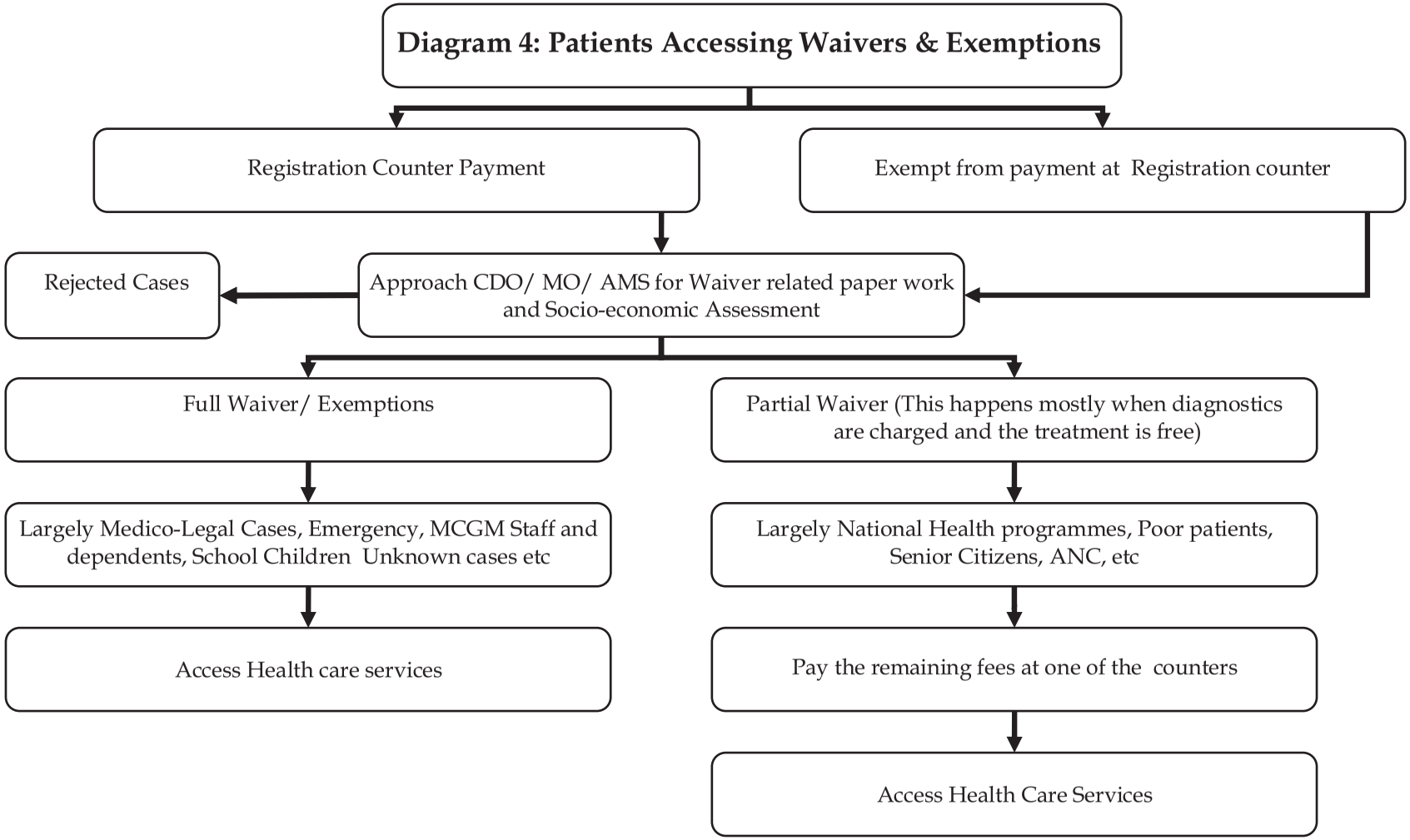


Diagram 4: Patients Accessing Waivers & Exemptions
Registration Counter Payment
Exempt from payment at Registration counter
Rejected Cases
Approach CDO/ MO/ AMS for Waiver related paper work and Socio-economic Assessment
Full Waiver/ Exemptions
Partial Waiver (This happens mostly when diagnostics are charged and the treatment is free)
Largely Medico-Legal Cases, Emergency, MCGM Staff and dependents, School Children Unknown cases etc
Largely National Health programmes, Poor patients, Senior Citizens, ANC, etc
Access Health care services
Pay the remaining fees at one of the counters
Access Health Care Services

As per the hospital norms, patients getting the waivers were categorized into different types. Although there was no clarity as to who is eligible, according to both clinical and administrative staff, the following are the categories that are broadly eligible to avail themselves of free treatment:

National Health Programmes (NHPs)

On paper, services under NHPs are free for all, thus making it an exemption. But in reality, only some components are available to the patients for free. The registrar notes, "Under the Blindness Control Programme the surgery is free. But the government does not supply the lenses". About national disease control programmes he says, "Before diagnosis of diseases under NHPs, the patients are charged. After detection, treatment is free". In other words, unless and until a patient is sure to have a disease under one of the National Programs, the services are not free. Each step till when the diagnostics results are out is always charged.

In the hospital under study, the services that are part of the Revised National Tuberculosis Control Programme (RNTCP) or the Antenatal Care (ANC) under the Janani Suraksha Yojana, or care under the Malaria Control Programme are provided free. Treatment is provided free of charge for the cataract patients under the Blindness Control Programme. The Family Planning Programme also comes under free services. In fact, vasectomy/ and tubectomy are the only surgeries which are conducted for free. In addition to the national programmes, in cases of epidemic situations such as swine flu, treatment is provided free and suspected patients are admitted.

An observation regarding NHPs was that the treatment was provided only after a diagnosis of the disease, which meant that the patient had to bear all the other user charges including the case paper charges, X-ray charges for a TB patient or Sonography charges in the case of an ANC patient. The same was the case with patients who wanted to opt for cataract operations. As informed by the physicians, the hospital had no lenses and the patients had to buy them from outside and then the operation would be done free of cost. Additionally, no information mentioning the list of waivers or exemptions under NHP was found in the hospital premises.

Government Employees and government Schoolchildren

The local government staff is given a family card where all the information about the family members is mentioned. The Staff, in order to get free treatment, have to bring the card. Treatment is provided free of cost for the local government employee, partner and dependant children. Even after retirement, the employee and the dependents can avail themselves of free service from the hospital. There is a separate window for children from government schools, where they can be registered to avail themselves of free service. Apart from the existence of a separate window, there is no information displayed anywhere regarding free care to children from government schools.

Senior Citizens

Though inclusion/non inclusion of senior citizens in this category remained unclear among the clinical staff, the RAs sitting at the case paper windows who are actively involved in the collection of user fees, clarified that only if a person brings his/her senior citizen card he/she gets a waiver on the case paper charges. Their names are sometimes noted in the register as 'waived because senior citizens'. This is done though senior citizens do not belong to a category that is eligible for free treatment.

There is a special window for case paper administration for senior citizens; with a board mentioning 'free service for senior citizens'. However, with respect to other services, there is no clear guideline

regarding waivers for senior citizens. During our visits, we noticed that this window often remained closed during office hours. The clinical staff seems to be aware of this during the interviews conducted. When asked about this, a doctor said, "Till now there has not been any instruction that services are free for Senior Citizens."

What the doctor said is correct, as we have seen in the CR analysis. The medical officer did speak about free diagnostic services for senior citizens, while the housemen clearly stated that senior citizens were eligible to get free treatment; there were contradictory statements from the registrar and the assistant medical officer who claimed that services were not free of charge for senior citizens, but they were eligible for waivers if they were also needy and poor, which then brings them into the common pool of people who need fee waivers. It is clear that whenever a senior citizen gets his/her fees waived, it is something that is based completely on the CDO/MO's arbitrary judgment.

The registrar went on to say that there is no such rule to make services free for senior citizens. This was also supported by the MS who informed that even though there is no such rule to provide a waiver for senior citizens, public hospitals under the local government body are providing it. Lack of clarity about waivers for a particular section could be related to the unavailability of proper guidelines. This also brought forward the fact that some guidelines that exist are not being followed with the same rigidity, strictness and enthusiasm with which the rule regarding the 20% cap on the total waivers is being followed.

Unknown Patients/ MLC Patients/ Emergency Cases

"For unknown patients, unless anyone claims them, they become our responsibility", a lecturer said. Once a patient is noted as an unknown patient, all the service charges till the patient's identity is known are waived. In case of an emergency all the charges including the X-rays, investigations and blood bank services are waived till the patient's relatives arrive. However, the blood has to be replaced by a donor if one is present. If no donor is available, the blood is given free of charge.

Poor People

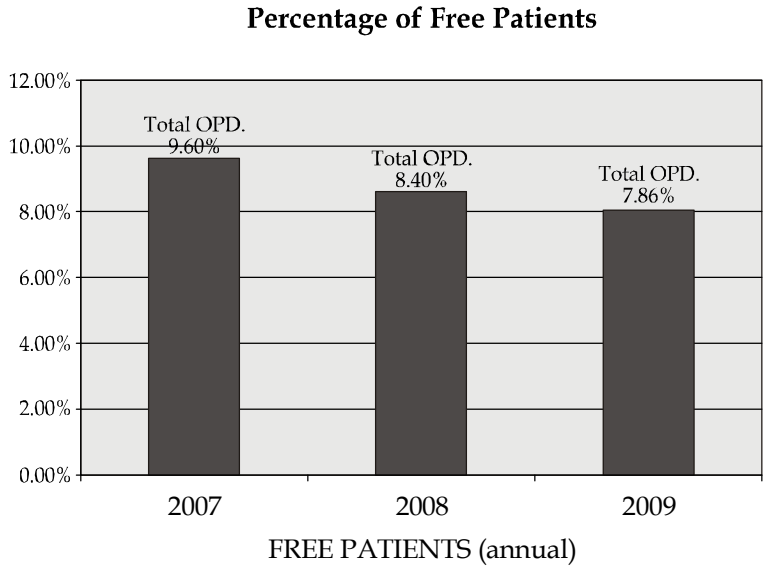
According to a few doctors, patients who are Below the Poverty Line (BPL) are treated free. The Registrar mentioned that if they possess BPL ration cards, they are not charged for diagnostics and other services. There was neither any clarity between the clinicians whether the BPL card holders were to be given free treatment nor was there any such mention at the case paper window as in the case of senior citizens. According to a CDO, however, BPL is not a sufficient condition for accessing free care though it is a very important criterion in Socioeconomic Assessment.

It is interesting to note here that Below the Poverty Line (BPL) is not prescribed as a criterion by Resolutions (CR) or any other guidelines. CRs often use more generic terms such as 'poor patients', 'those who cannot afford to pay' and 'the ill who cannot bear the charges'. The guidelines, in fact are very vague, but at the same time they put a cap on the maximum number of patients whose fees can be waived/reimbursed at 20 per cent of the total.

3.8 Data on Waivers/Exemptions - An Analysis

The researchers also analysed data from the hospital records to see how many patients actually access concession schemes and whether the perceptions that we had after the interviews were actually reflected in the data collected at the hospital. The study found that the proportion of patients who received free

OPD[10] care has been falling over time, almost by two percentage points, from 9.6% in 2007 to 7.9% in 2009- in the course of just three years. Here we see the number of free OPD patients as shown by the data available with the Medical Records Officer. This trend, as shown in the next graph is worrying, particularly since the absolute proportion of waivers and exemptions are very low even to start with. Added to this, the OPD fee waiver which is a minor fee waiver happens to be one where there are less difficulties and delays for patients. In fact, these were also years when the annual OPD attendance improved continuously, however marginally. However, the number of free patients fell as a proportion as well as in absolute numbers. The numbers were even larger than the additional increase in total OPD numbers. While OPD showed an increasing trend at 295453, 309083, and 317237 for these three years, the number of free OPD patients was 28350, 25976 and 24935 respectively for the same years, a substantial fall.



Source: Data from Hospital records

Interestingly, our study found out that among the patients who are able to access 'free' care, only a small proportion are poor. At the same time, as we have seen in the case of OPD charges, the number of 'free' patients in itself is quite small. Free patients, apart from the poor, typically include local government Employees and their dependants, Medico-Legal cases, Senior Citizens, School Children, unknown patients and patients undergoing family planning related procedures. Poor people often are a very small sub-set of the overall 'free' patients as we will see in the following series of tables which use data collected from the point of delivery of the service. For example, it is evident from the following table that while overall 10.91% patients (excluding family planning cases) are given free ECGs, the family planning cases taken alone is 5.76%. Also, just fewer than 11% of patients received free X-ray service.

[10] It has to be noted that this just means that they did not pay the mandatory Rs 10 to register.

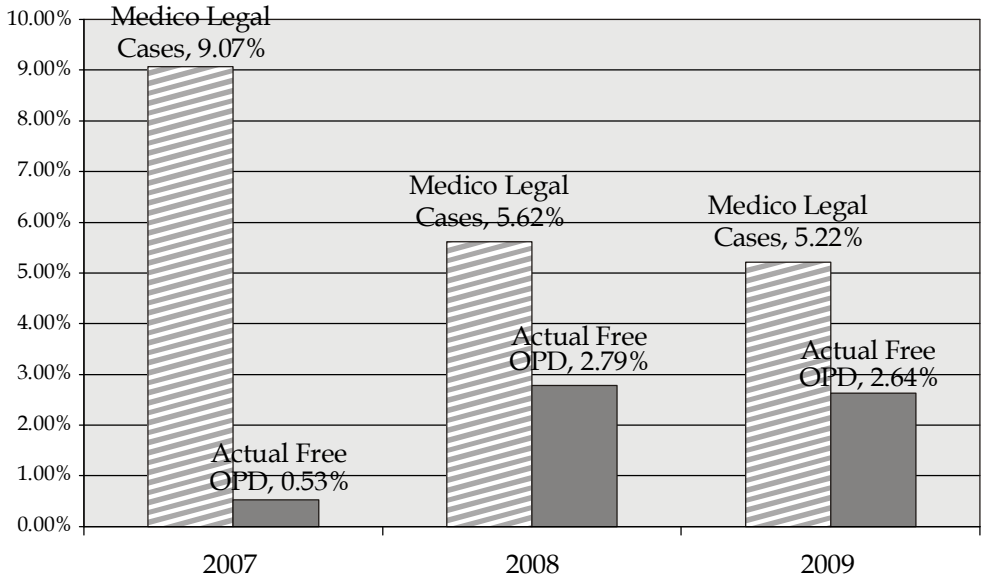
ECG Charges @ 20 for the month of October 2010			
Total	**Free patients (Municipal Employees and their dependents + Medico-Legal cases + Senior Citizens + School Children + unknown patients + The Poor)**	**Family Planning Cases**	**Patients Paying Fees**
660	72	38	550
100%	10.91%	5.76%	83.33%
X-Ray Charges @ 30 for a week (1-7 October 2010)			
937	95	6	836
100%	10.14%	0.64%	89.22%

Source: Data from Hospital Records

Since the hospital does not compile user fees data, our researchers had to sit with the Registration Assistants and copy the data from their registers. For practical reasons, only a month's/week's data was collected and analysed for ECG and X-ray respectively, to arrive at some indicative results. The column, 'Free Patients' in the table is a residual category which also includes poor and needy patients whose fees have been waived. Here, many categories like local government employees and dependants, medico-legal cases, senior citizens, school children, unknown patients and the poor are lumped together. Some of these categories are disproportionately larger than others, as we have seen with ECG. We will look at this issue in the next diagram. Although we do not speculate their percentages, it is quite obvious that the number of poor patients who are able to access this system of waivers is abysmally low.

The next table will look at data from the OPD register to see the kind of patients who avail themselves of fee waivers.

Percentage of Free OPD Patients



Source: Data from Hospital records

It is clear that a huge proportion of the 'free' category is in fact, medico-legal cases like accidents or other emergencies, and this has been corroborated by staff interviews. In the course of our fieldwork, we also met PF, who was a rag picker who had come to ask for an exemption for a roadside patient. The patient had no relatives and lived on the footpath. The patient had been shifted to the Medical Ward and was granted full exemption during the stay. Unfortunately, data on OPD is the only data about free patients that is available in a compiled format with the hospital administration. The hospital does not seem to collect or compile data on various types of waivers in a centralised manner, nor does it seem to require such data for annual auditing.

Many of the categories discuss blanket waivers for groups. The following section looks at poverty-specific waivers to the extent possible with the available data. With respect to major and minor surgeries, the data available with the CDO on free waivers for the poor, for the year 2008 is examined. It was seen that of the total surgeries conducted in the year 2008, only less than 1.5 % patients received free surgeries because they were poor. The figures are given in the table below.

Free surgeries in 2008			
	Total	**Free**	**% of free surgeries in 2008**
Major	3487	50	1.43%
Minor	2556	35	1.37%

Source: Data from Hospital records

Here the data available with the CDO at the hospital is looked at, as it may give a better estimate of the poor among the free patients. This is because the poor whose fees are waived are supposed to approach the CDO first and get his/her approval. The CDO's signature is required for poverty related waivers. It has to be noted that the data with the CDO covers largely the poor, but also old people and dependants of employees of the local government body. However, that issue becomes irrelevant here because the proportion of 'free patients' as a whole is appallingly low. Even though the CDO/ social workers have this data, it is not collected in a systematic manner and no reports are prepared.

Coming to other paid services, as the next table suggests, because of lack of collected/compiled data at the facility level, we do not have separate numbers for each service category. But the table is still indicative of the very low number of people being able to access free care, for each category of service. In almost a year between January and October 2010, when the IPD and OPD attendance were much more than 10056 and 152833 respectively, we can clearly see the extremely low number of patients under each category who could access free care. IPD and OPD figures are for January-June 2010 while free patients numbers are for January- October 2010 because of lack of data on OPD/IPD till October and also because, month-wise number of free patients is not available with the CDO. This means that 0.22% of poor patients are in fact, an overestimate.

The number of Free Patients Jan-Oct 2010						
Sevices	**Rate (Rs)**	**IPD Attendance (Jan-June 2010)**	**OPD Attendance (Jan-June 2010)**	**IPD + OPD (Jan-Jun 2010)**	**Free Patients (Jan- Oct 2010)**	**Percentage of free patients in (OPD Jan-Jun 2010) ***
Medical ICU	@200	NA	NA	NA	89	NA
Surgical ICU	@200	NA	NA	NA	100	NA
X-Ray	@30	NA	NA	NA	39	NA
Colour Doppler	@500	NA	NA	NA	8	NA
USG Abdomen	@100	NA	NA	NA	38	NA
Major Surgeries	@500	NA	NA	NA	45	NA
Minor Surgeries	@200	NA	NA	NA	12	NA
Total		**10056**	**152833**	**162889**	**331**	**0.22%**

Source: Data from Hospital Records

3.9 Poor Box Charity Fund as a Charity-based, Equity enhancing Mechanism

As mentioned earlier, PBCF is a fund which is used to reimburse poor patient's charges. Poor Box Charity Fund Committees were constituted in the hospitals run by the local government body in 1926 with the approval of the Standing Committee by Resolution No.6736 of 29.9.1926. The primary function of this committee was to provide medicines and surgical appliances unavailable for free in the hospital to the poor and needy patients (Hospital Manual 2005). A diagram plotting the process of patients trying to access PBCF reimbursement, prepared based on information collected during various interviews with clinical and administrative staff, as well as the patients, is given below.

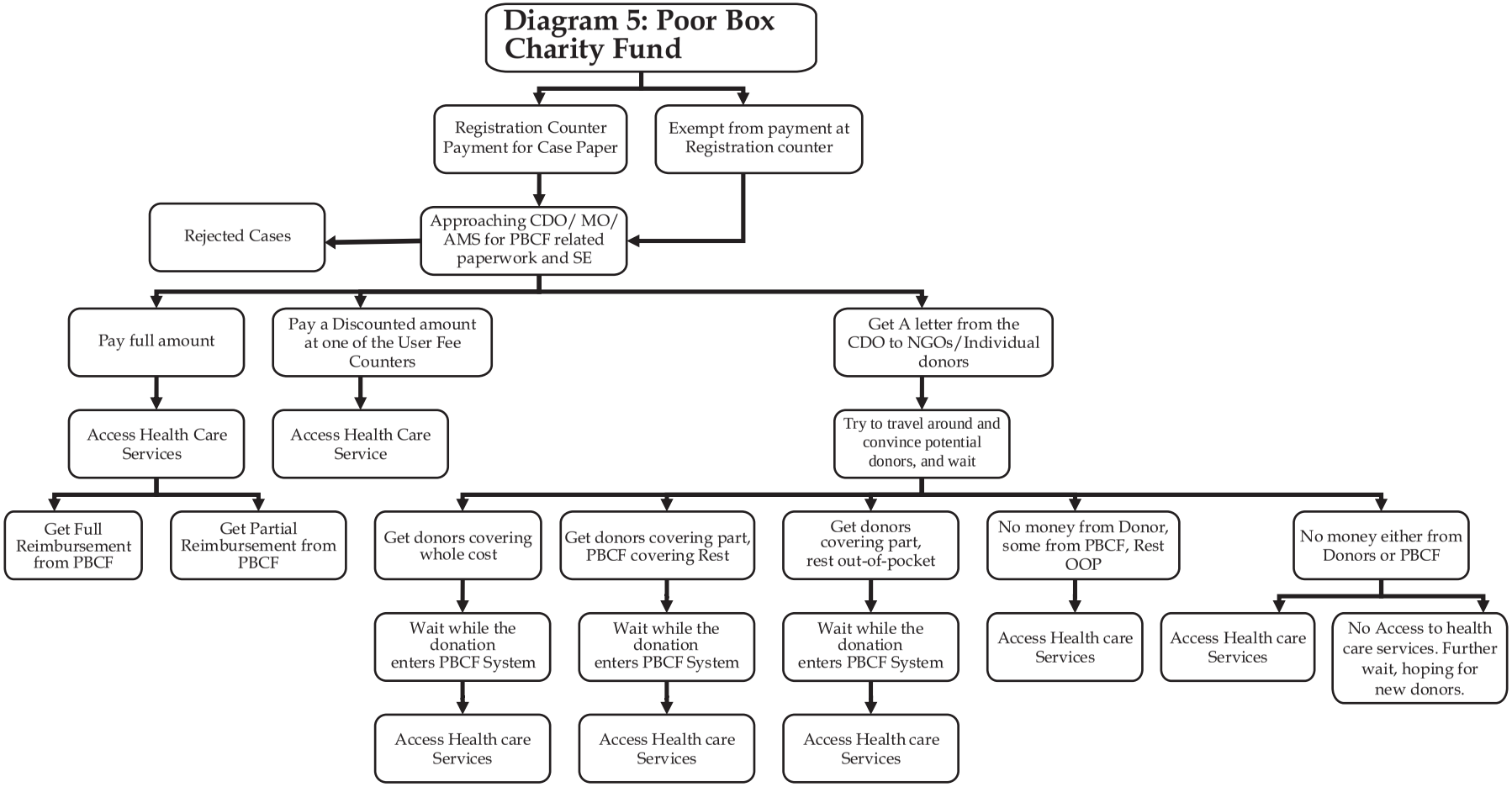


Diagram 5: Poor Box Charity Fund
Registration Counter Payment for Case Paper
Exempt from payment at Registration counter
Approaching CDO/ MO/ AMS for PBCF related paperwork and SE
Rejected Cases
Pay full amount
Pay a Discounted amount at one of the User Fee Counters
Get A letter from the CDO to NGOs/Individual donors
Access Health Care Services
Access Health Care Service
Try to travel around and convince potential donors, and wait
Get Full Reimbursement from PBCF
Get Partial Reimbursement from PBCF
Get donors covering whole cost
Get donors covering part, PBCF covering Rest
Get donors covering part, rest out-of-pocket
No money from Donor, some from PBCF, Rest OOP
No money either from Donors or PBCF
Wait while the donation enters PBCF System
Wait while the donation enters PBCF System
Wait while the donation enters PBCF System
Access Health care Services
Access Health care Services
Access Health care Services
Access Health care Services
Access Health care Services
No Access to health care services. Further wait, hoping for new donors.

The study found that the scope of PBCF as an equity enhancing mechanism is rather limited. It often happens that the poor patients are required to chase the CDO as he is not available in his room. PBCF is primarily funded by money from donations from individuals and private and charitable trusts. Some money collected from the patients as blood bank and morgue charges go into PBCF. Along with this, interest income from a Fixed Deposit instituted by the local government body in 2004, flows into PBCF. As revealed by the interviews with many of the hospital staff, while either allowing for waivers or granting PBCF reimbursements, there is an insistence bordering on obsession to prevent inclusion errors. The glaring exclusion errors are not given the priority they merit.

The patient load per day in this hospital is indicative of the vast number of people choosing services provided by this hospital. Given the fact that almost all of these patients come from slums or are homeless, it becomes essential to look at the proportion of those getting referred to PBCF for financial assistance. As reported by the doctors in interviews, only 10%-20% of the total patients are referred for financial assistance through PBCF, and much less reimbursed as many cases are rejected. The break up according to the information collected in the interviews is as follows- General medicine- 8-10 referrals /week, General suregery-2-3 per day and Orthopedics- 2-3 /day.

The link between user fees collected and Poor Box Charity Fund needs to be explored briefly. Some money collected from the patients as blood bank and morgue charges, indeed goes into PBCF, but as our study found out, this is just around 2% of total collections, as evident from the following table.

The amount of user fee collected that goes into PBCF

	Blood Services Charges	**Morgue Charges**	**PBCF Contribution Total**	**Total User Fee Collection**	**PBCF Contribution as proportion of total collection**
2007	58125	57400	115525	4513000	2.56%
2008	47150	59875	107025	5600000	1.91%
2009 (RE)	38525	98900	137425	6890000	1.99%

Source: Data from Hospital Records

The table shows the quantum to which available money with PBCF is spent to help the poor. It is clear from the table that only a very low percentage of the money available (11.14%, 34.39%, 14.42%) is used to reimburse the expenditure incurred by the poor and the needy. The sudden jump in 2008 from 11.14% to 34.39% is not because of an increased utilisation of funds, but because of a fall in interest income. The reasons for this fall remain unclear.

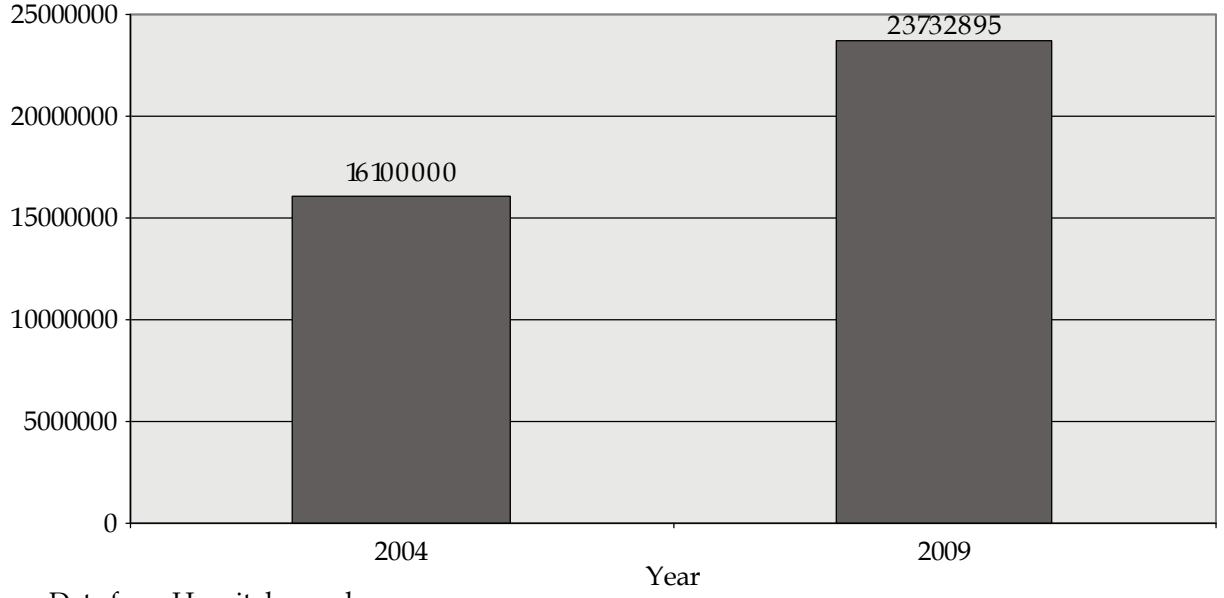
Poor Box Charity Fund payments Vs Available Funds								
Poor Box Charity Fund Receipts (Rs)							Payment to Poor Patients as Reimbursement	Reimbursement as percentage of total PBCF
YEAR	Blood Services Charges	Morgues Charges	Cash Donation	Total Receipts	Interest Income	Total PBCF = Receipts + Interest Income		
2007	58125	57400	43745	154420	1454661	1609081	179305	11.14%
2008	47150	59875	22361	137589	376591	514180	176849	34.39%
2009	38525	98900	46000	184850	1776419	1961269	282877	14.42%

Source: Data from Hospital records

It must be noted here that PBCF funds have not been free from misuse, largely because of lack of transparency and monitoring mechanisms. A Commission enquiry last year confirmed 'procedural irregularities' in the way PBCF funds amounting to crores of rupees were used in another hospital run by the local government body (Express News Service 2008). More cases of misuse of funds came up this year, and a Medical Superintendent was even suspended from another public hospital. (Mumbai Mirror Bureau 2011). Lack of clear guidelines has resulted in the lack of transparency.

It would be apt to look at the bank account that keeps the seed money from the local government body, the interest income from which is to be used to run the PBCF. As the following graph shows, over the five years between 2004 and 2009, the amount in the account -in which the local government body had invested seed money of Rs. 1.61 Crores the interest of which was to be one of the main sources that finance PBCF-, has actually grown from Rs. 1.61 crores to Rs. 2.37 crores. This growth is solely because of accumulated interest earnings, primarily a result of money being unused to reimburse needy patients.

Accumulation of interest in the Seed Money account



Source: Data from Hospital records

3.10 Caps on PBCF Payments, Partial Reimbursements, Referrals to NGOs and Delays

The most prioritized services to be chosen for PBCF, as reported in the interviews are CT scan and MRIs, which were within the range of Rs.2500/-. Such information questions the openness of the system for providing help to all kinds of ailments in all ranges.

> *"CT scan help is often needed. The bill is submitted. Sometimes partial amount is also given. If the bill is of Rs. 2000/-, sometimes Rs. 1000/- is given from PBCF" (Registrar).*

None of the clinicians or the CDOs directly accepted the existence of any caps on the PBCF reimbursements, maintaining that needy patients receive the entire amount. However, from the information sought from the registrar and the MS it became clear that the maximum amount which is sanctioned in practice is Rs. 5000/-.

> *"The PBC provide help for around Rs. 1000- Rs. 2000, maximum Rs. 5000".*

For approval of funds from the PBCF, no clear guidelines exist. Largely, the same steps taken to determine eligible patients for waivers are followed in the socioeconomic assessment done by the CDO. It was seen that not just poor but even retired local government employees come seeking help from PBCF. Along with the BPL criterion, the following conditions are often used to determine eligibility for PBCF reimbursements:

- ✓ When the bread winner of the family falls sick the family suffers, earning stops and there is additional burden of medication. Such patients are given preference.

- ✓ Patient in high-risk jobs such as unskilled labour and contractual workers are given preference.

All these criteria do not guarantee that PBCF is a mechanism that many patients find helpful in times of dire need. Patient VK's example shows the uncertainty and delays that are inherent in the system.

VK is a 55 year old male who works as a night watchman at a marriage hall. He supports a large family and finds his income inadequate. He has been working on an evening shift (12-8 am) the entire week and so, he has been visiting the hospital every day. He was unaccompanied. A lump could be seen on the right side of his neck. The doctor had not diagnosed it, but he doubts that it may be cancerous. He comes to the hospital regularly whenever he is unwell, so a familiarity with the hospital was clearly seen while he went from one department to another. The doctor had asked him to get a CT scan done from a private hospital. He spoke to the doctor at the private hospital, who informed him that the cost for the CT scan was Rs. 2400/-.

VK told the doctor that he could only pay Rs. 1000/- and that he would arrange for the money after the test. But the doctor did not agree. He had come on the day of the field visit to meet the doctor in the public hospital and get some concessions. The doctor wrote on his case paper about his lack of funds and sent him to the CDO. There were two more patients waiting for the CDO outside his office. When VK finally met the CDO, he refused to give him money for the CT scan and asked him to arrange for it. VK went back to the ENT OPD and spoke to the doctor. She told him that she could not do anything and that he would have to arrange for the money and wait until then. VK did not know what to do next and was thinking of borrowing money from someone for the CT scan, as he shared his problems with the researchers at the CDO's office.

There are also cases where the money being offered out of PBCF is so inadequate vis-à-vis the income situation of the patient that delivery of care is infinitely delayed. This is also because most of the health care services with a higher cost are delivered only on the payment of the whole fees.

DG was a 55 year old man from Allahabad. He used to work as a porter earlier but is unemployed now and stays at home in his village. He had a rod placed in the upper part of his leg 45 years ago. He was having a problem while walking and came to Mumbai for a check up. He had come ten days before the day we met him. He had registered after paying. Despite the fact that case papers are valid for 15 days, he was asked to pay again.

> The old implant in his hip is damaged causing terrible pain and he now needs new implants before the onset of an infection. Last time he had opted for an inexpensive implant. Understandably, he hopes to have the better quality implant this time; however his income earning capacity is severely compromised. The CDO has informed him that he can only reimburse a maximum of Rs.5000/- which is not even one-fourth of the total charges. DG has inadequate funds and he hopes that the CDO will eventually change his mind.

Partial reimbursements are the norm, and complete expenditure is reimbursed very sparingly. It was observed that lower amounts had a higher chance of getting reimbursed fully, and this information was verified in the staff interviews also.

> D was a 33 year old woman who suffered from epilepsy and was in the ICU for five days. Her brother sought help at the CDO's office because of financial problems. She was sent to the nearby private Hospital for an MRI costing Rs. 6000/- where she was given a concession of Rs. 3500/- and they were asked to pay only Rs. 2500/-. She was also administered an injection worth Rs. 1500/-. At the hospital, the CDO sanctioned Rs. 850/- from the PBCF. The family has incurred expenditure of Rs. 600/- for ICU, Rs. 30/- for X-ray, Rs. 100/- for USG and Rs. 830/- at a chemist.

Various case studies and field observations point to the fact that there are no clear guidelines to decide the 'eligibility' of a patient for the PBCF funds and the responsibility lies entirely with the CDO. The CDO was found to be the authority with regard to the PBCF funds, where 'who and what amount' should be sanctioned depended entirely on his wish. Even if socioeconomic criteria are considered for PBCF sanctions, the cases which get rejected would also fall in the poor patients' category. A lot of ambiguity and arbitrariness could be seen around the decision-making regarding partial concessions, full concession or no concessions. In fact, a few junior doctors mentioned their concern that since the CDO does not have any medical background, taking his/her decision as final would not be justified as he/she would not know about the patient's medical conditions.

When a service is unavailable in the hospital, many patients get a letter of introduction to private hospitals where they get their procedure done at a rate lower than the market rate. Of the remaining expenditure, a proportion is reimbursed. It is not often that the entire money is reimbursed. As noted already, for amounts higher than a couple of thousands, a full reimbursement is very rare. At the same time, it must be noted that the Resolutions do not put any upper limit on the amount that can be reimbursed out of PBCF. The study found that there was no such upper limit in the policy documents, there was some arbitrary upper limit in granting these funds. When asked about how much money can be signed through the PBCF, the CDO answered that it is '60% of the total amount'. This is indicative of a cap put on the amount by the hospital. This also raises questions about the equity enhancing effect of the PBCF.

Patients' Struggle

Usually patients who are denied waivers or who have got a meagre or no PBCF help end up borrowing money from other sources or wait until they gather the required amount. However, the study also came across certain patients who took great efforts to get access to PBCF concessions and seek treatment from the hospital. It also brought out certain issues of power hierarchy between the CDO, the patient, and the junior doctor, which ultimately affect the access. Instead of the system being patient-friendly, it is the patients or the relatives who have to work out different strategies to arrange for their own treatment. The following case studies give a detailed account of such strategies.

Getting Help from Multiple Sources

Patient X suffers from spinal tuberculosis. In course of time he became bed ridden, could not move his lower body, suffered immense pain and had trouble urinating. After being detected with Spinal TB at a private hospital, he was admitted to this public hospital. He was asked to go to a nearby private hospital for the MRI worth Rs.6000/-. Before going there, the doctors gave him a letter addressed to Dr. P of the private hospital. With a family income of a mere Rs. 2000/- Rs. 3000/-, his relatives were not able to gather enough amount for the test and the MRI could not be performed, causing much delay. The patient's brother then approached the doctors at the hospital who requested the MRI staff at a private hospital to waive half the amount for the MRI after which it was conducted, although they had to wait because they were given low priority. The patient was operated upon later and was discharged after a week. Of the total amount spent, despite the delays, only a part could be raised from various trusts and individuals and the rest had to be borrowed. They are on the lookout for new donors for their recurring expenditure on drugs, and keep coming to the CDO for help.

From the above case, it becomes clear the patient was bed ridden, and that his relatives had to approach many sources for availing monetary help and though the operation was performed, post operative care requires additional expenditure, which is a burden on the family. Also, there was a long, much avoidable delay in treatment.

Case of a Patient with a Letter from an MLA -CDO rejects but MS signs

AS was a 76 year old woman who suffered from a fracture and required an orthopaedic surgery that cost Rs. 20,000/-. It was ten days since she had been admitted. In those ten days, her family had spent Rs.1000/- on medicines from outside the hospital and Rs. 200/- on ambulance charges. AS had to undergo 2D Echo test worth Rs. 900 in a nearby private nursing home and also, another Rs.500/- as consultation fee at another public Hospital. Her grandson had accompanied her to the CDO to get his signature on a letter stating that the surgery was required; the cost of the surgery, and this letter was drafted by the doctor in charge. He required this letter as a proof to his area MLA who was willing to give him the money on the condition that the money would be used for the surgery only. The letter was written by him and it was evident that he was willing to make his own arrangements for funds and had no intentions of asking the CDO for funds. When he met the CDO he conveyed the same, however the CDO was unwilling to sign. The CDO was unhappy with the fact that the person had written the letter directly without consulting him first. He also said that he could give him a maximum of Rs.1000/- instead for the surgery, but not the letter. They were arguing for a long time but the CDO did not agree to sign. The doctor in charge of the patient also came in and tried to convince the CDO, but he did not relent. AS's grandson then went to the MS. When we came across him later in the day he told us that the MS had signed the letter and called the CDO to his office and made him sign the letter too.

Such unnecessary disagreements and friction between the staff that result in undue delays in treatment are not rare, as the researchers learnt from various interviews. In fact, the relation between the provider and the social worker is critical as the CDO is involved in making decisions about the waivers and exemptions through PBCF. The data shows that during this process, there is some interaction between the two which might affect the important decision to be taken for the needy patient. There is a conflict seen between the doctors and the CDO where the doctors feel that the CDO needs to be given much more respect in order to get the work done.

> *"We have to call the CDO. Although his post is lower than a doctor's, my residents call him 'sir'. My juniors have to massage his ego" (Lecturer).*

> *"The CDO could take the socio-economic background, but the final decision should be of the doctor."*

Few other lecturers and Medical officers also express the importance of the CDO in the hospital throughout the day and during emergencies when the patient is in need of monetary help. They also added that the process of decision making regarding PBCF should be decentralized and should not remain entirely in the CDO's domain. All this means that such friction, which may be the result of multiple factors, exists in the hospital and causes avoidable delay in treatment.

Availing Help from NGOs

As reported by most of the clinicians, when the amount is large (particularly if it is more than Rs. 5000/-) there is the practice of assisting the patients to avail charity from NGOs and trusts that are willing to help needy patients. Those patients who require bigger amounts have to wait for as long as two-three months or even six months. These are mostly for orthopaedic procedures that require implants.

The long waiting period is justified by the orthopaedic doctors as according to them, these cases only need 'non emergency procedure'. Here too, the logic behind deciding which procedures come under the category of emergency and which are not were mostly arbitrary. Such cases are usually referred to the NGOs and trusts for help by the CDO. The CDO has a list of the NGOs which the patient or the relatives has to personally contact along with the hospital documents and the reference letter from the treating doctor. Here the patient or the relatives have to run around, contact various trusts and do the follow up with the NGOs. The process involves lot of running around and often becomes too cumbersome for the patients and their families to handle.

Staff Comments about Cases requiring an Implants

"If the patient says that they can afford an implant worth Rs.10,000/-, we provide them with an implant suitable to their budget. But if a Rs. 60,000/- implant is absolutely needed, and the patient has only Rs. 10,000 then we write a reference letter requesting financial aid".

"We wait for one or two weeks and see whether the patient is able to mobilize any funds. He/she usually approaches NGOs or charity organisations for help. We wait for the NGO to give us the green signal to carry on with the operation. If we get a green signal, we continue with the procedure."

The essential point here is that the implants are not provided by the hospital except in emergencies and the patients need to buy it straight from the company. Those patients who cannot afford to pay for the implants are referred to the CDO who will then provide the patient with a list of charitable organisations and the entire process is followed as usual. The lecturer added that frequency of such surgeries would be two to three in a month. It was observed by some staff in interviews that if the money needed was

substantial, then the delays would amount to many months. The delays are not only of the treatment but also of the reimbursement which can be burdensome for patients who are wage workers or whose income is not regular. Many trips are made for signatures, since sanctioning of the amount means sanctioning and verification of details at various levels. All this contributes to delays in accessing care.

"*If the amount is above Rs.1 lakh it takes 4-5 months or more*".

As a lecturer noted, it is up to the patient if he/she wishes to pay or go to the social worker. According to the doctor, "*If you pay then the things will be done faster. In the case of a social worker one has to wait till funds are arranged*".

How Patients raise Money for Treatment

Details of the fund raising process were narrated by the registrar, who spoke of how the money is raised from trusts/ NGOs and given to the hospital. The process through which such charity contributions are used through the PBCF account is illustrated below. A common, yet less transparent way of transfer of funds is when the NGO or individuals pay the required amount directly to the implant company. In both cases, guarantee from the organisation or individual that makes the payment is required for the delivery of the implant, and the conduct of the surgery.

Process of Fund Raising by Patients
1. The Donors put the money in the PBCF account and notify the hospital authorities. 2. The patient undergoes the required procedure. 3. The patient receives the bill which he takes it to the CDO along with the letter to the NGO/ Trust. 4. The CDO sanctions the application fills the form and forwards it to MS which is sent to the CMS. 5. The CMS has the final authority to sanction and sign it. 6. A DD/cheque will be made in favour of the implant company in case of an orthopaedic surgery or it is deposited in the hospital account. 7. The cheque comes to the CDO who then hands it over to the company. The entire responsibility to do the follow up lies with the CDO.

3.11 Additional Costs to Patients in the Public Hospital

In public sector hospitals, 'free care for the poor' does not translate into free access -because of shortage of medicines, travel costs, and loss of wages. It is well established that expenditure on medicines accounts for 50% to 80% of the total cost of treatment in India (Srinivasan, S. 2011). The clinical staff who were interviewed from the hospital under study are aware of this expenditure that is incurred due to the shortages in the hospital. An honorary opined, 'We are short of all kinds of stuff. What is available is not needed... Drugs shortage is another administrative problem that we face'. Although such spending is acknowledged, many among the staff seem to be unaware about its scale, and this also contributes to their common perception that user fees in general are very low and affordable for patients. A lecturer who talked to the researchers was of the opinion that "*Almost every patient requires a prescription (to be bought from outside). It is basic and not a large amount*".

Outside referrals were common amongst most of the patients. What emerged from the staff interviews was that sometimes even a cap mask is prescribed from outside strongly reflecting the non availability of all these materials in the hospital. In addition to the persistent drug shortage, some patients complained that the medicines and injections procured from outside have hardly been used. These unused materials are not returned. Such an experience is narrated below.

Patient bearing the cost of the plaster

AJ met with a minor scooter accident and came to the hospital on the following day. He took a case paper (Rs.10/-), and got 2 X-rays done (Rs.60/-). He had suffered a fractured leg which was put in a cast for three weeks. The total cost incurred for the treatment including medication was more than Rs. 1400/- of which a major portion was spent on the plaster material.

Besides shortage of essential material and drugs, pushing up expenses for ordinary patients, overcharging and delays in delivering even available services have been observed during the study. The following case explains how an old patient was charged double the amount for a diagnostic test.

Case of Overcharging

MN, a 66 year old woman had come to meet the skin specialist who asked her to get a Colour Doppler test done. The day she was to undergo the test she promptly reached the hospital early in the morning but had to wait until afternoon for her test to be conducted, only to be told in the afternoon that she had to return later. The reason cited was that there were too many sonography emergencies that day. On the next day, the patient was asked to pay Rs. 1000/- for the test at the senior citizen counter and since she was eager to get it done soon, she had to comply.

Non availability of diagnostic facilities such as CT scan, MRI or the hormone tests results in a situation where sending patients to other facilities becomes inevitable. As a houseman admitted that when a service is unavailable, "the patient has to be sent elsewhere". It is but normal to assume that when there are other hospitals under the same local government body where such facilities are available, the patients will naturally be referred to those facilities. However, it was observed in our study that services are being outsourced to private facilities. While a CT scan at the teaching hospital costs Rs.2600/-, it was seen that patients are being sent to private diagnostic facilities where it is charged Rs. 4000/- presumably because of 'convenience for the patients' in terms of distance. Looking at the cost difference between public and private facilities and the patients' affordability, it is very clear that the patients had to bear unnecessary expenses by going to a private facility, especially when the service was available at another public hospital.

Communication about User Charges

From the queries being made at the CDO's office, it was clear to the researchers that many patients from the marginalised sections had no information that certain services in the hospital are paid for. This inevitably resulted in delayed care as evident from the following instances. Shockingly, it is often the administrative staff in charge of collecting the user fees, who take a call on whether to send the patient back home, thereby delaying treatment. It was observed that even without any information on the urgency of the need; they decide to send back the patients who may not have the money, even without consulting the doctors about the severity of the ailment.

Patient not Informed about Operation Charges

The patient was a middle aged male accompanied by his wife. He had sustained a hand injury a week prior to coming to the hospital and had not been to any doctor. He came to this hospital because his index finger was swollen. They first took the case paper and also got an X-ray done which was Rs. 30/-. Then the doctor told them that an operation would be needed and referred them to the cash section to pay the cash for a minor operation. The patient was unaware of the charges and did not have enough money to pay. The cash counter clerk asked them to come the following day with the money. The patient had no idea that there would be additional charges for the operation.

Patient not Informed about ECG charges
LG was 60 years old woman from UP suffering from a prolapsed uterus. She had come from UP to stay with relatives in Mumbai. She was undergoing treatment at the gynaecology department. A blood test was done, which was free of charge. The doctor had also told her to get an ECG done. She was not aware that she had to pay Rs. 20/- and she did not have the money. When her turn came, the lab technician asked her to go back and return after she had paid the charges.

These cases clearly show a lack of patient-provider communication, especially communication at the first point of contact resulting in delayed treatment. Though a rate list is displayed at the case paper registration counter, patients are not informed about additional user charges, and moreover they are not given an idea about the high cost while being referred to a private diagnostic facility. Such delays not only add to the physical discomfiture and suffering of the patient, but increase the economic burden.

The doctors as well as the social workers seemed to take it for granted that most of the patients coming to public hospitals are aware of the special concessions reserved for poor patients and so do not brief them. This apathy adds to the patients' woes.

3.12 Perceptions of the Staff regarding User Fees and PBCF

Information was obtained from the clinical staff and administrative staff about the services which are charged by the hospital. These services range from Out Patient Department and Diagnostics to Intensive Care Unit (ICU) and Operations. It was observed that most of the clinical staff, barring the honoraries, seemed aware about the free services. Honoraries were less aware of user fee related issues because of their special status; they are senior doctors, not under direct employment and are not involved much in the day-to-day activities in the hospital. All the other doctors were working in the hospital for about two years and more. Though there was confusion amongst the doctors about charges for certain services, whether they were applicable or not for senior citizens, or Below the Poverty Line patients (BPL), the Community Development Officer (CDO) and the Registration Assistants (RAs) at the collection counters were clear about the applicability of these charges since it was a part of their daily work. These charges were broadly categorized as minor and major charges. Minor charges include OPD, X-ray, ECG and USG charges; the rest come under major charges.

It was a mixed set of opinions when the staff expressed their views about user fees, which were mostly formed on basis of the staff's experience in the public hospital, also depending on their seniority. While some of the staff was very rigid in their views about the user charges or availability of medicines, there were a few doctors who tried to understand the patient's point of view and acknowledged problems existing within the system.

Defending User Charges

> "*I don't think there is anyone in Mumbai without Rs. 10/-.*" *(Houseman)*

> "*Minimal charges should be there because then the patient values the services offered.*" *(Medical Officer)*

Most of the doctors had a firm opinion about user charges and some of them strongly defended it by comparing it favourably with the charges at private hospitals. A common thread of their argument was that in a metropolitan city like Mumbai, not having such small sums to spend on medical care was not possible. Few went to the extent of suggesting introduction of charges on services that are not

charged at present. This can be related to their perception that user fees add to the revenue. Some of the junior doctors felt that it is through user fees that they get their salaries.

The clinical staff and social workers were not empathetic towards the patients and they refused to accept the fact that they could not afford health care. This is the main reason why only a microscopic minority of the poor are able to access waivers, exemptions and also PBCF reimbursements as seen in the analysis of quantitative data. The staff's perception of the poor is undoubtedly reflected in their sanctioning of funds from the PBCF and also in allowing waivers.

Patients taking Advantage of the System

It was a common thread in interviews with many doctors that the patients take undue advantage of the system. It follows that any policy that prevents this exploitation of the system by the patients is acceptable. In many cases, these attitudes often sustained through the anecdotes that are shared among the fraternity get translated into an unconditional and unquestioned acceptance of user fees. It was also observed that most of the hospital staff had internalised the logic behind the implementation of user fees and considered it something inevitable. It was in line with the arguments presented in various resolutions and other official documents of the local government body. It is interesting to note that most of the same doctors had inadequate information regarding proper guidelines and procedure to be followed regarding exemptions and waivers to the poor.[11]

Many of the staff seemed to think that patients are in fact trying to take undue advantage of the system. Even though majority of the doctors reported that the patients belonged to weaker sections of society, their reflections when it came to user fees affordability, showed a very different view. A doctor observed,

> "*Sometimes when we take surprise rounds and find the CDO interviewing some patient, who is complaining that he cannot afford to pay, but are wearing good clothes and gold ornaments then we know that he is faking it*".

An honorary doctor complained,

> "*My mobile is an ordinary one but they have costlier mobiles than what I use. But they take treatment for free. They have 4-5 ration cards, one to show the hospital, one to show the passport office.*"

Yet another doctor complained that the patients would not leave, when the care is free:

> "*Since there are no bed charges the patients get admitted and do not want to leave.*"

Some senior doctors had a very pessimistic attitude while they were talking about patients' affordability and the charges at the hospital. They considered that the patients were taking advantage of the system, either by staying in the hospital for free or availing themselves of free food etc. It also reflected their attitude, that 'patients do not deserve these free services'.

User Fees do not affect Access - Perceptions

Studies have shown that the patient's access gets affected due to deficiencies in the implementation of the user fees mechanism. The present study also tried to find out what the clinicians think about user charges and what kind of problems are faced by patients while accessing care from the public hospital.

[11] This is irrespective of the fact that many a times, guidelines themselves were vague.

It was observed that part of the frustration of clinicians could stem from the fact that there is a shortage of staff, medicine and material, and also, delays in the dispensation of their salaries. The following rationalisations were offered for user charges:

> *"I don't think the charges have any impact on the increase or decrease in the patient load." (AMO)*
> *"They know that they will not get a better deal in a private hospital." (Lecturer)*

But unfortunately, a high proportion of the staff is unaware that the patient load may not be showing a falling trend because of the high costs in the private sector. As observed in various other studies, the patient load increases slowly after the initial dip in demand that follows the introduction/hike of user fees and this is a normal phenomenon. It just shows that despite the additional financial burden that the fees entail, patients return to the hospital since public sector care is the only care that is within their reach. This would invariably be at the cost of some other essential consumption of the household. The issue becomes all the more important because the exemption/waiver systems that are in place in the hospital are a failure.

Some doctors felt that the charges could not hamper the patients' access to care in any way. At the same time, indirect effects such as increased delay in treatment resulting in the worsening condition of the patient are acknowledged in interviews. Also as pointed out by some of the staff, the patients have no choice but to come to the public hospital, and to get treatment, they have to persist with the system.

Many doctors seemed to think that while small fees may not be avoidable, a lot of time is spent in long-drawn processes that could be avoided. The interesting fact was that the doctors in this government hospital had almost uncritically accepted their role as 'resource mobilisers' for the local government body, that none of the interviewed doctors said anything to the effect that their varied roles in the user fees mechanism and the ensuing delays are affecting provision of care in any way. Perhaps, what more than two decades of health sector reform has done to our public health delivery system is that it normalised marketing of health care, even in very low income settings.

Staff Perceptions about Patients' access to Waivers/Exemptions and PBCF

Providing Information about Existing Waivers

Owing to the preconceived notion that the 'patients are smart' and would know about the free services in the hospital, the doctors as well as the CDOs do not find it essential to inform the patients about the waivers available. Evidence from patient interviews and field visits indicates an urgent need to take necessary steps to rectify this.

> SK who was a 65+ male suffering from fits was admitted to the hospital for a week and he had to pay thrice for the case papers, one for each visit. He was not informed by anyone about the concession available.

> AS was a 76 year old woman who suffered from a fracture and was undergoing various diagnostic tests. She and her grandson, who accompanied her, seemed completely unaware about waivers for senior citizens.

The cases mentioned above also reflect the lacunae in the communication between the patients and the system, which would result in the patient's losing out on available concessions. We also came across two local government employees, one was retired and the other was working. Both knew about the concessions available to the government employees and took benefit of them, but apart from these

small sections of people who are aware, there are a lot more people who are unaware of these facilities. Communication need not be between a patient and a provider but also in the form of information displayed on the hospital premises, which was not seen anywhere during the course of the field work. Nowhere was there information about which services under the NHPs are charged and which are free. It is the same in case of unknown patients, MLC cases or emergency cases which does not have any mention either in the CRs or with the hospital in any form of a guideline.

Hence, our study found out that although various waivers and exemptions exist for the poor, there are no clear guidelines as to who can or how they can access the system. Selection is often arbitrary resulting in the objective of equity not being achieved.

We have found that Group Waivers are given the local government employees, retired staff and their dependants. Government school students get fee waivers. Medico-legal cases brought in by the police are not charged, but later the relatives who arrive are asked to pay. Unknown patients brought by others like beggars/pavement dwellers are not charged. Some partial waiver is given to senior citizens, provided they produce a senior citizen card. No guidelines exist that mandates waivers to BPL as a group. Interestingly, the CDO can ask the patient to produce a BPL card as part of the socioeconomic assessment, but, a BPL card is no guarantee for a full or partial waiver. Our interviews also revealed that the CDO is often approached by patients recommended by politicians.

PBCF Reimbursements

As in the case with waivers, most of the staff seems to share the view that there is no necessity for the hospital administration to publicize the availability of such a fund to the poor and needy. One CDO informed that the 'senior patients' who are in the hospital for long periods are completely aware of the system and the existence of PBCF. He even talked about a patient "who came from UP and directly asked about me!" They maintain that by means of 'word of mouth publicity' of this charity fund and the services provided by the hospital, even patients coming for the first time know about it. Also, newcomers may be informed by their relatives who take treatment regularly from the hospitals.

As mentioned earlier, CDOs have a perception that patients are 'smart enough' to know the availability of such funds. According to them, by choosing not to publicize this too much, the administration ensures that fewer and hopefully more deserving patients are able to take advantage of the system. The CDO's opinion is by no means typical; many of the doctors seemed to share the worry about 'habitual' patients. Even the registrar said that the patients had an idea about some concessions being given since it is a public hospital, but he added that most of them might not be aware of PBCF as a mechanism.

The field observations clearly showed that the patients who were accessing public health services for the first time were unaware about the availability of PBCF facilities and tended to waste precious time running around arranging for money, thus delaying treatment indefinitely. The bottom line is that in the absence of any mechanism to make patients aware about PBCF, a new patient, unaware of the system has to explore the system in his/her own way or wait till the doctor informs him/her. This inevitably leads to delayed care. It also results in deserving patients not getting concessions.

A clear lack of communication between the patient and the system leaves the patient confused as to why he/she has to approach another CDO for medicines reimbursements when one CDO is already present. There is no mechanism through which the patients are made aware about the different resource persons available at the hospital for different services. For instance, there are five CDOs -one is for blood bank, one is for medicines, one is for gynecology and other is for the orthopedic and general medicine department. One post is lying vacant.

Problems at Different Levels - Staff Perceptions

There were differences in the perceptions of the staff as a reflection of their seniority and roles in the hospital set up. The doctors higher in the hierarchy remained silent on the issue of availability of essential drugs as many of them were involved in the process of issuing requisitions. The senior doctors perceived that a Rs.10/- case paper is equivalent of getting all medicines free; housemen clarified that apart from antibiotics, most of the medicines had to be bought from outside.

The junior doctors acknowledged the non availability of certain drugs and other material for treatment. Housemen were the ones who worked throughout the day in the OPD or IPD, and they faced shortage of medicine and the additional burden of lack of human resources.

Doctors, including the honorary, mentioned that despite repeated requisitions, necessary material was not given to them on time. This chronic non-availability of drugs more than nullifies the minor relief that patients receive in terms of free beds and treatment, and adds to their financial burden.

> *"They pay me an honorarium of Rs. 1000/- per month. I pay Rs.4000/-Rs.5000/- on petrol to come here every month." (Honorary)*

While the housemen complained of being overburdened with patients and lack of doctors and support staff, the honoraries were not satisfied with low honorarium, absence of experienced anesthetists and lack of infrastructure. The experienced honorary doctors were also disappointed that their work was not appreciated.

The Other Side of the Coin

While there were some sharp comments about user fees from the providers, there were other instances when they expressed their helplessness about the system and also the different ways in which they try to help the patients.

> *"When I was a resident, I knew how to ensure that the patient's money is sanctioned. We used to fudge the papers for non affording patients, so that he/she could more financial help" (Lecturer).*

> *"If the patient needs Rs. 300/- worth of things, we write a prescription for Rs.500/-. The extra material worth Rs.200/- is used for poor patients" (Lecturer).*

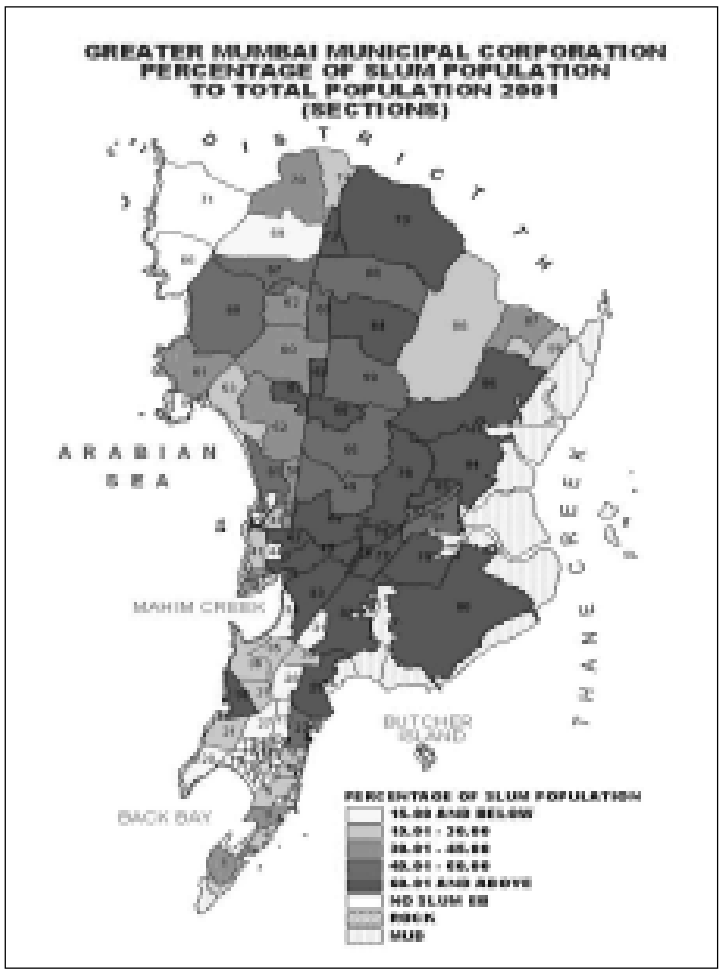
Some doctors also went out of their way to help needy patients either by providing extra medicines which they had stocked with them or by directing the patients to the CDO for financial assistance. They mentioned the different ways in which they could help the patient, though it did not fit in with the rules. One of the lecturers reported helping patients by mobilising funds through NGOs, while another doctor used his goodwill with the implant companies to help patients buying implants at lesser costs. A few others reported giving monetary help wherever they could.

> *"As a resident, I was working with the system, but now I am part of the system. I have to turn a blind eye for certain things."*

Some acknowledged their helplessness about delays in various processes, and were quite resigned to it. They also admitted that as they have become a part of the system, they have to accept it and this reflected their perceived ineffectiveness. While some doctors do try to help the poor patients by using whatever means they may have access to, such 'Robin Hood Practices' are not to be seen as part of any sustainable solution.

3.13 The Number of Poor who access the Hospital

The data clearly show that the proportion of poor patients who are able to get free treatment in this hospital is very low. This is not because there are less poor who visit the hospital, particularly since this hospital serves an area which has a substantial slum population as shown by the following diagram taken from the Mumbai Human Development Report 2009.



As per the above map, the hospital being studied caters to areas that have a slum population more that 60%. According to the hospital staff interviewed in the course of the study, the proportion of economically vulnerable population who visit the hospital is taken to be much more than 60%. Clinicians and the CDO maintain that majority of the patients who come to the hospital belong to a low economic class and one of the important reasons why they come to this hospital is that they are unable to afford health care at other facilities.

Nevertheless, it is well accepted that majority of patients who visit public hospitals run by the local government body in Mumbai are the poor from nearby slums who work in the unorganised sector. It was observed in the Mumbai Human Development Report 2009 that "A little over half of the users of public hospitals, in this case, the KEM, Parel, belonged to the unorganised sector and over two-thirds had a per capita income then of less than Rs. 500/- a month." The official survey conducted by the Municipal Corporation of Greater Mumbai, along with the Urban Development Department and the Directorate of Municipal Administration in Mumbai showed that "nearly 12 lakh families (around or over 50 lakh people) get by on less than Rs. 592 a month. That is, nearly 30 per cent of people in India's proud financial capital live below the poverty line - overwhelmingly without BPL cards or benefits". A

BPL census in Dharavi, one of the the biggest slums in the world and with a population of over a million, ended up with a list of 141 BPL cards (Dr NC Saxena Committee Report, 2009). This is corroborated by other available data; as the next table based on NFHS-3 data shows, the percentage of families among the slum population owning a BPL card is only 2.5%.

NFHS-3 : Percentage of Families owning a BP card in Mumbai

Source: NFHS 3

These factors- a) that there is a large number of poor who visit the hospital, b) that the number of poor who actually possess BPL cards is low, c) that BPL cards are used to identify poor who will access waivers and exemptions, and d) that the actual proportion of patients lucky enough to access waivers/exemptions is negligibly low- together mean that poor people in large numbers may not be able to access their right to free health care, or may be financially burdened while accessing health care, with adverse equity implications. It is quite apparent that most of the poor who visit the hospital are made to pay. This is because, according to the doctors themselves, most of the patients are "slum dwellers, road siders, destitute, orphans and beggars".

In conclusion, it would be instructive to present the research findings of a collaborative research project, Equity in Asia-Pacific Health Systems (EQUITAP) that spent three years assessing equity in the health systems of 16 Asian nations. The conclusions reached by this study regarding access of the poor to health services in Asia, which are given in the text box below, are revealing (Box 1):

BOX 1: Equity in Asia-Pacific Health Systems

- Protection of the poor is correlated most closely with health system design and not with national income levels. The countries that do well in most respects all share a common health system design.

- The countries where the poor are most effectively reached by services, are the countries where national policies stress universalism. Although universalism is often not in favour in development circles, because it is considered unfeasible in resource-constrained settings, the reality is that the only poor countries where the poor are effectively reached are those where policies do not explicitly target the poor, either through user fee exemptions or specially-targeted programmes.

- Most of the countries where the poor do worst, are ones which either continue to maintain significant user charges in government facilities or which tolerate a high incidence of informal fees in government facilities. Official user charges either deter the poor from seeking care, or sustain institutional cultures that legitimate the charging of unofficial fees by health service providers. It is a legitimate question given this experience, whether any pro-poor health strategy can be considered realistic as long as official policy continues to maintain user charges for health spending.

- The only low and middle-income countries in Asia which are successful in reaching and protecting the poor are ones that rely solely or predominantly on tax-funding and on public sector delivery. Although demand-side financing has recently become fashionable, there is no empirical evidence of any poor country in Asia being able to use such strategies to reach the poor at the national level. Such strategies almost certainly require a level of administrative capacity and funding, which does not exist in the poorest countries.

- The critical issue appears to be not how to means test and restrict access to the poor, but how to ensure that the poor really do have effective access to government services; if that can be achieved, then the rich will either use public services without reducing access of the poor, or voluntarily choose to use private services.

Extracts from (Rannan-Eliya and Swaminathan, (2005)

Chapter 4:

Conclusion and Recommendations

The discussion in the previous chapter reveals the adverse effect that user fees have on equity, forcing poor people to pay fees, delaying treatment and/or preventing poor people from accessing public facilities altogether. User fees as a mechanism for resource mobilisation is inadequate and it becomes a flawed policy prescription. In a situation of various infrastructural inadequacies, a policy that cuts access further cannot be equitable or ethical. It was observed that even those who accessed free care, through waivers or Poor Box Charity Fund reimbursements, had to face long delays and procedural difficulties. This was a complaint which emerged from both the staff and the patients.

A need for specific guidelines was mentioned by one of the clinicians. The CDO as well as a few physicians opined that the entire procedure of PBCF is very lengthy and expressed a need for a new mechanism to avoid delay in getting funds for the patients. They also suggested the provision of department wise PBC funds to speed up the process. A few doctors mentioned that the cap on the amount which the CDO can sanction should be increased.

Even as some manage to access free care despite procedural delays and a hostile administrative apparatus, their number, as seen in the quantitative analysis based on hospital data, remains woefully low. In a situation of widespread urban poverty, this points to poverty-ill-health spirals for a large number of people who are unfortunate enough to fall ill. A recent report by the Prime Minister's High-Level Expert Group set up by the Planning Commission on universalisation of healthcare, in the light of evidence such as those presented in the previous chapters, unambiguously stated that "User fees, even with exemptions to the poor, were not successful in raising resources and did not help in improving quality and access to healthcare" (Sidhantha 2011).

In this context, the Maharashtra government's recent decision to raise user fees in state owned hospitals substantially is deplorable (Isalkar 2011). Though the officials maintain that the raises are very "nominal", in many cases it has been raised substantially or even doubled. The rate of a case paper, which is Rs. 5/- at present has been increased to Rs 10. The rate of an MRI has been increased to Rs. 2500/- from Rs. 1600/-; blood tests to Rs. 25/- from Rs. 20/-; X-ray to Rs. 40/- from Rs. 20/-. This is being done by a state whose capital itself has 1.2 million people who earn less that Rs. 20/- per day (Bharucha 2009) .

Over the last twenty years, irrefutable evidence has emerged that user fees play a key role in preventing low income families from accessing health care. It is reasonable to assert that user fees are the most iniquitous and regressive form of health care financing, since they force the poor households to pay a higher proportion of income than the better-off ones. Hence, user fees remain the least desirable method of financing health care services, particularly in low income countries. Although there has been very little concrete and unequivocal action, over the last ten years, a consensus has emerged among global and national health policy makers with regard to user fees. (See Box 2)

Box 2

Policy Consensus on User Fees among Key Players

In its World Health Report 2000, the WHO agreed with this conclusion: "Out of pocket payments are usually the most regressive way to pay for health, and the way that most exposes people to catastrophic financial risks."

The World Health Report 2005 acknowledged that user fees are not the most effective way of pursuing universal coverage and the health-related MDGs, while also pulling over 100m families into poverty each year. The report was accompanied by policy briefings, one of which explores financial protection and the need to move away from user fees towards more prepayment mechanisms to protect the poor.

Among the 'quick win' strategies recommended by the Millennium Project was the removal of user fees for primary education and essential healthcare by the end of 2006 (Sachs, J et al, 2005).

The Commission on Social Determinants of Health in its final Report (2008) says: The policy imposition of user fees for health care in low- and middle-income countries has led to an overall reduction in utilization and worsening health outcomes. Upwards of 100 million people are pushed into poverty each year through catastrophic household health costs. This is unacceptable.

The World Health Report 2008 says that "As the overall supply of health services has improved, it has become more obvious that barriers to access are important factors of inequity: user fees, in particular, are important sources of exclusion from needed care. Moreover, when people have to purchase health care at a price that is beyond their means, a health problem can quickly precipitate them into poverty or bankruptcy".

There is now a global consensus among organisations like the World Bank, the WHO, the EC and UNICEF that charging fees for health care is one of the most significant barriers to progress in scaling up access to health care in poor countries and that they should be removed (Oxfam 2009).

"User fees, even with exemptions to the poor, were not successful in raising resources and did not help in improving quality and access to healthcare" (HLEG 2011).

In a recent report about the distributional impact of reforms, the World Bank noted that "The push for introducing user fees to finance improvements in health services in developing countries in the 1990s provides a good illustration of the way invalid empirical results can bring about adverse welfare consequences" (World Bank 2006).

UNDP acknowledges in the latest Human Development Report (2010) that at the global level, health progress has slowed since 1990. In fact, 19 countries have experienced declines in life expectancy in the past two decades. Interestingly, in the discussion of the causes for the global life expectancy reversal, HDR 2010 lists the introduction of user fees prominently, along with HIV epidemic and armed conflicts (WHO 2010). The WHO Director General, at the International Ministerial Conference on Health Systems Financing in 2010 said:

> *"Direct out-of-pocket payments at the time of care are identified as the single biggest barrier to universal coverage. While user fees have been promoted as a way to reduce the overuse of services, this is not what happens.*
>
> *User fees punish the poor. They are inefficient. They encourage people to delay seeking care until a condition is far advanced, and far more difficult and expensive to treat. And when people do pay out of pocket for care, financial ruin can be the result.*
>
> *In some countries, up to 11% of the population experiences catastrophic financial hardship each year because of health care bills, and as many as 5% of these people are pushed below the poverty line because of these costs."*[12]

[12] Speech accessed at http://www.who.int/dg/speeches/2010/Keynote_health_financing_20101122/en/ index.html

Conclusion

The content analysis of official documents such as local government Resolutions, Circulars, Standing Committee Resolutions and letters by the Commissioner threw up some interesting issues. It was seen that resolutions that the research team had access to seemed to deal exclusively with an introduction or increase of user fees. Indeed, increasing revenue may be one main objective, but alleviating its effect on those who cannot pay does not come across as a priority. Apart from a routine listing of groups like local government employees, doctors and nurses who should be given free care, and a customary and vague mention of PBCF help for the poor (not crossing the 20% limit) there are no clear guidelines on the criteria to be used to waive fees and whose fees need to be waived.

In fact, the CRs seem to assume that PBCF is a part of the user fees mechanism when it is not. It is a charity based mechanism that has been in operation in hospitals in Mumbai for decades. Putting 2% of the fee collected in PBCF would not make it an extension of user fee mechanism that could be used as an excuse to neglect waivers. Barring a couple of instances, there is no clear mention of waivers in the CRs. Whenever waivers are mentioned, it is made clear - as the senior administrators explained to us- that for each waiver/exemption, money equivalent to the fees that is foregone has to go from the PBCF to the local government body's account. This is not being followed as of now, but the researchers found from interviews with the senior administrators that this constant fear of the local government charging the hospital for waivers allowed with 'retrospective effect' (legally they can, and the hospital has to be ready for it, although it has not happened in the last eleven years) has a devastating effect on equity. On the one hand, there is pressure on the doctors to keep the number of waivers and exemptions to the minimum so that such claims are low, and also on the PBCF to keep reimbursements to a minimum so that there is ample money in the account just in case the local government body chooses to send a bill of eleven years. Together, these see to it that only the smallest possible number of the poor is able to access equity enhancing mechanisms and free care. These factors have in no small measure contributed to the general belief among the doctors and staff about user fees being just a tool for revenue mobilisation.

Analysis of hospital budget data collected reveal that the revenue generating ability of user fees is rather limited, thus corroborating the results of many earlier studies. Despite great costs in terms of equity suppressing effects, benefits in terms of revenue generated is very limited, and has been falling over the years as a proportion to total expenditure. Additionally, the money collected is not retained at the facility, but is automatically added to the treasury, barring a very small proportion, about 2% or so, that goes into PBCF. When we consider the huge administrative costs, keeping in mind the army of staff at the hospital whose almost exclusive duties are user fees related, even this money in real terms is not much. We have to also keep in mind indirect costs like the time spent by the doctors in screening processes, delays in accessing care caused almost exclusively by the long drawn processes of granting waivers and/or reimbursements.

Additionally, data on exemptions and waivers, or in other words free patients paints a very sorry picture. It is clear from the data that only a microscopic minority of the deserving poor who enter the hospital is able to access free care. When we examine the data on the status of reimbursements to the poor through PBCF, the situation is the same. Only a very small proportion of funds available is used to bring relief to the poor. The process itself is marred by arbitrariness, and is completely dependent on the personal judgement of some key individuals in the absence of credible guidelines. This, when added to the directly adverse effects it has on equity, proves that as part of state policy, cost recovery from such public hospitals is not advisable.

There has been a reappraisal of the role of the State in health - from universal provisioning to 'non governmental' mixed with a means-tested system of care (Akin et al 1987). The State is increasingly shifting from being the major provider of services to financier for a minority of the poor for a select and very limited set of needs. International agencies pushing such strategies have always been quick to appropriate concepts and slogans from peoples' movements worldwide. User charges by governments in the name of 'community financing' is an instance where the state is placing the onus of poor people's health back in their own hands, or more correctly, into their pockets (Kurian 2009).

Policies that guarantee free health care at the point of use are absolutely essential in low income settings, if we are to achieve anything close to the ambitious health targets set by national governments and international agencies. Several studies found that even where user fees have been accompanied by some quality improvements, demand for health care by the poor who get ''priced out'' of the market drops drastically (Kallahan and Wasunna 2006).

We live in an age of extreme contradictions. At one end of the spectrum in the private sector, 'socialisation of corporate losses' is presented as the only solution to the consequences of what is often retrospectively termed 'destructive innovation' in the financial markets. At the other end of the spectrum, in the social sector, we have specially designed 'innovations' to preclude what is perceived to be the apparently nightmarish scenario of 'socialisation of health care'. It needs to be emphasised that the last half a century's experience, if nothing else, should teach us that the path to government-sponsored 'business of health care' is strewn with the bodies of the excluded. It is public health commonsense that in low income settings, the public sector must work as the majority provider of free services to achieve health care access to all (Kurian 2011).

It is evident that the proportion of poor who visit the hospital under study would be much more than what the exemption/waiver related data represents. In other words, most of the poor who access the care are made to pay for the care that they are supposed to get for free. Thus, there is a clear case for doing away with user fees in the hospital studied, and in other public hospitals like this. It is quite unfortunate that despite the mountain of evidence that exists against charging user fees in government hospitals, the Indian government has yet to correct its policy errors. Much poorer countries in Africa are successfully getting rid of the public health problem of user fees, thus enhancing health care access to millions of poor without pushing them into a downward spiral of poverty and ill-health.[13]

The debate should not focus on how user fees should be implemented in public hospitals, but on whether they should be implemented at all. Recent official publications like the Mumbai Human Development Report 2009 (2010) acknowledges the fact that a "major part of the health infrastructure that currently exists in Mumbai was planned between 1950 and 1980 to cater to a population of about 52 to 70 lakh. Circa 2009, these very facilities are meant for more than twice the population at present". Faced with such great infrastructural constraints, it is suicidal for the local government body not to expand its health infrastructure substantially and at the same time continue with demand suppressing mechanisms like user fees, which has been rejected worldwide.

[13] For a summary of various country experiences regarding removal of user fees, see Annexure 4.

Recommendations

1. In view of the study findings, we maintain that user fees have a negative consequence on health equity and should be discontinued by the local government body, also taking into account the fact that the incremental income it offers is negligible; if not negative once the huge administrative and other costs are factored in. We hope that in the light of the Prime Minister's High Level Expert Group (HLEG) recommendations, the local government body will soon take a favourable decision. The following measures are suggested in the interim period, to offer much needed relief to the patients.

2. The cap on the quantum of waivers which mandates that "the total concessions related to the charges cannot exceed 20%" must go. As discussed in the report, a baseline survey by MMRDA in 2002 found that income levels of more than 30 percent of households in Mumbai were below the poverty line. Public hospitals like the one under study attract mostly the poor from nearby slums -as evidenced in the report- and so, a cap of just 20% is blatantly iniquitous. It has to be borne in mind that the actual proportion of waivers now are much lower than even 20%, indicating the degree of existing inequity. Along with this, clear instructions need to be given to the hospitals that there are no upper limits set by the local government body to the amount that can be reimbursed by the PBCF.

3. The study brought forward the necessity of effective guidelines to exempt at least the needy from paying user charges at the public hospitals. The rules and guidelines that exist now are very sketchy and arbitrary. While the CRs and Circulars focus on the prompt collection of user fees, the mention of exempting the poor almost always limits to a statement of intention, rather than any concrete steps. Our study revealed that even people from those categories that are specifically mentioned in the Circular as being exempt from fees were denied subsidy at the hospital. The room for ad-hoc decision making at the level of hospitals needs to be curtailed, and for that the local government body needs to bring out clear guidelines as to how they plan to have a policy of user fees while protecting the poor and the needy. The objectives of the policy need to be articulated and the steps of operationalisation listed out. Plans to introduce BPL as a criterion would be self defeating for reasons mentioned in the report.

4. One of the rationales given by the local government body for the introduction of such fees in its hospitals is that "compared to the charges at private hospitals these charges are minimal, fair and suitable". The role of the public sector vis-à-vis the poor needs to be rearticulated and emphasised; particularly, when it is working alongside a large and unregulated private sector. It may be a laudable goal vis-à-vis the middle classes to offer the same quality services at a lower cost. But for the poor, it is imperative that the services are free at the point of delivery. For hospitals which predominantly serve the slum population, geographical/ targeting location may be tried as one of the criteria.

5. It was seen that no publicity is given to either the exemption/waiver schemes or the availability of funds from the PBCF to poor and needy patients. Notices regarding this need to be displayed prominently at different locations within the hospital in the local language.

6. Steps should be taken to ensure that patients who are referred within the public system do not end up paying any charge twice. It must be ensured that patients are not referred to private facilities when cheaper public sector options are available. Awareness among the staff of user fees needs to be improved substantially. The focus should be on other objectives of user fees, besides that of revenue generation. A campaign to sensitise the staff to the needs of poor

patients is advisable. As of now, the staff seems to focus on avoiding inclusion errors, even at the cost of having substantial exclusion errors - that is preventing the non-poor from accessing free care, even if it means that a number of poor people are denied access in the process. It has to be made clear to the staff that excluding the poor from accessing free care is unacceptable.

7. It is necessary to set up a mechanism to redress grievances. In the current setup, patients are expected to go to the Medical Superintendent with their complaints. It is highly unlikely that poor patients get easy access to the person who heads the hierarchy. As the administrative head, it is also very unlikely that the MS is available all the time to address patients' complaints. A staffed information kiosk may be set up to advice patients on user fee related procedures, which can also collect complaints.

8. Even in the ideal sense, 'free care for the poor' does not mean free access, because of shortage of medicines, travel costs and loss of wages. Given this situation, the practice of transferring money (equivalent to the amounts waived off) from the hospital PBCF account to the local government body's account so that 'there is no deficit in the revenue' should be stopped immediately. As discussed in the report, PBCF and user fees are completely different and separate mechanisms, and PBCF should offer needy patients relief over and above what they receive as exemptions or waivers. PBCF was constituted to enable the poor to access health care that was not free. It must not be used to reimburse the local government body for the minimal care it is bound to offer for free to poor people. Such medicines can be purchased by the hospital and supplied to the patients using PBCF money. Charges incurred on any private investigation can be paid by the hospital directly.

9. The tendency not to use PBCF interest income that accumulates over time needs to be checked. The committee responsible should see to it that funds are utilized every year. For all these reasons, strict guidelines need to be evolved guiding the operation of PBCF mechanism. The process of PBCF should be decentralized, and the decision cannot be confined to one person. Clinicians should also be included in the decision making at some point, and their role should not be limited.

10. There is a grave need to put in monitoring and supervision systems in place. Regular auditing across all the hospitals under the local government body should be done and the reports made available. The system should make sure that procedural guidelines are being followed strictly. For this, information systems in the hospital need to be overhauled. It was observed that data is entered into registers while fees are collected; no compiled data is available anywhere in the system. There is no record of how many have availed themselves of waivers, and a roundabout method[14] is used to estimate the amount that has to go from the PBCF to the local government body's account. This situation has to change and foolproof data systems have to be introduced so that separate estimates for waiver/exemptions and PBCF reimbursements exist across different categories. This will help supervision and monitoring substantially.

11. Increase funding: An increase in the overall public health budget is an immediate requirement. In fact, Maharashtra's public expenditure on health has declined from about 1% in the mid eighties to 0.59% in 2006-07(Duggal 2007). 'Lack of funds' is given as the most important reason for the introduction and hike of user fees in public hospitals. Consistent fund flow to the hospital must come from general taxation. The increase in service use that follows fee

[14] According to a senior official, it is calculated by deducting the number of paid patients from the number of total patients for each service. The difference is 'assumed' to have availed free care because they deserved it. An equivalent amount then has to be transferred. This is a very inefficient system with much room for corruption.

removal is likely to be greatest in poorer areas, and so, these areas will need the largest injections of new funding. Along with this, the local government body must improve drug supply and procurement systems, and make provision for the increased demand for drugs which is likely to follow the removal of fees.

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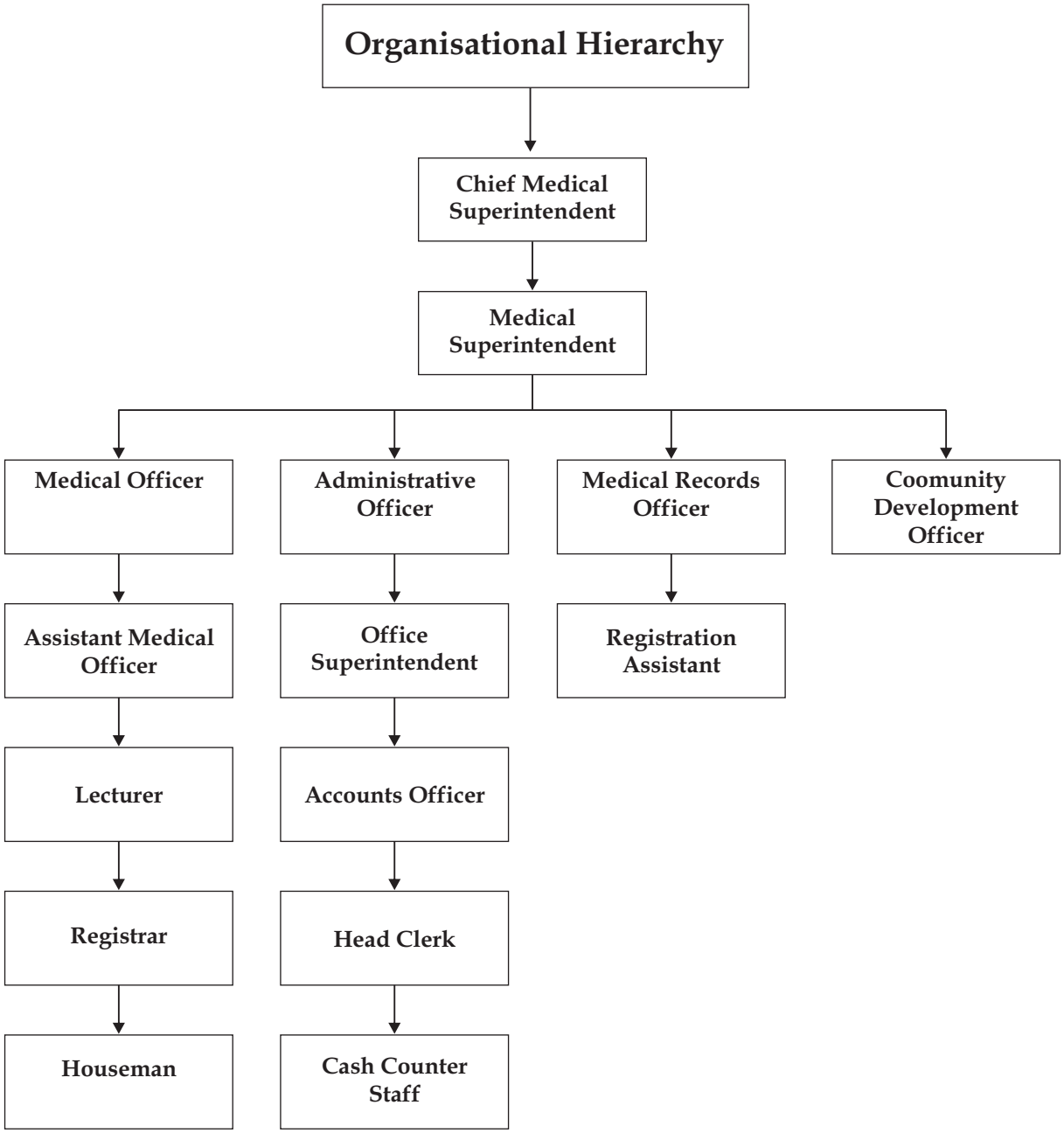
ANNEXURE 1
Department Profile

Orthopedics
The Orthopedic unit in-charge of the OPD is on call for 24 hours. During this time, they admit fracture and emergency patients. There are many sub-specialties in orthopedic like spine, joint replacement, arthroscopy, pediatric orthopedics for all of which they have consultants, except oncology, that is cancer in orthopedic. The Inpatient department has bed strength of 40-50 and arrangements for floor beds if and when necessary.

Presently the Department comprises of 3 senior consultants. As full timers, there are 2 Junior Consultants and 12 residents - 6 in each unit from 1st year, 2nd year and 3rd year. These residents are undergoing DNB training for orthopedics.

General Surgery
The General Surgery department can be divided into Surgery and Trauma. Trauma pertains to poly-trauma cases, that is, road or railway accidents wherein the housemen are in-charge of stabilizing and treating the patient. Surgeries are both elective and emergency in nature. Elective surgeries are those that can be done at a later point in time and are not urgent such as swelling in the body. Emergency surgeries include operative surgeries such as perforation of the intestine etc. The General Surgery Inpatient department consists of patients suffering from hernia, breast cancer, and abscess or requiring surgical procedures such as exploratory laparotomies while the Out Patient department undertakes minor surgeries done in the OT under local anesthesia. The general time line for OPD examination, diagnosis and treatment is as follows:
Day 1 - examination of patients
Day 2 - all investigations are done
Day 3 - all reports received
Day 4 -diagnosis and treatment given
The department has 1 lecturer, 2 registrars and 3 housemen.


Organisational Hierarchy
Chief Medical Superintendent
Medical Superintendent
Medical Officer
Administrative Officer
Medical Records Officer
Coomunity Development Officer
Assistant Medical Officer
Office Superintendent
Registration Assistant
Lecturer
Accounts Officer
Registrar
Head Clerk
Houseman
Cash Counter Staff

Obstetrics and Gynecology
The obstetrics and gynecology department has bed strength of 110 beds for its indoor ward, gynecology, ante-natal care (ANC) and post-natal care patients. Apart from this there are 8 beds in the labour ward and 20 warmers for newborns in the premature ward.

The department provides comprehensive Maternal and Child Health services including gynecology OPDs and ANC registration. Once the patient registers, she is provided all the care inclusive of delivery, postnatal services and family planning services.

There is a pediatric OPD where immunization facilities are provided. Diagnostic facilities such as sonography blood tests are provided by the hospital. The Operation Theatre is functional round the clock and there is a panel of anesthetists (presently shortage). The department also provides treatment for Reproductive Tract Infections and Sexually Transmitted Infections.

Currently the Department is divided into three units led by the head of the department, assistant honorary, and lecturer. The Head of the Department is generally the head of the Unit. At present there are 6 honoraries and 1 lecturer in the Gynecology and Obstetrics department. The lecturer is in turn assisted by 2 registrars.

General Medicine
The General Medicine OPD caters to simple wounds, chronic abdomen pain etc.

Plastic Surgery
The plastic surgery OPD is handled by honoraries and functions only on Tuesdays and Saturdays.

Dentistry
The dentistry department has a functional OPD. Information was not sought about this department.

Psychiatry
The hospital has a psychiatry department and also has a special social worker to deal with patients from this department. However, Information was not sought about this department.

ANNEXURE 2

Patient Load

The hospital comprises various departments - general medicine, general surgery, pediatrics, gynecology, dental, psychiatry, orthopedics providing both inpatient and outpatient facilities. There are also diagnostic facilities which the patients can avail. Data from the clinicians give a picture of the number of patients approaching these departments for various kinds of ailments.

The OPD: Hospital OPD starts at 8.30 am and within an hour all the departments get busy with patients. The most swamped is the department of general medicine which cater to about 120-150 patients in a day followed by the orthopedic department (80-90). Though the cases paper window shuts at 11 am, OPD continues till 1 pm.

Department wise patient load in the hospital	
Department	**Patients per day**
General Medicine	100-150
General Surgery	120-150
Orthopedics	80-90
ENT	20-30
Pediatrics (including immunization)	60-80
Ophthalmology	20-30
Skin	50
Gynecology	60-75
ANC	120-150

All the numbers are based on information collected from doctor interviews.

The IPD: The In Patient Department functions throughout the day, with a lot of surgical procedures and operations taking place.

Department wise patient load in the hospital		
Department		**New Patients per day**
General Surgery	Trauma	15-20
	IPD	>10
Orthopedics	Emergency	5-15 (range)
	IPD	50
Gynecology		15-Oct
Deliveries		15-20

All the numbers are based on information collected from doctor interviews.

The doctors from some departments such as orthopedics and general surgery were able to give a break up of their patients as emergency and IPD patients. The gynecologist gave a division of number of deliveries taking place in a day and the other gynecological patients admitted in a day.

Diagnostic procedures			
	Options available for patient	**Charges**	**Situations where made free/ Exempted through PBCF**
Blood test	Available	Free	N.A.
Sputum test	Available		
X-ray	Available	30	Could waived off by approaching MO
ECG	Available	20	
Sonography	Available	100	Could be reimbursed through PBCF Patient has to go through the CDO's assessment for being eligible
Color Doppler	Available	1000	
CT scan	Private diagnostic centre or another MCGM hospital	1500- 3000	
MRI		6000 (Nanawati)	

ANNEXURE 3

Charges at the Hospital

MINOR CHARGES		MAJOR CHARGES	
SERVICES	**RATE**	**SERVICES**	**RATE**
Diagnostic Services:			
1. X-Ray	Rs. 30/X-Ray	Ambulance charges	Rs. 50/hour
2. Electrocardiograph (ECG)	Rs. 20		
Radiology:		*Radiology:*	
1. Sonography	Rs. 100	1. Doppler Sonography/Color Doppler	Rs. 500
Operations:		*Operations:*	
1. Minor Operation Theatre (OT)	Rs. 200	1. Major OT	Rs. 500
		2. Supra major Operation	Rs. 1000
		3. Lower Segment Caesarean Section (LCSC) Gynaecology	Rs. 500
	Rs.10 (Valid for 2 weeks after which a new case paper has to be issued)		
OPD case papers	ICU ward charges – Rs. 200/day		

The following is a table depicting the rate list displayed at the hospital. The board stated: As per rule ODMCT 933 dated 2/4/2000 the following rates apply from 1/5/2000:

SERVICES	RATE
X-Ray	Rs. 30
ECG	Rs. 20
Ultra sonography (USG)	Rs. 100
OPD & IPD patients imaging film	Rs. 50
EEG	Rs. 250
ICU	Rs. 200/day
Delivery after 2nd child	Rs. 500
Special operation (patient has to bring essential items)	Rs 5000
Minor Operation	Rs. 200
Major Operation	Rs. 500

In addition to this, the hospital charges for issuing the following certificates:

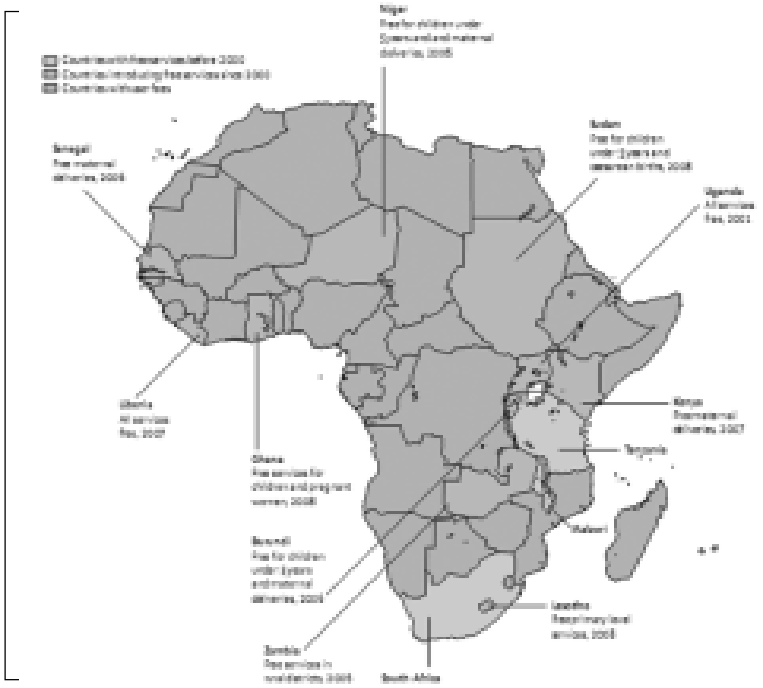
	Name of the Certificate	Charges Rs.
1.	Under treatment Certificate	30/-
2.	Age Certificate for Senior Citizen	30/-
3.	Disability Certificate	50/-
4.	Injury Certificate	100/-
5.	Fitness Certificate	30/-
6.	Confinement Card	30/-
7.	L.I.C. Certificate	150/-

Source: Hospital Manual

ANNEXURE 4

Removal of User Fees - Its Impact on Access

It is a fact that many considerable demographic/geographic/socioeconomic groups in India have worse health indicators than that in Sub-Saharan Africa. After 2000 when evidence of the ill-effects of user fees on poor peoples' health and well-being became too great to ignore, policy reversals became politically inevitable in Africa. The good news is that in Africa, as the following figure (Yates 2009) will demonstrate; many countries have been successfully abolishing user fees with great results.



After user fees were removed in South Africa in 1994, outpatient attendance increased by 77 % (Yates, 2006). In Madagascar, after a temporary abolition of user fees, monthly visits to public rural health centres almost doubled compared to the previous year. The main perceived reason for the increase in the number of visits, according to staff members, was the elimination of user fees (Fafchamps and Minten, 2004). In the case of Kenya, reduction of user fees resulted in an increase in utilisation averaging about 30% more than the pre-removal period (Pearson 2005). In Uganda, since user fees were scrapped in Government health units in 2001, outpatient attendance increased by an extra 14.9 million visits, amounting to 155 % (Yates, 2006). In Uganda, results of research undertaken by WHO and the World Bank demonstrated that the removal of user fees was very favourable for poor people (Nabyonga et al, 2004).

Uganda's experience has lead to some kind of a Domino effect across Africa and over the last three years countries like Zambia, Burundi, Niger, Liberia, Kenya, Senegal, Lesotho, Sudan, Malawi, Sierra Leone and Ghana have abolished fees for key primary health-care services as shown on the following figure from Yates (2009). In Niger, consultations for children under five increased four times and antenatal care visits doubled after user fees for pregnant mothers and children under five were removed in 2006. In Burundi, within a year of user fees being removed, utilisation for children under five increased by 40%. In Bo, Sierra Leone, a tenfold increase in consultations for children followed (Save the Children, 2008).

ANNEXURE 5

Secondary Data to be collected - A Checklist

Medical Records Department and Accounts Department

General

About the Hospital

1. Area covered by the hospital
2. Population catered to by the hospital
3. Available departments and services for the patients
4. Total bed capacity (breakup of the same)
5. Total OPD attendance - daily, weekly, monthly, annually (new patients and FU)
6. Total IPD attendance- weekly, monthly and annually
7. No. of free patients (user fees exempted, if possible service wise)

About User Fee Guidelines

1. Copy of the CR for implementation of user fee, all guidelines with revised guidelines
2. CR for exemption criterion
3. CR for user charges List (current)
4. Copy of the below mentioned list of CR -

Item No.12 (1.3.2000)
Letter from the Commissioner No. TRV/2080 dated the 24th February 2000 :-

Sub:- Revision of fees and charges for increasing revenue at Major Hospitals.

Ref.:-
1) C.R. No. 1285 of 29.2.88
2) S.C.R. No. 1639 of 8.3.91, C.R. No. 19 of 15.4.91
3) S.C.R. No. 888 of 12.10.91, C.R. No. 893 of 27.11.91
4) S.C.R. No. 851 of 14.10.91, C.R. No. 802 of 25.11.91
5) S.C.R. No. 108 of 5.5.93, C.R. No. 157 of 21.6.93
6) S.C.R. No. 994 of 8.11.93, C.R. No. 1189 of 16.12.93
7) S.C.R. No. 1567 of 24.2.95, C.R. No. 27 of 5.4.95
8) S.C.R. No. 581 of 22.8.95, C.R. No. 1556 of 11.3.96
9) S.C.R. No. 583 of 22.8.95, C.R. No. 1557 of 11.3.96
10) S.C.R. No. 790 of 11.10.95, C.R. No. 1119 of 11.12.95
11) S.C.R. No. 79 of 26.4.96, C.R. No. 256 of 8.7.96
12) S.C.R. No. 299 of 26.6.96, C.R. No. 358 of 9.8.96

5. If separate CR for peripheral hospitals exists or the same CR applies to Teaching hospitals, Peripheral hospitals, maternity homes and urban health posts.
6. CR for deposition of user fee and utilisation of user fee.
7. CR for funds collected in the poor box fund and its utilisation.

From the Accounts Department

1. Total collections from user fees in each department (USG, X-ray, Lab, OPD, IPD etc)
2. Total revenue generated by user fees (monthly, annually) if possible department wise (amount in Rs)

3. Total hospital expenditure (over the past five years) (in Rs)
4. Income to the hospital (donations, user fee, grants from the local government body etc)
5. Recurrent expenditure of the hospital (annual) for the past five years.
6. Recurrent non salary expenditure of the hospital for the past five years.
7. Budgetary allocations and revised estimates for the past five years
8. Any additional grant in the previous year, please give details of reasons for the same and how much.
9. Budgetary estimates and revised budgetary estimates for the preceding five years.
10. Data on income and grants to the hospital.
11. Total Health Budget of the local government body, Total Hospital Expenditure of the local government body and Total Collections from User Fees from all the hospitals of the local government body.

Documents/Data to be collected from PBC

1. Total collections in PBC from different sources (annually for the past five years)
2. Details of the beneficiaries of PBC (Gender, Socioeconomic Status, Religion)
3. Partial assistance from PBC funds (details) in the past one year (service wise)
4. Full assistance from PBC funds (details) in the past one year, total in the past five years annual figures (service wise).

ANNEXTURE 6
INTERVIEW PROTOCOLS

I. Interview Guide for the Staff at Cash Counter [14]

General Information

1. Name of the Participant
2. Designation
3. No. of years of association with the hospital
4. Major job responsibilities
5. Is this role/activity rotation based or you are the only one looking after this counter

Process of implementation

6. Is there a management structure for the implementation of user fee, if yes kindly elaborate. Probe
   a. (like your reporting to a supervisor who only looks at the proper implementation of user fees collection, deposition etc)
7. Please detail about all the activities carried out at your counter. Probe:
   a. Fee collection,
   b. receipt given,
   c. details about where is the department located where the patient needs to go,
   d. Which services are free to all (Is there a board displayed for the patients to refer and know about the fees and exemptions)
8. Is there any fee waiver/ exemption given to the patients, if yes, Please explain the exemption process in detail with examples.
   Probe List:
   a. What is the criteria (is it displayed anywhere for the patients)
   b. How do you identify if the patient falls under the exemption criterion
   c. Do you proactively ask the patient if the patient qualifies for the fee waiver?
   d. What are the documents that a patient needs to produce to get an exemption
   e. Do the patients carry the documents or they go back without treatment and the get the documents and then avail treatment (free)
   f. Do you have the authority to take decision for exemption or you refer them to the higher authority
9. Do you come across patients who do not have money but come here for treatment (how many in a month or day)

Exemption / PBC

10. Do you have to make a separate list or an entry in a register for exemptions given (if yes collect the data on exemptions in a yr/ mth).

[14] This schedule will be administered to staff at counters where user fee is collected (case paper registration, fee collection for diagnostic services, surgeries etc.)

Probe:

1. Do you fill any form for the same?
2. Do you have to report that separately along with daily collections,
3. Do you have to give reasons/ attach necessary documents along with the form or you just see the document and write that the person qualifies for an exemption under so and so criterion.

11. How much time do you spend in a day on providing exemptions (collecting required documents, filling specific form)
12. How much time does it normally take for a patient to get the exemption if s/he qualifies for the same.
13. How many patients on an average are exempted in a day/ week/ yr
14. Is there any criteria that in a day/week only so many patients will be exempted.
15. If the patient tells you that he/ she cannot pay for the service what do you do.
    - Do you send them to social worker …… pl. elaborate with examples
    - On an average how many patients a fall in this category
    - Are they ever sent back because they do not receive help from PBC/ exemption…

Accounting Procedure / Collections from user fee

16. On an average what is the daily collections at this counter.
17. Do you provide receipt to all the patients after they make the payment?
18. Where do you deposit the daily collection?
19. In which book, under which head is it accounted for?
20. Do you face any problems in collecting user fees?

Recommendations / Suggestions

21. Do you have suggestions to improve the current procedure in the hospital?
    Probe:
    a. Collection of user fee
    b. Identification of the social groups under exemption
    c. Documentation etc.
22. Is there any other information that you would like to share about user fee or your experience in collecting user fee?

II. Interview Guide for the Doctors/ Technical Staff [15]

General information:

i. Name of the Participant
ii. Designation & Specialty
iii. No. of years of association with the hospital
iv. Major job responsibilities

Process of implementation

1. Are you aware that certain services in the hospital are charged? What are these services?

Exemption/ PBC

2. Are there any exemptions or waivers given to some selected patients like " poor", senior citizens, local government staff , selected groups like adolescents etc?
3. Do you have a role in determining if patients fall in these categories of waivers?
4. Are there any services that are free for all, irrespective of the socio economic status?
5. Is the treatment under the National Health Programmers' (T.B, Malaria, and Leprosy) and emergency care, provided free to the patients?
   Note for the interviewer:
   1. *Is it that the patients makes a payment at the initial visit and then after it is diagnosed that the treatment falls under any National Health Programme, then all further services required are made free (ask for examples)*
6. Can patients coming to your hospital afford to pay the fees?
7. If not what do you do (where do you send the patient if the patient says that he/she cannot afford the treatment)?
8. When you send the patient for help from the PBC (Poor Box Funds), do you fill any form or write any reason for referring, on the case paper.
9. Who are the people involved in decision making for PBC help
10. How many patients in a day (on an average) do you refer to PBC?
11. How many of them get help (mostly or very few) Probe:
    1. Help from PBC for some particular services
    2. For some selected social groups, BPL etc
    3. How much time does it normally take for the patient to get help from PBC?
    4. Is there a lot of running around for the patient? Pl. give examples
12. How much time in a day, do you spend on such cases? Pl. elaborate
13. Are there any other options that you suggest if the patient does not get help from PBC?
14. If the patient does not get help from PBC or exemption does that affect the treatment seeking behaviour of patient?
15. On an average, in a day
    1. How many patients tell you that they cannot afford the treatment?
    2. How many patients do not take treatment because they cannot afford it? pl. give examples
16. Is the user fee for some services high, which many patients visiting the hospital cannot afford? Pl. list such services.
17. Does the user fee interfere with provision of care?

[15] Technical staff will include Resident medical officers and medical officers from paediatrics, gynaecology, and surgery (who are specialized in the respective disciplines)

Recommendations / Suggestions

18. Do you have suggestions to improve the current procedure in the hospital?
    Probe:
    1. Charges should be increased or decreased,
    2. About exemptions,
    3. Protocols and procedures involved,
    4. Authority to the doctor in making service free if pt. cannot pay and doctor feels that treatment is important for patient.
19. Is there any other information that you would want to share, from your experience, about user fees.

III. Interview Guide for the staff at the Poor Box Fund (PBC) (CDO/SW and AMO)

Background details of the provider

i. Name
ii. Designation
iii. No. of years of association with the hospital
iv. Major job responsibilities
v. Total staff in this department, their reporting to and the decision-making authority. Who is the in-charge of this PBC dept.

Guidelines

1. Is there a CR for the utilization of money from PBC and identification of the "needy" for PBC help?

Process of implementation (PBC)

2. What are the sources of funds in the PBC
   Probe:
   i. Donations, voluntary
   ii. Active fund raising
   iii. User fee from some services/ depts.
   iv. Grants from the local government body
   v. Seed money (any CR past or present)

3. Has there been an increase or decrease in collection of funds over past five years (pl. collect the figures Rs for past 5 yrs?

4. Who refers the patient to you for PBC help (can a patient be sent directly to you from the cash counter without seeing the doctor or is it mandatory that the doctor has to send the patient)
5. What is the procedure for utilization of the funds from the PBC
   Probe:
   i. For which services is the funds used
   ii. For which services partial payment made
   iii. For which services full payment made
   iv. After the patient comes to you what procedure do you follow
      a. Are there any documents required as evidence for the "needy"
      b. Do you fill any form or is it verbal (collect the form if any)
      c. Who take the final decision for the help from PBC (you or someone else, pl. explain the hierarchy)
      d. If not CDO then, Does the patient/ relatives of patient need to meet other decision makers or you go to seek permission to the higher authority
      e. How much time does it take to complete one case
      f. Does it happen that you forward the patient for PBC help at your level however the case in rejected at the higher Decision making authority?
         i. How often does it happen?
         ii. What are the type of cases that are denied help from the PBC?

g. Is the payment made in cash, for the service for which the payment to be deposited, or you mention Free on the case paper / or provide other instruments for the same. Pl. elaborate for both partial payment and full payment help.
h. Is the PBC help also provided for the services not available in the hospital (as the patient has come to your hospital / admitted in your hospital)? Please give example and explain the process in detail.

v. How many patients come to you daily (on an average) for PBC funds help.
vi. Is there a fixed percentage fixed in terms of help / payment for specific services and full payment for some services or
vii. Is there a fixed percentage or number or cash limit that in a month or yr. only these many patients will be helped from PBC
viii. Are there patients who need help but due to administrative procedures or resource constrain; you are not able to help them. Pl elaborates with examples.
ix. What do you do in case a patient needs help but does not qualify for PBC help?

Probe:

1. Does the patient come back to you,
2. If yes then what do you do (any trusts help or do you contact voluntary donors? Pl. elaborate with examples)

6. Is there an increase or decrease in the number of patients seeking help from the PBC over the years?
7. Do you receive any grievance / complaints with regards to user fee from patients? If yes, please specify.
8. What are the mechanisms available to handle patient grievances?
9. Are these mechanisms adequate to handle patient's grievances? If no, why?
10. What problems do you face in helping patients from PBC funds?

Recommendations / suggestions

11. What are your suggestions to improve the patient grievance handling mechanisms?
12. Is there any other information related to user fee or implication of user fee, on utilization of services at the hospital that you would like to share.

IV. Interview schedule for Office Superintendent

General Information

1. No. of years of association with the hospital
2. Major job responsibilities

Hospital Accounts related information

3. What are the incomes to the hospital (grants etc and under what heads) pl. comment in detail.
4. Is the income to the hospital in any way in proportion to the revenue generated by user fee?
5. User fee monthly income and expenditure statement?
   a. Who prepares?
      _____
   b. When is it submitted?
      _____
   c. To whom is it submitted?
      _____
6. Do you get regular feedback from the higher authority? Yes / No
7. If yes from whom? MS/SMO/AMO/any other
8. How do you calculate the demand before sending requisition for grants.
9. Is the user fee fund retained by the hospital (partial/ full). If not why, pl give reasons
10. If yes, what is the percentage of user fee that is retained by the hospital and how is it utilised. Pl. list all the heads under which it is utilized.

Recommendations / Suggestions

11. If the user fee is retained in the hospital, will it improve the quality of services?
12. Please give your suggestions or comments on the levying user fee to recover cost in local gov ernment Hospitals? Is it contributing to the sources or increasing the administrative costs and accountability without improving the quality of services as well as access to healthcare.

Interview Guidelines for the Policy makers or the Medical Superintendent

General Information

1. Name
2. Designation
3. Number of years of association with the hospital
4. Major job responsibilities

Policy/ guidelines related

5. What was the rationale behind the implementation of user fee?
6. Since the implementation of the user fee, there have been some revisions in the same, can you please elaborate on the same :

Note for the interviewer:

Do you have any idea about the underlying factors like?

1. *What were the reasons for the increase,*
2. *What was the criterion for the increase (was any % calculated for the increase)*
3. *Any changes in the guidelines for the utilization of fee in the facility.*

Procedure (exemption/ PBC)

7. Does the hospital have any additional staff for implementing user fee (like at the collection counter, for the provision of exemptions etc)
   - If not, then does these additional activities engage the staff and act as obstruction in their routine activities (like for doctors etc, they identify and refer the needy to CDO)
8. How do you ensure that guidelines on the exemption criteria listed in the CR are implemented efficiently?
   - Are there problems in identifying the needy
   - Are there any constrains on the number of people that can be exempted every month.

   i. Is there any CR for the utilization of the User Fee collected in the same facility?

   ii. If the user fee is deposited in the common treasury of the local government body, then, are the grants that the hospital receives from the local government body, in any way influ enced by the collections?
      a. Basically, if your hospital is contributing more in the treasury, does it receive more funds for maintenance of infrastructure, equipment etc.
9. What are the main sources of funds in the PBC
   a. Donations, Voluntary and active fund raising
   b. User fee
   c. Grants from the local government body
   d. Seed money (any CR, past, present)
10. Have you come across any constrains in extending best possible help to the needy (who cannot afford to pay for services but need it)
    a. Do you receive any grievance / complaints with regards to user fee from patients? if yes, please specify.
    b. What are the mechanisms available to handle patient grievances?
    c. Are these mechanisms adequate to handle patients grievances? If no, why?
    d. Has there been any change in the grants received from the local government body, since the introduction or revision of user fee.
    e. Is User Fee contributing substantially to cost recovery? Please elaborate.

Recommendations and suggestions

11. What are your suggestions to improve the patient grievance handling mechanisms?
12. Do you have any suggestions to improve the implementation of user fee?
13. Is there anything else about the User Fees that you would like to share information or your views on?

ANNEXTURE 7

Introduction letter and Consent form for conducting interviews

Introduction and Informed Consent Form

Dear Madam,

Greetings!

My name is ……., I am a member of the research team from the Centre for Enquiry Into Health and Allied Themes (CEHAT), Mumbai.

CEHAT (Centre for Enquire into Health and Allied Themes) is a health research and advocacy organization; the Research Centre of Anusandhan trust, Mumbai. The organization was set up in 1994 and, during the short period of its existence, it has established a creditable reputation in context to the quality of work and ethical principles guiding such work.

Purpose of the Study
We are conducting a study in Mumbai to understand the implementation and map the flow of User fee in a public hospital in Mumbai. This study will examine and explore certain key issues such as the ways user fees have contributed to hospital expenditure in Mumbai, the mechanism/s (if any) setup by the government hospitals to determine the poor and the 'needy' in Mumbai. We also wish to understand the role of health providers' in the process of exemption from user fee and provision of Poor Box Funds to the needy.

Nature of Participation
We would like to request your consent to participate in the study. If you agree to participate, you will be questioned about different issues related to user fee.

Risks and Discomforts
The following are the possible problems that may result from your participation in the study: Some of the questions may make you feel uncomfortable. Answering these questions is voluntary. The study will ensure complete confidentiality of your information.

Benefits
Although you will not receive an immediate benefit from this study, you and others from your community may benefit from this in the future, if this research succeeds in finding ways to improve the health care situation in Mumbai.

Duration of the procedures
The interview process may take about 30 - 45 minutes and your responses will be recorded on paper and tape, if you agree on tape as well.

Compensation
There will be no monetary compensation for your participation in the study.

Confidentiality
To make sure that no one learns about any information discussed by you in this project, your name will not appear on any document or other materials associated with the project and each record will be given a unique code. Interview notes will be kept in a safe place under lock and key and accessed by authorized persons designated by us. The identity of the interviewee will remain confidential. The tapes will be destroyed after the information has been noted down on the paper.

Right to refuse or withdraw
Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled.

Your refusal to participate in the study will not negatively influence the services that you are currently receiving. It is also possible that you will be invited to participate in an additional interview in the future, as part of the same research.

If you have questions about the research
The project staff is willing to answer any questions you may have concerning the procedures described. If you have any questions about the research, you may contact Center for Enquiry into Health and Allied Themes (CEHAT), Sai Ashray, Survey No. 2804 and 2805, Aram Society Road, Vakola, Santacruz (East), Mumbai - 55.
Tel: 91-22-26673571, 26673154, Fax: 26673156 E-Mail: cehat@vsnl.com

Participants' consent
I have read/been explained this entire consent form and any questions I have, have been answered to my satisfaction. I agree to participate in the study and to respond to the questions. I understand the purpose, nature, and length of my involvement in the study. I understand that I may choose not to participate at the beginning of the project or at any time during the project without penalty.

_____ _____
Date **Signature of Respondent**

In case of Verbal consent

I, the undersigned, have explained to the volunteer in the language he understands, the procedure to be followed in the study, and the risks and benefits involved.

_____ _____
Date Signature of Investigator

_____
Name of the Investigator