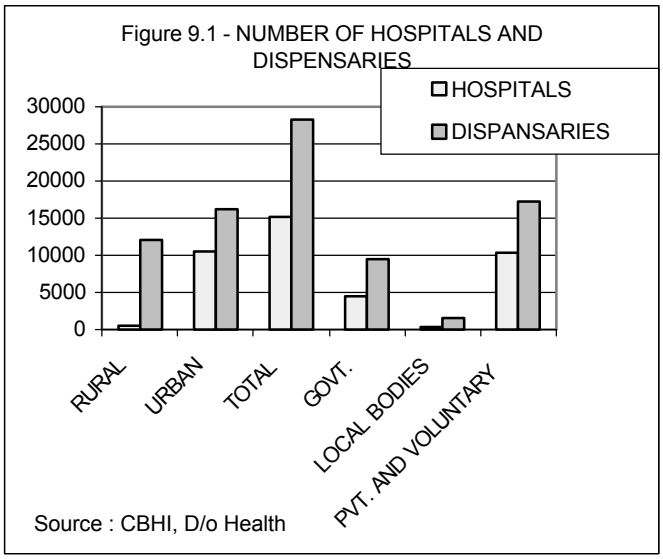
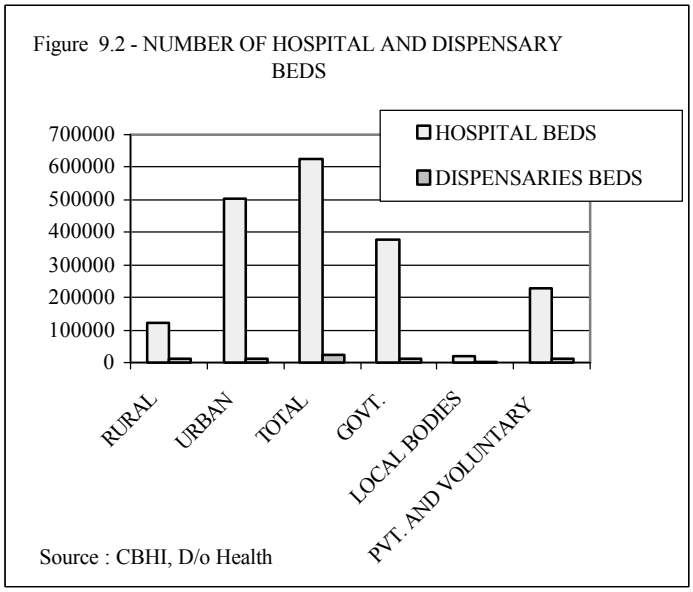
## CHAPTER IX
## PRIVATE PARTICIPATION IN FAMILY WELFARE SERVICES

The private health sector has played a significant role in health service delivery right from the pre-independence days. At the time of independence public-private participation was in the form of government doctors being allowed private practice, an arrangement that continues even today in majority of states. To cope with the lack of medical teachers in the 1950s and 1960s many medical colleges appointed private practitioners as honorary teachers and honorary physician in teaching hospital but the number of such teachers declined with the increasing availability of full-time paid government teachers.

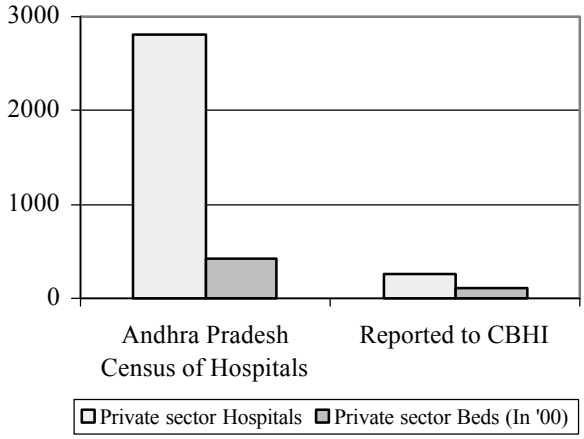



At present, there is no uniform nationwide system of registering either practitioners or institutions providing health care in the private/voluntary sectors nor is there a mechanism for obtaining and analyzing information on health care infrastructure and manpower in these sectors at the district level. During the Ninth Plan a Standing Technical Advisory Committee headed by the Director General of Health Services was set up and the Central was set up and the Central Bureau of Health Intelligence (CBHI) was given the task of compiling data on health care infrastructure and manpower at all levels in the private, voluntary, industrial, governmental and other sectors. So far, very little progress has been reported in this direction. This task should be taken up and completed on a priority basis during the Tenth Plan.




Available data on infrastructure and manpower in the hospitals and dispensaries (excluding PHCs and CHCs) in private and public sector from both rural and urban area computed from CBHI reports is shown in Figure 9.1 & 9.2. While information on the government sector institutions is reliable, data on the private sector is incomplete and is based on information provided by the state medical councils and state governments. Data from Andhra Pradesh indicate that there may

Figure 9.3 - NUMBER OF HOSPITALS AND BEDS IN PRIVATE SECTOR

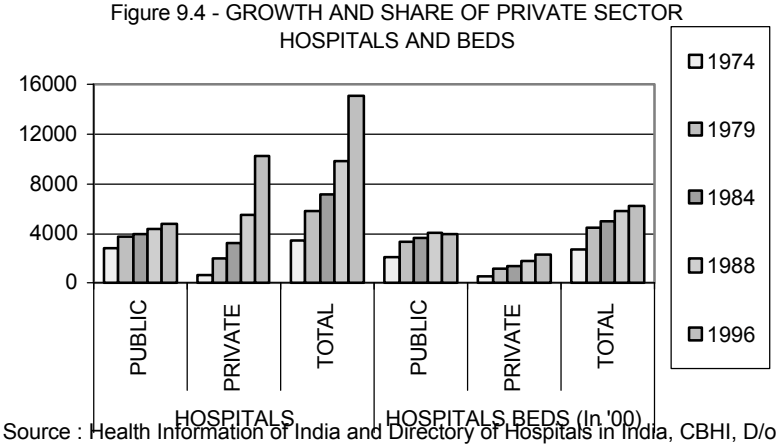



Source: Census 1993, Director of Health Services and the Andhra Pradesh Vaidhya Vidhan Parishad

be massive differences between the data reported by CBHI and the actual census conducted by the state government (Figure 9.3).

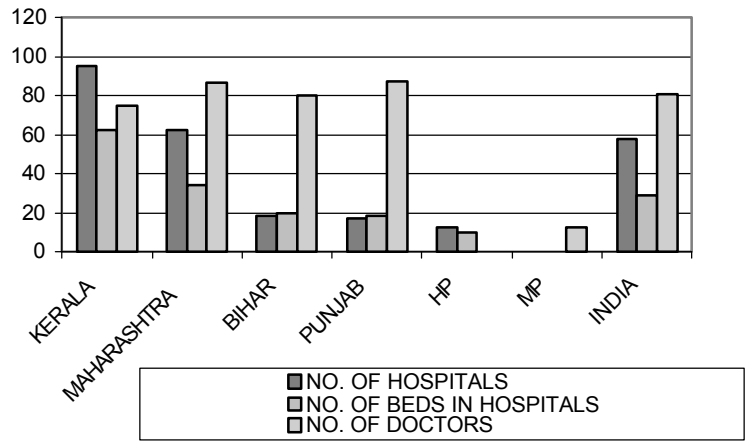
Available data from National Sample Survey Organisation (NSSO) carried out by independent investigators and studies funded by the Department of Health suggest that a majority of the physicians in both the modern system of medicine and ISM&H work in the private sector. The growth and share of private sector hospitals and beds over the years is shown in Figure 9.4. The growth and share of government sector hospitals and beds appear low because the CBHI does not include the PHCs (there are 22975 PHCs; majority have six beds) and CHCs (2985 each with atleast 30 beds) under hospitals and dispensaries. While there has been a substantial increase in the number of hospitals under the private sector during the 1990s, the rise in the number of beds has been modest (Figure 9.4).

Figure 9.4 - GROWTH AND SHARE OF PRIVATE SECTOR HOSPITALS AND BEDS




Source : Health Information of India and Directory of Hospitals in India, CBHI, D/o Health

Figure 9.5 - NUMBER OF HOSPITALS AND BEDS



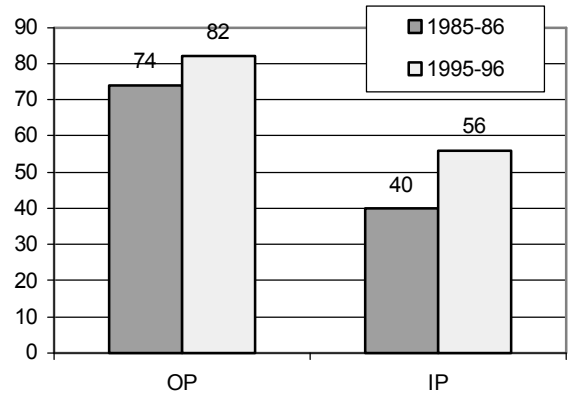

SOURCE : M. Uplekar, A. George, 1995 & 1996

Currently private sector health services range from

those provided by large corporate hospitals, smaller hospitals/ nursing homes to clinics/ dispensaries run by qualified practitioners and services provided by unqualified persons. A majority of the private sector hospitals are small establishments; 85 per cent of them have less than 25 beds; average bed strength of 10 beds. Private tertiary care institutions providing specialty and super-specialty care account for only 1 to 2 per cent of the total number of institutions while corporate hospitals constitute less than 1 per cent. There are wide inter-state differences in the distribution of private sector hospitals and beds. The private sector prefers to set up facilities in the more prosperous districts/states (Figure 9.5). The private sector accounts for 82 per cent of all outpatient visits and 52 per cent of hospitalisation at the all-India level (Figure 9.6), with no significant variations across income group.

A majority of government and private sector hospitals and beds are located in urban areas. Qualified and registered private sector doctors or private sector institutions are not readily available in remote rural and tribal areas because people do not have ability to pay and there is a lack of social infrastructure. Thus, the population in these areas where health care needs are the greatest have very poor access to functioning government health services or private facilities. In spite of the abundant supply of registered physicians in modern system of medicine and ISM&H, unqualified persons still provide health care especially to the poorer segments of the population living in urban slums, remote rural and tribal areas.

Figure 9.6 - SHARE OF PRIVATE SECTOR OF OUTPATIENT & INPATIENT CARE




SOURCE : NATIONAL SAMPLE SURVEY, 42nd & 52nd ROUND

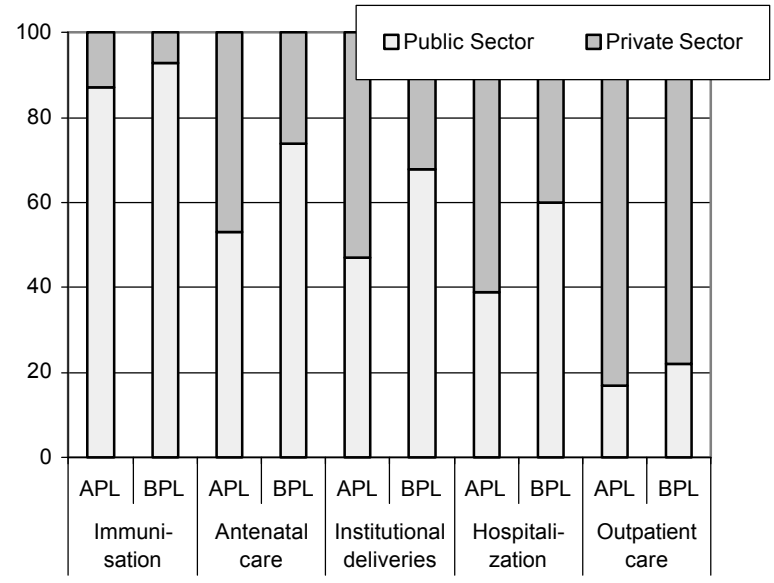
Majority of private sector institutions are single doctor dispensaries with very little infrastructure or paramedical support. They provide symptomatic treatment for common ailments and because they are conveniently located and easily accessible, patients from even below the poverty line utilize them and pay for their services. These private practitioners do not have access to updated standard protocols for the management of common ailments; hence the quality of care they provide is often sub-optimal. Some private hospitals have also been found to be using inappropriate, unnecessary and expensive diagnostic tests and therapeutic procedures as well as inappropriate and unethical treatment practices. Other problems reported in private sector include use of unqualified service providers, overuse of diagnostic and therapeutic measures leading to exorbitant costs. There is no attempt to screen patients for complications and refer them to the appropriate level of care, rationalise drug use or contain the costs of treatment. These problems have to be addressed through appropriate interventions, including CME to

update the knowledge and skills of practitioners, evolving and implementing standards for quality of care and operationalisation of an appropriate grievance redressal mechanism.

Data from 52nd round of NSSO 1995-96, National Family Health Survey (NFHS–2 and a National Council of Applied Economic Research (NCAER) study shows that there were distinct patterns for the utilisation of out patient and inpatient services.

A majority of the population both from below and from above the poverty line, approached the private sector for outpatient curative care for minor ailments. However, when it came to obtaining immunization or antenatal care, most people, irrespective of their income status went to government institutions. For inpatient care for all ailments 60 per cent of the below poverty line (BPL) families tend to use government hospitals and while an equal proportion of above poverty line (APL) families prefer private hospitals (Figure 9.7).

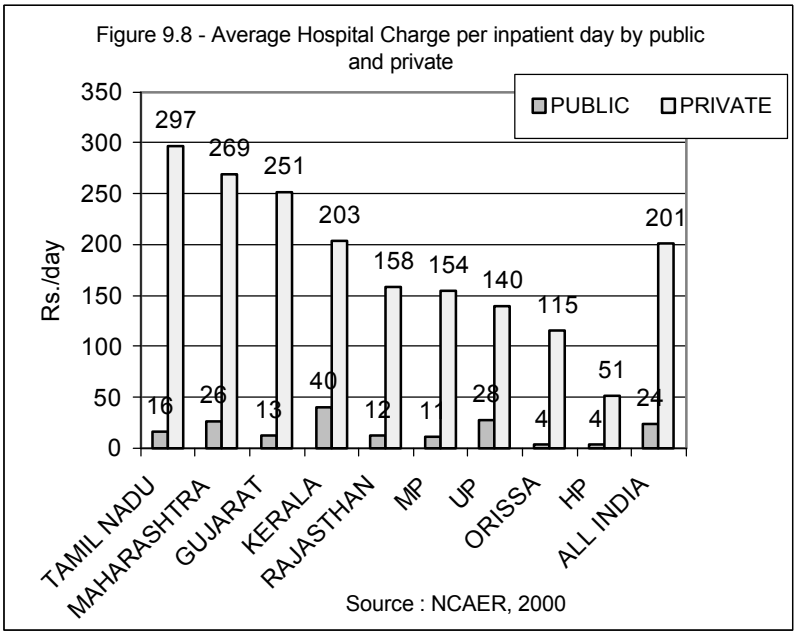
Figure 9.7 - Public and private sector shares in service Delivery for those Above and Below Poverty Line. All India, 1995-96




Source: NCAER, 2000

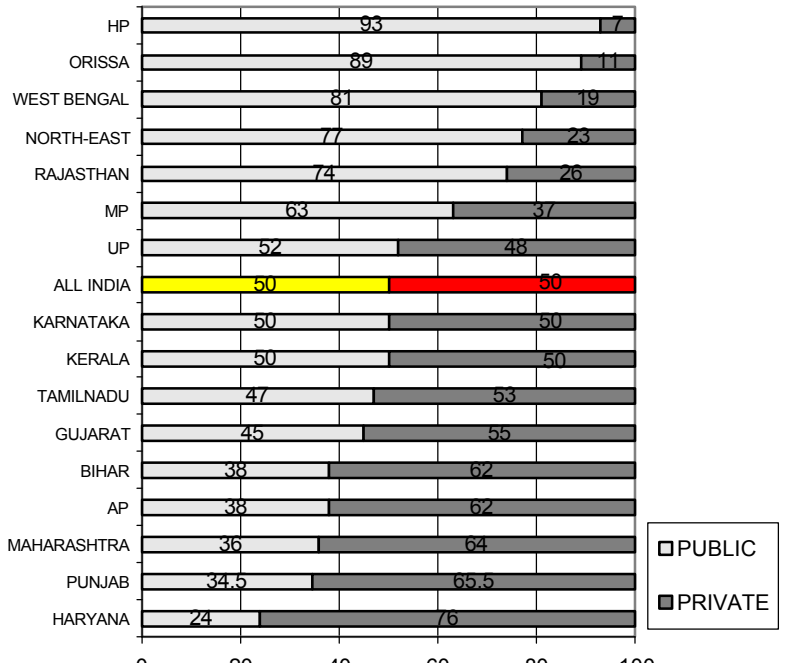
The average cost of hospital stay per day in government hospitals is low and there are no significant inter-state variations in this respect. The cost of inpatient treatment in the private sector is much higher (Figure 9.8). This has been cited as the major reason for poorer sections seeking inpatient care in government institutions. There are wide inter-state variations in the cost of private sector inpatient care, ranging from Rs.51 per day in Himachal Pradesh to Rs. 297 in Tamil Nadu. Part of the difference might be due to differences in diagnostic and therapeutic services available in these hospitals.

Figure 9.8 - Average Hospital Charge per inpatient day by public and private




Source : NCAER, 2000

Figure 9.9 - Distribution of inpatients between Public and Private by State




Source : NCAER, 2000

The state-wise distribution of in-patients in public and private hospitals is given in Figure 9.9. In spite of good government sector infrastrucure, a majority of patients in Punjab, Haryana, and Maharashtra went to private hospitals. In Himachal Pradesh, Rajasthan, West Bengal and the north eastern states a majority of the patients seek admission in government hospitals in spite of inadequacies in infrastructure. In Bihar, poor government infrastructure might be responsible for over 60 per cent of patients seeking admission in private hospitals. Obviously the choice between public and private sector facilities depends on several factors including the functional status of government infrastructure, the price differential between the public and private sector, the person's ability to pay and the preferences of the community.

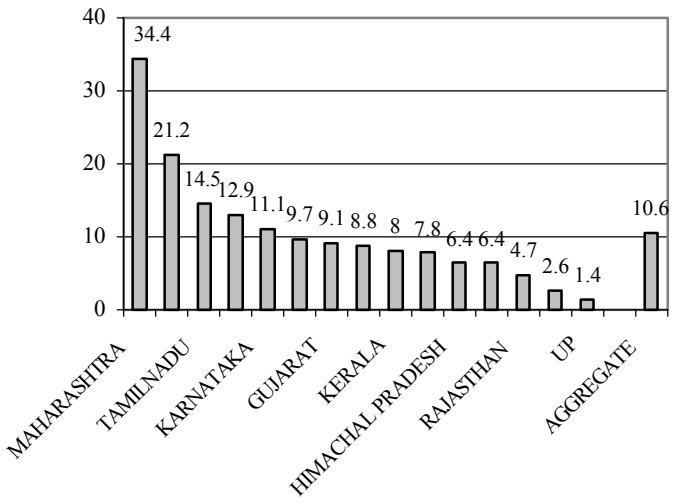
## NGO and voluntary sector

Apart from purely private providers of health care, the NGO and the voluntary sector have been providing health care services to the community. It is estimated that more than 7000 voluntary agencies are involved in health-related activities. Wide inter-state differentials exists in the coverage of villages by NGOs (Figure-9.10). NGOs providing a variety of services are relatively few, unevenly distributed across and within states and have limited area of operation. Some implement government programmes of the departments of family welfare and health. Others run integrated or basic health services programme or provide special care/ rehabilitation to people suffering from some specific diseases e.g., leprosy patients. Health care activities are also carried out by agencies like the Red Cross, Industrial establishments, Lion's Club, Helpage India etc.

The problems faced by NGOs in delivery of health care include:

- limited interaction between the government and NGOs;
- limited financial management, technical and managerial capacity of the NGO;
- paucity of funds; and
- delays in transfer of funds from the government.

Figure-9.10 - PERCENTAGE OF VILLAGES WITH NGOs, 1994




SOURCE : AJAY MAHAL, 1999

**Ongoing efforts in public - private collaboration in health care**

There have been very few studies documenting the geographic distribution of outpatient/inpatient facilities, existing collaborations between private sector and public sector institutions and the role each of them play in outpatient/ inpatient health care in different districts/states. The Ninth Plan had recommended that these shouldl be documented and the information utilised for decentralized district -based planning. This has not yet been done and may have to be taken up on a priority basis during the Tenth Plan. During the Ninth Plan period, the centre as well as the states initiated a wide variety of public- private collaborations. Some of the ongoing collaborations include:

- majority of states government doctors are allowed private practice. The doctor benefits monetarily; patients also gain because they are being treated by doctors who had updated their knowledge and skills through in-service training;
- contractual appointment of the health care personnel and hiring of private practitioners for providing services in the PHCs have been attempted in order to fill the gaps. However, the response has been poor; these practitioners need orientation training to fulfill the role expected of PHC doctors;
- part time hiring of general practitioners and specialists to visit and provide health care in PHCs/CHCs in under-served areas. Limited success has been reported in this experiment;
- state and central governments, PSUs reimburse cost of medical care provided by recognized private health care providers/institutions;
- involving NGOs/private sector practitioners in the national programmes e.g. utilizing the services of NGOs, and not for not for profit institutions in the leprosy eradication programme, involvement of private

practitioners/institutions in the blindness control programme and the HIV/AIDS control programme;

- private sector individuals/institutions/industry e.g. Tata Steel Company provide health care to the population living in a defined area;
- private super-specialty, tertiary/secondary care hospitals are given land, water and electricity etc. at a concessional rate and permission for duty-free import of equipment with the understanding that they should provide in-patient/out-patient services to poor patients free of charge. The experience and this has been varied with several problems being reported;
- private practitioners provide information for disease surveillance in some districts in Kerala.

The impact of all these on improving access to and affordability of health care and on the coverage under disease control programmes have not yet been evaluated. However, available information suggest that these schemes succeeded in places where there were well-defined committed groups and clear-cut memorandums of understanding (MOUs) and the MOUs were implemented properly. During the Tenth Plan attempts should be made to improve area-specific public-private collaborations, taking into account the health care needs of the population, the presence of each of these sectors, their strengths and weaknesses. Feasibility of GIS mapping to identify under-served areas and providing suitable incentives to encourage private sector to set health facilities in such areas should be explored. Monitoring the implementation of these programmes along with the PRIs and local leaders should go a long way in ensuring accountability.

Since private practitioners provide most of the curative care in the country, it is important that they are given ready access to updated protocols for the management of common illnesses and current regimens used in the national disease control programmes and family welfare programme. They must be allowed to have easily access to drugs, devices, and vaccines provided through the national programmes. If this is done, private practitioners can play an important role in increasing the coverage as well as containing the cost of care.

One essential pre-requisite for improving the quality of care should be the development of standard treatment protocols appropriate for each level of care. The medical colleges and research institutions should play a key role in preparing these documents quickly. The existing government institutions at each level should take up the responsibility of testing these management protocols, suggest necessary modifications. These protocols should be made available to all practitioners through CME programme for skill upgradation and training. Available IT tools have to be fully utilised by CME programmes to ensure easy access to the materials for updating skills and knowledge. Online consultation services between paraprofessionals and doctors and among doctors may improve the quality of services and reduce the problem of transporting patients to hospitals for diagnosis and advice regarding management. Government institutions in the states which should be 'model institutions' should evolve appropriate norms for the cost of care at different levels of institutions and monitor both the cost and the quality of care in their

own institutions,. The district health officials should monitor the performance of both public and the private sector institutions in the district and assist them in improving the quality of care and containing cost of care.

Over 80 per cent of the practitioners of modern medicine and a higher proportion of the ISM&H practitioners work in the private sector. It is estimated that while the private sector provides more than three-fourths of all curative health care services, its contribution to maternal and child health and family planning services is less than one-third. The major limitations in private sector participation include:

- the focus till now has been mainly on curative services ;
- the quality of services is often variable; and
- the poorer sections of population cannot afford to pay for these services.

Under the RCH programme, several initiatives were taken to improve collaboration between the public and private sectors in providing family welfare services to the poorer sections, especially in the under-served areas. Efforts were made to increase the involvement of private medical practitioners in RCH care by providing them orientation training and ensuring that they have ready access to contraceptives, drugs and vaccines free of cost. These efforts should be augmented during the Tenth Plan. The private sector has immense potential for improving the coverage and quality of RCH services. The challenge is to find ways to optimally utilise this potential.

During the Tenth Plan appropriate policy initiatives should be taken to define the role of government, private and voluntary sectors in meeting the growing health care needs of the population at an affordable cost. The public sector should develop institutional capability at the central, state and local levels to:

- evolve policies and strategies for providing healthcare and monitor their implementation;
- increase public-private-voluntary sector collaborations to meet the health care needs of the poor and vulnerable segments of population;
- draw up standards for appropriate quality and cost of care and establish accreditation systems for individuals/institutions;
- monitor and enforce regulations and contractual obligations;
- promote excellence and ethics among professionals, identify and punish professional misconduct;
- set up an appropriate and speedy grievance redressal mechanism.

**Role Of NGOs/Voluntary Organisations In The Family Welfare Programme**

The National Population Policy 2000 envisages increasing role of NGOs/voluntary organisations in building up awareness about and advocacy for RCH interventions and also in improving community participation. Until recently, only a small number of NGOs were getting funding from the

Department of Family Welfare, because a majority of them did not have adequate technical knowledge and the skills required. In an attempt to increase NGOs participation, the Department involved several well-established NGOs such as the Family Planning Association of India and Voluntary Health Association of India in selecting, training, assisting and monitoring of smaller, field-level NGOs for carrying out the following functions:

- advocacy for maternal child health interventions;
- promotion of small healthy family.
- improving community participation.
- counselling and motivating adolescents to delay the age at marriage, young couples to delay first pregnancy and couples with two children to limit their families by the use of appropriate contraceptive methods.
- act as a link between the community and health care providers.

Currently, the Department of Family Welfare funds 97 mother NGOs(larger NGOs looking after smaller ones) covering 412 districts and over 800 NGOs. These NGOs cover all districts in ten states. However, states with high fertility and mortality rates still have a large number of districts without any NGO presence.The state governments have also been trying to involve NGOs in providing services, or by adopting a PHC. The results have been mixed; these experiments need to be carefully monitored. The Department of Family Welfare has also proposed that the NGOs who have adequate expertise and experience may participate in RCH service delivery.

During the Tenth Plan, NGOs should have a major role in promoting community participation in the following areas:

- gender sensitivity and advocacy regarding providing adequate care for the girl child;
- baby-friendly hospital initiatives and promotion of exclusive breast-feeding for six months; advocacy for the introduction of semi-solids at the right time;
- social marketing of contraceptives, ensuring easy availability of ORS/social marketing of ORS;
- sensitising the community regarding the adverse consequences of sex determination and sex selective abortions.

**Monitoring of the activities of the NGOs**

The interventions undertaken by the NGOs should be independently assessed at the end of the project period. Funding of the NGOs should be dependent upon mid-term evaluation on specific bench-marks. Efforts should be made to improve networking between the NGOs, State district administration as well as Panchayati Raj institutions. The NGO movement should be provided with institutional support through establishment of Regional Resource Centres either in government institutions or in voluntary organizations. Appropriate training modules as well as IEC material for use by the NGOs should be developed. The district and state officials as well as Mother NGOs should assist the Field NGOs in preparation of model projects.

In order to strengthen the NGO Movement the Department should improve institutional support, provide financial flexibility, ensure technical skill/knowledge building. A stringent system of monitoring and evaluation should be followed. There should be:

- broadening the panel of upraising agencies to ensure timely submission of expenditure and utilization of the grants provided;
- random audit by a Chartered Accountant;
- involvement of Regional Directors, District Medical Officers and Civil Surgeons in fixing and coordinating the activities of the NGOs with that of government sector.

**Role of Industries and Other Organisations**

Governmental efforts alone should not be sufficient to achieve the desired goals of the family welfare programme. The NDC committee on population had recommended that the corporate sector should make Family Welfare an integral part of their planning and it should get priority in its budget. Labour employed in organised sector is easier to reach because of the concentration of workers in defined work areas. They are better informed, better educated and have exposure to process of organisation and modernisation. Support to Family Welfare must be seen as a vital factor for improvement in productivity, which is intimately linked to improved health and happiness of workers, the economic stability of the family and reduction in the burden of anxiety to which the head of a large sized family is subjected to. The organised industrial sector provides health/family welfare services to about 14 per cent of the country's population. Industry can improve acceptance of family welfare services by educating, motivating workers and improving access to services. Industries which provide health care to their personnel and their families can extend these facilities to the people living in the vicinity of factories, especially when they are located in under-served semi-urban and rural areas. They may take up an area-specific approach to improve services available in a block by adopting it. Smaller industries could form a cooperative group for providing health and family welfare services in collaboration with the government. Managerial and other skills available in industry can be made available to improve the efficiency of the government infrastructure. The marketing skills of industry may be useful in improving the IEC and motivation activities and in social marketing.

The labour force in the organised and unorganised sector and their families require coverage in order to achieve rapid improvement in health and demographic indices. Trade unions can expand their role to address the health care needs of workers and their families. The Ministry of labour covers the working population both in the corporate sector as well as non-corporate sector. The 5 major organizations under the Ministry of labour provide population and health education to working class. These are Employees State Insurance Corporations (ESIC), Directorate General of Employment Training (DGET), Central Board of Workers Education (CBWE), Vocational Training Institute and DG Labour Welfare.

The ESIC provides population education and family welfare services as an integral part of the health services through their120 hospitals and 512 Employees Centres. These organisations cover a population of 6.6 million workforce. ESIC also gives awards to the best performing States in respect of family welfare activities.

The DGET have developed modules on population education in their training programmes. These modules are displayed in the training Institutes. The Central Board of Workers education provides population education through its various training curriculum for overall skill development of workers and the vocational training provides this education through partnership training course as part of social safety net.

A number of industrial concerns and public sector undertakings namely TISCO, Escorts, Sail, UPASI (United Planters association of South India), L&T (Larsen and Tubro) etc. have done excellent work in Family Welfare, extending services not only to their own employees and their families but to the neighbourhood communities where the industry is located. FICCI had developed a scheme for voluntary expenditure by industry on social welfare programmes. According to the scheme, new industries to be set up should be required to earmark certain amount of the project cost to be spent on Education and Health care etc. Profit making units will have to spend 1 or 2 per cent of their net profit for social welfare programmes. AITUC had been able to persuade the workers and now the plant hospital of Bhilai Steel Plant is covering the total population of its command area.

During the Tenth Plan, attempts should be made to enhance the quality and coverage of family welfare services through the involvement and participation of the organised and unorganised sectors of industry, agriculture and labour representatives. The problem-solving approach of the corporate sector can be used to improve the operational efficiency of the health care services.

**Family Welfare services in organised sector**

Some Family Welfare Projects have been undertaken in the unorganised and semi-organised sectors in different areas in the country with UNFPA assistance. These ongoing projects relate to (I) The Working Women in Tamil Nadu; (ii) Plantation Workers in West Bengal; (iii) Tribal Population in Gujarat; (iv) Beedi Workers in UP, MP, Orissa and West Bengal and (v) Milk Producers in Gujarat.

There are 3 major areas in collaboration between the government and industry are likely to yield good dividends in terms of improved acceptance of the Family Welfare Programme These are:

- There are certain competencies and expertise in the industry which are additional to the abilities of Government, which can be used maximally for complementing Government's role in implementation of national and social programmes like Health & Family Welfare.

- In respect of marketing skills industry is in a position to carry the message of social programmes to the masses. Industries should, with the existing established Health Family Welfare infrastructure, adopt an area specific approach like adoption of a District. Smaller industries could form a group for providing health & family welfare services in collaboration with the government, so that managerial and other skills available in the industry can be made available through the government infrastructure for such work.

- Industry is already providing Health & Family Welfare Services to its employees at plant level but if the families of the workers and the population in the vicinity of the industry are provided similar services, the industry should gain in improvement of health status of the population and also cooperation of the population in welfare activities. The organised sectors of trade and industry can substantially improve acceptance of the Family Welfare services by educating and motivating the workers employed in the public and private sectors. NGO and Voluntary Organisations are also being increasingly involved to make the acceptance of the small family norm a people's movement. For this purpose a Tripartite National Committee on Family Welfare Planning consisting of representatives from the Industry, Trade Union Organisations and the Government Departments was constituted under the Chairmanship of the Union Minister of Health and Family Welfare in October, 1991. The Committee meets at least once every year.

During the Tenth Plan attempts should be made to enhance the quality and coverage of Family Welfare services through involvement and participation of organised and unorganised sectors of industry, agriculture, trade/labour , agriculture workers and labour representatives.

Managerial capability of corporate bodies should be utilized to improving efficiency in the field of social marketing of contraceptives. The problem solving approach of corporate sector can be of use in improving operational efficiency of the health care infrastructure. Possibilities may be explored to deliver health care services in unserved urban area through public, private and/or joint sector as the case may be.

The increasing involvement of Industry should be encouraged during the Tenth Plan. The confederation of Indian Industries (CII) and Federation of Indian Chambers of Commerce and Industry (FICCI) have already expressed interest in developing such a partnership with the public sector.