

Appendix - 1.1

Health Care Institution - Basic Information¹

I. Front Sheet (To be filled in stages corresponding to progress of data collection):

A. Health Care Institution (HCI):

Name of the hospital /
nursing home / clinic:

HCIId:

B. Surveyor Information:

Surveyor Name:

Surveyor Code

C. Initial contact was:

Scheduled by phone

Scheduled in person

Scheduled through a common contact

Notified through a letter

D. Date(s) of visit for collection of data:

Visit No.	Date	Start time	End time	Items filled and remarks
1				
2				
3				
4				

E. Persons contacted to collect information:

Name	Position	Items for which (s)he was useful, and remarks

F. General comments regarding the data collection process:

¹ Filling in of this form will require contacting more than one person conversant with various details regarding the health care institution, and multiple visits. You may have to visit places and persons outside of the particular health care institution but having information about it.

II. Addresses:**A. Mailing address:**Name of the hospital /
nursing home / clinic:

HCId:

Street:

Locality

City:

State:

PIN:

B. Telecommunication numbers & addresses:

Type

STD Code - Number / Address

Remarks

General Phone(s):

No. of phone lines:

Casualty Phone:

No. of phone lines:

Fax:

WWW Home:

E-mail:

C. TIDs (related territorial Ids and codes for mapping):

UbnId

HabtnId

VillageId

91 Census Code

III. Incorporation details:**A. Type of firm:**

For Profit	Sole Proprietorship Firm	
	Partnership Firm	
	Private Limited Company	
	Public Limited Company	
	Co-operative	

Non profit	Non Profit Company	
	Society / Association Registered under the Societies Act	
	Registered Trust	
	Unregistered Trust	
	Other (specify):	

B. Registration details:

Registration No:

Date:

Registering
Authority:

Regn Reference:

IV. Owner, Manager, or Such other Contact person² information:

A. Name and role:

Prefix	Given Name / First Name	Family Name / Surname	Suffix
--------	-------------------------	-----------------------	--------

Designation i.e. Position with respect to this Health Care Institution:

B. Mailing address (If different from the address of Health Care Institution) :

Street:	Locality
---------	----------

City:	State:	PIN:
-------	--------	------

C. Telephones etc.:

Work phone:	Home phone
-------------	------------

Fax:	Mobile phone:
------	---------------

E-mail:	Pager:
---------	--------

V. Establishment year and size:

Year established:	Beds when established:	Intensive Care Beds, then:	# OTs Then:
-------------------	------------------------	----------------------------	-------------

Current year:	Current bed strength:	Intensive Care Beds ³ , now:	# OTs now:
---------------	-----------------------	---	------------

² The person from management who knows the most about this health care institution and will be a suitable candidate to answer more questions about the institution's history and its current functioning.

³ Intensive Care Beds Definition: Beds supervised directly by doctors and nurses 24 hours. There is definite arrangement for posting of doctors and nurses on turn duty basis. Doctors and nurses are stationed within visible range of patient beds. The beds have dedicated equipment for monitoring of patient vital functions and ready availability of emergency drugs.

VI.Promoter(s) (In order of importance. Use addl. sheet if required):

Prefix	Given Name / First name	Family name / Surname	Qualifications	Profession
--------	-------------------------	-----------------------	----------------	------------

Street:	Locality
---------	----------

City:	State:	PIN:
-------	--------	------

Work phone	Fax:	Home phone:
------------	------	-------------

Prefix	Given Name / First name	Family name / Surname	Qualifications	Profession
--------	-------------------------	-----------------------	----------------	------------

Street:	Locality
---------	----------

City:	State:	PIN:
-------	--------	------

Work phone	Fax:	Home phone:
------------	------	-------------

VII.Establishment / Foundation remarks:**A. What was the top motivating force for its establishment⁴?****For profit:**

<input type="checkbox"/> Earn livelihood	<input type="checkbox"/> Practice facility	<input type="checkbox"/> For profit	<input type="checkbox"/>
--	--	-------------------------------------	--------------------------

Non profit:

<input type="checkbox"/> Missionary / Religious	<input type="checkbox"/> Philanthropy	<input type="checkbox"/> Voluntary	<input type="checkbox"/>
---	---------------------------------------	------------------------------------	--------------------------

B. Remarks and notes:**VIII.Premises:**

Type of construction:

HCI floor space in Sft.:	Owned by this health care institution	
Plot area in Sq. yards:	Rented from the promoter(s):	
Other occupants if any:	Rented from unrelated person:	
Others floor space in Sft.	Other arrangements (mention):	

⁴ Ask the owner manager, and others who may know about history of the health care institution.

IX. Services offered by this health care institution:**A. Curative services:**

Curative Service	Yes / No	Curative Service	Yes / No	Diagnostic Service	Yes / No
Burns		Urology		Contact lens clinic	
Cancer (Oncology)		Vaccination		ECHO cardiography	
Cardiology		Ante natal Care		Holter monitor	
Dental Services		Family planning		Eye testing	
Diabetology		Laparoscopic sterlism.		Gastroscopy	
Emergency Services (24		Nutritional follow up for		Allergy test	
ENT		Education for AIDS /		Peritoneal dialysis	
Family planning		Anti tuberculosis		Haemodialysis	
General Medicine				Traction	
General Surgery				Pap smear	
Gastroenterology				Bronchoscopy	
Infertility Services				Hormone test	
Intensive care					
Nephrology					
Neonatology					
Neurology					
Obstetrics &					
Ophthalmic surgery					
Orthopaedics					
Other Specialties					
Paediatrics					
Physiotherapy					
Psychiatry					
Tuberculosis					

B. Diagnostic services:

Diagnostic Service	Yes / No
Radiology (X-ray)	
CT Scan	
ECG	
Biochemistry laboratory	
Microbiology laboratory	
Pathology laboratory	
Blood bank	
Treadmill analysis	

C. Other Services:

Pharmacy	
Food Services	
Transportation (Ambulance) Services	

X. Basic Hospital Statistics:

Indicator	Reporting period*	Statistic	Exact or Estimate
Number of outpatients (new and old)			
Number of inpatients admissions			
Cumulative IP days			
Average bed occupancy			
Average length of stay			
Number of deliveries			
Number of Caesarian sections			
Number of major surgeries performed			

* Our preferred reporting period is for one year. Request for data relating to preceding 12 months and mention this period in this column. If, however, the health care institution does not have information for the preceding 12 months, collect for what ever period information is available and record that period in this column.

XI. Fee and service charges information:**A. What type of fee schedules does this hospital / health care institution use for the following services?**

	Published ⁵ schedule (Amount)	Not published but widely known (Amount)	Fixed on case to case basis
Room charges			
Board charges			
Consultations			
Lab. procedures			
Others			

B. When was the above tariff fixed or revised?

⁵ Try to obtain a copy of the published tariff.

XII. Referral and services:

A. Does this health care institution receive patients regularly referred by other health care providers?

B. If yes, what are the health care institutions from where or who are the providers from whom, you regularly receive cases?

HCId	HCName	Service Type	No of referrals in a year

C. Does this hospital / health care institution have any policy on how to refer patients to other hospitals?

D. If yes, what are the health care institutions to whom patients are referred?

HCId	HCName	Service Type	No of referrals in a year

E. Does this hospital handle medicolegal cases?

F. If no, where are these cases referred?

HCId	HCName	Service Type	No of referrals in a year

G. Are patients referred to outside diagnostic centres from this hospital?

H. If yes what are the main places patients are referred to:

HCId	HCName	Service Type	No of referrals in a year

I. Which visiting consultants are currently offering services at this facility?

Consultant's Home Institution		Name	Service Type	Periodicity
HCID / HC Name, City	Govt. Pvt			

J. What kind of medical records are maintained by the hospital?**K. How long are patient medical records kept at the hospital?****L. Does this hospital / health care institution use written medical protocols / therapeutic guidelines?****M. When was it last updated?****XIII. National - State Programmes Public health⁶****A. Do you participate in any of the following national health programmes, and how?**National health programme Yes No Type of involvement⁷

Polio campaign

Family planning

Leprosy control

Tuberculosis control

Blindness control

Malaria control

AIDS control

B. Would you like to participate in any of these national health programmes?**C. If yes, How?**⁶ Fill this section with help of the owner manager(s).⁷ Use following codes if applicable: 1. Provide information to the public, 2. Distribute contraceptives / drugs, 3. Refer cases, 4. Treat patients with the given condition, 5. Use guidelines from program authorities.

Appendix - 1.2

Additional¹ questionnaire for owner - managers of private health facilities (Hospitals / Nursing Homes)

I. Front Sheet (To be filled in stages corresponding to progress of data collection):

A. Health Care Institution (HCI):

Name of the hospital /
nursing home / clinic:

HCIId:

B. Surveyor Information:

Surveyor Name:

Surveyor Code

C. Initial contact was:

Scheduled by phone

Scheduled in person

Scheduled through a common contact

Notified through a letter

D. Date(s) of visit for collection of data:

Visit No.	Date	Start time	End time	Items filled and remarks
1				
2				
3				
4				

E. Persons contacted to collect information:

F. General comments regarding the data collection process:

¹ We call this additional questionnaire, because some portions of the HCI Basic Information Questionnaire need to be filled with the help of owner manager(s).

II. Personal information:**A. Name and role:**

Prefix	Given Name / First Name	Family Name / Surname	Suffix
Designation i.e. Position in this Health Care Institution:			Age:
Profession & Qualifications:			Sex:

B. Mailing address (If different from the address of the Health Care Institution) :

Street:	Locality		
City:	State:	PIN:	

C. Telephones etc.:

Work phone:	Home phone
Fax:	Mobile phone:
E-mail:	Pager:

III. Hospital work force and labor:**A. Summary of staff :**

	Full-time	Part-time-Pvt	Part time- Govt.
Specialist doctors			
General duty doctors - (Allopathy)			
General duty doctors - (Others)			
Certified Nurses			
Certified Auxillary Nurse Midwife			
Other Nurses			
Other paramedical staff			
Managers / administrators			
Support staff			
All			

B. How often do you have to face problems or worry on account of the following?

	Very often	Often	Occasionally	Never
Low productivity of laborers				
High cost of skilled employees				
Non availability of skilled employees				
Missed work due to illness or death				
Absenteeism				
Lack of skilled management				
Restrictions on laying off workers				
Regulations on working conditions				
Trade union activities or restrictions				
Seasonal shortages of unskilled labor				
High turnover of staff				
Other				

IV. Revenue income:**A. Please rank the following seven items on their contribution to total revenues at this health care facility.**

Give 1 for the item that contributes the most, to 7 for the item that contributes the least. Identify, in order the top three contributors to your revenue. Gone up or down is w.r.t. last year.

Revenue source	Rank	Gone up (↑) or down (↓)	Remarks
Patient fees for room and board			
Pharmacy sales			
Laboratory services			
Service contracts with employers			
Fees shared from diagnostic centers outside the hospital			
Fees shared from pharmacies outside the hospital			
Insurance payments			
Other _____			

B. Does your revenue from patient services cover your operating expenses? Yes / No

1. If no: How do you make up the difference?

C. Can doctors in this hospital set fee levels themselves? Yes / No

D. How often do you encounter the following payment related problems for your hospital?

	Very important	Of some importance	Of little importance	Not important at all
Nonpayment by patients				
Nonpayment by government				
Nonpayment by employer contractors				
Too few paying patients				
Too much competition from other hospitals and clinics				
Other _____				

E. Do you have any agreement to provide services for reimbursement by the Government? Yes / No:

1. If yes:
 - i. How long does it take to get reimbursed?
 - ii. What are the main problems with this arrangement?

F. Do you have any agreement to provide services for reimbursement by companies? Yes / No

1. If yes:
 - i. How long does it take to get reimbursed?
 - ii. What are the main problems with this arrangement?

V. Managing services to poor patients:

A. For patients who are very poor, do you offer help with paying for your services?

Yes / No

1. If yes: How?

Free care	
Discount prices	
Deferred payment	
Payment in kind	
Less expensive care	
Free samples of medicines	
Other	

B. How do you determine which patients are very poor?

Doctor's discretion	
Recommendation from local representative	
Social welfare agent makes assessment	
Use poverty card (e.g. white card scheme)	
Other _____	

C. Do you keep records on assistance given to the poor? Yes No

D. If Yes: How many patients have you offered help with paying for services in 1998?

E. How would you keep records on assistance provided to the poor if it were required?

VI. Capital investments:

A. Was a loan required to startup this hospital?

B. What was the source of the startup loan?

Commercial Bank		Relative or friend	
Development Financial Institution		Government	
Other Financial Institution		Others (specify)	

C. IF NO, Why has this hospital not taken a loan?

Didn't need loan		Collateral too much	
Interest too high		Bank refused	
Application process too difficult		No credit available	

D. Over the last year, has your hospital invested in buildings? Yes / No

1. If yes, what was the purpose of the investment?
2. And, what was the main source of financing?

	Primary source	Secondary sources
Donors and / or charitable sources		
Earnings		
Government allocation		
Personal / family resources		
Bank loan		
Other investors		

E. Over the last year, has your hospital invested in equipment? Yes / No

1. If yes, what was the purpose of the investment?
2. And, what was the main source of financing?

	Primary source	Secondary sources
Donors and / or charitable sources		
Earnings		
Government allocation		
Personal / family resources		
Bank loan		
Other investors		

F. Has this hospital received the following benefits (Write Yes or No):

Tax exemptions		Discounted or free land	
Duty exemptions		Low interest loan	
Reduced utility charges			

G. Based on your experience, how much of an obstacle, you think, are the following credit and other factors to the operation of your health care institution?

	No obstacle	Moderate obstacle		Very severe obstacle
		2	3	
Level of interest rates				
Excessive collateral requirements				
Too much paperwork, too many rules				
Need for connections with bank officials				
Problems with letters of credit				
Problems with money transfers and checks				
Lack of supplier credit				
Corruption of bank officials				
Donations reduced				
Accessing land				
Getting office space				
Other (specify)				

H. How often do you have problems with the following public services and infrastructure?

	A lot	Some	Occasional	No problem
Electricity breakdowns and voltage fluctuations/frequency variations				
Telecommunications breakdowns				
Inadequate water supply				
Poor drainage services				
General waste disposal				
Disposal of bio medical waste				
Availability of transportation				

I. Do you plan a major investment in building or equipment over the next year?**1. If Yes:**

- i. What is the purpose of your planned investment?
- ii. How do you propose to obtain finance for the planned investment?
- iii. Would you welcome a financial equity partner? Yes/No
- iv. If Yes: what share of equity would you be prepared to give to a financial equity partner?

VII. Opinion about regulation**A. How useful could the following procedures be in improving the quality of hospital services in this state?**

	Very useful	Of some use	Of little use	No use
Hospital registration				
Renewing hospital registration				
Registering doctors				
Renewing doctors registration				
Voluntary accreditation of hospitals by independent non government organisations				
Compulsory accreditation of hospitals by government				
Hospital quality assurance procedures				
Continuing education programs for doctors				

B. In operating your business, how much of an obstacle is each of the following issues dealing with regulations?

	No obstacle	Moderately sever		Very severe obstacle
		2	3	
Price controls				
Labor/trade union regulations				
High level of taxes				
Tax administration, collection procedures				
Functioning of the judicial system				
Quality standards				
Corruption by police				
Corruption by government officials				
Difficulty in getting government clearances				
Unfair competition from other health providers				
Other (specify)				

C. When a patient dies in this hospital, are there any procedures to review circumstances of the death? If yes, Please describe.

D. In the last three months, how many times has this hospital been visited by someone from government for purposes of monitoring?

VIII. Any other remarks:

Appendix - 1.3

Health Care Diagnostic Facility Questionnaire

I. Front Sheet (To be filled in stages corresponding to progress of data collection):

A. Health Care Institution (HCI):

Name of the
Diagnostic Facility:

HCIId:

B. Surveyor Information:

Surveyor Name:

Surveyor Code

C. Initial contact was:

Scheduled by phone

Scheduled in person

Scheduled through a common contact

Notified through a letter

D. Date(s) of visit for collection of data:

Visit No.	Date	Start time	End time	Items filled and remarks
1				
2				
3				

E. Persons contacted to collect information:

Name	Position	Items for which (s)he was useful, and remarks

F. Sampling Locator:

HCI Name:

HCIId:

G. General comments regarding the data collection process:

II. Addresses:

A. Mailing address:

Name of the diagnostic facility / nursing home / clinic:	HCIId:	
Street:	Locality	
City:	State:	PIN:

B. Telecommunication numbers & addresses:

Type	STD Code - Number / Address	Remarks
General Phone(s):		No. of phone lines:
Casualty Phone:		No. of phone lines:
Fax:		WWW Home:
E-mail:		

C. TIDs (related territorial Ids and codes for mapping):

UbnId	HabtnId	VillageId	91 Census Code

III. Incorporation details:

A. Type of firm:

For Profit	Sole Proprietorship Firm	
	Partnership Firm	
	Private Limited Company	
	Public Limited Company	
	Co-operative	

Non profit	Non Profit Company	
	Society / Association Registered under the Societies Act	
	Registered Trust	
	Unregistered Trust	
	Other (specify):	

B. Registration details:

Registration No:	Date:
Registering Authority:	Regn Reference:

IV. Owner, Manager, or Such other Contact person¹ information:**A. Name and role:**

Prefix	Given Name / First Name	Family Name / Surname	Suffix
--------	-------------------------	-----------------------	--------

Designation i.e. Position with respect to this Health Care Institution:

B. Mailing address (If different from the address of Health Care Institution) :

Street:	Locality
---------	----------

City:	State:	PIN:
-------	--------	------

C. Telephones etc.:

Work phone:	Home phone
-------------	------------

Fax:	Mobile phone:
------	---------------

E-mail:	Pager:
---------	--------

V. Establishment year and size:

Year established:	Size when established:
-------------------	------------------------

Current year:	Current size:
---------------	---------------

¹ The person from management who knows the most about this health care institution and will be a suitable candidate to answer more questions about the institution's history and its current functioning.

VI.Promoter(s) (In order of importance. Use addl. sheet if required):

Prefix Given Name / First name Family name / Surname Qualifications Profession

Street: Locality

City: State: PIN:

Work phone Fax: Home phone:

Prefix Given Name / First name Family name / Surname Qualifications Profession

Street: Locality

City: State: PIN:

Work phone Fax: Home phone:

VII.Establishment / Foundation remarks:

A. What was the top motivating force for its establishment?

For profit:

Earn livelihood Practice facility For profit

Non profit:

Missionary / Religious Philanthropy Voluntary

B. Remarks and notes:

VIII.Premises:

Type of construction:

HCI floor space in Sft.:	Owned by this health care institution	
Plot area in Sq. yards:	Rented from the promoter(s):	
Other occupants if any:	Rented from unrelated person:	
Others floor space in Sft.	Other arrangements (mention):	

IX. Work force and labor:**A. Summary of staff :**

	Full-time	Part-time-Pvt	Part time- Govt.
Specialist doctors			
General duty doctors			
Lab Technicians / Radiologists, etc.			
Other paramedical staff			
Managers / administrators			
Support staff			
All			

B. How often do you have to face problems or worry on account of the following?

	Very often	Often	Occasionally	Never
Low productivity of laborers				
High cost of skilled employees				
Non availability of skilled employees				
Missed work due to illness or death				
Absenteeism				
Lack of skilled management				
Restrictions on laying off workers				
Regulations on working conditions				
Trade union activities or restrictions				
Seasonal shortages of unskilled labor				
High turnover of staff				
Other				

X. Revenue income:

A. Please rank the following seven items on their contribution to total revenues at this health care facility.

Give 1 for the item that contributes the most, to 7 for the item that contributes the least. Identify, in order the top three contributors to your revenue. Gone up or down is w.r.t. last year.

Revenue source	Rank	Gone up (↑) or down (↓)	Remarks
Patient fees for room and board			
Pharmacy sales			
Laboratory services			
Service contracts with employers			
Fee shared from diagnostic centers outside the hospital			
Fee shared from pharmacies outside the hospital			
Insurance payments			
Other _____			

B. Does your revenue from patient services cover your operating expenses? Yes / No

1. **If no:** How do you make up the difference?

C. Can doctors in this diagnostic facility set fee levels themselves? Yes / No

D. How often do you encounter the following payment related problems for your diagnostic facility?

	Very important	Of some importance	Of little importance	Not important at all
Nonpayment by patients				
Nonpayment by government				
Nonpayment by employer contractors				
Too few paying patients				
Too much competition from other hospitals and clinics				

C. Do you keep records on assistance given to the poor? Yes No

D. If Yes: How many patients have you offered help with paying for services in 1998?

E. How would you keep records on assistance provided to the poor if it were required?

XII.Capital investments:

A. Was a loan required to startup this diagnostic facility?

B. What was the source of the startup loan?

Commercial Bank	Relative or friend
Development Financial Institution	Government
Other Financial Institution	Others (specify)

C. IF NO, Why has this diagnostic facility not taken a loan?

Didn't need loan	Collateral too much
Interest too high	Bank refused
Application process too difficult	No credit available

D. Over the last year, has your diagnostic facility invested in buildings or equipment?
Yes / No

1. If yes, what was the purpose of the investment?

2. And, what was the main source of financing?

	Primary source	Secondary sources
Donors and / or charitable sources		
Earnings		
Government allocation		
Personal / family resources		
Bank loan		
Other investors		

General waste disposal

Disposal of bio medical waste

Availability of transportation

H. Do you plan a major investment in building or equipment over the next year?

1. If Yes:

i. What is the purpose of your planned investment?

ii. How do you propose to obtain finance for the planned investment?

iii. Would you welcome a financial equity partner? Yes/No

iv. If Yes: what share of equity would you be prepared to give to a financial equity partner?

XIII. Opinion about regulation

A. How useful could the following procedures be in improving the quality of diagnostic facility services in this state?

	Very useful	Of some use	Of little use	No use
Diagnostic facility registration				

Renewing diagnostic facility registration

Registering doctors

Renewing doctors registration

Voluntary accreditation of hospitals by independent non government organisations

Compulsory accreditation of hospitals by government

Diagnostic facility quality assurance procedures

Continuing education programs for doctors

XIV. Pathology / Microbiology laboratory services offered by this facility:**A. Availability, monthly output and fee:**

Test / Service	Yes / No	No of tests / month (approx.)	Fee	Remarks
----------------	----------	-------------------------------	-----	---------

Pap smear

B. Type of fee schedule for these services:

Published Not published but widely known Fixed from case to case basis.

C. When was the above tariff fixed?**XV. Biochemistry laboratory services offered by this diagnostic facility:****A. Availability, monthly output and fee:**

Test / Service	Yes / No	No of tests / month (approx.)	Fee	Remarks
----------------	----------	-------------------------------	-----	---------

Hormone test

B. Type of fee schedule for these services:

Published Not published but widely known Fixed from case to case basis.

C. When was the above tariff fixed?

XVIII. Other services offered by this diagnostic facility:

A. Availability, monthly output and fee:

Test / Service	Yes / No	No of tests / month (approx.)	Fee	Remarks
Blood bank				
Allergy test				
Peritoneal dialysis				
Haemodialysis				

B. Type of fee schedule for these services:

Published
 Not published but widely known
 Fixed from case to case basis.

C. When was the above tariff fixed?

XIX. Patient Referral:

A. Does this health care institution receive patients regularly referred by other health care providers?

B. If yes, what are the health care institutions from where or who are the providers from whom, you regularly receive cases?

HCId	HCName	Service Type	No of referrals in a month

C. Does this facility share fees received from diagnostic services with the concerned referring health care institution or doctor?

Appendix - 1.4

Health Care Professional - Personal Questionnaire

We are conducting a study to find out what aspects of work are important to health care providers. Please fill out the following questionnaire to the best of your ability. No individuals will be identified from this survey.

I. Personal information:

A. Name and role:

Prefix	Given Name / First Name	Family Name / Surname	Suffix
Designation:			Age:
Profession & Qualifications:			Sex:

B. Mailing address (If different from the address of the Health Care Institution) :

Street:		Locality
City:	State:	PIN:

C. Telephones etc.:

Work phone:

Home phone

Fax:

Mobile phone:

E-mail:

Pager:

II. What factors are important to you in an ideal job?

1. (Disregard the extent to which these factors are present in your current job.)
2. Key:

EI	Extremely Important
VI	Very Important
SI	Of some importance
LI	Of little importance
NI	Not important at all

# Statement	EI	VI	SI	LI	NI
	1	2	3	4	5
1 Having sufficient time for your personal or family life					
2 Having good working relationships with your colleagues					
3 Doing challenging work which gives you a sense of accomplishment					
4 Having training opportunities to improve your skills or learn new skills					
5 Having good physical working conditions					
6 Having the tools and materials to use your skills fully on the job					
7 Having a good income					
8 Having good employment benefits (e.g. pension, housing)					
9 Having good opportunities to advance to a better job					
10 Having a superior who recognizes your good work					
11 Having independence from interference by superiors					
12 Knowing that you can keep your job for as long as you want it					
13 Having your work influenced by political decisions					
14 Being respected and trusted by your clients					
15 Being based in a desirable location (e.g. with good schools and housing)					
16 Knowing what you are expected to do and achieve at work					
17 Being able to get what you want within the organization by paying favors/bribes					

III. To what extent are these same factors present in your current job?

1. Key:

- FP Fully present
 LE To a large extent
 SE To some extent
 AL A little
 NA Not at all

#	Statement	FP	LE	SE	AL	NA
		1	2	3	4	5
1	Having sufficient time for your personal or family life					
2	Having good working relationships with your colleagues					
3	Doing challenging work which gives you a sense of accomplishment					
4	Having training opportunities to improve your skills or learn new skills					
5	Having good physical working conditions					
6	Having the tools and materials to use your skills fully on the job					
7	Having a good income					
8	Having good employment benefits (e.g. pension, housing)					
9	Having good opportunities to advance to a better job					
10	Having a superior who recognizes your good work					
11	Having independence from interference by superiors					
12	Knowing that you can keep your job for as long as you want it					
13	Having your work influenced by political decisions					
14	Being respected and trusted by your clients					
15	Being based in a desirable location (e.g. with good schools and housing)					
16	Knowing what you are expected to do and achieve at work					
17	Being able to get what you want within the organization by paying favors/bribes					

Thank you for taking the time to complete this questionnaire.

Appendix - 1.5

Questionnaire for Alternate Private Practitioner

I. Front Sheet (To be filled in stages corresponding to progress of data collection):

A. Health Care Institution (HCI):

Name of the hospital /
nursing home / clinic:

HCIId:

B. Surveyor Information:

Surveyor Name:

Surveyor Code

C. Initial contact was:

Scheduled by phone

Scheduled in person

Scheduled through a common contact

Notified through a letter

D. Date(s) of visit for collection of data:

Visit No.	Date	Start time	End time	Items filled and remarks
1				
2				
3				
4				

E. Sampling Locator:

HCI Name:

HCIId:

F. General comments regarding the data collection process:

II. Addresses:**A. Personal data and mailing address:**

Name of the private practitioner / clinic:	HCIId: Age	Sex:
Street:	Locality	
City:	State:	PIN:

B. Telecommunication numbers & addresses:

Type	STD Code - Number / Address	Remarks
General Phone(s):		No. of phone lines:
Casualty Phone:		No. of phone lines:
Fax:		E-mail:

C. TIDs (related territorial Ids and codes for mapping):

UbnId	HabtnId	VillageId	91 Census Code

III. Establishment Information:**A. Registration details:**

Registration No:	Date:
Registering Authority:	Regn Reference:

B. Year of establishment and size:

Year established:	Size when established:
Current year:	Current size:

C. Describe the circumstances leading to establishment of this practice / clinic:

IV. Qualifications, and Training:**A. Educational qualifications (List most recent first):**

School, College, University or Institution	Certificate, Diploma or Degree	Year
--	--------------------------------	------

B. Internship, apprenticeship and practical experience

Name	Person / Institution where worked	Credentials	Position during apprenticeship	From	To	Duration
------	-----------------------------------	-------------	--------------------------------	------	----	----------

C. Please list the top three reasons¹ why you became a doctor?

1.

2.

3.

D. What system of medicine do you practice?

Allopathy Ayurveda Siddha Unani
 Homeopathy

E. Are you a member of any professional society? If yes please mention details below:

Name of the Society, Address, etc.	Member since	How is it useful to your work?
------------------------------------	--------------	--------------------------------

V. Facilities:**A. Equipment: Check the equipment from the following list, that is available in your clinic.**

Thermometer Stethoscope BP Apparatus Microscope
 Steriliser Operation theatre

¹ For example; 1. (a) Following a family tradition, (b) Having a good source of income, (c) Providing service to people in need, (d) Being free from bosses, (e) Being trusted by clients, (f) Being able to live in a good place.

B. Medicines: Check the medicines from the following list, that is available in your clinic.

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Paracetamol | <input type="checkbox"/> Antibiotic capsules | <input type="checkbox"/> Antibiotic injections | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Oral rehydration salt | <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Saline and IV fluids | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

C. Clinic / Hospital requisites: Check the clinic requisites from the following list, that is available in your clinic.

- | | | | |
|---------------------------------|--|--|---------------------------------|
| <input type="checkbox"/> IV Set | <input type="checkbox"/> Surgical suture | <input type="checkbox"/> Spirit cotton | <input type="checkbox"/> Savlon |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

VI. Practice details:

A. What are the three most common conditions that you treat?

- 1.
- 2.
- 3.

B. Do you perform surgery?

C. If yes, please list the three most common surgical procedures done by you.

- 1.
- 2.
- 3.

D. How many patients did you treat today and the last two days?

Today:

Yesterday:

The day before yesterday:

E. Did you treat any of the following conditions, today and the last two days?

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
Diarrhoea		Vaginal discharge		Tuberculosis	
Cough		Sexual dysfunction		Diabetes	
Fevers		Problems during pregnancy		Fractures	
Pains and aches		Delivery		Snake bites	
Skin conditions		High blood pressure		Insect bites	
Penile discharge					

F. What treatment do you prefer to give to a patient with tuberculosis?

G. How long is the course of treatment you prefer to give for a patient with tuberculosis?

H. What treatment do you prefer to give to a patient with malaria?

I. How long is the course of treatment you prefer to give for a patient with malaria?

J. For what conditions do injections work best?

K. Please list the conditions where you usually have to prescribe injections:

- 1.
- 2.
- 3.
- 4.
- 5.

L. Do you participate in any of the following national health programmes, and how?

National health programme	Yes	No	Type of involvement ²
Polio campaign			
Family planning			
Leprosy control			
Tuberculosis control			
Blindness control			
Malaria control			
AIDS control			

M. Would you like to participate in any of these national health programmes?

N. If yes, How?

² Use following codes if applicable: 1. Provide information to the public, 2. Distribute contraceptives / drugs, 3. Refer cases, 4. Treat patients with the given condition, 5. Use guidelines from program authorities.

VII. Referral services:

A. Do visiting consultants offer services at this place? And what type of services are offered by them? Give details.

Consultant's Home Institution		Name	Service Type	Periodicity
HCID / HC Name, City	Govt. Pvt.			

B. When is the last time you referred a patient to another doctor or hospital?

What was the condition of the Patient ³	When	To where	Why did you select that facility
--	------	----------	----------------------------------

C. How often do you accompany a patient you have referred to another hospital / doctor?

Always
 Usually
 Some times
 Never

D. Do you refer patients to outside diagnostic centres?

E. If yes what are the main places patients are referred to:

HCID	HCName	Service Type	No of referrals in a month
------	--------	--------------	----------------------------

³ For example; Patient with severe diarrhoea, Complicated delivery, Cough or difficult breathing, Chest pain, etc.

F. When you refer a patient for diagnostic tests, do you get any payment from the diagnostic centre?

G. If yes, what are the rates or type of payment and basis?

Test	Nature of arrangement with diagnostic centre (Ex: Per test Rate or a percentage of the fee, etc.)
X-ray	
Lab test	
Others	

H. How many times have you been visited by a medical (pharmaceutical) representative in the last month?

Name of the company represented	Did he give free samples? If yes, of what product?	What reward does this representative or company give, if you promote their product?

VIII. Fees and service charges:

A. What is your usual charge for seeing a patient?

B. Are you engaged in any other profession apart from the medical practice?

C. What portion of your income comes from your medical practice? Would you say ...

Nearly all About 3/4th About half Less than half

D. What is your average monthly income (approximately)?

E. Do you see very poor patients, who may not afford to pay your charges, or cost of treatment?

F. If yes;

1. How do you help them pay for your fees and cost of treatment?

Free care Discount prices Deferred payment Payment in kind

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Less expensive care | <input type="checkbox"/> Free sample of medicines | <input type="checkbox"/> Medical camps | <input type="checkbox"/> Senior citizen discounts |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. How many patients have you offered help with paying for your services over today, and the last two days?

Today:	Yesterday:	The day before yesterday:
_____	_____	_____

3. How do you know which patients are very poor?

- Common knowledge Manner of clothing Question family and patient Other

IX. Opinion about government health services and policy:

A. How would you rate government health services in your area?

	Very good	Good	Poor	Very poor
Public health services (Eg: Immunisation, Disease control programmes, Control of epidemics, etc.)				
Ambulatory (out patient) medical care				
Hospital services				
Family planning services				

B. What type of assistance will help to improve the quality of your practice?

Assistance	Yes / No	Examples, details etc.
Training		
Equipment		
Communication materials, eg. posters for patients		
Books, guidelines for practitioners.		
Others:		

Appendix - 1.6E

Patient Exit Interview

I. Interviewer Information:

Interviewer Code

Date of Interview

Place of Interview

II. Provider Information:

Provider (HCI) Name

Provider (HCI) Id (HCIId)

Date of Client - Provider
Encounter (Ex: Date of
admission, Date of
consultation etc.)

III. Informant:

Name

Same as patient

Attendant

Relationship with patient

Address:

IV. Patient Information:

Name

Address:

Age

Sex: Male

Female

Caste: SC

ST

BC

If age \geq 15 years; How many years you have attended school?

If age $<$ 15 years; How many years has the mother attended school?

V. Interviewer / Surveyor's observation about the house:

Pucca house Semi pucca Kacha house

VI. Patient's Household Information¹:

A. What is the main source of drinking water for members of your household?

Private protected (piped / deep bore well)

Private unprotected (shallow bore well, open well)

Public protected (piped, deep bore well)

Public unprotected (open well)

Natural unprotected (spring, river, pond, lake)

Other

B. What kind of toilet facility do most members of your household use?

Private flush toilet

Shared flush toilet

Shared flush toilet

Traditional pit latrine

Ventilated improved pit latrine

Other

No facility / bush / field

C. What type of fuel does your household mainly use for cooking?

LPG / Natural gas

Biogas

Kerosene

Coal

Fire wood / straw

Dung

Other

D. Does your household own any of the following?

Yes No

A sewing machine?

A clock or watch

A sofa set?

A fan?

A television?

A bicycle?

A moped, motor cycle or scooter?

A bullock cart?

A water pump?

¹ Explain to the respondent the purpose of these questions first. Some respondents may find these questions irrelevant to the topic at hand. Clarify that these questions are designed to understand the socio - economic status of patients using a health care facility. Also clarify that the same questionnaire is used to interview patients in urban and rural areas.

VII. How satisfied were you with:

#	Statement	Poor	Fair	Good	VGood	Excellent
		1	2	3	4	5
1	Getting through to the hospital / health center to get an appointment?					
2	How long you had to wait to get an appointment?					
3	Convenience of the health facility location?					
4	Length of time spent waiting?					
5	Personal manner (courtesy, respect, sensitivity, friendliness) of the physician?					
6	The technical skills and quality (thoroughness, carefulness, competence) of the physician?					
7	Personal manner (courtesy, respect, sensitivity, friendliness) of the nurse?					
8	The technical skills and quality (thoroughness, carefulness, competence) of the nurse?					
9	Personal manner (courtesy, respect, sensitivity, friendliness) of other staff?					
10	The technical skills and quality (thoroughness, carefulness, competence) of other staff?					
11	The explanation of what was done to you?					
12	The overall visit / stay?					

VIII. How will you rate the hospital / clinic in terms of the following facilities?

#	Statement	Poor	Fair	Good	VGood	Excellent
		1	2	3	4	5
1	Doctors					
2	Nurses					
3	Medical, surgical and diagnostic equipment					
4	General comfort					

IX. Miscellaneous questions:

A. Did the doctor tell you your diagnosis?

B. What was the diagnosis, you were told?

C. Has the doctor asked you to pay a repeat visit?

1. When?

D. What kind of medicines were provided by the hospital / clinic?

1.

2.

3.

E. What are the medicines, you have had to buy?

1.

2.

3.

F. Will you go to the same health facility again, if there is a need?

G. If some one in your house falls ill, will you recommend the same health facility?

H. Was the billing in the hospital fair (rational and transparent)?

I. If no, how, you think, the billing process should be improved?

Appendix-1.6T

రోగి వైద్యానంతర సమాచారము

I. ఇంటర్వ్యూ సమాచారము:

ఇంటర్వ్యూ కోడ్ :
ఇంటర్వ్యూ చేసిన తేది :
ఇంటర్వ్యూ నిర్వహించిన స్థలము :

II. వైద్యసేవలు అందించిన వారి సమాచారము:

వైద్య సంస్థ పేరు
వైద్య సంస్థ గుర్తు
ఆసుపత్రిని సందర్శించిన తేదిల వివరములు-
(వైద్యసంస్థలో చేరిన తేది, డిస్చార్జ్ తేది)

III. రోగి/రోగి బంధువు లేక మిత్రుని సమాచారము:

పేరు
సమాచారము ఇచ్చినది బంధువు రోగితో బంధుత్వం
చిరునామా

IV. రోగి సంబంధిత సమాచారము:

పేరు
చిరునామా :

వయస్సు స్త్రీ పురుషుడు కులము యస్సి యస్.టి బిసి ఇతరులు

వయస్సు15 >= సంవత్సరములు అయితే ఎన్నిసంవత్సరాలు విద్యనభ్యసించారో తెలపండి

వయస్సు15 < సంవత్సరములు అయితే మీ తల్లిగారు ఎన్నిసంవత్సరాలు విద్యనభ్యసించారో తెలపండి

V. గృహ సంబంధిత పరిశీలన

పక్కా యిల్లు రేకుల/పెంకుల ఇల్లు కచ్చాయిల్లు ఇతరములు

VI. రోగి యొక్క కుటుంబసమాచారము:

A. మీ కుటుంబ సభ్యులకు తాగునీటి సౌకర్యము ఎటువంటిది?

స్వయంగా నిర్మించుకొన్నవి
ప్రకృతి నుండి రక్షణ కలిగినవి
(పైపు/గొట్టపుబావి)

స్వయంగా నిర్మించుకొన్నవి
ప్రకృతి నుండి రక్షణ లేనివి
(దిగుడు బావి/బావి)

ప్రభుత్వంచే నిర్మించినవి
ప్రకృతి నుండి రక్షణ కలిగినవి
(పైపు/గొట్టపుబావి)

ప్రభుత్వంచే నిర్మించినవి
ప్రకృతి నుండి రక్షణ లేనివి
(దిగుడు బావి/ బావి)

సహజముగా ఎర్పడినవి
(నది/కొలను/గుంట/ సరస్సు)

ఇతరములు

B. ఎక్కువగా మీకుంటుంబ సభ్యులు ఉపయోగించుచున్న మరుగుదొడ్ల సౌకర్యము

స్వంతంగా నిర్మించుకొన్నవి-(నీటి సౌకర్యము కలిగినవి)

భాగసామ్య మరుగుదొడ్లు

సాంప్రదాయ మరుగుదొడ్లు

అభివృద్ధి చెందిన ఆధునిక గుంట మరుగుదొడ్లు

ఇతరములు

ఎ సౌకర్యములేదు/పొదలు/పొలము

C. వంట కొరకు మీ కుటుంబము ముఖ్యముగా ఎమి ఉపయోగిస్తారు

ఇంధన గ్యాస్

గోబర్ గ్యాస్

కిరోసిన్

బొగ్గు

కర్రలు/ చెక్క

పేడ/ పిడకలు

ఇతరములు

D. క్రింద తెలిపిన వస్తువులు మీకు ఉన్నాయా?

	అవును	కాదు
కుట్టు యంత్రము		
గోడగడియారము		
సోఫా -		
ఫంకా -(ఫ్యాన్)		
టెలివిజన్ -		
ద్విచక్ర వాహనము(సైకిలు)		
స్కూటరు		
ఎడ్ల బండి		
నీళ్లపంపు -(మోటారు పంపు)		

VII. వైద్య సంస్థ సేవలపై మీ యొక్క సంతృప్తి

వరుస నెం	అంశములు	బాగా లేదు	పరవా లేదు	బాగుంది	చాలా బాగుంది	అద్భుతంగా ఉంది
		1	2	3	4	5
1	సందర్శించిన వైద్య సంస్థలో అనుమతి పొందడంలో మీ అనుభవం					
2	అనుమతి పొందుటకు పట్టిన సమయము					
3	వైద్య సంస్థ ఉన్న ప్రదేశం అందుబాటు లో ఉన్నదా?					
4	మీరు వేచియున్నటువంటి సమయము					
5	వైద్యుని ప్రవర్తన (మర్యాద, స్నేహపూరిత, దయ, ఆప్యాయత)					
6	వైద్యుని నైపుణ్యత మరియు నాణ్యమైన సేవలు (జాగ్రత్త/అవగాహన)					
7	నర్సుల ప్రవర్తన (మర్యాద, స్నేహపూరిత, దయ, ఆప్యాయత)					
8	నర్సుల నైపుణ్యత మరియు నాణ్యమైన సేవలు (జాగ్రత్త/అవగాహన)					
9	ఇతర సిబ్బంది ప్రవర్తన (మర్యాద, స్నేహపూరిత, దయ, ఆప్యాయత)					
10	ఇతర సిబ్బంది నైపుణ్యత మరియు నాణ్యమైన సేవలు (జాగ్రత్త/అవగాహన)					
11	మీకు అందించిన వైద్య సేవల గూర్చి మీకు వివరించారా?					
12	ఈ వైద్య సంస్థ పై మీ అభిప్రాయము/అనుభవము					

VIII. ఈ క్రింద తెలిపిన విషయాలు/సౌకర్యములను బట్టి ఈ వైద్య సంస్థ గూర్చి ఎలా చెప్పగలము

వరుస నెం	అంశములు	బాగా లేదు	పరవా లేదు	బాగుంది	చాలా బాగుంది	అద్భుతంగా ఉంది
		1	2	3	4	5
1	వైద్యులు					
2	నర్సులు					
3	వైద్య/శస్త్రచికిత్స, రోగనిర్ధారణ పరిక్షలకు సంబంధించిన పరికరములు					
4	ఇతర సౌకర్యములు					

IX. ఇతర విషయాల గూర్చి ప్రశ్నలు

A. డాక్టరు గారు మీ వ్యాధి/రోగలక్షణాలు గూర్చి తెలిపారా?

B. మీకు తెలియపరిచిన వ్యాధి/రోగలక్షణాలు ఎమిటి?

C. మీరు ఈ వైద్యసంస్థకు మరల రమ్మని డాక్టరుగారు చెప్పారా?

1. ఎప్పుడు

D. ఆసుపత్రివారు ఏ ఏ మందులు ఇచ్చారో తెలపండి?

1.

2.

E. మీరు ఏ ఏ మందులు బయట నుండి కొనవలసి వచ్చినదో తెలపండి?

1.

2.

F. మరల అవసరము అయితే అదే ఆసుపత్రికి వెళతారా?

G. మీ ఇంటిలో ఎవరికైనా ఆరోగ్యము సరిలేకపోతే ఇదే ఆసుపత్రికి వెళతారా?

H. ఆసుపత్రి లో రుసుము (ఫీజు) సబబుగా/ చెల్లించేవిధముగా ఉందా?

I. లేనట్లయితే రుసుము-(ఫీజులు) పద్ధతి అభివృద్ధి చేయుటకై మీ సలహా ఎమిటి?