Chapter - 15

Executive Summary

This chapter is merely a collection of chapter summaries from previous chapters. Please refer to the respective chapters for a fuller understanding of the issues covered and interpretation of findings presented here. Our aim here is to assist those who may not have time to go through the full report straight away. We hope that this summary will not only provide an overview of findings from this study, but will also interest readers to read through the full report. Private health sector and state health policy in India

Public financing and provision of health care services has been the mainstream of health policy for nearly half a century of post independence India. Early planners of health care delivery system for India were concerned about availability of resources for provision of National Health Service. The idea of public provision for all types of health care services was reinforced by the fact that the size of private sector was insignificant at the time of independence. All plans and policy statements by government of India have remained silent on the role of private health care institutions, until the National Health Policy, 1983 made a mention about the existence of "private and voluntary organisations active in the health field". Many factors have contributed to an interest in the structure and dynamics of private health sector in India. Firstly the private health sector has grown in many parts of the country, particularly in the areas experiencing agricultural, industrial and service sector developments. The private health care institutions and services have grown in the absence of explicit policy to define their role. The vision for a National Health Service allowed for the existence of small private sector providers to meet the demands of people who would be willing to pay for their services. Since a comprehensive National Health Service is yet to take shape, more and more people are willing to pay for services from the private health sector, leading to its growth. The general economic reforms with its emphasis on privatisation have also contributed to policy interest in private institutions and services in the health care sector. Growth of private forprofit health care institutions in an unregulated market has raised concerns about exploitation of consumers (High Court of AP, 1999) and quality of care. Concerns have also been raised about utilisation of tax concessions by the state and responsiveness of private corporate health care institutions to the needs of poor (AP legislative Assembly, 1996). Several studies have established the rapid expansion of the private sector in both the provisioning and financing

of health care services in India. But there is a paucity of information regarding the manner in which different parts of the private health markets operate, the incentives and the motivation and systems which form the basis for their sustenance. This study seeks to understand the structure and dynamics of the private health sector in Andhra Pradesh, in order to provide insights for meaningful policy intervention to define the role of private health sector and realise its potential in improving the population health status. Government has responsibilities beyond the public provision of health services. Because of it's concern for the health of the population and for the poor in particular, government is caretaker for the societal goals of ensuring access to an affordable, appropriate high quality health services. To what extent can the private health sector support these goals? This study would help in identifying: (a) how national and state health policies can clarify the roles for the public sector interactions with different parts of the private sector; (b) enhance opportunities and overcome constraints to enable the private sector to fulfill social goals; and (c) possible avenues for cooperation between the public and private sectors.

I. Materials and methods

To understand the structure and dynamics of the private health sector in AP, we studied a sample of 256 health care institutions (HCIs) consisting of 150 HCIs from the private sector and 106 HCIs from the public sector. Three types of HCIs were sampled from both the sectors. These are clinics, small hospitals of 30 to 100 beds and big hospitals with 100 or more beds. The clinics sample included solo clinics, nursing homes with less than 10 beds, primary health centres (PHC), dispensaries etc. The sample of HCIs from private sector consisted of 76 clinics, 69 small hospitals and 10 big hospitals. The public sector sample had 53 PHCs, 41 small hospitals and 12 big hospitals. Six questionnaires were used to collect information. These include (a) a questionnaire to collect basic information of all HCIs in the sample, (b) a questionnaire for private HCI owner-managers, (c) the diagnostic facility questionnaire, (d) the health care professionals (HCPs) questionnaire to assess job satisfaction of HCPs working in private and public sector, (e) a patient exit interview form to assess levels of patient satisfaction in private and public sector, and (f) an instrument to survey alternate private practitioners (APP). The diagnostic facilities and APPs were located through the HCIs in the primary sample. For the exit interview around 10 patients were sampled from each HCI in the primary sample. Primary data collected in this do not allow us to examine evidence about all relevant policy issues and research questions about private health sector. Hence we supplement by analysis of secondary data collected from other sources in India. In addition we review the literature, particularly from a some what similarly placed mixed economy like the United States.

II. Motivation and establishment of private health care institutions

Private HCIs can be broadly divided into (a) forprofits and (b) nonprofits. Forprofits include proprietary and corporate HCIs. There are important differences between proprietary and corporate HCIs. Proprietary HCIs are usually single owner, physician practice facilities or joint partnership of physicians. Life span of proprietary hospital is usually linked to the professional career of their physician founder. Some of these may change to corporate or nonprofit hospitals. Proprietary hospitals usually have lower assets per bed. Corporate hospitals tend to remain in business for longer terms and are usually of bigger size. Corporate hospitals grew in the US during a period of liberal reimbursement by government through the Medicare and Medicaid programs. As the reimbursement climate changed there was a decline in corporate hospitals. Nonprofits play a major role in healthcare delivery in the US. Majority of HCIs in most economically developed countries are either in the public or nonprofit sector. Major advantage of forprofit health care institutions is their quick response to changes in demand. Hence a small complement of forprofit health care institutions can be useful to ensure responsiveness of the health system changes in demand for healthcare services.

A glaring gap in India is the near absence of nonprofit health care institutions. No doubt there are some charitable and nonprofit health care institutions in various parts of the country. But their numbers and size is too small compared to the overall size of the health sector. There appears to be a decline in building of nonprofit healthcare facilities in AP. This is a disturbing trend. It will be desirable to encourage development of nonprofit HCIs in the long run. This is best achieved through social movements and by building up awareness among community leaders. Policies to encourage nonprofit healthcare institutions should be accompanied by streamlining of the general regulatory environment for nonprofit organisations. This is required to minimise the risk of misuse of public funds.

Growth of private forprofit HCIs in AP started during the 1970s and has continued to show an increasing trend since then. A large number of private diagnostic facilities have also appeared during this period. Almost all (99%) of solo clinics, 84% of small hospitals and 87% of diagnostic facilities in the sample were proprietary. Only 20% of big hospitals were proprietary. Another 30% of big hospitals were corporate and the rest 50% were trust (nonprofit) hospitals. The number of corporate hospitals in AP is currently very few. At present the private forprofit HCIs largely consist of proprietary firms. The private forprofit HCIs are definitely experiencing a period of growth in many parts of the state.

III. Accessibility character of private and public HCIs.

Some general patterns have emerged from the review of available evidence on geographic spread and patient composition of health care institutions in private and public sectors, respectively. We found that public sector HCIs have a wider geographic spread compared to the private sector HCIs, which tend to be located in urban areas. 150 private HCIs randomly sampled for this study were from 19 cities or villages. The 106 randomly sampled public HCIs were from 76 cities or villages. Economic development of an area tends to improve the overall availability of health care facilities both in public and private sector. The geographic spread of private sector HCIs is more restricted compared to the public sector HCIs. The private sector HCIs have grown mostly in areas with higher levels of socioeconomic development. Although economic development does appear to some extent influence the public sector health care capacity, geographic distribution of public sector HCIs appear to have been comparatively better than in case of the private sector.

Available evidence on socioeconomic composition of patients suggest that the public sector HCIs tend to serve more number of socioeconomically poorer patients compared to similar sized institutions in the private sector. National level estimates for all India and state level estimates for Andhra Pradesh, available from various studies are consistent with this observation that the share of patients from socioeconomically poor households is comparatively higher in case of public sector HCIs. Within the private sector the nonprofit health care institutions tend to be more accessible to socioeconomically poorer sections compared to the forprofit health care institutions. Review of studies in the US where a mixed health system is in place suggests similar differences in accessibility characteristics of forprofit, nonprofit and public health care institutions.

IV. Patterns of resort to private or public HCIs

Let us summarise the available evidence on patterns of resort to private and public HCIs. All the four nation wide surveys conducted during the 1980s and 1990s show that majority of people (60% to 80%) resort to the private HCIs for ambulatory care. In rural areas, however significant number of people (10% to 20%) turn to the Primary Health Centres or Sub centres for ambulatory care. The level of resort to private HCIs for ambulatory care, has remained constant or marginally increased between the 1980s and 1990s. However, there are notable regional exceptions to this trend. For example in Andhra Pradesh, the level of resort for ambulatory care to public HCIs increased during this period.

In rural areas of AP the number of people resorting to public HCIs increased from 12% in 1986-87 to 22% in 1995-96. In urban areas of AP, the increases was comparatively less, from 16% in 1986-87 to 19% in 1995-96. There is some evidence to suggest that the proportion of people who do not seek any ambulatory care in times of need is higher in states spending comparatively less money on public health services. For inpatient care, traditionally more people have been resorting to the public hospitals. Till about 1993, about 60% of people needing inpatient services resorted to the public sector. The situation appears to be changing. By 1995-96 the proportion of people resorting to public hospitals for inpatient services reduced to about 43% with a corresponding increase for the private sector. We have found in this study that private hospitals and nursing homes have grown at a much faster rate in numbers and bed capacity during the 1980s and 1990s. This would appear to be the most plausible explanation for the increase in resort to private hospitals during the 1990s. Estimates of pattern of resort to private and public HCIs by socioeconomic status reveal that people from poorer households tend to rely more on public HCIs. As socioeconomic status increases more and more people resort to the private HCIs. At the all India level, people in rural areas tend to rely more on the public sector. In AP, however, the rural-urban difference is not so much.

V. Efficiency of health care institutions in private sector

Review of available literature does not support the hypothesis that private for profit hospitals are more efficient. Contrary to popular belief, administrative costs tend to be slightly higher in forprofit hospitals compared to nonprofit and public HCIs. The overall cost of health care in areas largely served by private forprofit HCIs is generally more compared to areas largely served by nonprofit and public HCIs. Both forprofits and nonprofits responded to incentives of reimbursement policy by maximising their revenue, rather than minimising their cost of providing the services. But forprofit hospitals are usually more aggressive in pricing compared to nonprofits. One such aggressive pricing strategy is to keep the charge for routine services competitive and charge higher prices for ancillary services, which are less easy to compare from hospital to hospital.

The only efficiency related information collected by this study were the utilisation rates like bed occupancy, turnover rate, outpatients per bed, etc. Even these estimates are based on rough data, since the private HCIs do not generate statistics to arrive at accurate estimates of utilisation rates. There was no difference in utilisation rates between private and public HCIs, except for the outpatient load, which was considerably higher in the public HCIs.

VI. Quality healthcare in private and public institutions.

We have proposed a framework for assessment of healthcare quality consisting of achievement of health attainment goal (technical quality) and responsiveness (interpersonal quality). Both technical quality and responsiveness ought to be measured using structure, process and outcome criteria. Unfortunately the quality of healthcare assessment subsystem is yet to develop in India. There is hardly any licensing requirement for health care institutions in India. Health care accreditation systems are yet to develop. India is yet to develop any national program for development of practice guidelines, medical review criteria, etc. Research capacity for measurement of medical outcomes and risk rating of patients is yet to develop in the country. Most quality of care related information in the country is about the interpersonal aspects of care. Without the integrated framework for assessment of health care quality, one may assume the information on interpersonal aspects of care to be the whole information on quality. So the important policy recommendation emerges even without looking at the available information on interpersonal quality of care. That is the need for systematic development of a quality of health care assessment infrastructure in the country.

Available evidence from the US suggests there is no clear difference in quality of healthcare delivered by forprofit, nonprofit or public HCIs. Note, however, that the healthcare quality assurance infrastructure is well developed in the US. Studies in India suggest that technical quality of care may be slightly better in public sector HCIs and interpersonal quality, may be slightly better in private sector. But the more important finding from Indian studies is the poorly developed healthcare quality practices both in private and public sector.

Only some rudimentary information on infrastructure, and process of care could be collected in this study. Approximate data on premises collected by this study showed that public sector HCIs are generally better endowed with land and floor space. Comparatively more number of public HCIs, particularly the PHCs and small hospitals reported that they use written medical protocols and therapeutic guidelines. More than 90% public HCIs reported that they maintain medical records, compared to only 65% in case of private HCIs. Comparison of the availability of auxiliary services in private and public HCIs gives a mixed picture. More public HCIs (85%) provided pharmacy services compared to private HCIs (42%). Prevalence of 24 hour emergency services was similar (about 40%) among private and public HCIs. Prevalence of telephone facility was much more among the private HCIs (88%) compared to public HCIs (29%). Results from the patient exit interview showed that the level of patient satisfaction was generally low in both private and public HCIs. Overall level of patient satisfaction was similar in the private and public sector HCIs. However,

the private HCIs received better scores on access, availability and convenience, communication and general comfort. On the other hand, the public HCIs received better scores on the technical skill and interpersonal sub scales. The private HCIs received significantly more number of "very good" and "excellent" ratings on (a) manner of physician, (b) technical skill of physician, (c) getting an appointment, (d) convenient location. Most of these are on interpersonal aspects of care. The limited data available from this study suggests that the interpersonal quality of care in private HCIs is comparatively better than that in public HCIs, which tend to show slightly better ratings about infrastructure, and technical aspects of care. Most importantly the level of patient satisfaction was generally low in both private and public HCIs, suggesting an environment of poor client orientation in the health sector.

VII. Range of services in private and public health care institutions

Private forprofit HCIs tend to more readily offer certain services and shy away from others. This may mean that there are healthcare services where the private forprofit HCIs have a comparative advantage. In addition, forprofit health care institutions (HCIs) may cream skim best paying patients by focusing on most profitable services. Restricting the range of available services is one form of cream-skimming. Experience from industrialised countries suggests that forprofit HCIs cater to more defined demands like ambulatory care, surgery and maternity services. Findings earlier studies in AP and from this study are consistent with the experience from industrialised countries. We found, for example, that availability of clinical services in hospitals was more or less similar between private and public sector. But the later provided in addition other services related to various public health programmes.

The study also revealed that private HCIs are quick to enter into the diagnostic services provision. All primarily diagnostic facilities in the study sample were private forprofit institutions. Similarly, ambulatory care very readily appears in the private forprofit sector, mostly by way of proprietary physician practice facilities. The proprietary physician practice facilities may have a distinct comparative advantage in provision of ambulatory care, by locating nearer to client locations, more compatible timings and better interpersonal care. Experience from industrialised countries also supports the general preference for proprietary physician practitioners as far as ambulatory care is concerned. Household survey data on health seeking behaviour in India shows higher preference for private HCIs for ambulatory care. Some of the factors giving a comparative advantage to private proprietary HCIs for ambulatory care are obvious. Since these are usually small in size ranging from solo clinics to small

hospitals, they have the required locational flexibility to site nearer to their clientele. Distance is an important consideration for accessing of services from health care facilities and more so for ambulatory care. Another clear advantage of proprietary HCIs is their flexible timing, which again is an important consideration for accessing ambulatory medical care. Thus it would appear that private forprofit HCIs have a distinct comparative advantage for delivering ambulatory medical care.

There is some evidence of cream-skimming. For big hospitals, there appears to be no restriction in availability of public health services between private and public HCIs. Rate of participation in national programmes drops to around 30% in case of small hospitals and around 20% in case of private clinics. Polio and family planning programs are exceptions. More than 60% of small hospitals in the private sector reported to have participated in these programs. Rate of participation of private clinics in polio control program is around 30%. It would appear that big hospitals would play some role in National Health Programmes to broaden the scope of their services and in response to expectations of their clients. Participation by clinics and small private hospitals would appear to be determined by the interest of respective owner managers and effectiveness of the concerned programmes to involve the private sector. The higher rates of participation by private clinics and small hospitals in Polio and Family Welfare programmes would appear to have been due to specific efforts by these programmes to involve the private sector.

An important finding from the data on the range of available services is about failure of rational planning process in the public HCIs. The range of services available in a cross section of private health care institutions would be a result of two factors, namely the range of skills that doctors have to offer and demand for various services. On the other hand, we would normally expect the public sector to offer a smaller but more consistent range, if they were implementing something like an essential clinical package. We found that the range of clinical service available in public sector health care institutions in AP is not very different from that of in the private sector. It appears that in the matter of general clinical services both private and public sectors operate alike. Availability of clinical services in public sector appears to be determined by what doctors working in public sector have to offer. This is mainly because the personnel policy does not yet adequately define the cadre strength of doctors by specialty.

of patient fees suggests that the growth in private health care institutions will continue for some more time. If the environment for employer reimbursement improves and health insurance schemes expand, growth of the private health sector may gain additional impetus for growth. Patient revenue income also appears to be the dominant source of financing of capital investment in private health care institutions. More than half of the owner-mangers reported that they did not require a loan. Those who needed, took loan mostly from commercial banks, and loan from relatives and friends. Although some credit market difficulties like too much paper work, unrealistic collateral, etc. are experienced, owner-managers were not deterred by these to take loans if they needed them to start or develop their health care institutions. Data on rates and charges for commonly delivered clinical and diagnostic services, collected from HCIs and diagnostic facilities are presented. Majority of private HCIs operate with unpublished tariffs for their services. It will be desirable to require private HCIs to publish service charges for commonly encountered and well defined services, to bring about some openness in billing practices. The level transparency Although almost all private HCIs claimed to have some fair financing arrangement for poor patients, these are mostly informal and ad-hoc. These informal arrangements of free care or discounted fees based on doctor's discretion would benefit some poor and needy patients, but is incapable of meeting the needs of most of them.

X. Patient referral, regulatory environment and infrastructure problems faced by private HCIs.

The Primary Health Care approach to the Health for All (HFA) goal envisages a referral system that fosters easy movement of patients between institutions based on patient's need and availability of optimal care facility in different institutions. Information collected from private and public HCIs in AP suggests that an informal but active referral system exists to meet patient needs. The system is sustained by professional contacts of physicians, shared knowledge about the service character of different type of HCIs. Domain specific regulation of health care services, like state licensing requiring conformity to standards of care, definition of services and compliance of ethical norms is lacking. This could be the reason why unfair competition was cited as an important obstacle faced by owner-managers of private HCIs. Private HCIs also reported obstacles on account of high and cumbersome tax regime and poor governance such as corruption of public officials. Electricity, followed by water supply and drainage were reported as important infrastructure constraints faced by private HCIs.

XI. Alternate Private Practitioners

To understand the private health sector market, we sampled 158 alternative private practitioners (APP) by locating the nearest APP for each clinic or PHC. APPs essentially provide ambulatory (outpatient) medical care and quite well integrated into the health care market. Homeopathy (34%), Ayurveda (19%), Ayurveda plus Allopathy (23%), and Allopathy (14%) systems of medicine are in vogue. Most Homeopathy practitioners (74%) had a professional degree. A little less than half (40%) of the Ayurveda practitioners have professional degree. The rest (60%) appear to continuing family tradition of practice in Ayurveda. A lot (73%) of those who practice Allopathy alone, had gained experience and knowledge through internship with Allopathy practitioners. On an average each APP would see about 50 patients per day. Most of them treat common complaints like cough, fevers, pain, skin diseases, diarrhea, etc. APPs readily adopt simple technologies like the use of thermometer, stethoscope, blood pressure apparatus and oral re-hydration salt, irrespective of the system of medicine from which they originated. An important strength of APPs is the readiness to escort their patients to hospitals if necessary.

XII. Experiences from the United States (US)

Experience from the United States of America (USA) may have some relevance for India since the two countries share mixed health care delivery system. relevance for India in many respects. More over the dominant American ethos is to favour free enterprise and small government. Hence the health care policy and regulatory environment for private HCIs in the US can give some idea about what would be the most liberal boundary regulation of health care institutions, elsewhere. Health care delivery institutions in the US need license to operate. This institutional licensing is in addition to the requirement of license to practice by individual health care professionals. The respective state hospital or health care facility licensing boards have to satisfy that the health care institution meets the state building standards as well as minimum standards for delivery of health care. In addition, there are voluntary accreditation systems in the US like the Joint Commission of Accreditation of Health Care Organisations (JCAHO).'Most states in the US have one or more nonprofit health insurance organisations popularly called the Blue Cross. . These plans were exempt from insurance regulatory laws. In view of their nonprofit status, they also had tax exemption. In return for these benefits the Blue Cross plans were expected to serve the entire community and provide insurance plans affordable by persons with moderate to low income. Their accounts and rate structure could be examined by public bodies. The US Federal tax code allows income tax

exemption to employers for health insurance coverage of employees. To reduce geographic imbalances in availability of doctors, the US Federal government operated a hospital construction and equipment grants program, popularly called the Hill-Burton program from 1947 till 1973. This program contributed to a small increase in the stock of short term general hospitals and most importantly helped reduce the imbalance in distribution of hospital capacity across states. Capital grants were provided to nonprofit and local body hospitals only. This might have contributed to a marginal reduction in share of forprofit hospitals in the US, but the effect if any was small. The program did help improve availability of physicians in backward areas, through an increase in hospital stock of those areas. Most American states have some kind of certificate of need (CON) law to regulate expansion of hospitals and acquisition expensive equipment by health care institutions. Although the federal certificate of need program under the National Health Planning and Resources Development Act has been discontinued, the state certificate of need programs are continuing. To slow down rapid increase in health care costs the US federal government has been encouraging setting up of health maintenance organisations (HMOs) which combine health insurance and health care provision functions. There are many programs in US to improve quality of health care. Some important initiatives by the federal government include, (a) peer review organisations and (b) development and dissemination of clinical practice guidelines.

XIII. Policy Recommendations

We feel time is ripe for the Central and State governments India to pursue a proactive policy of fully integrating the private health care institutions into the health system. Based on our understanding of the state of private health sector in India, with particular reference to Andhra Pradesh and review of literature on the subject, we have proposed in Chapter-14 a set of policy recommendations. We reproduce the operative parts of the recommendations below.

1. Develop and adopt a set of comprehensive policy towards the private forprofit and nonprofit health care institutions.

2. Ambulatory medical care is best provided through a network of family physicians (FP), who would usually be self employed doctors but can include ambulatory care services by other institutions as well. Steps to develop such a network will include the following.

   i. Definition of the package of basic ambulatory care and family physician services.

   ii. A capitation fee based scheme of enrollment with FPs with some provision to allow for annual review of choice of FPs by the covered families.

iii. Public funding of FP service coverage at least for families who can not afford to pay.

3. In the short and medium term, private hospitals and nursing homes capacity should be used to increase the incidence of institutional deliveries in the country. Raising the incidence of institutional deliveries vis a vis home deliveries would help reduce maternal mortality rates. Public funding of institutional deliveries by women from poor families, in private HCIs will facilitate health sector reform by providing incentives for private HCIs to adopt standards and assure quality of maternity services, as well as build experience in public financing and private provision of healthcare services.

4. Public health authorities should explicitly define standard range of services based on local burden of diseases and availability of costeffective of interventions to be delivered by the public health care institutions. Governments should review the job descriptions, cadre strength, recruitment systems and posting policy to improve consistent availability of predefined services through all public HCIs. This we believe will help in better targeting of public subsidies to the poor.

5. In the near and medium term, the public sector hospitals will have to respond to the hospitalisation needs of the poor. This would mean upgrading and expansion of first referral hospital facilities in the public sector. The First Référral Health Systems project in Andhra Pradesh and few other states have program components to upgrade and expand the first referral hospitals in the public sector. More work is needed to estimate requirement of hospital stock in view of current and future levels of disease burden and hospital service requirements.

6. Encourage development of nonprofit health care facilities in the long run. Actually this later objective is best pursued through social movements. It will be difficult to achieve sustainable growth of nonprofit health care institutions through government policy. Limited role of government policy towards nonprofit HCIs will be to provide a signal about the desirability of voluntary action. The range of nonprofit HCI promotion policies would include (a) legislative mandate for incorporation of nonprofit HCIs for different purposes related to healthcare, (b) legislative recognition of the special needs of health insurance organisations, (c) land and capital grants to nonprofit HCIs, etc.

7. Government programmes encouraging nonprofit HCIs will inevitably attract opportunistic nonprofit institution building in addition to spontaneous voluntary action. Hence the nonprofit HCI promotion policy should be accompanied by development of appropriate regulatory mechanisms for the nonprofit sector. These would include model code of transparency in

governance of civil society institutions, and standards of accounting practices for nonprofit institutions. Clearly some of these policy measures require action outside the health sector. For example standards of accounting practices can be prescribed under the income tax rules that provide for registration of nonprofit institutions.

8. Substantially increase allocations for healthcare services by;
   i. Streamlining and expansion of fiduciary social security services, and
   ii. Substantial increases in allocation of government expenditure to health sector.
9. Establish rate setting policies and authorities to set fair rates of healthcare service charges. These rates will facilitate purchase of healthcare services by the government from private forprofit and nonprofit providers. It will well recognised that health care institutions both forprofit and nonprofit have a motivation to maximise revenue by exploiting the rate structure and payment systems. Hence, the rate setting mechanism should provide for research programmes to monitor impact of rate setting decisions and take appropriate remedial action from time to time.
10. Streamline existing state licensing mechanisms for healthcare professionals.
11. Create state licensing mechanisms for healthcare facilities of all kinds including group practices, nursing homes, hospitals, diagnostic facilities etc. Develop national network of institutions to contribute towards development of standards and specifications for different aspects of the healthcare facility licensing process. The standards development should be done by an organisation with adequate research and documentation on the subject. Standards should be developed by professional and research teams following wide ranging consultation among various stake holders. The minimum standards should be specified on the basis of size and service offering. In other words both bed size and service offering of the hospital should be taken into consideration to arrive at the minimum required facilities. Marginal modification to standards may be allowed on the basis of location features like urban, rural and remote areas. Substantial deviation on the basis of rural urban character of the hospital should not be allowed. Instead appropriate restriction in range of service may be made.
12. Encourage voluntary accreditation in addition to the state licensing mechanism.
13. Government may facilitate availability of incentives to encourage accreditation: For example social insurance schemes run by government could require accreditation as a prerequisite for empanelment. Require

information on accreditation status and factor it into the decision making process while considering requests for any direct or indirect state subsidy like tax concessions etc. Where the subsidy precedes setting up and / or operation of a hospital or service, a condition may be imposed by the concerned government requiring that the beneficiary institution will obtain and maintain accreditation within a certain period of time.

14. Establish a program for development, periodic updating and dissemination of clinical practice guidelines (CPG).

15. Establish a program of research on measurement of medical outcomes which will help in the long run, use of risk rated medical outcome data for comparison of technical quality of care by health care institutions.

16. Essential clinical package definition: Immediate priority is to explicitly allocate existing cadre strength of entry level medical officers in first referral hospitals among the five commonly required specialties namely, (a) General Medicine, Obstetrics and Gynaecology, Paediatrics, General Surgery and Orthopaedics. between the Define essential clinical package of services to be delivered at the first referral hospitals. Medium term priority is to explicitly define the essential clinical package of services. Reorganise staffing in public HCls commensurate with the essential clinical package.