PRIVATE HEALTH SECTOR IN INDIA

Review

and

Annotated Bibliography

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PREFACE

The private sector is not new to Indian health services since it was a predominant mode of service for the well off as well as the common people till the end of the colonial period. Over the next couple of decades, especially during the late seventies and eighties, the private sector has expanded and diversified. The acceptance of the Structural Adjustment Programme during the nineties provided a boost and legitimacy to the already dominant private sector in state policy. The growing assertion by the private sector coincided with the emergence of international financiers entering the Indian market in the insurance, technology and financial sectors among other areas.

Given the above developments there was a need to reassess the public health needs in India, by both the State and the private sector. A vision for the future demanded that the State and the private sector reassess the experience of the nineties in order to face challenges in the future. There is no doubt that the State will have to take responsibility for setting the agenda, prioritize health issues and for planning suitable interventions. These cannot be limited to health services alone, but would have to address welfare services as well. The vital issue is how the State can harness the private sector creatively, while retaining its identity, and contributing to the challenge of building a socially responsible health care system. In addition, the State also faces the challenge to be able to make use of international initiatives on its terms, without allowing global entrepreneurs to set the terms.

In order to formulate appropriate policies towards the private sector, the Ministry of Health Family Welfare had initiated several studies to understand the nature, role, and functioning of the private sector in health care services in India. One of the initiatives involved undertaking a systematic literature review of the available studies on the private health sector in India and develops suitable policy options towards this sector.

The review attempted to document, understand, analyze and offer options concerning the private sector in some specific areas which included a) characteristics, heterogeneity and distribution, b) incentives and disincentive mechanisms for the private sector c) involvement of government doctors in private sector d) partnerships between public and private sectors at primary, secondary and tertiary level e) experiences in regulatory mechanisms for the private sector f) experiences in contracting out of clinical, non-clinical and supportive services and subsidizing g) experiences of role of provider and consumer information.

The three institutions collaborating in the study were Centre for Enquiry into Health and Allied Themes (Mumbai), Indian Institute of Technology (Chennai) and Jawharlal Nehru University (New Delhi). Each institution covered a specific geographic area CEHAT (Gujarat, Maharashtra and Rajasthan) Indian Institute of Technology (Karnataka, Kerala, and Tamil Nadu) and Jawharlal Nehru University (Delhi and Uttar Pradesh).

This review consisted of identifying published and unpublished empirical studies on the private health sector from institutions conducting and funding them. It involved contacting libraries and documentation centres at various universities, governmental and other institutions in the respective states. Searches from international and national

journals, bibliography sources, policy documents among others were incorporated. The review also included examining experiences from developed and developing countries. Institutions were corresponded with and visits made to collect the studies. Institutions included organizations specifically involved with health services, social science research organization institutions in government and non-government sector, market research agencies and academic institutions. Annotations of the studies identified were made according to a standardised format, including study identifiers, subject areas, objectives, methodology, findings among other aspects. All three institutions for the annotations used one common structure. These were entered into a common electronic database (Access). Besides the literature review, a few key persons from non-government organizations, international agencies, professional organizations and government officials, were identified and interviewed.

This book has been divided into two major sections; Section 1 includes the three papers that spell out policy options towards India's private sector. Section II is an annotated bibliography of selected studies on the private health sector in India. The three policy options vary in perspectives and approach but share the view that in order to realize the goal of accessible, affordable and quality health care the State will have to intervene and deal with the heterogeneous private health sector.

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Concerns, Challenges and Options

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Introduction

Context

India's health care system is complex. It is characterised by a mixed ownership pattern, many types of providers, and different systems of medicine. Recent government data indicates that there is one formally qualified registered doctor for 862 people. Similarly, we have one hospital for 11,744 persons and one hospital bed for 693 people (Table 1). In absolute terms, the size of the health care sector appears to be "good enough." Unfortunately, the distribution is lopsided, with the bulk of services located in urban areas, and dominated by the private sector. There is an absence of a holistic approach to the provision of services. The issues related to the private health sector have not been addressed substantially by the planners and policy makers in the five-year plans or the National Health Policy of 1983. This has led to a fragmented approach in the health care services; with the public focussing on the delivery of public health care services. The growth of the private sector was not planned or promoted as part of an overall health care system. The power acquired by the private sector in curative health care is now so great that unless a strategy for public health reforms is combined with reforms for the entire health sector (both government and private), we may not be able to achieve the desired results from our health system (Jesani A., 1999).

Health reforms undertaken in the country need to be placed in the context of broader reforms taking place in the economic spheres. In essence, health care is part of the broad development process, and therefore shaped by it. The objectives of health sector reforms are to effect changes in the health system, on the one hand supporting national health objectives and on the other making the system sustainable financially, organisationally and politically. In the present scenario, there is a compelling need to have an overall comprehensive framework, using various options for interventions by the government in the realms of policy setting, provision, financing, regulations, and also providing incentives and information. Both long-term and short-term strategies are needed. Many of the areas for intervention are overlapping, and in some respects, changes in one area would influence another. The feasibility and appropriateness of the options also depend on the existing structure of the health care system. For example, one set of choices may involve how to encourage the private sector to deliver certain services, whereas another may involve changing the manner in which they deliver specific services (e.g. following treatment algorithms for tuberculosis), and yet another may seek a more direct collaboration between the public sector and the private sector in the provision of care. The government may also wish to bring changes in its financing of health care or promote certain mechanisms in the private sector for financing health care while retaining the authority to regulate the same.

This paper makes an attempt, based on available evidence from the 3 states (Mumbai, Gujarat and Rajasthan) to analyse issues, identify concerns and challenges based on the review, and suggest policy options that need to be addressed. This paper examines four major areas:

1. Understanding the nature, size, spread and heterogeneity of the private health sector;

2. Collaboration and partnerships between the private and public sectors;
3. Regulations affecting the health sector; and
4. The role of provider and consumer information.

Government intervention with the private sector raises two major questions. Firstly, how and where should the government intervene; and secondly, how and where should the government collaborate with the private sector? The policy options suggested here are broad-based, so that it is possible for individual state governments to implement them based on the particular state's needs and capacities. In examining collaboration and partnership options, the paper takes into account contracting of health services, transfer of public health facilities, and providing incentives for private participation. Under the regulation options, the paper examines issues of licensing and registration, and private practice by government doctors. Though the policy options suggested are restricted to the private health sector, the fact remains that policy options need to encompass the overall health sector in its totality.

Overview of the studies reviewed

The types of studies published can be grouped into several categories. One type of study examined the profile and characteristics of the private health sector, focussing on allopathic practitioners and hospitals specifically (Bhat, 1999; Kabra S. et al, 1991). A related set of studies examined the role of traditional practitioners and its various dimensions (BAIF, 1997; Kumar D. et al, 1992; Chand S.K., 1988; Yesudian C.A.K., 1994).

A broader group of studies took up the issue of specific diseases and the role of the private sector in relation to them. Three studies examined the role of the private sector in relation to abortion and gynaecological morbidity (Ganatra B.R. et al, 1996; Bardhan A. et al, 1985; Parikh I. et al, 1994), whereas another study examined the tests being done of prenatal sex determination (Kulkarni S., 1986). There were also studies that examined various dimensions of the private health sector in relation to tuberculosis (Uplekar M. et al, 1996; Sheela R., 1995) and malaria (Kamat V. unpublished). One of the studies examined the role of private practitioners in an epidemic situation (Shah G., 1996).

Another group of studies focussed on specific components of the private health sector, such as physical standards for specific types of private facilities (Parmar H. [undated]; Nandraj S. and Duggal R., 1997); and the use of drugs, which comprised an analysis of prescriptions by private providers (Phadke A., 1995; Ray K. et al, 1996).

There were a number of studies that examined the relationship between the public and private sector. One policy paper assessed public partnerships with the private health sector (Bhat R., 1999). One study examined the contracting out of certain services from public health institutions (Bhatia M. and Mills A., 1997). Another examined a new initiative to be undertaken in providing quality health care by private hospitals (Nandraj S. et al, 1999). There were also secondary studies that examined the regulation aspect of the private health sector. These studies took into account the range of laws related to individual practitioners and hospitals (Bhat R, 1996; Jesani A., 1996).

A few studies examined the financing aspects related to the private health sector. One of them went into the investments in the private health sector (Kavadi S., 1998), two took up the earnings of the private practitioners (George A., 1991; Kansal S., 1992), and one examined the feasibility of social insurance to cover private provision (Jajoo U.M., 1991).

Finally, there were a number of studies that were not directly related to the private health sector, but indirectly reflected on the private health sector by examining levels of utilisation and health seeking behaviour (Duggal R., 1989; Chirumule D., 1997).

The methodologies of a number of the studies reviewed involved primary data collection, but many were based on secondary data analysis. The methods used in the primary data studies were largely cross-sectional studies, often with purposive rather than randomised sampling schemes, and using instruments such as standardised interview schedules and questionnaires, focussed group discussions, and various other methods to document systems and opinions.

Limitations and gaps

One major finding that comes out of the review of the private sector is that there is a paucity of studies on this dominant sector. It is only in the recent past that an interest has been shown in documenting and studying this crucial sector. Firstly, there is very little information on the spread, size and characteristics of the providers in the private sector. Data from government sources are questionable, as many of the states do not send timely and validated reports, and do not have a proper system of collecting the data. Secondly, the understanding of the dynamics of the private health sector in India is based on small studies conducted by various non-government organisations and academic institutions. A summary of the areas covered point out that there have been few studies that focussed exclusively on the for-profit health sector. Some studies tended to concentrate on specific aspects of the private health sector while some examined it as part of a broader study. Many non-government organisations have taken the initiative in conducting the studies, most of which have occurred after 1985. The coverage of these studies has been restricted to small geographical areas, mostly in a specific town or city, with very few studies examining issues at the state or national level. In some studies, the methodologies utilised are flawed, and the recommendations and conclusions appear questionable. Further, many studies are carried out on an ad hoc project basis, so that the majority of them are not published. There is reluctance on the part of organisations to share the reports of their work.

The studies reviewed do not form an exhaustive list of all the experiences of the private sector. Further work is needed to fill in the gaps in information and documentation regarding some of the experiences and experiments that have been carried out in the country. There are many areas of work related to public-private partnerships that have not been documented. In many instances, issues related to transfer of public facilities or contracting out are not discussed openly or documented by government functionaries. There were also very few studies that examined the financing aspects of private health services, particularly questions of investment, payment mechanisms, charging practices, method of financing, or use of health insurance. There was very little documentation in

the three states regarding the question of allowing private doctors access to public facilities, or involving them in disease-control programs. There was also very little information on the pharmaceutical and medical equipment industry and technology in the private health sector.

Analysis of the Issue

Characteristics, size, spread, heterogeneity and quality

The data brought out by the government regarding the growth of and size of the private health sector suggest that in the three states reviewed, there has been a tremendous growth of the health sector. This growth is largely in urban areas and in the private sector, especially in the developed states of Maharashtra and Gujarat, but not to the same degree in Rajasthan.

It is only recently that studies have been conducted on the role, profile, characteristics, functioning and quality of care provided by the private health sector in India. These studies tend to concentrate on the practitioners and hospitals. (Bhat R., 1999; Kabra S.G., 1991; Nandraj S. and Duggal R., 1996; Baru R., 1998; Kavadi S., 1998). There are also studies that examine the role of traditional practitioners in its various dimensions (BAIF, 1997; Kumar D. et al. 1992; Chand S.K., 1988; Yesudian C.A.K., 1994). Broadly, these studies reveal that majority of the qualified solo practitioners practise in urban areas. Unqualified practitioners, faith healers, traditional birth attendants, priests and local medicine women and men largely cater the rural areas, though they are also present in the cities. Viswanathan and Rohde (1990) estimated that there are around one million non-qualified rural medical practitioners, with the majority of them being solo practitioners in outpatient settings. Allopathic treatment is the dominant care provided in both urban and rural settings. Most institutions are small urban nursing homes, with an average size of 10 beds, and are operated by doctor owners. The services provided range from simple treatment to sophisticated operations. The provision of private laboratory and diagnostic services, and blood banks are limited to urban and semi-urban areas (Nandraj S. and Duggal R., 1996). Another trend observed is a mushrooming growth of corporate hospitals in metropolitan cities (Jesani A. and Anantharam S., 1993; Baru R., 1998). One of the interesting features revealed by the various studies is the wide variation in the type of providers available in India. They range from the unqualified person to the super-specialised consultant, and from the temporary outpatient clinic or hospital having less than three beds, to the sophisticated multi-speciality corporate hospital with technology as current as any place in the world.

In terms of utilisation of services, various studies conducted in the recent past reveal that the majority of the people utilise private health services, so that the private sector is now the major provider of curative health care in India (Duggal R. and Amin S., 1989; Kannan K.P. et al, 1991; NCAER, 1992; George A., Shah I. And Nandraj S., 1993; NSSO, 1989). The 52nd round of NSSO conducted in 1995-96 shows that 81% of outpatient care and 56% of inpatient care was provided through the private sector across the country, though considerable regional variation exists. Further analysis in terms of hospitalised treatment by government reveals that the rural population have relied more on the public sector than the urban population (NSSO, 1998). Table 2 further reveals that

among the three states selected, there is a higher utilisation of government health services both for inpatient and outpatient care in Rajasthan as compared to other states. This correlates with the data on hospitals and hospital beds in Rajasthan, which indicates that the private health sector has not penetrated much. In the majority of the studies reviewed, there is a correlation between urbanisation and the growth of the formal private health sector (Kavadi S., 1998; Baru R., 1998; Nandraj S. and Duggal R., 1996). Even in Rajasthan, we find that the growth of private hospitals has been higher in urban areas (Kabra S.G. and Malti Patni, 1991).

The financing of health services is dominantly private, through out-of-pocket spending by households on a fee-for-service basis. Studies reveal that on an average, Rs 500 per capita per annum is spent privately on health by households (Nandraj S. et al, 1998; Madhiwala N. et al, 1997). Compared to expenditure incurred by the government, private households spend about four to five times as much (Duggal R., Nandraj S. and Vadair A., 1995). The share of this sector works out to between four to five per cent of the Gross Domestic Product. There is, however, very little documented information available regarding the financing, payment, and charging practices in the private health sector. There were two studies, one in Mumbai and another in Delhi, which documented the earnings of the doctors and hospitals operating in the private health sector. The Delhi study reveals that the average monthly net income of a doctor practising at a clinic/residence works out to about Rs 29,800 and for a doctor running a nursing home, about Rs 80,000 per month (Kansal S.M., 1992). The Mumbai study revealed that the average monthly net income was over Rs 18,000 for a successful general practitioner (George A., 1991). Although this is around three times more than that earned by a doctor working in the government, this does not account for non-salary benefits and pensions earned in the public sector, or the business risks taken in the private sector.

Evidence from various studies point out the poor quality of care provided in the private sector. Stories are recounted of problems with diagnostic and treatment practices, inadequate facilities and equipment, over-prescribing and subjecting patients to unnecessary investigations and interventions, charging patients exorbitantly, unethical and irrational practices, and failure to provide information to patients. In spite of the problems with poor quality of care, the majority of people still approach the private health sector, probably because of its accessibility in terms of distance and timing, private providers' responsiveness to patients, and because of poor quality of services in the public sector. (Yesudian C.A.K., 1994; Uplekar et al., 1998; Bhat R., 1999; Nandraj S., 1994; Nandraj S. and Duggal R., 1996; Phadke A. et al, 1995).

From this description, it is clear that the growth of health services has been largely left to market forces, with the government playing a minimal role. As is discussed in more detail below, it is now necessary that government intervene in the private sector, particularly in the area of pricing practices and quality of care.

Collaboration and Partnerships

Contracting

Contracting has emerged as a new trend in public sector management, which identifies private sector mechanisms to improve the efficiency and responsiveness to its users. It is propounded that contracting would improve efficiency through promoting competition, greater transparency, provision of quality service at lower costs, accountability regarding outputs and outcomes and enhancement of accessibility to services. Contracting is defined as a normal market exchange of services which is formalised in advance by the issuing of a contract binding the buyer and seller to the conditions of this exchange (McPake B. and Hongoro C., 1995). Usually in a contractual arrangement, the purchaser and provider functions are separate. Contracting could take various forms and for various aspects of health care services. Certain services or all aspects of health facilities or programs could be contracted or handed over, including clinical and non-clinical services.

In India, discussions with key persons reveal that contracting has occurred under the blindness control program and AIDS control program, and franchising arrangements have been set up with private providers under the new national TB control program. There have also been a number of recommendations regarding contracting: that support services at hospitals be contracted out "wherever feasible"; that contracting out of mainstream diagnostic services and clinical services be evaluated; that contracting be used in the delivery of national disease control programs; and that non-government organisations (NGOs) be contracted to provide primary health services in remote rural areas (World Bank 1995 & 1996).

Highlights of studies reviewed : Many state governments, especially those having state health system projects, have contracted out non-clinical services. In Maharashtra, contracting of ancillary services was already common, particularly in Mumbai. The Bombay Municipal Corporation has been contracting out services such as catering, laundry and hospital maintenance. In spite of the importance attached by funders and government, there has been very little evaluation on the effect of contracting out of health services. We were able to identify one study that provided an assessment of the performance of contracting services. This study examined the contracting out of catering services by public municipal hospitals in Mumbai. The study points out that contracted-out catering services are significantly cheaper than those provided in-house, but the quality of services was assessed to be lower. The authors of the study point out that none of the hospitals attempted to monitor the quantity and quality of food provided by the contractor. (Bhatia M. and Mills A., 1997). It has been reported that in the West Bengal Population Program, decentralisation of the services in order to sustain and care for the urban poor is a strategy implemented where the complete ownership of the facility is with the local body, and all the clinical services have been out-sourced. 23 maternity homes are working on the same strategy around Calcutta.

Although several countries already engage in contracts for clinical and support services, little is known about the conditions required for the successful implementation of these

reforms, especially in the context of developing countries. Evidence of contracting in hospital services in developed countries comes mostly from the US and UK and suggests that though there were financial savings, transactional costs were high and the evidence is mixed on quality (Mills A. and Broomberg J., 1998). Evidence on the extent of contracting out in developing countries in this field is extremely limited and evaluation of its advantages and disadvantages has been virtually non-existent (Mills A. and Broomberg J., 1998). The London School of Hygiene and Tropical Medicine commissioned studies on contracting of health services in Bombay (Bhatia M. and Mills A., 1997), Ghana, Tanzania, Zimbabwe (McPake B. and Hongoro C., 1995; Gilson et al, 1997), Mexico (Alvarez et al, 1995), South Africa (Broomberg J. et al, 1994) and Thailand (Tangcharoensathien et al, 1997). The findings of these studies provide evidence on the issue of contracting in various settings. The justification for contracting of non-clinical services was that the costs were lower, it was less troublesome for the managers, and there was greater flexibility in the use of labour. Concerning clinical services, the justification was either the unavailability of the service in the facility or area, or the inability of government to provide service. In many African countries, many of the services were usually contracted out to not-for-profit providers, usually church-based organisations. Contracting for non-clinical services were consistently awarded competitively though it is notable that contracts rarely changed hands. In contrast, clinical services have rarely been awarded competitively, though in South Africa and Thailand, efforts were being made to introduce competitive bidding. The monitoring of contractor performance was frequently judged to be neglected. Contracts were not sufficiently specific on performance requirements, making monitoring difficult. Responsibility of monitoring was not clearly allocated. Contractors were capable of delivering adequate non-clinical services at low costs; however, quality was also low. It was also noted that there were problems with low wages paid to their workers, and poor management of the contracting process. Ann Mills, who reviewed the experiences of various countries on contracting mentions that "there remains relatively limited and contradictory evidence on the impact of selective contracting on efficiency and equity at the facility and / or at the health system level." She further states that the efficiency gains from contracting appear to be contingent on government capacity to act as an efficient purchaser, and more specifically to take appropriate decisions, design efficient contracts, and to monitor effectively contractor compliance (Mills A. and Broomberg J., 1998).

Concerns, challenges and options : In the Indian context, contracting out services may not be a solution to the problems plaguing the public health facilities and programs. A government that fails to deliver quality services due to lack of basic administrative capacity is unlikely to be able to contract either clinical or non-clinical services effectively. One crucial aspect concerning contracting is that it is based on the government's capacity to act as a competent and efficient purchaser in terms of designing efficient contracts and monitoring compliance. Lack of capacity would lead to inefficiency through exploitation by contractors. It is suggested that because of the 73rd and 74th Constitutional Amendments in India, whereby powers would be transferred to the local bodies, it will be possible to manage contracts better because supervision of contracts would be done closer to the sites in question. One justification for contracting clinical services may be to fill gaps in the public system where there are shortages of staff or facilities, although these places are also likely to be where there is also a limited private sector presence. It would be necessary to develop the local body's capacities to take on such contracts. A government with limited capacity could concentrate on services that are easy to contract, and where performance can be readily

measured, e.g., non-clinical services such as cleaning, laundry and security. Further, there is a need to strengthen information systems to monitor contractor performance.

Transfer of public health facilities

Another phenomenon is the transfer of public health facilities to private providers on a contract basis. Transfer of health facilities could be either in part or total.

Highlights of studies reviewed : There is very little documentation on this vital issue. In one recent case, the majority ownership of a public tertiary care hospital in Mumbai was bid to private firms in association with a state health system project funded by the World Bank, but it is too early to assess the impact of such a move. The Bombay Municipal Corporation has taken a policy decision to hand over many of its peripheral hospitals to the private sector. Many maternity homes had been built by the corporation, but were unutilised or used for other purposes. In one case, a peripheral hospital was handed over to a private medical college for clinical teaching, since it did not have a hospital of its own. This was done in exchange for a sum to be paid to the municipal corporation, but the deal became controversial, and as per our knowledge, the sum has still not been paid. Until recently, the Medical Council of India did not recognise the said private medical college. In this relationship, there was no apparent benefit to the people.

In Ahmedabad, a maternity hospital (minus staff) belonging to the municipal corporation was handed over to an NGO. Discussions with the management revealed that though the quality of care and utilisation improved, this was at the cost of cutting down the number of staff and giving those that remained wages below the minimum standard. Also, an infusion of funds from outside was needed. This practice has been repeated by a number of NGOs who have taken over the running of Primary Health Centres (PHCs), Health Posts in urban areas, and some health programs.

Concerns, challenges and options : Any transfer of public facilities needs to be examined in relation to the benefits that would accrue to the people, especially the poor. Further, there should be greater transparency, and the views of people should be taken into account when public facilities are handed over to the private sector, since these facilities have been built with the taxpayers' money. For example, the government should collaborate with NGOs that follow the rules of the country in terms of minimum wages and other social security benefits. One of the justifications provided by the government for handing over health facilities to the private sector is that they are under- utilised and function inefficiently. Clearly institutional changes are needed in both public and private sectors to increase accountability, improve efficiency, and to better meet social mandates such as providing services to the poor. Such changes are more important than changing the ownership of capital. There is no evidence to show that ownership of capital will in itself facilitate the type of changes needed. Based on experience elsewhere, we can speculate that private ownership and management may improve efficiency and quality, but there is also greater risk of not meeting social mandates for equity and improving other accountabilities.

Incentives and disincentives

Incentives are used to influence price, quantity or quality. Two major methods commonly used are to provide direct subsidies and to purchase goods and services. In India, incentives have been provided to the private health sector by giving land at subsidised prices, providing customs duty exemptions for the importation of medical equipment and drugs, and getting financial institutions to offer loans at low interest rates. There has been

little documentation and study to assess the effect of incentives in terms of the methods, finances, volume, process and the impact it has had on public health.

***Highlights of studies reviewed* :** Historically, government has given land at subsidised rates to the for-profit and not-for-profit sectors. Ramesh Bhat studied three governments' (Rajasthan, Punjab and Delhi) initiatives to provide land for setting up private hospitals, nursing homes and diagnostic centres for tertiary care. His findings reveal that land offered was mainly in urban locations with the exception of Rajasthan where land was also offered in rural areas. Further, his studies revealed that the government had limited capacity to handle such schemes, which were plagued by administrative and procedural bottlenecks.. It is ironic that governments were providing incentives to set up institutions in urban areas instead of rural areas where the need is more and that the provision of services to the poor in these institutions is handled in an improper manner. In Punjab, there was no provision in the contract for providing free care to the poor. This is of serious concern since, if such is the case, the purpose of providing incentives by the government remains unclear.

Another form of incentive the government has been putting forward is the customs duty waiver for import of medical equipment. According to Notification 64 A of the Customs Duty Act, imported hospital equipment would be exempt from customs duty only when the hospital provides free care to 40% of the outpatients and 10% of the inpatients. However, there is no regulation or monitoring being conducted on a periodic basis in the country. The major documentation has been by the government. There were two committees appointed by the government to examine this aspect in private hospitals. The first one is the House committee on Corporate Hospitals constituted by the Legislative Assembly of the Government of Andhra Pradesh. It found that private hospitals that had received concessions in land acquisition and import of medical equipment were not providing free services to the poor as per their agreement with the government. Further, the private hospitals were not providing sufficient information to the authorities concerned. There was lack of monitoring by any government agency. (Government of Andhra Pradesh, 1996). Another committee under the chairmanship of Mr Rosha has been set up by the Government of India to examine the violations by private hospitals that were provided incentives in terms of customs duty exemptions for import of medical equipment. The report is still awaited, but preliminary findings point to similar findings as of the Andhra Pradesh house committee. Recently the government has taken a decision not to provide customs duty waiver to the hospitals.

***Concerns, challenges and options* :** Currently donors emphasise strategies that include the provision of incentives to modify private care provision. At the international level there has been very little work done on this issue. Hughes (1993) examined target payment to physicians in the British National Health Service. The study found that in the long term, physicians had the incentive to reorganise existing services rather than provide extra services and still continue to receive the target payment. Experience with incentives has little history and is limited. International studies suggest that incentive-based schemes may be feasible in wealthier countries with sufficient capacity to monitor the schemes, but there is little experience of well-designed incentive schemes in low-income countries. While little use has previously been made of these schemes, it is clear that participants do respond to financial incentives, although not always in the manner predicted. (Lilani K., 1997).

Overall, it appears that incentives provided by the state governments in India have not been used to positively influence private care provision. In many instances, it has been seen that the government provides incentives to the private sector without ensuring any returns for the poor and disadvantaged people of the country. Such incentives have been put in place reactively to private sector interests, and have not been monitorable. It

remains to be seen if pro-active incentives, whether financial or otherwise, can be established in India to support public policy goals such as improving quality of care, influencing preventive care, or increasing the accountability of health care. From the perspective of public interest in the health system, there is little reason to perpetuate the type of subsidies that have been given to private, for-profit health providers in India.

Regulation

Regulation can be thought of as occurring when a government exerts control over the activities of individuals and firms (Roemer M.I., 1993). More specifically, regulation has been defined as " government action to manipulate prices, quantities, (and distribution), and quality of products" (Maynard A., 1982). The exact "action" is often described as the regulatory intervention or regulatory mechanism. The interventions used to affect action can be legal controls or incentives. Legal controls are legislated requirements that can lead to punitive action it they are not met. Effective regulation requires substantial information and enforcement machinery. The regulatory process involves setting the policy agenda; designing the legislation; and implementing and enforcing it. Regulation serves as a mechanism to discourage perverse practices and helps address equity concerns.

Highlights of studies reviewed : The studies reviewed primarily examined laws and their implementation concerning individual practitioners and hospitals (Jesani A., 1996; Nandraj S., 1994; Bhat R., 1996). They say that factors that contribute to the poor quality of services offered by the private sector are a lack of monitoring by authorities, outdated and inadequate legislation, and the inability or failure of the government to enforce existing regulations. The laws relating to registration and licensing of individual practitioners are not being enforced by the respective medical councils across states in India. The inept functioning of medical councils has required the judiciary to intervene in affairs that should have been handled by the medical councils of the states concerned. The studies also indicate that professional bodies, whether government sanctioned or voluntary medical associations, have not played a significant role in improving the practices of private medicine. One of the studies in Mumbai examined the views of a range of stakeholders on the need for an accreditation system for private hospitals. And the response was overwhelming. (Nandraj S. et al, 1999). Presently efforts are being made in Mumbai to set up an accreditation system consisting of various stakeholders. The above mentioned studies reveal that there is an absence of laws and regulations governing the practices of laboratories, polyclinics, diagnostic centres, and the various types of health care centres related to other systems of medicine. Where laws exist, they are inadequate and are not being implemented. The current laws do not provide a framework to ensure that minimum standards are maintained by the private providers. Further, there are no laws that try to influence the distribution of providers, the types of technology to be made available, the way charges are levied, or the prices themselves.

Studies have shown that that there is an abundance of medical equipment and technology in urban areas as compared to rural areas, leading to excess capacities. Between 1984 and 1986, over 60 diagnostic centres entered the market with an investment of over Rs 2000 million in sophisticated equipment. Bombay had thirteen body scanners, Delhi eleven, Madras eight, Calcutta three, Hyderabad two, Pune three, and Ahmedabad three (Jesani A. and Anantharam S., 1993). The influx in technology may well have led to irrational use of medical equipment and services, though this has not been systematically analysed in India. Yet unnecessary investigations, referrals and hospitalisation inevitably occur in settings where it is known that there are kickbacks between referring

practitioners, hospitals and laboratories. In many hospitals, doctors are under pressure to see that the beds are occupied all the time and the equipment utilised fully. Many hospitals fix the amount of "business" a physician or surgeon has to bring over a certain period. Oversupply of doctors in the private health sector has also created unhealthy competition that has led to unnecessary, or over–medication of otherwise healthy people (Nandraj S., 1994).

The failure of the government to enact the necessary legislation and strengthen existing laws permits many of the market imperfections to proliferate. The government's efforts to regulate in many instances are opposed by powerful medical lobbies using various means. Many state governments that wanted to enact and implement legislation for private hospitals found their efforts thwarted. The NHA (Nursing Home Act) of Gujarat faced resistance from the solo practitioners because it was just copied from the NHA Delhi, 1953. Similar opposition arose for the Consumer Protection Act, but it was not scuttled, in part because it received overwhelming support from the consumers. A survey was done on the litigation, and it found that more than 50% of the cases were against the solo practitioners (Bhat R., 1996). The capacity of the government to regulate the private health sector has been found lacking (Bhat R., 1996; Jesani A., 1996; Nandraj S., 1994).

Concerns, challenges and options **:** A review of existing literature on regulation in developing countries finds that regulations have mainly focussed on the behaviour of private providers of health care. In most cases, basic legislation on health personnel such as registration/licensing requirements, the establishment of professional councils and restrictions against dangerous or unethical clinical practice exist. Despite the existence of these regulations, the degree to which they are enforced, and hence their effectiveness, is low (Bennet S., 1991). The enforcement of regulatory controls is often lacking or weak, with limited funding available to the professional bodies concerned. In Thailand extensive legislation affecting the health sector have been hampered in their implementation by the small number of staff used for proper monitoring and enforcement. Secondly, even if the bodies are adequately resourced they are more often reluctant to operate against their own membership and self-interest.

The limited studies conducted in India and internationally makes a strong argument for a minimum set of basic regulations covering licensing of practitioners and institutions, measures to ensure minimum standards of quality, guidelines over pricing, and actions to prevent the oversupply of services (including technology). One important aspect of the need for legislative regulations is that they can be pursued in the larger context of the judicial process. The example of the Consumer Protection Act in the Indian context provides evidence in this regard. There is a need to examine existing legislation that is outdated and make appropriate changes. Or else have a comprehensive legislation which would encompass all aspects related to public health: licensing, price, distribution, financing, information provision, and consumer protection, among others.

In India, with its dominant private health sector and relatively weak government oversight, there is a need to develop self-regulatory systems that involve the stakeholders and which are less threatening. Accreditation as a self-regulatory system is gaining acceptance as revealed in the study conducted in Mumbai. One of the foremost steps for any intervention or involvement would be to develop an appropriate information base on the private health sector. Presently there is inadequate and insufficient information on the size, role, and functioning of the private health sector. Many governments are

handicapped by the lack of information on this dominant sector. Information of private providers could be linked with registration/licensing mechanisms.

Private practice by government doctors

In India it is common knowledge that individual providers in the public sector will often see patients on an informal basis after duty hours or even during them at an official public health care facility for the payment of usually illegal fees. The involvement of government doctors doing private practice blurs the distinction between the public and private sectors, since the same individuals operate in both. Many state governments have banned private practice by government doctors with varying degrees of success, due to the opposition from doctors. Where it has been banned the enforcement of the bans has not been effective and the mechanisms to check this practice have been weak.

Highlights of studies reviewed : The few studies conducted have shown that a large percentage of doctors employed in the public sector practise privately. They often use the government hospitals to treat their private patients. (Rama Devi, 1985 as quoted in Baru R., 1998). Another study in a teaching hospital found that of those who responded, almost all the civil surgeons and more than half of the assistant civil surgeons practised privately, with some of them having clinics and some operating as consultants in private hospitals. (Baru R., 1998). There have not been many studies we came across that examined the extent of private practice across states and the mechanisms for monitoring of enforcement or regulations in the states that have banned them at some time. It is assumed that there are wide differences in pay scales for government doctors, and in the amounts doctors could make in the private sector, often depending on their location of practice. A literature search revealed that there is very little written about private practice by public doctors in India, which is partly due to the sensitive nature of such practice and difficulty in collecting valid and reliable data. However, it appears to be rather widespread.

***Concerns, challenges and options* :** There are various problems associated with this form of dual practice. The physician seeing the patients privately would provide more time and better care and normally would treat the patient in the public sector. While the system may work fine for those can afford private care, it is much to the detriment of the poor who approach the public sector. Another problem is that potentially paying patients in the public sector are diverted to private practice, which hurts the income of the public health services. The public health care services are hurt further as one finds the care provided by government doctors hurried and impersonal. Charging fees privately in government facilities raises problems of accountability and trust within public hospitals. Doctors in public hospitals also divert patients to private clinics or hospitals by being critical of the public facilities. The above statements cannot be backed by empirical data, since the limited studies have not covered these issues but discussions with key persons both in government and outside reveal the prevalence of such practices. Although there is limited documented evidence, the effects of private practice on physician behaviour and staff morale lead us to believe that the government ought to effectively ban private practice by government doctors. To make up for past failures, different mechanisms would need to be put in place to enforce the ban, and increased government spending would be needed to improve the salaries, working conditions and accountabilities of those working in the public sector.

Provider and consumer information

Some of the problems related to the private health sector are due to insufficient information available about the providers and consumers. Two studies were conducted in Bombay on the knowledge and awareness of doctors regarding tuberculosis and leprosy. It was found that for treating tuberculosis patients, 100 private doctors prescribed 80

different regimens, most of which were inappropriate and expensive (Uplekar M.W. and Shepard D.S., 1991). In the study with regard to leprosy, it was found that there was a gross lack of knowledge and awareness among private doctors about leprosy and about the National Leprosy Control Program. (Uplekar M.W. and Cash R.A., 1991). It was also observed that providers do not provide sufficient information to the patients. Many of the doctors, while dispensing medicines and injections, or recommending investigations, do not provide information to the patient regarding the diagnosis and side effects. These observations are also reflected in the above mentioned study by Medico Friends Circle, which found that 41% of the doctors did not give information about the diagnosis and among those who gave information only half gave complete information. Only 16% of the respondents were given information about side effects of drugs (Medico Friends Circle, Bombay Group, 1993). The patient has a right to be informed, and the doctor a duty to inform the patient. Yet there is no reasonable system of continuing education for the doctors to encourage such behaviours, or to update physicians with current information in medicine. The licensing of doctors is not dependent upon upgrading knowledge and skills. In India the main source of continuing education for doctors are the medical representatives of pharmaceutical companies.

Concerns challenges and options : One of the major reasons for the ills in the private heath sector is the ignorance of the consumer. There is information asymmetry, and providers have a financial interest in continuing treatment, and to exploit the situation as long as the client is ignorant. One area the government could focus on is the provision of public information. Provision of information to both the provider and consumer is lacking in the country. There is a need to establish centres where such information could be provided to both of them in a language and form that is understandable. A citizen's charter needs to be designed to inform the public about nursing homes, definition of nursing homes, quacks, etc. Further, there is a need to look at the patient's perspective of quality.

It is imperative that government intervenes through various means in the private health sector. The foremost concern is to articulate and define the roles of the public and private health sectors. The underlying assumption is that the government would have to provide and finance some health care services, and intervene in the area of regulation.

The government should provide basic health care services to the people, as the majority of the poor are dependent on it. It just cannot shirk this responsibility. In areas where it is not able to provide services, it should collaborate with the private sector. It needs to be mentioned that the partnerships between the private and public health sector have certain basic contradictions. Given that the state has a responsibility to ensure that health services are available to all the population, a divergence of objectives between the state and the private for-profit sector can be anticipated. The state aims toward equitable service provision, and the private sector is driven by the desire to maximise profits (Bennett S. et al, 1994). The challenge, therefore, is to develop and evolve partnerships that serve public health goals. This collaboration could be in the areas of limited contracting of health services and facilities where the private sector would be a partner. Such arrangements would need to overcome the current situation where the private sector provides little preventive care. Transfer of public facilities to the private sector needs to be examined in the context of provision of care to the poor and needy.

Another assumption relates to regulation. It is a general belief that India is typified as being an over-regulated economy due to the extension of the state in many activities. However, Dreze and Sen (1995) argue convincingly that this applies only to business spheres, and in the social sectors, the state has been notable by its limited presence. The government should not shirk its responsibility to regulate. It needs to understand the new roles it has to perform and develop capacities to handle those new roles. The roles of policy formulation, monitoring and evaluation will assume greater importance in the new environment. The existing structure and functioning of many departments dealing in health is not at all conducive to the new roles. Effective implementation of these functions would need creative structures. Regulatory capacity requires a considerable degree of decentralisation and local responsibility and authority. In addition, sufficient funding and resources need to be provided to regulators to carry out regulations. The point is not just regulating the private sector, but to go beyond it. The regulation of private sector needs to be articulated within the fundamental reforms aimed at making health care universally accessible, of high quality, financially fair, and responsive to people's interests.

Table 1: Health Care Services in India

Doctors	Total Number (1995) (includes all systems) (CBHI)	**9,81,325**
	Population Per Doctor	862
	% age of Doctors in rural Areas (1981) (Census)	41
	Estimates	
	% age of all Doctors in Private Sector	85
	Population Per Private Doctor	1014
Dentists	**Total Number (1995)**	**23953**
	Population Per Dentist	35332
Nurses	**Total Number (1995)**	**867184**
	Population Per Nurse	976

	Doctors Per Nurse	1.4
Hospitals	**Total Number (1995)**	**15097**
	Population Per Hospital	56,058
	% age of Hospitals in Private Sector	68
	Population Per Private Hospital	82253
	Population Per Govt. Hospital	176020
	Estimates	
	Total Number	71,860
	Population Per Hospital	11,744
	% age of Hospitals in Private Sector	93
	Population Per Private Hospital	12,628
Hospital Beds	**Total Number (1995) (CBHI)**	**623819**
	Population Per Hospital Bed	1357
	% age of Beds in Rural Areas	21
	Rural Population Per Rural Bed	6911
	Urban Population Per Urban Bed	1688
	% age of Beds in Private Sector	37
	Population Per Private Bed	3709
	Population Per Govt. Bed	2139
	Estimates	
	Total Number	12,17,427
	Population Per Bed	693
	% age of Beds in Private Sector	64
	Population Per Private Bed	1,083
	Population Per Govt. Bed	1,926

Sources:

1. CBHI (Central Bureau of Health Intelligence), "Health Information of India" respective years.
2. Census of India, 1981, Census Commissioner of India, Ministry of Home Affairs, Government of India

Notes:

1. Our estimation of proportion of doctors in private sector is an underestimation.
2. In order to calculate Doctor-Population ratio for rural and urban areas, the proportion found in 1981 Census has been applied, as the 1991 Census data on this are still not available.
3. Our estimations of number of hospitals and beds are based on the extent of under-estimation in government (CBHI) data found in Andhra Pradesh in 1993 Survey (Census of all hospitals) by the Director of Health Services (Andhra Pradesh) and the Andhra Vaidya Vidhan Parishad. They found 2802 hospitals and 42,192 hospital beds in the private sector in Andhra Pradesh as against only 266 hospitals and 11,103 beds officially reported by the CBHI in that year. Thus, the Official (CBHI) data under-reported the private hospitals by 10.5 times and beds by 3.8 times. This indeed is very rough and inaccurate estimation. However, the intention is only to show the trend.
4. 1991 Census population (rural, urban, total) figures are used for calculating ratios.

Table 2: Health care services in selected states

	Gujarat		**Maharashtra**		**Rajasthan**		**All India**	
	1981	**1995**	**1981**	**1995**	**1981**	**1995**	**1981**	**1995**
Hospitals								
Total	828	2528	1002	3115	229	218	6805	15097
% Urban	96	93	90	85	90	93	73	69
% Private	81	85	68	83	16	* 17	44	68
Hospital beds								
Total	32081	63417	69810	78920	16589	21187	476226	623819
% Urban	95	91	93	87	96	94	86	80
% Private	53	58	37	48	12	* 10	28	36

Total Doctors (Allopathic) (Registered)	18385	26132	41078	57167	8713	16612	268712	405224
Population per Allopathic Doctor	1854	1580	1528	1381	3932	2649	2543	2088
Health Expenditure								
As % total govt. revenue expenditure	7.11	5.21	6.53	4.67	8.28	6.97	3.29	2.63
As per capita expenditure (in Rs.)	18.83	80.00	19.94	77.87	16.61	92.56	17.35	85.10
NSS 52nd Round (1995-1996)								
% non hospitalised treatment from govt. sources (rural)		25		16		36		19
% non hospitalised treatment from govt. sources (urban)		22		17		41		20
No. (per 1000) of hospitalised treatment from govt. sources (rural)		321		312		649		453
No. (per 1000) of hospitalised treatment from govt. sources (urban)		369		318		731		431

Notes : *Data relates to 1990 and is an underestimate.

Population figures in column 1995 relates to 1991.

Population : Exclude figures for J & K where the 1991 census could not be conducted due to disturbed conditions.

1995: Data on expenditure are Budget Estimates.

Sources:

Health Information of India (earlier Health Statistics of India), Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, Government of India, respective years.

Doctors (census) Census of India, General Economic Tables, Registrar General & Census Commissioner of India, Ministry of Home Affairs, Government of India, 1981

Population: Census of India, 1981, 1991, Census Commissioner of India, Ministry of Home Affairs, GOI

Health expenditure: Combined finance and Revenue Accounts, CAG, GOI, 1981, Demand for Grants, Respective state governments, 1995

NSS: National Sample Survey Organisation (1998). Morbidity and Treatment of Ailments: NSS Fifty-second Round, July 1995 - June 1996. Government of India: Department of Statistics.

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Private-Public Sector Partnership in Health Care Sector in India:

A Review of Policy Options and Challenges

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Introduction

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The primary motivation for this paper was the following question: What can the state and central governments do in dealing with the private sector provision and financing in India? This question may be rephrased as what should or can governments do to make private sector function better than it does now? I would like to extend this further, and add a corollary question: Should governments worry about private sector in order to improve their (governments') own functioning[1] ? And then: Can both private sector and public sector improve their functioning through a "partnership" of some kind?

To those who believe in evidence-based policy making, the suggestion for "partnership" between private and public sectors is yet to be demonstrated as superior to other ways of meeting certain health policy goals (either at state or smaller regional contexts) in India.[2] Two possible reasons for lack of such studies are:

(a) The idea of forging partnership with the private sector has been pursued as a policy option rigorously only in the recent past.

(b) Even in those few instances where partnerships had played a role, no study had been planned to compare their outcomes with alternative policy options.

But a fair basis for pursuing partnership on an experimental basis can arise from the mere fact that private sector is all-pervasive and its reach is far greater than that of the public sector.

Needless to say, such policy experiments should eventually be subjected to evaluation in terms of their outcomes. Analytically, partnership between public and private sectors in health can be seen as a form of intervention in the overall structure and functioning of the health care system. A series of concerns arise: What options exist for forging partnership? How should they be implemented? How should they be paced and how long should be pursued to establish stability of reforms and desired effects? What are the enabling conditions for reforms to have continued positive (intended) effects?

But there is also an overarching question: *Does the government have capacity to intervene and be effective?* This is a very fundamental question that state and central governments must address to assess realistically what they can do and what they cannot do, lest they end up being over-ambitious in setting goals and devising strategies.[3]

We present a review of literature available on the various characteristics of the private health sector in the states of Tamil Nadu, Karnataka and Kerala. This will help us identify what we do not yet know but should know in order to develop desired partnership. further we describe the policy context for policy options and propose a set of policy options for partnership. The concluding remarks are given in the last section.

There are very few studies on the private health sector in the states of Tamil Nadu, Karnataka and Kerala. Although they are insufficient to draw definite inferences for our purpose, they do provide certain insights into the nature of private health sector in these states in particular and in India in general. These are presented below

Size, growth and distribution

The size of the private sector can be shown in terms of number of beds, number of private clinics with and without inpatient facilities, size of workforce, market-share (in terms of the number of in-patients and out-patients it caters to), assets owned, etc. It is also useful to have their rural-urban distribution. But there is very little information available on these rudimentary aspects in the regions of our concern. A crucial aspect of this issue is the number of indigenous medical practitioners. It is very difficult to estimate their number, and more efforts are needed to do so. Not only should we have an estimate of their number, but also knowledge of variations in their practice, the quantum and quality of services they provide, and the charges thereof.

A recent census on private medical institutions in Kerala (1995) provides the following findings:

1. As on 31 March 1995, there were 12,618 private medical institutions in the state. This shows an increase of 31% over 1986. There were 4288 allopathic medical institutions, 4922 ayurvedic institutions, 3118 homoeopathic and 290 institutions following other systems of medicine.

2. A total of 70,924 beds were available in all institutions, compared to 50,766 beds in 1986 – an increase of 40%.

3. 45% of 4288 allopathic institutions had in-patient facilities, whereas only 4.7% of ayurvedic institutions and 1.4% of homoeopathic institutions had in-patient facilities.

4. Some of the private institutions provided training facilities to paramedical personnel. The study reveals that 155 institutions had training facilities for nursing, 52 institutions for laboratory technicians, and 19 provided training for family welfare programmes.

5. 305 allopathic units had intensive care units, 83 had scanning facilities, 64 had echo test facilities and 18 had laser treatment facilities. These details were not collected during the 1986 survey.

It is also useful to know the size of the private sector within a given region (in a specific town or district, rural or urban area). In simple terms, this can be shown in terms of their total bed size. But such micro-level studies are practically not available. Muraleedharan's (1999a) study provides an estimate of private sector within Chennai (formerly known as Madras). While the average bed-size of a private hospital in Chennai was about 30 (N=383) and that of a public hospital was 495 (N=25), their share in the total beds were almost equally divided, 48.6% and 51.4%, respectively.

Ownership, work force, volume of work, and performance

Available evidence suggests that a majority (about 60%) of private hospitals are owned by one individual, usually by a practising doctor (Muraleedharan, 1999a, and Government of Kerala, 1996). These are classified as "sole-proprietorship" hospitals. A substantial number of private hospitals are likely to have a "partnership" model of organisation, with a very few belonging to "corporate, public limited", or "trust hospital" (equivalent of not-for-profit category). The size of sole proprietorship and partnership categories is likely to vary across states, but there are very few corporate public limited hospitals in these states (Muraleedharan, 1999a). If we also consider stand-alone clinics that cater to only out-patient services, the proportion of sole-proprietorship category is likely to comprise more than 80% of the private sector.

Data on workforce in the private sector is hard to come by. In fact, there is very little reliable data even on the total strength of active medical and other health care professionals in any state. A recent study in Tamil Nadu estimates that as of December 1997, there were a total of 37,733 allopathic physicians in the state of which about 10,000 physicians were employed in government services (Muraleedharan, 1999b). This means that about 70% of physicians were in private sector in these states. We have no estimate of how they are distributed across rural and urban areas. However it is not difficult to imagine. In and around Chennai city alone, about 10,000 doctors (including those in private and public sectors) are located. Likewise, about 35 percent of an estimated 2035 dentists in Tamil Nadu was located in and around Chennai city. The current estimate indicates that there is one doctor to 800 people in Chennai city, while the average population coverage per doctor for the whole state is about 1590. If we exclude those medical personnel located in district capitals and other large towns, we find very low population coverage in rural areas.

The Kerala census shows that about 13 percent of private allopathic medical institutions have just one physician and about 42 percent have not more than four physicians (Government of Kerala, 1996). Most sole proprietor type hospitals employ one or two junior-level physicians and often depend on visiting consultants. The survey reveals that while there were 12,473 doctors and 15,221 paramedical staff in 1986, there were 19,963 doctors and 28,641 paramedical staffs in 1995. Nearly 50% of doctors were employed in allopathic institutions. This is followed by ayurvedic (30%) and homoeopathic (17%) institutions. In the case of paramedical staff, allopathic institutions employed about 88% of the total employed in all institutions.

It is thus easy to imagine how difficult it is to obtain data on volume of work done by, and performance of, the private sector. The Kerala census reveals that about 30% institutions treated less than 1,000 patients per year. Only 300 of them treated more than 25,000 patients per annum. *Based on this we cannot say whether or not these institutions are underemployed, but it is suggestive of underemployment of personnel.* Muraleedharan's (1999a) study of the private hospital sector in Chennai showed that on an average a physician spends 3.11 hours per day in a hospital. This study also showed that most physicians visit at least two different practice localities.

Data on volume of work and performance of private hospitals is perhaps the most difficult to obtain. Most hospitals, including many large hospitals, have no proper patient

records and retrieval system. Financial performance data is impossible to obtain. Homan and Thankappan's (1999) study, based on primary data collected from nine private hospitals in Trivandrum district shows that those located in Trivandrum Taluk were operating at a high occupancy rate, while those in other Taluks in the same district were not. Their explanation is that these hospitals were established recently, and the general perception is that better quality of care is available only in large city hospitals. This study also reveals other interesting dimensions of private sector:

(a) The shortest average length of stay tends to be in private sector

(b) Doctors in private hospitals tend to order more x-rays per patient (55%) than in the public sector

(c) About 25% of laboratory tests in the public sector are referred to the private sector.

In Chennai city, the majority (45 of 72) of private hospitals surveyed reported to have a contract with one or more diagnostic centres or hospitals for diagnostic purposes. Evidently this requires further study.

Payment methods and incentives for quality

The nature and functioning of private physicians' market, and therefore of the private health sector, is likely to be influenced by how the physicians are paid for their services. Except Muraleedharan's (1999a) study, there is virtually no study on this important aspect of the private health sector. This study identifies three different payment methods prevalent in the urban private hospital sector. These are

(a) Flexible Fee Schedule (FLFS),

(b) Fixed Fee Schedule (FFS), and

(c) Fee Sharing System (FSS).

All of these methods involve fee-for-service payments taken directly from patients. Of the three methods, FLFS is the most widely prevalent. Typically, in these payment methods, three parties are involved: patient, physician and hospital. In India, most payments by patients are made out of their own pocket. In FLFS, the patient pays the physician's fee directly, while the hospitals also charge the patient directly. The physician does not interfere with what goes on between the patient and the hospital, and the hospital does not interfere with what goes on between the physician and patient. The physician will be required to make a periodic payment to the hospital (for office space and other expenses). In some instances, the doctor may collect a fee from patients for distribution to teammates, or the hospital may do this. The essence of this FLFS is that there is no control over the physician's charges. It is left to the physician to fine-tune it based on patient characteristics, including medical condition and socio-economic situation.

In a Fixed Fee Schedule (FFS), the fees for physicians are fixed, usually by the hospital. Only about 15% of hospitals are known to be following this method. But it is important to note that FFS is not uncommon in smaller hospitals. The Fee Sharing System (FSS) is perhaps more common in large hospitals, particularly in certain specialities such as Cardiology, Urology, and Neurology. In this case, the fees are fixed per consultation. The patient pays first directly to the hospital. For each payment, a physician code is entered. As a result, total fees collected against individual physicians can be obtained over a period of time. At the end of every month, or week, a fixed percentage of this total is paid to the concerned physician as his or her share. In addition, he or she may get some incentive amount based on volume of patients consulted. The remaining goes to the hospital's account. The latter two methods (FFS and FSS) are not so common, but it is important to know that such variations exist.

Given that most patients pay out of pocket, none of the three payment methods has any built-in mechanism for cost containment. As a result, quality is likely to suffer under such a payment system. There is enough international literature to show that wherever out of pocket payment and fee for service payment method exist, physicians will have incentives to oversupply care, pushing total costs of care. The Indian urban scenario fits this story well. Both Pai et al's study (1999) and Muraleedharan's survey (1997) in Chennai showed an alarmingly high caesarean delivery rate of above 40%. Both studies attributed this to the payment system prevalent in private hospital system (see also Muraleedharan, 1999c, for a summary of issues relating to caesarean-section deliveries). However, this requires a more detailed investigation and research.[4]

Competition and market strategies

Again, there is a dearth of studies on this important dimension of the private health sector. It is evident that the private health care market has grown significantly over the last decade or so in India. The growth is more evident in urban areas[5]. As a result of overcrowding, one would expect private providers to have competitive charges for services they offer. But how could one test this hypothesis?

The difficulty lies not so much in availability of analytical skill or methodology, as in lack of systematic data on relevant variables. Muraleedharan's study (1999a) of charges for comparable services in private hospitals in Chennai city showed that there were no significant differences amongst them. His study also suggested that private hospitals' competitive (pricing) behaviour does not seem to be influenced by presence or absence of public hospitals, it being "indicative of non-price competition among private hospitals (in urban areas)".

Private providers, as part of their competitive behaviour, also have learned to make use of public sector resources, particularly the experience of physicians in public hospitals. In Tamil Nadu, as in many other states of India, it is common for government doctors to work as consultants in private hospitals. This is believed to be more common in large urban areas. Muraleedharan's (1999a) survey showed that nearly two-thirds of private hospitals had government doctors in their panel as consultants.

On average, a private hospital had 2.10 government doctors as visiting consultants. Having them in their panel provides a competitive advantage over those that do not to the extent that they offer additional services. It is very essential to capture this phenomenon in greater detail since they have direct relevance to policy decisions and are useful for devising mechanisms to tap private sector resources.

Sukanya's study (1995) on capital investment in large private hospitals in Chennai reveals that investment on high-technology equipment is viewed as a competitive strategy for increasing market share. Many hospital managers in that study also shared the view that they were forced to recover the investment on capital equipment through "excessive" referrals[6]. Several state financing institutions give term lending to private hospitals for capital investment purposes. But many of them complain that most hospitals do not repay the loans either due to mismanagement of resources or due to overestimation of their capacity to attract adequate patient load.[7]

Contracting and regulatory issues

Bennett and Muraleedharan's (1998) study provides a critique of contracting and regulatory mechanisms in operation in the health sector in Tamil Nadu. But their study is not an evaluation of the impact of contracting and regulatory policies. Overall, they observed that in Tamil Nadu, the administration has forged ahead with certain aspects of New Public Management reform. This is bringing about a number of changes in the role of the government, using autonomous organisations, and strengthening of regulatory mechanisms. Many of these changes can be seen as a focus on liberalisation (on freeing government activities from bureaucratic procedures) rather than on privatisation *per se*. Most states in India until recently have ignored regulatory issues of the private health sector.[8] Bennett and Muraleedharan (1998) brought out the poor communication between the Department of Health and the various statutory self-regulatory bodies over regulatory issues. Improving communication between the various members of regulatory bodies therefore seems a critical task ahead, if government wishes to improve regulatory performance. Until recently, professional bodies exercised regulatory authority over medical and allied professionals in India. Though several explanations can be given for their lack of control over their members, it cannot be denied that they were also constrained by lack of autonomy and certain external factors, such as civic-public interaction, political structures and preference, in their performance. But it is difficult to brush aside other maladies, such as lack of motivation and self-interest, which undermined their efficacy. The process of implementing the recent Private Clinical Establishment Act (1997) in Tamil Nadu offers some insights into factors that limit government's capacity to address such issues. There is much opposition to this Act among several interest groups stemming from the concern amongst private providers that this Act is aimed at promoting rent-seeking behaviour by government and that government hospitals are being excluded from this Act. Also, there is a substantial lack of awareness about this Act amongst medical professionals themselves; and disagreement over who constitutes a "competent authority" with powers to inspect and suspend the licensed private hospitals/providers. To gain the confidence of the various stakeholders,

particularly of the private health sector, policy makers are now forced to consider simultaneously the problems of the public sector as well.

Bennett and Muraleedharan (1998) identified four different contract arrangements in Tamil Nadu. They relate to laundry services, high-tech equipment in public hospitals, equipment maintenance services, and advertisement for the AIDS control programme. For laundry services competitive bidding was advertised in newspapers, while for high-tech equipment maintenance, direct negotiation with a provider was employed. In the case of AIDS advertisement, bidding and a short-listing of competitors based on their experience was employed. Thus, a variety of procurement methods have been tried, for non-clinical and clinically-oriented services. In all cases, there were very few bidders for contracts. Virtually all the contracting arrangements studied were for new services, which did not involve stopping direct provision or retrenchment of staff, and so there was no opposition from trade unions. The only exception was an attempt to contract for laundry services in Coimbatore General Hospital. The attempt ran into opposition from the staff. It was not possible to lay off existing staff, and the contractor was unwilling to take on government employees. The government employees were also not willing to work for the contractor. Overall, the study concluded that both internal and external factors operated in constraining governments' ability to contract. Internally, central bureaucracy affected contracting out arrangements critically. Although Chennai has a sizeable presence of private sector, which in principle should mean considerable number of competitors for contracts, for specialised services such as medical equipment maintenance, there were few firms bidding for contracts.

Internationally, public partnership with the private sector has grown in the form of contracts. Available evidence from developing countries shows that contracting is contingent upon "government capacity to act as an efficient purchaser, and more specifically to make the appropriate decisions as to whether and when to let out contracts, to design efficient contracts and to monitor effectively, contractor compliance. Conversely, lack of this capacity may lead to inefficiency through exploitation by contractors, through distorted resource allocation" (Mills and Broomberg, 1998, p.29). Contracting also requires several generic skills and resources that governments require, including skills in planning, economic analysis, contract design and negotiations, as well as a suitable information system (*Ibid*. p.29). *There is also evidence that contracting capacity will be very weak when there are inadequate financial resources* (*Ibid.* p.30).

In the Indian context these observations broadly hold good, as shown in the case study of Tamil Nadu (Bennett and Muraleedharan, 2000). But as yet, there has been no evaluation of the limited contracting experience to examine savings, transaction costs, quality changes and equity implications. The existing literature suggests several generic factors that may impact on the capacity of government in addressing both regulation and contracting issues in the health sector (Hildebrand and Grindle, 1995; and Bennett and Muraleedharan, 2000). The following three factors are worth mentioning here:

1. The private sector is sceptical about govern-ment's intention to improve quality of care. This springs from the low credibility that the government enjoys in the eyes of the private sector and public in general. To some extent the government is aware of these constraints.

2. Public sector unions pose further constraints on the capacity of the government to take on new roles.

3. Government's capacity to design contracting mechanisms is likely to be weak under a weak administrative and legal system.

The effectiveness of the third factor varies from one state to another in India. Although it would fit the overall picture, the judiciary in India is playing a more positive role with respect to the Consumer Protection Act. However, there is no study on the effects of various civic action groups or other mechanisms providing information to consumers and providers.

As mentioned in the introductory section, the primary aim of this paper is to explore policy options for promoting partnership between private and public sectors. We identified, from a review of available literature, a number of weaknesses in the present structure and functioning of the private sector. These weaknesses constrain policy options available for effective partnerships. They may be summarised as:

(1) weak regulatory regimes to oversee the behaviour of private health sector;

(2) weak capacity of government to design and implement contractual arrangements with the private sector;

(3) lack of a research and information base on the dynamics of private providers;

(4) lack of a policy framework for promoting private health sector (till date, the private health sector has grown passively, without any proactive policy).

To this we should add a more serious constraint: There is mutual distrust between the government and the private sector. This was brought out clearly in Bennett and Muraleedharan's study (1998) of the Tamil Nadu health sector. To put it differently, there is a need for the government to improve its credibility, if effective and long-standing relationships have to be evolved. Much of the contractual arrangements should focus on relational aspects rather than on cost *per se*.

Policy options for forging partnership should also recognise another crucial dimension of the private health sector in India. This relates to increasing the out-of-pocket expenditure for health care. A recent study from Kerala (Kunhikannan and Aravindan, 1999) on health expenditure shows clearly the increasing financial burden of care on the poor over 1987—1996. Among other things, their study shows that the medical expenditure per ill person per episode increased from Rs 16.50 to Rs 165.20 during the decade, an increase of more than 1001%. The per capita medical expenditure rose from Rs 88.92 to Rs 548.80 during the period, an increase of about 520% in nominal terms.

- This explosive increase was not confined to medicine alone. The period witnessed a big increase in doctor's fees, laboratory charges, etc. This phenomenon, (called "mediflation") also affected other systems of medicine, although not to the same extent.
- It is important to note that the difference in expenditure in private and government sectors were not significant.
- The most "disturbing fact" arising from this study, according to the authors, is that the impact of "mediflation" was most severe in the lower socio-economic groups. "While the rise in per capita medical expenditure in the study period is 326% in higher socio-economic groups, it is 768% in the poorest group, and a whopping 1002% in its next higher lowest group. Similarly, the ratio of annual per capita medical expenditure to the per capita income shows a very uneven distribution across the social groups. In the richest segment, this ratio as a percentage was 2.18 in 1987 and 2.44 in 1966, whereas in the poorest it rose from 7.18% to an almost unbelievable figure of 39.63%" (Kunhikannan and Aravindan, 1999).

This has lead many people to indebtedness in rural and urban areas. In absolute terms, the poor are spending as much as the richest on medical care. This has occurred in a period of remarkable decline in morbidity.

It is indeed a worrying trend that the poorest are spending more than 20 per cent of their income for health care Evidently, equity considerations have not received adequate attention. But here again, recent comparative research on various financing mechanisms have shown both out-of-pocket basis and fee for service payment method (both of which are highly prevalent in India) to be highly inefficient and inequitable in access to care (WHO, 1999). Clearly, the challenge lies in devising a combination of financing mechanisms, that will protect adequately the poor and also ensure efficiency in delivery of care to a wider section of the population.

Recent national surveys have also shown that in *both rural and urban areas, dependence on private sector for outpatient and inpatient services has substantially increased over the last decade.* The 52nd NSSO data shows that the number of people treated as outpatients in private sector in rural areas has increased from 74% in 1986—87 to 81% in 1995—96; in urban areas it has increased from 72% (in 1986—87) to 80% (in 1995—96). In the case of inpatient care, the increase in both rural and urban areas over the same period has been 40% to 56%, and 40% to 57%, respectively (NSSO, 1998). What is even more important is that the financial burden per episode in both public and private institutions has grown several-fold. The average expenditure (at constant 1986—87 prices) for inpatient treatment per episode in rural areas has gone up in public institutions by 26% to Rs 912 (in 1995—96) and by 48% to Rs 963 in urban areas. The increase in out-of-pocket expenditure for inpatient treatment per episode in private sector is even more alarming: 63% in rural areas and 50% in urban areas, over the same period at 1986-87 prices[9]. How should governments react to this increasing financial burden on the poor in particular? Does the fact that people are paying out of pocket for health care imply their willingness to pay? Mathiyazhagan's study (1998) in rural Karanataka suggests that there is considerable scope for health insurance through community financing in rural India. Although his study does not quantify how much rural people are able to pay, it does bring out clearly their willingness to pay and participate in rural health insurance schemes. This underscores the need for a clear policy framework and guidelines for financing mechanisms, which are absent at present in India.

Given the weaknesses in the system and inequitable "out-of-pocket" financing mechanism, the question we have to face is: what are the options available for governments to develop partnership with the private sector? In what follows we offer some realistic options keeping in mind the above outlined scenario in the Indian private health sector. These options do not relate to large private (corporate) hospitals. Nor do they relate to direct partnership only with clinicians and hospitals. We assume that the primary need of the government is to find ways to join hands with numerous small-scale providers, including charitable institutions and non-governmental organisations (NGOs) concerned with health and other developmental activities in rural and urban areas. But realistically speaking, there can be no effective and sustainable policy options unless many of the weaknesses we identified are addressed simultaneously. These are complex challenges and cannot be addressed overnight, but it is important to make all stakeholders feel that appropriate efforts are being made to address these issues. They can be evolved only slowly but it is possible to give a sense of their evolution over a period of time.

Theoretically, it is possible to list a variety of ways in which partnership between private and public sectors can be evolved. But the concern here is to highlight only what appear to be feasible. Some of the options given below are also derived from experiences in other sectors. Some of these are also based on the author's own experiences and reflections over a period of time.

In each option, potential benefits and costs to the partners are also indicated. The incentives and disincentives must be clear, as far as possible, to all stakeholders. Although for all practical purposes, patients in most instances will remain outside the negotiation process, their interests should weigh foremost in the mind of the government while designing partnership. These options for partnership are discussed below:

Partnership in disease surveillance activities

It is possible to network with private hospitals and physicians (in solo practice) in developing an information system for Disease Surveillance at district and even at village levels. The *NADHI* information model popularised by researchers in Christian Medical College, Vellore (John, 1998) has proved to be a highly replicable mode and is now being tried in certain districts of Kerala also. Under this programme, private practitioners and hospitals are asked to report all notifiable diseases treated by them. Specific methods have been worked out by which data from network members are supplied to a centralised information system. This has proved to be extremely useful in the management of public health programs, monitoring of communicable diseases, and evaluation of disease control programs. The success of the model has been attributed to "simplicity of reporting procedure, low budget, private-public participation, and personal rapport with the people reporting". What are the benefits to the private sector in joining such efforts? Specific incentives can be given to them, which may include regular continuing medical education, allowing access to such information base for research purposes, etc. Limited experience with the *NADHI* model shows that a significant number of private practitioners can be mobilised and can contribute to district level health policy planning and evaluation activities.

Partnership in drugs purchase and supply

This is another option that has not yet been tried, but appears worth exploring. We propose that each state create an organisation similar to the Tamil Nadu State Medical Corporation, which has gained considerable reputation for their efficient drug

management system within the public sector. It appears worthwhile to extend their operations to the private health sector. Although we need to think further through the details we can indicate the manner in which such partnership may work. The proposed Drug Supply Corporation (DSC) in each state can purchase drugs on behalf of many small private hospitals / providers (particularly the non-profit organisations) and supply drugs to them at cheaper rates. Since such an organisation will be a large purchaser, there is considerable scope for them to purchase drugs at cheaper rates directly from manufacturers / distributors than the prices prevailing in markets. As a result, it will help reduce considerably the financial burden on those seeking care from the private health sector, given that a large portion of out-of-pocket expenditure goes towards purchase of drugs. As an extension of this method, it could encourage private entrepreneurs to set up pharmaceutical shops under the agreement that they will purchase drugs from the proposed DSCs and sell at specified rates. Appropriate checks and balances will have to be worked out. These private small entrepreneurs may be given financial assistance (loans) either by the proposed corporation or by other state financial institutions in establishing their outlets.

This option offers clear advantages to all the parties involved. For small entrepreneurs, it affords employment opportunities. For small providers, it makes them more competitive in comparison to those who are not part of this scheme. For patients it may reduce out of pocket expenses for drugs. For the DSCs, they can also make substantial profits even with small margins with greater volume of business. At present, the retail markets in the pharmaceutical sector suffer from many unhealthy practices, including the intractable financial nexus between private providers and retailers.[10] The option we suggest may help reduce some of these undesirable practices in this market. There seems no disincentive to anyone of the stakeholders, but as mentioned already, proper checks and monitoring should be in place.

Partnership in managing high-risk pregnancies

It is true that caesarean section deliveries can not be carried out in Primary Health Centres. Most often those who depend on the public system have to travel a long distance to reach the District Hospitals for this purpose. Considering that the government is committed to improving access to institutional deliveries, it is necessary to explore options available for managing high-risk pregnancies. The option is to get anaesthetists and / or other specialists (such as obstetricians and gynaecologists) on contract for performing caesarean sections at Community Health Centres (CHC), or Taluk hospitals. Alternatively, the government could enter into contracts with certain private hospitals, wherever possible and necessary. Under this option, certain recognised private hospitals (or specialists on contract) may be paid a fixed amount per operation performed, irrespective of patients' economic status. The direct benefits to high-risk pregnant women from this option are immense. The benefits to private providers can also be substantial based on the volume of services they are able to provide. But there is a possible misuse of this option: the providers may induce demand for unnecessary caesarean-section deliveries, although this may be reduced with strict referral practices. This option arises

directly from the recent experience of the Blindness Control Program, under which the Government of India or the separate state governments have contracts with private providers, who get paid a fixed amount per cataract operation performed.

Partnership in public health programs

There are many useful experiments from other sectors, particularly from waste management and environmental programs. Recently, in many large cities, garbage clearing has been contracted out to private parties. It appears possible to adopt this approach for certain public health programs, too. Take for example, controlling mosquito breeding. This may well be contracted out, very much like garbage clearing activities. But unlike the garbage-clearing program, it need not be given to large multinational companies. Several small entrepreneurs from local areas may be encouraged for this purpose.

As part of this strategy, we can also try contracting-out for upkeep of large tertiary hospitals. Typically, contracting-out of non-clinical services such as catering and laundering are tried in large public hospitals. They have given rise to many difficulties. But not many have attempted contracting-out to private firms for upkeep of large tertiary level public hospitals.

There are also examples of private-public partnership under the Tuberculosis (TB) Control Program, using the Directly Observed Treatment, Short-Course (DOTS) strategy. Although we do not have studies on the impact of such collaborations in the three states that we have covered, one on-going effort may be mentioned here as an example. The Advocacy for Control of Tuberculosis (ACT) program initiated under the Resource Group for Education and Advocacy for Community Health (REACH) in collaboration with Tuberculosis Research Centre (TRC), Chennai, has now about 50 private practitioners engaged in DOTS. ACT has covered more than 250 patients during 1998—99, with the help of a large number of volunteers who acted as observers for following up patients during the entire treatment process (REACH, 2000). The program began rather ambitiously with about 400 private practitioners showing interest in participating in DOTS but slowly many dropped out in the process.[11] It is important to know what factors led to their dropping out of the DOTS but it remains a fact that this effort continues in several ways. We are not suggesting that the ACT model of collaborating with private sector be adopted and extended. On the other hand we are emphasising that such experimentation deserves more careful attention and an analysis is needed of their performance for exploring suitable policies to promote private-public partnership.[12]

Partnership in promotive care

There is enormous scope for forging partnerships with the private sector in promotive care. Most information, education and communication (IEC) activities lend opportunities for such partnership. To some extent this has already been tried. For example, advertising for AIDS control has been given to many private agents. Promoting NGOs to take up

health education programs for adolescent population in urban and rural areas, is yet another example for partnership.

Partnership with communities and industries

It is possible to involve local industries and communities in various health care programs. For example, in Tamil Nadu, several primary health centres, particularly in under-developed districts, have been constructed with contributions from local communities. Typically their contributions have come in the form of free labour, material, land, and furniture. In some cases, contributions have been in the form of ensuring water supply, meeting expenses for electricity, maintenance of beds, or upkeep of the PHCs' environment. Such contributions are not uncommon and in many places people participate rather enthusiastically.

To this may be added another novel way of augmenting public resources. Often many small, medium and large industrial organisations have shown interest in contributing resources for health programs in their regions. Several large companies in the past have contributed to running of PHCs, by way of providing beds, equipment, meeting expenses for utilities, etc. We propose that this should be explored more systematically to augment state's resources for health programs

But the incentives for such contributions should be very clear and every effort should be made to ensure that such health centres deliver care to the people. Where local communities contribute in kind, it is legitimate for them to expect availability of care when needed. Similarly the government can provide tax concessions to those industrial units for their financial contributions.

The primary reason for exploring partnership with the private sector arises from the fact that they are already playing a substantial role in meeting people's curative care demands. But the legitimacy for partnership also arises from the government's concern to reduce financial burden on the poor, and to ensure that all health services are safe, of high quality, and accountable to the public.

We have identified six specific policy options for forging partnerships between private and public sectors in providing health care. This is based on the belief that such partnerships will help increase access to care to the poor and those in need, reduce costs of care, improve overall effectiveness of health programs, and bring about a sense of ownership among the various partners involved. We believe that these policy options are worth experimenting with, but every effort should be made to rectify the weaknesses in the system to produce better policy outcomes. Evidently, we have not exhausted all possible options. For example, we have not explored, in particular, options for collaborating with large corporate hospitals. In the past, several tax concessions and subsidies have been extended to large corporate hospitals located in large cities (Bhat, 2000). In return, among other things, they were expected to provide a portion of their services free of cost to poor patients. In some states, governments have also entered into joint ventures with large hospitals on certain conditions. There has been further demand from these large hospitals for higher concessions. *It is necessary to assess in a systematic manner the impacts of those policies before extending their coverage*. In fact, Bhat's analysis shows that the "recent initiatives of providing subsidies private facilities have not produced any results" (*Ibid*. p.8),

We have deliberately confined our attention to exploring policy options for promoting partnership with small and medium health care providers. They include NGOs, missionary organisations, and other charitable institutions. The other stakeholders, such as communities and local industrial units, have also been suggested not only for primary curative care, but also for provision of preventive, and promotive services.

Available empirical literature (from Tamil Nadu, Kerala and Karnataka) shows that there is very little experience in partnership for clinical services. Bennett and Muraleedharan (1998) have argued, based on their examination of Tamil Nadu, that there is little scope for partnership in clinical services. This is largely due to some of the weaknesses that we identified, in particular the weak regulatory mechanisms available to monitor quality of care provided by the private sector (and public sector). Broader social and environmental factors, such as transparency, stronger political will (shown in terms of increased financial allocations), implementation skill, and efforts to contain corruption and leakage, among other things, are essential for building partnership. These have been dealt with in greater detail in Bennett and Muraleedharan (1998).

Policy makers must provide adequate resources for evaluating alternative policy options in terms of equity and efficiency. Such an evaluation should also include the options that we have proposed in this paper. We strongly recommend that specific studies be initiated to:·

- Evaluate more rigorously the limited experience in contracting and regulation of the private health sector, including medical equipment sector. Some states have gone ahead in regulating the private sector, but we have little understanding of the processes that they have gone through in putting regulatory mechanisms in place.

- Assess the impact of the Consumer Protection Act on both providers and consumers (particularly in assessing how far it has enabled consumers in obtaining accessing better quality of care.

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State and Private Sector in India :
Some Policy Options

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Introduction

The health sector reforms have resulted in substantial withdrawal of state investment in general health services, which has created unmet needs for large sections of the population in Third World nations. In order to bridge this gap between unmet needs and the shrinking provisioning of services, both at the national and international level the policy that is being advocated is a public-private mix of services. However, while proposing such a strategy the proponents do not address the limitations of the public-private mix, of which there is considerable evidence.

There are several important issues that need to be addressed in the public-private mix for developing countries. The role of the private sector has to be defined relative to the public sector, specially in countries where a majority of the population lives below the poverty line. Therefore, the role of the State is important and central to ensure universality and equity.

Another issue of importance that needs to be recognised is that comprehensive care includes not only curative services but also preventive and promotive services. Historically, the private sector has provided mainly curative care where there is a potential for making profits. In the process of providing comprehensive health care therefore, the objective of private and public sectors are often irreconcilable. Inevitably, private sector is not inclined to share the burden of preventive care; the latter being time consuming and also demanding higher investment and coverage. In addition the results cannot immediately be quantified in monetary terms. Inclusion of the private sector in the provision of comprehensive health care therefore, inevitably tends to fragment planning into curative and preventive activities rather than comprehensive care. Any policy which advocates a public private mix therefore needs to keep these concerns in mind for issues of coverage and effectiveness of services.

Another dimension that needs to be underlined is the parasitical manner in which the private sector has grown over time and undermined the public sector in developing countries. This kind of growth of the private sector has resulted in its penetration of the State sector. The latter has become weak in defining its role and regulating the private sector. Global experience suggests that the unregulated growth of private sector dissipates public health programmes by disrupting the curative inputs and tends to fragment efforts to provide comprehensive care. In addition, deeply entrenched private interests in health services, pharmaceutical and medical equipment industries, tend to pressurise the State to protect their interests, thereby, reducing the State's effectiveness in regulating and defining a role for the private sector in the health service system.

While the private sector may have a space in the health care system, it needs to be defined by the State where the principles of equity guide the policy formulation. The objective of this paper is to offer some policy options that help to rationalise and regulate the private sector in medical care. The paper discusses these options to ensure that private interests do not undermine public health services; a consequence that will be detrimental to the health of the majority. These options are based on a critical review of published and unpublished studies from both India and other countries. In the Indian context, it must be kept in mind that efforts at regulation are being considered after the private sector has grown considerably over the last fifty years without any control and is well entrenched in the health care system. The official need to regulate the private sector arises out of the ambiguous quality of care that it provides. This is due to the inadequacy of infrastructure and competence of some of its providers on the one hand and, on the other

hand, excessive use, at times misuse, of technology and high costs. However, there are some additional problems that are associated with the private sector in health care. These broadly include the following: its primary motive of profit maximisation without a collective concern for maintaining minimum standards; it's failure to address public health concerns; the lack of coordination with Government programmes and services; and its higher wages attracting professionals from the public sector (Bennett: 1994). In addition, the more modernised hi-tech medical establishments demand that those less equipped be accredited or closed. It is for these reasons that the State needs to take the lead in setting the guidelines for regulating the private sector through dialogue with professional bodies and consumer organisations.

Experience shows that setting up a regulatory system is often a long drawn process, specially in those countries where it has grown without controls and is bound to face resistance from professionals. Regulating a nascent private sector is qualitatively different from trying to regulate a well entrenched one and therefore, a variety of mechanisms and strategies need to be evolved based on available research on the structure, characteristics, and behaviour of providers. (Griffith et al: 1987; Bennett,S : 1994; Baru:1998). Across countries it is seen that the State has always played the key role in regulating the private sector. The professional organisations may have taken initiatives at certain points in time but largely, it is the State that has played the role of a regulator through financing and setting up of regulatory bodies, as seen in the case of the United States. (Starr,P: 1982; Higgins: 1988) .

State policy towards the private sector has to be addressed within a systemic perspective covering not just providers of health care services but also other related components in the health care system. Within this perspective it is essential to delineate the extent of private sector involvement in provisioning and financing, medical technology, medical/paramedical education, research, and pharmaceuticals (Qadeer:1985). This integrated approach is necessary for evolving an effective policy towards the private sector because a piecemeal effort often leads to a fragmented and ineffective outcome. This has been amply demonstrated by the American experience, where there was initially an effort to only regulate provisioning but, during the seventies, the growth of medical technology and corporate hospitals gave rise to an increase in costs of medical care. Subsequently the federal government had to set up offices for technology assessment and boards for regulating technology in order to prevent its overuse or even misuse. (Relman:1983) As a result, during the seventies and eighties, regulatory authorities were set up in order to register equipment and also set ceilings for the number of high technology equipment for a given population (Iglehart:1977; Starr,P: 1982).

Financing

During the eighties, the Indian government gave fiscal concessions by way of reduction of import duties on medical technology. In addition, by being granted the status of industry, private corporate hospitals have been able to mobilise loans from large financial institutions. Public insurance schemes like the Central Government Health Scheme and several public sector undertakings have permitted their beneficiaries to avail of medical care in private hospitals. The introduction of medical insurance by the General Insurance Corporation and its subsidiaries has also given a fillip to the growth of the private sector. The current policy of allowing entry of foreign insurance companies in this field is bound to further accelerate this process.

Studies from the US highlight the role of insurance in inflating the cost of medical care and, more importantly its implications for equitable access because large sections of lower middle class and poor people who cannot afford to pay the premiums are excluded from insurance cover (Carrasquillo: 1999). Studies on the interface between public insurance schemes and the private sector in India indicate considerable variability in costs and quality of services, and a lack of transparency and accountability among participant private providers. They underscore the difficulty of implementing health insurance schemes in an unregulated private market (Baru et al:1999). An effective system of public regulation of provisioning by private hospitals and also of insurance and putting in place an authority for effective monitoring and enforcement of the regulations is therefore, essential.

Medical Technology

In the Indian context, where the government offers subsidies to private hospitals for import of high technology equipment, it is important for the State to provide guidelines and structures for licensing the use of equipment. So far there have been no initiatives to

either register or regulate the flow of medical technology (1). Some form of a regulatory authority is essential for registering and regulating the flow of medical equipment.

Apart from regulations for banning specified drugs and laying down procedures for testing of new drugs - whose enforcement again leaves much to be desired - pharmaceutical companies and medical research centres are left free to decide their research priorities and budgets. The current trends in this respect have a significant bearing on the kind of drugs and technologies being developed and therefore on the costs of medical care and its accessibility to the lower income groups (This is reflected in our scanning of Newspapers). Some of the tertiary private hospitals have also been given tax exemption for research purposes but there seems to be no system of monitoring the research output available in the public domain. The government has no doubt laid down conditions for institutions availing of these subsidies essentially aimed at promoting some degree of equity through free treatment to the poor. These conditions however are not effectively enforced. Remedying these lacunae again calls for a stronger, more effective regulatory system.

Medical and Paramedical Education

Similarly, in the case of medical and paramedical education, a number of private medical, nursing, technician, and auxiliary nurse midwives training institutions have been established in several states. However there seems to be no control on their growth or the content and quality of training being offered by them. The State just does not have any policy for dealing with such institutions. The norms/ standards for these training institutions need to be evolved along the lines of public sector institutions and national guidelines are needed to ensure some uniformity across states.

All these are issues have important policy implications. But, since each of these sub-systems comes under the purview of a different ministry, they are dealt with in a fragmented manner. There is clearly a need for mechanisms by which there can be better coordination between them, with the health ministry taking a lead role for such an initiative. It is worth considering the constitution of a regulatory authority at the national level under the purview of the health ministry, with representatives from each of the concerned ministries along with those of professional and consumer organisations, to provide integrated guidelines on different and interrelated aspects of the health care system to be followed by state and local, municipal bodies and Panchayati Raj institutions.

Comprehensive Health Care

Quality and cost of medical care however, are not the only issues that call for regulatory mechanisms. There are other aspects of health care as well that are dependent upon adequate regulatory mechanisms. For example even though private sector largely deals with individual clinical care, the medical care inputs it provides overlap with the preventive components of components of comprehensive health care at several levels: -

a) The provision of clinical care and therapeutics for diseases which also come under national disease control or elimination programmes. Here, by virtue of participating in treatment - which is the mainstay of prevention of infectious diseases such as tuberculosis, malaria, leprosy, etc - the private sector contributes to lowering the possibility of disease spread and overlaps with preventive programmes.

b) Since immunisations have now become an expressed need of a significant proportion of people, they seek these services from the private sector. The latter provides it on payment but gets the supply of vaccines free from the government.

c) Health education is a key component of any clinical care and providing patients correct information goes a long way in comprehensive care. Thus, providing patients and their families information about personal protection, duration of treatment, preventive strategies, referral point, etc. is common to both the sectors.

d) Provision of curative care and information to the public during an infectious disease outbreak are important activities for epidemic control that again involve the private sector.

The fourth component of comprehensive care, i.e., nutrition, sanitation, drinking water supplies, housing, etc., in any case falls outside the scope of health service activities and thus requires intersectoral strategies.

It is therefore, necessary to recognize that the private sector, despite its clinical and individual orientation, can not absolve itself of its comprehensive care (i.e., preventive) responsibilities. To a contribute to the national efforts of disease control and prevention, it will have to adopt the uniform therapeutic norms and standarised procedures for diagnosis, treatment and follow up set for the control programmes. In addition, establishing channels to enrich national monitoring systems by providing feedback from private providers to these units will contribute to national efforts. There is an urgent need to develop mechanisms that will guide and promote these kinds of coordination and control systems.

Another dimension that needs to be highlighted is the fact that the private sector, despite having primary, secondary and tertiary levels to it, has a very restricted inbuilt referral system of its own. Given its profit orientation, there can be no automatic referral system as higher levels are costlier and often inaccessible. Also, very often private providers continue to treat even though they are not in a position to do justice to the patient. As a result, after primary or secondary private sector providers, a large number of users seek referral to public sector institutions of the next level. This link too needs to be streamlined. The referring practitioners should follow certain practices of providing clinical and laboratory information along with treatment provided. This is essential for 'comprehensive care' which demands integration of different levels of care.

These various dimensions of the interface between private and public sector health care need urgent attention and regulatory mechanisms are required to streamline the sharing of responsibility between these two sectors. The next section presents a review of available studies on the characteristics of the private sector at different levels of care.

The private sector in India presents a picture of plurality and heterogeneity. It includes a large proportion of individual private practitioners providing mostly primary level curative services of extremely variable quality. These practitioners are located in urban and rural areas in the country. The next level of care is provided by the private nursing homes with bed strengths ranging from 5 to over 100 beds (Jesani:1993, Bhat: 1993 ;Baru:1998). While in most states they are largely an urban phenomenon, in other states, where private sector growth (relative to public sector) is high, they have spread to even peri urban and rural areas. Most of these nursing homes offer general and maternity services and are managed by doctor entrepreneurs (Baru:1998). Within this category there is a further division between small and large nursing homes which differ widely in terms of investments, equipment and facilities, range of services offered and quality of care. In fact it is difficult to judge how many of them are capable of providing secondary level care of reasonable standards (Nandraj:1994). For example in Delhi only around 26 per cent of the nursing homes met the standards laid down by the Delhi Nursing Homes Act. The large majority therefore are not in a position to comply with the minimum standards (Interview with official at Directorate of Health Services, Delhi).

Private sector institutions providing tertiary care constitute roughly 1-2 per cent of the total number of medical care institutions. They are mainly the large hospitals run by trusts, private or public limited enterprises. These are only an urban phenomenon and have been the largest beneficiaries of subsidies given by the government. Their interests are at variance with owners of nursing homes whose scale and nature of operation is much smaller. Given these differences it is important that the State has a differential policy towards the two segments. The norms used for the public sector can be used as the basis for defining the parameters for primary, secondary and tertiary service delivery in the private sector and also arriving at certain minimum standards that need to be adhered to by the different levels. Based on the available studies we make some concrete suggestions.

Primary Level Care

The available studies on private sector in India suggest that a considerable section of the population in both rural and urban areas access the services of individual private practitioners for primary level care (Sunder,R: 1992; Krishnan:1994). Micro-level studies show that the poor from both rural and urban areas use these practitioners as a first resort for acute conditions but also use government facilities (Nanda & Baru: 1994; Bisht:1993; Kakade:1998). These utilisation studies further show that the private practitioners are resorted to for a variety of minor illnesses as a first level of contact for curative care. These studies also indicate the type of practitioners being resorted to for treatment. There is much heterogeneity among providers in terms of qualifications, systems of medicine, and practices. They include herbalists, indigenous and folk practitioners, compounders and others (Vishwanathan & Rhode: 1994; Soman: 1992;). These practitioners being easily available and accessible locally are utilised extensively. Studies conducted in urban slums and rural areas indicate that the better off sections in these areas use private practitioners but the really poor are unable to afford the charges and hence, either opt for

the government hospitals or often go without care (Bisht: 1993; Desai: 1997; Nair: 1993; Soman:1992; Vijaya: 1997; Krishnan: 1994; Kakade: 1998).

A few studies have shown that the knowledge regarding treatment is largely guided by the information that they receive from chemists and drug manufacturers' representatives about the drugs to be prescribed. Studies by Phadke and Greenhalgh have amply demonstrated the nexus between the marketing network of the pharmaceutical industry and prescribing patterns of doctors, both qualified and unqualified (Greenhalgh: 1986; Phadke: 1998; Thaver: 1998; Shah: 1997). Given the poor knowledge base of these practitioners it is not surprising that their treatment of even common ailments are often irrational, ineffective, and sometimes harmful. Studies that have looked into provider behaviour with respect to specific diseases like tuberculosis and diarrhoea reveal the same (Uplekar: 1991; Bhandari: 1994; Balambal et al:1997).

Given that these are the predominant source for curative care for the large majority of people especially in rural areas and since there is little prospect of their being replaced in the foreseeable future by qualified government or private doctors, there is a strong case, even if a second best one, for a purposeful initiative to train and upgrade their skills. The purpose of the training programme should be to familiarise private practitioners with the basics of rational therapeutics. It should also include standardised regimens for treating common ailments as well as major communicable diseases covered by the national disease control programmes. In addition there is also a need for guidelines for referral to a higher level of care when required and reporting of cases to the public health surveillance system.

Role of Private Practitioners in Epidemic Situations

Apart from routine treatment rendered by private practitioners, they are also being resorted to by communities during epidemic situations. Studies that have looked at the management of epidemics in urban areas show that the private sector has been unable to respond to crisis situations and is ill equipped to avert deaths. During the outbreak of the cholera epidemic in the slums of Delhi in 1988 it was seen that it was unable to recognise the gravity of the situation, or provide rational therapy. Once the epidemic was publicly recognised, both the private practitioners and those affected preferred treatment at public hospitals for those with diarrhoeal disease. The running back and forth between private practitioners and public hospitals led to loss of valuable time and unnecessary deaths (Priya: 1989). In the case of the plague in Surat, it was the public hospitals and doctors who treated people because the private sector was ill equipped to respond and actually left the city when the plague broke out (Shah: 1997). A similar situation occurred in the Adilabad district of Andhra Pradesh when there was an outbreak of gastro-enteritis. The private practitioners who were sought by the people during this crisis used irrational drugs and indiscriminate use of IV fluids as a result of which a number of people died.(2) All these studies point to the dire need for rationalising and registering this level of the private sector and evolving methods for training them over time. The process of registration, and, later, training of private practitioners in order to integrate them with the

existing primary health care network, needs to be initiated across states and sustained over time.

Prior to recommending training programmes there is a need for registering all practitioners irrespective of whether they are qualified or not. Since many of these studies indicate a range of common ailments for which people resort to these practitioners, any effort at initiating training programmes must not be restricted to their involvement in vertical programmes which are disease specific, but needs to address a range of the common ailments as reported by the macro and micro level studies. The training has to be seen as an ongoing process whereby there is dissemination of information as a part of a network of practitioners providing primary level care.

Role of Professional Organisations

Any effort at registering or licensing has been consistently opposed by the Indian Medical Association (IMA), though banning quackery has been an important campaign carried out over the years (3). The demands of the IMA are not very realistic because the State is not in a position to expand its services to such an extent that it replaces these practitioners nor are qualified practitioners willing to move to remote rural areas, as is evident from the macro and micro level studies.

Given that there are few alternatives that can replace these practitioners, it is important to regularise, give them the required training, and define the range of services they can be expected to provide. It may in fact be a good idea if the Licentiate Medical Practitioner Scheme is reviewed and revived. Here, it is possible to draw on the experiences of training of barefoot doctors in China where the State defined the scope of the conditions that they can treat and trained them accordingly. This can be done only after there is a systematic effort to register these practitioners at the district level with panchayats playing an important role in the process of registration. It needs to be mentioned here that in the search for studies on private practitioners, there are very few that provide details regarding their social background, process of skill acquisition and methods of updating their knowledge base (Singh:1993; Vishwanathan & Rhode: 1994). This requires more attention in future research.

Secondary Level Care

A few studies on the secondary level of care show that it consists of institutions that provide both out-patient and in-patient with 5 to over 100 beds. These studies provide insight into the heterogeneity of these institutions in terms of scale of operation, services offered, technology employed, and the social background of patients using these facilities (Bhat:1993, Jesani: 1993; Nanda & Baru:1994, Baru:1998). These studies have shown that there is variability in the quality and costs of services provided by these institutions. As a result there are no standards for these nursing homes and the consumer has no information regarding the costs he or she is likely to incur when they seek care (Phadke: 1998; Nandraj: 1994). Given these trends it is essential that nursing homes be required to follow procedures for providing information regarding facilities available, the rates of the

services provided, maintaining patient records, and ensuring access to them, and also build in the provision for medical audit.

The heterogeneity of nursing homes and hospitals in the secondary level results in conflict of interests between the smaller and larger players in the market. In some cases the contradictions are so sharp that it leads to divisions within the professional organisation and, in extreme cases, leads to the formation of separate fora like the Private Nursing Homes Association in Andhra Pradesh or the Nursing Homes Association in Delhi. Even where there are legal provisions available for registering nursing homes, these conflicts often cripple their implementation. In some instances the differences between the smaller and larger enterprises were used by the government to initiate the regulatory process, as was seen in Andhra Pradesh and Delhi. While some progress was made, the owners of small nursing homes formed a powerful lobby and tried to slow down, if not reverse, the process (George, A: 1998; Bhat: 1994).

This was seen in the case of Delhi, when serious efforts were made to implement rules for regulating the nursing homes during the nineties through a series of negotiations between the owners the government and the owners of nursing homes. Firstly, the Directorate took the initiative to undertake a survey of all nursing homes and then they were inspected. After inspection, they found that only around 10 per cent of the nursing homes qualified to be registered. Those, which were found wanting were appraised of the kind of upgradation required for qualifying them for registration. Through dialogue with these owners, the medium and larger enterprises were registered. However the real stumbling blocks were the smaller nursing homes, who were not only numerically strong but were also located in slums where there was a genuine constraint for space. These nursing homes were largely concentrated in the resettlement colonies in West Delhi. Due to constraints of space, they could not comply with minimum physical standards. By virtue of sheer numbers, they were able to bring strong enough political pressure to slow down the process of regulation. (Interview with senior official, formerly with the Directorate of Health Services, Delhi) A study of private nursing homes in Delhi not only vividly captures the heterogeneity but also their uneven distribution and overcrowding in residential areas. The issue of regulation of private nursing homes has become closely intertwined with town planning and land use that the DDA had raised a few years ago (Nanda & Baru:1994; Priya,R :1993). While it is the Delhi Development Authority that grants permission for establishing nursing homes, as per its master plan, the registering authority lies with the Directorate. In addition, the Directorate is supposed to oversee compliance of private hospitals to conditionalities but they have problems enforcing it, since there is no clear definition of who constitutes the poor. Issues like these can hamper efforts at regulation and therefore, these must be addressed based on the evidence put together mostly through interviews with those who have tried implementing the legal provisions available. What is clear in such a situation is that if different authorities have control over different aspects then regulation by just the Directorate becomes difficult (Interview with officials in the Directorate of Health Services, Delhi).

In Uttar Pradesh there are no laws for regulating the private nursing homes. Very recently, the UP government has proposed a system of licensing for all practitioners but this has been opposed by the Indian Medical Association. The IMA is of the opinion that this will only increase corruption and will not serve any purpose. The secretaries of various local branches also opined that the idea of introducing licenses was duplication of efforts since doctors have to register with the Medical Councils. They did not really see the need for regulating the private sector but insisted on doing away with quackery instead (Interviews with Secretaries in IMA, UP) .

The few unpublished studies from small towns in UP however underscore the need for regulations. These studies show that the private sector in small towns comprise mainly small and medium nursing homes, and promoters are from both allopathic and indigenous systems of medicine. There seem to be even instances of unqualified owners promoting such enterprises. These studies, being based on very small samples and case studies, may not give a representative picture but their findings are consistent with impressions of informed observers and researchers of this sector.. These case studies also provide some information into how practitioners of indigenous systems of medicine practice allopathic medicine (Bharti: 1993; Pandey:1993; Tomar:1993).

Some of these studies have also shown that government doctors have links with the private sector as consultants, or in some cases, as even promoters. This kind of a scenario exists in all states where private practice has not been banned as seen in Andhra Pradesh, Bihar, Madhya Pradesh etc (Baru:1998). This was not seen in the case of Delhi because private practice by government doctors is officially banned in this state. At the national level there needs to be a clear policy direction regarding the banning of private practice by government doctors, which should be adopted as the norm by state governments as well. This is an absolutely essential step to strengthen the public sector and at the same time rationalise the private sector. The recent efforts at setting up accreditation systems need to be supported and further strengthened. However, these need not preclude the government initiating regulatory mechanisms simultaneously at all levels of care. (Interview with President, IMA, Delhi).

A few studies have commented on the power that doctors wield in modifying and reversing State policy when it comes to any form of regulation. This phenomenon is not restricted to India but is seen in developed countries as well. Professional associations have largely adopted a conservative stance when it comes to regulating themselves or responding to external pressures to regulate them. The history of the British Medical Association and the American Medical Association and the positions that they took vis a vis a nationalised health service or regarding private practitioners and hospitals has been well documented. The pace and content of any regulatory effort by the State has met with resistance and challenges primarily from these associations. This is an important issue for the government to deal with while coming up with a regulatory framework because of which clarity on the objectives of regulation is very essential (Starr:1993; Relman:1987; Higgins: 1988; Quam:1989).

Even in India, one finds that the picture is very similar. The social background of promoters of private institutions provides the base for political manouvering which can effectively block efforts for regulation. A preliminary analysis of the members of IMA in UP shows the predominance of the bania and the brahmin castes which have considerable clout in UP politics. Thus, any effort at regulation can be blocked by these sections (3). However as a slight contrast in AP, while the forward castes do dominate the social composition of hospital owners is more diverse and therefore it tends to break solidarity on caste lines. This could be an important factor for the process and outcome of efforts at regulation in the states.

Tertiary Level Care

The tertiary level of care consists of hospitals which offer a range of specialist services promoted by business groups as trust, private, or public limited enterprises. These are located in metros and larger cities in the country. The promoters of many of these enterprises have strong Non Resident Indian links and have influenced State policy since the late eighties for giving subsidies to this sector. Most of the subsidies offered by the government in way of land at concessional rates, granting medical care the status of industry, and reduction of import duties on high technology equipment, have largely benefitted these hospitals (Baru:1998). During the recent budget the promoters of these hospitals have been demanding for increase in subsidies. While these large, private hospitals have been demanding more subsidies and concessions from the government, many of them have been found to be flouting conditionalities prescribed by the government when duty exemption for import of medical equipment was granted. An important conditionality was that 20 percent of in-patients and 40 percent of out-patients should be from among the poor and that they must be treated free of cost. A major controversy was aired in the media last year relating to the fact that larger private hospitals, both for-profit and non-profit, have not adhered to the conditionalities prescribed by the government (Newspaper clippings). As a result of these reports a Committee has been set up by the Delhi government to examine these issues. While the findings of this committee will be crucial for future policy, it needs to be recognised that there is a basic contradiction in the demands put forth by the larger private hospitals. On the one hand, they demand the status of an industry for financial support and, on the other hand, they want to retain the privileges of a welfare institution. Therefore, this committee must not only take stock of the performance of the private sector and its adherance to conditionalities, but also define the role of the State in monitoring these hospitals.

Staffing and Conditions of Work

Research studies on private hospitals have also shown that there are problems of getting access to data on personnel employed, their wages, and cost of services in these hospitals. This poses a major constraint for doing any analysis of the costing pattern in this sector. The prevalence of poor qualifications, wages and working conditions have been demonstrated through studies on private nursing homes in Bombay, Delhi and Hyderabad (Nandraj:1994; Nanda and Baru:1993; Baru:1998). These studies have shown that paramedical and supporting staff often work for very low wages and are not qualified for

the work that they do. Hence, there is a great deal of turnover of staff at these levels and they work under abysmal conditions, which is bound to have a direct impact on patient care. Since these nursing homes are not even registered, the question of getting information on the staffing or wage patterns becomes extremely difficult. While these issues have been commented on for the smaller enterprises, it is assumed that the large corporate and charitable hospitals, which are located in the larger cities, employ better qualified staff at all levels with better pay and working conditions. However, even in this category of hospitals there is a lack of transparency in information relating to costing of services and the wage structures of the medical, paramedical, and supporting staff.

A recent enquiry conducted by Workers Solidarity entitled "Critical Condition: A Report on Workers in Delhi's Private Hospitals" has looked into the working conditions of fourth class employees in eight of Delhi's bigger and well known private hospitals: Apollo, Batra, Sunderlal Jain, Gangaram, BL Kapur, Tirathram, Jessa Ram and Mool Chand. The findings are, to say the least, very shocking and revealing. This enquiry has primarily elicited information regarding the status of workers, viz. permanent or contract workers, employed by these large hospitals, their working conditions and wages. Based on largely qualitative methods, this report provides some valuable insights into the proportional distribution of the total expenditure of a hospital on various items like drugs/equipment, wages, and maintenance.

The report states that 50 per cent of the expenditure is incurred for equipment and drugs; 30 percent for wages and 20 per cent for maintenance and sundry expenses. As the report observes: "Hospital managements try to ensure that their total wage bill does not exceed thirty percent of all expenditures; wage expenditures above that level are deemed by managements to make a hospital unviable"(workers solidarity: 2000. p.3). These hospitals spend a high proportion of their earnings on paying their specialist consultants. A con-siderable proportion of the thirty percent on wages forms the fees paid to consultants. Over half the consulta-tion fees that a hospital charges a patient is paid to the doctor by the hospital. This proportion of wages paid to consultants has gone up since the earnings of private hospital consultants have shot up in recent years. For instance, doctors in large private hospitals currently earn five times the salary of their counterparts in All India Institute of Medical Sciences (Workers Solodarity: 2000) .

The hospital managements keep their expenditure on wages low in two ways. One is through the contractualisation of fourth class employees, thus paying them much less than the stipulated minimum wages and the prescribed benefits. The other way is by gradually undermining the established rights of permanent workers. Economic efficiency justifies paying low wages to the paramedical and supporting staff in order to make profits. In the selected hospitals, the contract system prevails among fourth class employees viz. ayahs, ward boys, sweepers, security guards and also among canteen workers, laundry workers and pharmacy workers. While the older Trust hospitals employ a higher proportion of permanent compared to contract workers, in the newer hospitals there is a much larger presence of contract labour. As the report observes: "The contract workers often work without a weekly break. This is a violation of Section 17 of

the Delhi Shops and Establishments Act, 1954, which states that every employee shall be allowed atleast twenty-four consecutive hours of rest in every week. Section 18 of the Act states that no wages shall be deducted for this weekly holiday... Principal employers tend to wash their hands off the responsibility of stipulated and fair wages, despite the law clearly stating that the responsibility of payment of minimum wages and other shortcomings lies with the principal employer (in this case the hospitals) in case the contractor does not fulfil his obligations" (Workers Solidarity: 2000; p.6-7). The report shows that the contract workers are overworked in terms of long hours of work often without even a weekly break. When there is a shortage of labour the available workers are made to work overtime without adequate break or rest from their earlier shift. These kinds of conditions will definitely affect the productivity of these workers and, in fact, reduce their efficiency.

The job insecurity and poor working conditions of this class of workers is bound to affect the quality of care provided to patients. In any hospital it is the paramedical and supporting staff who interact very closely with patients by attending to their physical and emotional needs while the medical personnel look after the clinical aspect of treatment. Therefore, a hospital that is responsive to patient needs, requires well trained personnel at various levels who interact together as a team, co-ordinating and complementing each other's role. It is not enough to have well qualified specialists alone, it is equally important to have well trained paramedical and supporting staff to ensure good quality patient care. The problems of contractualising the support staff without adequate supervision will definitely cut costs for the hospitals but will not necessarily help in improving quality of care since it does not generate a sense of belonging and loyalty among the workers. This is definitely not conducive for building commitment among the workers towards the hospital that employs them.

While contracting out is seen as a way of responding to inefficiency of permanent workers and of reducing costs, there is no reason why the institutions that employ these measures cannot put in place administrative mechanisms that can monitor and ensure that there is adherence to minimum conditions of work. These would be essential to provide and maintain quality services in hospitals. In fact over-worked, ill-trained and insecure workers are likely to make more mistakes and hide them too! In short, the reputation of the consultant alone supported by a shaky and over-stretched staff at different levels is responsible for whatever quality of service that is provided.

Like the contractualisation of workers, a similar issue of concern for both the public and private sectors is the contracting out of ancillary services. These measures are very often viewed as promoting better efficiency, in narrow economic terms. This is indeed the dilemma that all health care institutions must face when they demand the status of an industry, since the profit motive leads to cutting costs which has a bearing on the quality of care. Like all other industries, hospitals also need to be governed by rules to ensure the quality and safety of their workers. Experiences of contracting out of laundry, diet and other ancillary services in other developing countries show that this process requires administrative structures which can periodically monitor the quality of services provided by the contractors since there is a tendency for them to cut costs which affects the

quality of care. In fact in some African countries the administrative costs to oversee the contracting out in public hospitals has proven to be an expensive proposition (Mc.Pake & Banda:1994).

Many of the older, charitable hospitals in Delhi have become more commercial in their operations. The report refers particularly to the case of BL Kapur hospital that was established as a trust in 1959 but, during the nineties there, was a move by some of the trustees to allow a private company to take over this hospital in order to re-develop and renovate the hospital into a state of the art super speciality hospital with 250 beds to be set up with a substantial investment (Workers Solidarity: 2000 p.10). Hospitals like BL Kapur, Moolchand, Jessaram, Tirathram, and Gangaram had earlier employed a larger proportion of supporting staff as permanent workers. The recent trend among these hospitals is to supplant or replace the permanent workers with contract workers. However, compared to the newer, corporate hospitals, the proportion of permanent workers is still much higher in these hospitals. If these are the trends in the larger hospitals then one can well imagine what the conditions of the paramedical and supporting staff would be in smaller hospitals and nursing homes.

While there has been some discussion on the need to specify physical standards in private nursing homes and hospitals, there is a need for much more specific policy initiatives with regard to qualifications of the various levels of personnel employed and some norms for remuneration and working conditions. This would have to be built into the initiatives of the efforts at accreditation that are now underway. The concern here is that while the initiatives in cutting costs by employing contract labour would definitely show private hospitals as being cost effective, however, this has serious implications for the quality of patient care.

Yet another way of saving costs in the private sector is to discharge patients early in order to ensure quick turnover. Studies from both developed and developing countries have shown that private hospitals often discharge patients, even before they are ready for it, in order to maximise patient turnover and increase interventions. According to a promoter of a corporate hospital, it is only during the first few days of hospitalisation that a hospital makes profits on beds, after which the profit margins tend to fall. It is during the first few days of hospitalisation that all the procedures, both surgical and non surgical are completed. There is little scope thereafter for charging patients more than bed charges. The only charges that the hospital is likely to derive profits from during the recovery phase are on drugs, and nursing care (Baru et al:1999; also see McKinlay: 1980). This is an important reason why private hospitals tend to discharge patients much earlier than public hospitals. As the report points out: “Much of a private hospital’s profits are derived from the usually steep charges for inpatient services and diagnostic tests. It is also extracted from exorbitant bed charges.” (Workers Solidarity: 2000).

In view of the increasing demands on the government by these hospitals, it is imperative that they ensure certain minimum working conditions for their employees, which is expected of all industries. Hospitals are labour-intensive organisa-tions which are not merely dependent on medical expertise but require the coordination of different levels of

staff to provide quality patient care. However, the report points to poor working and wage conditions and raises issues of setting standards for working conditions of supporting staff. Here, the State needs to play a more proactive role in ensuring that hospitals comply with certain norms and standards for the subsidy that they receive and ensure that they do not deny access to the poor. It is clear that, for the private sector, efficiency is seen only in terms of profits that can be generated and ruled by market principles. It is therefore imperative that the State have effective administrative mechanisms which will ensure that these private hospitals comply to conditionalities for receiving subsidies. Until the conditionalities are enforced and complied by these hospitals the government must not offer more subsidies. With increasing privatisation it is quite apparent that the private hospitals have been adopting practices that undermine consumer needs and also the minimum rights that workers are entitled to in such institutions. The larger hospitals that have received subsidies should ensure greater transparency in their operations, viz. services offered, rates, cost of diagnostic tests, patient records, billing procedures, and periodic medical audit (Baru et al:1999).

Role of Consumer Organisations

The need for a rational and regulated health care has been raised by people's movements across countries and these have had an impact on evolution of policy. This is amply demonstrated by the passing of the public insurance schemes for the elderly and the poor during the sixties in the US. Similarly the movement for a rational drug policy and health care in Latin American and Asian countries, and also for a national health insurance scheme in Canada are examples of this (Fiedler:1996; Evans & Law:1991). In developed countries where the Charter of Patient's Rights has been adopted, the sheer power of the professionals does not allow patients to assert their rights. Merely enunciating a charter of rights will not automatically result in either the practitioner or the health care system responding to patient needs. However this does not detract from the importance of such initiatives (Tailor & Mayberry:1995).

The Consumer Protection Act definitely provided the opportunity for raising the need for regulation in the Indian context and the role of consumer organisations has been that of a pressure group, whose interests must get articulated in State policy. Consumer activism can and has raised a number of issues like medical negligence, over medicalization, use of irrational drugs, lack of transparency, lack of medical ethics in medical practice etc. These organisations have been an important pressure group during the last couple of years and have demonstrated the lacunae in the private hospitals. The Consumer Protection Act brought the issue of quality of services in the private sector under public scrutiny and debate. The medical profession however, reacted very negatively and defensively to the issue (Bhat:1994). In this scenario the issues raised by the consumer groups need to be further strengthened by the government to push for regulation. Another reason that the State needs to play a more pro-active role is that it is evident that the professional bodies have divided interests and are therefore unable to provide a coherent direction to policy.

These developments have definitely influenced policy makers to react but it is important to recognize that there are limitations to such forms of activism. In interacting with the medical professional even the informed consumer may be unable to overcome the unequal relationship that exists between a doctor and a patient. Here one needs some systemic checks and balances which only the State can initiate in order to protect the welfare of its citizens.

This paper has provided evidence from a wide range of studies on the private sector which clearly suggests the need for regulation.

- It is evident from the international and national studies that the State will have to continue to play an important role in providing services, and also rationalise the existing services in the private sector within the ambit of its planning process.
- There is a need for creating an information system on the private providers at various levels of care, medical technology and its use, fiscal concessions, and compliance to conditionalities.
- There is a need for developing uniform guidelines for all states.
- The regulatory process has to take into account the diversity and address different levels of care.
- There is a need to define what is expected of primary, secondary and tertiary levels of care and the minimum norms in respect of manpower, skills, and equipment. These norms may be adapted from the public health care system.
- There is also a need for evolving standardized treatment regimens for treating common ailments as well as the major communicable diseases..
- Training of private practitioners and evolving reporting systems into the public health monitoring and surveillance systems at the primary, secondary, and tertiary levels of care need to be put in place.
- The tertiary corporate sector must not be given more subsidies but must comply with conditionalities which try to build equity concerns.
- Staffing and physical standards must be applicable to both secondary and tertiary levels of care.
- Recent initiatives at accreditation must be strengthened but this must not preclude other initiatives for making the private sector play a more socially responsible role in future.

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Section II

Selected Annotations

Economic Impact of Tuberculosis on Patients and Family

Author/s: Balambal, R. Jaggarajamma, K. Rahman, Fathima. Chandrasekaran, V. Ramanathan, U And Thomas, A.

Publication source: Tuberculosis Research Centre, ICMR, Chennai

Year of publication: 1997

States covered: Tamil Nadu

Social geography: Rural and Urban

Data source: Primary

Type of study: Cross sectional survey.

Type of private sector: For profit hospitals, individual general practitioners (and government hospitals)

Issues addressed: Household expenditure, direct and indirect expenditure on rural and urban patients, impact on school going and pre-school children of TB patients.

Objectives: The study aims to (a) estimate the total costs attributable to TB on patients and their families, (b) gender differentials in their economic impacts and (c) the consequences on other family members, especially children of TB patients.

Methodology: Seventeen focus-group discussions with TB patients were conducted. A total of 304 TB patients (of which 153 were in rural and 151 in urban areas) were studied. Female patients formed 120 of the total. Both qualitative and quantitative data were collected on social and economic status, demographic aspects, employment status, assets, debts of patients and families, expenditure incurred towards illness, and effects of illness on TB patients.

Findings and conclusions: Participants perceived TB caused significant economic loss. The direct costs observed were Rs.1443/-. There was no gender differential. But urban patients had higher direct cost (Rs.1570/-) than those of rural patients (Rs.1338/-). Patients going to private facilities spent 8 times more than those going to General Hospitals or an NGO hospital. Direct medical expenditure for consultation was Rs.613/-, for investigations Rs.149/- and for drugs Rs.591/-. The direct expenditure was least for patients going to General Hospitals, 1.5 times more for those attending NGO hospitals and 5 times more for those going to private hospitals. The average non-medical costs (Rs.353/-) were more or less the same for all patients, irrespective of type of facilities. The average indirect cost for those employed was Rs. 3663/- per patient, irrespective of type of facilities. The rural patients had an average indirect cost of Rs.3610, whereas urban patients suffered an indirect cost of Rs.4100/-. The average workdays lost were 83-82 for males and 85 for females. Out of 83 days, 48 were lost during pre-treatment period and the remaining during treatment period. Thus there was a diagnostic delay of nearly 6 weeks. The working days lost were maximum for the elderly rural illiterates (111 days) and least for young rural patients (15 to 25 days). There was no relationship between the loss of workdays and the type of occupation or the type of health facility attended. The total cost for “shopping for diagnosis”, treatment and indirect cost was Rs.3469/-. This was 1.2 times more among urban patients compared to rural patients. The average debts incurred by TB patients were Rs.2079/-. Urban patients had much higher debts than rural patients. A significant number of patients (69% in rural and 67% in urban areas) expressed mental agony arising out of economic impact and lack of attention by family members. The impact on children was significant: more than 50% of patients expressed their inability to attend to the needs of their children. About 12% of children discontinued studies and another 8% took up employment to support the family. Most of them were children of male patients. Most female patients avoid discussing their illness with neighbours. Illness reduced their activities by at least 30% in urban areas and more than 35% in rural areas.

The study concludes that there is need to reduce the direct and indirect costs on patients attending government facilities. This study could not capture cost borne by providers. There is need to carry out such studies. The RNTCP should take measures for early diagnosis of TB. The current delay of nearly 6 weeks in diagnosis is too long. Also, reducing shopping for delay will reduce indirect costs of care substantially. There is also a need to study the impact on pre-school children of TB patients. Policy measures are required to attend to the needs of their children.

Impact of Tuberculosis on Private for Profit Providers

Author/s: Balambal, R. Jaggarajamma, K. Rahman, Fathima. Chandrasekaran, V. Ramanathan, U and Thomas, A.

Publication source: Tuberculosis Research Centre, Chennai

Year of publication: 1997

States covered: Tamil Nadu

Social geography: Urban and Rural, Poverty

Data source: Primary

Type of study: Case Study

Type of private sector: Qualified allopathic private practitioners

Issue addressed: Private Sector, Private Providers, Utilization of Private Sector Quality of Private Providers.

Objectives: The purpose of the study was to look into the diagnostic and the treatment practices of qualified private practitioners and also to assess their willingness to collaborate with the Revised National Tuberculosis Control Programme.

Methodology: This study was conducted in the urban areas of Chennai and the rural areas of Chinglepattu. Altogether 303 qualified private practitioners from both rural and urban areas were interviewed. For the purpose of this study a private practitioner is defined as a person with a basic medical qualification either in allopathy or one of the indigenous systems of medicine.

Findings and conclusions: The study revealed that the median age of practitioners was around 42 years and a majority were males. Fifty-nine percent of the qualified private practitioners in rural areas and 42% in urban areas had a basic MBBS degree. Most of them were in general practice followed by practice in private hospitals. The study revealed that there were a few differences in the practices of urban and rural practitioners with respect to tuberculosis. They were aware of RNTCP and DOTS. The techniques that they relied on were mostly chest radiography and not on sputum examination. As far as therapeutics was concerned they prescribe short-term chemotherapy but do not use intermittent regimes. The study found that they maintained very poor patient records and although they used government facilities there was no feed back to any government agencies. The study revealed that the most important reason for referring patients to government centres was the poor socio-economic status of the patient. Apart from this reason, 35 percent of rural private practitioners refer cases to government hospitals for management of clinical complications. Contrary to Uplekar's findings, this study showed that a majority of non-allopathic practitioners did not prescribe allopathic medicines. There was much variability in the costs incurred by patients, which ranged from Rs 101 to as much as Rs 5000. Interviews with patients revealed that 62% of the patients went to government facilities for financial reasons and 30 % as a result of referrals. In Tamilnadu, qualified allopaths in rural areas were very few.

A number of issues are thrown up through this study which are important for policy. These include the uneven distribution of qualified private practitioners affects accessibility. While these practitioners may be aware of RNTCP, there is still a need to train them in diagnosis and treatment. There is a need to develop a reporting system of patients treated for TB to the public health system. The poor and complicated cases treated in the private sector are being referred to the government hospitals. Therefore it is important that government hospitals are strengthened. The issue of the diagnostic tools being used for diagnosing TB is important since the private practitioners rely largely on radiography rather than on sputum testing.

Illegal Abortion in Rural Areas

Author/s: Bardhan Amita, M.E Khan, L. Ramachandran, R.K Upadhyay, Saraswati Swain

Publication source: Indian Council of Medical Research (ICMR) New Delhi
Year of publication: 1989
States covered: Uttar Pradesh, Rajasthan, Haryana, Orissa, Tamil Nadu
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Unqualified Practitioners
Issue addressed: Utilization, Quality, Regulation

Objectives: To study the prevalence of illegal abortions. To study the socio-demographic profile of the women seeking illegal abortions. To identify the factors responsible for illegal abortions. To study the complications encountered by providers, procedures used, duration of pregnancy and measures undertaken for handling the complications. To study the cost involved in such abortions.

Methodology: The study was conducted in five states - Uttar Pradesh, Rajasthan, Haryana, Orissa, and Tamil Nadu. Two districts in each state were selected on the basis of the family planning performance i.e. good and poor. In each district two Public Health Centres (PHCs), one of them with MTP services was selected following stratified random sampling technique. Ten villages from each PHC were selected randomly for community survey. A sample of 500 households per PHC and one eligible woman per household was selected randomly. A sample of 20 villages per PHC and 3 providers per village were also selected randomly for provider survey.

The tools used for the data collection were interview schedule for providers, household information form, and interview schedule for community members and guidelines for case study. Two surveys were conducted. They were the provider survey & the community survey. In the provider survey, people were identified who acted as informants such as community level health and family planning workers, village heads and other influential persons, druggists, indigenous practitioners in order to find out who the providers of induced abortions were. The field investigators contacted the sources and after taking them into confidence, they sought from them the names, addresses and identification of the providers of illegal abortions. After preparing a list of the providers, these providers of illegal abortions were approached and interviewed. The providers were asked about the types of services they provided and also about specific issues related to induced abortions such as the methods used for conducting the abortions, type of cases they dealt with, gestation period and other such questions. The community survey was carried out immediately after the completion of the provider survey. The married (eligible) women who were aged between 15-45 years were interviewed. The focus of the survey was to find out the characteristics of the community members i.e. their age, sex, education, occupation etc, awareness of induced abortions, awareness about the place of the availability of the services and other related issues.

Findings and conclusions: The study revealed, that the extent of illegal abortion was 13.3 per 1000 pregnancies, in comparison with legal abortion i.e. 6.1 per 1000 pregnancies, which was high. Knowledge about inducement of abortion to get rid of unwanted pregnancy was 85.5% and about its safety, i.e. upto 4 months, was 85.2%. However, the awareness about the provision of legal abortion, i.e. MTP services was as low as 36.5%. The sources of information about abortion were mostly neighbors and friends who constituted around 27%.

Among the providers of health services, around 63.1% of the women preferred the qualified government doctors The reasons were that doctors were experienced, efficient and people had faith in them. However, it was revealed that the services were not available free in the Government set up. The next majority of respondents around 19.2% showed their preference to 'provider's home / place' i.e. the private hospital / clinic. The reason was that it was easily accessible and people were aware of its existence. Private doctors conducted abortion in the first trimester and occasionally beyond 3 months of pregnancy in their own clinics. They followed the method of vacuum aspiration and had not come across any complications. Fees charged were Rs.150 - 200/- per case. Government doctors were found to be conducting abortion in their private clinics. The reasons given were that clients desired special attention and secrecy and also that they could attend the cases carefully and devote more time, outside hospital hours.

The dais' abortions were regarded more as a social obligation rather than a professional need since this profession did not generate adequate income and also it was not well respected. They charged for their services either in cash (Rs. 50- 100) or in kind. They used indigenous methods and techniques for conducting abortions such as insertion of herbs and foreign bodies into the vagina and use of indigenous preparations containing roots, leaves, pools etc that were orally consumed. In Tamil Nadu the dais gave Erbolin tablets to the patients to be consumed orally and they claimed that the abortion was complete in two days without any complications. The utilization of dais was much less in Tamil Nadu and U.P, whereas in Orissa and Rajasthan there was dependence on local dais for abortion.

From the interviews with the women, it was evident that the awareness about MTP and the facilities provided by Government were very poor. Around 37.9% did not know whether abortion was illegal or legal and 21.1% thought that abortion was illegal. The media played a very small role in disseminating information on abortion. There is an urgent need for giving wide publicity about free abortion facilities at the Government centres. The knowledge about the complications of abortion during the second trimester and afterwards needs to be provided. For better MTP services, more centres in rural areas need to be equipped and authorized.

Expanding the infrastructure facilities and training doctors should improve the accessibility of MTP services. The training of the doctors should inculcate a spirit of service and ethical considerations. The doctors should be educated not to exploit the client's predicament. The unauthorized providers of abortion should be educated about the possible risks involved in illegal abortion as well as the ethical aspects in order to discourage them from doing so. The unauthorized providers of abortion should be counseled to refer the clients approaching to them to the Government hospital / PHCs and they should be given incentives for this. A very wide and intensive dissemination of information about all aspects of abortion and the MTP facilities available at Government hospitals and PHCs is urgently required.

Efficacy of Private Hospitals and the Central Government Health Scheme: Study of Hyderabad and Chennai

Author/s: Baru R. Purohit, B. and Daniel, Kumar

Publication source: Administrative Staff College of India, Hyderabad

Year of publication: 1999

States covered: Andhra Pradesh, Tamilnadu

Social geography: Urban

Data source: Primary

Type of study: Cross Sectional

Type of private sector: Corporate, Trust Hospitals and Nursing Homes.

Issue addressed: Organization of Private Sector; Cost of Care; Consumer Issues

Objectives: The overall objective of the study was to look at the efficacy of the CGHS and private hospitals in Chennai and Hyderabad. In order to address this overall objective the age, sex and nature of ailment and treatment were analyzed for all CGHS beneficiaries undergoing treatment in the recognized private hospitals. An effort was made to arrive at costs of specific interventions across types of hospitals in the two cities. In addition select case studies of beneficiaries were used to explore their experiences with the scheme.

Methodology: An analysis of all CGHS beneficiaries treated in the recognized private nursing homes and hospitals from Chennai and Hyderabad was carried out for getting insights into the age/sex distribution; nature of ailment treated; the number of days hospitalised and the cost of treatment. In addition, indepth interviews were done with the three major stakeholders viz. the beneficiaries, the CGHS officials and the owners of private hospitals.

Findings and conclusions: The study finds that many more corporate hospitals are recognized by the CGHS in Hyderabad than in Chennai. For several conditions, there is variability in costs for specific interventions like appendectomy, caesarian sections, deliveries and cataract surgeries across the different types of hospitals. On an average the cost of intervention is twice or three times in a corporate hospital compared to a trust or a single owner enterprise. The study also reveals that the hospitals do not adhere to th government package rates but infact charge the CGHS beneficiaries according to the market rates. This clearly defeats the purpose of a public insurance scheme. The study also points to the loopholes in the working of the scheme and the problems of a public insurance scheme in an unregulated private medical care sector. This study points to the variation in the costs for medical interventions and also to the fact that the difference in cost is borne by the patient. It also shows that the hospitals do not maintain the necessary records and there seems to be a lack of transparency in the process of recognition, billing and referrals from the CGHS to the private hospitals. There is dissatisfaction on the part of consumers regarding the functioning of dispensaries, the availability and quality of drugs provided and the indifferent treatment by some of the private hospitals.

The Household Management of Diarrhoea in the Social Context: A Study of a Delhi Slum
Author/s: Bhandari Nita
Publication source: Ph.D. Thesis, Jawaharlal Nehru University, New Delhi
Year of publication: 1992
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Individual Private Practitioners
Issue addressed: Private Sector Utilization for Diarrhoea, Practices of Private Practitioners.
Objectives: To study the occurrence of diarrhoea and its management within an urban slum.

Methodology: The study was conducted in a Jhuggi Jhompri cluster in New Delhi and the study sample consisted of 60 families with at least 1 child aged less than 5 years. In addition to the health seeking behaviour of families, the providers were also studied.

Findings and conclusions: The study shows that diarrhoea is the second most common illness for which treatment is sought outside the home for nearly 60% of the cases. Private sources of care are preferred, as

they are perceived as being more effective and providing prompt care. However, the very poor often seek care from a government hospital since they cannot afford private care. An in-depth study of the providers of all systems of medicine reveals that these practitioners use inappropriate and irrational drugs for the management of diarrhoea. A majority of them place excessive emphasis on using drugs rather than fluid replacement therapies. This study points to the dependence of urban slum populations on private practitioners who have varied backgrounds and training. Their practices are far from rational in the management of diarrhoea in children. This is the trend that has been observed in the management of other communicable diseases as well. Given the fact that people do utilize their services for primary level care it is extremely important to register and train them in rational therapeutics.

A Study of the State of Medicare Facilities in Agra
(with special reference to Nursing Homes of Agra), Project Report
Author/s: Bharti Ramkishan
Publication source: Unpublished Masters Dis-sertation, M.S.W. Agra University, 1992-93.
Year of publication:1993
States covered: Uttar Pradesh
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Nursing Homes, Indian Systems of Medicine.
Issue addressed: Characteristics of Private; Staffing, Costs and Prices of Services, Quality of Care

Objectives: The study focuses on the infrastructural facilities available at nursing homes. It also studies the qualifications and experiences of service providing professionals in the nursing homes.

Methodology: A survey of a few nursing homes in Agra city was conducted for this study.

Findings and conclusions: he study shows that the average academic qualifications of the service providersin the nursing homesare varied. Fifty percent have passed the intermediate; forty percent are graduates and another ten percent are post graduates. The post graduate doctors are either BAMS or BHMS qualified and eighty percent of these practitioners practise allopathic medicine.

About 30% of the professionals have 15 to 20 years practice, followed by another 25% with 10-15 years, 25% of them have 5-15 years and 20% of them have only 0-5 years of experience. A majority of them (90%) act as consultants to various nursing homes on a casual basis and the remaining 10% are employed temporarily in these nursing homes. Most of the nursing homes i.e. 85% have employed paraprofessionals who are intermediate (12th standard) or Matric pass. Not a single pharmacist was found during the study in these nursing homes. About 25% of nursing homes have employed technicians who are intermediate (12th standard pass). A large number of nursing homes i.e. 90% refer their patients to other hospitals (both government and private) due to inadequate infrastructural facilities at these nursing homes.

The consultancy charges range between Rs. 25/- to Rs. 50/- per patient and the bed charges range from Rs. 50/- to 150/- per bed. The private room charges lie between Rs. 100/- to Rs. 200/- per day excluding the additional nursing charges. The average number of patients admitted to these nursing homes are 171 in private rooms as compared to 240 patients in general wards. The average income of nursing homes in Agra city around is Rs. 53,000/- per month. In a small town in Uttar Pradesh the study shows that fifty percent of the promoters were unqualified. This is different from the trends observed by studies of private institutions, in large cities, which are mainly promoted by practitioners atleast with an MBBS degree. This kind of a trend has implications for quality of care and raises the need for ensuring some minimum regulations. From

this study it is also evident that nursing homes are earning quite a substantial amount per month. This raises questions regarding over-charging of patients, and the quality of services being provided by these nursing homes.

Public Private Partnerships in Health Sector: Issues and Prospects

Author/s: Bhat Ramesh

Publication source: Indian Institute of Management, Ahemdabad

Year of publication: 1999

States covered: Rajasthan, Maharashtra, Tamil Nadu, Delhi, Punjab, West Bengal

Social geography: Rural and Urban

Data source: Secondary

Type of study: Review cum Policy paper

Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit

Issue addressed: Partnerships, Incentives, Organisation, Utilisation

Objectives: Today most of the state governments face the problem of shrinking budgetary support and thus findi it difficult to provide and expand health facilities and thus cater to the health needs of the people. To overcome this problem, several state governments are trying to involve private sector in public health care activities and to work jointly. This is done in the hope that private sector involvement would bring investment into the health sector and would provide health services to the people.

The paper has given an account of the policy initiatives by various state governments to develop such relationships between the public and private sector.

Methodology: Policy Context: The government budgetary allocations for the health sector are low and with the changing technology the government are not able to cater to the health needs of the people at various levels such as primary, secondary and tertiary. Emphasis has been given on the control of communicable diseases overlooking the important curative and tertiary areas. In most states the salary component accounts for over 70% of the total budget. Due to the economic pressures, governments are cutting down their expenditure and this has affected the improvement of quality as well as the quantity of the curative health care. The option of meeting this expenditure through user fees has been tried out by various state governments. However, this could not provide a solution since the receipts were less than the expenditure. In 1992-1993 the average hospital receipts were 1.4 % of the total hospital expenditures. The involvement of the private sector is another option. In recent years, the private sector has emerged as a dominant sector. In 1997, the private expenditure on health was estimated to be 4.25% of the GDP. Recent data has suggested that 80% of the qualified doctors work in the private sector. In recent times, government has started looking at Public-Private Partnerships as a viable option for the health care delivery.

Public-Private partnership initiatives: Offer of sites for the specialty/superspeciality hospitals in Punjab: Government of Punjab had proposed to start a partnership venture for setting up specialty or super specialty hospitals. The share of the government was supposed to be in the form of subsidized land. The bids were invited for six locations having an area of 5 acres to 10 acres. In response Punjab Urban Development Authority received 20 bids out of which 12 respondents were short-listed. However, the bidding institutions insisted on specific locations and a workable agreement could not be reached. In a few cases land was allotted but later the deal was cancelled. In 1997 the government revived the proposal and invited fresh proposals for 5 specified locations. However PUDA did not provide adequate information about the locations. No detailed policy document was available regarding this proposal. The total expected costs were 500 million, excluding the land costs. Only those bidders who had at least 10 years' of experience could set up the hospitals. The response to the new proposal was very poor. Only five applicants showed their interest in the proposal. The entire process of revising of initiative took 2 years and the selection was not finalized. The Director of health services, Government of Delhi proposed to set up 10 hospitals as joint

ventures on the sites available with the government. It was planned to acquire the hospitals from the Municipal Corporation of Delhi. The proposal indicated that government 's contribution would not exceed 26% of the total share capital. It was in the form of the land price. In cases where land prices were less than 26% of the total share capital, the government had promised to contribute other resources to meet the capital requirement. The government laid down the condition that 1/3rd of the broad nominees would be from the government. The applicants were given the option of either setting up hospital or a superspeciality facility. Each facility was expected to offer free care to a certain percentage of Out Patient Department and In Patient Department patients. The bidding institutions were required to specify the percentage of OPD and IPD care they propose to provide. More than 30 applicants responded to the proposal since it was commercially attractive. However the proposed location of the facilities attracted public attention and a public interest litigation case on social grounds was filed in the Delhi high court. The court issued a stay order against the scheme.

Private Investment in Medical Institutions: The policy document of the Rajasthan government was the most comprehensive policy statement on public private partnership by any state government. In order to encourage private investment in hospitals, nursing homes, diagnostic centers, etc. Medical and health departments of the Government of Rajasthan came out with a policy in 1996. In the policy statement, the government specified the need for development of effective secondary and tertiary care system. It acknowledged the financial crunch faced by the government and the need for efficiency and better clientele servicing. These were specified as reasons for involving the private sector in health care. The policy document of the Government of Rajasthan provided land at subsidized rates as well as the duty exemption and other benefits to attract private investment. GOR also provided fiscal incentives on all medical equipment, plants and machinery under a condition that they were from the approved list of DOHFW and the facilities were set up before 31 March 1999.A time frame of two years was given from the date of allotment for the use of the allotted land. However, the implementation of the policy was difficult due to the procedural constaints. The proposed locations were not declared at the beginning and it led to a considerable amount of confusion. Getting clearance from various departments was a difficult task. As a result, the policy proved to be unsuccessful.

Involving Industry and Non Government Organizations in Running Public Health Centers (PHCs): The Government of Tamil Nadu evolved a scheme involving the industry in improving the performance of the PHCs. The industry was supposed to adopt a local PHC. They had the responsibility of maintaining, and equipping the facility. The scheme got a reasonable response from the companies and they adopted the PHCs, which were in their vicinity. In Gujrat, an NGO, SEWA-Rural was given the responsibility of the PHCs in one district. The government financed the project. The PHCs were to be manned by the SEWA people. The institution was required to fulfil all targets set under various health schemes, which the government had fixed from time to time.

Private involvement in MOFW, GOI RCH program: The RCH implementation scheme declared by the government has made a provision for hiring services of private anesthetists on payment of Rs.500. per case. In case of MTP, the district can engage the services of a private doctor once in a week or a fortnight for performing MTPs and they would be paid Rs. 500 per visit. The schemes also included number of other measures such as involving NGOs for various components of the RCH program.

Contracting out of Services: Another way by which public private partnership was formed was through contracting out of the clinical and non-clinical services. On clinical side it included speciality care services reaching to the targeted population. Non-clinical services included services such as dietary services, laundry services, Security, etc. The Directorate of health and Family Welfare allowed the District Health Committee to hire the services of private doctors on a contract basis. The West Bengal government and DOHFW decided to employ private practitioners on the PHCs to fulfill the manpower requirements. It also

proposed to bring 341 PHCs under the control of Panchayat Samities, which would also have the power to employ the private practitioners. The contracting out of the non clinical services such as dietary services, laundry services, security, etc. was done in states such as Maharashtra, Tamil Nadu, and W. Bengal. In recent times a new trend of contracting out of the specialized and super specialised health care departments has emerged. Maintenance of equipment's and facilities is another area where contracting out is done.

Findings and conclusions: The study has concluded that in our country, the Public-Private initiatives are in a premature state. Without the availability of a proper institutional mechanism, these ventures have a very low success rate. While designing a Public Private Partnership (PPP) venture, the government should pay attention to the following aspects

Information: The process of PPP starts with the policy statement from the government, defining the scope and nature of any proposed partnership. The central and state governments should clearly define its policies regarding partnerships . It should specify the terms and conditions under which such partnerships can take place. The clarity of the information would make it easier for the private bidders to take decisions. Along with the availability of information the other thing required is the appropriate mechanisms to involve the stakeholders and the transparency. The involvement of the partners and the stakeholders in the process can be a way of ensuring a close partnership.

Co-ordination and monitoring: The finalisation of the partnerships requires co-ordination between various departments such as finance, urban development, industry, etc. Inter departmental policies should be carefully formed to make the partnerships convenient. The experiences of various states have suggested that in the past the governments lacked in developing mechanisms to co-ordinate between various departments. Another important area is the monitoring of the PPP ventures. With out a proper monitoring mechanism, the private sector might operate unregulated and might exploit people. The authority should ensure that the private partner meets all the requirements regarding safety, quality, etc.

Public Goal and Private Initiative: The partnership between the public and the private sector should be evolved taking in to mind the surroundings and the local needs. The issues of quality and cost are the issues on which there is a difference of opinion. Consumer protection has to be ensured. The issue of equity which has been the primary principle of the public sector should be assessed along with the private motive. Ensuring equity and the access is the most difficult task. To find the appropriate way out, various mechanisms such as strengthening the public facilities along with the growth of the private sector should be tried out.

Market subsidy and Incentives: In most of the cases of the public private partnerships, the government input comes in the form of the subsidized inputs such as land. This is done to encourage the private investor to come forward. The private provider in return has to provide free care to a section of the society. There is a need to find out more such ways of PPP.

Institution and Organisation: There are various institutional and organizational issues, which emerge during the process of public private partnerships. The issue of staffing and control over the staff is a key area where more study has to be done. Because too much of control would hamper the process since the private providers would hesitate to come forward.

The study has emphasized the importance of the Public Private Partnerships as a form of privatization. If implemented properly, these ventures could provide an efficient and equitable option of health care delivery.

Regulation of Private Health Sector in India
Author/s: Bhat Ramesh
Publication source: (Book), Private Health Sector Growth in Asia: Issues & Implications ed. William Newbrander
Year of Publication: 1999
States covered: National
Social geography: Rural & Urban
Data source: Secondary
Type of study: Review cum Policy Paper
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit,
Issued addressed: Regulation, Quality, Financing

Objectives: The private sector plays a dominant role in India's health care delivery system. The factors such as New Economic Policy, influx of medical technology, growing deficits of the public sector hospitals and rising middle class have contributed to its large-scale growth in the last decade. But this growth has not been without its consequences. The private health services are costly and many times ignore the quality factor. There is no serious effort to regulate the private sector and so that it can be used as an effective means of health care delivery. The Consumer Protection Act, Medical Council of India and State Medical Council have been discussed in the study of health care delivery. The Consumer Protection Act, Medical Council of India and State Medical Council have been discussed in the study.

Methodology:

Findings and conclusions: The Consumer Protection Act is the most commonly recognised legislation among all. A survey conducted in Ahmedabad has shown that 93% of the medical practitioners are aware of the Act. COPRA was promulgated in 1986 to protect the interests and rights of the consumers. The main purpose of COPRA is to resolve the complaints of the aggrieved consumers in a less costly and less time consuming manner. The redressals are made by quasi judicial bodies formed at district, state and national level. The medical practitioners have argued that they should be kept out of the scope since their services are personal services. The supreme court has clearly stated that any paid medical service does fall under the scope of COPRA. However, COPRA has not been very successful in providing protection to the consumers as far as the medical sector is concerned. In the cases of medical negligence the responsibility of proving negligence lies with the consumers. The effectiveness of COPRA is in doubt also because of the number of cases pending with the courts. A study in Gujrat has shown that 50% of the cases filed were pending. However, a survey conducted to assess providers' opinion has shown that 64% of the providers believed that COPRA is an effective tool for protecting the interests of the consumers. Fifty-nine percent of the respondents feel that the act would increase the cost of diagnosis, while 91% believe that the cost and the use of diagnosis have increased and 58% of the respondents thought that the Act would increase the amount of time a doctor spends on each patient. A number of questions need to be resolved to make this act effective. 1. There is a danger of practitioners practicing defensive medicine or in other words over

diagnosis. 2. There is no provision of action against the petitioners filing false cases against the doctors. 3. The absence of medical professionals in the implementation. The upper committee of the upper house of parliament has recommended that the doctors should provide information about their fee structure to MCI and then MCI should make it public. There is also a need of an orientation program for the newly graduated doctors. The Medical Council of India came in to being by an Act of Parliament, The MCI Act, 1956. The council is composed of one nominated member from each state, one elected member from each university, one member from each state registered, seven members from those enrolled in any of the state medical register and 8 members nominated by the government. The functions of MCI include giving recognition to medical qualifications, maintaining register, maintaining standards for post graduate medical education, defining a professional code of conduct, etc. However it cannot provide redressal to the grievances of an aggrieved person.The other main activity of the council is to maintain and monitor medical ethics for practitioners. The ethics are based on the Geneva declaration adopted by the General Assembly of World Medical Association, 1949. Though MCI has produced a list of medical misconducts that can be brought before the council, it does not specify punishments for such misconducts. The State Medical Councils have been created by various state governments for registration of practitioners, maintaining the standards, etc. The councils perform the same tasks as that of MCI, at state level. There are very few examples of the councils intervening directly into the matter and taking action such as cancellation of registration of a practitioner. The role of the government is also limited. The government officials intervene only if they feel that the councils have not followed the provisions of COPRA. Thus it can be concluded that MCI and SMCs have largely failed to regulate the medical profession and protect the rights of the consumers.

Characteristics of Private Medical Practice in India: A provider perspective

Author/s: Bhat Ramesh

Publication source: Health Policy And Planning; 14(1):26-37, OUP, 1999, London

Year of publication: 1999

States covered: Gujrat

Social geography: Urban

Data source: Primary

Type of study: Cross Sectional

Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, For profit

Issues addressed: Financing, Quality, Costs,

Objectives: To identify areas of intervention so that the private health sector becomes responsive to the problems of its growth and to understand the views of each stakeholder.

Methodology: A sample of 500 doctors was selected randomly from a list of 2920 doctors registered with the Ahmedabad medical Association {AMA}. A questionnaire was sent to 495 private doctors. 108 doctors responded to the questionnaire. Respondents included both graduates and post-graduates. The mailed questionnaire was followed by an in-depth interview of 22 private doctors selected randomly from the list of 500 doctors. No statistically significant differences were found between the questionnaire responses and the interview results. The questionnaire consisted of a set of closed -ended questions and a few open ended questions which pertained to the operational activities of private practitioners and their opinions regarding cost, quality of care and regulatory mechanisms affecting private medical practice. A number of questions required the ranking of factors to arrive at the most important factor. A 5-point scale was used to rank the factors and the average score was arrived at using the rank information and number of observations.

Findings and conclusions: Around 84% of the respondents {General Physician, Gynecologist, Surgeons and others} experienced growth in their practice. The reasons they gave for was experience of the doctor, availability of specialized skills and technology, accessibility of private medical services, increasing demand for health care, promotion of private medical practice by private practitioners. Fifty percent of providers have a maximum patient load of 26 or more per day. Discussion with the doctor suggested that a doctor could see only 25 patients a day and spend 20 minutes with each patient, which works out to 8 hours a day, that is the maximum time the doctor can work. But the study found out that 45% of the doctors spend less than 15 minutes on each patient so that they are able to see more patients. Fifty percent of the private doctors occasionally referred patients to other specialists. In case of investigations, 56% doctors referred patients frequently to diagnostic facilities. The study indicates that recommendations by physicians are generally based on quality and proximity factors.

The fee setting practices of providers are primarily determined by cost considerations (47%). There is very little influence of professional medical bodies on deciding the fees charged by providers. Only 11% of providers decide on fee on the basis of association recommendations. In leaving fee-setting decisions to the providers, the existing cost inefficiencies considerably influence their decisions. It thus becomes important for the professional medical bodies to evolve some norms and appropriate practices for the provider payment system. Only 59% of the providers indicated that patients ask for a copy of the prescription and diagnosis. About 90% of providers indicate that private practice has become capital intensive. Factors that affect the establishment cost of private facility are location of the clinic, which is mostly in commercial areas, sophisticated equipment and new technology, maintenance of the clinic, manpower and other related costs.

In the present survey, 92% and 5% of the establishments are registered as sole proprietor and partnership firms, respectively, with unlimited liability. The perceived risk of these organizations is generally highest and therefore normal channels of finance are not easily available to them. This affects the capital cost of medical establishments. The survey results indicate that 46% of provider's do not use any borrowings to finance their total capital employed. In these cases, all investments are financed by the owner(s). On the other hand, 35% of the providers used heavy debt to finance their investments. Only about 19% of the providers use moderate levels of debt to finance their capital investments.

Private providers experience shortage of paramedical staff, hence they hire untrained people to man their health care facilities. The providers considered 'cost of hiring' as the second most important problem associated with manpower. Of the providers, 94% consider seasonal fluctuations in patient flow as the most relevant risk factor, 88% of the providers consider cost-recovery as the second risk factor, 79% consider risk arising out of regulations as the third risk factor. According to the private providers interviewed the regulation giving more rights to consumers through the Consumer Protection Act has also increased their risk environment. Prevalence of undesirable practices over prescription of drugs was ranked as the most common malpractice, followed by fee-splitting practices, inadequate measures of disposal of waste and over-prescription of diagnostics. Awareness about private health sector regulations: Around 93% of the providers were aware of the Consumer Protection Act {COPRA}. More than 50% of the providers were familiar with the Indian Medical Council Act, the Medical Council of India Code of Medical Ethics. Providers exhibited low awareness about the drug-related legislations.

The Government and professional medical bodies need to make a concerted effort to address the above mentioned issues in the findings in a holistic manner and develop appropriate strategies to handle the

various concerns. The information dissemination role of government and professional bodies, developing and strengthening the institutional mechanisms for a continuing medical education programme, developing appropriate and effective regulations and the development of standards should be given priority. Important implementation issues to address in the future should be: first, prioritisation of issues both within and outside the government, second, the development of institutional mechanisms and management structures within the government and professional medical bodies to address public policy on the private health sector.

A Study on Contracting out of Dietary Services by Public Hospitals in Bombay
Author/s: Bhatia M.R

Publication source: Department Of Health Services Studies, TISS, Bombay
Year of publication: 1997
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Hospitals
Issues addressed: Contracting, Costs, Organisation, Quality

Objectives: To review the contracting arrangements in the public hospitals of Bombay. To study the existing contracting arrangements of dietary services in the study hospitals. To compare the costs of direct provision of services with the price of contracted services. To examine and assess patient satisfaction, quality of the dietary services and attempt to develop appropriate quality indicators for the dietary services in public hospitals under consideration.

Methodology: The study was undertaken in one teaching and two peripheral public hospitals where dietary services were contracted (contract hospitals) and in the same teaching hospital and three other peripheral hospitals where dietary services were managed by hospital staff was taken for the control group (in house). In the teaching hospital studied, 40% of dietary workload was on contract the rest of the workload was in house. The study utilised a mix of methodologies. Original contract documents were analyzed with respect to duration, nature of contract, reasons for contracting out, monitoring of contract, penalty clauses etc. To assess the costs to the public hospitals for direct provisions of dietary services and price of the contracted services, costs were identified and measured under heads-salary, raw material, gas, water, electricity, space and capital costs of equipment. The patient satisfaction was assessed through a survey of 1100 patients through structured interview schedules. An attempt was made to assess the quality of the dietary services by using the Input-Process-Output model for quality assessment. In addition, the expert opinion of a dietician was considered with regards to nutritional and caloric content of the diets. In addition semi structured interviews were undertaken with the contractor, hospital administrators, BMC diet committee members and other experts.

Findings and conclusions: It is observed that there are hardly any private contractors bidding for tenders to realize the benefits of competitive tendering. The study reveals that formal competitive tendering does not exist in the true sense. Contractors continue year after year in most instances. Although the contract document specifies the contents of the diet, it does not specify any quality guidelines. In the absence of any specific quality standards, the hospital administrators are unable to monitor the quality of food supplied by the contractor effectively. Although all the hospitals studied, where diet is contracted out are under one authority, i.e. Bombay Municipal Corporation, the terms and conditions of the contract document vary. It is interesting to note that the criterion for selection of the contractor was mainly on the basis of Rate / meal

quoted by the contractor at the teaching hospital, whereas in the peripheral hospitals, the criterion for selection was on the basis of maximum royalty the contractor was willing to pay to the hospital, as the price per meal is fixed. There is no formal mechanism for supervising contractor performance. No records are maintained by the hospital in this regard. It is observed that only those municipal hospitals which have either recently started or have undergone recent expansions have dietary services on contract and hence the question of retrenchment of staff does not arise. Also, because of the strong union that operates in municipal hospitals, this is not be feasible.

The price per meal is less in contract hospitals (Rs. 5.75, Rs.4.00 & Rs. 3.70) as compared to the cost per meal in the in-house hospitals (Rs. 7.47, Rs.7.48, Rs.9.32 & Rs. 11.99). This could be attributed mainly to salary costs, which are lower in Contract Hospitals. Comparing the In-house Dietary services, it is observed that the cost per meal is less in teaching medical college hospitals (Rs.7.47, Rs. 7.48) as compared to the peripheral hospitals (Rs. 9.32 & Rs. 11.99). This could be attributed to the increased efficiency in teaching hospitals, economics of scale, high bed occupancy and availability of trained professionals. Among the peripheral hospitals, significantly more number of patients receive food on time. In In-house hospitals it is (99.1%) as compared to Contract hospitals (86.%). This difference is not observed in teaching hospitals. Among peripheral hospitals significantly more number of patients are satisfied with quantity of food served in In-house hospitals as compared to Contract hospitals. A similar trend is observed with regards to certain quality indicators like taste, flavour, appearance etc. There is no significant difference with regard to patients' satisfaction to the quantity and quality of food served in teaching hospitals. Overall patient opinion regarding dietary services in peripheral hospital shows that significantly more patients are satisfied with In-house dietary services (92.4%) as compared to contract hospitals, Kandivili and Centenary where the overall satisfaction was only 65.1%. Although a higher percentage of patients were overall satisfied with dietary services in teaching hospitals (79.4%), this difference was not significant. Overall diets provided by In-house services were much better than the contract diets (both in terms of quality and quantity).

The Diet Committee of the BMC should be entrusted with the job of centralized drawing of contracts for all its hospitals. This would lead to uniformity in diets in all its hospitals. This would also reduce transactional costs and increase possibility of negotiation for contracts. The monitoring and implementation of the contracts would be the total responsibility of the local hospital administration. Administration should be trained to draft, monitor, implement and evaluate contracts. There is a need to develop quality indicators with respect to dietary services in public hospitals. Periodic evaluations of contracted services is necessary with regards to levels and standards of services, satisfaction of users and the quality of services. The hospital should develop a system for formal evaluations. Penalty clauses for performance failures as laid down in the contract document should be used as and when necessary. The selection criteria for the contractors need modifications. New entrants should be encouraged. In the absence of true competition and absence of inadequate system for monitoring the performance of contractor, BMC may consider partial contracting in which only the labour is on contract. Therefore, the hospital is free from day to day labour problems and at the same time management has total control over the quantity and quality of diets served to patients. To set in motion an effective method of self-checking of the performance of diet services, patients should be made aware of their food entitlement.

Understanding Environmental Health: A Study of Some Villages of Pauri Garhwal

Author/s: Bisht Ramila

Publication source: Unpublished M.Phil Dissertation, Jawaharlal Nehru University, 1993.

Year of publication: 1993
Status covered: Uttar Pradesh
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Private Practitioners, Traditional Practitioners
Issues addressed: Private Sector Utilization

Objectives: The broad aim of this study was to explore the objective and subjective components of environmental health of the Himalayan eco-system. The sub-objectives were: - a) To understand the socio-economic and environmental problems and people's perception about it them b) To understand the process that has led to the present situation. c) To examine the relevance of different developmental approaches that have emerged in relation to the existing realities in this area.

Methodology: This study explores factors determining environmental health in Pauri Garhwal. It is based on a sample of five villages where all households were studied. This was preceeded by a total study of the population consisting of 981 persons.

Findings and conclusions: Though private practitioners were not the primary focus of the study, it throws some interesting light on the utilization patterns and their reasons. The area had its prescribed PHCs and CHCs, however, their distribution was such that it made access difficult for some villages because of the terrain and the distances. As a result private practitioners of a wide range were not uncommon. Of these the Registered Medical Practitioner (RMPS) were the commonest. The reasons (cited for not utilizing the other than distance and terrain) cited were lack of medicine at PHCs, timings of the PHC, the poor attention given by the staff which was often compared and contrasted to the 24 hour availability of the private practitioners. The traditional practitioners still continue to play an important role in these areas and religious healers also practice. As a result the practice of mixing systems of medicine by the people is prevalent in this area. This study documents the presence of a plurality of practitioners in the rural areas of the hilly areas of Uttar Pradesh. The villagers go to these practitioners for primary level care and an important reason for this is the accessibility and availability of these practitioners.

The Traditional Herbal Medicine System of Chotanagpur: A study of its present Status & Future Prospects
Author/s: Chand S K
Publication source: Research Department of Xavier Institute of Social Service (XISS), Ranchi, Bihar
Year of publication: 1988
States covered: Bihar
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, ISM, Unqualified practitioners
Issues addressed: Utilisation, Quality

Objectives: To find the extent of the popularity of the herbal system of medicine among the tribal population of Chotanagpur and to collect information regarding the healing properties of the herbs.

Methodology: The study was undertaken in Chotanagpur which represents areas of concentration of different tribes, such as Munda, Oraon and the Ho tribes who use herbal medicine for treating various kinds of diseases. As part of the study a total of 913 households were surveyed in 12 villages of 5 blocks in 3

districts i.e. Gumla, Palamau and Singhbhum. In each block 2 remote villages were selected. In one block 2 extra villages were studied, since the population of two selected villages was very small. A questionnaire was administered to the head of the household. The questionnaire dealt with information regarding family composition, marital status, education levels and occupational characteristics of rural households. Details about the diseases suffered and their frequency, type of herbal treatment resorted to, source of knowledge about the herbal medicine, herbal medicine practitioner consulted by the tribal people etc were also collected. All families in the selected villages were covered by the survey. Practitioners of herbal medicine were also interviewed. Information was also gathered about the medicinal herbs available in the area and the types of diseases for the treatment of which herbs were prescribed.

Findings and conclusions: When asked about their preference for different system of treatment i.e. between homeopathy, ayurvedic, allopathic and herbal, out of total 913 households only one household responded in favour of homeopathic treatment, 56.62% were in favour of allopathic, 40.31% favoured herbal medicine, 2.96% favoured ayurvedic system of medicine. Thus, the real choice of rural households was between herbal and allopathic systems of medicines. The main reasons for opting for herbal system of medicine were easy accessibility and effectiveness. The two main sources for procurement of herbal medicine were from the ohja or baidh? [Vaidh] (86.89%) and the forest (82.46%). It was found that the availability of facilities for allopathic treatment has adversely affected the popularity of the herbal system of medicine. It was found that there is a direct relationship between the literacy level of the family and their preference to use allopathy and an inverse relationship between the literacy level of the family and preference to use herbal system. As the literacy ratio of the families increases the percentage of families favouring allopathy increases, while the percentage of families favouring herbal system decreases.

The study revealed that the nature and extent of morbidity was fairly high in remote rural areas and almost each family had some illness to report. This was partly due to poverty and unsanitary condition of rural living. High incidence of malaria among the tribes was also reported. A significant percentage of households depended upon medicinal herbs for treatment of acute and chronic illness, either on the basis of their own knowledge or with advice and guidance from tribal medicine men. The most common diseases, the people suffered from were malaria, cold and cough, fever, typhoid, diahorrea, dysentery and jaundice. Around 44% of the children were suffering from severe malnutrition. Unlike practitioners of allopathy, ayurvedic and homeopathic system, who are registered for practice, the herbal medicine men were neither formally trained nor registered for private practice. The tribals were finding it hard to keep the indigenous healing system alive, because of large-scale destruction of forest.

The study shows that herbal medicine is very popular among tribal people of Ranchi, Gumla, Singhbhum and Palamau districts. Dependence of tribal people on herbal medicine is mainly due to non-availability of modern medical facilities, easy accessibility of herbal medicines, cheap treatment costs, faith of tribals in the healing capacity of the ojhas. An important advantage of herbal medicine is that of population control. There are many herbs, which are used by the tribal people for anti-fertility purpose such as pupraria tuberosa, tithi, annona sqamosa, cassifistula etc. Tribals are concerned about the future of this system of medicine and are interested in their preservation and propagation.

Measures should be undertaken for identification of threatened herbal species with the co-operation of herbal medicine practitioners, conservation of the forest areas where such species are grown, educating

people on the methods of collecting herbs for personal use or for commercial purposes. If necessary curbs will have to be imposed on the commercial exploitation of important herbs which may be in danger of becoming extinct on account of over exploitation. Regulating their marketing should also be done. Further, training should be given for practitioners of herbal medicine and they should be educated about the protection and propagation of the important herbs.

Factors Affecting Health Seeking And Utilization of Curative Health Care

Author/s: Chirmule Deepti, Anuradha Gupte

Publication source: Bharatiya Agro Industries Foundation, Pune

Year of publication: 1997

States covered: Gujarat, Maharashtra, Karnataka, Uttar Pradesh, Rajasthan

Social geography: Rural

Data source: Primary

Type of study: Cross Sectional

Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit

Issues addressed: Utiilisation, Expenditure, Quality

Objectives: To identify the factors influencing decisions regarding the type of health services to be used. To study the preferences of the people regarding the choice of health care provider in relation to their socio economic background. To identify necessary interventions for increasing the reach of health services to the poor people.

Methodology: The study was conducted in the rural areas of five major states namely Gujarat (Dist. Valsad), Maharashtra (Dist. Ahmednagar), Karnataka (Dist. Dharwad), Uttar Pradesh (Dist. Allahabad) and Rajasthan (Dist.Bhilwada). Data was collected from three thousand households from each of the study areas. For Data collection, an interview schedule was prepared, which contained questions related to the demographic information, socio economic status of the household, morbidity in the previous week, morbidity for specific ailments and type of treatment sought by the people. In addition to the probing list, qualitative information, focusing on health culture of the area and health seeking behaviour was also collected. Anthropologists who resided in the study areas collected the qualitative information. The probing lists or the interview schedules contained questions on morbidity in the household during the week preceding the study.

Findings and conclusions: The study has revealed that in Gandevi district of Gujarat, out of 14464 people, 261 were sick. In Akole District, Maharashtra, the number was 756, where as 487 people in Laila district reported sickness. Fevers and coughs were the most common complaints. Private modern health care services were the popular choice in Gamdevi (Gujarat) and Akole (Maharashtra) constituting 73% and 66.4% where as in Laila, Rajasthan only 9.2% of people sought private health care. Here home remedies were very popular, as 58% of people sought their help. Less than 100 patients from all the areas sought help from the ANMs. Only in Laila (Rajasthan) 3.5% of the people were found to seek treatment from the ANMs. During the study period, there was large-scale prevalence of typhoid in all the villages of Laila district. There it was known as Nikhalo or Miyadi bukhar. But people were treated at home with dietary restrictions and ashes (vibhuti) given by a local healer. This was due to the superstition of the people that the fever was a result of the wrath of the goddess. Since the healer was believed to be the incarnation of the goddess, people often went to him. The government health services were not popular on account of longer waiting period, arrogant behaviour and attitudes of the doctors and non-availability of medicines. In

Karchana district (Uttar Pradesh) only 16% of the people used the PHC services. This was the lowest in all districts under study. Several Registered Medical Practitioners were found to be practicing in the study area. Though law has stopped the practice of RMPs, people still preferred going to them since they were easily accessible and often worked on credit. Most of them were from the same community. In Karchana district of Uttar Pradesh they were popularly called 'Zola chaps' since they carried their Zola of medicines with them. The excessive use of injections was the characteristic of these practitioners., One of the reasons of their popularity was that they treated their patients with injections. Since most of the people were on daily wages, they could not afford to stay at home during sickness and thus often insisted on injections.

The utilization of health services was linked with their affordability. People with incomes higher than Rs.10, 000/- preferred seeking private treatment. where as people with lower assets or no assets preferred not to take any treatment or resorted to the PHC facilities. Caste was an important factor in determining the choice of treatment. In Gujarat, 825 of the people from dominant castes sought private treatment while for the higher classes the percentage was 100% and65% of the schedule caste people sought treatment from private practitioners. However no treatment was dependent on caste.

The study concluded that the utilization pattern of health services is determined by many factors such as cost, quality of services, their availability, etc. However quality of services play a dominant role in people's decision about seeking medical help. The study shows that due to the inefficiency of the Public Health Centres people prefer seeking treatment from private practitioners. For example, in Laila (Rajasthan), people did not have any choice but to go to the private practitioners or to seek home remedies since the health infrastructure was not well developed. Economic factors such as poverty restricted the people from having modern scientific health care. Another fact is that there is no gender bias as far as the morbidity or treatment seeking behaviour is concerned. Factors such as caste class etc. are still dominant and are important in determining the type of health care sought.

The first thing that needs to be done is the improvement of the PHC structure. Curative capacities of the PHCs should be enhanced by ensuring adequate supply of medicines and proper training of the personnel. The private practitioners must update their knowledge through continued Medical Education. The private practitioners should be brought under regulation. Doctors of other systems should also be incorporated into the health system along with doctors practicing modern scientific medicine. This can be done through training and education of the practitioners. Poverty is one of the most important reasons for the limited access to the health care facilities. Thus, efforts should be made to improve the overall economic condition through the pursuance of rural education. This will have a positive impact on people's health seeking behaviour. The health infrastructure should be developed in such a way that it would suit the local conditions and would cater to local health needs. The priority of development action should be the development of the relevant health infrastructure.

Quality of Primary Health Care with specific regard to Gender Dimensions
Author/s: Community Health Department
Publication source: Christian Medical College, Vellore, Tamil Nadu
Year of publication: 1999
States covered: Tamil Nadu
Social geography: Rural
Data source: Primary
Type of study: Cross sectional survey, and policy paper.
Type of private sector: Registered Medical Practitioners, Private general practitioners.
Issues addressed: Utilization of private and public services, quality of services, government policy.

Objectives: The primary objective of this study is to examine the gender dimensions of the quality of health services provided for RTI by primary health centres in Dharmapuri and Villupuram districts of Tamil Nadu. Among many specific objectives, this study also seeks to examine the utilization of health services for RTI and STI and compare utilization by gender.

Methodology: Twelve Health Sub-centres were chosen from each of Dharmapuri and Villupuram districts, by the probability proportion to the population size sampling procedure. From each sub-centre, one village was chosen by random sampling. The survey in each district included three components: demographic, clinical and qualitative.

Findings and conclusions: The government was the predominant provider of ante-natal care in both districts. However, the proportion attending antenatal clinics in the referral centres was 3% in Dharmapuri and 9.7% in Villupuram district. This is lower than the expected 20%, indicating that the high-risk approach is not being used. A large proportion of the population goes to local RMPs (Registered Medial Practitioners) and private practitioners for health care. The predominant reason is the quality of care and client satisfaction. Different reasons are given for not using government services: Some PHCs are inaccessible and lack transport facilities, while some others provide poor quality of care. The response has been good wherever the doctors and attending staffs have been kind to the patients. Corruption and lack of punctuality also contribute to the negative image of government hospitals. 8.3% of all pregnancies in Dharmapuri and 2.7% of pregnancies in Villupuram end in induced abortion. Qualitative studies show that the primary reason for thisi s sex-selection, which is common in these districts. More than 50% of abortions are conducted in government health centres in Dharmapuri, while in Villupuram only 25% of abortions are conducted in government health centres. RTIs are found in 41% of ever-married women between 15-49 in Dharmapuri and 35% in Villupuram. The prevalence increased with age at marriage in Dharmapuri but not in Villupuram. The RTis higher among the widowed, divorced and separated as compared to currently married women. RTI decreases with increasing education. PHCs and HSCs are grossly inadequate for the management of RTI. Family planning is still an area of need. Female infanticide and foeticide are significant problems in Dharmapuri. There is an urgent need to address this issue. People prefer not to use government services. The reasons for this include quality, inaccessibility, attitude of staff, lack of supplies and corruption. There is a scope for greater sensitivity to gender issues in many training programmes.

A Psychosocial Study of Selected Health Problems in Low Income Urban Colonies of South Delhi

Author/s: Desai Kalpana N

Publication source: Unpublished Ph.D. Thesis Submitted to Jawaharlal Nehru University, 1997.

Year of publication: 1997

States covered: Delhi

Social geography: Urban

Data source: Primary

Type of study: Cross Sectional

Type of private sector: Individual Private Practitioners, Alternate Systems of Medicine

Issues addressed: Utilization of Private Sector, Government Hospitals.

Objectives: This study primarily focusses on problems faced by people from low income families, their relationship with the family environment and its influence on health perception and behaviour. This study was conducted in a resettlement colony in South Delhi.

1. To study the psycho-social aspects of selected health problems across three urban colonies in Khanpur area of Delhi.
2. To assess the family environment in households across these colonies and study its relationship to health problems.

Methodology: This study was done in three types of urban slums which included a resettlement colony, an unauthorized colony and an urban village all seen as part of a continuum. Forty households were chosen on a random basis from each of the categories mentioned above. These were essentially in-depth case studies and focussed on selected health problems. These included fever, diarrhoea, alcoholism, mental retardation, epilepsy, skin infections, tuberculosis, psychoses, gynecological problems, Sexually Transmitted Diseases and AIDS.

Findings and conclusions: The physical and socio-economic conditions were the poorest in the unauthorized colony, followed by the resettlement colony and then the urban village. The extent of family support networks also varied across the three types of settlements. When asked about satisfaction with different providers viz. private clinic or nursing home, government hospital and alternate systems of medicine, a very high percentage of the study households (95-97 percent) expressed satisfaction with private clinics. The high satisfaction levels were expressed with government hospitals by the households in the unauthorized colony while only 70 percent of the households in resettlement and 75% in urban village were satisfied with the government hospital. The proportion of households which found alternate systems of medicine satisfying, was high in all three settlements. Across all three settlements there was a difference in type of services sought for various types of ailments. For a number of acute conditions like fevers and diarrhoea and skin infections the majority of the households resorted to the private practitioner. For chronic ailments like tuberculosis, and STDs there was less reliance on the private practitioner; around 40-60 percent of the households relied on the public hospital . For conditions like mental retardation, epilepsy and psychoses a large proportion used the public sector hospitals. This study points to the selective use of private practitioners for treatment of illnesses in the three settlements where the poor predominantly reside. For acute conditions they resort to private practitioners but for several chronic ailments there is greater reliance on the public hospitals. This kind of resort pattern requires the importance of strengthening the public sector and working out referral systems from the private to public sectors in case of all diseases. There is also a need to develop management and reporting systems for specific diseases for which people resort for treatment to the private sector.

An Integrated View of Developmental Programmes in Kutanad: Implications for Health and Well-being of Agricultural Labourers

Author/s: Divakar Sindhu

Publication source: Unpublished M.Phil dissertation submitted to Jawaharlal Nehru University, New Delhi, 1994.

Year of publication: 1994

States covered: Kerala

Social geography: Rural

Data source: Primary

Type of study: Cross Sectional

Type of private sector: Qualified private practitioners

Issues addressed: Utilization of Private Services -Qualified Practitioners in Government and Private Institutions

Objectives: The larger objective of this study was to take an integrated view of developmental programmes and their implications for the health and well being of agricultural labourers in Kuttanad district of Kerala. The study also includes some observations on the state of health care services in the area.

Methodology: A review of secondary literature reveals that the health care infrastructure is not equipped to cope with the kind of demand for services particularly, during harvest season, when agricultural labourers migrate from other places. Although the primary healthcare network exists, and there is a mobile outreach service, it cannot reach areas where the services required.

Findings and conclusions: The survey reveals that people often visit private practitioners largely due to poor communication and transport facilities to develop management and reporting systems for specific diseases for which people resort for treatment to the private government hospitals. Further,health staff do not prefer to be placed here. This causes understaffing, leading to a negative sector impact on access and utilization of government health institutions in the area.

Employee Medical Benefits in the Corporate Sector

Author/s: Duggal R
Publication source: Foundation for Research in Community Health, Mumbai
Year of publication: 1993
States covered: National
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Financial Institutions
Issues addressed: Financing, Prices, Organisaion

Objectives: To document and analyse the medical benefits provided to employees of public as well as private sector companies.

Methodology: Out of a total of 1872 companies having a sales turnover of more than Rs. 50 million, 775 companies were randomly selected from the Center For Monitoring Indian Economy's data on larger industrial units. Mailed questionnaires were sent to 641 companies. The researchers decided to visit the remaining 134 companies, anticipating a high non-response rate. Response to the mailed questionnaire was very poor. Only 75 completed questionnaires constituting a response rate of 12% were received. Out of 134 companies visited, 59 responded giving a response rate of 44%.

Findings and conclusions: The details of statutory benefits (compensation paid due to deaths or injuries, maternity benefits, the benefits paid under the mine labor welfare fund, ESI scheme) were not provided by most of the private companies. They were often merged into total medical benefits. Only a few employees were covered under the Employee State Insurance Scheme. This was due to the fact that ESIC benefits are paid only to those workers whose incomes are below rupees 1600 per month. In the sample, the mean income per employee was Rupees 2445, which was much higher than the minimum limit for the ESIC. Most of the companies were paying claims against bills with upper limits. The percentage of the private sector companies paying for such claims was 61%. In the public sector, the percentage was 77%. Thirty seven percent of the companies had owned hospitals or clinics, while 27% of the companies were paying compensation through the group insurance scheme. Lump sum payments were made by 15% of the

companies. In the case of lump sum scheme, 6% of the public sector and 12% of the private sector companies paid the benefits where as 4% of the public sector and 11% of the private sector companies paid benefits under the group insurance scheme. The pattern also diferred for the managerial staff and workers. The total medical care and related expenditure was 755.53 million rupees. That is 5.64 million per company and 1648.58 per employee per year. If the average family size is assumed to be 4.5 persons per family then the expenditure by the corporate sector comes to Rs. 366 per capita per year. There was a major difference in the public and private sector in the medical care expenditure. On an average, a public sector company paid 13.56 million rupees per year as against 3.25 million paid by the private sector. This amounted to Rs. 2251.10 per employee per annum for the public sector as against Rs 1225.46 per year for the private sector.

The study has concluded that the medical benefits given by the employers were supplementary to the wages and were meager. The system hardly provided total relief to the employees. The workers were benefited only when the company owned a clinic or a hospital facility. The working class has to review this situation and reform its demands and policies because in pursuit of their demands regarding the employment and wage rights, they have neglected social security issues. They are important for the long-term stability and only with their establishment as a right can the struggle of the working class get extended to the large unorganized sector.

Cost of Health Care

Author/s: Duggal R, Amin S
Publication source: Foundation for Research in Community Health (FRCH), Bombay
Year of publication: 1989
States covered: Maharashtra
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Utilisation, Financing, Costs, Expenditure

Objectives: To document and critically analyze various aspects of household health expenditure and to evolve a methodology for the study of health expenditure.

Methodology: The study was conducted in six villages of Jalgaon district in Maharashtra and six wards (including two slums) of Jalgaon city. Jalgaon was selected for the study in terms of its socio economic development. A stratified random sampling method was employed to select 1,629 households from both rural and urban areas of Jalgaon City. An interview schedule was administered to the household at three points of time during the year, in order to take into account the seasonality factor. The recall period was 30 days.

Findings and conclusions: The findings of the study showed that the overall monthly prevalence rate was 148.89 illness episodes per 1,000 population, and the incidence rate was 96.56 per 1000 population. Of the acute illnesses 83.45% were treated by the private practitioner / hospital, whereas public facility utilization was only 9.07%. Of these cases, 70% received injections as part for their treatment. The study brought out the fact that the perception of illness depended on the purchasing power and the income level of the people. The lowest class had the highest non-utilization rate, the lowest private facility utilization rate and

the highest public facility utilization rate. The per capita annual expenditure incurred by the household on health worked out to Rs.182.49. This was 7.64% of the total consumption expenditure, and 9.78% of the reported income.

Utilization and Impact of Private Healthcare Services in Rajasthan

Author/s: Finch B. Cedric, Rajesh Misra
Publication source: Voluntary Health Association of India (VHAI) and Rajasthan Voluntary Health Association (RVHA), Rajasthan.
Year of publication:
States covered: Rajasthan
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Utilisation, Regulation, Costs, Quality

Objectives: To assess the distribution pattern and to present the profile of the private healthcare services in Rajasthan.
To evaluate the changing pattern of the hospitals and the economic burden on the families due to healthcare expenses.
To assess the peoples perception about private healthcare services in Rajasthan.
To assess the socio-economic background of the people visiting private hospitals for treatment.

Methodology: The study area covered five districts of Rajasthan; they were Jaipur, Jodhpur, Udaipur, Ajmer and Bharatpur. The 5 districts cover around 60% of the total private hospitals in Rajasthan. A general survey was conducted in the 5 districts to assess the profile of different hospitals. The researchers tried to select only those hospitals that have multiple facilities and more than 20 indoor beds, but since it was not possible, a total of 25 hospitals with a single facility and some hospitals with less than 20 indoor beds were selected as the sample. One interview schedule was used to assess the profiles of hospitals and a second schedule was used to interview the patients and their attendants. This schedule was designed to collect information about the socio-economic background of the patient, treatment cost, perception of the respondent about health care services and other related information.

Findings and conclusions: A total of 313 patients were surveyed. Of these, three fourths of the patients belonged to the poor economic strata. Around 48.28% of the patients accounted for malaria and 24.14% for tuberculosis. The main reason they went to the private hospital was the better healthcare services there and non-availability of Government health services. It showed that 29.71% of the respondents found the services provided by the private hospitals to be good. It was found that 74.1% visited the private hospital directly to receive healthcare services. Only 21.7% were found to go to public hospitals.
People were not fully convinced or satisfied with the fees charged by the private healthcare services. They found the charges to be high and irrational. Around 44.73% found the charges reasonable, 29.71% found it comparatively high and 14.70% very high. They also felt that unnecessary surgery and tests were on the

rise because of this patients had to borrow and take loans. Around 47.28% borrowed money for their treatment, 10.86% took loans. This shows that the major proportion of patients belong to the poor economic strata. Through this study it becomes clear that the private health sector is more accessible and popular with those who can afford it. However, it is found that the private health sector in its present unregulated form does not favour the low-income groups since they suffer from a heavy economic burden due to high treatment costs. The reason the poor are forced to go to the private hospitals is the non-availability of government medical services, better quality of services, easy access. Unless certain minimum reforms are undertaken to ensure good service by the Government, the poor will be forced to go to the private hospitals and get exploited, thus leading to the increase in their economic burden.

Induced Abortions in a Rural Community in Western Maharashtra: Prevalence and Patterns

Author/s: Ganatra BR, SS Hirve, S Walawalkar, L. Garda, V N Rao
Publication source: K E M Hospital Research Centre, Pune.
Year of publication: 1996
States covered: Maharashtra
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Utilisation, Expenditure, Quality, Regulation

Objectives: To explore maternal deaths in rural western Maharashtra and to examine the choices among providers and the expectations and experience of abortion services from a woman's perspective.

Methodology: The study was conducted in the districts of Pune, Ahmednagar and Aurangabad in Western Maharashtra. The study area covered 139 villages with a total population of 324,431. A total of 1853 women who had abortions during the 18 months study period were identified. Information was collected through case finding methods such as self - reporting, snowball sampling, community women's group, schoolteachers and health functionaries within the community. Public, private and non-formal service providers for abortion services were also consulted. A structured interview schedule with open and close-ended probes was used for the married group and in-depth unstructured interviews were used for the unmarried women. Dummy or diffuser interviews based on the same questionnaire were used on other women simultaneously so that those women with abortion cases are not singled out for unwarranted attention. Out of 1853 women interviewed, 1717 were married; of these 196 could not be interviewed either because they refused to be interviewed or subsequently migrated out of the study area. There were 136 unmarried women. This included never married (45) separated (66) and widowed (25) women. Out of 136 unmarried women, 32 could not be interviewed and information about these women was collected through secondary sources.

Findings and conclusions: A total of 1950 induced abortions occurred in the study period as some women had had more than 1 abortion. Only 1 death (of an unmarried 16 yrs old girl) was reported. The vast

majority of women (81.3 %) had their pregnancies terminated in the private hospitals. Private sector providers included gynecologists, general practitioners and those trained in ayurveda but using modern methods for conducting abortions. 52.5 % of abortions in the private sector and 49.9 % of all abortions took place with providers who were either not legally recognized as MTP service providers or were performing abortion in a place that was not legally approved. 2 % of the married women used traditional practitioners such as traditional birth attendants, herbalists or quacks. The cost of individual abortion in private hospitals was higher as compared to public hospitals where the cost was Rs. 412 and in the private hospital Rs. 540.

Sex - selection abortions were becoming common. In the rural community, nearly one in every six-pregnancy terminations among married women was because sonographic sex determination showed a female fetus. Knowledge of legality of abortions was low among abortion seekers. Post - abortion care was lacking. There was a need for post - abortion services for psychological morbidity as well as contraceptive counseling. Unmarried women include not only the known vulnerable group of unmarried adolescents but also widowed and separated women who are completely out of the purview of most health care programs. Unmarried women constitute a special group of abortion seekers. They have different needs and they behave differently from the married women. The significantly higher use of traditional providers by this group is a reflection of the fact that this group is marginalised both by social stigma and the exploitation and insensitivity of service providers.

Improving the Performance of Reference Health Center A Case Study of Urban Health Center, Dharavi, Bombay.

Author/s: Garg Renu
Publication source: Dept. of Health Studies, TISS, Bombay
Year of publication: 1995
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Case Study
Type of private sector: Hospitals, Practitioners, Not for Profit
Issues addressed: Utilisation, Organisation, Quality

Objectives: To assess the role of the Dharavi Urban Health Center, in providing primary health services to the residents of Dharavi.

Methodology: The location of the study was Dharavi situated in the 'G' north ward of Bombay. The study was conducted between June, 1994 and Oct 1994. For the study, both qualitative and quantitative methods were used. Around 2,018 households were surveyed using multistage sampling technique. A structured interview schedule was administered to the respondents. The interview schedule consisted of demographic, socioeconomic, utilization of health services, maternal and child health services, reasons for use and non-use of the UHC. In addition semi structured interview of 50 General Practitioners were interviewed to study the pattern of referral services from private sector. The qualitative methods involved key informants, focus group discussions with community members, community health workers and anganwadi workers,

Findings and conclusions: The overall utilization of the UHC is low for all the services. The UHC is bypassed by the catchment population, as most people prefer to use private sources for minor ailments and

rely on the teaching hospital close by for major illnesses. Private practitioners are preferred especially for the treatment of minor ailments. Private practitioners are in the vicinity and they offer quick cure and provide personalized treatment. The poor who are daily wage earners find the timings of private practitioners suitable. The other factors responsible for the low utilization of the UHC are inconvenient timings; non- availability of medicines and the feeling that the services provided by private practitioners and the teaching hospital are better. Although most of the people utilize private practitioners for minor illnesses, they depend on public facilities for major illnesses. More than half of the [55%] private practitioners referred patients to the teaching hospital, while 15% of them referred their patients to other private practitioners. For investigations, voluntary agencies offering subsidised services were preferred. The reasons for the non-referral of patients to UHC by the private practitioners were that they had a poor opinion about the quality of services provided by the UHC and that they lacked competent staff. Rapid urbanization all over the world, especially in developing countries has led to the growth of urban poor who constitute nearly 60% of the population in some cities of the developing countries. The complexity of their health problems needs a comprehensive health and social action. The existing model of healthcare system in urban areas has not been successful in meeting the healthcare needs of the poor. A reference health centre can be an important means of improving urban health services by bridging the gap between the functional roles of apex hospitals and first contact level health facilities. Referral protocols should be evolved and communication links should be developed with health posts, dispensaries and private practitioners to improve the referral system

Earnings in Private General Practice: An Exploratory Study in Bombay

Author/s: George Alex
Publication source: Medico Friend Circle Bulletin 173-174, July/August, 1991
Year of publication: 1991
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, For profit,
Issues addressed: Financing, Costs, Incentives, Regulation,

Objectives: The study aims to understand the type and nature of medical practice in a city, to evaluate the cost of private medical practice and to document details of expenditure on privately purchased medicines.

Methodology: The study was carried out in the city of Bombay. A sample of 45 general practitioners and their patients (1 to 5 patients of each practitioner) were selected for the study. The practitioners, selected for the study were from different localities such as rich areas, middle class localities and working class areas. It included doctors, practicing on main roads as well as those practicing in the inner lanes. The researchers visited the doctors and asked them about their earnings and expenditure. Out of 45 doctors, 33 responded giving a response rate of 73.33%. The patients of the doctors interviewed were also interviewed to get information regarding the fees, prescriptions, diagnosis etc.

Findings and conclusions: The study revealed that 30.33% of the doctors interviewed had 6 to 10 years of experience of private practice and put in 43 hours of work during the week. The mainstay of their income for nearly 66% of the doctor came from their clinics. Fifty-four of the doctors have their own clinics. The average number of patients attended by them per month, were 945. The average investment needed for setting up the clinic was Rs.85000. They were earning an average monthly income of 17,675 rupees because of the service charges and medicines. The income from injections amounted to Rs. 5,466 constituting 29.82 percent of the net income. The consultation fee mostly was merged with the medicine charges. The average net income of the doctors, after deducting expenditures such as drug cost, maintenance charges, attendant's salaries. etc amounted to Rs. 18,332.88. The doctors never disclosed their

real income. It was much higher than what was told to the researchers. The expenditure of the doctors constituted only 17.95% of their total income. The major chunk of the expenditure was due to the drug cost, which was around 65% of the total expenditure. Though the doctors were not supposed to earn profit on the medicines dispensed by them, the reality was exactly the opposite. The study has revealed that medical profession is one of the best-paid professions, assuring an average net income of above Rs.16,000/-. Since the doctors earn such a huge amount from the society, they should be made socially accountable. The people have begun to suspect the medical ethics of the private practitioners as more and more evidences of malpractices are coming to light. This has made the regulation of the private practitioners necessary for the betterment of the society.

A Study of Household Health Expenditure in Madhya Pradesh

Author/s: George Alex, Ila Shah, Sunil Nandraj
Publication source: Foundation for Research in Community Health (FRCH), Bombay
Year of publication: 1993
States covered: Madhya Pradesh
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Utilisation, Financing, Costs, Expenditure

Objectives: To estimate the expenditure of households on health as a proportion of total consumption expenditure. To estimate the household level expenditures on health care and to document the components of health expenditure and its differentials by variables such as class, social geography, etc.

Methodology: The study was conducted in two districts of Madhya Pradesh i.e. in Sagar and Morena. These districts were selected as they were representative of developed and underdeveloped districts. Multi-stage sampling was employed to select 770 households covering a population of 5202, (62.08% from rural areas and 37.92% from urban areas) from these districts.

Findings and conclusions: It was found that the acute prevalence rate was 162.16/ 1000, and the chronic prevalence rate 128.33 / 1000. Acute morbidity was found to be high in the urban areas, whereas chronic and handicapped morbidity was high in the rural areas. It seemed to indicate that the definition of morbidity was influenced by the seriousness of illness and the accessibility to health facilities. The annual per capita health expenditure was Rs.299.16, which formed 8.44% of overall consumption expenditure. There was a steady increase in the annual per capita health expenditure between the classes. It was Rs.28.16 in the lowest class, which went as high as Rs. 563.94 in the highest class. The difference between the lowest and the highest class was as high as 339.79%. The per episode cost for health care was much higher than the per capita figures. It was as high as Rs.134.23 for a one-month recall period for the whole sample. The corresponding figures for the lowest class was Rs.71.91, and for the highest class was Rs.243.60. The intra-rural and intra-urban difference in per capita and per episode expenditures was wide. Within the rural areas, the annual per capita expenditure was the highest (Rs.314.16) in the PHC villages, but monthly per episode expenditure was the lowest, as against remote villages, where it was the opposite (viz. Rs. 219.96 and Rs. 145.63). Within urban areas, the annual per capita and monthly per episode costs were higher in district headquarters (Rs.322.448, Rs. 134.7) than in small towns (Rs.280.92 and Rs. 116.86). The utilization of the private sector for health care was found to be as high as 69.05%. Only 15.52% of the episodes sought public health care, out of which 6.14% utilized government /civil hospitals, and 6.88% utilized the PHC / government dispensaries, while Sub Centers were used only by 1.73%. In 85.39% of the episodes, the patient received medicines, or medicines with injections alone.

Hospital Based Urban Health Care Services

Author/s: Gill Sonya, Lalitha D'Souza, Anagha Pradhan and Dina Patel
Publication source: Foundation for Research in Community Health (FRCH), Bombay
Year of publication: 1996
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Hospitals
Issues addressed: Utilisation, Costs, Quality, Organisation,

Objectives: The present study explores the nature of health needs and problems for which people seek the out-patient services of the public hospital, the level of care needed for these ailments and people's help-seeking behavior and utilization of the health care services.

Methodology: The location of the study was The King Edward Memorial (KEM) Hospital, Bombay which has a bed strength of 1800 and 28 departments belonging to the basic and superspecialities. On an average, 5,000 people daily attend the out-patient clinics (OPDs) in the hospital. The study focussed on the users of (OPDs) in four basic specialties - General Medicine, Paediatric Medicine, General Surgery and Gynaecology-Obstetrics. were selected. The total sample size was 1,763 and was distributed over the selected departments using the proportionate probability sampling (PPS) method. All relevant attendance data was obtained from the medical records department of the hospital. A semi- structured interview schedule was administered to the respondents. The data was collected in two phases i.e. before and after the patient had seen the doctor. Data on the healthcare services in Greater Bombay was collected from the Public Health Department of the Municipal Corporation. Data on the morbidity recorded at and utilization of municipal dispensaries in the F/South Ward was collected from the ward Public Health Department. Brief visits were made to 3 dispensaries in this ward.

Findings and conclusions: Over half the users i.e.54% belonged to the urban unorganized sector and two-thirds of the user households had per-capita income of less than Rs.500 per month. However, over half the users (54%} were drawn from the close vicinity of the hospital itself, with only a quarter (23%) coming from Greater Bombay. As a specialist clinic, the gynaecology OPD was utilized equally by women in the suburbs and the inner city. In the range of diagnosed conditions, diseases due to infections took up over 1/4th of all OPD cases, ranging from 40% in Medicine and Paediatric Medicine OPDs to 20% in surgery to 12% in Gynaecology OPD. The majority of the people (60%) needed secondary level care; this indicated a limited scope for decreasing the load on public hospitals so long as specialist services are centralized in them. The gynaecology OPD was the most optimally used for the secondary and tertiary level services associated with a teaching hospital. Public hospitals in Bombay are free and have openly accessible facilities. It is often assumed that people 'unnecessarily' use higher level facilities for lower levels of health care. However, not only was specialist care indicated in about half the cases, but over 2/3rds (70%) of the users had sought prior treatment. The provider most commonly contacted (50%) at the onset of the illness was the private practitioner. Long lasting relationships, close proximity to their residence and convenient timings were some of the reasons for resorting to private practitioners. There were, however, limits to continuing private treatment. Lack of quick relief that people associated with minor conditions and the prospects of costly treatment led them to seek higher care. The most common reason for changing the prior provider, especially the private practitioner (57%) was due to 'no relief' for the patient. The unplanned expansion of private practitioner services in the localities served by the dispensaries was highly visible. According to Municipal Corporation data estimates, there was one private practitioner for less than 2000 people in the municipal ward (4.2-lakh population) in which the hospital was located. In comparison, the dispensary was meant to serve a population of 50,000. The public system could hardly match the coverage of the private sector or consider itself the main provider of first level care.

There was thus an urgent need to review the organization and performance of the public primary care services. At the same time, the development of a referral system would need to view the existing health care services as a whole, integrating both the public and private services into a holistic urban health system. There is a need to integrate health care services within a properly functioning referral system. Such a

system is urgently needed in the urban setting where the over supply of medical human power, duplication of services and increasing competition and costs of care adversely affect the poor and lower income population. This, however, needs to be done in stages. The access of the poor to the quality services of the public hospital should not be cut off without providing an adequate at the first level of care. Strengthen the first level of services in the public sector based on the dispensaries, maternity homes, health posts and health centers. All facilities should have a catchment area; timings should be such that it should be convenient for working people; there should be adequate supply of essential drugs. To increase the quality of services in these units the first referral specialist clinics and a wider range of basic investigations could be decentralized. These clinics could be the out-reach services of the local hospital, simultaneously providing the necessary experience to medical students about conditions and health needs in the community. Develop a system of monitoring of private practice patterns and mandatory record keeping by practitioners. This would form the basis for integrating them within the referral system. A properly worked out system of referrals is needed for accessing the hospital, including communication and referring back the patient to the original doctor. Administrative reorganization of the urban public health departments to achieve co-ordination and decentralization.

Willingness to participate in Health Insurance

Author/s: Gupta Indrani
Publication source: Paper presented at Health Insurance Conference at Indian Institute of Management, Ahmedabad, 18-19 March, 2000.
Year of publication: 2000
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Cross sectional survey, primary data.
Type of private sector:
Issues addressed: Financing, Payment Mechanisms, Insurance

Objectives: The study examined the willingness and ability of individuals to participate in private health insurance programmes.The other aspects that the study examined were the following: What do consumers feel about private health insurance? Are all sections of society willing and able to participate in private health insurance programmes ? Should India have only private insurance or a mix of private and government schemes? What happens to the existing insurance schemes in the event of privatization?

Methodology: A primary study of 504 households in Delhi, representing three distinct economic groups was done. The duration of the study was eight-months.

Findings and conclusions: Preliminary results revealed that the willingness to participate in health insurance schemes differed according to the extent, nature and period of their coverage, premium for adults and children, withdrawal amounts and whether unused funds would be returned in future. Most low and many middle income households considered the premium beyond their reach, while lower income households were wary of private schemes and trusted government schemes. Those in the middle-income group have been unwilling to consider coverage outside what they had at the time of this study (mostly

government health schemes). They thought that there was no need for such schemes as they had no major illness. Moreover, they could always borrow when needed. Those who were in favour of the insurance schemes, consider it a good investment, that returns with interest. They also thought that such schemes were not only good for serious illnesses but also provide better treatment.

Socio-economic and Political Determinants of People's Responses to their Health Problems: A Case Study of New Seema Puri - A Resettlement Colony in Delhi

Author/s: Gupta Snehlata
Publication source: M.Phil Dissertation Jawaharlal Nehru University, New Delhi. 1990.
Year of publication: 1990
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Individual private practitioners
Issues addressed: Utilization of Private Sector, Characteristic of Practitioners

Objectives: The objective of this research was to understand the health situation of a specific group of people within their socio-economic, political and cultural milieu.

Methodology: The study was conducted among the slum dwellers in one of six blocks in New Seema Puri resettlement colony of Delhi, during the years of 1988-89. Ninety-seven households, that is 20 percent of the total, constituted the sample for observation. Qualitative information was gathered through interactions with local institutions, groups and individuals and quantitative information was collected through a questionnaire formulated on the basis of key issues that emerged through the qualitative analysis.

Findings and conclusions: The main thing that the study points out is the range of providers. They vary from traditional and R M P to full fledged MBBS doctors and charitable hospitals, Red Cross and St. Stephens dispensary all of which charge fees. Of the 30 private practitioners, the majority were unqualified. They had picked up practice by working as assistants or apprentices to doctor, compounders and dispensers. With their low cost, availability and easy access, they used their good bedside manners to gain popularity. They used instruments like thermometer, stethoscope, tongue depressor as well as intra-venous sets and treated people on credit as well. The charitable hospital charged only Rs. 2/- for OPD in contrast to Rs. 5/- by the unqualified practitioners. However, the indoor charges were much higher. People in distress were ready to pay but the treatment they received was not necessarily comforting. This study showed that the economically 'better off' in the slums use the government hospitals and go to private practitioners. They are in a position to choose the services as and when required. For the people in the poorer categories access to medical services is limited due to their resource constraints. For general ailments, adult male earners usually go to private practitioners. Those who cannot afford to go to qualified practitioners go to the 'local quacks'. They prefer to go to these quacks instead of a government hospital since they need not lose their daily wages or spend on transport. Thus one sees a differential pattern in resort across economic categories.

Disease Surveillance at District Level: A Model for Developing Countries

Author/s: Jacob John, Reuben Samuel, Vinohar Balraj and Rohan John
Publication source: The Lancet. Vol. 352. July 4, 1999. Pp.58-61.
Year of publication: 1999
States covered: Tamil Nadu
Social geography: Rural
Data source: Primary
Type of study: Policy paper.
Type of private sector: Solo and small hospitals and nursing homes.
Issues addressed: Disease surveillance system, partnership between private and public systems, monitoring and evaluation of programs.

Objectives: This paper describes a vaccine-preventable disease surveillance system that was developed in North Arcot District (Tamil Nadu). This model disease-surveillance system (called the NADHI, meaning river in Tamil) was developed in late 1980s for a project to control poliomyelitis. The model later expanded its scope.

Methodology: This system combines government and private sectors, with every hospital enrolled and participating. Reports were scanned daily on a computer for any clustering of cases. Interventions included investigations, immunization, antimicrobial treatment, health education and physical rehabilitation of children with paralysis.

Findings and conclusions: All vaccine-preventable diseases have declined markedly, whilst malaria and HIV infections have increased steadily. The annual expense was less than one US cent per head. The reasons for the success and sustainability of this model include simplicity of reporting procedure, low budget, private-sector participation, personal rapport with people in the network, regular feedback of information through a monthly bulletin, and the visible interventions consequent upon reporting. The author argues that this district-level disease surveillance model is replicable in developing countries for evaluating polio eradication efforts, monitoring immunization program, detecting outbreaks of old or new diseases and for evaluating control measures.

Financing for Primary Health Care: Sevagram (India). Experiences from Voluntary Sector

Author/s: Jajoo U.M
Publication source: MFC Bulletin 177-178, Nov / Dec, 1991
Year of publication: 1991
States covered: Maharashtra
Social geography: Rural
Data source: Primary
Type of study: Case Study
Type of private sector: Hospitals,
Issues addressed: Financing, payment mechansims, Incentives, Insurance

Objectives: The following alternative was carried out by a voluntary sector hospital in Sewagram, Wardha in Maharashtra to provide health insurance for the rural population. The insurance scheme was evolved by the Kasturba hospital to finance the provision of health care facilities to the poor.

Methodology: The hospital provides both indoor and door step medical care to the villages in the vicinity. The system has all the characteristics of a people oriented system such as accountability, acceptability, and affordability. Kasturba hospital at Sewagram is a 501 bedded hospital attached to a medical college. A private trust 'Kasturba Health society' runs the hospital and the college. The trust shares 25% of the total expenditure while 75% of the expenditure comes from the state and central government. The contributions to the scheme are made in kind in the form of grain such as Jowar-Sorgam at the harvest time. This is because payment in this form is easier for the villagers. The grain collected forms the village fund, which is utilized to support the health program. The grain is collected as per the capacity to pay principle. The payment from the lowest income group is 8 payali of Jowar-Sorgam per family per year and from a landowner it is additional 2 payalis per acre. The 8 Payalis of Jowar-Sorgam is equivalent to Rs. 16 at market price. Those who do not contribute to the fund are omitted from the scheme for that particular year. The village fund covers the cost of drugs, mobile transportation team and the balance goes to the payment of the VHW. The hospital adopts the village only if 75% or more people from the village agree upon having such a system in the village. In case of drop in the membership the project people review the situation and take corrective action. Some times due to the political differences with in the village the membership drops. It might lead to closure of the scheme. But such incidences only help in making the people understand the importance of scheme.

Findings and conclusions: The hospital offers free indoor treatment for the unexpected illness to a person who is part of the scheme. For the expected health related episodes 75% subsidy is provided. The non-members are also allowed to avail themselves of the hospital facilities but only at full charges. Community health workers are the main providers of preventive and symptomatic drug treatment. They work with the help of the visiting health team members. They also make the referrals to the hospital. ANM and the social worker organise the visits for vaccination and Maternal and Child health program. The doctor incharge has the role of supervision, coordination of village meetings and education. The Gram Sabha meets every year before the Jowar collection. The doctor in charge, Social worker, ANM and the VHW, attends the meeting. The villagers discuss among themselves, the performance of the health services and what is required to be done. Over 75% of the people have registered themselves to the scheme. The vaccine preventable diseases such as measles, poliomyelitsis etc. are in control in the area covered by the scheme. The villagers have become aware of the services they get since they pay for it. Since the health team has gained credibility over the years, their advice is often sought by the villagers in other related issues, such as irrigation, dairy development, etc. The insurance scheme at Sevagram is based on the principle of capacity to pay and has proved to be extremely successful. It is people oriented and has provided an alternative mechanism of health financing.

Law and Health Care Providers: A Case Study of Legislations and Legal Aspects of Health Care Delivery

Author/s: Jesani Amar
Publication source: Centre for Enquiry into Health & Allied Themes (CEHAT), Mumbai
Year of publication: 1996

States covered: National
Social geography: Rural and Urban
Data source: Secondary & Primary
Type of study: Review Paper
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit,
Issues addressed: Regulation, Personnel, Licensing, Consumer, Quality

Objectives: To document, collate and critically examine the legislations and regulations applicable to the practitioners and institutions.

Methodology: Questionnaires were sent to all health secretaries of the law and judiciary ministries of all states asking for information regarding various aspects of health such as 1) legal requirements for setting up the individual practice, nursing homes or hospitals 2) legal action taken against an unqualified, unregistered doctor, 3) constitutions of the state and district consumer councils. 4) minimum physical standards prescribed for the private hospitals and nursing homes and their inspections. 5) legal requirements for establishing and running the pathological laboratories blood banks, radiology units etc. The responses were inadequate, as all the questions in the questionnaire were not answered. The researchers also studied the functioning of various medical councils and tried to obtain information from them. The available legislations were then studied and analysed with the help of expert lawyers.

Findings and conclusions: The laws affecting the healthcare professionals cover a wide range of areas such as medical education, entitlement to medical practice, control over medical practice, ethics, drug laws, control over hospitals, etc. The study has given a brief account of various laws related with the above mentioned aspects. Some of the laws covered by the study were Indian Medical Council Act, 1956, concerned with modern medicine, Medical Council Act 1955, Maharashtra Medical Council Act 1961, Homeopathy Central Council Act 1973, The Dentists' Act 1948, Nursing Council Act 1947, etc. It has been evident that all the Acts follow a similar pattern. The only exception is The Dentists' Act where there are no state laws. Various medical council acts have also given directions regarding the functioning of the medical councils.The researchers found that the councils were not operating in the manner, prescribed by the law. Structural constraints such as paucity of funds, political interference, bureaucratic pressures, etc further limited their efficiency. Malpractices were evident in their functioning.

Only two legislations governing hospitals and nursing homes were found. The Bombay Nursing home Registration Act: - It was enacted with three distinct purposes 1) to provide for the registration of the nursing homes. 2) To affect the inspection of the nursing homes. 3) To provide for other purposes connected with the registration and inspection of nursing homes. The law has given clear directions regarding the registration, penalty for offences, registration renewals etc. The Act also empowers the state Government to frame rules and regulations regarding the registration. Delhi Nursing homes Registration Act.1953: - It incorporates all the aspects of the Bombay nursing home registration Act. Another regulation, which the researchers found out, was The Karnataka Nursing Home (regulation) Ordinance.1976.

Malpractice despite legislations, are rampant in this area. The negligence on the part of the medical personnel falls under the preview of Tort laws. However, in India the courts were hesitant to hold the medical practitioners responsible for the negligence during treatment. But now the situation is changing and

the patients are given more weightage in the matters of medical negligence. The medical practitioner is liable for the death of the patient under section 304-A of the Indian Penal Code. In order to punish a doctor, the patient or his relative has to seek redressal in the criminal court. Hospitals are also liable of being prosecuted by the aggrieved person.

The study has concluded that there are very few health legislations available in the country. The laws are differentially applied to the public and private sector. There is a need for the formulation of comprehensive healthcare Act to regulate the vast health sector. The experiences from the developed countries also show that the objective of provision of universal healthcare was not achieved until the private and public sectors were brought under the purview of law. The legislations play an important role of formalising the state policy. They guarantee a certain amount of stability in the health policies formed by the government. In India, the issue has remained unresolved for over fifty years and is likely to be so for the forthcoming period.

The State of Medicare Facilities in Agra City (with special reference to medical practitioners)

Author/s: Jincari, Bharat Bhushan
Publication source: Department of Social Work, University of Agra (1992-93)
Year of publication: 1992-93.
States covered: Uttar Pradesh
Social geography: Urban
Data source: Primary
Type of study: Case Study
Type of private sector: Qualified Practitioners.
Issues addressed: Organization of Private Sector, Utilization, Cost of Care.

Objectives: The objective of this study was to understand the state of medicare facilities provided by medical practitioners in the city of Agra. It also examines the emerging trends such as commercialization and malpractice in the Medicare system by exploring the conditions under which these practitioners operate.

Methodology: A quantitative research design was used in which a sample of 25 qualified practitioners were selected out of 870 practitioners from three localities of Agra viz. Shahagany, Kharia and Sadar areas.

Findings and conclusions: The study comes to the conclusion that the lower classes in the city are unable to meet the high cost of medical services prescribed by the medical practitioners. Medical care provided by the private sector has become very commercial and as a result malpractices are common. These practitioners possess an MBBS degree as their academic qualification, and none of them have post graduate degrees. About 50% of them have undergone specialized diploma courses and post graduate diploma courses. More than 50% of practitioners are general practitioners. Respondents with M.D. and M.S. degrees are also practise as general practitioners. More than 75% of the respondents also dispense medicines as their mode of practice. The obvious reason is that dispensing ensures greater patient load and thereby more

income. A compounder supports each of these doctors. The compounders are not illiterate but their employment with the doctor is temporary in nature.

Only 32% of the respondents provide their services in their respective clinics. Some of these doctors are permanent employees of the government hospitals. All of them provide first aid facilities at their clinics None of them provides anti rabies or anti toxic treatment, and very few of them provide immunization services. More than 80% of the respondents charge consultation fees below Rs. 35/-, which they perceive as affordable by the patients. None of these practitioners refers his cases to other professionals. These professionals serve mainly lower and lower middle class patients.

This study gives some insights into those who practice as qualified general practitioners, and these are mainly MBBS doctors. Their practice is mainly curative and they provide very little preventive input . This study also shows that some government doctors have a private practice. These qualified practitioners cater mainly to the lower middle classes and their role in providing preventive medical care is minimal.

Involvement of Indian System of Medical Practitioners in the Delivery of RCH Services in Rural Areas

Author/s: K.G. Medical College, Lucknow, State Institute of Health & FW, Jaipur & State Institute of Health Management & Communication, Gwalior

Publication source: Indian Council of Medicals Research (ICMR)

Year of publication: 1999

States covered: Uttar Pradesh, Madhya Pradesh and Rajasthan

Social geography: Rural

Data source: Primary

Type of study: Case Report: Prospective/ Randomized Control Trial

Type of private sector: Indian Systems of Medicine

Issues addressed: Government Policy, Practitioners with Public Sector for RCH Services, Utilization of Private Services

Objectives: The objective of this study is to involve ISMPs to improve the utilization of RCH services in rural areas with the existing infrastructure available at PHC/CHC/ district level.

Methodology: The project was implemented in three states of U.P., M.P. and Rajasthan. Poor family performance was chosen as the criteria for selecting these three states. In each state, one district with poor family planning performance (CPR 40%) was selected through random sampling technique. Within the selected district, two PHCs were selected randomly for the experiment and the two for control purposes. Similarly, two urban wards were also selected, one for experiment and the other for control purposes. In each of the selected PHC, the identification of ISMPs was done and their willingness for involvement in the study was sought. About 75 ISMPs were trained in batches on the various aspects of RCH are. Monthly monitoring was done about their involvement for RCH care in the community.

Findings and conclusions: Progress Report: The baseline survey of ISMPs and the community have been completed and the ISMPs selected for the project trained in batches. The data received form the centres, Utter Pradesh, M.P and Rajasthan have shown an upward increase in the referral of various RCH services by the ISM practitioners by propagating the distribution of contraceptives, antenatal and natal care, MTP, provision of Iron and folic Acid, Vitamin A and ORS packets as well as referral of children of immunization.

Current Status: The post intervention survey of Lucknow (UP) and Gwalior (MP) centres is yet to be completed. It is expected that by March 2000 the post intervention evaluation data will be available for impact analysis.

A Study of Growth in Health Services Provided by Private Health Care Institutions in Jaipur

Author/s: Kabra S.G, Malti Patni
Publication source: Rajasthan Voluntary Health Association and Voluntary Health Association of India
Year of publication: Unstated
States covered: Rajasthan
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Utilisation, Quality, Financing

Objectives: To collect, collate and analyse a representative sample of baseline data of private health care facilities in Jaipur as an indicator of the rate and extent of privatisation. To document the private health care facilities developed in Jaipur in the period 1960 to 1991. To study the use of the private facilities by both the inpatients and outpatients in the hospitals.

Methodology: The study was conducted in the city of Jaipur. A list of all private nursing homes was compiled from various sources such as institutions, doctors, pharmacists, etc. A questionnaire was mailed to the hospitals & nursing homes. The researchers had to revise the sample keeping in mind the time constraint under which they were working. Thus they decided to limit the sample only to 50 private health institutions. Initially, the hospitals were hesitant to reveal the information but when the purpose and utility was properly explained to them, they showed their willingness to cooperate. The researchers were able to generate a response rate of 70%. The only difficulty, which the researchers faced, was the authenticity of the data. Since the hospitals did not maintain proper records of their In and Out patients, the researchers had to rely upon the oral information given to them.

Findings and conclusions: The number of patients who visited the Out Patient Departments per annum was 6 lacs as of 1991. The IPD figure per annum was approximately 60 thousand. The total bed strength of all the hospitals was 1283 beds. The cumulative growth rate of the bed strength over the period between 1960 to 1992 was 951.64%. It grew 9.5 times over this period. The cumulative growth rate in bed strength over this period was 1229.69% (12.30 times). The cumulative growth rate in IPD was 1689.91% i.e. 16.90 times growth. The number of beds grew from 122 beds between 1960-1969 to 1283 beds between 1990-1992.The number of OPD and IPD patients rose to 611659 and 60857 respectively in the above-mentioned period. However, the increase in the number of beds varied every five years. The highest number of beds was added between the period of 1980-1985. This also meant the highest patient handling capacity by both OPD and IPD in that time span. An average of 400 beds were added per decade. The health care services provided by the nursing homes grew at a decreasing rate. The study states that the sharp increase in the private health care facilities in the last decade indicates the new trend of privatisation, which began in 1991.

The study also indicates that the capacity of the people to pay for the health services is increasing. At the same time they are not satisfied with the government services. The growth of small private speciality hospitals is due to their financial viability. Lastly, the study has emphasized the need of carrying out more such studies. This kind of database would be useful for determining areas for government intervention. This is necessary to maintain standards in the private health sector and check it from becoming exploitative.

The Development of Public Health Services and their Utilization: A case study of The Bombay Municipal Corporation

Author/s: Kakade Narendra
Publication source: Unpublished M. Phil Dissertation, Jawaharlal Nehru University, New Delhi, 1998.
Year of publication: 1998
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross sectional
Type of private sector: Individual private practitioners; hospitals
Issues addressed: Public hospitals; utilization of private sector

Objectives: The study explores the distribution of health services in the urban slums of Bombay. The objectives of the study are:
The development of provisioning in the public health services of Bombay Municipal Corporation (BMC) since independence.. The nature of curative health services available in the city and their utilization. The differences in terms of health services offered by BMC across its administrative wards.

Methodology: The study adopts a qualitative research design in which extensive secondary data was gathered mainly from reports of Public Health Department and the administrative department of Bombay Municipal Corporation. In addition, informal interviews were held with Medical and Health officers of BMC.

Findings and conclusions: The findings of the study are that there is an overall decrease in the expenditure on health by BMC. The major part of the expenditure is on big hospitals i.e. teaching hospitals rather than dispensaries and health care centres. Of this a large proportion is spent on establishment than on diet or other equipments for patients. BMC pays more attention to the curative services than preventive care. The sharp growth of the private health sector towards the end of the sixties was prompted by several factors: the falling state-spending for health, the increasing numbers of medical personnel, who could not find adequate employment in the health institutions, a growing middle class dissatisfaction with public sector and willingness to payto the private sector. It is the poor who are the major public hospital users who show a preference for private providers in the first instance and come to public hospital only when their conditions get serious or their finances are low. Therefore, they accept whatever care they get. This leads to the dubious money making practices of private hospitals like-unnecessary investigations and irrational therapies. Even though there is not much pressure on the public hospitals to be quality conscious, this aspect has to be stressed or else, their place will be overtaken by the private sector and will lead to weakening of health planning. The public systems work in an inefficient manner thereby making people resort to private clinics. Right from the time a patient queues up for registration as an outpatient or an in-patient, to getting a bed and other diagnostic facilities, medical attention etc., a huge investment of time and money is needed.

Private Practitioners and their Role in the Resurgence of Malaria in Mumbai (Bombay) and Navi Mumbai (New Bombay), India: Serving the affected or Aiding an Epidemic?

Author/s: Kamat Vinay
Publication source: Unpublished
Year of publication:
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not for profit
Issues addressed: Utilisation, Prices, Costs, Quality, Regulation

Objectives: To study the practice the role of private general practitioners (GPs) in the management of malaria at a time of a 23 severe malaria epidemic

Methodology: An ethnographic study was carried out in Mumbai and Navi Mumbai. The study consisted of a sample of 48 private practitioners. The study utilised interviews, followed by a discussion of the data gathered through unstructured interviews with practitioners and patients, complemented by observational data on doctor-patient encounters gathered at 16 clinics over a nine-month period.

Findings and conclusions: The findings of the study suggest that many practitioners in Mumbai and Navi Mumbai were poorly qualified and did not play a supportive role in the ongoing efforts of the public health departments of the two cities to bring the epidemic under control. The majority of the practitioners had adopted diagnostic and treatment practices that were not consistent with the guidelines laid down by the WHO and India's National Malaria Eradication Programme (NMEP). Very few practitioners, especially those practising in low-income areas, relied on a peripheral blood-smear test to make a diagnosis. Practitioners whose clientele was mostly the poor, commonly resorted to giving one-day treatment that often included injectable antimalarials and broad-spectrum antibiotics to febrile patients. Such practitioners volunteered to justify their mode of diagnosis and treatment by asserting that they were only responding to the demands placed on them by their patients who could not afford a blood-smear test or a full prescription. The study argues that practitioners, who acquiesced to patient demands, were at once exacerbating the health problems of their patients and jeopardizing the prospects of the epidemic in the two cities being brought under control. Driven primarily by profit motives, the need to retain the patronage of patients and maintain one's popularity in a highly competitive health arena, such practitioners practiced medicine that was unethical and dangerous. A plea is made for a more empirically grounded and ethnographically authenticated health policy.

Pharmacies, Self-medication and Pharmaceutical Marketing in Bombay

Author/s: Kamat Vinay
Publication source: Unpublished
Year of publication: NA
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Pharmaceuticals, Laboratory Investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Quality, Regulation, prices, Incentives,

Objectives: The study was conducted with a primary objective of critically examining the role played by the pharmacists, shop attendants, wholesalers, salesmen, and pharmaceutical representatives in the active promotion of the ethical sale of medicines over the counter promoting self-medication in India.

Methodology: The study was conducted in the city of Bombay between the months of April and August 1992 and between August to December 1993.The researcher interviewed 75 pharmacists in the city, 25 each from different localities such as low income, middle income and high income. The researcher actually participated in the day-to-day activities of the six identified pharmaceutical shops to get more information about their working pattern. Exit interviews were carried out of randomly selected sample of 150 people consisting of 70 males and 80 females. Drugs sales data was recorded for three full days in each of the six shops. The researchers interacted with 35 medical representatives informally and in-depth interviews were conducted with 14.

Findings and conclusions: Proliferation of the pharmacies: The large number of chemist shops in the study area had led to the cutthroat competition among the chemists. The survey of 75 chemists showed that 57% of the shops were started as pharmacies. The rest were started in the beginning as grocery shop, general store, a cosmetic shop, hair cutting saloon, dispensary, etc. The oldest shop in the study was established way back in 1910.

In most of the cases the shops were not managed by the pharmacists themselves but through the family members or salaried personnel. The customers were usually attended by the clerks or the shop attendants and not by the pharmacist. A majority of the pharmacists interviewed were unable to give the average per day figures of their customers. Rough estimates suggested that the figure was between 125 to 175 customers per day. Almost all the pharmaceutical shops under study insisted on the prescription regarding the drugs such as barbiturates, tranquilizers, sedatives, anti depressants such as calmpose, valium, etc. The customers requested for the medicines with or with out the prescription. The drug sales data revealed that out of 1599 customers interviewed, 64% purchased the medicines without a prescription. Seventy-four percent of such customers were from a high-income locality.

The purchase of the medicines was always dependent on its price. People with low incomes often consulted the shop attendant if the prices of the drugs were above their purchasing capacity. The attendants often suggested to them various options of buying only a few drugs which were very necessary and which were within their budgets. It was observed that in the low-income locality, 75 rupees was the upper limit of the people to spend on drugs. If the cost exceeded this limit, the attendant would give a word of caution to the customer. The maximum difficulty was found to be with the chronic patients than with the occasional buyers of the drugs. They

were the ones affected the most by the rising prices. In one of the shops the researcher observed that people always grumbled about the prices of the drugs, which they purchased regularly.

It was observed that less than 25% of the customers buying medicines on prescription asked for the bill. The shopkeepers were reluctant to give bills as well. Many times patients were in a hurry and thus did not have the time for the bill. The bill was demanded only when the patient was hospitalized or the medicine was expensive or reimbursement was assured.

There was a chain of commissions and sub-commissions between the pharmaceutical companies, whole sellers and retailers. Various incentives such as percentage in the profit, cash discounts, credits, bonuses were given by the companies to their wholesale buyers and by the whole sale buyers to their retailers. The sales personnel of the companies always highlighted the bonus schemes, which the company was offering along with the purchase of the drugs. Many times the retailers first asked about such schemes even before getting to know about the merits of the drugs. Some shops also gave medicine on credit to a few selected customers. The pharmacy owners also offered gifts such as letter pads, calendars, etc. to the local doctors who in turn give prescription to their patients on same pads indirectly suggesting to them to go to that particular shop. In 75% of the pharmaceutical shops visited, the owners informed the researchers that around 35-40 salesmen visited their pharmacies every week from the wholesalers or the distributors. Medical representatives play a crucial role in promoting company's products because they maintain contacts with the doctors and give them various samples of their company's drugs. Seventy-two percent of the pharmacists admitted that they recommended substitutes when their stock got over. However only 345 said that their patients accepted the substitutes suggested. In one shop the researcher found that 50% of the patients came back to return the substitutes suggested by the chemists. None of the pharmacies covered in the study had maintained systematic stocks of the inventory to keep track of their stock position.

The study has concluded that the retail medicine business in Bombay is a lucrative one because of the high volumes of sales and profit margins. However, it has become an attractive place for businessmen who want to make profits with out fulfilling the legal requirements such as licensing, qualification required to run the business, etc. The medical shops rarely insist on the prescriptions. Drugs such as steroids, antibiotics, psychotropic drugs are bought over the counter. Often the customer does not follow the prescriptions. The pharmacy personnel are also responsive to the demands of the patients, as they fear of losing business. Social and economic class difference is observed in the practice of self-medication as the people in middle or higher income classes resort to it the most. The purchase of the over-the-counter drugs is influenced by the pharmaceutical industry as they promote such practice through various incentives and benefits they give to the pharmacists. Aggressive marketing strategies such as counter pushing, substitution are used by the M.Rs to increase the sales of their company. More attention should be paid at the system of promotional activities and the pharmaceutical marketing as it indirectly promotes self medication, use of irrational drugs, etc. The regulatory mechanism should be improved to keep a check on the malpractices in the pharmaceutical industry and enforcement of the regulation. Further study, which will lead to the self-medication, should be carried out to find ways of educating consumers on this aspect. Education and training of the staff at the pharmaceutical shops can be another way by which awareness regarding this issue can be promoted. Short-term training programs for the shop attendants should be arranged to give them adequate knowledge of the drugs that they dispense. Consumer education can be the most effective way of regulating the malpractices fostered by the pharmaceutical industry. Till this happens, the risks of pathogens developing drug resistance will persist.

Contribution of Other Services Sector to Gross Domestic Product in India: An Evaluation

Author/s: Kansal S M
Publication source: Indian Statistical Institute, (published in EPW, Sept, 19, 1992)
Year of publication: 1992
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, For profit
Issues addressed: Financing, Costs, Payment Mechanism, Regulation

Objectives: The study attempts to bring out the disparity in income between different categories of private practitioners, and between doctors

Methodology: A survey of 200 medical practitioners was conducted in Delhi. A questionnaire was canvassed to the medical profession by investigators. Various visits were also made to collect information about charges, either directly from the respondents or indirectly through the patients. The private practitioners were selected on the basis of a stratified random sample. Stratification was done on the basis of zone (area) and qualification of doctors.

Findings and conclusions: The study reveals that the average monthly income of a doctor practicing at a clinic/residence works out to about Rs.29,800 and for a doctor running a nursing home, about Rs.80,000 per month. The ration of expenditure to gross receipts works out to around 18 percent for doctors practicing in clinics and around 25 percent for the nursing home doctors. In terms of qualification, it was found that post-graduates from the gynecology specialization were the maximum earners. In clinics, the net average monthly income was Rs.53,870 and in nursing homes it was Rs.1,03,530. Comparing this income with that of government doctors, it was found that in government service about 84 percent of doctors receive total emoluments below Rs.10,000. In contrast, only 10 percent of private practitioners fall in that category. The condition of privately employed medical personnel is extremely growing as compared to government employees in the same categories.

Health Resources, Investment and Expenditure: A Study of Health Providers in an Indian District

Author/s: Kavadi Shirish (edit)
Publication source: Foundation for Research in Community Health (FRCH), Pune
Year of publication: 1999
States covered: Maharashtra
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit, Financial

Issues addressed: Financing, Prices, Costs, Payment mechanisms, Expenditure

Objectives: To conduct a comprehensive survey of the nature and volume of health resources available and accessible to the population of a district. To analyse the nature and pattern of health investment and expenditure incurred by health providers.

Methodology: Ahmednagar district was selected since it was an average district as per the CMIE indices for socio economic development. Data on the health resources in the district was compiled by scrutinising official and private sources. The accuracy and reliability of the data was verified by conducting sub sample survey in villages randomly selected and through administering a questionnaire to personnel in government establishments and private practitioners. The authenticity of the information gathered was ascertained. Further, a postal survey was also carried out through a questionnaire mailed to all the listed health providers who were also asked to identify other practitioners in their locality. A second set of mailed questionnaires to doctors and health establishments addressed issues such as fees from patients and expenditure incurred on maintaining their establishment. This questionnaire was sent only to the respondents of the first round of the postal survey. The response rate was around 20%. Another technique that was used to gather information on medical practice was holding of three workshops for a few selected practitioners from among the respondents to the mail survey. The focus of the workshop was on the setting up of medical practice - the economics of setting up practice, problems and constraints encountered in setting up and continuing practice etc. For the study on expenditure and investment 137 units from 6 talukas were randomly selected from respondents to the mailed questionnaires. The units covered were private practitioners (all systems of medicine) (qualified and unqualified), general practitioners and specialists, public and private health facilities with varying bed strength, located in the urban and rural areas of these talukas. The questionnaire focused on historical information about practice or facility, information on

Findings and conclusions: The study identified 3059 doctors (qualified and unqualified) located in urban and rural areas, representing all systems of medicine. Though doctors from both the public and private sector were included, nearly 92% were from the private sector. Overall the health institutions numbered 860, which included 274 hospitals - with bed strength ranging from 3 to 200 beds, while 565 medical stores were found to be functioning in the district.

Non-allopathic health providers, both qualified and non-qualified outnumbered allopathic doctors. Those practising Indian (Ayurvedic and Unani) systems of healing constituted 41.7% of the total, while homeopaths made up 16%, Registered Medical Practitioners' (RMPs) were 3.5% and non-qualified quacks and folk healers formed 0.2%. Dentists accounted for 1.5% for the entire district. The low proportion of nonqualified doctors and RMPs was due to the fact that they were not likely to appear in published lists. The geographical distribution pattern for doctors reflected the same urban bias so evident in all developing countries. Fifty-one percent of the doctors were based in urban areas and 49% of the doctors in the rural areas. The doctors to population ratio in urban areas were 3 per 1000 against the ratio of 0.5 doctors per 1000 population in the rural areas. The propensity of the modern medical practitioners in urban areas was determined by the availability of 'market'. The level of economic development creates this 'market'. The economically five developed talukas had a concentration of doctors accounting for 71% of the total. This unequal distribution was further highlighted in the proportion of doctors to population, wherein the five above-mentioned talukas had a ratio of 1.26 doctors per thousand population. As against this the remaining eight economically backward talukas had a proportion of 0.56 doctors per thousand population. Hospitals (Nursing and Maternity Homes, TB and leprosy hospitals included) were distributed on a pattern similar to

that of doctors. The five developed talukas accounted for 80% of the total hospitals, and urban centres 73% of the total. The study found that the private health sector in Ahmednagar district began expanding during the 1980s. This trend conformed to the national trend. During this period there was an increase in the number of private medical colleges in the State contributing to an increase in the number of doctors passing out. The non-availability of sufficient public sector jobs and the reluctance of doctors to serve in rural public health services contributed to the further growth of the private sector. Faulty government policies were also responsible for the growth of the private health sector. Besides supporting the establishment of private medical colleges, the government created opportunities for doctors to avail themselves of loans for setting up medical practice. For e.g. the Maharashtra State Finance Corporation and Nationalized banks extended loans to doctors to set up dispensaries and nursing homes. This availability of capital gave a boost to the private sector.

The study shows that the investment in the private health sector was made mainly for the creation of infrastructure. Money was spent on buildings, furniture and medical equipment. The public sector barely expanded during this period. Very little investment had gone into creating new public health facilities. Very rarely did additional investment go into expanding medical care services. This showed both the non-availability of funds in the public sector and also the low priority the government attached to health services. The study showed that the burden of expenditure incurred by health providers was on recurring heads of expenditure. Thus, the salaries, drugs and maintenance of equipment consumed the bulk of the funds spent by health providers in delivering health care.

Quality of Heath Services In Rural India - A Comparative Study of Three States

Author/s: Khan M.E, A.K. Tamang
Publication source: Operation Research Group (ORG), Baroda
Year of publication: 1987
States covered: Bihar, Gujrat, Himachal Pradesh
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Quality, Utilisation

Objectives: To study the functioning, the quality of services provided, and the obstacles faced by the PHC/Sub center. To analyze peoples' perception about the functioning of the PHC / Sub center and the reason (given by them) for its non-utilization.

Methodology: The study was conducted in Bihar, Gujrat and Himachal Pradesh. Within each state 2 districts, and within each district one PHC was selected. One PHC in one district of each state selected was a tribal or a remote primary health center. A multi disciplinary approach was adopted. The data for the study was collected using anthropological approach as well as through intensive in-depth discussion with state and district level officials, PHC doctors and field staff, village health practitioners, and community members.

Findings and conclusions: One of the major problems of the state of Bihar was rampant corruption at all levels of government services together with the total lack of authority among the programme managers in giving reward or punishment for the work of their subordinates. In Bihar, it was found that the PHC doctors were primarily busy in private practice as government had allowed them to practice privately during their off-time. However, most of them first attended their private practices and then came to the PHCs, often very late. As a result, the patients in a hurry or in an emergency had no choice but to pay the doctor his fees for consultation or go to some private practitioners. Private practice was observed in Gujarat too. In all the three states it was found that doctors were not ready to serve in backward and tribal areas. They preferred to work privately so that they could earn more money. Doctors joining government service insisted on getting posted at their place of preferences. Doctors who agreed to serve in tribal areas practiced privately in those places. Doctors were found to charge patients for injections and medicines during OPD. The higher authorities ignored these facts, perhaps because they did not have doctors to replace them.

The poor turnout of patients in PHCs particularly in Bihar was largely because of low credibility of the doctors among beneficiaries and also their lack of confidence about the availability of doctors at PHCs. This was of the highest order in Bihar. Doctors were available at the PHCs only for 2 hours a day, in Gujarat 3 hours a day. In Himachal Pradesh where the non-availability of doctors was not an issue, one doctor was available to attend OPD for 7 hours. The supply of medicines was inadequate, irregular and non-need based. This led to the discreditation of the government health care services. Government health care services were worse in Bihar, followed by Gujarat and Himachal Pradesh in that order.

In all the states excessive emphasis was given, to the achievement of Family Planning targets by the district and PHC level authorities. It was done at the cost of other health care programmes. In all the 3 states, the performance of the workers was evaluated mainly by his/her sterilization target achievements and those who were not able to achieve the target had to pay bribes. The health and Family Planning delivery system in these 3 states were unable to deliver the services to rural masses. The health services were only accessible to a few . Corruption and weak administration, inadequate logistic support in the form of material and manpower training, inaccessibility of healthcare services, absence of proper monitoring system and overemphasis on achievement of sterilization target, were some of the obstacles in the healthcare systems in the 3 states.

Prenatal Sex Determination Tests and Female Foeticide in Bombay City

Author/s: Kulkarni S
Publication source: Foundation for Research in Community Health (FRCH), Bombay
Year of publication: 1986
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Hospitals, For Profit
Issues addressed: Utilisation, Quality, Regulation

Objectives: To study the extent of spread of sex determination tests and female foeticide in the city of Bombay. Also to study any other aspects related to sex determination and female foeticide, and to know the views of doctors on this issue.

Methodology: 50 private gynecologists were selected randomly and approached with a questionnaire. Information was also collected through personal interviews. The second part of the study, which was to collect information from genetic laboratories, could not be undertaken since the laboratories refused to give any information.

Findings and conclusions: Eighty-four percent of the doctors performed amniocentesis. Eighty-seven percent of them have been performing these tests over the last five years. On an average, 42 doctors, between them perform 271 sex determination tests per month, while 64.37% of doctors perform the tests solely for sex determination. According to 73.8% of the doctors, 51-100% of the women who come for sex determination tests belonged to the middle class. According to a big majority of the doctors, the tests are accurate in 95-100% of the cases. Most of the doctors said that the majority of the women who come for sex determination have two or three daughters.

Study of Knowledge, Assessment and Practice of ISM practitioners and Health Functionaries in the Context of Delivery of MTP Services in Bihar and Maharashtra.

Author/s: Kumar Dilip, Bella Patel, Ranjana
Publication source: Operations Research Group (ORG), Baroda.
Year of publication: 1992
States covered: Bihar, Maharashtra
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional B Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit,
Issues addressed: Knowledge, Quality, Regulation

Objectives: To assess the extent of knowledge of Indian System of Medicine (ISM) practitioners and health functionaries about MTP. To assess to what extent and how they administer MTP and act as referral points. To ascertain from ISM practitioners and health functionaries their opinion about acceptability of MTP among currently married couples. To assess the current level of availability of MTP services and future needs.

Methodology: The study was carried out in two states of India, Bihar and Maharashtra. To ensure geographical representation, the states were divided into three regions and atleast two districts were selected from each region. In the second phase of the study, a minimum of six PHCs was selected from each district. All the villages within each PHC area were covered. In all, around 500 villages were covered in both the states to get the required number of ISM practitioners. A total of 2492 ISM practitioners, 110 Medical officers, 794 health workers and 599 Dais were interviewed.

Findings and conclusions: In both the states, most ISM practitioners had entered the practice either through paternal inheritance or by working as compounder under a practitioner or by reading books on their own. During the survey it was found that a good number of ISM practitioners did not confine to their own system and over a period of time started practicing 'Allopathy'.

The ISM practitioners by and large had correct knowledge about the 'safe', "some what risky" and "very risky" periods during pregnancy for conducting MTP or abortion. In comparison, to other practitioners, the Ayurvedic practitioners, who also practiced allopathy possessed better knowledge about the risks associated with abortion. A majority of the ISM practitioners in Bihar (95%) and Maharashtra (86%) reported bleeding as a major complication following abortion. The other possible serious complications such as uterus and cervical injuries etc. could not be perceived by most of them. In both the states the Ayurvedic and Homeopathy practitioners who practiced allopathy as well, had a better knowledge of possible complications following an abortion. About half of the ISM practitioners in both the states said that stopping of bleeding was an indication of successful completion of abortion. According to 70% of ISM practitioners in Bihar and 50% in Maharashtra, the major sources of MTP services were private clinic and district hospital. Most ISM practitioners from Bihar (79%) and Maharashtra (82%) reported that the pregnant women sought their help or advice for getting aborted. Seventy-one percent of ISM practitioners from Maharashtra and 53% from Bihar reported that they referred abortion cases to the PHC or the district hospitals. However, 22% of the ISM practitioners in Bihar and 14% in Maharashtra reported that they themselves conducted abortion or provided women who wanted to abort with oral medicine to induce abortion.

The ISM practitioners learnt abortion techniques, while they underwent training or picked up the techniques or the name of medicine from the doctors under whom they worked before establishing their own clinic. In Bihar, the majority of the ISM practitioners, who were involved in this activity, gave oral medicine to get the pregnancy aborted, this kind of practice was more frequent among the Homeopathy practitioners. While in Maharashtra, though use of oral medicine for abortion was less prevalent, the Ayurvedic doctors generally followed this approach. As far as use of sophisticated techniques like D & C were concerned, the ISM practitioners from Maharashtra were better placed compared to those from Bihar. In Bihar, the majority of the ISM practitioners conducting abortion, conducted it at the clients' house while in Maharashtra, the ISM practitioners used their own house or clinic for conducting abortion. The interest of ISM practitioners to participate in MTP programme : 55% of ISM practitioners in Bihar and 75% of ISM practitioners in Maharashtra approved of women undergoing abortion. 83 % of the ISM practitioners in Bihar and 73% of the ISM practitioners in Maharashtra were interested to participate and get involved in MTP programme.

Most of the dais in both the states had knowledge about the "safe period" (13 weeks of pregnancy) and the "very risky" period (after 13 weeks) for undergoing abortion. 57% of the dais in Bihar and 49% in Maharashtra reported bleeding as one of the major possible complications of undergoing abortion. In both the states 24% to 26% of the dais , were totally ignorant of the possible complications of undergoing abortion. About 50% of the dais in both the states provided help or advice to women seeking abortion.Among the dais, 82% in Maharashtra and 51% in Bihar referred abortion-seeking women to the PHC or the district hospital.

Most of the ISM practitioners particularly from Bihar were interested to get involved in the programme. In fact they wanted to undertake MTP themselves, as they would get enough number of clients. However, they were not fully confident of the knowledge they had and they wanted to undergo training. They also wanted to have necessary equipment; some of them were even prepared to pay for the equipment supplied by the government. The functionaries and dais by and large displayed their partial knowledge about abortion/MTP. In particular, they could not perceive serious complications associated with abortions. Informal discussions with certain community members in the villages surveyed indicate that many dais were involved in illegal abortion and their partial knowledge about the harmful effects of the crude and frequent abortions would be dangerous. However, the dais were not honest enough to admit the facts and only very few agreed about their current involvement in induced abortion. The trained dais mentioned that they started referring the cases to PHCs where MTP facilities were available.

Thus the study suggests an urgent need to extend MTP services to large number of PHCs and dais may be given some incentives to encourage more and more referral cases. The ISM practitioners certainly constitute a reckonable force for using them mostly as motivators. However, the pure Ayurvedic and Homeopathy doctors who felt abortion is against religion and society norms should be handled more cautiously and need to be given reorientation training to affect change in their views

Changes in the Health Status of Kerala : 1987, 1995

Author/s: Kunhikannan K T and K P.Aravindan
Publication source: KSSP, Kerala, 1999
Year of publication: 1999
States covered: Kerala
Social geography: Rural
Data source: Primary
Type of study: Cross sectional survey
Type of private sector: For profit hospitals.
Issues addressed: Utilization of private and primary health services, costs of care, household expenditure, place of delivery, morbidity,

Objectives: The primary objective of this study was to link the socio-economic and health status of the Kerala State. The study followed up a sample of households surveyed in 1987 and conducted a repeat survey of their health and socio-economic status in 1996. The study was undertaken by the Kerala Sastra Sahitya Parishad (KSSP). (Refer Kannan et al (1987) for findings of the original study).

Methodology: A sample of 8.53% (about 5000 households) of the original households (of 1987) were resurveyed in 1996. The study design was identical to the 1987 study, because the chief objective of this study was to make a comparison of morbidity and health expenditure between these two study periods. Thus the data constitutes a panel and was close to a sequential cohort database. A structured questionnaire was used to collect household information. Volunteers were trained in seven centers (one center for two districts) in one-day training camps. The study also accounted for inflation in prices over the 10 year period, at a compound rate of 10% per year. The cut-off levels for categorizing income into four groups in

1996 were Rs.236, Rs.448, and Rs.590, compared to Rs.100, Rs.190 and Rs.250, respectively, in 1987. All the districts in the state were represented in proportion to the population.

Findings and conclusions: The proportion of the poor declined from 63% to 49.5% of the population. The poorest class decreased from 15% to 7% during the 10-year period. Significant improvement in housing and sanitation were also seen: Thatched houses decreased from 32% to 14% with concomitant increase in the tile and concrete roofing. The practice of open defecation declined from 51% to 28%, and 70% of the houses had latrines in 1996 compared to 48% in 1987. Access to safe drinking water: Families with their own well and house pipe rose from 57% to 70% during 1987-1996. Access to public taps fell from 8.5% to 7.5%.

Cardiovascular events, cancer, accidents, and suicides continue to be the leading causes of death (as in 1987). The overall morbidity rate for acute disease was 121.9 per 1000 population. The rate for chronic diseases was 115 per 1000. A two-week recall period was used for this survey. Though both acute and chronic diseases registered a reduction of 41% and 17%, respectively, the proportion of non-communicable diseases increased in 1996. But the acute morbidity pattern across socio-economic classes was the same in 1996 as in 1987. About 58% of the total acute morbidity was contributed by communicable diseases and 42% by non-communicable diseases. Among the disabled, the number of people with mental retardation increased from 210 (1987) to 244 (1996) per 100, 000 population. Blindness declined from 208 to About 80% of the people seek care from the modern medical system. The study did not look into the reasons for this continuing pattern. About 63% of the people seek care from the private health sector, 30% seek care from the government sector. Nearly 10% depend on self-care first before going to either private or public hospitals.

Institutional deliveries accounted for 97% all deliveries. In 1987, it was 78%. The proportion of deliveries made in private hospitals increased from 42% in 1987 to 58% in 1997, whereas, government hospitals accounted for only 39% (in 1996), just 2% more than its coverage in 1987. Caesarean deliveries went up from 12% in 1987 to 21.4% in 1996. This was a rural sample. If the urban sample was included, the figure would be higher. The average expenses for a delivery in a government hospital were Rs.2025. It was Rs.2870 in a private hospital. In private hospitals, the average expense for a normal delivery was Rs.2456, while for a caesarean delivery it was Rs.4944. In the case of a government hospital, it was Rs1670 and Rs.2864, respectively. Surprisingly, c-sections form a greater proportion of total deliveries in government hospitals (30%) than in private hospitals (17%). The major shift to c-section has taken place in the government sector. More than 80% of people know about the existence of PHCs, but only about 40% of rural population attends them. Lack of medicine and long distances were the two main reasons for the low utilization of PHCs. About 75% of the people reported that health workers from PHCs had not visited their house in the preceding one month.

The survey collected information about medical expenditure incurred during the fortnight prior to the study. The medical expenditure per morbid person per episode increased from Rs.16.5 to R.165.2 during the decade, an increase of nearly 900%. The per capita medical expenditure rose from Rs.88.92 to R.548.8 during the period, an increase of about 520%. After accounting for inflation (at 10% per year), the per capita medical expenditure still showed an increase of nearly 400% over the decade. This explosive increase was not confined to medicine alone. The period witnessed a big increase in doctors' fees, laboratory charges, etc. This phenomenon, (called mediflation) also affected other systems of medicine,

although not to the same extent. It is important to note that the difference in expenditure in private and government sectors was not significant.

The most important "disturbing fact" arising from this study, according to the authors, is that the impact of mediflation was most severe in the lower socio-economic groups: While the rise in per capita medical expenditure in the study period is 326% in socio-economic groups (3 and 4, these are better off groups), it is 768% in SES I (the poorest group) and a whopping 1002% in SES 2. Similarly, the ratio of annual per capita medical expenditure to the per capita income shows a very uneven distribution across the social groups. In the richest segment, this ratio as percentage was 2.18 in 1987 and 2.44 in 1966, whereas in the poorest it rose from 7.18% to an almost unbelievable figure of 39.63%. In SES 2, the medical expenditure is 16.11% of the income. This has led many people to indebtedness in rural and urban areas. In absolute terms, the poor are spending as much as the richest on medical care. This has occurred in a period of remarkable decline in morbidity.

Health, Households & Women's Lives: A Study of Illness and Childbearing Among Women in Nasik District, Maharashtra

Author/s: Madhiwalla Neha, Sunil Nandraj, Roopashri Sinha
Publication source: Centre for Enquiry into Health & Allied Themes (CEHAT), Mumbai
Year of publication: 1999
States covered: Maharashtra
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit
Issues addressed: Utilisation, Financing, Costs, Expenditure

Objectives: To determine differences in morbidity, utilisation of health care services and expenditure on health care based on differences in the social position of women (in the context of age, marital status, caste, class and the position of the women in the household).

Methodology: The study covered 1193 households in rural areas of Igatpuri taluka (817 households) and the city of Nashik (366 households). These households were drawn from 13 villages and five urban clusters. There were 7212 individuals in these households, of whom 3631 were males and 3581 were female. An interview schedule was administered to each household, which elicited information on the profile of the individuals and the household, the illness suffered by any member of the household in the past month and the health care utilisation and expenditure incurred. Data was also collected information on all maternity events (pregnancy, delivery and abortion) in the past year and the use of contraception. The interview schedule was administered to the women of the household above the age of 12 ears. An attempt was made to make the methodology of the study sensitive to women's experience through the designing of the tools, the use of female investigators and the use of a probe list of symptoms to record additional illnesses among women above 12 years.

Findings and conclusions: The findings of the study revealed that the morbidity rates for males was 330 per 1000 and for females, it was 362 per 1000. Morbidity among adult women was higher than the morbidity among girls, and had a substantially large proportion of chronic and non-infectious illness. Reproductive health problems were more prevalent among young women, while weakness and aches and pains constituted a large part of the morbidity of ageing women. Morbidity is highly correlated with age, marital and occupational status. Apart form these individual factors; it was found that the socio-economic class of the household and the composition of the household were also correlated with morbidity. Cultural factors did inhibit the reporting of morbidity, as was seen in the case of tribal women, who had reported lower morbidity than women living in a similar economic and social environment.

The utilisation of health care by women was quite low. The use of informal care was an important part of women's health seeking. It was found that while the use of home remedies constituted 15% of the services utilised, the use of self-medication accounted for 11% of the total services used. Use of formal public facilities in the rural and urban areas - it was found that 24.2% of all the facilities utilised and 30.3% of the formal facilities utilised by rural women were government facilities or home based care provided by government paramedics. In the urban areas, 10% of the total facilities and 17.3% of the formal facilities used were public sector services. The rate of hospitalisation was significantly higher among rural women as compared to urban women. For certain types of illnesses, such as aches and pains, injuries, weakness and sense organ problems were mostly treated in the informal sector. However, other illnesses such as fevers and GIT infections were invariably treated using formal health care. It was found that financial problems were the cause for not seeking treatment. Care was not sought for 12.4% of the untreated episodes because the health facilities were not accessible or adequate.

The expenditure per capita and per facility in the rural areas was higher than in the urban areas. However, due to more frequent hospitalisation among rural households, the overall expenditure on health care in the form of doctors' fees, the cost of medicines and injections was high. It was found that the expenditure was highly correlated with the duration of illness. The longer the duration of the episode, the lower was the expenditure on it. When medicines alone were dispensed, the per-facility expenditure was Rs.24. However, when injections were administered, the expenditure rose Rs 77. This indicated the economics behind the overuse of injections in the private sector. There was a considerable difference in the expenditure incurred on men and women in each facility.

Twenty Nine of the 82 pregnant women in the rural areas had not sought any ANC care. It was found that 70% of the deliveries were conducted in the rural areas by relatives or untrained midwives. However, in the urban areas too, similar providers conducted one third of the deliveries at home. Primarily, public centres were used for PNC. This was chiefly because immunisation facilities were provided at the public centres and women would specifically access these centres to get the baby immunised. Contraception services were overwhelmingly accessed from the public sector, except the use of medicine shops to buy oral contraceptive pills.

The major source of curative services in the urban as well as rural areas was the private sector. They ranged from quacks, who rode into the village on motorcycles once a week and dispensed medicines to more than 40 patients in a couple of hours to highly trained specialists in the urban centre of Nasik, who charged Rs. 200 to Rs. 500 for a single consultation. Remote villages were served almost solely by quacks, who visited once a week. The study also found fairly well established dispensaries in fairly inaccessible villages, which were prosperous on account of irrigation and capitalist farming. They were also to be found in small

villages, which had only a grocery shop and a flourmill, where they could attract patients from remote villages. Slum settlements within the city were totally dependent on private services for treatment. This had a negative impact on the poor women, who were driven out by their inability to purchase services. The varied pattern of morbidity helps to reveal the complexity of women's health problems. Women tend not to report problems related to work and fatigue, childbearing and contraception. Thus, a large proportion of their illness is obscured from view because it does not enter the health system at all. To improve women's health some of the strategies include, women's education, employment, and more accessible health care services. The re-distribution of power within the family can radically alter the decision making process in the household.

It was evident from the study that the health services were both inadequate and unequally distributed. However, it was found that the use of public facilities was extremely limited even where the services are physically accessible, both in the rural and urban areas. The study of urban households revealed the importance of the market as a provider of health services. It was found that the poor households had extremely poor access to formal services and resorted to the use of informal services. They were totally dependent on the private services. There is an undeniable need to strengthen the public services in the urban areas as well as to make them more accessible to the poor. There is also a need to rethink the strategies used for primary health care for the cities, where the services are physically abundant and, yet, completely inaccessible. The problems of the public sector services can be remedied by stricter implementation of guidelines and reorganisation. The fact remains that the government funding for health needs to be increased in order to meet the needs of the rural and urban areas.

Willingness to Pay for Rural Health Insurance through Community Participation in India

Author/s: Mathiyazhagan K
Publication source: International Journal of Health Planning and Management, vol. 13 (1998), pp.47-67.
Year of publication: 1998
States covered: Karnataka
Social geography: Rural
Data source: Primary
Type of study: Cross sectional
Type of private sector: Private sector in general.
Issues addressed: Willingness to pay, rural health insurance scheme, financing of private health care, consumer choice.

Objectives: To examine the willingness to pay for a viable rural health insurance scheme through community participation in India.

Methodology: Willingness to pay is estimated through Contingent Valuation approach (logit model) by using rural household survey on health from Karnataka state. The sampling was carried out in three stages. The districts were stratified into three groups based on development statistics. Six districts were selected, two from each strata (of low, middle and high income districts). From each district, taluks were stratified into two groups in terms of their accessibility to health services (measured in the form of beds per 1000 populations). One taluk from each group was selected. Thus a total of 12 taluks were selected. From each

taluk, one village having a primary health centre and private / non-governmental organization hospital services was selected. This selection was purposive, in the sense that the village was selected to obtain a large community. One or two more villages proximate to the selected village with PHC only were included in the sample. Thus a total of 36 villages were surveyed. From these villages, a sample of 1000 households was covered. These households were allocated in relation to the number of households in each of the villages. Simple systematic sampling was followed in choosing individual households.

Findings and conclusions: The results show that the insurance / savings schemes were popular in rural areas. People have relatively good knowledge especially of life insurance schemes. Most people stated that they were willing to join and pay for the proposed rural health insurance scheme. The main reasons for joining the proposed scheme were (a) poor quality of existing government services and (b) inaccessible and ineffective services in the government sector. The local bodies (Panchayats) have potential for participating in health insurance schemes. If such schemes are followed at Panchayat level, people will have a greater choice of heath care services. The study also validated the use of Contingent Valuation approach using binary responses on willingness to pay for rural health insurance scheme.

Patient Provider Interface: A Public Survey

Author/s: Medico Friend Circle
Publication source: Medico Friend Circle, Bombay Group, Mumbai
Year of publication: 1993
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit
Issues addressed: Quality, Regulation, Utilisation,

Objectives: The study aims to (1) understand patient's views on the present health care system to look at their experiences with the various health systems, and (2) study their perception on various aspects of present health care systems.

Methodology: A short questionnaire was published in the letters to the editor column of various newspapers, both in the English and the vernacular press. Also, various organization working with various groups were asked to give the questionnaire to the people and these were then collected from them.

Findings and conclusions: Nearly seventy-seven percent of the total episodes of 208 reported approached private health care. Among these, 69.7% suffered from acute illness, 5.3% received GP care, followed by 34.6% of the episodes, which received consultant care. With regard to waiting period newly, 61.1% of the episodes felt it was unreasonable. They had to wait for more than 20 minutes. According to information provided on figures, 40.9% of the episodes were not informed and 25.5% were informed only partially. With reference to information on side effects, 53.4% of the episodes reported that they were not given any information. Questioned on the reasonability of charges, 44.2% felt the charges were unreasonable. An equal number, 45.2% of the episodes, felt the charges were reasonable. Of them 58.7% were not given any

receipt for the payment made and 64.9% of the respondents felt that there should be standardization of fees. The main expenditure per acute episode for non- hospital cases was Rs.182.

Issues in Worker's Health of the Unorganised Sector: A Case Study of some Steel Utensil Making Units of Wazirpur,

Author/s: Mudgal Jyoti
Publication source: M.Phil Dissertation Jawaharlal Nehru University, New Delhi.
Year of publication:
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Private Practitioners
Issues addressed: Utilization of Private Sector

Objectives: This broad based study focuses on the multiplicity of sources of ill health and the social dynamics of this process. It also addresses the health-seeking-behaviour of the workers.

Methodology: The study is based on an in-depth exploration of the issues concerning steelworkers in the unorganized sector of Delhi industrial area in Wazirpur. It is based on interviews with 200 workers, along with their trade union traders and the entrepreneurs who provide employment.

Findings and conclusions: This study provides interesting insights into the relationship that owners have with workers in these industries. Though legally the sector is covered by the Employee State Insurance Scheme (ESIS), the management creates many hurdles in order to avoid registering workers. This is a method by which owners protect their own interests. These owners are often small or petty owners whose capital is too small to cover workers' risks. These owners prefer to help workers by sending them to private practitioners and are willing to pay for it thereby avoiding the legal complications. Very few among the 200 workers ever register with the ESI and even fewer get treated at the ESI hospitals. In fact, the workers themselves choose to go to the private sector in order to minimise conflicts with owners and some even hide their injuries to retain their jobs.

Hospital Services in Urban Tamil Nadu: a survey of maternity services in Madras city and Chidambaram / Cuddalore region

Author/s: Muraleedharan V R
Publication source: Report prepared for Citizen, Consumer and Civic Action Group (CAG), Chennai, October 1997
Year of publication: 1997
States covered: Tamil Nadu
Social geography: Urban
Data source: Primary
Type of study: Primary
Type of private sector: For-profit, corporate hospitals, Government hospitals.
Issues addressed: Prices and Costs of private care, consumer satisfaction, physical facilities available in private and public hospitals,

Objectives: The study has two objectives: (1) to understand the experience of women who had been delivered of a child either in public hospitals or in private hospitals, and (2) to understand the nature of private and public hospitals providing maternity services in urban Tamil Nadu.

Methodology: The study involved two different surveys: In survey I (related to objective 1) 377 women (285 from Madras city, and 92 from Chidambaram/Cuddalore region) who had delivered a baby either in government or private hospitals were interviewed. Survey II collected information from 30 hospitals (22 from Madras city and 8 from Chidambaram/Cuddalore region) to throw light on facilities available. The surveys were conducted during January - March 1997, covering deliveries made during October - December 1996.

Findings and conclusions: Survey: I On average, a sum of Rs.12, 965 was spent for a caesarean delivery in private hospitals in Madras city, while in Chidambaram/Cuddalore region, the corresponding amount was Rs.6985. Considerable variation in expenditure exists across private hospitals. For example, in Madras city, it ranged from Rs.3000 to Rs.30, 000. For a large number of caesarean deliveries, the expenses incurred were between 10 to 15 thousand rupees in private hospitals in Madras city. A noteworthy point is that 75 of 129 caesarean cases surveyed in private hospitals in Madras city had spent equal to or more than 10,000 rupees. Of these 75, twelve belonged to the poorest income groups (less than Rs.20,000 per annum per family). A large majority of women in public hospitals (61% in Madras city and 96% in Chidambaram/Cuddalore region) had paid speed money to the providers. In the case of private hospitals, 16% in Madras and 88% in Chidambaram/Cuddalore had paid for services that were not billed. Only about 50% of users of public hospitals said they had access to clean drinking water. In the case of private hospitals, more than 90% had access to drinking water in both the study regions. More than 70% in private hospitals, and 90% in public hospitals in both regions said that they found the consulting rooms very clean. In Madras, more than 70% of users found toilets clean in both private and public hospitals; whereas in Chidambaram/Cuddalore, it was 20% and 2% for private and public hospitals, respectively. Nearly 100% of users in private hospitals found garbage bins for use, while about 80% in public hospitals had access to garbage bins. Waiting time for antenatal checkups: a third of the users in private hospitals in Madras said that often they waited for less than 15 minutes for regular antenatal check up; while only 9% of the users in Chidambaram had such low waiting time. Only 7% in Madras said they had to wait for more than 30 minutes, while it was 33% in Chidambaram region. Only 33% in private hospitals in Madras paid an advance before admission. In Chidambaram/Cuddlaore, only 7% paid any advance. In the case of public hospitals, 2% in Madras and 6% in Chidambaram/Cuddalore had paid an advance (note: this is for being delivered of a baby). Users were asked to identify services that require improvement from their point of view: more than 80% in Chidambaram/Cuddalore said they would like authorities to do something about maltreatment in both private and public hospitals. About 50% in private hospitals said that the staff were very helpful. In Chidambaram/Cuddalore, only 20% in public hospitals said their staff was helpful. In Madras, about 60% in public hospitals said they found the staff very helpful. Overall, about 70% in private hospitals characterised their general experience as “good”. Users of public hospitals in Madras showed a similar response, while it was only 6% in Chidambaram area. But, it is noteworthy that more than 95% overall had felt “secure” during their stay for delivery.

Survey II: Some of the large private hospitals in Madras city have an occupancy ratio of less than 25%. The average occupancy ratio for private hospitals is 54% (figures for sample public hospitals were not available). Overall, smaller hospitals have a higher occupancy ratio. Larger private hospitals (in terms of bed size) have a lower ratio of auxiliary personnel to physicians employed than smaller hospitals. Data for

Chidambaram/Cuddalore region were not available. Average charges for urine test; ECG and x-ray in private hospitals in Madras city are Rs.56, Rs.67 and Rs.75, respectively. Average charge for ultrasound (maternity related): Rs.202 (max:350; min:50). Average charge for labour room per delivery: Rs.306 (max: 500; min: 125) Average charge for anesthetist (per procedure for delivery): Rs342 (max: 600;min: 150). Average charge for OT per delivery: Rs.533 (max: 700; min: 400). Fifty percent of the private hospitals surveyed in Madras operate in their own premises. 65% of the private hospitals have an emergency ward. All the private hospitals in Madras said they had a back up for power supply; while none in Chidambaram/Cuddalore region has a back up. In the case of public hospitals, none has any back up for power supply. Most hospitals (private and public) had drainage connection. None of the private hospitals in Chidambaram had space for washing patients' clothes (it is important to note that none of the public hospitals have answered this question). What is important to note is that very few (only 4 out of the entire sample hospitals) said they had play area for children. This is important since many women (from the poorer families) would be accompanied by younger siblings, who would require some play area. Often it is difficult for the women to leave their children due to lack of domestic support for various reasons. Only half the sampled hospitals in Madras have been declared baby-friendly.

This preliminary study of maternity services in urban Tamil Nadu has thrown up important policy issues for consideration. A substantial amount is being spent for delivery (in both private and government hospitals). But it is not clear whether the amount spent reflects the quality of care received adequately. More specifically, it is not clear how far the variations in costs of care/services provided can account for the variations in total expenditure incurred for such care/services. This problem remains for all types of services, whether in private or public health sector, from primary to tertiary care level. Needless to say that it will be a very difficult exercise to undertake, but it is equally important to emphasize that without such studies no meaningful approach can be designed and adopted to assess how efficiently the health care sector functions. This leads us to the next issue arising out of this study. There is a complete lack of database on the hospital sector. For example, there is no reliable list of even the number of private clinics and hospitals in Madras city. As for government run hospitals, the Health department maintains a list, although there is no consistency between the data sets maintained by various directorates within the Health Department and those published in the Administrative Report of the government of Tamil Nadu. There is no data on manpower employed in various hospitals, nor about volume of services provided annually or monthly, and many other rudimentary aspects that are required for public policy purposes. Besides, private hospitals/clinics also are also reluctant to participate in such studies because of the fear that such information may be used against them by consumer activists groups and others. Such apprehensions are not without any basis. The question of government's credibility is also part of the problem. It is important to impress upon the providers the urgency of sharing such information and promote a more healthy atmosphere among the various stakeholders, the health care professionals, policy makers, patients, employers who pay for their employee's health care, and consumer activists. Such an atmosphere is essential in order to identify feasible areas of reforms and how they can be effectively introduced and sustained. There is an impression amongst many (including the most well-meaning) people that providing a high quality of care would necessarily entail greater expenditures. There are reasons to believe that this so called "quality-cost" trade-off is often a myth. The study suggests that there is scope for reducing costs of providing health care (whether in government or private health care institutions) without compromising on the quality of care.

Characteristics and Structure of Private Hospital Sector in Urban India: a study of Madras city

Author/s: Muraleedharan V R
Publication source: Small Applied Area Research Paper 5, Bethesda, MD: Partnership for Health Reform Project, Abt Associates Inc.
Year of publication: 1999
States covered: Tamil Nadu
Social geography: Urban
Data source: Primary
Type of study: Cross sectional primary survey and policy paper.
Type of private sector: For profit, small and medium private hospitals, private consultants.
Issues addressed: Prices of private care, provider payment mechanisms, personnel issues, incentives and disincentives, government policy

Objectives: The objectives of the study were to analyze the size and geographical distribution of private hospitals in Madras city. Study the extent of infrastructural facilities provided in these hospitals. Study the range of specialty services offered, their organizational features, personnel employed, their work- load, utilization and pricing of selected services. Assess the various payment/incentive schemes prevalent in various private hospitals and identify strategies for improving the performance and accessibility of the private hospital market.

Methodology: The study covered a sample of 73 private hospitals from various zones of Madras city (now known as Chennai City, capital of Tamil Nadu state). The number of beds in all except a few hospitals was between 10 and 50. The study also involved in-depth discussions with 30 physicians from various private hospitals. This study excludes both corporate public limited hospitals and Trust (not-for-profit) hospitals. The study focused primarily on maternity care services, although details of other services were also collected. Two specific survey instruments were used for data collection: One was a structured questionnaire used by a field investigators to collect original data directly from hospitals. The other instrument was a set of questions used for conducting personal interviews with physicians on payment methods prevailing in various hospitals. The details of these two questionnaires are summarized below.

Survey Instrument I collected the following information from private hospitals. This was a structured questionnaire consisting of 50 questions divided into 4 parts. Part I concerned background information on hospitals (such as nature of organization, range of specialties offered). Part II concerned information on infrastructural facilities (such as water supply, power supply, drainage connection etc). Part III concerned hospital personnel (including physicians' profile, their consulting hours, strength of other personnel). Part IV concerned information specific to maternity services, in addition to information on charges for a number of diagnostic and minor procedures (many of which relate to maternity care).

Survey Instrument 2 (to collect information from physicians on fee payment method and nature of relationship with hospitals). Physicians were asked to describe the method of fee payment they adopted and whether they had any agreed basis for sharing their fees with hospitals they visit as consultants. During interviews, data on physicians' professional qualifications, years of service, names of hospitals where they do consulting etc. was also collected.

Findings and conclusions: The city of Madras (recently renamed as "Chennai") has close to 400 private hospitals, for a population of nearly 8 million people including the suburban areas. Individual physicians

own most private hospitals. There are only 6 Corporate Public Limited Hospitals (which are listed in the stock markets). The average size of private hospitals in the city is around 30, and there are many with fewer than 10 beds located in various parts of the city. Broadly, one can say that the private/public ratio of beds in the city is about 48 percent / 52 percent. The private hospitals sector in India has grown passively over the years, without any kind of state policy directing its growth and development. As a result, the private hospitals have had no incentive to follow any norms either with regard to physical infrastructures (space per bed, provision of certain utilities such as drinking water, drainage facilities, elevators, back-up power etc) and staffing pattern. For example, there are no common norms for setting up an Intensive Care Unit, as a result there is a vast variation in provision of ICU facilities across private hospitals. The study has shown that on a number of accounts there is prima facie evidence for policy makers to worry about the quality and quantum of physical infrastructure available for good patient care in private hospitals.

In Tamil Nadu, as in many other states in India, it is common for government doctors to work as consultants in private hospitals. This is more common in large urban areas. Also, there is a complex network of arrangements between these private hospitals and physicians, and with local diagnostic centers. These diagnostics centers may be independent (stand-alone type) or may be attached to larger private hospitals. It would be worthwhile to conduct a separate study on the nature of relationship between them, as they are likely to influence their financial performance for mutual benefits since most payments are made out of pocket on a fee-for-services basis. While it is difficult to provide an accurate analysis of the competition and market strategies amongst private hospitals in Madras city, it is not altogether impossible to say anything in this respect. Out study indicates a strong presence of non-price competition among private hospitals in Madras City.

The study concludes with a number of issues of policy concern and also suggests certain policy options. One of them concerns the issue of regulation. Who should regulate the private hospitals, what should be regulated and to what extent, and by what process should governing be carried out? These three questions are constantly raised by the private hospitals whenever the issues of regulation and standards are discussed with them. The study has provided some basic data showing the prevailing practice on a number of physical facilities and staffing pattern in private hospitals for policy makers to make a beginning. Given that public sector physicians are in demand in many private hospitals, it is necessary to think of policies that would be beneficial to both private and public health sectors. One possible policy could be to identify specialties in high demand from private sector and develop specific measures to moderate their practice. Additional components of this policy could include: (a) public sector physicians may be asked to share his/her fees with government since he/she is allowed to practice in private hospitals and (b) limit the number of public sector physicians that could be allowed to practice in a private hospitals based on some mutually agreed criteria. Another possible but less realistic policy option is to ban private practice of public sector physicians, which will be met with intense resistance from the medical community and perhaps some other influential groups close to policy makers. The latter policy option would achieve, if it could be enforced, one definite result: The government doctors during office hours will not practise in private premises. But, whether or not that would ensure substantial improvement in the provision of care within government premises during those hours is a moot question.

The study has shown that the current payment system has an incentive for physicians to over-provide care depending upon patients' ability to pay. The relevant policy issue would be to address how far such over-provision could be contained. The study argues that while it is difficult to implement such policies, it

cannot be allowed to persist and therefore policy makers must give adequate legal protection to the indigent and medically needy patients who could otherwise be a victim of over-or under- treatment. Several policy options can be put forward to promote a health growth of private hospitals market in urban India, but they must be acceptable by those who represent it. Much of what can be done depends on how providers perceive the current scenario in the market. Most physicians and hospitals expressed concern over the 'intense competition' in the market, and how as a result they are not doing well financially. Although it is difficult to prove such impressions one way or another with 'hard data', they cannot be brushed aside as mere concoctions to fool the analysts or policy makers. It is difficult to regulate and moderate the private hospital sector given their past reckless unbridled growth in the past, but some positive initiatives can be made by the Government. The first step in that direction should be in building their own credibility. As a part of this exercise, the state could perhaps create a separate body - which may be called the State Private Health Sector Development Agency - concerned with developmental needs of the private hospitals in the state. The primary aim policies should be to develop a healthy relationship between the private and public health care system in the state.

Heath status, Socio-economic Conditions and Expenses for Delivery:
A Household-level Analysis of Pregnant Women in Dindugal slum areas

Author/s: Muraleedharan V R and Saradha Suresh
Publication source: Report submitted to the UNICEF, Chennai
Year of publication: 1999
States covered: Tamil Nadu
Social geography: Urban
Data source: Primary.
Type of study: Prospective study. In fact, this study also has control groups for measuring effectiveness of interventions to improve
Type of private sector: For profit private hospitals and nursing homes.
Issues addressed: Utilization of private and public maternity services

Objectives: The primary objective of this household-level survey is to understand the various socio-economic factors that influence the state of health of pregnant women and the new born babies, and the utilization of private and public health care facilities in the slum areas in Dindugal town (Tamil Nadu). More specifically, this study analyzes: 1. Differentials in the health status of pregnant women, new-born babies and their socio-economic conditions; and 2. Differentials in the use of antenatal care of pregnant women, and expenditures for delivery with respect to socio-economic conditions.

Methodology: The survey tracked 1273 pregnant women in 61 slums in Dindugal town during the period May 1998 September 1999. The survey tracked every single known pregnancy in these slum areas. A detailed questionnaire was administered for collection of both qualitative and quantitative data directly from pregnant women. An important aspect of this study was that it collected hemoglobin levels of women during all three trimesters. The following information was collected by the survey. Details of family members (such as age, sex, relationship with the woman, occupation), socio-economic risk factors for

poverty, previous pregnancy details (such as menstrual history, white discharge), history of ante-natal check-up (such as weight, hemoglobin in each trimester, details of medicine taken, illness during pregnancy, nutrition supplementation), delivery details (such as type and place of delivery, duration of hospitalization, bleeding during and after delivery, sex and birth weight of baby, condition of the mother and the baby during one month after delivery, details of breast feeding, expenditures for delivery purpose). Typically, the field investigator with a help of an assistant followed up all pregnant women during their entire pregnancy period, and also one month after the delivery. This report has used only a portion of the collected data, which is relevant to the specific issues examined.

Findings and conclusions: For the purpose of this annotation, only results pertaining to objective 2 are summarized here:

Ante-natal care, place and type of delivery: All deliveries at the Municipal Maternity Home (MMH) were normal. 35% of total deliveries were made in private hospitals; 55% in government facilities, and about 10% at home. 59% of all C-sections were delivered in private hospitals. The remaining (41%) were made in government hospitals; 13% of all deliveries made in private hospitals were C-section deliveries; and 55% of (1273) women in non-UBSP areas had taken IFA tablets as nutrition supplement during pregnancy period. Overall, the mean Hb level among those that had IFA supplement (9.89) was not significantly different from those that did not have IFA supplement (9.85) (N=212 panel data) But this observation does not hold good at dis-aggregated level. Among women from the lower poverty risk group, those that had IFA supplement had a higher mean Hb than those that did not have IFA supplement.

***Place of delivery and socio-economic conditions*:** Those who had Home deliveries belonged to the highest poverty-risk category, while those who had deliveries at private hospitals were from the lowest poverty-risk category. But it should be noted that a sizable number of women from both low and high poverty-risk categories used public health care facilities.

Expenditure pattern: Variations in expenditures with respect to place and type of delivery, and socio-economic risk factors. As already noted, all deliveries registered at home and Municipal Maternity Hospital were normal deliveries. The mean expenditures per delivery at Home and MMH were Rs.295.00, and Rs.238.00, respectively. But the difference in mean expenditure per normal delivery between General Hospital (GH) (Rs.485) and MMH (Rs.238) was substantial. It should be noted that most of those that had delivered at Home, GH or MMH belonged to higher poverty-risk groups. On average, a slum women spent Rs.1895 for a normal delivery, compared to Rs.8774 for a C-section delivery in a private hospital. Whereas in GH, it worked out to Rs.485 and Rs.2410, respectively, for normal and C-section delivery. The difference is quite substantial indeed.

The study makes the following observations. For all home deliveries, there is an enormous variation across socio-economic risk groups. In the case of normal deliveries made at private hospitals, there is much greater variation expenditure among women with lower poverty-risk index. In the case of GH, the variation is greater among those with higher poverty-risk index. Most women who had C-section deliveries in private hospitals are from households with low poverty-risk index. But the spread in expenses appears large. Quite a few women had spent more than Rs.10000 per C-section delivery. This is also true of women who had C-section deliveries in Government Hospitals. Although the mean expenses in GH are Rs.2410, several women had spent more than Rs.4000 for C-section delivery.

The study makes three key observations:

1. A large majority of slum population bear a considerable amount of financial burden for delivery purpose at public health care facilities. Such expenses are not uniformly borne by all sections of the population. For example, out of pocket expenses per normal delivery in Municipal Maternity Home varied from Rs.45 to Rs.2000. The financial burden seems to fall to a greater extent on the poorest groups than on others. Also, in the case of C-sections in government hospitals, variations in out of pocket expenses per delivery is quite large: Many women from poorer groups spend more than Rs.4000.00 per C-section delivery. A considerable number of women from high poverty-risk groups had chosen private facilities for deliveries and had spent as much as Rs.15000 per C-section.
2. Evidence strongly suggests that efforts to improve women's Hb level from pre-pregnancy period would have greater beneficial effects on the new-born babies than if they were confined to only pregnancy period.
3. The rate of C-sections in government or in private facilities appears more closely associated with socio-economic risk factors than with health status of pregnant women. Nearly 16% of all deliveries in private hospitals were C-sections, while it was 12% in GH. This is indeed on the higher side for a slum population, considering the fact that those who had normal deliveries were of similar health status. The study suggests that a mere increase in budgetary allocations will not be adequate to achieve poverty reduction in urban slum areas. We need to address systemic reforms issues in providing health care for the urban poor.

Living and Working Condition of Coir Workers and their Implications for Health? A case study in Alleppey district

Author/s: Nair, Bindu B.
Publication source: Unpublished M.Phil dissertation submitted to Jawaharlal Nehru University, New Delhi, 1993.
Year of publication: 1993
States covered: Kerala
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: individual private practitioners
Issues addressed: Utilization of Private Services: -Government of Private Services Private Practitioners.

Objectives: The main objective of the study was to develop insights into the working and living conditions of the coir workers and the implications for the health and well being of workers in this sector. Within this larger objective, the study gives some information regarding the utilization of health care services.

Methodology: Information was elicited through a case study of yarn spinning units under co-operative societies in Kokkothamangalam village of Shertallai taluk in Allepey district. The study includes four categories of workers:-those who are directly recruited under the society, members who hire workers from outside to get work done in their homes, non member households doing similar work and members who themselves work. One hundred and fifty workers were randomly selected from two societies with the largest number of workers. While seventy-five of them represented the first category of workers as described above, twenty-five each were picked up from the rest of the categories. Information elicited by administering pre-tested interview schedules, through informal interviews and information from secondary sources.

Findings and conclusions: It has been found that in the unorganized coir industry, workers suffer from a range of work related health problems, even within the cooperative institutions. The terms and conditions of work are far from the norms recommended. Neither the cooperative society nor the employers are able to extend help for accidents and injuries. Maternity benefits are also not available. A large majority of workers utilize government health services, which have a poor delivery system in this area. In addition, workers are forced to spend a considerable part of their earnings on buying medicines. Treatment in private hospitals means an additional expenditure for consultation. This becomes a burden on the workers who are already underpaid. State intervention in health services and improving workers welfare are considered important requirements for policymakers. For the poor, treatment in private hospitals becomes an additional burden. The study also points to the availability of private hospitals and practitioners in rural and urban areas in Kerala.

Private Nursing Homes and Their Utilization: A Case Study of Delhi

Author/s: Nanda, P. and Baru, R.,
Publication source: Voluntary Health Association of India; New Delhi, 1993.
Year of publication: 1993
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Nursing Homes, Private Practitioners
Issues addressed: Heterogeneity of Private Sector; Organization of Private Sector, Subsidies Received, Government Policy, Utilization of Private Sector, Regulation, Staffing

Objectives: To study the trends, characteristics and services offered by the private medical sector in Delhi. To discern the factors that influence the choice of health care and gauge how the trends in privatization affect individual choice. .

Methodology: This study of nursing homes and hospitals was conducted in Delhi. The nursing homes were selected on a stratified, random sample in order to capture the variation and heterogeneity of institution according to ownership and size. A total of 68 nursing homes from upper income, middle class colonies and resettlement colonies were covered. In addition to the institutional study, the profile of users of medical services was undertaken.

Findings and conclusions: There were approximately 1200 to 1300 nursing homes and about 7000 private medical doctors in Delhi. A very small percentage of the nursing homes had obtained government support in terms of land, custom duty exemption, or tax exemption. An exercise to rank the areas where there is maximum return revealed that these were OPD followed by maternity, general surgery and investigative facilities. A majority of these nursing home offer out patient services but confined in patient services to maternity and surgical services. The promoters of small nursing homes are mainly from both business and professional backgrounds while a majority of the promoters of middle and large enterprises hail from business families. Getting information on staffing was difficult. However, the promoters expressed difficulty in getting nurses. They recruit mainly grade 'B' nurses and the turnover rate among them is found to be high. Further, the prevalence of consultants attached to these nursing homes is found to be high. The social background of the users is related to the size of nursing homes. The small nursing homes cater mainly to low-income families; the medium sized nursing homes are used mainly by middle-income

families. The second part of the study focusses on trends in utilization among residents from resettlement colonies. For initial treatment the preference is for the private practitioner and 60 percent of the people interviewed in the resettlement colony opted for it. However, when it came to major complaints requiring hospitalization a high 80 percent opted for government hospitals. This study also highlights the utilization of Ayurveda and homeopathy along with allopathic services. The interviews at the government hospital show that for minor treatment both the lower and middle income use these services. The lower income group uses the private sector very little. The usage of private nursing homes increases with income levels.

This study provides insights into the heterogeneity in provisioning of services and plurality in utilization patterns. The heterogeneity and haphazard growth of the private sector clearly points to the need for some planning, which would include registration and regulation. The utilization of medical cares shows that a high percentage of people resort to the individual private practitioner for initial treatment. However, for minor and major ailments people use the government and municipal hospitals. Although more poor people use the government hospitals, the middle and higher income groups also use them for major ailments. These trends have implications for policy since high utilization for out patient services in the private sector must not be equated with high utilization for inpatient treatment as well. Secondly, a fairly high percentage do use the public sector. Therefore, this aspect needs to be considered while making a policy. A low rate of registration of private nursing homes in Delhi is of concern since registration is the first step towards any other effort at future regulations. Here, there is a need to document the experiences of registration and the constraints faced. There is also a needs to create systems for monitoring quality of services and cost of care.

Private Nursing Homes / Hospitals: A Social Audit

Author/s: Nandraj S
Publication source: Committee for Regulating Private Nursing Homes and Hospitals, Mumbai High court
Year of publication: 1992
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Quality, Regulation, Personnel, Licensing,

Objectives: To find out the conditions of private nursing homes/ hospitals in the city of Bombay and to find out the functioning of private nursing homes/hospitals. This study was undertaken for the committee set up by the Bombay High Court to go into the regulation and the laying down of minimum standards for nursing homes and hospitals.

Methodology: The nursing homes/hospitals were selected on a random sample basis from each of the wards in the Eastern zone of Bombay. The researcher visited twenty-four nursing homes/ hospitals and physical verification was done along with a checklist and an interview guide.

Findings and conclusions: Fifty percent of the nursing homes are either in a poorly maintained building or they are in dilapidated condition. A seventh of them are run from sheds or left in slums. Most of the nursing homes are congested, lack adequate space. The passages are congested, and entrances are narrow and crowded. Seventy-seven percent do not have scrubbing rooms. Less than a third have qualified nurses. Seventy-seven percent of the nursing homes that have an Operation Theatre did not have a sterilization room while 66.7% did not have a generator. None of the nursing homes incinerate infectious waste material but instead dump it in municipal bins. None of them keep records of notifiable diseases.

Women and Health Care in Mumbai – A study of morbidity, utilisation and expenditure on health care in the households of the Metropolis

Author/s: Nandraj S, Neha Madhiwalla, Roopashri Sinha, Amar Jesani
Publication source: Centre for Enquiry into Health & Allied Themes (CEHAT), Mumbai
Year of publication: 1998
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit
Issues addressed: Utilisation, Financing, Costs, Expenditure

Objectives: To document and analytically understand the perceived morbidity patterns, access and constraints of women to health care facilities and their utilization and expenditures by households on women's health problems with special reference to socio economic differentials.

Methodology: The study was conducted in the 'L' ward of Greater Mumbai City, a congested pocket with residential units as well as small-scale factories and commercial establishments. A stratified random sampling method was used in the five clusters, two slums, two chawls and one apartment block. A household interview schedule was administered in the study area. Since women were the focus of the study, women investigators conducted the interviews and the respondents were all women. The sample consisted of 430 households. A 'probe list' of 14 symptoms, was used to probe for the existence of specific symptoms among women that might otherwise go unreported. Data was collected in July 1996, with a reference period of 1 month for morbidity-related questions and a reference period of 1 year for questions related to pregnancy, delivery, abortion and contraception.

Findings and conclusions: The findings were quite revealing. The monthly prevalence rate of illness worked out to 363 per thousand, (males 169 as compared to 297 for females and when we add those illness with probe for females it goes up to 597 per thousand). Due to the modifications that were made in the methodology, the researchers were able to record a significantly higher burden of morbidity among women. The study attempted to create an environment, which encouraged women to feel, unhindered to speak about their health problems even while a deliberate attempt was being made to elicit information about unreported illness through the probe list. Morbidity by physical environment revealed that the non-slum

population, who comprised 41% of the total population, had 31.79% of total morbidity and the morbidity among slum dwellers was 10% higher than that of the total population. Reproductive illnesses form the largest group of problems accounting for 28.2 % of all episodes among females. We found that 127 out of the 167 reproductive episodes reported by women were related to menstruation and child bearing (Menstrual problems, uterine prolapse, low back ache and lower abdomen pain). We found a steady rise in the morbidity rates with age of females.

In terms of utilization the study reveals high non-utilization 32.5% of the illness episodes were not treated. Non-utilization was also found in relation to pregnant women and those who had delivered. Forty-three of the pregnant women did not utilize any facilities. These findings clearly show that Mumbai inspite of some of the best health facilities in the country, people residing within the city were not able to access them. The study found a very high utilization of the private health services and the limited role played by the public sector in the city of Mumbai for provision of health care. 85% of the illness episodes approached the private facility, with public facility accounting for only 10%. Public facilities were mainly utilised by the people in slum areas. The private practitioners mostly treated illnesses such as fever, respiratory and gastro intestinal problems. In case of the reproductive illnesses, about 70% of the facilities utilised were private. Of those pregnant women who utilized health facilities, 57% utilized private facility and only 32% utilized public facilities. With regard to deliveries the public sector accounted for only 30% of the deliveries as compared to the private sector, which accounted for 31.7%.

The average expenditure incurred per capita per episode was Rs. 95.45 working out to Rs. 415.68 per year. In terms of gender difference per episode cost worked out to Rs. 148.56 for males and Rs. 78.59 for females. In 90% of all the illness episodes, the combined expenditure was incurred on the fees paid to the doctor and the purchase of medicines. The expenditure incurred is much higher than what is spent by the government which is just Rs.250 per person in Mumbai city and very much less than the national per capita expenditure of Rs. 90. There was a high expenditure incurred on pregnancy, which works out to Rs. 213.08, Rs. 2428.90 for a Delivery & PNC and Rs. 989 for an abortion. The strong gender bias is very much evident right across the findings of the whole study. Women receive a raw deal both in terms of utilization and the expenditure incurred on their illness and non-illness events. One finds that irrespective of the age, education, occupation, earning status, location of the households there was a wide difference among men and women in terms of utilization.

The study shows that the methodology employed for studies of this nature needs to be sensitive in relation to women's health with emphasis on eliciting information from women with regard to illness that are not perceived as illnesses as such and illnesses relating to reproductive and sexual aspects. In both slum and non-slum areas households were spending less on women's health. The study has brought out these and many other important issues related with women's health, which require proper attention and corrective action. The study has emphasised the need of examination of these issues at a broader level and in a more gender sensitive manner. This study throws up the issue of non-utilization of health services especially women who suffer from various illness and for deliveries even in a premier city such as Mumbai that has more public health facilities compared to other parts of the country. This raises the question that though the services may be available, the access to them is determined by factors operating within the household and outside.

Physical Standards in the Private Health Sector- A Case Study of Rural Maharashtra

Author/s: Nandraj S, Ravi Duggal
Publication source: Centre for Enquiry into Health & Allied Themes (CEHAT), Mumbai
Year of publication: 1997
States covered: Maharashtra
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Quality, Regulation, Personnel, Licensing,

Objectives: To study the existing physical standards of health care in rural areas provided by private practitioners & hospitals

Methodology: An average district was selected on the basis of CMIE socio economic indices of development. Two talukas one economically developed (Karad) and economically backward (Patan) were chosen for the study. The researchers had to compile a list of the practitioners and institutions existing in the two selected talukas of the district. The researchers used various sources such as handbooks, membership lists compiled by various local associations of doctors to get the information. Key informants such as drug stores, senior doctors, and government health officers were also contacted. A sample of fifty-three private practitioners and forty-nine private hospitals was selected. The tools consisted of a structured interview schedule along with an observation schedule and checklist for equipment.

Findings and conclusions: One-fourth of the practitioners were found to be unqualified, with the economically backward taluka, having nearly five times as many unqualified practitioners as the economically developed taluka. Of the total sample of practitioners, 40 per cent were allopaths, 52.5 per cent from Indian systems, and only 7.5 per cent were homoeopaths. In the economically backward district, however, a whopping 75 per cent of practitioners were from Indian systems, with only 8.3 % practicing allopathy. Even the non-allopathic and unqualified practitioners largely practiced modern medicine, despite not being trained for it. Though only 30 per cent of the sample were qualified allopaths, 79 per cent practised only allopathy. If you add this to those practising allopathy along with the system in which they were trained, the percentage of those actually practising allopathy goes up to 94.

Only 55 per cent of our total sample had the appropriate registration, and even amongst the qualified practitioners, only 72.5 per cent were registered. Only 38 per cent of the practitioners maintained any sort of case records, and in most cases this was merely a record of the medicines administered and amount collected/due. Essential equipment and instruments such as thermometers, sterilisers, examination table, weighing machine, sheets, towels, wash basin were sorely lacking in most functioning clinics. In Patan, only 36.4 per cent of practitioners had a thermometer, and only 9.1 per cent had any sutures or ligatures. Of the 49 hospitals surveyed, none have been registered by any authority, although the Bombay Nursing Home Registration Act is supposed to apply to all of Maharashtra. Most of the hospitals had between six and 15 beds. As many as 29 per cent of the hospitals were being run by doctors trained in other systems of medicine but they were providing allopathic cures. There were only three qualified nurses in the entire

sample. Only 2 per cent of hospitals were treating emergency cases. Only 18 per cent of hospitals had the minimum facilities for pathological tests. None of the hospitals surveyed had blood banks or quick access to one. Only one quarter of the hospitals had uninterrupted power supply, and not a single hospital had an ambulance. Of the hospitals surveyed, 39 per cent functioned without a full-time doctor or visiting consultant. There were 14 hospitals, which did not have any nurses, at all even unqualified ones! In 71 per cent of the hospitals, not a single bedpan was available. Though most of the hospitals providing surgical services had OTs, only 71 per cent had an operating table, and 39 per cent shadowless lamps. Only 10 per cent of hospitals had an ECG monitor, 65 per cent a steriliser, and 56 per cent an oxygen cylinder. The findings of this study bring into sharp focus the haphazard growth of the private health sector, the unreliable quality of care, the poor implementation of existing legislation and the lack of standardisation in health institutions.

The study has revealed the inadequacy of the physical standards in private hospitals as well as in private clinics. It shows that the large-scale growth of private sector has not resulted in provision of health care to the masses. There are inequalities in the distribution of the health services. The situation warrants government intervention at the earliest. Private health services should be relocated and should be brought under regulation. Maintenance of records regarding fees, patients, diagnoses, etc. should be made compulsory. Minimum physical standards should be laid down and be made legally binding to make the private health sector accountable and people oriented. This study makes it obvious that there was an absence of state regulation and no minimum standards were laid down for the functioning of private hospitals. Even where regulations exist on paper, they are not enforced. The State and medical councils must ensure that only qualified persons practice. The government should encourage, through licensing and incentives, a more widespread geographical distribution of practitioners and hospitals to prevent over-concentration in urban areas. There must be regular medical and prescription audits, with renewal of licenses and registration dependent on such audits.

Household Survey of Medical Care

Author/s: National Council for Applied Economic Research
Publication source: National Council for Applied Economic Research, New Delhi
Year of publication: 1992
States covered: National
Social geography: Rural & Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory, ISM, Unqualified practitioners,
Issues addressed: Utilisation, Expenditure, costs,

Objectives: In 1990, under the aegis of their "Market Information Survey of Households", the National Council of Applied Economic Research (NCAER) conducted a household survey on medical care in all major states and union territories. The study was undertaken in the pre-monsoon period, during May-July. Data was collected on the prevalence of reported morbidity, health care utilisation, and out-of-pocket health expenditure.

Methodology: The sample was a multi-stage stratified sample. All the districts in the states and union territories were selected. For the rural sample, 2-5 villages per district were selected, with a probability of

selection equal to the proportion of the population of that village in the district population. In all, 1061 villages were selected. All the households in the village were listed, and then classified according to levels of income. Households were then randomly selected from each income slab. For the urban sample, all 41 cities of the country with a population of above 5 lakhs were included. The remaining cities/towns were classified into 5 strata on the basis of population size, and a random sample taken from each stratum. The 632 cities and towns selected covered 61 per cent of the total urban population. Once again, all the households in each city/town were listed, and the households randomly selected from each income slab.

Findings and conclusions: The illness prevalence rate for all India worked out to 67.70 per episode per 1,000 population for urban areas, and 79.06 for rural areas. Assam, J & K, Kerala, Meghalaya and Pondichery reported a higher rate of illness than the all India average. The prevalence rate by class shows that in households with low-income category, it was 77.21 per 1,000 population, in the middle income category it was 63.07 and in the high income category it was 57.62. The allopathy system of treatment was the most favoured. For 55% of the illness episodes, private medical practitioners were utilized, as compared to 38 to 39 percent for the services of Government doctors. Himachal Pradesh, Jammu & Kashmir, Orissa, Rajasthan and the Union Territory of Pondicherry showed a high reliance on government doctors. The situation was similar in the urban areas of Delhi and rural Andhra Pradesh. The study also brought out that households with low-income category utilize the government doctor more. It brought out the fact that with increase in the income levels of the household the dependency on Government doctor seems to come down in both rural and urban areas of the country. Looking at source of medical care, the study found that 43% of the illness episodes were treated in private hospitals or clinics. The PHC and SC catered to 8.2% and 5.8% of the cases respectively. In nearly 20% of the illness cases, the rural households travelled more than 10 kms for treatment. In Meghalaya, 54.56%, and Orissa, 33.47% of rural illness cases, patients travelled more than 10 kms. The average household expenditure for treatment of illness worked out to Rs.142.60 per illness episode in urban areas, and Rs.151.81 per episode in the rural areas. Fees and medicine category account for nearly two thirds of the total households expenditure on the treatment of illness. The average expenditure goes up from Rs.122.55 for low-income household to Rs.225.85 for the high-income households in urban India. In the case of rural India, the average goes up from Rs.138.55 to Rs.194.59 per illness episode when we go from the low to the high-income category.

A Review of the Rules & Regulations Concerning Private Sector Participation in Health Care in India & An Assessment of the Functioning of ESI, GIC & Hospital Insurance Schemes

Author/s: Operations Research Group
Publication source: Operations Research Group, Baroda
Year of publication: 1989
States covered: Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh, West Bengal, Tamil Nadu
Social geography: Urban
Data source: Primary & Secondary
Type of study: Policy review
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Regulation, Organisation, Financing, Incentives, Partnerships, Payment mechanismms, Insurance

Objectives: The study reviews the rules and regulations of private sector participation in health care, and assesses the functioning of the ESIC, GIC, and hospital health insurance schemes.

Methodology: The methodology includes (1) discussions with officials of the concerned ministries or insurance agencies, and their State branches, obtaining documents on regulations and published data on current coverage and financial viability of insurance schemes, (2) discussions with hospital superintendents of Apollo and Birla Heart hospitals, and obtaining published data, (3) interviews with a sample of beneficiaries, (100 insured persons belonging to each scheme in the four state capitals, and 34 1 ps of Apollo scheme) and providers (40 ESIC doctors from 4 State capitals), for their perceptions of the schemes. The data for State-level operations of GIC was problematic.

Findings and conclusions: The study reveals that the GIC scheme operates in towns with population above 5,000. The policy holders are government employees and professionals, with incomes above Rs.3, 000/- except in Bihar where the cited income was Rs.1,500-3,000. Private nursing homes and practitioners are the main providers of health care, except for government hospitals in Rajasthan and monthly health care expenditure per family is cited as Rs.100-200, but below Rs.100 in Uttar Pradesh. The beneficiaries expressed dissatisfaction with cumbersome claims processes, delays in settlement, and lack of coverage for minor ailments like flu, malaria, etc. The financial viability of the scheme is not a concern because the claim ratio is low. The state-level coverage and infrastructure of ESIC scheme is reviewed. All four states incurred lower per capita expenditure than the national ESIC average. The respondents identified the following problems: low quality and quantity of drugs: delays in claims settlement: malpractice and corruption: poor services, especially OPD for TB, skin diseases, etc. A brief review of the Apollo Health Association's intermediary role between patients and Apollo hospital is presented, and the nature of benefits listed. The Apollo Health Association is proposed as a model for other specialist private hospitals, and a future project of medical insurance for rural areas is listed. The findings are in the form of observations, and a large scale evaluation, based on sound sample design, is suggested especially for the ESIC scheme.

A Study of the State of Medicare Facilities in Agra City (With Special Reference to Medical Practitioners),

Author/s: Pandey, Baidya Nath Kumar
Publication source: Masters in Social Work. Agra University, 1992-93.
Year of publication: 1993
States covered: Uttar Pradesh
Social geography: Urban
Data source: Primary
Type of study: Case Study/Descriptive
Type of private sector: Qualified Private Practitioners
Issues addressed: Personnel in Private Sector; Prices and Costs of Medical Care;

Objectives: This study aims at the nature and standard of health care delivery by qualified private practitioners. It also explores the nature of private practice and the cost effectiveness of their services provided.

Methodology: It is a case study of selected private clinics in Agra. It is an exploratory study, which looks into the condition of these clinics.

Findings and conclusions: The study revealed that a majority of these practitioners belong to the 30-40 year group and are engaged mainly in private practice. A majority of these doctors who had joined for M.B.B.S.after intermediate want to acquire specializations. A majority of them have five years of

experience and prefer to practice privately. Their practice is mostly specialty-based rather than general practice. They have trained technicians as their supporting staff. Routine first aid is the primary service provided by these clinics. Other preventive services such as immunization, anti rabies, and anti toxic services are secondary in nature. Many doctors are found to charge additionally for these facilities and the consultation charges of these practitioners range between Rs. 30- 35 for each alternate visit and their daily earnings are between RS- 300-500. Most of them refer their patients to specialist doctors due to inadequate facilities available in their clinic. Most of the patients who use these services are from the upper middle class. A majority of the practitioners interviewed are of the opinion that services have become commercial as a result of increased competition. This, in turn, has led to a number of undesirable, unfair practices. This study shows that there is a trend towards specializations rather than general care. Here, the emphasis is solely on curative services with minimal preventive inputs. The earnings by these doctors' ranges from Rs. 10,000 to 15,000 a month. This trend requires regulation of medical practice in both government and private institutions. Some process needs to be initiated at the state level, which at the moment is lacking.

Study of Gynecological Disorders in Women from the Slums of Mumbai

Author/s: Parikh Indumati. Vijaylaxmi Taskar, Neela Dharap, Veena Mulgaokar
Publication source: Streehitakarini, Mumbai
Year of publication: 1994
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Utilisation, Quality,

Objectives: To determine the levels, patterns of Gynecological morbidity, Women's perception and assessment of their gynecological health, medical assessment and laboratory test, the women's health seeking behaviour.

Methodology: The location of the study was a slum of Bombay City. Data for this study was collected by conducting surveys on married women of the slum. The survey comprised a socio-demographic survey of respondents, their reported symptoms and morbidity and reproductive histories, a clinical examination and a Laboratory test. Qualitative data was obtained through group discussions with health workers. Informal interviews were conducted with health practitioners. Interviews were also conducted with 100 community women on their perception of disease pattern among them. Interviews were conducted through Marathi language. A random sample of 10% was drawn i.e, out of the estimated 15000 women, 1500 women were drawn as samples since efforts were not made to keep the sample size constant. As a result of migration and demolition of their huts, 50% of the samples size was lost. The refusal rate of respondents was 28%. The sample at the end comprised a total of 756 women. After the interviews, respondents were asked to attend the Streeihitkarini Clinic for medical examination. If women were reluctant to attend the clinic then examination were occasionally conducted at convenient locations close to the homes of the respondents in well-equipped medical vans. Female gynecologist conducted examinations. The examination samples

were sent to Bombay Hospital for testing. Those women who were in need of treatment were immediately provided with medical care.

Findings and conclusions: Since the sample was drawn from a single homogeneous slum, the variations in the women's income and education of hygiene levels were narrow. Women in the slum sought health care provisions from health workers, local medical practitioners, faith healers, pharmacists and also group of local women. Many of the health workers could not perceive a gynecological problem. Of the 22 local health practitioners only 4 were women. Not a single male practitioner had conducted a gynecological examination. Diagnoses were made and treatment given on the basis of reported symptoms. A large majority of practitioners did not consider gynecological illness serious unless cancer was suspected and only a few cases were women referred to public gynecological clinics. Women also visited faith healers especially for reasons of infertility. Interview with one faith healer showed that he treated gynecological problems by mystical healing powers and incantations (meditation and reciting mantras). It was also found that women sought medication for gynecological problem from a few local pharmacist and paan - shopkeepers in order to save time and money needed to visit a doctor or clinic and also to spare them the awkwardness of undergoing a medical examination. Women sought more of home remedies for their gynecological problems than seeking healthcare provisions in hospitals. Other findings include the high prevalence of gynecological morbidity among the slum women. 70% women reported gynecological complaints. Large proportions of women almost 3 in 4 were diagnosed as having one or more gynecological morbidity. Contraceptive users and sterilized women suffered from a high level of morbidity. Older women had reduced risk of STDs. Many women perceived gynecological problems as a normal aspect of womanhood. Prohibitive cost of treatment acted as a barrier in seeking healthcare. Also many were inhibited in discussing gynecological problems with male practitioners. They relied heavily on home made remedies. These results stress the fact that gynecological morbidity is unacceptably high and constitutes a major public health problem. There is an urgent need to incorporate reproductive health services, treatment of STDs, gynecological infections within the scope of family welfare programs. Attention also needs to be given to the private healthcare providers, who are consulted more often by patients. In short the results present a forceful plea for greater attention to and investment in the reproductive health needs of the poor Indian women.

Present Day Private ICU / ICCU in the City of Mumbai and the Patients Right to Healthcare

Author/s: Parmar Heart
Publication source: Bombay University, Mumbai
Year of publication:
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Hospitals, Laboratory/investigation, ISM, For profit
Issues addressed: Quality, Regulation, Licensing

Objectives: To study the extent to which patients' rights are respected or violated by private Intensive Care Unit (ICU) / Intensive Critical Care Unit (ICCU) in Mumbai. To study the infrastructure, equipment,

staffing and overall functioning. To examine the existence and non existence of regulation by various bodies expected to be responsible and their role.

Methodology: 40 private hospitals were selected from the central and western suburbs of Mumbai which displayed an ICU / ICCU board. The hospitals included those that were run individually, partnership ventures and those run by businessmen in collaboration with practicing doctors. A questionnaire was administered to either the owner doctor, Resident Medical Officer (RMO) or nurse on duty. The questionnaires were prepared based on a review of standard critical care books and literature available. Attempts were made to check and know about the working conditions of equipment, oxygen cylinders and central oxygen.

Findings and conclusions: There was absence of new and sophisticated gadgets that were needed for critical care. Life saving drugs was not stored in sufficient quantity. All hospitals in the sample employed non-allopathic doctors on a round the clock duty for critical care, where experienced, qualified specialists were needed. Basic cleanliness was absent. The charges per day levied on patients were exorbitant. There was total lack of holistic approach and teamwork amongst the specialists. There were no attempts made to upgrade the unit or the application of basic knowledge and concepts in critical care. During many discussions, cardiologists, physicians, surgeons and others who ran such hospitals themselves admitted that such units cannot be proclaimed as ICU / ICCU at all. The study found that many of those deaths in private ICU / ICCU could have been prevented, if the admission had been made in an higher level institution. Many of the deaths were hushed up and the belief of the public that 'death in ICU / ICCU is expected' was taken advantage of. The lack of awareness about what is expected in terms of 'critical care' has helped the mushrooming of these units. The study also found out that the phenomenal mushrooming of private ICU / ICCU hospitals parallels the commercialization of the medical profession after 1985 onwards. Kickbacks and commission in medical practice has been responsible for admissions to such units.
As a first step, people should be made aware of their rights and doctors their duty vis-à-vis health care for people. The patients should have access as a mater of right to 'minimum standards' of these services for which admissions are done. There is a need to lay down standards for every hospital and nursing homes, and they must be made legally binding. There is also a need to formulate laws, rules and regulations for private hospitals. Lastly, current private ICU / ICCU hospitals in Mumbai must recognize and adapt to the realities of available resources rather than permitting inadequate care detrimental to the health and life of the public and against all human rights.

Modernization of Fish Economy and Its Impact on the Well Being of Fishermen: A Case Study

Author/s: Pepin S
Publication source: Unpublished Ph.D. thesis, Jawaharlal Nehru University, 1986.
Year of publication: 1986
States covered: Kerala
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Individual Private Practitioners; Alternate Systems.
Issues addressed: Utilization of Private Sector; Government Hospitals, NGOs

Objectives: This study examines the well being of fishermen in relation to the basic needs viz. Nutrition, health, education and related services, the availability of and accessibility to health services provided by the government and other agencies. The main objective of this study was to analyze the production relation in fish economy and its impact on the well being of fishermen.

Methodology: This study was conducted in a village in Kanya Kumari district. Two major castes viz. Paravas and Mukkuvas among the fishermen have been represented here. The households in this village are stratified according to the kind of technology used for fishing viz. artisan fishing crafts and gears and mechanized crafts. In addition the merchants cum moneylenders and the middlemen cum money lenders featured in the stratification of the households. A total of 149 households representing these various strata were studied in depth to explore linkages between the ownership pattern, the credit and marketing system, type of technology used and its impact on the well being of fishermen.

Findings and conclusions: The section on accessibility to and utilization of health services shows a plurality in provisioning. There are government, private NGO and traditional healers in and around the village under study. The village is seven kilometers from the PHC and under this PHC there are 15 maternity centres, 21 allopathic private medical practitioners, 23 homeopaths, 8 Ayurvedic physicians and one siddha private practitioner. Eighty-eight percent of the households surveyed did not visit the PHC. The reasons included distance from the village and availability of other health institutions within the village. This study revealed that for common fevers about 73 percent of them used allopathic medicine, while 27 percent used indigenous medicine. Other diseases for which they resorted to allopathic medicine included ulcers, tuberculosis, appendicitis, whooping cough, scabies and diarrhoeas. For conditions like measles, chickenpox, jaundice and sprain/dislocation of bones, they resorted to traditional healers or indigenous practitioners whom the households perceive as 'effective' treatment. The utilization of private hospitals was less when compared to the 'non profit' institutions, followed by government hospitals. This study points to the plurality in provisioning and utilization patterns among the fishermen in Kanya Kumari district. With fishermen the presence of an active NGO, the hold of private practitioners is not as high. The type of facility chosen varies according to the nature of illness and even for a given condition the individual may resort to several healers. In this plurality of utilization pattern, the role of the private practitioner is not very prominent.

A Study of Supply and use of Pharmaceuticals in Satara district. (Part1)

Author/s: Phadke Anant, Audrey Fernandes, L. Sharda, Pratibha Mane, Amar Jesani
Publication source: Foundation for Research in Community Health (FRCH), Pune
Year of publication: 1995
States covered: Maharashtra
Social geography: Rural & Urban
Data source: Primary & Secondary
Type of study: Cross Sectional, Prospective
Type of private sector: Hospitals, Practitioners, Pharmaceuticals, Unqualified practitioners
Issues addressed: Utilisation, Financing, Prices, Quality, Regulation, Costs, Cost effectiveness

Objectives: This study had various components and various objectives: The present abstract concerns itself only those related to the private sector. To study the amount and the pattern of drug supply to the public and private health sector in Satara district and the shortages of drugs faced by the public health sector. To study the role of pharmaceuticals in Satara district.

Methodology: The location of the study was Satara district and the study was conducted between 1992 - 1993. This district was chosen for the study since it fulfilled the study conditions such as socio-economic development, size of the civil hospital {number & beds}, existence of cottage hospital, expenditure on drugs and logistical convenience. For the study of the private sector, doctors from each of the following educational backgrounds were chosen from each of the three zones. Post graduate, MBBS, non-allopathic degree holders (Ayurvedic or Homeopathic - both types as a rule prescribe allopathic medicines) and Registered Medical Practitioners (who do not have any recognized degree as such).

To estimate the cost of drug supply in the private sector, discussions with the medical representatives, medical storeowners, distributors and others were held. But it was impossible to get information since companies wee reluctant to reveal their sales figure for reasons of competition and income tax. Access to the audited figures for 17 of the largest drug distributors who were operating in Satara, Karad, Phaltan towns of Satara district were obtained along with information from the Medical Representatives (MR) and the medical storeowners

Findings and conclusions: By taking into account only the audited sales figures of the major 17 drug distributors and the estimated sales figures of the other distributors it was estimate that there was a minimum sale of Rs.26.6 crores of drugs in Satara. If the estimate of the drug store owners were to be taken into account then the minimum estimate would be Rs.30 crores. If unbilled and unaccounted sales are taken into account then the MR estimate would be Rs.50 crores. It was also found that there was a 20% growth in drug sales per year. The sale of drugs in the private sector in the Satara district in 1991 - 92, was atleast Rs.21.28 crores, which is 38 times the drug supply to the public sector.

A Study of Supply and use of Pharmaceuticals in Satara District. (Part 2)

Author/s: Phadke Anant, Audrey Fernandes, L. Sharda, Pratibha Mane, Amar Jesani
Publication source: Foundation for Research in Community Health (FRCH), Pune
Year of publication: 1995
States covered: Maharashtra
Social geography: Rural & Urban
Data source: Primary & Secondary
Type of study: Cross Sectional, Prospective
Type of private sector: Hospitals, Practitioners, Pharmaceuticals, Unqualified practitioners
Issues addressed: Utilisation, Financing, Prices, Quality, Regulation, Costs, Cost effectiveness

Objectives: This study has various components and objectives: The present abstract concerns itself only those related to the private sector. (Also refer part1). The overall aim of this second phase was to study the use of pharmaceuticals in Satara district. To study the prescriptions of doctors in public and private sector in order to assess their rationality, the extent of the use of unnecessary injections. To correlate these aspects of prescriptions with the educational status of doctors, and the relevant socio-economic factors. To study

the factors affecting prescription behavior of doctors, viz. the Continuing Medical Education of doctors, the extent of competition amongst doctors; the marketing practices of the drug - companies and drug stores etc. To study the extent and nature of sale of prescription-drugs (schedule - drugs) which are sold over the counter (OTC) without prescription. To estimate the wastage in both public and private sector on account of use of irrational drugs by doctors. To study the extent of expenses incurred by patients on account of "private - prescriptions" given by doctors in the Public Health Facilities (PHFs)

Methodology: The location of the study was Satara district and the study was conducted between 1992 - 1993. This district was chosen for the study since it fulfilled the study conditions such as socio-economic development, size of the civil hospital {number & beds}, existence of cottage hospital, expenditure on drugs and logistical convenience. For the study of private sector, doctors from each of the following educational backgrounds were chosen from each of the three zones. Post graduate, MBBS, non-allopathic degree (Ayurvedic or Homeopathic - both types as a rule prescribe allopathic medicines) and Registered Medical Practitioner (who do not have any recognized degree as such. To record all the drugs given to the patient, data was collected prospectively by posting pharmacist-investigation for a day in each of the clinics to record both types of drugs - those given in the dispensary and those prescribed for buying from a medical shop for first 30-35 cases.

Prescription analysis: It is widely believed by critics that doctors' prescriptions in India are irrational to a large extent, leading to a lot of financial wastage. The current study has conducted such an analysis of 1944 prescriptions collected in 59 visits to Out Patients Clinics of 30 public health facilities and of 1638 prescriptions from 62 visits to 19 private clinics from different parts of Satara district.

Factors Influencing Prescription - Behaviour Of Doctors: A pretested structured questionnaire was administered to seek information regarding qualifications of the doctor, his/her sources of continuing medical education the number of medical representatives that visited him in a week, his/her views on patient's expectations, his/her opinions on drugs available in the open market.

Focussed interviews were conducted with those doctors who were willing to give information beyond the questionnaire.

Financial Wastage Due To Irrational Prescriptions: Out of the 1080 and 810 prescriptions collected in summer 1993 from public and private sector respectively, 10% sub-sample was picked up by systematic random sampling. This sub-sample was subjected to cost analysis. The per day cost of drug treatment according to prescriptions by doctors, minus the per day cost according to Standard Drug Treatment Regimens (SDTRs) gave, the financial loss to the patients due to irrational prescriptions per day of drug treatment.

Proportion Of Private Prescriptions In Public Health Facilities: Out of the 561 prescriptions copied from PHFs during winter 1993, a 20% sub sample was selected by systematic random sampling. In the case of the 145 prescriptions thus selected, the drugs prescribed through the "outside - prescriptions" and the "dispensed drugs" were listed separately. The cost of both types of drugs (prescribed and dispensed) was calculated as per retail prices as given in the 1992-93 edition of Indian Pharmaceutical Guide (IPG)

Findings and conclusions: ***Prescription – Analysis:*** The average score per prescription was very low. The proportion of rational prescriptions was low and of irrational prescriptions high in all types of doctors. The proportion of rational prescriptions and the average score per prescription directly proportionate with the

educational qualification of the doctor. Though the overall score of consultants (post graduate doctors) was slightly better, they tend to use more unnecessary drugs. A very high proportion of prescriptions of all types of doctors contained irrational or unnecessary hazardous drugs or unnecessary injections or more than 3 drugs. Public sector prescriptions were more rational than the private sector prescriptions. However, the proportion of irrational injections in the public sector was slightly higher than in the private sector. All types of doctors from Registered Medical Practitioner (RMPs) in a small village to post graduates in large town were found to be writing grossly irrational prescriptions.

Factors Influencing Prescription - Behaviour of Doctors: CME in the private sector is almost entirely left to the discretion of the individual doctors and only 12.6% actually subscribed to periodicals other than those published by drug companies. In the public sector, the department of health services conducted trainings at frequent intervals for Medical Officers, though these mainly stressed the implementation of National Programmes. The drug company propaganda, through its printed literature (i.e. pamphlets and periodicals), Medical Representatives form the most important source of "Continuing Medical Education for doctors. Though this is promotional literature and therefore biased, it receives the sanction of more than 68.1% of private and 50% of public doctors as being a source of education. Cost of drugs influenced prescribing patterns in a significant way. The rising costs of drugs made it difficult for a doctor to dispense drug as well as charge a fee. Some doctors therefore resorted to dispensing less and prescribing more. Increased crowding of doctors led to private doctors seeking ways to draw and keep patients leading to a change in prescribing habits. Administration of placebos, in the form of unnecessary injections, drugs, prescribing of more expensive drugs to appease the patients' notion that 'the more expensive the medicine the better it is' were all strategies to keep the clientele with them.

Illegal Sale of Over The Counter(OTC) Drugs: It was found that all types of drugs were available OTC without doctor's prescription. OTC sales in a day (Rs.497.99) accounted for 11.23% of the total drug sales (Rs.4436) in a day in that shop.

Financial Wastage due to Irrational Prescriptions: Due to irrational prescription of medicines, a whopping 63.6% of money spent on drugs was wasted. The proportion was much higher in case of private sector (69.2%) as compared to that in the public sector (55.4%). Based on available estimates of the rate of morbidity in India, in the community, and the 1991-92 OPD attendance data in PHFs in Satara district, this wastage was Rs. 4.76 and Rs. 2.08 in private and public sector respectively per day, per prescription. If this data was projected at Satara district population, (1991) the wastage amounts to Rs. 17.70 crores.

Proportion of Private Prescriptions in Public Health Facilities: In the case of 145 randomly selected O.P.D. cases the cost of 'private prescriptions' in Public Health Facilities, was 15.43 % of the cost of drugs. In absolute terms, the cost of these privately prescribed drugs if distributed over all these 145 patients, came to only Rs. 0.82 per patient (It may be noted that out of these 145 patients, many were not given any private prescription). In the bigger and small towns also, the cost of privately purchased drugs as a proportion of cost of dispensed drugs on an average was 15.64%. It ranged from zero to 221.5%. The average cost of privately purchased drug, per prescription in these 7 PHFs was found to be Rs.7.97, which was much higher than that found for all centers. (Urban and rural together). It appeared that the overall proportion of privately prescribed drugs in PHFs was not high but was sizeable. In some Public Health facilities in big and small towns, it ranged considerably, from zero to a very high of 22.5%

The overall conclusions of the study are: The drug supply to the public sector in Satara District was a mere Rs. 5.6 million, as compared to the most minimum, reliable estimate of a drug sale of Rs. 212.8 m in the

private sector during 1991-92. The drug supply especially to PHCs and RHs suffers from chronic gross shortages and haphazardness. The overall quality of prescriptions of doctors both in public and private sector was low. There was a very high proportion of use of unnecessary, irrational, hazardous drugs and injections especially in the private sector. Public Sector prescriptions were more rational than private sector prescriptions. The proportion of rational prescriptions increased with educational qualification. There was very little of proper Continuing Medical Education of doctors. This along with the influence of the medical Representatives, increasing prices of drugs and competition amongst doctors influenced the prescription of doctors in the private sector, whereas in the public sector, the chronic shortage of drugs affected prescriptions, apart from lack of proper CME. Due to irrational prescriptions, 69% and 55% of the money spent on prescriptions in the private and public sector, respectively, was wasted, with an average of 63%. Projected to the Satara-district level, this wastage amounted to Rs. 17.7 crores out of the total drug supply of Rs. 22 crores. Patients visiting government clinics in Satara district had to buy 15% of the drugs prescribed to them, instead of getting all drugs free. If all the patients coming to the six PHC under study were to be adequately and rationally treated, there would be a drug short fall of Rs. 30284 per PHC. The shortfall could be met by a mere 8.34% increase in the annual recurring expenditure of Rs. 0.363 million per PHC. If all the patients in Satara district were to be adequately and rationally treated and if all children and women were to be fully covered in the MCH Programme in 1991-92, the drug-expenditure would be Rs. 20.61 crores, compared to the total drug expenditure of Rs. 21.84 crores in Satara district. It was thus, not lack of resources, but its irrational waste which was responsible for the unmet drug needs of the Satara district.

Sunder Nagri Mein Ulti-Dust Ka Prakop Va Uski Roktham-1988

Author/s: Priya, Ritu, Sumitra And Maharani
Publication source: Sabla Sangh, Delhi, 1989 (Supported by ICSSR).
Year of publication: 1989
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Case Study
Type of private sector: Individual private practitioners
Issues addressed: Utilization of Private Practitioners for Cholera, Public Hospitals, knowledge of Private Practitioners.

Objectives: The report is based on a study of the gastroenteritis/ Cholera outbreak in the slums of Delhi in 1988. The objectives of this study were to examine the nature of the problem and debate on whether it was an epidemic or not. Examine the role played by different agencies viz. Public and private health sectors, affected people and the media in recognizing the epidemic. Examine the nature of the official control measures undertaken. Study the treatment seeking behaviour of affected persons and the communities. Study the impact of all these initiatives on the control of the problem.

Methodology: The study is based on interviews with key officials in the Delhi Health Service Administration and a detailed study of one of the slums, which was officially rated as the most affected. In

the slum, interviews were held with the different health care providers. In addition a household sample survey was conducted among 161 households who had been taken ill.

Findings and conclusions: The findings from this study that are relevant for the private sector are early detection of he cholera epidemics was done by the public institution. Both the private practitioners and large sections of the community did not recognize the early warning signs. This study highlighted the crucial role for emergency services and accessible medical care facilities in preventing deaths. The private practitioners did not adequately provide this kind of emergency care. The private practitioners were the first level of resort, 43% of those affected sought the services of a private practitioner for less serious conditions. 75% of those who were seriously ill resorted to the government hospital. The control measures propagated by the government dispensaries, mobile teams and hospitals recommended the use of oral dehydration solution. However, very few private practitioners were prescribing it. The special public sector measures to provide medical care during the epidemic was only partially effective because centralized system was developed for the identification of cholera cases. This was being done at the Infectious Disease Hospital, which is located at a distance of 30 kms. This study shows that the private sector is not reliable for dealing with epidemics caused by infections diseases. The public sector is crucial for public health surveillance and control of epidemics. Efforts need to be made to involve local private practitioners in the government camps during such crises. They should be also be given information on management of such epidemics. This study showed that the public sector adopts more rational practices for prescribing drugs compared to the private practitioners. Therefore there is a need for systems to be developed for involving private practitioners in the early detection, treatment and management of such epidemic like situations.

Review of Private/Public/NGO Sector Collaboration with in TB Care in India

Author/s: Priya, Ritu.
Publication source: DFID Consultancy, July 19, 1997.
Year of publication: July 19, 1997.
States covered: National
Social geography: Rural and Urban
Data source: Secondary Review with interviews
Type of study: Review cum Policy Paper
Type of public sector: Individual Private Practitioners, NGOs.
Issues addressed: Quality of Private Services; Public-private Collaboration; Cost of Care; Impact of High Cost on Vulnerable sections.

Objectives: To review the existing grey literature on private/NGO/public sector collaboration with the Revised National Tuberculosis Programme. To synthesize the above information in a background document.

Methodology: The document was based on extensive review of available studies and consultations with persons from both public and private sectors who were involved in the tuberculosis programme.

Findings and conclusions: Based on the review of literature, the author says that there is a need to make a distinction between private practitioners, NGOs and Voluntary Public Action (VPA). These groups represent heterogeneity in terms of location, training and systems of medicine practised. Therefore, any effort at collaboration will have to contend with these complexities in provisioning. The quality of private services for both general and tuberculosis treatment are variable. For tuberculosis there are serious shortcomings in terms of diagnostic testing and treatment regimens followed. In addition, there is no mechanism to check these services. The major cause of default in the treatment process of tuberculosis is the 'high cost' of treatment in both the public and private sectors. This has serious consequences for access to TB care to the lower socio-economic groups. There is little in way of collaboration between the public and private sectors. NGOs have had a longer history of involvement with TB care. Here again, there is heterogeneity in the NGOs with those involved in advocacy, networking, production of IEC material, training of professionals and those, which deliver services for TB care. There is collaboration between NGOs and the public sector RNTP at the macro level but in a rudimentary form at micro levels.

The policy recommendations are made in light of the involvement of the private sector. Here, specific suggestions for involvement of private practitioners for case finding, testing and as observers for the DOTs programme are made. In addition, the author suggests that additional inputs are required for providing information to PPs for management of tuberculosis in terms of diagnosis and treatment regimens. This review lists a number of possibilities for collaboration of the private sector with the Tuberculosis programme. It makes concrete recommendations about the inputs that are required to help private practitioners for diagnosis and treatment of TB.

Perception of Users about Health Care Services in a General and Superspeciality Government Hospital of Delhi

Author/s: Pushp Lata, Ingle G.K, Singh, Saudan.,
Publication source: Maulana Azad Medical College, New Delhi.
Year of publication:
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector:
Issues addressed: Consumer Issues, Public Hospitals, Satisfaction of Patients.

Objectives: In the developing world especially in India, there is a paucity of literature pertaining to users' satisfaction, hence a study was conducted to find out the perception of users about health care services provided in a General and Superspeciality Govt. Hospital and users' willingness to pay.

Methodology: Two hundred and forty patients from the outpatient Department (OPD) and 160 Indoor users of General hospital and 120 Indoor users of Superspeciality Hospital of Delhi were interviewed. Twenty OPs and 20 Indoor users from each discipline (except psychiatry) were interviewed. A sample frame was designed to include all the OPDs and wards of the hospitals. Indoor users were interviewed after

they had received the discharge slip. OPD users were interviewed at the final exit point. Users were taken into confidence and relevant information was recorded on a restructured proforma.

Findings and conclusions: Out of 280 Indoor users 271 (96.8%) were satisfied. In General Hospital satisfaction was 94.4% and in Superspeciality Hospital 100% satisfaction was observed. Total of 97.9% users were satisfied with Doctors' services, 97.85% with Nurses' services, 97.9% with drug supply and 92.5% users were satisfied with investigation facilities in the hospital, A total of 95.3% users were satisfied with the hygiene in the ward, 96.9% with the quality of food provided in the hospital. A total of 68.9% of users were dissatisfied with the hygiene of toilets and bathroom. Out of 280 users, 166 (59.3%) were willing to pay. The percentage of users willing to pay according to different characteristics viz. age, sex, literacy, occupation and per capita income were as follows: 66.7% in 31-45 years vs 32% in > 60 years age group, 60.3% Males vs 58.1% females, 94% Graduates vs 35% primary educated, 100% semiprofessionals vs 32% unskilled worker, 87.5% with per capita income Rs. 2000/- 2999/- vs 41.7% with per capita income below Rs. 1000/-. The willingness to pay was directly proportional to the level of satisfaction.

Out of 240 OPD users, 214(89.2%) were satisfied and 26 (10.8%) were not satisfied with the hospital OPD services. A total of 92.2% were satisfied with Doctors' services, 44.2% with the investigation facilities, 58% with drug supply and 79.2% were satisfied with registration in the hospital. The percentage of users willing to pay according to different characteristics viz. age, sex, literacy, occupation, per capita income were as follows: 61.9% in 18-30 years vs 38.6% in 31-45 years age, 55.9% males vs 50.8% females, 33.7% illiterate vs 100% post graduates, 35.1% unskilled worker vs 84.6% clerk, shop owner, farm owners, 83.3% with per capita income Rs.3000/- and above vs 39.4% with per capita income less than Rs. 1000/-. There was no statistical relation between willingness to pay and level of satisfaction. Other studies from urban areas show that the users of public hospitals belong to the middle, lower middle-income groups and the poor. Apart from showing high levels of satisfaction with in-patient care, this study suggests that there is an association between satisfaction levels and willingness to pay. There is ample evidence to suggest that professionals and semi professionals are more willing to pay for services, compared to the unskilled workers.

Morbidity Pattern, Health Care utilization and Per Capita Health Expenditure in a Rural Population of Tamil Nadu

Author/s: Rajaratnam J.R. Abel, Duraisamy. Sr, John, K.R
Publication source: National Medicine Journal of India, Vol. 9, no 6. Pp.1996
Year of publication: 1996
States covered: Tamil Nadu
Social geography: Rural
Data source: Primary
Type of study: Cross-sectional study
Type of private sector: Private practitioners, Indigenous practitioners, Allopathic
Issues addressed: Utilization of private services, Morbidity, expenditure

Objectives: To collect information on the existing morbidity pattern, pattern of health care utilization and the per capita health expenditure so as to provide a need based health care delivery to a rural population.

Methodology: The study was conducted in the K.V. Kuppam Block, North Arcot Ambedkar District, Tamil Nadu. It was a cross-sectional study, interviewing respondents form 300 households, from 3 panchayats using a multistage sampling technique. Information relating to 1440 persons was collected. The morbidity date was obtained initially for the week prior to the day of interview, followed by one week to one month and then for two months to one year.

Findings and conclusions: During 1990-91, 825 of the 1440 persons (57.3%) did not have any illness. Sex had no bearing on the number of incidents of illnesses. Of the 60 children less than 2 years of age, 42 (70%) had one of two incidents of illness. The period prevalence of infective and parasitic diseases was found to be 21.9% with an average of 3 episodes. Services rendered by private practitioners (registered, non-registered and indigenous) were utilized by 59% of the households and 79% of the households had used allopathic treatment at some time. The average per capita per annum health expenditure was RS 89.9 (Rs 449 per household). This increased significantly with increase in the household size ($p<001$) and per capita income ($p<0.01$). The health-seeking behaviour of this population can be changed if efficient services are rendered through government primary health centres and sub-centres. This would allow the existing voluntary agency to withdraw without much change in the per capita health expenditure.

An Epidemiological Study on the Outbreak of Malaria in Valiyathura: A coastal area of Kerala

Author/s: Ramesh Harihara Iyer
Publication source: M D dissertation, Dept of Community Medicine, Medical College, Thiruvananthapuram, Kerala, 1997
Year of publication: 1997
States covered: Kerala
Social geography: Rural
Data source: Primary
Type of study: Prospective survey.
Type of private sector: Private practitioners (allopathic and other systems of medicine)
Issues addressed: utilization of private services

Objectives: (a) To determine the prevalence of malaria, (b) To examine the relationship between demographic, socio-economic, cultural factors and prevalence of malaria, and relationship between certain vector factors favouring prevalence of

Methodology: A sample of 1475 individuals from about 2000 households were studied. A survey was conducted in March - June 1996 in Valiyathura, ward of the Thiruvananthapuram city. The locality is known to be poor and has very few private General Practitioners. There is one voluntary scheme sponsored by Valiyathur Church.

Findings and conclusions: The study estimated a point prevalence rate of 1.98% for June 96 and a period prevalence rate of 13% for 1995-96, with a case fatality of 1.74%. Malaria was prevalent among the most illiterate. Malaria was more prevalent among fishermen than among students and housewives. It was also more prevalent among those living in thatched / sheet houses. Malaria was more prevalent among those

with inadequate light and ventilation and was higher among large families. It was lower among families with domestic animals and birds. Sixty percent of the families used chemicals to control malaria, while 30% used larvicides. Eighty eight percent of the patients used government facilities for treatment, while only 4.5% used private facilities. Close to 95% of the patients used allopathy, the remaining used other systems of medicine.

User Perspective in Urban Tuberculosis Control

Author/s: Rangan Sheela
Publication source: Foundation for Research in Community Health (FRCH), Bombay
Year of publication: 1995
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, for profit, Not - for profit
Issues addressed: Utilisation,

Objectives: To assess the performance of the T.B control programme from patients' point of view.

Methodology: A sample of 60 T.B patients from Bombay and 196 patients from Pune was selected for the study. The patients from Bombay were registered with the Area TB Centre (ATC) which fell under City Tuberculosis Programme (CTP). The patients from Pune were either taking treatment from the TB clinics run by the corporation or from the district TB centre run by the state government. The data obtained from 61 patients from the Pune City who were followed for a period of nine months was also incorporated wherever required. The data was based on two separate studies carried out in Bombay and Pune

Findings and conclusions: Though TB is considered to be a major disease, the medical help-seeking pattern in case of TB is similar to the pattern in other diseases. In the study area it was observed that after developing the first symptoms of TB such as chest symptoms 62% of the patients were found to be seeking the help of private practitioners. Forty percent of them were diagnosed by the doctor and the treatment was started for 25%. It was found that the private practitioners were the major providers in the diagnosis and treatment of TB. However, due to their high cost the public services were preferred. When the patients were asked to compare between public and private services most of them agreed that given a choice they would prefer going to the private practitioner. The reasons were non-availability of medicines at the TB centers long waiting hours for treatment and check ups, inadequate provision of the information, etc. Despite these difficulties, 25% of the patients were able to complete the treatment.

The National TB Programme offers both diagnosis and treatment free of charge. But many times patients seek other sources of treatment and end up spending extravagantly. In the study the patients had visited average 2.9 sources in Bombay and 2.5 sources in Pune before registering with the TB programme. The average total expenditure of the Bombay sample was Rs. 826/- where as in Pune it was Rs. 325/-. Even registering with programme did not result in cuts of their spending since money was spent on travelling. In the sample, 32% of the patients interviewed were spending Rs. 10 on travelling. When the total cost was not supposed to go above Rs.1500/- even with the private treatment, it was found that some of the patients

had spent Rs.1000/- to Rs.7000/- on the treatment. Even after registering with the public services their income on drugs sometimes continued since they were asked by the TB clinics to purchase the drugs from private chemists. The figures revealed by the study are disturbing since 66% of the people in the sample were from the low-income group and their earnings were meager as compared to the expenditures they made on the treatment. E.g. in Bombay, the mean per capita income of the people from the sample was Rs. 238.74.

Defaulter's identification and retrieval are the most important aspects of the National Programme. It is a duty of the health workers to see that the people registered with the TB center complete their treatment. In the study sample from Bombay all the patients had at least once not reported for drug collection. However only one patient was sent a reminder post card and only two were visited personally by the health workers. The problem resided with identifying the patient's address. It was found that 20% of the people had not filled up the address properly in the registration form and 15% of them were not residing at the mentioned address. The health workers however admitted that the follow up was not according to the programme standards due to various administrative and personal reasons. The motivation of the health workers was sometimes a problem, which needed proper attention by the programme manager. The conversations with the patients revealed that 37% of the patients from Bombay were sent back from the clinics due to the non availability of the drugs or were told to come after two or three days. This was in sharp contrast with the argument, which puts all the blame of non-adherence on the patients

The study has concluded that the patients were not fully satisfied with the performance of the TB control Programme as they had difficulties with the treatment they received. The costs of the treatment, the availability of the medicines, follow ups, etc. were the areas where patient's dissatisfaction was registered. By analyzing the performance according to various parameters such as case finding targets, sputum positivity, case holding, etc. from patient's point of view, the study has suggested that the programme managers should look at the problems at various stages of implementation and evolve improvements. This is necessary to make it people oriented.

Prescription Audit Analysis - A study of Drug Prescription Practices in India.

Author/s: Ray Krishnangshu, Jaishree Mitra Ghosh, S.B Chaudhri, Adhip Mandal, Shivani Prasad
Publication source: Voluntary Consumer Action Network (V- CAN), Consumer Unity & Trust Society, Calcutta.
Year of publication: 1996
States covered: Rajasthan, West Bengal, Gujarat, Maharshtra, Tamil Nadu, Andhra Pradesh
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross Sectional, Prospective
Type of private sector: Pharmaceuticals, Practitioners, Hospitals
Issues addressed: Utilisation, Regulation, Quality, Costs, Consumer, Licensing

Objectives: To explore the prescribing practices of both general practitioners and consultants practicing either privately or attached to Government organisations. To ascertain the cost effectiveness of each prescription by estimating the total cost v/s rational cost.

Methodology: The study was conducted in 6 states, Rajasthan (Jaipur, Ajmer, Masuda, Beawar, Chittorgarh) West Bengal (Calcutta), Gujarat (Ahmedabad), Maharashtra (Bombay), Tamilnadu (Cuddalore, Trichy) and Andhra Pradesh (Vijaywada, Guntur, Tenali, Mangalagir. Around 2000 prescriptions were randomly collected either from local pharmacies or directly from consumer interviews. All prescriptions were entered into the specially designed prescribed Proforma. These prescriptions belonged only to allopathic doctors. In the Government hospitals prescriptions were collected mainly from the O.P.Ds. For assessing the rationality of each prescription, the 'Prescription Audit Guidelines' by WHO and modified guidelines developed by Phadke A and others (FRCH,1995) were followed. The guidelines included completeness of each prescription, scrutiny of each prescription and rationality scoring. The cost of each prescription was calculated. All incomplete and illegible prescriptions were excluded. The cost of each drugs was calculated from the available current price lists mentioned in latest editions of MIMS, CIMS, Drugs Today and Indian Pharmaceutical Guide. Interviews with chemists were also conducted to ascertain the costs of the drugs.

Findings and conclusions: West Bengal (Calcutta): A total of 250 prescriptions were analyzed. Out of these 125 prescriptions (50%) were considered incomplete, 65 prescriptions were obtained from General Practitioners in which 50% were rational, 31% were acceptable and 19% were irrational prescriptions. Forty prescriptions obtained from consultants in which 75% were rational, 20% acceptable where as 5% were irrational. Amongst all prescriptions 8% of the prescriptions were grossly unscientific and alarming and most were obtained from private practitioners. Consultants were more rational than fresh medical graduates were. The average estimated total cost of eligible prescriptions (125) was Rs.72.81, whereas the rational cost was Rs. 58.62. The average cost difference was Rs. 14.19

Andhra Pradesh: A total of 307 prescriptions were analyzed. Out of these 88 prescriptions (20%) was incomplete. 108 prescriptions were obtained from General Practitioners in which 61% were rational, 20% were acceptable and 19% were irrational whereas out of 99 prescriptions by consultants 65% were rational 21% were acceptable and 14% irrational. About 4% of all prescriptions turned out to be alarming. General Practitioners and consultants wrote equal amount of rational prescriptions, which showed that post - graduate studies did not necessarily improve the quality of prescriptions prescribed by consultants. The average estimated total cost of eligible prescriptions (219) was Rs. 57.25 whereas the average rational cost was Rs. 42.80. The average cost difference calculated was Rs. 14.45.

Rajasthan: A total of 291 prescriptions were analyzed. Out of these 70 prescriptions (27%) were incomplete. 133 prescriptions were obtained from General Practitioners in which 50% were rational, 33% acceptable and 17% were irrational. Out of 74 prescriptions by consultants, 54% were found to be rational, 30% acceptable and 16% were irrational. About 5% of all prescriptions were alarming. Prescriptions obtained from Jaipur showed an increase in the number of incomplete prescriptions and consultants wrote the majority of rational prescriptions. The average estimated total cost of eligible prescriptions (221) was Rs. 63.25 whereas the average rational cost was Rs. 29.75. The cost difference calculated was Rs. 33.50

Maharashtra: A total of 350 prescriptions were audited. Out of those 91 prescriptions (26%) were incomplete. Prescriptions were obtained from General Practitioners in which 46% were found rational, 33% acceptable and 21% were irrational. Ninety eight prescriptions were obtained from consultants in which 64% were found rational, 20% acceptable and 16% irrational. About 8% of all prescriptions were alarming. Consultants were comparatively more rational than General Practitioners. The average estimated total cost

of eligible prescriptions (259) was 48.15 whereas the average rational cost was Rs. 32.60. The average difference calculated was Rs.15.55

Gujarat: A total of 304 prescriptions were analyzed out of which 65 prescriptions (21%) were incomplete, 174 prescriptions were obtained from General Practitioners among which 50% were rational, 24% were acceptable and 26% were irrational. 65 prescriptions were obtained from Consultants. Among them 75% were rational, 15% were acceptable and 10% were irrational. About 10% of all available prescriptions were alarming. Consultants wrote the majority of rational prescriptions. The average estimated total cost of eligible prescriptions (239) was Rs. 62/-, whereas the average rational cost was Rs. 57/-. The average cost difference calculated was Rs. 5/-.

Tamilnadu: A total of 269 prescriptions were analyzed. Out of those 40 prescriptions (15%) were incomplete. Prescriptions were obtained from General Practitioners and among them 50% were rational, 25% were irrational. Fifty-two prescriptions were obtained from consultants in which 48% were rational, 36% acceptable and 16% were irrational. The number of rational prescriptions by both General Practitioners and Consultants were more or less equal. The number of acceptable prescriptions was higher amongst the consultants. The average estimated total cost of eligible prescriptions (229) was 79.50 whereas the average rational cost was Rs. 58/-. The average cost difference calculated was Rs. 21.50

Practitioners prescribed the costliest prescriptions on diseases that required only symptomatic medicines. These diseases include common cold, viral fever, general debility in elderly people, diarrhoeal diseases etc. Useless prescriptions of antibiotics or restoratives in such conditions increased the total cost of therapy. These costly prescriptions were rampant amongst both General Practitioners as well as Consultants but comparatively lower in the prescriptions available from Government Hospitals.

Cost versus rationality assessment: The average cost of rational prescriptions obtained from total samples was Rs. 40.85 whereas the average cost of alarming and irrational prescriptions was Rs. 114. It was clearly evident that the cost difference between the rational and alarming groups was Rs 73.15. It was also evident that the degree of irrationality in prescribing habits accelerated the cost of therapy and vice - versa. Since faulty drug information or biased prescribing habits cause the irrationality, the correction of both these pertinent factors might protect the consumers from financial loss and exposure to hazardous formulations.

An Examination of Public and Private Sector Sources of Inpatient Care in Trivandrum District, Kerala (India), 1999

Author/s: Rick K Homan and K R Thankappan
Publication source: Achuta Menon Centre for Health Services, Thiruvananthapuram, Kerala
Year of publication: 1999
States covered: Kerala
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross-sectional study
Type of private sector: For profit, corporate hospitals, and public sector hospitals.
Issues addressed: Performance of private and public hospitals, personnel issues, government policy, partnerships with public sector,

Objectives: The purpose of this study is (a) to provide a description of the structure of the health care sector in Trivandrum district of Kerala state, (b) to examine patients' perception of quality, factors affecting choice of provider, (c) to evaluate the financial burden of care, and (d) to analyze the inputs and performance of both private and public hospitals in the district. The study concludes with a description of the challenges facing the public sector health delivery system and identify some potential responses to these challenges.

Methodology: The study collected relevant data from 29 public hospitals and 9 private hospitals in the district. Public sector hospitals included one super specialty, two tertiary hospitals, five secondary levels hospitals, three Community Health Centres, four Block Primary Health Centres (one from each taluk), four mini primary health centres and four sub-centres. Out of 9 private hospitals, three were within the city boundary, and six from three taluks in the periphery. Structured interviews were conducted with hospital superintendents or the medical officer in-charge of each institution. Information was collected to describe the following issues: waiting time for various services, areas of shortages or surpluses, perceived patient preferences for the facility, referral patterns to and from other providers and patient billing information. In addition, data was collected on the volume and mix of services provided by the facility, the inputs to the provision of care, the capacity of selected areas of facility and operating expenditure.

Findings and conclusions: Based on a 5 point Likert type scale of self-reported satisfaction, patients from the public sector reported lower levels of satisfaction with the care received than the level of satisfaction of the patients from the private sector facilities. The poor and somewhat poor tended to be more neutral about the care received, and the better off were more likely to be at one extreme or another. The reported behaviour of clinical staff appeared to improve with the socio-economic status of the patient. The key perceived problems with government hospitals were : they are too far away (57% agreed), lack of attention from caregivers (54%), bad behaviour of staff (405) and lack of hygiene (30%). Geographic accessibility was not a cause for concern while choosing a private facility. The study suggests that the demand for hospital care among private sector patients may be fairly inelastic. The hidden cost of care associated with care in public hospitals was greater for the poor. This was indicative of the longer lengths of stay or more chronic nature of diseases faced by them in public hospitals. Both at secondary and tertiary level care, inpatient charges as fraction of total out of pocket expenditure was predominant. It was about 75% at the tertiary level; at the secondary level, it was 42% in public sector and 71% in private sector.

Hospital and Laboratory performance: Private hospitals at Trivandrum Taluk operated at a high level of occupancy rate while those in other taluks had a surplus of beds, staff and an occupancy rate of less than 50%. This is attributed to the fact that these hospitals were recently established and the general perception that better quality care was available only in large cities. The shortest average length of stay tended to be in private hospitals. Most doctors in public hospitals believed that "quantity kills quality of care" delivered by them. On the average private hospitals performed three times the number of caesarean deliveries in the public hospitals; but it is not known whether these women in private hospitals are older than those in public sector. 25% of lab tests in public sector were referred to private laboratories. Private sector hospitals tended to order more x-rays per patient (on average 55% more) than the public sector;
For private hospitals, a larger share of personnel expenditures went to physicians than in the public hospitals. The higher personnel costs in the private secondary and tertiary level hospitals was due to the use of many more physicians than in the public sector, and a lower use of qualified nurses and paramedical personnel.

Over crowding in large public hospitals needs to addressed. This can be done by extending the consultation hours and capacity of the outpatient area and by use of more qualified nurses, physicians assistants, etc. There is a need to have co-operative arrangements with private hospitals: For example, the government could use private hospitals for government employees at lower negotiated rates. Given the history of ineffectual regulation of private enterprises by the public sector, one should not hold out too much hope for regulatory approaches. Recruitment and retention of physicians particularly in rural (out-lying) areas pose another major challenge. Increasing the intake of students in medical colleges is not likely to solve this problem. The study suggests that the issue of geographic preference needs to be addressed. This will see a noticeable increase in the number of physicians in the outlying areas . The private sector in out-lying areas also faces the problem of recruiting and retaining physicians. The study is unable to assess the relative efficiency of hospitals since there is no control for the variation in quality of care produced. But the study makes an attempt to draw some inferences based on the scale of operations within the hospitals: The public sector hospitals are experiencing "x-efficiencies" in that they are producing services beyond their intended capacity. For private sector hospitals, the low occupancy levels create the opposite problem (of under-utilization). The authors suggest that the root cause for most problems seems to be the misallocation of resources. It is feared that the momentum of the system overwhelms the ability to focus on long-term goals and the result is a series of short-term crises. The government must improve documentation of the medical records and additional control to monitor performance of providers.

Public Health-Urban Society Interface: A Study Of Pneumonic Plague In Surat

Author/s: Shah Ghanshyam
Publication source: Centre for Social Studies, Surat

Year of publication: 1996
States covered: Gujrat
Social geography: Urban
Data source: Secondry
Type of study: Case study, Review paper
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Utilisation, Quality, Regulation

Objectives: The outbreak of a deadly infectious disease (widely believed to be the pneumonic plague) which gripped Surat in 1994, created widespread panic not just in the country but throughout the world. Though the disease was controlled within a week, it had raised many fundamental and still unresolved issues concerning the state of the public health system and the path of urban development in India.

Methodology: This study treats the Surat episode as a symptom of a socio-political disease related to the value system of the populace, the lopsided nature of development, the crises in governance, and a fragile and fragmented civil society.

Findings and conclusions: In Surat, the plague first broke out in the outskirts. Floods preceded the plague in Surat. Constant rain for nearly three months followed by the floods caused unusual water logging in many parts of the city. After the floodwater began to recede people began to clean their surroundings. In

this process, some might have handled or come in contact with dead and infected rodents and developed the disease. The disease however immediately spread to all parts of the city, including the posh areas. The local population was the most affected and a larger number of males than females were victims of plague. The news about the outbreak of the plague was not equally disseminated to all the citizens. The doctors were the privileged group that first got the news of the outbreak of the plague. At the first instance people from the lower middle and lower classes were deprived both of information and medicine. Following the death of a few people, rumours spread about poison in water and release of poisonous gas in the air. These had communal overtones, in which the members of the minority were the victims of suspicion for the act.

As soon as the news broke out, doctors in the area immediately closed their dispensaries. Besides a large number of private practitioners, many doctors employed or attached to the charitable public hospitals also absconded from the city. Among the doctors as many as 70% fled from Surat and not all those who remained, attended their duties. But a few performed their duty with sincerity and many out of moral conviction. The doctors of the New Civil Hospital (NCH) worked against all odds but a few attended duties out of fear of suspension from the job. The apathetic attitude rendered by the doctors towards their services made people very angry and as a result a small crowd of 200 people ransacked the clinics of several doctors. Cases were filed against medical practitioners who ran out of the city, on the ground of negligence of duty. An agitation was launched against important municipal officials such as the Administrator, the Deputy Commissioner (Health), the Director of Urban Development and the Deputy Health Commissioner.

After the floods, the SMC health department in the second week of September registered more than 2000 cases of diarrhoea and gastrontitis. Quite a few died of a 'mysterious disease' that was neither diagnosed as malaria nor pneumonia. Private doctors did not report deaths of such instances to the SMC and they failed to detect fatal cases. The surveillance team was not quick enough to act swiftly and their presence was not felt by the cross sections of the society. Municipal staff deployed to collect garbage, spraying of insecticides and distribution of medicines was inadequate. Half of them abstained from duty till they were threatened for penal action. At the same time those who were performing their duty were not protected by minimum measures for safety and protection like gloves, mask, goggles etc. Quite a few sanitary workers were bare footed collecting garbage and carcasses.

There was no co-ordination among various departments, needed for the efficient management of the crises. The information network regarding the diagnosis and treatment was narrow. Many staff members were excluded from getting information and hence were alienated from the working of the hospital. Conflicts between the hospital staff and the officials of the health department (services) came to the fore during the crises, which further lowered the image of the public health system. Record keeping was adhoc and apathetic. Drugs were not available in the required quantities especially, in the initial, crucial stage. 'Secrecy' in keeping evidence created distrust in the diagnosis and in the functioning of the public health system. Besides scarcity of drugs, the public was given contradictory information regarding the disease, administration of drugs and number of deaths. The members of the public depended upon getting information from private doctors who were by and large indifferent to public health.

The plague in Surat is a warning of a series of epidemics that the country could face in the coming years with changing ecology, environmental degradation and uneven growth. Policy makers in and outside the government have to deal with the main social cause of the disease, and not just merely the symptoms. The fragmentary approach to economy and health has to be replaced with a holistic approach. Preventive

medicine should be the core of the public health system. The public health system has to be expanded to meet the needs of the poorest of poor.

Determinants of Access to and Utilization of Health Care Services in Kerala

Author/s: Shenoy K T
Publication source: Clinical Epidemiology Resource and Training Centre, Medical College, Thiruvananthapuram, June 1999
Year of publication: 1999
States covered: Kerala
Social geography: Rural and Urban
Data source: Primary
Type of study: Cross-sectional survey
Tye of private sector: For Profit hospitals
Issues addressed: Utilization of private services, morbidity pattern and expenditure

Objectives: To study the utilization pattern and factors determining the utilization of private and public health care services, and patterns of expenditure.

Methodology: 1001 households (504 from rural and 497 from urban areas) from 5 the panchayats of Thiruvananthapuram, district were studied using multistage cluster sampling and the subjects were evaluated. Data on the following variables was collected: Socio-economic status, demographic status, morbidity in the past one month, access to and utilization of private and public health care services. Data on pattern of severity of illnesses, distance traveled to seek care and expenditure incurred were also collected. The data was analyzed using univariate and multi-variate logistic regression methods.

Findings and conclusions: Out of 2237 participants with morbidity in the past one month, 1552 utilized health care services (private 1044 and public 508). Logistic regression showed that people in the age group 45-49 were significantly less likely to use private services compared to adults in the age group 14-44 years. The lower socio-economic groups were significantly less likely to use private services than higher SE groups. The urban subjects were significantly less likely to use private services than rural subjects. Patients with chronic illness were significantly less likely to use private services compared to those with acute illness. Patients who traveled long distance (more than 5 km) were significantly less likely to use private services compared to those who traveled less distance, Private services are more used than the public services. Strategies to improve public health care services need to be planned for better access and utilization.

Cost-effectiveness of Public-funded Options for Cataract Surgery in Mysore, India

Author/s: Singh A J, Paul Garner and Katherine Floyd
Publication source: Lancet, Vol 355. January 15, 2000. Pp180-184.
Year of publication: 2000

States covered : Karnataka
Social geography: Rural
Data source: Primary
Type of study: Policy paper; evaluation of interventions
Type of private sector: NGO hospitals.
Issues addressed: Quality of service delivery, government policy, cost-effectiveness

Objectives: This paper assesses the cost-effectiveness of public-funded options for delivering cataract surgery in Mysore, Karnataka state, India.

Methodology: Three types of delivery of cataract surgery were studied: mobile government camps, walk-in services at a state medical college hospital, and patients transported in from satellite clinics to a non-governmental hospital. The article assesses outcomes in a systematic sample of patients operated on in 1996-97 by follow-up at home: average costs by provider derived from actual expenditure during the year.

Findings and conclusions: Almost half the patients operated on in government camps were dissatisfied with the outcome. More than one third were blind in the operated eye. User satisfaction was higher with other providers (medical college hospital 82%); non-government hospital 85% and fewer patients remained blind. Camps were low-cost options, but the poor outcomes reduced their cost-effectiveness to US$97 per patient. The state medical college hospital was least cost-effective, at US$176 per patient, and the non-governmental hospital was the most cost-effective at US$54 per patient. The government of India should review its policy for government camps surgery, and consider alternatives, such as transporting patients to better permanent facilities. India and other developing countries should monitor outcomes in cataract surgery programme, as well as through put.

A Study of the State of Medicare Facilities in Agra City (with special reference to Ayurved and Unani)

Author/s: Singh Pratap
Publication source: MSW, Project Report Agra university, 1993.
Year of publication: 1993
States covered: Uttar Pradesh
Social geography: Urban
Data source: Primary
Type of study: Case Study/ Descriptive
Type of private sector: Indigenous Systems
Issues addressed: Practices and Characteristics of Indigenous Private

Objectives: The study aimed to understand the present conditions of Medicare facilities and elicit the preferences of the patients towards various medical system/agencies. It sought to study the extent of use of allopathic methods of practice by Ayurvedic and Unani practitioners.

Methodology: It is a case study of a few selected Ayurvedic and Unani practitioners. It is an exploratory study which tries to study the conditions under which these practitioners operate and the trends of preferences of patients for utilization of available Medicare facilities.

Findings and conclusions: The average age of these indigenous practitioners is 70 years and above and the average duration of their practice is around 20 years. With regard to the qualification of the practitioner about 50% of them have studied up to intermediate (12th standard) level, about 10% of them have studied up to graduation level, 15% of them are of middle to high school level and about 25% of them have done qualifications called Ayurved Ratna. It has been found that 75% of them have general practice and none of them provides any specialized practice. About 65% of them agreed that their profession is based on training, 35% it was a family profession. 35% of them belong to the third generation of family practice, 25% are the second generation of practitioners and the remaining are first generation practitioners. It is found that these practitioners do use allopathic methods of treatment along with ayurvedic and unani medicines. This study provides some insights into the social background and nature of practice of the practitioners of indigenous systems of medicine.

An Exploratory Study of Social Dynamics of Women's Health in Adityapur Village of Birbhum District

Author/s: Soman Krishna
Publication source: M.Phil Dissertation, Jawaharlal Nehru University, New Delhi, 1992.
Year of publication: 1992
States coverd: West Bengal
Social geography: Rural, Gender, Family.
Data source: Primary
Type of study: Cross Sectional and Case Reports
Type of private sector: Individual private practitioners
Issues addressed: Utilization of Private Sector

Objectives: The study was conducted in Adityapur village of Birbhum district in West Bengal. The purpose of the study was to understand the family dynamics of women's health and illness and their interaction with the larger social processes.

Methodology: A complete census of the socio-economic status of households was conducted. Simultaneously, information was elicited on the health problems of the population in the age group of15 years and above. This was supplemented by qualitative information on social, economic and political life of people, their health care practices and in-depth exploration and case reports on specific illnesses across various socio-economic strata. The study included 272 households. There were 971 individuals in the specified age group of them, 456 were women.

Findings and conclusions: Despite significant transformation in different aspects of life in the village, the life of women was the least affected. They continued to stay within the boundaries of households, performed labour without actively participating in decision making process. Estimates of annual reported illness of women showed direct differentials in socio-economic categories. Moreover, they were more ill than their men folk in corresponding socio-economic categories and the gap was maximum among the poor. While seeking health care, women were in a much more disadvantageous position compared to their men folk in corresponding socio-economic categories. For illness, they were dependent upon the private practitioners in the village who did not have any medical qualification-and mostly received training as compounders or were self-trained. For a few in the socio-economically 'better-off' sections, even if the

initial consultation was with qualified private practitioners in town, follow-up was inadequate. Women in the poorer section were mostly using government services for immunization and iron supplementation . The reasons for women's restraint in seeking medical treatment were their perceptions of severity, sense of responsibility towards family, relationships within family, its economic conditions and priorities of men. Men's illness was an added factor in the delay in seeking treatment by women. While similar factors were active at the family level too, the more visible among them were the economic status of the family and men's attitude towards women's illness. At the larger level, it was the balance of power within the patrilineal structure of the society that kept women away from quality health care.

A study on Capital Investment Decisions in Private Hospitals in Madras City

Author/s: Sukanya S
Publication source: M.S.Dissertation, Department of Humanities and Social Sciences, I.I.T (Madras) Chennai
Year of publication: 1994
States covered: Tamil Nadu
Social geography: Urban
Data source: Primary
Type of study: Cross sectional survey, primary data.
Type of private sector: For profit, sole proprietorship, partnership and corporate hospitals.
Issues addressed: Investment in medical equipment, government policy, competition strategy, regulation.

Objectives: a) To understand the pattern of investment in medical equipment in private hospitals in the city of Madras (now knows as Chennai). b) To determine the influence of financial and non-financial factors on investment decisions. c) To understand the role of the stakeholders in the decision- making process for investment in medical equipment ,and d) To assess the extent to which private hospitals use capital budgeting techniques in investment evaluations and to find the reasons therefore.

Methodology: This study was confined to "for-profit" hospitals, offering multi specialties in allopathic medicine. These hospitals offered both inpatient and outpatient services. The study excluded all non-profit (sometimes called voluntary) and government hospitals. Purposive sampling method was used in selecting hospitals for survey since there were no reliable data on their size and distribution in the city. Also very few hospitals were expected to participate in this survey. Hence purposive sampling was adopted. Yet the study chose 50 hospitals from different parts of the city. Out of these 50 hospitals, 25 were sole-proprietary, 10 were partnership and the remaining 15 were corporate hospitals. Three of these were public limited and twelve were private limited companies. A structured questionnaire was used to collect data from hospitals. Information was collected regarding the following: Nature, size and form of organization, range of services/ specialties offered, medical and paramedical and other personnel employed, total value (cost) of capital equipment (including imaging, laboratory equipment, surgical equipment, medical and intensive care equipment etc) volume of inpatients and outpatients. Besides, a number of questions seeking insights into decision- making process within hospitals were asked.

Findings and conclusions: Hospitals with a high bed capacity (more than 90) and corporate hospitals invest more on intensive care and therapy equipment and less on laboratory equipment, while the reverse is the case with smaller hospitals. Investment in imaging equipment is the highest and that in laboratory is the lowest. Investment in imaging equipment accounts for 50% of the total investment. All hospitals strongly perceived that non-financial factors significantly influenced their investment decisions. The extent and the order of influence do not vary with ownership pattern and bed-capacity. But the perception of the decision makers on the role of financial factors varied with ownership. Bed capacity did not influence the perception of the decision makers. Corporate hospitals aim at wealth maximization in the long run. Capital budgeting techniques were not used by most hospitals in investment evaluations. It is necessary to introduce medical audit and technology assessment in private hospitals. It is necessary to make a more detailed study of private hospitals investment pattern in capital equipment. This will help policy makers to think of appropriate regulatory mechanisms. Under the existing payment mechanisms, such heavy capital investments are likely to make providers both over-utilize and charge high for the services.

Bangalore Hospitals and the Urban Poor: A Report Card

Author/s: Suresh Balakrishnan and Anjana Iyer
Publication source: Public Affairs Centre, Bangalore
Year of publication: 1997
States covered: Karnataka
Social geography: Urban
Data source: Primary
Type of study: Cross sectional survey study.
Type of private sector: For profit, mission and charity hospitals. Also government hospitals.
Issues addressed: Cost of care, patients' perception of quality of care, consumer issues, regulation.

Objectives: To generate feedback from the urban poor on the quality of hospital services they receive.

Methodology: The field survey covered a sample of 361 citizens drawn from 12,896 economically weaker households scattered across 65 locations in and around Bangalore city. Households with incomes below Rs.3500/- per month were considered for the study. The inpatient sample covered 108 users of government hospitals, 46 users of Municipal Corporation Hospitals, 63 users of Mission and Charity Hospitals, and 63 users of Private Hospitals. The study covered 81 out-patients, of which 47 were from government hospitals, and 34 from Mission and Charity hospitals. The study used a purposive selection of three government and three private hospitals. The following information was collected by the study: Usage profile of different types of heath care facilities, quality of medical care and facilities, cost of services, behaviour of doctors and services, dynamics of speed money, overall satisfaction of patients.

Findings and conclusions: 31% of patients from government hospitals gave clear positive ratings, while only 20% from Corporation hospitals did so. In contrast 57% of the users in Mission and private hospitals gave positive ratings. Only 30% of the users of government and corporation hospitals made the choice primarily for inexpensive treatment. But only 10% of the users of government hospitals reported satisfaction with free treatment. Around 50% of users in government hospitals and 80% of those in corporation hospitals reported spending amounts from Rs.100/- to Rs.800/- for treatment. Costs of treatment in Mission and Private hospitals were much higher. But a significant portion of what the poor

spent was on speed money (un-billed charges). Around 51% of users in government hospitals and 87% of users in corporation hospitals reported paying speed money. In contrast, this figure was 29% in Mission hospitals and 22% in private hospitals. This study observes that this difference in the practice of accepting speed money existed though there was no major difference in the staff salaries across private and public hospitals. About 60% of the patients (from all sectors) reported a waiting time of more than 10 minutes for emergency care. The cleanliness of hospitals was reported to be lowest in the government sector (40%), while it was 73% for mission hospitals and 81% for private hospitals. More than 70% of the patients from Mission hospitals felt that the nursing staff was helpful, while it was only 30% in government and corporation hospitals.

The public hospitals may be cheap but the poor have to pay extra in terms of speed money and still cope with poor quality of services. Such problems are not because of lack of facilities. There is a problem of poor quality of management in tackling grievances of the users, particularly when they are poor. The public hospitals, which are supposed to play this crucial role, have little capacity development support in this vital area. There are no publicly stated standards of performance that public or private hospitals will have to adhere to. A wider awareness of procedures and standards, and mechanisms to make individuals publicly accountable for adherence to procedures and standards, would make a strong impression on the performance of the hospitals.

Preventive Measures against Hospital Aacquired Infections : Awareness and compliance by health care delivery staff with special emphasis on AIDS

Author/s: Suresh R
Publication source: MPH dissertation, Achutha Menon Centre for Health Services Studies, Thiruvananthapuram, Kerala, 1999
Year of publication: 1999
States covered: Kerala
Social geography:
Data source: Primary
Type of study: Cross sectional survey of medical and paramedical staff
Type of private sector: For profit and government hospitals
Issues addressed: Quality of care.

Objectives: (1) To assess the extent of knowledge about AIDS (especially about its spread) among the health service delivery staff,

(2) to observe the actual practice followed by them in preventing HIV infection and (3) to study the reasons for non-adherence to guidelines, if any.

Methodology: The study sample consisted of a total of 379 staff including doctors, nurses, laboratory technicians and nursing assistants working in different hospitals and laboratories in Thiruvananthapuram district. The survey was carried out during January February 1999. Two hospitals and one laboratory, and two blood banks from public sector, and three 75-150 bedded private hospitals and three small private

clinics were selected. The researcher included, in the study, all the staff on duty at the time of the visit. Both direct observations of staff activities and discussion with them provided the data for the study.

Findings and conclusions: The results of this study indicate that there was no significant difference in knowledge between those who were trained and untrained. The knowledge on AIDS control measures as perceived by the individuals was quite good irrespective of whether they received training or not. In actual practice, the correct procedures were not followed. This was more obvious in wards while the procedures were followed to a certain extent in operation theatres. Blood banks maintained a very high standard on control measures but laboratories were not up to the mark. The main obstacle in the way of implementing the AIDS control measures appears to be operational. The main problem seems to lie in the system itself. The system suffers from two flaws: one is money-driven and the other is management-driven. Both will have to be weeded out in order to have successful control of AIDS.

A Study of the State of Medicare Facilities in Agra City (with special reference to Pathology Labs)

Author/s: Tomar Vishal Singh
Publication source: MSW, (Project Report) Agra University, 1993.
Year of publication: 1993
States covered: Uttar Pradesh
Social geography: Urban
Data source: Primary
Type of study: Case Study
Type of private sector: Pathology Labs
Issues addressed: Organization of Private Care (Pathology Labs), Subsides form Government, Referrals to Labs Cost of Services.

Objectives: The objective of the study was to find out the nature of sources provided by pathology labs towards medical care and to list all the health services provided in all the wards of Agra city.

Methodology: It is a case study of 12 selected pathology labs of the city. It is an exploratory study, which sought to look at the conditions of the pathology labs and the kind of services they provide.

Findings and conclusions: The study identified forty-eight pathology labs in the city and of these twelve were studied in depth. The study revealed that no government incentives or subsidies were given to run these labs. On an average the cost of the services provided by these labs is very high. As a result, the poor do not have much access to it. It has been found that the services provided by the labs are generally below average. In almost all laboratories there is a lack of advanced technology. The average income of the lab ranges between Rs 12,500 to Rs 50,000 per month. There has been an increase in the number of patient referrals to these pathology labs in recent times and allopathic doctors refer most of their patients to these labs for routine lab testing. The summary of findings are no subsidy has been offered for setting up pathology labs. There is variation in size, quality and cost of services provided by there labs. These labs do not conduct high technology testing. They are confined to routine tests and X-rays. The average income of the lab ranges from Rs. 12,500 to Rs. 50,000 per month. There has been an increase in the number of patient referrals to these labs.

Report on the Census of Private Medical Institutions in Kerala

Author/s: Unknown
Publication source: Not Known
Year of publication: 1995
States covered: Kerala
Social geography: Rural & Urban
Data source: Primary
Type of study: Cross sectional
Type of private sector: All systems of medical institution.
Issues addressed: Assessment of institutional capacity and workforce.

Objectives: To find out the number of private medical institutions in Kerala state under various systems of medicine, and the strength of medical and para-medical staff employed in these institutions.

Methodology: Details were collected panchayat-wise. Statistical investigators attached to 811 zones for collection of agricultural statistics were entrusted with the field work. Statistical inspectors, Taluk Statistical Officers and District level officers supervised the fieldwork. The investigators were directed to prepare a list of the private medical institutions under their jurisdiction by local inquiry before the commencement of the canvassing of details in the prescribed format.

Findings and conclusions: As on 31 March 1995, there were 12,618 medical institutions in the state. This shows an increase of 31% over 1986. There were 4288 allopathic medical institutions, 4922 ayurvedic institutions, 3118 homoeopathic and 290 other systems of medical institutions in the state. A total of 70,924 beds were available in all institutions, compared to 50,766 beds in 1986 – an increase of 40%. Forty five percent of allopathic institutions had inpatient facility, whereas only 4.7% of ayurvedic institutions, and 1.4% of homoeopathic institutions had inpatient (bed) facilities. The survey revealed that while there were 12,473 doctors and 15.221 paramedical staff in 1986, there were 19,963 doctors and 28,641 paramedical staffs in 1995. Nearly 50% of doctors were employed in allopathic institutions. This was followed by ayurvedic (30%) and Homoeopathic (17%) institutions. In the case of paramedical staff (including ministerial staff), allopathic institutions employed about 88% of the total employed in all institutions. Some of the private institutions provided training facilities to paramedical personnel. The study revealed that 155 institutions had training facilities for nursing, 52 institutions had facilities for laboratory technicians and 19 provided training for family welfare programmes. Three hundred and five units had intensive care units, 83 had scanning facilities, and 64 had echo test facilities and 18 had laser rays treatment facilities - these details were not collected during the 1986 survey. The survey revealed that 13% of 4288 allopathic hospitals had only one doctor. Forty two percent of these had two to four doctors. In the case of ayurvedic and homoeopathic institutions, 53% and 76%, respectively, had one doctor. This means that on average, 46% of all medical institutions had only one doctor. The survey also revealed that about 30% institutions treated less than 1000 patients per year. Only 300 of them treated more than 25000 patients per annum.

Treatment of Tuberculosis by Private General Practitioners in India

Author/s: Uplekar M W, Shepard D S
Publication source: Foundation for Research in Community Health (FRCH), Bombay
Year publication: 1991
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, ISM, For profit
Issues addressed: Quality, Personnel, Knowledge,

Objectives: The study examines the prescribing pattern of private medical doctors practicing in the low socio-economic areas of Bombay.

Methodology: A list of all doctors practicing in a large low-income settlement of Bombay was prepared, and 143 selected from 287 by simple random sampling, which included 79 allopaths and 64 non-allopaths. Doctors were visited individually and provided a slip with a request to write a prescription for a TB patient, including drugs used, dosages and duration.

Findings and conclusions: Among the doctors listed, 22% refused to participate. 102 prescriptions were finally analysed. The study shows a lack of awareness among doctors, who treat TB patients in their own clinics, and about the standard drug regimens for treatment of TB, recommended by national and international agencies. These doctors, most of which were inappropriate and expensive, prescribed eighty different regimens. Many non-allopaths prescribed more expensive regimens, but irrespective of their background and training many doctors used modern chemotherapeutic agents in the treatment of TB.

The Private G P and Leprosy A Study

Author/s: Uplekar M W, Cash R A
Publication source: Foundation for Research in Community Health (FRCH), Bombay, Mumbai
Year of publication: 1991
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Laboratory/investigation, ISM, Unqualified practitioners, For profit
Issues addressed: Quality, Utilisation, Knowledge, Personnel,

Objectives: The study examines the KAP and beliefs about leprosy among private doctors with a view to identifying areas of investigation and interaction for their active cooperation and participation in leprosy control.

Methodology: Three slum areas in Bombay were selected: one with only municipal services, one with only NGO - run services and a third with both. GPs in the third area had been exposed to intensive leprosy training five years previously. Listing of all doctors in the was done and GP's selected by simple random sampling. GPs were interviewed using an open-ended structured questionnaire. Totally 106 GPs were interviewed.

Findings and conclusions: The doctor's responses on types, diagnosis, treatment, and cause of leprosy indicated a gross lack of knowledge and awareness about leprosy. About 20% of doctors from all three areas felt worried about their private practice being adversely affected by treating leprosy patients in their clinics. Doctors in the third area who had received training, were comparable to others, showing that the training effect had diminished over time with regard to knowledge, but the difference was seen in the attitude. The majority of GPs in this area thought it safe not to isolate leprosy cases while on treatment and to let cured patients work in public places. Though most doctors answered questions on diagnosis correctly, they still preferred referring these cases to specialists for treatment.

Tackling TB : The Search for Solutions.

Author/s: Uplekar M W, Sheela Rangan
Publication source: Foundation for Research in Community Health {FRCH}, Pune.
Year of publication: 1996
States covered: Maharashtra
Social geography: Urban & Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not - for profit
Issues addressed: Partnerships, Incentives,

Objectives: This study attempts to understand the nature of the social and operational constraints affecting TB control and identify ways to remedy them. To examine the role of private health providers in control of TB. To determine the areas and possible means of intervention for strengthening TB control.

Methodology: The study was conducted in the rural and urban areas of Pune district, Maharashtra. Data collected was both qualitative and quantitative in nature. Interviews were held of 605 households in 12 villages (in 6 primary health centre areas) and 408 households in urban areas in 42 census blocks, a total of 1013 households. Informal interviews with 299 TB patients in 6 PHCs and 3 urban TB clinics were conducted. Data was collected from the healthcare providers such as the health functionaries at different levels of PHCs and urban clinics and private medical practitioners in selected rural and urban areas. Data was also collected from the supervisory and administrative staff at the district TB center and the state TB directorate. Other sources of data collection included observations, informal interactions and focussed group discussions, case studies with both the users and providers of health services.

Findings and conclusions: People who developed symptoms of TB generally went to private medical practitioners for treatment. The patients were rarely subjected to sputum examination. The emphasis always was on diagnosis based on the x-ray of the chest. Patients of TB preferred the services of private doctors for 2 reasons- less waiting time and convenience of clinic timings. But patients did end up in the public health services either by themselves or referred by private doctors chiefly due to their inability to pay for prolonged care in the private sector. Non-adherence to treatment by patients is known to be a major impediment in controlling TB. The reasons for this were high cost of care, disappearance of most of the troublesome symptoms on partial treatment, and also non-availability of services, low image of public services in people's mind. According to the study, about a third of the patients had incurred debts in order

to bear the expenses of their treatment. Rural patients had spent almost double the amount spent by their urban counter parts. In the private sector, drugs and doctors were the main item of expenditure; in the public sector, travel and prescribed medicines often as a result of shortage of drugs, were the main items of expenditure. In the case of urban patients, spending drastically dropped once they were registered with the public health services. In rural and urban areas, all kinds of private medical practitioners entertained patients of TB. They were oblivious to the detrimental effects of their management practices like x-ray based diagnosis, use of multiple irrational drug regimens, lack of education of patients, lack of patient follow up and total absence of maintenance of any kinds of records. These practices were due to inadequate basic training, lack of continuing education, a casual approach to public health importance of diseases and the influence of promotional tactics of drug companies.

Training for health workers must be made simple, demonstrative, on-site, periodic and cover not only the technical and managerial aspect but also the social and behavioural dimensions to help them tackle effectively the problems of non-adherence to treatment at the field level. PHCs have to be strengthened by providing them with adequate resources, and this will need proper monitoring and surveillance from the levels above. Diminish the DTCs role in curative care: poor functioning of the PHCs make patients from rural areas crowd at the DTC. This has converted the DTC into a TB clinic restricting its functions chiefly to providing curative care. This has affected its importance and essential functions of the DTC like training, support, supervisions, surveillance and monitoring of lower levels. The curative component of the DTC maybe restricted to providing care to problem cases that cannot be tackled at the lower levels.
It is essential for the programme managers to take the initiative to establish communication and seek graded involvement of private doctors and the NGOs into the main programme, since they cater to the TB patients. Depending upon their willingness to cooperate and adhere to the basic tenants of the programme, diagnostic treatment and patient follow-up services maybe made available to the private and voluntary providers. Ways to regulate the harmful practices of private providers should also be monitored. Strengthening peripheral services alone will not suffice if the higher levels continue to be indifferent, contented with modest achievements and reluctant to ensure that the programme operates effectively. It is for them to be sensitive to the need of the people and the programme functionaries, provide moral support, encouragement, and freedom to innovate and rewards for performance. Programme directors should ensure that their programme does not suffer as a result of shifting priorities and that other programmes and services do not deteriorate due to their domination.

Factors Determining Health of Home-Based Women Weavers - A Case Study of Karur

Author/s: Vijaya S
Publication source: Unpublished M.Phil Dissertation, Jawaharlal Nehru University, 1997.
Year of publication: 1997
States covered: Tamil Nadu
Social geography: Rural,
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Private Practitioners; Chemists, Private Hospitals
Issues addressed: Utilization of Private Sector; High Cost of Care.

Objectives: The overall objective of this study was to get an insight into the influence of socio-economic factors on the health of home-based women weavers. As a part of this study, a specific objective sought to study the perceptions of these workers towards health services and its utilization.

Methodology: The study was conducted among women weavers in Karur district in Tamil Nadu. These twenty-five indepth case studies have explored the different aspects of women weavers' lives and work.

Findings and conclusions: With respect to utilization of services, the type of treatment sought is dependent upon the severity of the illness. For minor ailments like fever, headache, stomach ache etc, treatment is through self-medication on the advice of elders. Sometimes tablets advertised on TV and radio such as Anacin, Metacin, Dolopar, Ibuprofen are bought from pharmacists. Sometimes pharmacists are consulted for prescriptions as well. When the illness really interferes with their work and affects their earnings, they go to the government hospital or to the private clinics. However, because of long waiting time in the government hospitals, they prefer private hospitals for treatment. Despite the difficulties and problems with the government hospitals, 70% depend on them largely because they are unable to afford the cost of private health care for each episode of illness. The study reveals that one third of their earnings is spent on food and a major chunk of 15-20% is spent on medical expenses, which include direct and indirect costs. The absence of social security measures such as maternity benefits, sick leave, workmen compensation and medical care, compounds the problem further. This study once again shows the constraints of resorting to private health care for this section of workers.

Diarrhoea in Rural India, A Nationwide Study of Mothers & Practitioners, All India Summary

Author/s: Viswanathan H, Rohde J E
Publication source: Indian Market Research Bureau, UNICEF, New Delhi
Year of publication: 1990
States covered: National
Social geography: Rural
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Nonqualified practitioners, rural doctors,
Issues addressed: Utilisation, Quality, Regulation

Objectives: The study aims to understand and document the range and diversity of KAP regarding diarrhoea across India.

Methodology: There was a two-stage research design : a qualitative exploratory stage followed by a quantitative assessment stage. In the qualitative stage, two villages per representative district from each of the 35 socio-cultural regions of India were selected and two focus group discussions with mothers of children under five per village held. In addition, there were four in-depth interviews with mothers whose children had current diarrhoea, eight depth interviews of health practitioners, including PHC/ICDS frontline workers, and four in-depth interviews among medical retailers per region. In the quantitative stage, by stratified random sampling, there were 144 focus groups with mothers, 61 interviews with mothers of children with diarrhoea, 256 depth interviews with health providers, 136 depth interviews with

retailers, and interviews with 9.927 mothers of under fives in 408 villages. Also 12-15 rural doctors, within 10 km distance of five small towns per state, were purposively selected, and interviewed a total of 266. A salt-to-taste study was done to test if the sodium concentration of fluids prepared by salt-to-taste technique fell into acceptable limits: 20 mothers of children under three per village, from 3-4 villages around three towns each, were selected purposively from three states.

Findings and conclusions: Period prevalence of common illness among under fives was estimated. Mothers appeared to have a casual attitude to normal diarrhoea, though health practitioners had a more cautious approach. Though a majority of mothers had contacted doctors, most of them were unaware of the signs and symptoms of dehydration. The causes of childhood diarrhoea was believed to be related to food, the physical condition of the child, climatic conditions and, to a lesser extent, supernatural forces. Though breast-feeding was continued, and withholding nourishment was not commonly noticed, a considerable number of women reduced quantity and frequency of food given. Education had a strong correlation to both knowledge and practices. 83% had sought help from private practitioners, and only 7.5% from government health centres. Of the 266 rural doctors interviewed, only eight were MBBS, 62% had no medical qualifications, and 61% practiced more than one type of medicine. It was estimated that the number of non-qualified rural medical practitioners at 1 million almost all were solo practitioners located in clinics. Though 60% were aware of ORS, it was used generally secondary to medicines. Only 2% of the recent episodes were prescribed ORS and only 2% of mothers had used ORS for a recent episode, while 17% were aware of it. There was discordance between states with the highest awareness and those with highest usage.

Critical Condition: A Report on Workers in Delhi's Private Hospitals

Author/s: Workers Solidarity
Publication source: New Delhi
Year of publication: 2000
States covered: Delhi
Social geography: Urban
Data source: Primary
Type of study: Case Study
Type of private sector: Corporate Hospitals Trust Hospitals
Issues addressed: Working conditions, health personnel, costs, private hospitals, subsidies

Objectives: This report examines the status of the permanent as well as the contract workers in Delhi's eight large private and charitable hospitals.

Methodology: Data on the wages, and working conditions of the Class IV employees in these hospitals was obtained through interviews. The data also shows the extent of contractualisation of this category of employees and their poor working conditions. Further,the report examines the extent to which these hospitals comply with conditionalities for receiving subsidies

Findings and conclusions: The study reveals that in all these hospitals there is a difference between the wages of permanent workers and the contract wageworkers. In the older thrust hospitals, the proportion of

permanent workers is higher than contract workers. However, in the more recently established ones, the proportion of contract workers is higher. This report gives an insight into the poor working conditions of contracted employees who often work without adequate rest in addition to insecure working conditions. This report shows that none of the 'for profit' and 'non profit' hospitals honour the conditionalities of the government which stipulates that a certain proportion of beds be earmarked for treating poor patients free of cost. This study shows how the large private hospitals cut their costs by engaging employees at low wages and poor working conditions, which will definitely have an adverse impact on the quality of care provided. In addition, the lack of adherence to conditionalities is a serious area of concern, which the government should address.

Behavior of The Private Sector in the Health Services Market of Bombay

Author/s: Yesudian C.A.K
Publication source: Department of Health Services Studies, TISS, Bombay
Year of publication:
States covered: Maharashtra
Social geography: Urban
Data source: Primary
Type of study: Cross Sectional
Type of private sector: Practitioners, Hospitals, Laboratory/investigation, ISM, Unqualified practitioners, For profit, Not- for profit
Issues addressed: Quality, Regulation

Objectives: To study the complex behavior of health services providers in the private sector in terms of different forms of operation., delivery of services, and to assess the existing control mechanisms and policy options available for their regulation.

Methodology: Fifteen key informants were interviewed to obtain the necessary information. The informants held key positions in the health sector. These included hospital administrators, senior clinicians and members of social action groups interested in health sector. Information regarding various aspects such as physical location, disposal of waste, equipment, manpower, medical malpractices, etc was sought from the informants.

Findings and conclusions: The private facilities in Bombay range from sophisticated hospitals to small clinics run in the slum areas by semi-qualified doctors. The types of nursing homes and clinics vary widely in terms of services offered. However, the sector faced sharp criticism from the people and the media. Litigations were filed in the court and a committee was appointed by the court to look in to the matter. The salient features of the committee's report found that the condition of private hospitals was poor. A majority of the respondents said that majority of the hospitals were situated away from the residential locality. However nursing homes and clinics situated in the poor areas were near the residential locality causing nuisance and posing health hazards to the people in the vicinity. According to the respondents waste such as surgical material, bandages, dressing material, placenta, were usually thrown in the public dustbins. Even amputed toes and limbs were found in the bins occasionally. Three major reasons were given justifying the use of modern equipment in the private sector. Firstly there was a lack of improvement of

technology in the public sector hospitals and thus modern technology should be encouraged in the private sector. Secondly, if the modern technology is available to the rich people the poor will get the benefits of the public health system. Thirdly since the private sector is highly competitive, modern technology is necessary to improve its' performance. The people opposing the modern technology were raising questions about the overuse of the diagnosis, high costs of treatment and unethical medical practices and commercialization of the sector. Less than half of the respondents felt that the private facilities had skilled manpower to operate the modern equipment. Almost all the respondents felt that the nursing homes did not have a properly trained staff. Some hospitals and some nursing homes appointed non-allopathic doctors. These doctors did not have the necessary expertise in modern medicine nor were they able to handle emergency situations. There was a shortage of the qualified nurses in the hospitals and nursing homes. All the respondents agreed that the patient care would suffer badly if qualified nurses were not employed. The respondents also emphasized the dangers of the administration of wrong drugs by the nurses. They were highly critical of the private clinics and nursing homes because they employed uneducated staff.

Consultants working for public hospitals admitted their patients to these hospitals. If they did not have particular equipment at his private nursing home or clinic, they used the facility of the public hospital to treat their own patients. In addition, the public hospitals were used by these consultants as means of getting clients who could afford private treatment. Most of the respondents agreed that private practitioners were involved in large-scale malpractices. There was a prevalence of 'cut' practice among the doctors in the city. The cuts were received by the doctors for the referrals to the laboratories made by them. The percentage of such cuts went even to 40% of the fees received by the laboratories or by the specialists. Unnecessary investigations and even surgeries were carried out by the doctors. The other area of the malpractices was false bills and certificates issued by the doctors to their patients. Poor sterilization led to diseases such as Hepatitis-B or even the HIV infection. Many respondents complained about the negligence in the post-operative care. Often intravenous drug administration was carelessly done. The specialists often neglected patients in the general ward. The practitioners in the slum areas did not follow any guidelines regarding the treatment. In recent years, there has been growing pressure to regulate the private sector both from the public and from various organizations. However, the provisions of the BNHRA (1949) have not been implemented properly and there are many loop hole in the act, which need to be checked. Even the high court took notice of bad implementation of the act and directed the formation of an apex committee and three zonal committees to review the act and to suggest changes. The study has concluded that private sector has become a major provider of the health care services. It makes all levels of curative care available to the people across all economic strata. However the services provided by the private sector have not been up to the standard. Medical negligence and medical malpractices have proliferated in the private health sector.

Policy related to the private sector in Bombay should be directed towards two main issues 1) Development of the municipal health services 2) regulation and monitoring of the private health services. Private sector should be given incentives such as tax benefits to start more secondary and tertiary level facilities. Private participation in some of the municipal facilities in the non-poor areas should be encouraged. Strengthening the public facilities would force the private sector to improve its services in the poor areas. Regulatory norms for various aspects such as physical standards, qualified manpower, etc. should be evolved and be made compulsory. A holistic approach to direct and regulate the growth of the private sector in Bombay is much needed.