The Private Sector in Public Health: A Solution for the Urban Poor?

Centre for Community Medicine
All India Institute of Medical Sciences, New Delhi

10 May, 2008

Venue:
Board Room, The Constitution Club,
Vithal Bhai Patel House,
Rafi Marg, New Delhi – 110 001

WORKSHOP REPORT
Objectives

The Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi, organized a workshop on 10 May, 2008 on *The Private Sector in Public Health: A Solution for the Urban Poor?* The main objectives of the workshop were:

- To present the findings of a study in India as part of a multi-country research project on “Health System Reform and Ethics in South and Southeast Asia”.
- To discuss specific policy implications of the findings of the study in light of the proposed National Urban Health Mission.

Background

The research project, which was initiated on 1 April 2004 and concluded on 31 March 2008, has been carried out as a collaboration between All Institute of Medical Sciences, New Delhi (India), University of Aarhus (Denmark), Naresuan University (Thailand) and Gadjah Mada University (Indonesia), and funded by the Danida Council for Development Research (FFU), Denmark. The project has studied the role of the private health care sector in poor urban neighbourhoods in Delhi and Bhubaneswar in India, Yogyakarta in Indonesia and Phitsanulok in Thailand.

The main objective of the project has been to identify feasible regulatory mechanisms and strategies for the private healthcare sector to improve quality of care, including for the urban poor, in these countries. Very few studies exist on this topic, and it was observed that the situation varies considerably from country to country, and within countries. The study was designed as a comparative case-study including four cities where a ‘case’ was constituted by a local, micro-level healthcare system (i.e., a poor neighbourhood).

In each site, four sub-studies were undertaken to:

- understand the ethical and legal frameworks of private practice,
- understand the clinical work and decision-making of private practitioners,
- understand decision-making at household level in poor neighbourhoods,
- assess the economic impact of ill-health and treatment-related practices at the household level.

The project, therefore, supplements an understanding of the patients’ perspectives with an understanding of the private practitioners’ and drug vendors’ perspectives. The policy implications of the findings of this study are significant. Policy briefs have been drafted keeping the different scenarios in Delhi and Bhubaneswar in mind. The policy implications were discussed in the light of the proposed National Urban Health Mission in the India at the workshop reported here.

Presentations

Dr C. S. Pandav welcomed the participants and stressed the importance of establishing an iterative feedback mechanism between research, policy and society.
He highlighted a number of social factors that influence patients’ choice of treatment and said that the social sciences are required to understand such factors based on use of qualitative methods and also pointed out that the focus for the project had been private for profit practitioners in low-income urban areas and at the primary health care level. The powerpoint presentation is provided in Annex 3.

Dr Jens Seeberg then gave a brief introduction to the project, including its objectives, organisation and involved partners. He outlined the stress on qualitative methodology, including repeated long-term observation visits in private practitioners’ clinics. Also, GIS, survey and desk studies had been included. The slides from the introduction to the project are available in Annex 4.

Dr Nupur Barua, on behalf of the research team at AIIMS, then presented the findings of the Delhi study. Dr Barua’s presentation examined the reasons for the overwhelming preference of the urban poor for the individual untrained private practitioners in a slum in Delhi. Expenditure on use of government facilities was found to be more expensive than these practitioners. The modalities of treatment inside these clinics and competence constructions of different practitioners by the care seekers were discussed in a context where the patient struggles to survive and the practitioner thrives by providing health services in situations in which they are most needed. It was observed that qualified medical practitioners were unwilling to set up clinics inside the slum area and that, therefore, there was no genuine alternative to non-qualified practitioners. Therefore, the raids that had been conducted against these so-called ‘quacks’, were unlikely to have a beneficial public health effect. In addition, the study found that there was not much difference in prescription practices of the qualified and non-qualified practitioners as observed during first consultation, and that in neither case were rational drug use practiced. Rather, ensuring good business by meeting the patients’ expectations for quick symptomatic relief was in focus for both groups of practitioners. The slides from this presentation are provided in Annex 5.

The health services available to the poor in Bhubaneswar are markedly different from conditions in Delhi, as was pointed out in Dr Jens Seeberg’s presentation. He pointed to the rapid growth of the city, which he divided into centre and periphery, with most health care facilities concentrated in the centre and higher proportions of poor people in the periphery. He then showed that the social dynamics of the small slum studied worked to divide the poor and the very poor in terms of access to drinking water and stressed the need for health insurance and community risk sharing mechanisms that could function in spite of such inequities among the poor. He pointed out that the urban poor in the sampled slum area in fact had access to government facilities, and that these constituted the most used treatment option. However, in many cases, chemist shops functioned as de facto primary health care institutions.

The structure and behaviour of the pharmaceutical industry and its interface with providers and the medical representatives as mediators between the producers, service providers and consumers was discussed. The study showed that fierce competition between pharmaceutical companies led to use of aggressive marketing strategies that was implemented by medical representatives. The key role of the chemists, how they do not have trained pharmacists and how they act as informal agents for the pharmaceutical industry was delineated. Here, the pharmaceutical companies have found effective ways of exploiting the weaknesses of the public sector for their own
benefit, thereby ultimately increasing use of unnecessary drugs and out-of-pocket expenditures. Dr. Seeberg ended by saying that NUHM clearly represents a major leap forward for urban public health and suggested a number of discussion points that could be taken up at the round table discussion. This presentation is available in Annex 6.

Rundtable Discussion

Chair: Dr. G.C. Chaturvedi, IAS, Additional Secretary & Mission Director, NRHM, Government of India
Co-Chair: Mr. Suyash Prakash, IAS, Mission Director, Delhi State Health Mission, Government of India

Mr Suyash Prakash initiated the discussion by taking up the issue of the anti-quackery bill which had been drafted. He suggested a definition of a quack as a person who practiced outside his/her area of expertise, irrespective of which system the person might be trained under. He discussed the need to integrate AYUSH (Ayurveda, Yoga, Unani, Siddha & Homeopathy) but also warned that some conditions had to be treated by allopathic medicine. He mentioned the resistance within different practitioners of AYUSH to mutual recognition of qualifications. He said that the less qualified practitioners in Delhi could be permitted to practice under certain preconditions, including that they only use over-the-counter drugs and that they refer serious cases to qualified practitioners or hospitals. He ended his discussion by stating that the survival of the quacks in Delhi is due to the lack of public primary health care.

Dr G. C. Chaturvedi pointed out that the mega-cities of India also differ markedly in terms of development of the health sector, with Delhi currently having the most difficult scenario. He pointed to the experience from National Rural Health Mission that AYUSH and RMPs (Registered Medical Practitioners) needed to be integrated into the health system for the simple reason that in many places there were none better qualified. He said that perhaps with 3 months training courses they would be able to improve prescription practices and pointed to a current project with RMPs in Bihar. Standard treatment guidelines and protocols should be adopted, but so far these had met huge resistance from the medical fraternity, even if (or because) they could largely improve the services provided by paramedical staff, and that, perhaps, IT could play a role in this context with certain computer programmes being seemingly able to diagnose symptoms with 80% accuracy. He pointed to the huge complexity involved in the urban health system, that also included bureaucratic constrains and that necessitated a very flexible national framework within which different cities had to develop their own models. He mentioned the role of the USHA (Urban Social Health Activist) in the proposed NUHM in the planning and management of health care services in slums and the issue of the number households that should be served by one USHA as a case in point. Dr Chaturvedi then requested from the participants of the workshop that they should provide specific recommendations that could be fed directly into the draft document of the NUHM. He specifically mentioned the complex issues related to the introduction of health insurance that may be linked up with urban health centres and, to the extent necessary, also with private providers and hospitals. The role of insurance companies introduces another level of complexity and
posed new challenges, and the suggestion to introduce smart cards seemed to involve very substantial and potentially insurmountable problems in terms of implementation.

Dr William Aldis, in his comments, strongly discouraged the use of software instead of face-to-face clinical assessment, which he felt would continue to be required irrespective of the quality of software, because the clinical investigation cannot be disregarded in diagnosis. In terms of ensuring increased access to health care, substantial advances could be achieved if the focus was changed from formal qualifications to actual skills, thereby softening the unproductive dichotomy between qualified and non-qualified practitioners. Treatment guidelines and protocols had been proved to be very useful in the context of disease classification and often can help less qualified staff to substantially improve the quality of performance when introduced along with appropriate training. He cited the case of training drug vendors in Nigeria for diarrhoea management in this regard. He stressed that such treatment protocols had to be introduced as part of medical training and that, in his experience, professors at medical colleges appreciated such protocols when their scientific basis was appropriately explained to them. This, he suggested, could over a period of time help overcome the resistance to such protocols among the medical doctors.

Dr. Manoj Kar stressed the heterogeneity of populations in slum areas and intra-slum variations and cited Panschilnagar slum in Bhopal as an example. He also stressed the importance of engaging Urban Local Bodies (ULBs) for improvement of slum areas. While standard treatment guidelines could facilitate better treatment protocols, the important issue would be to determine if they were actually used.

Dr Monica Rana stressed the importance of focussing on existing infrastructure. She suggested that primary health care should be a state level responsibility and recounting her experiences in the field, stressed that secondary care was more appropriate for PPP. In this context, she mentioned that PPP should be initiated only if the partner was found to be credible. She also stressed that community mobilizers were very important and suggested health staff should not be programme linked.

Dr. Sanjay Kumar discussed the need for “regulatory mechanisms to ‘check the quacks’” and suggested that government doctors should visit slum areas.

Dr Ritu Priya Mehrotra raised the important issue of similar (symptomatic) treatment being provided by both qualified and non-qualified practitioners, whereas in fact government facilities offered a medically much more appropriate treatment based on rational drug use, which, however, did not meet the consumers’ expectations of quick symptomatic relief. She suggested that a realistic category of various providers should be made and stressed the importance of focussing on who is actually providing specific services in specific contexts. She pointed out the need to increase the efficiency of existing services rather than creating new PUHCs. Irrational practices, in particular, inappropriate use of injections by the private practitioners, need to be publicized. She also discussed the issue of NGO selection for PPP and in this regard stressed on the importance of verification of credibility of NGOs, pointing to recent experiences in NGO involvement (and devolvement) in the AIDS field.

Dr. Jens Seeberg then synthesized some of the issues that had been ranged. Taking as a point of the departure the issue of patient satisfaction, he noted that this was not
necessarily as benign as it seemed, since the standard cocktail of drugs being given to
ensure this satisfaction - which often includes antibiotics and steroids as had been
observed systematically in the study – may have harmful effects both because it is
often unnecessary and hence represents a superfluous out-of-pocket expense for
patients to the benefit of practitioners, chemists and industry and because it hides
serious symptoms and delays appropriate diagnosis of these cases, sometimes with
long-term consequences involving development of chronic conditions. He suggested
that the fact that qualified and non-qualified practitioners in Delhi were observed to
deliver the same type of treatment was a result of stiff competition and that consumers,
if they did not get quick symptomatic relief (i.e., were ‘satisfied’) would simply move
to the next practitioner who would meet the expectations in order to get the business.
The implication is, that this unregulated competition does not lead non-qualified
practitioners to perform as well as qualified practitioners, but to the contrary that
qualified practitioners often may have to perform as poorly (as measured by standards
of rational drug use) as non-qualified practitioners in order for their business to
survive. In order to address this conflict between patient satisfaction and rational drug
use, he suggested the need to explore whether the introduction of simple treatment
protocols that would lead to better prescription practices could be linked to the
proposed insurance system. The implication is that - irrespective of their formal
qualifications but with a necessary minimum of clinical training - only private
practitioners who implement a determined set of treatment protocols would be
accredited for inclusion in the proposed health insurance scheme. Since inclusion in
this scheme ought to be good for business, they would hereby get a financial incentive
to adopt more rational prescription practices. In order for this to gradually change
public expectations, a critical mass of practitioners should be enrolled, and behaviour
change communication about what constitutes a good consultation should be
developed. While the discussion was primarily taking the Delhi scenario into account,
a similar strategy could be adopted with chemists in Bhubaneswar and with non-
qualified practitioners in the periphery of the city. Finally, he concluded by suggesting
that the level of PPP could focus more on professional and corporate organisations,
thereby promoting self-regulation of their respective practitioners and companies
(including in the large pharmaceutical industry in India), and he noted that the
roundtable discussion had not been able to address the important problem of
household units being suggested as the primary unit for proposed risk pooling and
insurance mechanisms in NUHM, thereby risking to leave out the many homeless.

Dr G. C. Chaturvedi concluded the meeting by thanking for the input that had been
suggested and by inviting written comments and suggestions for the group in the
one/month window that still existed for this purpose.
# ANNEX 1: Programme

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<tr>
<th>Time</th>
<th>Activity</th>
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<tr>
<td>10.00 - 10.10</td>
<td>Welcome: Dr. C. S. Pandav</td>
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<tr>
<td>10.10 - 10.15</td>
<td>Introduction of participants</td>
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<td>10.15-10.30</td>
<td>Health System Reform &amp; Ethics&lt;br&gt;Project overview: Dr. Jens Seeberg</td>
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<td>10.30 - 11.00</td>
<td>Tea/Coffee Break</td>
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<td>11.00 - 11.30</td>
<td>Private Practitioners in Poor Urban Neighbourhoods in Delhi and Bhubaneswar&lt;br&gt;Dr. C.S.Pandav, Dr. Nupur Barua and Dr. Jens Seeberg</td>
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<td>11.30 - 13.30</td>
<td>Roundtable: Recommendations for the proposed National Urban Health Mission&lt;br&gt;Chair: Dr. G.C. Chaturvedi, IAS, Additional Secretary &amp; Mission Director, NRHM, GOI&lt;br&gt;Co-Chair: Mr. Suyash Prakash, IAS, Mission Director, Delhi State Health Mission, GOI&lt;br&gt;Facilitators: Dr. C.S. Pandav, CCM, AIIMS, New Delhi &amp; Dr. Jens Seeberg, University of Aarhus, Denmark</td>
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<td>13.30 - 14.30</td>
<td>Lunch</td>
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ANNEX 2: List of Participants

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15) Dr. Nupur Barua  
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16) Dr. Vivek Gupta  
Senior Resident  
Centre for Community Medicine, All India Institute of Medical Sciences  
Ansari Nagar, New Delhi – 110 049

17) Mr. Joe C. Mathew,  
Business Standard
ANNEX 3: Welcome by Dr. C. S. Pandav. Presentation Slides.
Moral:
So oft in theological wars, The disputants, I ween,
Rail on in utter ignorance, Of what each other mean,
And prate about an Elephant, Not one of them has seen!

ITERATIVE LOOP
Research, Policy, Programme

PROGRAMME (Society)

POLICY (Statesman)

RESEARCH (Science)

From Evidence to Policy to Program

Health Problem/Issue (Assessment)

Etiology or Causation

Synthesis & Implementation of Program

Efficiency

Policy Process

Factors Influencing Choice of Treatment

- Shared Exclusion
- Struggle to Survive
- Security
  - Tenure
  - Livelihood
- “Wanting to get back to work”
- Perception of severity of condition
  - “Chota Daktar” / “Bada Daktar”
- Choice of Treatment
  - “Angrezi Dawai” / “Desi Dawai”
I keep six honest serving men  
They taught me all I knew  
Their names are What, Why, and When  
And How, and Where and Who  

- Rudyard Kipling

ANNEX 4: Project overview by Dr. Jens Seeberg.
Presentation slides
Health System Reform & Ethics: Private Practitioners in Poor Urban Neighbourhoods in India, Indonesia and Thailand

Objectives

- **Main Objective**
  - To identify feasible regulatory mechanisms and strategies to address iatrogenic health problems in the private healthcare sector, with focus on poor neighbourhoods in selected urban centres in India, Indonesia and Thailand.

- **Specific Objectives**
  - To identify systematic constraints in private practice with negative consequences for healthcare, in particular pertaining to treatable infectious diseases;
  - To determine constraints for practitioners’ and poor patients’ treatment-related decision-making;
  - To identify similarities and differences through comparison of data and findings across centres within and outside the project and describe their health policy implications.

Project overview

- **Project period (India):** 01.04.2004-31.03.2008
- **Four substudies**
  - Health Systems Ethics Among Private Practitioners: Ethnographic Sub-Study
  - Family-Level Decision-Making About Treatment: Interview Sub-Study
  - Household Survey: Health Economics Sub-Study
  - Existing Regulatory Mechanisms, Including Ethical Codes And Legislation With Direct Implications For General Private Practitioners: Desk Study

Emphasis on qualitative methodology and analysis

- Approx. 2 years of qualitative data collection among poor households in selected slum areas of Delhi and Bhubaneswar AND among both qualified and non-qualified (i.e. without formal qualifications) private practitioners
- Methods comprised both repeated series of observations in clinical settings and households and repeated qualitative interviewing with practitioners, patients and relatives concerning treatment practices and health seeking behaviour
- Focus on issues of HOW and WHY practitioners and poor families do what they do in pursuing health-related goals
- Qualitative data subjected to rigorous coding and thematic anthropological analysis leading to understanding of distinct patterns of social practices
- Combined with quantitative health economics survey (HOW MANY, HOW MUCH) (panel data, approx 200 households in each city, interviewed 1-4 times)

Findings in context og NUHM

- International workshop held in Thailand in June 07 to discuss findings and policy implications, resulting in specific policy recommendations for each country, including India
- Substantial overlap between these recommendations and the NUHM as discussed in the draft mission document
- Fortunate timing of completion of project and shaping of the NUHM
- Opportunity to compare very different scenarios in two cities from Category A (Delhi) and Category C (Bhubaneswar) as defined in draft NUHM document

Partners

- All India Institute of Medical Sciences, India
- ICCIDD, India
- Naresuan University, Thailand
- Gadjah Mada University, Indonesia
- University of Aarhus, Denmark
- Funding agency: Danida Research Council (Danish Ministry of Foreign Affairs)
ANNEX 5: Private Practitioners in Poor Urban Neighbourhoods in Delhi by Dr. C.S. Pandav and Dr. Nupur Barua. Presentation Slides
Health System Reform & Ethics:
Private Practitioners in a Poor Urban Neighbourhood in Delhi

Chandrakant S. Pandav
Nupur Barua
Centre for Community Medicine
All India Institute of Medical Sciences
New Delhi

Delhi: An overview
- Capital city, one of the richest regions in the country
- Population: > 13 million (MoHFW/UHRC, 2008)
- Highest population density in country
  9224/sq.km vs. all India ~ 324/sq.km (Planning Commission, 2008)
- Large populations (64.5% of total) live in JJ clusters, slums & unauthorized colonies (Planning Commission, 2008)
- Large scale migration

The study
- Study site
  - *Jhuggi-jhopdi* cluster, S. Delhi
  - Population size: ~ 15000
    - majority migrants, wage earners
      (Bihar, UP, Rajasthan, Haryana, Andhra Pradesh)
- Selection of respondents
  - 207 households: household expenditure study
  - 25 households: in-depth case studies
  - 25 private practitioners: 18 located in slum, 7 outside

The study
- Methodology
  - Unstructured, & later semi-structured interviews
  - Observations: clinic interactions
  - Exit interviews of patients, when possible
  - Questionnaires: household economy substudy
- Constraints
  - Raids on nonqualified PPs
  - Media reports
  - Demolition of slums across Delhi

Part 1
- Substudy on:
  - Health Seeking Behaviour

Midan Puri: Living on the edge
- Among observed households, at least 1 member from a HH visits a practitioner once every 5 days
- > 4/5 visit individual private practitioners in jhuggi
- Of 471 observed clinical interactions:
  - Majority: Fever, cold, diarrhea, injury, asthma, cough, body pain, weakness, TB, skin problems, mental problems, BP, sexually-transmitted diseases
  - Abortions, mental health problems, HIV/AIDS
  - Repeated surgery after abortions
**Avg. expenditure on healthcare**

- **Average expenditure of visiting private clinic < visiting public hospital**

**The patients**

- **Who are they?**
  - Patients requiring immediate ‘action’, basic care
  - Some chronic patients

- **What do they want?**
  - Situational assessment of best treatment: both cost & quality
  - **Return to work as quickly as possible**

**Preferred point of treatment**

- **92% cite private practitioner in jhuggi as 1st preference**
- **Of 207 households, only 2 cases (registered during 18m fieldwork) visited government dispensary located 4 km from settlement**
- **Selection informed by contacts, previous experience**
- **Overwhelming preference for biomedical treatment**
  - medicines/ injections
  - **Level of certification – not a deterrent**

**‘Hierarchy of competencies’**

- **Collective categorization**
  - **Bada doktar**
  - **Chota doktar**
- **Individual/local categorization**
  - **Local hierarchies**
  - **Specific illness**
  - **Previous experience**

- **‘Big’ hospitals/ pr. Clinics**
- **Clinics in slum**
- **Chemist shops**

**Part 2**

**Substudy on:**

**Private Practitioners**

**The dispensation of cure?**
A snapshot…

- **Proliferation of clinics** (Jun 04 - 17, Dec 07 - 27 clinics)
- **Practice:**
  - Location: NQPPs – inside, QPPs – outside
  - 3/4* do not possess formal degrees
  - 80% ‘trained’ outside Delhi
- **Associations & networks**
- **Patient load:** 10-35
- **Consultation time:** 3-5 min
- **Payment system**

The practice

- **Focus:** ‘What the patient wants’
- **Medicines**
  - Approx. 40% cases medicines given sans examination
  - Mostly: Antibiotics, injections with corticosteroids, tranquilizers
- **Explained in detail**
  - Loose medicines: according to colour, size, shape
  - Medicines in foil: *pudiyas* according to doses
  - Descriptions: “for heart”, “for bones”, “for tension”, “for sadness”, “for B.P.”
  - Doses given according to the amount of money in hand
- **Home visits**

Case 1: Antibiotic for infant diarrhea?

- 4 women carrying infants, all suffering from diarrhea
- PP takes a thermometer dipped in a small bowl of murky water & inserts into the mouth of the infant for 1 min, & places it back in the bowl. He gives the same drugs to all: 6 tablets of Norflox TZ informing tablets be ground, mixed with water & fed to the infant twice a day.
- When researcher questions him about soiled water & infection, the PP says ‘there is no such concept [of infection] among children’.
- He does not possess any degrees, says that his knowledge of ‘ill health and treatment’ (*bimari aur illaj*) is ‘inherited’
- When questioned that Norfloxacin is not recommended for children, the PP asks the researcher to leave his clinic.

Case 2: Injection use

- 21 cases of fever observed in consecutive sessions
- In all cases, PP uses a disposable injection, & reuses the same on the next patient
- **The hype over disposable injections is being generated by the media & the ‘English company’ (manufacturers) to increase sales…**
  - Was there AIDS when they had no plastic injections? In the olden days nobody died of using the same injection…so it is a myth….
- 11 patients present in the clinic agree with the PP: Angrez doctors use these tools to excuse them from charging more fees

Comparing NQPP & QPP

- Comparisons of QPPs & NQPPs for fevers (undetermined), diarrhea, dengue, vaginal discharge, TB
- **Similar prescriptive behaviour of QPP & NQPP on 1st consultation**

Qualified vs. Non-qualified

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<tr>
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<th>QPP</th>
<th>NQPP</th>
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<tr>
<td><strong>Time spent</strong></td>
<td>Less</td>
<td>More</td>
</tr>
<tr>
<td><strong>Questions asked</strong></td>
<td>Less</td>
<td>More</td>
</tr>
<tr>
<td><strong>Physical examination</strong></td>
<td>Less</td>
<td>More</td>
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<tr>
<td><strong>Evaluation of competence</strong></td>
<td>Higher</td>
<td>Lower</td>
</tr>
<tr>
<td><strong>Referrals to govt. hospitals</strong></td>
<td>Less</td>
<td>More</td>
</tr>
<tr>
<td><strong>Referrals to pvt. hospitals</strong></td>
<td>More</td>
<td>Less</td>
</tr>
<tr>
<td><strong>Diff. in what they know &amp; what they do</strong></td>
<td>More</td>
<td>Less</td>
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How do they diagnose?

- Experience: chemists, helpers in doctors’ clinics & hospitals/nursing homes
- Press releases: current public health issues
- Short-term diplomas in ISM: basic information on human physiology

Aspirations

- Eager to participate in workshops & national programmes
- Research team was constantly asked, towards the end of the project, whether they would assist in training them, acquiring higher skills

Robin Hoods of the mohalla

- Only ones ‘on the spot’ to provide basic primary care
- Seem able to discern complicated cases
- Seem highly aware of health epidemics & media campaigns
- Appear to treat patients with dignity, respect
- Piecemeal medication options: boon for daily-wage earners
- Police raids not the answer – local networks relay information, PPs helped to ‘close down’, continue practice from next day...

Raids: before…and after

- Before
  - Signboards pulled down
  - Fake registration numbers hidden
- After...
  - People want to assign blame, and it is better to target doctors like us… even big doctors make mistakes…how many times is that reported in the media?
  - There is no point holding a knife….having great degrees….the main thing is are they here?

THUS,
The main issues - NQPPs

- No legal accountability, few complaints registered
- Referrals
  1. To diagnostic facilities
  2. Government-run hospitals
  3. To other (qualified) doctors
- Similar prescriptive behaviour of QPP & NQPP on 1st consultation

THUS,
The main issues- Households

- (Perceived) quality of care drives selection, use of facility
- Competence in public facilities considered higher
  - BUT
    - ‘We don’t get what we need [in public facilities]’
- Long distances, waiting time, registration procedures, disrespect, loss of wages prefer “better care” by NQPPs than “no care” in public facility
Way forward?

Responsive public sector  Responsible private sector

But HOW…?

Outlawing has not made them, and will not make them go away

What then should we as a collective do?
ANNEX 6: Private Practitioners in Poor Urban Neighbourhoods in Bhubaneswar by Dr. Jens Seeberg. Presentation slides
The Private Sector in Public Health: A Solution for the Urban Poor?

Workshop held at Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi, 10 May 2008

Jens Seeberg, PhD, University of Aarhus, Denmark

- Samir Diabagh
- Sasmita Sahani
- Amita Kanungo
- Rosalina Baral
- Braj Das
- Jens Seeberg

Urban growth in Bhubaneswar

- 17-fold increase in population of Bhubaneswar over 50 yrs
- Rapid growth creates different city-scapes with different populations, facilities and opportunities
  - Key census 2001 data:
    - Population = 648,032
    - Scheduled Castes = 8%
    - Scheduled Tribes = 4.5%
    - Illiteracy = 22%

Actual and projected growth, Bhubaneswar

![Graph showing actual and projected growth, Bhubaneswar](image)

Lakh popul Year(Source: Census of India)

<table>
<thead>
<tr>
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<tbody>
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<td>1961</td>
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<td>1971</td>
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<tr>
<td>1981</td>
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<td>1991</td>
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<td>2001</td>
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<tr>
<td>2011</td>
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</tbody>
</table>

Substudy on health-related behaviour in Bhubaneswar: Belam Basti

- 520 households
- Population is >2000, mostly SC and ST
- Predominantly Hindu, approx. 30 Muslim and <10 Christian households
- Distinct ST communities include Kondh and Pradhan
- 388 families w BPL cards
- The average HH size of 4.3 persons
Health problems in Beluam basti

<table>
<thead>
<tr>
<th>Symptom Description</th>
<th>Corp. (55)</th>
<th>Govt. (17)</th>
<th>Drug store (27)</th>
<th>Private (14)</th>
<th>Unknown (11)</th>
<th>Total (114)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Cold</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Pain in back</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Cough</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sore in mouth</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Wrist/sweat/febrile</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Stomach worm inf</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Vaginal Discharge</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Jaundice</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tumor in Stomach</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>114</td>
<td>34</td>
<td>48</td>
<td>6</td>
<td>9</td>
<td>3</td>
</tr>
</tbody>
</table>

NB: One patient may have >1 symptom. Number of patients = 72 (March)

First point of entry for treatment

Out-of-pocket health expenditure by category of provider

Mean INR spent pr. household w. illness in one month (Rnd. 4, n=72)

Comparison of treatment seeking

Comparison of spending pr. visit
Relevance for NUHM?

- The NUHM policies for community risk pooling and health insurance of utmost importance
- Need to pilot test insurance across different categories of cities
- The organisational unit of Mahila Arogya Samiti seems very appropriate, especially if local social structure is taken into account
- Importance of evaluation at the disaggregate level (i.e. individual sahai in BBSR case)
- How to promote equity across the social divides that exist even among the poor and very poor?
- Rights and the notion of biocitizenship

Connections influencing Dr P.’s practice

A Case Story from Bhubaneswar

- Dr. P., a medical specialist, has been working in public health system >15 yrs
- Various districts, mostly rural, for 10 yrs. in BBSR
- Married to doctor (specialist)
- Not satisfied with career path, placed in Gov. dispensary despite substantial experience
- Also works in Capital hospital once a week
- Runs private practice out of residence
- Has recently set up new clinic in peripheral area of Bhubaneswar
- His new clinic involves a substantial financial burden in terms of bank loan for construction
- Sees around 20 MRs every day
- Dr. P. has been working in public health system >15 yrs.
- Various districts, mostly rural, for 10 yrs. in BBSR.
- Married to doctor (specialist).
- Not satisfied with career path, placed in Gov. dispensary despite substantial experience.
- Also works in Capital hospital once a week.
- Runs private practice out of residence.
- Has recently set up new clinic in peripheral area of Bhubaneswar.
- His new clinic involves a substantial financial burden in terms of bank loan for construction.
- Sees around 20 MRs every day.

Implications

- Dual govt–pvt practice is common and affects out-of-pocket expenditures for the poor
- Patients’ reasons for accepting the referral and additional costs include:
  - Better timings
  - Less waiting time
  - Shorter distance
  - Experienced increase in quality of services
  - Perceived increase in quality of drugs
- New drugs are introduced through trial-and-error procedure, and pushed via the periphery.
- But: Pt. dissatisfaction → Doctor shopping → No feedback about efficacy and adverse effects

Local (and) Pharma industry

- 290 drugs on State essential drugs list
- 30 drugs earmarked for local small-scale industry production
- The locally produced drugs delivered to the government are considered of low quality by chemists and private practitioners and are generally not available in the market
- Policy managed by Industry Department, not Health Department (conflict of interests)

Implications for NUHM

- Public health problem that drug sales constitutes the ‘engine of the machine’
- Issue of NUHM accreditation of PPs and enrollment in insurance scheme may need to take the conflict of interest in this dual practice into account
- CME in the hands of the industry – an issue for NUHM?
- How to address the role of the chemist shops as de facto main primary health care institutions and monitoring link between practitioners and industry – is that a public health problem?
Level of Public–Private partnerships

› Necessary to engage with private sector because of its dominance as a service provider in India
› Experiences with PPPs are largely case-based and focusing on clinical practice
› Is there a need to engage in PPP at a higher level, engaging with the pharmaceutical industry to have it clean up its own act and promote self-regulation?

Some discussion points

› NUHM clearly represents major leap forward for urban public health
› Possible discussion points
  - Pilot-testing of insurance in different categories of cities, taking social structure into account
  - Coverage of HIV/AIDS
  - Household as unit for insurance (vs. biocitizenship)
  - Monitoring insurance impact on practitioners w. dual practice
  - Strengthening of CME at all levels (partnership w. IMA and others)
  - Initiating national level PPPs
  - Moving from drugs and other pharma products as the organizing principle for service delivery to health as the organizing principle?

Thank you for your attention
ANNEX 7: Research Brief

HEALTH SYSTEM REFORM AND ETHICS: PRIVATE PRACTITIONERS IN INDIA, INDONESIA AND THAILAND

A MULTI-DISPLINARY, COMPARATIVE STUDY

2004 - 2008

A COLLABORATIVE PROJECT BETWEEN

CENTRE FOR COMMUNITY MEDICINE & ICCIDD*
ALL INDIA INSTITUTE OF MEDICAL SCIENCES
NEW DELHI
UNIVERSITY OF AARHUS, DENMARK

www.hum.au.dk/etno/hsre

* Indian Coalition for Control of Iodine Deficiency Disorders (ICCIDD), Room no. 28, Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi – 110 029.
1. **OBJECTIVES OF THE STUDY**

The main objective of this collaborative study has been to:

1.1] Identify feasible regulatory mechanisms and strategies to address iatrogenic health problems in the private healthcare sector, with a focus on poor neighbourhoods in selected urban centres in India (Delhi and Bhubaneswar), Indonesia and Thailand.

1.2] Specifically, the project has aimed to:
   1.2.1] Identify systematic constraints in private practice with negative consequences for healthcare; and
   1.2.2] Determine constraints for practitioners’ and poor patients’ treatment-related decision-making.

2. **SUB-STUDIES**

The project supplements an understanding of the private practitioners’ and drug vendors’ perspectives with an understanding of the patients’ perspectives. The study has consisted of 4 sub-studies, which have complemented each other in order to give a detailed and multi-faceted understanding of the local health systems under study:

2.1] Existing regulatory mechanisms, including ethical codes and legislation with direct implications for general private practitioners: desk study
2.2] Health systems ethics among private practitioners: ethnographic sub-study
2.3] Family level treatment decision making: interview sub-study
2.4] Household survey: health economics sub-study

3. **COLLABORATING PARTNERS & FUNDING**

The research project has been carried out in collaboration with the University of Aarhus (Denmark), All India Institute of Medical Sciences (India), Naresuan University (Thailand) and Gadjah Mada University (Indonesia). Field work has been carried out in Delhi and Bhubaneshwar in India, Yogyakarta in Indonesia and Phitsanulok in Thailand.

The project is primarily funded by the Danida Council for Development Research (FFU), Denmark. The financial resources of the project are shared by the participating institutions with a major contribution from Danida.
4. The India Study

4.1] DELHI

Midan Puri, a slum settlement in Vasant Vihar in south Delhi has been the site for this research.¹ The population size of the settlement is estimated to be around 25,000.

<table>
<thead>
<tr>
<th>Private practitioners</th>
<th>25</th>
<th>Households</th>
<th>207</th>
</tr>
</thead>
<tbody>
<tr>
<td>All private practitioners in the settlement were contacted personally for inclusion in the study, irrespective of type of medicine practised.</td>
<td></td>
<td>200 households for the health economics survey, randomly selected</td>
<td></td>
</tr>
<tr>
<td>A total of 25 practitioners have been studied (17 practitioners from inside, and 8 practitioners from outside, the settlement).</td>
<td></td>
<td>25 households as case studies (for sub-study 3), 18 from health economics study &amp; 7 from exit interviews in clinics.</td>
<td></td>
</tr>
</tbody>
</table>

Households

- 92% cite private practitioner in the jhuggi as the first preference for treatment
- More than 80% visit individual private practitioners
- Of 207 households, only 2 cases from 2 households (registered during 18 months of fieldwork) visited government dispensary in Ber Sarai, located 4 km from settlement
- Average expenditure on first consultation:
  - Government facility: Rs 68
  - Qualified private practitioner: Rs 82
  - Nonqualified private practitioner: Rs 35

  When expenditure is computed on the basis of costs incurred on consultation fee, medicines and travel, there is not much difference in expenditure on public and private medical care, while cost of visiting a government facility is almost double of what it costs to visit a local practitioner in the neighborhood.

Private Practitioners

- Only ones on the spot to provide primary care to the inhabitants of the slum
- Proliferation of clinics inside slum:
  - June 2004 = 17 clinics, Dec 2007 = 27 clinics
- 25 out of 27 practitioners do not possess formal degrees in any system of medicine; 26 out of 27 dispense allopathic drugs
- Active associations of these practitioners
- Networks with diagnostic facilities

¹ The name of the settlement has been changed to retain anonymity of the study area, based on a decision taken by the Steering Committee of the project.
Majority ‘trained’ outside Delhi, certificates from West Bengal; Certificates indicating ‘Registered Medical Practitioner’ displayed in 11 clinics
Police raids not a deterrent; pay-offs through local networks, and clinics continue to function from next day onwards
Similar prescriptive behaviour noted between qualified and non-qualified practitioners during first consultation

4.2] BHUBANESHWAR

Bhubaneswar, the capital of Orissa, with a population of 6,57,000, has a very dramatic growth rate, and bastis (slum settlements) are scattered all over the city. Beluam Basti was selected as the research site. The basti has 482 households and a population of approx. 2,100 people. The difference between the two sites is marked, but both may be said to be typical scenarios in urban India.

<table>
<thead>
<tr>
<th>Private practitioners</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practitioners were recruited on the basis of utilisation pattern among the inhabitants in the settlement</td>
<td></td>
</tr>
<tr>
<td>No practitioners with formal qualifications practices inside the settlement.</td>
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</tbody>
</table>

Households

<table>
<thead>
<tr>
<th>Households</th>
<th>229</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 households for the health economics survey, randomly selected</td>
<td></td>
</tr>
<tr>
<td>29 households as case studies (for sub-study 3) based on purposeful sampling (incidence of illness during data collection)</td>
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</tbody>
</table>

Of 188 households in the fourth round of the health survey, 50% had used the private sector and 40% the government sector as point of first entry.

The private sector was dominated by chemists and drug vendors, accounting for 32% of the total.

Access to the government sector was almost entirely limited to one small facility (police hospital).

Average expenditure on first consultation:
- Government facility : Rs. 12
- Private practitioner : Rs. 45
- Chemist/drug vendor : Rs. 79
- Unknown : Rs. 33

Substantial difference in expenditure on public and private medical care. However, it is important to note that the Government facility in this study generally sent patients to certain private drug stores to buy medication; hence, the boundary between the categories may be blurred in practice.

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2 The name of the settlement has been changed to retain anonymity of the study area, based on a decision taken by the Steering Committee of the project.
Private Practitioners

- A couple of traditional healers and one Ayurvedic practitioner provided services inside the basti.
- Medically qualified private practitioners consulted were generally medical specialists, seen at a late stage or in perceived serious cases, if the required funds could be mobilised.
- The main provider of primary health care to the urban poor are drug vendors and chemists, who often engage in diagnosis and replacement of prescription drugs.
- The pharmaceutical industry plays a huge role in influencing the prescription and dispensing patterns of chemists and medical doctors through networking systems, intensive monitoring of prescription practices and individual outlets, combined with packages of attractive gifts to the most profitable doctors and chemists.
- Government facilities are primarily available in the centre of the city; in the fast growing periphery, the poor are to a larger degree left to practitioners without formal qualifications.

5. The Next Step

- Recommendations were discussed at a research-to-policy workshop in June 2007. These are being further developed and will be included in policy briefs for the proposed National Urban Health Mission.
- It is planned to present the findings of the research project from Delhi and Bhubaneswar and discuss policy implications during a meeting with officials from the Ministry and selected researchers active in the area of urban health on 10 May, 2008 organised by the All India Institute of Medical Sciences, New Delhi.