How to develop a pro-poor private health sector in urban India?

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Introduction
India has the second-largest population in the world. But it is estimated that more than 290 million people in India live below the poverty line. While the urban population has nearly quadrupled over the past fifty years, one in three persons lives in abject poverty, in slums, squatter settlements, construction sites and on pavements in urban areas. The growth rate of the population living in slums, vis-à-vis the total urban population growth in the decade 1991-2001, has been summarized as a 2-3-4-5 syndrome: pointing to the annual growth rate of India’s population at 2 percent, of urban India at 3 percent, of mega cities at 4 percent and of the growth of populations living in slums at 5 percent (EHP 2003).

Primary health care is largely absent in urban centres. The public sector provision of health care, albeit extensive and free, is fragmented and suffers from a lack of accountability, a poorly operating referral system, weak stewardship and poor staff quality and attitudes (World Bank 2003). These pose major access barriers for the poor. For them the impact of poverty is exacerbated with every episode of illness as out-of-pocket expenditures on health and complete lack of insurance cover pose debilitating shocks. Evidence of the extent of the inequitable access to facilities has been analyzed in a report by Mahal et al (2001) where they report that the poorest 20 percent of the population only capture about 10 percent of the total net public subsidy. In other words, the higher income groups benefit three times more than the poorest sections of the community.

Amidst such a scenario, the private sector is emerging as a striking phenomenon in the health seeking behaviour of the poor in urban areas. Since the early 1990s, the private medical sector has expanded enormously in the country (Peters et al. 2002; Purohit 2001; Berman 1997). Recent studies indicate that almost 60-86 percent of people from rural and urban India turn to private facilities for ambulatory care (Peters et al. 2002; Bhatia and Cleland 2001; Nandraj, Khot and Menon 1999; Uplekar et al. 1998). There is, however, great variation in the package of services and quality of care offered. (Peters et al. 2002; Bhat 1999). This sector, although readily available, remains largely unregulated. Malpractices, over-medication, random prescription of drugs and inappropriate treatment regimes pose dangerous consequences to the individual and the iatrogenic effects of the burgeoning number of practitioners are, therefore, emerging as a major public health concern.
An ongoing study, therefore, attempts to explore feasible regulatory mechanisms for strengthening ethical practice in the private healthcare sector in poor urban neighbourhoods in India, Indonesia and Thailand. The study has four components to it: an in-depth study of interactions between providers and patients in private clinics; a longitudinal household study of disease burden and resort to treatment; a household economic survey; and a desk study of the existing regulatory mechanisms of private practice in India. This paper is drawn from data being collected in Delhi as part of this study.

*I only go to private*…

In Delhi, with a population of 13 million (Census of India 2001), health service is provided by the private sector in most poor urban neighbourhoods. Most prominent is the burgeoning number of unregistered practitioners who are not formally trained in any system of medicine. It has been estimated that there are around 40,000 ‘quacks’ in and around Delhi (Ranjan 2004). These practitioners make regular headlines in the media in the aftermath of fatal accidents caused by misdiagnoses, and the Delhi government conducts raids in an attempt to shut their ‘clinics’. Although the Supreme Court of India has deemed their operations to be illegal, the fact remains that most of them continue to practice. Our ongoing field research indicates that they have their own associations for internal support amongst its members; many of these practitioners operate out of ‘clinics’ that bear no signboards or placards. And it is they who are the backbone of the ‘health service’ for the urban poor. Another level exists of medical doctors, who are legally qualified to prescribe biomedical treatment. But, in their case, empirical research documents rampant over-prescription of drugs and indiscriminate use of diagnostic tests (Thaver et. al. 1998, Uplekar et. al. 1998, Kamat 2001). Also, chronic cases are often misapprehended as common problem and the delay in diagnosis leads ultimately to prolonged therapy and an increase in health expenditure (Singh 2002).

In our ethnographic study of the health seeking behaviour of households in poor areas and provider-patient interactions in private clinics, the overwhelming preference for the private sector is clearly evident. Irrespective of the presence of free government institutions in urban areas, a startling majority of the poorest of the poor go to these practitioners as a first resort. Reasons for this preference include issues of access, perceived quality of treatment, affordability and convenient timings. Narratives of treatment seeking strategies are replete with mistrust of the public delivery of health care.

*Only people who have lots of time in hand and do not depend on daily wages should go to sarkari [government run] places. If you go to dispensaries, the staff is never there and .... we have to wait indefinitely.... In hospitals...queues...why waste our time? I only go to private [doctors] ....

(SS, male, 46 years old, construction worker, Midan Puri)

How will that help? If they go to Medical or to Safdarjung, it will take more time. They’ll keep running here and there. They should not waste their time doing that..... what’s the point?

(Private doctor, Midan Puri)
That’s true. We get harassed when we go to these big places (i.e. government hospitals). They don’t have time for us. We have to stand in queue early in the morning to get a parchi [patient card] done. Sometimes it takes many days to get just that done. And the doctors are so rude. They spend two minutes with us - just write names of medicines, we buy the medicines from outside. If we have to get tests done, we wait endlessly to show the results .... They don’t even listen to us.... What’s the point in all this?

(Budhram, male, 45 years old, resident of Midan Puri)

These sarkari (government) places are the last places where you must go. They are good if you need to have [an] operation. Not much cost. But these things...at least a week ...
And who can afford to lose wages for that much time .... That’s why I come here when I am ill. Only to private...

(Vijay, male, 54 years old, resident Midan Puri)

I have 5 children. They keep falling ill, especially in this [summer] season.... If I have to go to public hospitals, it means one full day gone each time...wait in line, buy medicines from outside and sometimes get [diagnostic] tests done outside. It is also expensive that way. My employers will throw me out if I keep taking so much leave. That’s why I always go to private… [Name of local private practitioner] sahib checks...gives tablets .... and It’s all done in 10 minutes...he’s polite too, unlike the sarkari doctors...

(MD, female, 49 years old, works as domestic help)

These vignettes illustrate a widely held ambivalence towards government institutions. Time, we see, is a crucial factor as it, among other things, translates itself into wages; and wages as opposed to pay are won and lost on a daily basis. Whether it is time spent waiting in queue to get the patient card; or time spent on getting the tests done or the amount of time the doctor spends with the patient. On all these counts, the dice obviously rolls in favour of private (practitioners).

‘Doctor sahib’ in Midan Puri
Midan Puri (MP) is a low-income settlement located in south Delhi near one of the city’s most affluent neighbourhoods.¹ With an estimated population size of around 15-20,000, it is composed almost entirely of migrants from Uttar Pradesh, Rajasthan, Bihar, Haryana, Madhya Pradesh, Uttarakhand, Kerala, Karnataka and Andhra Pradesh. Of the 200 households visited as part of the ongoing study, almost 83 percent are wage labourers; a significant majority of the women work as domestic help in adjacent affluent neighbourhoods.

There are 15 private clinics in the neighbourhood, and 2 free dispensaries run by charitable organizations, run the local Gurudwara and Arya Samaj.² There is no government health centre in the slum. All the people we have spoken with, almost without exception, have told us that they visit private doctors or private health facilities

¹ The name of the locality has been changed to maintain anonymity.
² A Gurudwara is a Sikh temple; and the Arya Samaj is a “Hindu” reformist organisation that began in the late nineteenth century.
when they fall ill, either in the neighbourhood or outside. Mention was made of the city’s most well known public hospitals, Safdarjung Hospital and the All India Institute of Medical Sciences (AIIMS), which they visited only in the event of a ‘serious condition’.

The typical practitioner is male. Most are not formally trained in any system of medicine. The few, who are trained in different medical traditions (other than biomedicine), hold diplomas in ayurveda and homeopathy. Notwithstanding the different bases of medical training and knowledge, almost all the private practitioners in the area engage in what is referred to as ‘mixed’ or ‘cross-system practice’ by Kielmann et al. (2005). Biomedical drugs are the most popular medication given.

In-depth case studies of private practitioners indicate hurried diagnoses and over-medication of patients. Injections are given on demand. The practitioners themselves agree that very often they accede to the demands made by their patients. It is very common for a patient to ask for ‘strong’ medication so that he ‘can get back to work’. But I don’t refuse to treat them. If I don’t give them medicines, they will simply go to another doctor in the locality…. They all want to get well soon. At least they come back if I treat them successfully…. says a practitioner, MB, who has his clinic in the locality. MB has been working ‘as a doctor’ in the locality for the past sixteen years. He set up his clinic in the neighbourhood 6 years ago after having worked in a private polyclinic in another part of Delhi ‘as a helper’ and then as a chemist in the same area. By his own admission, he does not have formal training in any system of medicine but his 16 years of experience with patients have ‘enabled’ him to ‘become a good doctor’. He ‘became a doctor’, he says, because this was ‘something [he] always wanted to be’. His decision to set up a clinic in this area was motivated by the fact that at that time there were not many practitioners in the area and he felt that a clinic would mean lucrative business.

The ‘clinics’ are usually single room establishments. Most of them have a partitioned section for a separate ‘examination room’. Bottles and tablets of medicines are prominently displayed. So are the sphygmomanometer and the stethoscope. At the end of each session tablets are given. Despite repeated queries, we are not able to discern what many of the medicines actually are. Most tablets are loose and are taken out of envelopes and packets and instructions are given to the patient in terms of the colour of the tablet or syrup. A dose is usually given for 2-4 days at a time. The patient is told to come back after the dose is ‘complete’. Their fee structure ranges from Rs 15-Rs 50, depending upon the medication given to the patient. There is no separate fee for consultation, and the money charged includes the medicines given. Regardless of the type of training they have received, none of them give prescriptions – they dispense medicines. The dispensation of medicines is based on the presentation of symptoms as narrated by the patient. Very rarely are cases referred to other physicians or medical facilities. There are cases where patients are asked to get pathological tests done but the reports are analysed by these practitioners and medication dispensed.

Private doctors listen…
Tarrant et al. (2004) have observed that a history of past interactions between a doctor and patient and anticipation of future interactions make cooperation and good quality care
more likely. Along the same vein, Gutek (1995) had inferred that ongoing provider-
customer relationships promote mutual cooperation and improved quality of service. 
Trust is also an important factor because it enables better communication and initiates 
confidence which then facilitate people to utilize health services and adhere to the 
prescribed treatment (Gilson 2003). Recent research on continuity of care in a medical 
setting indicates that continuing relationships between doctors and patients are associated 
with a range of measurable positive outcomes, including quality of care, adherence to 
treatment, and patient satisfaction, although the authors (Pereira et al. 2003) suggest that 
this may also be associated with negative outcomes including poorer control in diabetic 
patients and difficulty in the application of evidence-based care.

In direct contrast to an observation made by Willems et al. (2005) that patients from 
lower social classes receive “less positive socio-emotional and partnership building 
utterances” and a more directive consulting style, characterised by significantly less 
information giving and less directions from their doctor, it is found that the private 
practitioners in this neighbourhood seem to have their pulse on what the key actors want – 
-diagnosis (‘I know what the matter is’, is a common refrain), and a course of action that 
the patients want (be it antibiotics, painkillers or injections). Many of the patients we 
have interviewed so far talk about established relationships with these practitioners in 
their neighbourhood. They take medicines on credit, discuss household issues with them 
and some even pay social visits to these practitioners if their clinics are empty.

From the point of view of the patient, much emphasis is laid on the ability of the 
practitioner to give ‘good medicines’. In all cases, ‘good medicines’ mean strong/
effective medicines which enable them to return to work. ‘Effective medicines’ and 
ensuring ‘quick cures’ seem to be driving concerns for the practitioner as well.

Most cases I see are cases of infections. And I know exactly which antibiotics to 
give. There are many doctors in Midan Puri but most of them don’t know 
anything. I have so many patients – you have seen them..... And they come to 
me because I know how to treat them quickly. And that is what is important, 
 isn’t it...

(DS, male, 56 years old, Midan Puri)

Conversations inside the clinic are informal; although social distance between the 
‘doctor’ and his patient is evident, the patients do not feel disempowered in a way that 
they feel when they consult sarkari (government) doctors. Observations of provider-
patient interactions reveal that patients invariably seem at ease in the presence of the 
practitioner. In many cases, after the consultation is over, the patient (and often 
accompanying person/s) remain in the clinic and have conversations with the practitioner. 
The possibility of several options, concerns and preferences are discussed at length and 
most often interactive decision making determines the course of action taken.

The extensive procedures in public hospitals are often cited to be daunting. Barua and 
Singh (2003) find evidence that the lack of ‘urban literacy’ (that is, the lack of familiarity 
with the various tests and the relative impersonal environs of the public hospitals) is a 
major impediment in seeking care within its environs. In private clinics, the atmosphere
is markedly different. The patients find it a more comfortable and enabling environment. The accent is clearly on client satisfaction, and pragmatic concerns of ensuring a continuing (and sustained) patient base drive the practitioner to perform in accordance to the needs of the patient.

**Collaborations for health care**

There is increasing acknowledgement that instead of health strategies and interventions being developed independently by the public and private sectors, public-private collaborations are a viable option to enhance health service delivery to underserved populations. Therefore, the National Population Policy of 2000 and the National Health Policy of 2002 have highlighted the importance of partnerships in the formulation and implementation of health and family welfare policies and programs of both national and state governments. Moreover, the Tenth Five Year Plan indicates a significant shift from the earlier the governmental stance on NGO, community and corporate sector participation (WHO 2002).

The results of experiments with collaborations are promising, but their approach is often piecemeal, without regard to sustainability or impact on the health of the urban poor. Experience of private sector participation in national disease control programmes has been mixed. NGOs are increasingly playing a facilitative role in health programmes and the Indian government has even shown its willingness to hand over to NGOs or other forms of peoples’ groups the governmental infrastructure for providing health care to the masses within the assigned budgetary provision (ibid.).

Notwithstanding the form of collaboration that is envisaged in the delivery of health services, the formulation of a mechanism to regulate the functioning of the private sector and to oversee the partnership ventures between public and private sectors needs attention to contextual circumstances (Kamat 2001). Of equal importance is the implementation of these regulations (Yesudian 1994; Bhat 1999). Thus far, in a scenario dominated by the unprecedented mushrooming of the private sector, and despite the existence of basic regulatory legislation in India, regulations have not been effective: as there is no policy frame to have a common set of regulations for the private health sector; many regulations are out-dated and irrelevant in the present context; and there are no institutional mechanisms to address the private health growth as a high priority in the policy agenda (Bhat 1999). A consensus on how to improve the situation is clearly lacking.

En route to suggesting recent policy recommendations to improve quality of services for the poor, the World Bank (2004) has suggested that training and accreditation and public education campaigns could be possible strategies to improve the performance of informal private providers. Some suggest continuing medical education (Bhalla 2001). Uplekar (2000) has suggested that health be considered as a public good and not as a market commodity. But as Peters et al. (2002) have pointed out, while framing possible partnerships, it is particularly important to understand the motivation and incentives of the providers and patients, transaction costs, and the willingness of the private sector to participate in public health activities.
During the course of our study we hope to address these issues as we explore feasible and sustainable ways to come up with a regulatory framework to ensure ethical practice in the private sector in poor neighbourhoods in urban settings.

**Conclusion**

The ambivalence of the urban poor towards the public sector emerges clearly in our empirical research. It is often seen as a last resort for obtaining health care because the service offered is perceived to be of inferior quality, inconvenient, perfunctory and, above all, the poor feel that there are substantial indirect costs involved. The narratives of the poor recounting their lived experience of illness are replete with references to private doctors as the first course of action in their search for treatment. Most popular are the mushrooming private clinics in or within the immediate vicinity of the locality in which they live. These clinics are run by practitioners with little or no training in any system of medicine. While some of them are trained to practise Ayurveda or homeopathy, all these doctors prescribe and dispense biomedical drugs. The knowledge and skills of these providers to practise biomedicine is highly moot. Official discourse around these ‘nonqualified’ medical practitioners in Delhi is dominated by attempts to shut down their clinics. Another level of private practitioners is sought out and consulted by the poor. These are doctors who are legally qualified to practise biomedicine but existing research shows that inappropriate treatment strategies pose potential iatrogenic threats to the health of the population seeking treatment from them.

Given the overwhelming preference for the private sector by the urban poor, it is clear that the private sector does play a crucial role if the Millennium Development Goals for health are to be achieved. Recent deliberations for enhancing health services have been rife with discussions about public-private mix in the delivery of health services. This mix can take many forms: collaborations, participation, or contracting out. Notwithstanding the form of collaboration envisaged by stakeholders, there are risks involved in promoting a public-private mix given the current status of the private health sector in urban India.

Of immediate concern, therefore, is how to strengthen ethical practice in clinics of private medical practitioners. Any discussion of improving the situation would need an in-depth analysis of their actual prescribing practices. Particular importance then should be given towards paying attention to detail – what ensues inside these clinics, what the practitioners do on a daily basis and the exact motivations that drive the practitioners to perform during interactions with patients. These details can only be unravelled through micro-level research.

Equally imperative is the necessity to understand the actual perspective of the community. Public health programmes which take cursory cognizance of the factors that drive people to utilize certain services will not be sustainable in the long run. Emphasis on expanding coverage at the cost of overlooking the minutiae influencing treatment seeking strategies is counter-productive. Any reforms would be viable only if pro-poor urban health policies are developed where the service delivery is responsive to the needs of the poor. While recent discussions of appropriate health service provision have been
rife with references to public-private mix in health service delivery, it is clear that whatever form that package takes, there is an urgent need to redefine public-private mix on the basis of an urban poor community perspective. The social, moral and economic bases guiding their preference for the private sector need to be unpacked with an eye to detail.

Micro-level analyses of the patient-provider dynamic, therefore, would best inform why the poor prefer to visit private practitioners rather than turn to qualified and often ‘free’ state-run institutions. In other words, an analysis of clinical encounters between patient and practitioner is both the crucible and the possible future basis for an understanding of why urban poor patients have to spend money on poor quality treatment in the private sector. An understanding of the motivations guiding this treatment seeking behaviour and the dynamics underlying the interactions in these clinics is crucial to guide a regulatory framework that would work to protect patients in poor urban neighbourhoods against iatrogenic events when utilizing the private health delivery system. Our ongoing study uses long-term ethnographic research to unravel the motivations of both providers and patients along its different axes to understand these issues.

References


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