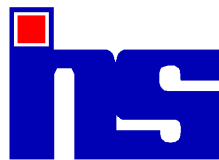


The private health sector in Andhra Pradesh

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THE INSTITUTE OF HEALTH SYSTEMS

Studies on

The Private Health Sector in Andhra Pradesh.

And proceedings of a workshop on the Private Health Sector in AP,
sponsored by the AP First Referral Health System Project.

Editors:
Prasanta Mahapatra and M. Nagarjuna

Price: INR 400/-

Preface

This report is the result of the collaborative efforts of the Institute of Health Systems (IHS), Hyderabad and the AP First Referral Health System (APFRHS) Project based at the AP Vaidya Vidhana Parishad (APVVP) office.

The Institute has been actively studying various aspects of the private health sector, with special emphasis on standards and quality assurance. To enable research and study of the private health sector the Institute has built up a computerised database of health institutions in AP. The private hospitals and nursing homes component of this database was incorporated in 1993 and was further validated in 1994. The Institute has been researching about the feasibility of accreditation systems in India and Andhra Pradesh in particular including development of minimum standards for reproductive services delivered by private hospitals and nursing homes etc.

Recognising the inadequacy of facilities for first referral health care the APVVP is implementing the AP First Referral Health System Project funded by the World Bank, to augment first referral hospital stock in the public sector. The project also seeks to facilitate formulation and implementation of suitable policies for development of the private health sector and thereby improve the overall health care facilities of the state. Consequently the APFRHS project commissioned the IHS to take up a set of rapid studies and take stock of the private health sector in Andhra Pradesh and identify appropriate policy choices to improve their overall development. These studies include on going work pursued by the IHS on a long term basis and also on short duration studies taken up to meet the requirement of the APFRHS project. As a part of this study a workshop was organised in May 1998, with participants from the private health sector and public health officials. Result of the studies spearheaded by IHS were presented in the workshop and various issues were discussed.

This report is the result of studies culminating in the workshop on the Private Health Sector in Andhra Pradesh, May 23-24, 1998. Although the studies and workshop were organised in the context of Andhra Pradesh state, the issues, findings and solutions proposed here are relevant to the health systems of all states in India as well as many other developing countries.

Editors

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A study of the private sector medical facilities in Andhra Pradesh:1998.

Dr. Prasanta Mahapatra

I. Introduction:

In addition to the public sector, private and voluntary health sectors play a key role in provision of health care services. Analysis of the 42nd round National Sample Survey (NSSO 1989) data showed that for outpatient care about 70% in both rural and urban areas sought treatment from private sector. However, the case was reverse when it came to inpatient care. Only 37% of inpatients in the rural as well as urban areas sought treatment from private health sector. The figures for out patient utilisation of private health sector in A.P was 75% in rural areas and 71 % in urban areas, only slightly higher than the all India figures. In AP utilisation of private hospitals and nursing homes for inpatient care is much higher compared to the national average (69% in rural areas and 58% in urban areas).

**Table-1: Sources of medical care in All India and Andhra Pradesh in 1989.
(NSS 42nd Round)**

Area		Out patient						In patient	
		Public		Private		Public	Private		
		Clinic	Hospital	Both	Clinic	Hospital	Both	Hospital	Hospital
All India	Rural	7.53	17.67	25.2	53.01	15.98	68.99	59.74	36.85
	Urban	2.94	22.6	25.54	51.83	17.33	69.16	60.26	36.59
AP	Rural	4.54	14.38	18.92	40.05	34.64	74.69	29.91	68.58
	Urban	2.09	18.46	20.55	26.62	44.23	70.85	37.98	57.88

¹ Figures will add up to a little less than 100%. The balance is from other sources like ESI, and non profit institutions. Some authors (Nandaraj 1998) include non profit sector with the private sector. Figures for non profit sector are very small. However, they have been excluded from both private and public sectors here.

Utilisation pattern of available hospital stock gives us an idea about relative preference of people, accessibility of institutional services to households etc. Over all service utilisation by households is, however, constrained by the total hospital stock available. Recognising the need to increase the first referral hospital stock and achieve wide dispersal of this stock all over the state, the state government is implementing the AP First Referral Health System (FRHS) project. A large number of first referral hospitals in the public sector, managed by the AP Vaidya Vidhana Parishad (APVVP), are being upgraded by this project. New public hospitals are being added.

Adequate development of private hospitals and appropriate inter linkages between the public and private health sector is required to improve overall availability of first referral hospital services in the state. Although private hospitals and nursing homes have grown in number and size, there are concerns about standards and quality of service, and accessibility. To understand the dynamics of the private health sector and to help formulate appropriate policies that will allow complementary and synergistic development of the private sector pari pasu the public health sector, the FRHS project sought to take up required private health sector studies with following objectives:

- i. Make a quantitative assessment of the medical facilities available in the private sector in the state.
- ii. Analyse the nature of services being provided by the private sector and examine the role of this sector vis-a-vis the public sector.
- iii. Identify the range of medical interventions where the private sector institutions have an advantage over the public sector in terms of service as well as acceptability among the users.
- iv. Examine the scope for regulation of the private sector through (a) self regulation and (b) legislative process.
- v. Develop a program for monitoring the growth both in quantitative terms as well as in terms of the range of services provided by the institutions in the private sector.

The Institute of Health System (IHS) was commissioned¹ to do a quick study to address the above terms of reference. This paper summarises the study method, results and recommendations on each of the above issue referred to the IHS by the FRHS project authorities.

II. Methodology:

The time frame available for completion of the study was very limited. So the scope for primary data collection was not there. Reasonable secondary sources of data exists in Andhra Pradesh to on the study objectives. The AP Health Institutions DataBase (APHIDB) maintained by the IHS provides reasonably accurate information about private hospitals and nursing homes as in 1994. Although primary data collection would have improved accuracy of estimates sought from the study, the nature of policy recommendations would not be very different since information about public and private sector as in 1994 was compared. One of the terms of reference of this study is to recommend a system of monitoring changes in size and service offerings by the private sector. So further improvements to availability of data by periodic primary data collections is expected follow this study rather than precede it. The study used information from multiple sources including the following four:

- 1) Information from the APHIDB,
- 2) Studies on quality assurance and accreditation systems done at the IHS and elsewhere in the country,
- 3) Two sub studies commissioned by IHS for this study, and
- 4) The workshop on the private health sector in AP.

A. AP Health Institutions Database (APHIDB):

The AP health institutions database (APHIDB) is maintained by the Institute of Health Systems, Hyderabad. It is a database of all health care institutions in Andhra Pradesh. The APHIDB is maintained by IHS and is made available over its local area network to visiting public, researchers and health policy analysts for reference. Special queries have been written to meet specific requirement of researchers. Mostly people have used the database to generate list of hospitals at a chosen place, to generate a sampling frame of hospitals in a given area for purposes of research.

The private hospitals component of the APHIDB originates from a private hospitals survey conducted by the government of AP around December 1992 to January 1993. Data collected

¹ Vide The Project Director, AP FRHS letter number 2249/WB/F/98 dated April 4, 1998.

by the Director Health was obtained by the IHS and incorporated into the APHIDB. This data is being gradually validated by the IHS through periodic validation campaigns.

Validation campaign typically start with mailing of a letter to each private health institution (PHI) included in the APHIDB. A printout of the information pertaining to the respective PHI is enclosed to the letter. A request is made to the owner manager of the PHI to check the information furnished to them and make necessary corrections based on ground realities. Corrections made by the responding PHIs were carried out in the database.

A field enquiry is then to supplement the mailing effort. Purposes of field enquiry include (a) check a sample of authenticated replies in mail to ensure that the information received by IHS can be relied upon, (b) check with those who returned the form but did not authenticate if the data is correct, (c) contact all those who did not respond at all, and (d) look for new health institutions if any that may not be in the database.

Experience and information gathered from the validation campaigns show that the data on private hospitals and nursing homes in the APHIDB was about 90% accurate as of 1993-94. Validation campaigns were conducted till 1994. The campaigns could not be pursued further due to lack of funding.

Data from the APHIDB was used to arrive at the size and range of services offered by the private sector hospitals (Mahapatra 1998).

B. Commissioned studies:

Two sub studies were commissioned to collate and analyse secondary information. The study by Nanda (1998) used records of debates in the AP legislative assembly and news reports pertaining to health sector to look at evidences of expressed felt need for quality assurance and accreditation systems in the health sector. The study by Srilatha (1998) took stock of all, mostly unpublished, work in APVVP about standards and quality assurance measures in APVVP.

C. Studies on quality assurance and accreditation systems:

Quality of services assurance appeared to be a major issue about development of the private health sector. Studies on standards, accreditation and quality assurance systems in the Indian health sector are few and far between. A set of studies relevant to the discussion on private health sector in Andhra Pradesh in particular and India in general, were identified. Either the authors or persons well versed with them were invited to present the study to the workshop discussed later. These papers, presentations by the invited speakers and discussions on each of them have been referenced to arrive at conclusions for this study. Following is the list of such studies and presentations:

1. Typology of health systems in OECD countries (Mahapatra, 1998) presented by the author.
2. Consumer Protection Act and the Medical Profession (Eshwar and Satyanaryana, 1994) presented by Dr. Satyanarayana.
3. Report of the AP Legislative Assembly Committee on Corporate Hospitals (AP Legislature, 1996), presented by M. Nagarjuna.
4. Accreditation system (Nandaraj, 1998), presented by the author.

5. Women's perception of quality of reproductive care in private hospitals in Andhra Pradesh (George 1997) presented by the author.
6. Assessment of demand for accreditation services in Hyderabad. A pilot study (Mahapatra and Rajaratnam, 1994) presented by Dr. Appala Naidu.

D. Consensus development workshop:

A workshop was organised to consider the estimates of medical facilities arrived from APHIDB, results of commissioned research and selected literature in light of the objectives of this study. Participants were invited from all over the state. Some participants from institutions outside of AP and known to have an understanding of various issues regarding development of the private health sector were invited. An effort was made to identify persons with intimate knowledge and understanding of the private hospitals and nursing homes in AP. Current involvement in management and / or service provision in private hospitals and nursing homes was used as a criteria to identify participants. Representatives of the AP Nursing Homes Association, State branch of the Indian Medical Association, persons associated with the Medical Council of India, Nursing Council etc. were invited. Officers from APVVP and the AP FRHS project also participated. The work shop took place over two days. Four presentation sessions including the inaugural session, two group discussions and a final panel discussion were planned and adhered to. Estimates derived from the APHIDB, information regarding other national health systems, standards, quality assurance and accreditation efforts in India, etc. were presented. Papers from the two commissioned studies and other papers from earlier work and relevant to the private health sector were discussed during the presentation sessions. Participants were informed about the objectives of the study commissioned by the FRHS project. The group discussions and the panel discussions were directed to resolve various issues relevant to the objectives of the study and to arrive at the recommendations based on consensus among the participants. Details regarding participants, program and discussions are contained in the workshop proceedings.

III. Results:

Results have been classified according to the list of objectives set out in the terms of reference for the study and are presented below. More details can be found in respective papers and the workshop proceedings.

A. Quantitative assessment of medical facilities in the private sector:

1. Latest data on the number of private hospitals and their bed capacity is not available. The best available information is from the AP Health Institutions Database (APHIDB) maintained by the IHS. This database provides fairly accurate information for the year 1994 till which time data validation was carried out. Data validation and updating could not be continued due to lack of funding for the database. According to the experience of workshop participants a large number of private hospitals and nursing homes have started operating during the last three years i.e. after 1994. However the patterns emerging from out the data in the APHIDB would most likely hold as on date.
2. The state had about 79000 hospital beds in 1994. About 59% of these were in the private sector, 35% in the public sector and the balance 6% were maintained by non profit voluntary organisations.
3. There are significant regional differences in public private mix of the states hospital stock. Socio-economically developed areas tend to have more private hospitals.

4. In areas where private hospitals and nursing homes are more prevalent, about half of them are in mandal headquarters. These are essentially small towns.
5. A large proportion (87%) of private hospitals and nursing homes have 30 or less beds. Most (37%) private hospitals and nursing homes are between 10 to 20 beds in size.
6. Only four hospitals in the private sector had more than 250 beds. Three of the four hospitals with more than 25 beds were located in Hyderabad. Another 37 hospitals had beds ranging from 100 to 250 beds. Most of these are located in the state capital, regional cities and a few socio-economically more developed districts.

B. Nature of services provided by the private sector:

1. Obstetrics turns out to be one of the main services offered by the PHIs.
2. Many (47.35%) of the PHIs offer "all services" which include medical, surgical, obstetric and "other" services. After this comes the combination of medical, surgical and obstetrics (18.31%), medical (9.67%), and then medical and surgery (6.47%).
3. Emergency and casualty services are not so well developed in the private sector. There appears to be some reluctance among many private hospitals and nursing homes to refer accident cases to nearest public hospitals.

C. Range of medical interventions where private institutions have an advantage:

1. For hospitals of comparable size and speciality composition, ownership does not as such give any advantage or disadvantage in dealing with various medical conditions. Hospitals in both the public and private sector can handle almost all types of conditions.
2. However, preferences for private or public hospitals do exist on other accounts, namely (a) paying capacity of the patient, (b) distance to be travelled to reach the hospital, (c) size of the hospital, etc.
3. Factors like size of hospitals, medicolegal implications, etc. do translate, at the macro level, into certain broad patterns of distinction between the public and private sector.
 - i. Most private hospitals and nursing homes are small in size. This usually restricts the range of services offered by them to reproductive services, abdominal surgery, general medical and paediatric cases.
 - ii. Small size implies that each hospital or nursing home is staffed by a few doctors. Usually there is one doctor focusing on a particular type of service and supplemented by part time consultants for other specialities.
 - iii. Private hospitals and nursing homes, for various reasons², are usually not geared up to handle medicolegal cases. Since most accidents would have some medicolegal implication, ability of private hospitals to handle emergencies is compromised. In case of smaller private hospitals, other factors like lack of equipment, etc. may also contribute.
 - iv. Empirical data collected by the IHS and contained in the APHIDB shows that obstetrics is the most common service provided by the private hospitals and nursing homes.

D. Scope for regulation of the private sector:

1. There was a consensus about the need for a quality assurance system. A voluntary accreditation system supported by formal and informal incentives in favour of accreditation was recommended. Legislative support if any should enable a regime of voluntary accreditation system rather than a legally mandated government regulation.

² Some of the reasons are; (a) additional burden on its staff to answer questions from states investigating agencies and to attend courts for giving evidence, (b) lack of staff to do additional documentation required for such cases.

2. Quality of health service is important both in the public and private sector. Concerns about quality of service in the public sector hospitals is expressed frequently. What distinguishes the private health sector is the lack of mechanism to redress specific grievances and to raise issues about quality of service in specific hospitals. The general grievance handling infrastructure in the public sector provides forums to raise issues about failure or poor quality of service in the public sector and take remedial action. In case of private sector no such mechanism is available, causing frustrations among the consumer public.
3. Following characteristics will be desirable for the proposed accreditation system.
 - i. Mechanisms to develop minimum standards with following essential features:
 - a. The standards development should be done by an organisation with adequate research and documentation on the subject.
 - b. Standards should be developed by professional and research teams following wide ranging consultation among various stake holders.
 - c. 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.
 - d. Initially physical and process standards may be developed so that hospitals and nursing homes acquire skills to operate them. At a later date the concept of outcome standards can be introduced.
 - e. Accredited hospitals and nursing homes should satisfy the minimum standards.
 - ii. An accrediting institution with following responsibilities and characteristics.
 - a. Responsibilities:
 - 1) Identification, training and empanelling of surveyors who can apply the standards to specific situations and assess compliance by hospitals.
 - 2) Formation of an accreditation board with representatives from all stake holders.
 - 3) Organisation of a secretariat to process accreditation proposals and to service the accreditation board.
 - b. Desirable characteristics of an accrediting institution.
 - 1) A non profit organisation, so that it does not have a profit motive behind the accreditation process.
 - 2) Should not be representing a particular interest group.
 - 3) The accreditation set-up should not fully depend on the accredited hospitals for its financial sustenance. In that case there will be pressure on the accrediting institution to liberally grant accreditation so that its revenue can be maximised. On the other hand hospitals seeking accreditation should also pay for part of the cost to ensure that the process is voluntary and the hospital appreciates the value of accreditation service. The accreditation set up can be funded jointly by the hospitals seeking accreditation, through accreditation related fees, and major users of accreditation information like insurance companies, large corporations who may use accreditation status as a criteria for empanelling of hospitals to provide medical care for their employees, and the government.
 - 4) The organisation should have the capacity to develop standards.

- iii. Incentives to encourage accreditation:
 - a. Institutions responsible to provide medical care to their respective clientele and having a need to out source the same in part or full may be persuaded to empanel hospitals and nursing possessing valid accreditation for the concerned service. These institutions would include;
 - 1) Large employers both in public and private sector,
 - 2) Central Government Health Scheme,
 - 3) Insurance companies providing coverage for medical conditions,
 - 4) Employees State Insurance (ESI) scheme,
 - 5) and such others.
 - b. Build public awareness by taking up information, education and communication (IEC) campaigns through mass media and other forums.
 - c. 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.
- 4. Continuing education:
 - i. The idea of renewal of licensing and mandatory continuing education now broached by the Medical Council of India is a very positive step and when implemented will improve quality of professional services.
 - ii. The AP University of Health Sciences should have a program of affiliating and certifying continuing education programs so that the MCI recommendation is supported by complementary academic regulatory mechanism in the state.
 - iii. The Bulletin of Hospital Services started by the APVVP may be published regularly.
 - iv. Full co-operation between the public and private sector hospitals for purposes of continuing education. The practice of inviting local private practitioners to clinical seminars and discussions in APVVP hospitals may be continued and emphasised.

E. Monitoring changes in private health sector:

- 1. Public registry of hospitals and health professional:
 - i. A public registry is a facility where information about registered entities are filed regularly so that people can search and retrieve such information when needed. There is no regulatory role for registries except to act as information ware houses. Three basic functions of a registry are:
 - a. Maintenance of a register i.e. database of the entities covered by it.
 - b. Provide facilities to log reports from various sources. Logging of information could be classified on the basis of the extent to which it is authentic. For example findings by judicial authorities, statutory regulatory authorities, public health officials and laboratories based on specific investigations would form one category. Findings and certification by voluntary accrediting agencies etc. could be another. Consumer opinions and replies by concerned registered entity would form yet another class.
 - c. Provide access to public to search and browse the database.

- ii. It is important to make sure that access is real and cheap. The registry should provide multiple access to the computerised database, for example through dial up lines, the Internet, distribution through CD ROM and floppy diskette etc.
 - iii. Important health system entities for which public registries are required include;
 - iv. Medical practitioner's database, which essentially should be an extension of the state medical register. For example, in the US there is a national database of physicians. In this database all court judgements in malpractice cases are filed. Hospitals are required to search this database while considering to recruit any physician. It is expected that hospitals would take into account findings from malpractice cases about specific physicians while considering recruitment.
 - a. Health institutions database where all health institutions are listed.
 - b. Nursing practitioners database.
 - c. Other professional databases.
 - v. The proposed law for public registry of health care institutions should allow for more than one public registries by providing a mechanism for authorisation of such registries by a government agency which would act as a registry of registries i.e. a super registry. Each authorised registry will be responsible to maintain a register, periodically share its content with other registries and the super registry. Each registry will maintain a database of registered institutions to contain information from all registries in the state and provide public access to the database. This will avoid the bottlenecks and delays that may result from a single registry managed by the government and at the same time allow a centralised database of all registered institutions.
2. Strengthen the existing APHIDB in IHS by continuing the validation campaigns. Since the IHS has already developed methodological tools for validation and maintenance of the database supporting the APHIDB will be the quickest way of building up a mechanism to monitor changes in the private sector. Eventually IHS could be designated as a registry.

IV. References:

1. Mahapatra Prasanta, 1998; An overview of private hospitals in Andhra Pradesh: Data from AP Health Institutions Database (APHIDB); IHS Working Paper No.25, 1998.
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7. Sunil Nandaraj, 1998; Situation review and analysis of accreditation system for health care organisations in India; IHS Working Paper No. 21/98.

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9. Eshwar M. and Satyanarayana P.; From apathy to awareness and action - The Consumer Protection Act and Medical Profession, a case in point; Clinical Proceedings of NIMS, 9:2; 7-10; April 1994.
10. George Alex; Women's perception of quality of reproductive care in private hospitals in Andhra Pradesh in An Enquiry into the quality of reproductive health care provided at private hospitals and nursing homes and Women's perception in Andhra Pradesh, Interim Report-1996-97; IHS Working Paper No12/97.

Private Health Sector in AP

Sponsored by the

AP First Referral Health System Project, Government of AP.

Dates: May 23-24, 1998, Venue: Hotel Viceroy, Hyderabad, AP.

I. Introduction to the work shop:

A. Back ground:

In addition to the public sector, private and voluntary health sectors play a key role in provision of health care services. Analysis of the 42nd round National Sample Survey (NSSO 1989) data showed that for outpatient care about 70% in both rural and urban areas sought treatment from private sector. However, the case was reverse when it came to inpatient care. Only 37% of inpatients in the rural as well as urban areas sought treatment from private health sector. The figures for out patient utilisation of private health sector in A.P was 75% in rural areas and 71 % in urban areas, only slightly higher than the all India figures. In AP utilisation of private hospitals and nursing homes for inpatient care is much higher compared to the national average (69% in rural areas and 58% in urban areas).

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All India Rural	7.53	17.67	25.2	53.01	15.98	68.99	59.74	36.85
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AP Urban	2.09	18.46	20.55	26.62	44.23	70.85	37.98	57.88

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Utilisation pattern of available hospital stock gives us an idea about relative preference of people, accessibility of institutional services to households etc. Over all service utilisation by households is, however, constrained by the total hospital stock available. Recognising the need to increase the first referral hospital stock and achieve wide dispersal of this stock all over the state, the state government is implementing the AP First Referral Health System (FRHS) project. A large number of first referral hospitals in the public sector managed by the AP Vaidya Vidhana Parishad (APVVP) are being upgraded by this project. New public hospitals are being added. Enlargement of the APVVP hospital stock and standardisation of its hospitals facilities takes care of the public sector component of the first referral hospitals. Adequate development of private hospitals and appropriate inter linkages between the public and private health sector is required to improve overall availability of first referral hospital services in the state. To understand the dynamics of the private health sector and to help formulate appropriate policies that will allows complementary and synergistic development of the private sector pari pasu the public health sector, the FRHS project sought to take up required private health sector studies.

The Institute of Health Systems (IHS), a non profit research institution, has been doing health systems research to identify processes that can work to improve the health of the people. A major target of IHS research effort has been quality assurance in health care, accreditation of health care institutions, health institutions database, etc. For example IHS has set up the computerised AP Health Institutions Database (APHIDB) consisting of public, private, and voluntary health care institutions. The Institute has developed a standard for reproductive health services in the private sector, and has developed methodological tools to study various aspects of the private health sector.

The present workshop on the Private Health Sector in Andhra Pradesh, was sponsored by the AP FRHS Project with the following terms of reference.

1. Make a quantitative assessment of the medical facilities available in the private sector in the state.
2. Analyse the nature of services being provided by the private sector and examine the role of this sector vis-a-vis the public sector.
3. Identify the range of medical interventions where the private sector institutions have an advantage over the public sector in terms of service as well as acceptability among the users.
4. Examine the scope for regulation of the private sector through (a) self regulation and (b) legislative process.
5. Develop a program for monitoring the growth both in quantitative terms as well as in terms of the range of services provided by the institutions in the private sector.

B. Participants:

Participants were invited from all over the state. Some participants from institutions outside of AP and known to have an understanding of various issues regarding development of the private health sector were invited. An effort was made to identify persons with intimate knowledge and understanding of the private hospitals and nursing homes in AP. Current involvement in management and / or service provision in private hospitals and nursing homes was used as a criteria to identify participants. Representatives of the AP Nursing Homes Association, State branch of the Indian Medical Association, persons associated with the Medical Council of India, Nursing Council etc. were invited. Officers from APVVP and the AP FRHS project also participated. Complete list of the participants is provided in annexe-1.

C. Program:

Detailed program that was actually followed by the work shop is provided in annexe-2. The work shop took place over two days. Four presentation sessions including the inaugural session, two group discussions and a final panel discussion were planned and adhered to.

II. Inaugural session

Dr. Prasanta Mahapatra, work shop chair person informed the participants that the Honourable Minister of Health, Medical and Family Welfare was not able to come in view of his other engagements. Dr. Thyagaraja Reddy State President of IMA had kindly agreed to be the chief guest and inaugurate the work shop.

Dr. Alex George Director IHS, welcomed all participants, the chief guest and requested Shri M. Nagarjuna, Project Director, AP FRHS Project, to preside over the inaugural session.

Shri M. Nagarjuna project director informed that the APVVP manages first referral hospitals ranging from 30 to 300 bed capacity spread all over the state. He gave an overview of the AP FRHS project and its efforts in improving the first referral hospital services in Andhra Pradesh. The project has a two pronged approach. Firstly, seeks to strengthen and expand the first referral hospitals in the public sector which are managed by the APVVP. Secondly, the project seeks to facilitate proper role definition and development of private health sector, since the private hospitals and nursing homes are providing bulk of the first referral hospital services. The public and private sector first referral hospitals will have to recognise each others presence, co-ordinate and interact to improve the first referral hospital services to public. He emphasised the need to put the roles of public and private sector hospitals in perspective. It is important to note that both the public and private hospitals have an important role to play. In the recent past certain statistics have been used to convey an impression that a large number of people, say about 75% of all hospitalisations, are using the private hospitals and nursing homes. These statistics reflect the sectoral composition of inpatient visits made by households but do not include the large amount of unmet need. There are a large number of people who are living with medical conditions to the detriment of the quality of their life. For example he cited the statistics from a cataract screening program taken up by the government as a part of the Janma bhoomi program. One of the objective of the recently concluded round of Janma bhoomi program was to identify the extent to which cataract exist and see if we could deal with the problem. The number of people identified by household survey in an area was 2.5 lakhs. Out of them only about 60000 agreed to come for the screening camp. When the screening camp is actually conducted, we expect, based on our past experience, that about 20000 may come. So this means that a large section of the population needing hospital service are not getting hospitalised due to various personal and socio-economic reasons. A problem of this nature can not be handled by the private sector alone. One alternative would be to have a very large private sector and depend on altruistic motivation of private health sector owners and managers to take care of the needs of socio-economically poorer sections of the population. But this is an unrealistic expectation. There fore some investment by the public sector to provide adequate hospital facilities accessible to socio-economically poor population in all parts of the state is required. Obviously interaction between the private and public sector hospitals is required. One objective of the FRHS project is to understand where and in what manner such interactions can take place.

Citing reference to the AP legislative assembly house committee on corporate hospitals Shri Nagarjuna said that it is interesting to see what the legislatures and leaders perceive about the private sector hospitals. Very often people are found to believe that the private hospitals are concentrated in urban areas. It will be useful to look at the actual data so that some of the misconceptions can be removed. This will facilitate a more informed decision making. These is the reason why the FRHS project approached IHS and has funded this work shop. He expects that work shop participants will examine various data and research findings, presented during the course of the workshop, in the light of their own experience and understanding and will share their thoughts.

Finally Shri Nagarjuna, offered an apology on behalf of the Honourable Minister for Health, Medical and Family Welfare and said the Minister could not come due to some programs not anticipated earlier. Considering that the Honourable minister is himself a doctor and has a lot of personal experience with the health care system of the state, he would have enjoyed the deliberations of the work shop.

Dr. Prasanta Mahapatra presented an overview of the private health sector in AP using data from the APHIDB maintained by the IHS. He drew attention to the paper titled “An overview of private hospitals in Andhra Pradesh: Data from AP Health Institutions Database (APHIDB)” which had been included in the work shop pack. Briefly; the APHIDB incorporates public health institutions, private hospitals and nursing homes. The database has been built up by starting with some data collected by the directorate of health and the APVVP, and then building upon it. IHS developed and tested survey and validation methodology to ensure accuracy of the database. However validation process could not be continued because funding for this project was not forthcoming. However various research and operational tools required for maintenance of the database has been developed. He then summarised the status of private hospitals and nursing homes in AP using data from APHIDB. He mentioned that the validation effort for APHIDB was sustained till about 1994, by which time a few districts had been covered. Results of the validation exercise showed that the number of private hospitals and nursing homes increased by about 5% after validation. Considering this it can be assumed that the APHIDB data is a reasonable reflection of ground realities around 1993 if we allow for 5 to 10% of hospitals not to have been covered by the database.

Considering the state as a whole private sector hospitals are providing about 59% of total hospital bed strength and the public sector is providing about 35% of the total bed strength.

Thus bulk of hospital stock appear to be in the private sector. There are, however regional differences. For example share of public sector and voluntary hospitals appear to be more in the Rayalaseema area. The regional differences become evident if we disaggregate to the district level. Public sector hospitals account for more than half of the total hospital beds in the following seven districts, namely Srikakulam, Warangal, Visakhapatnam, Adilabad, Kurnool, Ananthapur, and Vizianagaram. In Chittoor district the public sector and voluntary hospitals provide more than half of the hospital beds. In the rest 15 districts, private sector hospitals alone are providing more than half of the hospital beds. We find that a large number (49.93%) of private hospitals and nursing homes (PHN) in Andhra Pradesh are functioning in mandal headquarters which are essentially small towns. The average bed strength of PHNs in mandal headquarters is only 14. Divisional (Commonly referred to as subdivision In many other parts of India) headquarters account for 10.82% of PHNs. Average size of PHNs at these places is 17. The information on PHI wise bed strength distribution shows that while 41% PHIs fall in the 1-10 bedded category, their percentage share in bed strength is only about half i.e.19.09%. Just 1.17% PHIs in the 100- 249 bedded category account for 11. 42% of the total bed strength.

Dr. Thyagaraja Reddy, State President IMA and past President of the AP Nursing Homes Association, delivering the inaugural address, appreciated the efforts of IHS and AP first referral health system project and said that conducting of this work shop is timely. Information from the AP Health Institutions Database presented by Dr. Mahapatra relates to 1993-94. It is well known that during three years between 1994 and 1997, the private health sector scenario has changed remarkably. Many private hospitals and nursing homes have been added. Although the private hospitals and nursing home sector have grown a lot, people in economically backward areas still depend on the public hospitals. Once upon a time the public hospitals used to play a premier role in provision of medical care. In the recent past the range of services provided in public hospitals has lagged behind. Medical technology is developing very fast. But common people are not able to afford the cost of latest techniques and procedures. Public hospitals are not able provide for the latest techniques. Some

voluntary and charitable hospitals are making efforts to bring the fruits of high tech medicine to the reach of common man. He cited the example of Sri Satya Sai hospital at Puttaparthi where high tech procedures like cardiac surgery is made available to common people free of cost.

He appreciated the efforts of IHS in building up the APHIDB and recalled that a person did visit his nursing home to collect data for this database. Evidently the database has been built up with a lot of painstaking effort. A lot of information has been collected. Incidentally, he clarified, no licensing or permission is required to set up a nursing home. He recalled that a doctor registered with the State Medical Council (SMC) can set up a nursing home, put a board and start practising. The data collected by APHIDB will have to be viewed against this constraint.

He recognised the need for some form of quality assurance so that people are able to discriminate and identify hospitals and nursing homes that have the minimum facilities and service standards. The list of hospitals satisfying the minimum standards should be known to people, so that consumers are able to differentiate between hospitals. The AP Nursing home association has recently communicated to its members a booklet containing minimum requirements for various nursing homes. Although a lot of systematic work needs to be done the Nursing homes association thought of making a beginning and communicated some minimum requirements to act as a starting point. He appreciated efforts in the Institute of Health Systems to develop standards and the research being done about quality assurance in health sector.

Dr. Thyagaraja Reddy stressed the need for government policy to encourage and facilitate development of the private health sector. For example, he continued, the hospitals, nursing homes and other health service providers have been referred to as the health care industry. Although most industry have received some form of incentive and infrastructure support by the state, from time to time, no such policy exists for the health sector. For example hospitals and nursing homes are not allowed to have sales tax registration to avail of the central sales tax that is usually lower than the state sales tax. The rates of customs duty on medical equipment has been very high around 100 to 150 percent. Probably some reduction in the customs duty has taken place recently. High rates of customs duties and taxes result in highly priced services. It will be desirable to explore the scope of insurance to pay for health care costs.

It is high time that government recognise the important role being played by the private hospitals and nursing homes in provision of first referral hospital services and suitable policy decisions are taken to encourage them. Many opportunities exist for sharing of resources so that installed capacity of diagnostic equipment etc. can be utilised to provide more services to people. He recalled that earlier there used to be a scheme of private practitioners working as honorary surgeons in government hospitals. It will be desirable to revive the system of honorary surgeons. He informed that the representatives of AP nursing homes association had a discussion with secretary to government regarding reimbursement by government of an approved fee for deliveries conducted by private hospitals and nursing homes. Such a scheme could increase the proportion of institutional deliveries and thereby reduce maternal mortality rate.

III. Session-1 (May 23, 1998: 11 am to 1 pm):

A. Dr. P. Mahapatra - Typology of health systems in OECD countries:

Dr. Mahapatra drew attention to his article with the same topic, included in the work shop packet. At the outset he clarified that typology of health system is now used as a descriptive tool to compare and study various health systems. Efforts to use typology of health system as an explanatory tool to account for health system outcomes or health care expenditure incurred by a country has not met with much success. Although, comparison of the type of health systems with level of expenditure may give rise to some hypotheses, and premonitions, it is difficult to establish a clear cut nexus.

B. Dr. P. Satyanarayana - Consumer protection Act and the health sector:

1. He presented findings from a study (Eshwar and Satyanarayana, 1994) on cases under the Consumer Protection Act. (CPA). Copy of a paper about this study had been circulated to workshop participants. However he set out to present additional information not available in the paper and stressed the findings about ground realities of cases filed under the CP Act. Findings sought to be highlighted by him were; what exactly is the magnitude of actual cases filed under the CP Act., the nature of complaints, the respondents, type of damages reported by complainants and what else could be motivating people to approach consumer protection forums. The study was done by a post graduate student in NIMS using information from the AP State Consumer Commission, Hyderabad and Ranga Reddy district consumer forums. Data was collected from the three consumer courts namely, the AP state commission, and the district forums for Hyderabad and Ranga Reddy. Case data was collected right from the inception of respective forums till 1993 i.e. for five years.
2. Number of cases filed in the respective forums is given below for the years 1989 to 1993.

Year	AP State Commission		Hyderabad district forum		Ranga Reddy district forum	
	Total	% Medical	Total	% Medical	Total	% Medical
1,989	9	22	330	-	8	-
1,990	176	5	500	-	64	-
1,991	324	4	840	1	96	2
1,992	223	11	1,313	2	137	2
1,993	267	7	2,252	1	208	3
Total	999	6	5,235	0.8	513	1

3. Distribution of medical complaints in the state commission by nature of complaints were as follows:

Type of complaint	No	%
Deficiency in treatment / care / operation	29	46.77
Deficiency in diagnosis and treatment	8	12.9
Deficiency in diagnosis only	5	8.06
Loss of life	14	22.58
Loss of organ	6	9.67
Total	62	

4. Characteristic of respondents: named in the complaints before the state commission is given in the table here. Cases were filed against hospitals as well as individual doctors.	Respondent	State commission	Hyderabad	Ranga Reddy
	Doctor	49%	13%	43%
	Corporate hospital	16%	45%	-
	Nursing homes	27%	11%	43%
	Diagnostic centres	8%	14%	14%
5. Outcome of filed cases: Disposal of medical cases has generally lagged behind in comparison to disposal of total cases. The decision in favour of the consumers is significantly lower in the medical cases on technical grounds.	Total cases (N)	62	44	7

Stage of cases	AP State Commission		Hyderabad district forum		Ranga Reddy district forum	
	Total	Medical	Total	Medical	Total	Medical
Total cases since inception	999	62	5,235	44	513	7
Disposed cases % of total	22%	11%	56%	36%	70%	43%
Decided in favour of consumer % of disposed	8%	2%	58%	31%	45%	-
Dismissed for technical reasons % of disposed	8%	6%	42%	69%	55%	67%
Pending cases % of total	78%	89%	64%	30%	30%	57%
Decided within 90/150 days % of total	55%	14%	14%	43%	43%	-

6. Out of 60 claims for which data was available, amount claimed was between 1 to 4 lakh rupees in 48%, 5 to 8 lakh rupees for another 42% and more than eight lakh rupees for the balance 10% of claims.
7. When doctors were asked about possible remedial measures to reduce incidence of litigation against medical profession, they recommended medical audit and some form of vigilance by the Medical Council of India (MCI).
8. Dr. Satyanaryana then recommended some Dos and Don'ts for practicing doctors, based on the consensus opinion of various stake holders involved in the study and his own experience as a hospital administrator.
 - i. Dos:
 - a. Exercise warmth, compassion, understanding in dealing with patient.
 - b. Keep full and accurate medical records.
 - c. Record precisely the history of illness and substantial physical findings about the patient on your prescription.
 - d. Exercise reasonable skill and care.
 - e. Update your knowledge.
 - f. Record the condition of the patient in specific / objective terms.
 - g. Write the names of drugs clearly using correct dosages, correct methods and interval of administration. Also mention precautions to be taken.
 - h. Specify additional precautions to be taken such as rest, food, avoidance of certain drugs, etc.
 - i. Instruct where the patient should contact in case of your non-availability / emergency.
 - j. Good communication with patients / attendants, provide as much information as possible.
 - k. Be polite.
 - l. Buy indemnity insurance.

- ii. Don'ts:
 - a. Do not forget to mention date & timing of the consultation.
 - b. Do not guarantee a cure.
 - c. Do not fail to get written informed consent.
 - d. Do not hesitate to discuss the case with your colleagues / patient / attendants.
 - e. Do not try to examine a patient if you are sick, under effect of alcohol.
 - f. Do not talk ill about your professional colleagues without knowing full facts.
 - g. Do not undertake experimental method in treatment without written consent.
 - h. Do not forget to employ qualified staff.
 - i. Do not forget to guard against therapeutic hazards.
 - j. Don't be rude. It may precipitate a complaint in spite of good patient care.
- 9. Dr. Satyanarayana said that the consumer protection act (CPA) is causing a lot of apprehension among doctors and nursing home managers. It is being perceived by many doctors as a menace to their profession. The link between a punitive legal system like CPA and quality of health care is very tortuous. Instead a system designed to assure minimum facilities in nursing homes and hospitals will help improve quality of care.

C. Sri M. Nagarjuna - Report of the AP legislative assembly house committee on corporate hospitals:

1. The committee was set up because it was realised that government had given significant tax concessions in the nature of customs duty exemption etc. to many corporate hospitals. Some hospitals were given land. While giving these concessions government expected that the respective hospitals would provide a part of their service to poor people. Conditions like 10% of inpatient and 40% of outpatient services to be given free to poor had been agreed. A widely prevalent view among the legislators was that most of the corporate hospitals were not fulfilling these promises. The committee was constituted to go into all aspects of this problem. Detailed report of the committee has been published by the AP legislature secretariat (AP Legislature, 1996).
2. Recommendations of the house committee are annexed to this workshop proceedings. Highlights of the recommendations of the house committee are as follows:
 - i. A legislation to be out to regulate the private hospitals, nursing homes, diagnostic centres etc.
 - ii. All private and corporate hospitals availing direct or indirect subsidy in lieu of promise to use a certain proportion of their facility for treatment of poor patients to be required to provide monthly returns and compliance to be closely monitored by government.
 - iii. Encourage charitable and non profit hospitals by providing appropriate tariff concessions for utilities.
 - iv. Doctors practicing in a hospital to be registered by the hospital as such. Only registered doctors to be allowed to practice in the said hospital.
 - v. Doctors in government service, now allowed to practice privately in their chambers, not to be allowed to practice in private and corporate hospitals.
3. Important lessons to be learnt from the experience in giving of concessions by government to hospitals are as follows:
 - i. Private hospitals, some how, believed that there was no scope for government to regulate their activities. This perception was vindicated for some time since government assumed that the private hospitals will develop their own mechanisms to satisfy the promises made to government. Now the legislature is responding by asking for regulation and strict accountability on the part of corporate hospitals. Private

hospitals will have to recognise that regulation is bound to follow, in one way or other, any scheme of state subsidy.

- ii. From the governments point of view the experience so far with private corporate hospitals availing state subsidy directly or indirectly, it is evident that compliance is usually not forthcoming without specific regulatory mechanism to monitor the same. An alternative approach would have been to reduce the customs duty in general and then collect the same from all hospitals. The revenue generated could be used by the state to provide service to poorer sections of the society.
- iii. Private nursing homes and hospitals are now responding to the legislators' concern and are talking of some standards and voluntary regulation. However the standards now being set may not be adequate. Standards development requires fairly great deal of documentation. Appropriate institutional mechanism to achieve this need to be discussed.

D. Discussions:

1. Dr. Venkat Rao:
 - i. He drew attention to reference to development of private hospitals and nursing homes as “commercialisation of medicine”. Instead the correct attitude will be to view these as industries.
 - ii. Differences in paying capacity of clientele in different areas need to be taken into consideration. A doctor practicing in a rural or remote area would usually not be able to provide for the full range of investigations and procedures available to a doctor practicing in a city. On the other hand expectations by courts administering consumer protection act may be shaped by the facilities usually available in cities. Conditions for application of a law like the CP Act is perhaps not yet available. It will be desirable to postpone application of this Act to medical profession for some time.
2. Dr. Satyanarayana mentioned that the feeling that medical care is getting commercialised is there among many doctors. What doctors are referring to is the motivations for prescription of diagnostic and therapeutic procedures that may not always be necessary. Once a high tech facility is put up the tendency of those who put it up will be to maximise its use.
3. Dr. Rama Baru:
 - i. She referred to a widely prevalent myth that high cost means that the care is of high quality. Certain cases under the Consumer Protection Act have helped clear the perception that high cost does not necessarily mean high quality of care. To this extent the Act has made an useful contribution.
 - ii. She agreed that there is a need to write standards to correspond to the size of hospitals, the area in which the hospital is operating etc.
4. Mr. Nagarjuna: Instead of asking for deferment of application of the CPA to the medical sector, it will be desirable to write standards corresponding to the size, location and other operating environment of hospitals so that various regulatory and judicial authorities can use them as reference points. The initiative and primary responsibility for development of such standards should in fact be coming from within the medical profession.
5. Dr. Ch.Sudhakar: The practice of buying things according to the lowest quotation, prevalent in public hospitals is contributing to poor quality of care in government hospitals. Some changes in purchase procedure is required to allow purchase of good quality drugs, therapeutics, and hospital consumable.
6. Dr. Mahapatra clarified that government guidelines and rules do not require purchase of substandard things on the basis of lowest quotation. The general guideline prescribed by the Financial Codes followed by governments require that officers exercise the prudence

and care that a person of ordinary prudence will do while spending his own money. In fact quite a large number of exceptional powers have been given to the Director Medical Service to deviate from the regular tendering procedure, in case of life saving drugs and therapeutics. Unfortunately enough work has not been done by medical and health administrators to clearly define and specify the products required. As a result substandard products find their way into the tendering process along with their lower pricing. He cited the work done in APVVP to develop specifications, hospital formularies and revamping of purchase procedures to improve the quality of drugs, therapeutics and hospital consumable purchased for public hospitals. These guidelines were reiterated by the government for adoption in all other hospitals and health care departments of the state.

7. Dr. Balamba:
 - i. She agreed that technical committees do have the discretion to discard offers of substandard things even if they are quoted at lower prices. She recalled that such decisions have been taken many times.
 - ii. The quantum of work load in some public hospitals is very high and that affects quality of service.
8. Dr. Sham Sundar referred to the data given in Dr. Mahapatra's paper on OECD health systems. It is important to note that even in a country like the USA, the public sector contribution to total cost of health care is very high. It is usually believed that the American health care system is primarily market driven.
9. Dr. Mahapatra clarified that a large part of the health expenditure in the USA is contributed by the Federal government through the Medicare and Medicaid schemes. There is a wrong perception that the American health care set up fully private market oriented. In fact what the Americans have is public funding of a large part of health care cost, but provision is mostly through the private sector.
10. Dr. Eswar Rao:
 - i. There are aberrations in judgements being given by consumer courts, largely due to misunderstanding or lack of understanding of technical aspects. Cases before the consumer court also acts to adversely affect doctors morale. It will be desirable to reduce the frequency of cases taken up by the consumer courts. Two steps recommended by him are;
 - a. Include persons with medical and health background as members of the consumer forums,
 - b. Constitute screening committees who can scrutinise the prima facie validity of medical injury complaints. Such a committee will help reduce the incidence of frivolous cases against doctors.
 - ii. Direct and indirect incentives to private hospitals and nursing homes should be viewed as state subsidies directed to encourage economic activity in a particular area. Government are giving many incentives to industries without asking them to directly set apart any of their capacity for the poor. The same approach should be taken in case of hospitals and health care industry.
 - iii. He informed that the AP Nursing Homes Association has come forward to do some self policing with participation of the hospital management's.
11. Dr. Brahma Reddy: No sane doctor will knowingly cause harm to a patient. But medical injury do occur as accidents. Instead of finding fault with a specific doctor it will be desirable to find a way of compensating the injured to rectify the injury and to prevent occurrence of such accidents in future. It will be desirable to put in place a comprehensive system of continuing education for doctors all over the state so that they are equipped with latest knowledge and skills. Medically injured patients should receive

compensation to rectify the injury from a common fund which can be built up by taking contribution from all doctors. This will facilitate quick redressal of patients grievance. The present system under the CPA is designed to find fault with doctors. Such an approach demoralises medical practitioners, encourages defensive medicine and delays redressal of grievance due to long drawn out court battles.

12. Dr. Mahapatra congratulated Dr. Brahma Reddy and informed that a comprehensive study (Weiler et al, 1993) done by the Harvard University has arrived at similar conclusions after an extensive study of medical injury cases in New York State.
13. Sunil Nandaraj:
 - i. Dr. Satyanarayana's presentation mentioned that a large number of cases before consumer court against doctors was due to instigation by other doctors. He felt there is nothing wrong about it. On the other hand it will be desirable to review the ethical norms governing behaviour of practicing doctors. Medical ethics should explicitly clarify that it is ethically correct to bring out malpractice by other doctors. Instead there is a lot of reluctance on the part of doctors to give adverse opinion against other doctors. As a result investigation of medical injury cases by consumer courts are difficult.
 - ii. Doctors should pay more attention to explaining things to patients and attendants. A lot of dissatisfaction on the part of patients is arising due to poor communication.
 - iii. It will be useful to recognise the environmental constraints in which a public hospital operates. For example a public hospital can not refuse to accept a case. Private hospitals can afford to refer terminally ill cases to public hospitals, which have to take care of them. These are important services being rendered by public hospitals. Hence it will not correct to view private sector hospitals as a solution or replacement to public hospitals. Instead their complementary role need to be understood.
14. Dr. Thyagaraja Reddy opined that lack of knowledge and understanding of the medical profession is leading to unreasonable decisions. It will be desirable to have a screening committee with professional membership. The screening committee should examine all claims of medical injury and decide if a prima facie case against a doctor or hospital exists. Only if the screening committee finds that there is a prima facie case, the matter should be taken up by the consumer court.
15. Dr. Mahapatra noted that the professional councils have not been active and assertive enough to play their role. Although a large number of doctors have been registered by medical councils in the country the incidence of proceedings by medical councils against alleged violation of conditions of registration is almost zero.

IV. Group discussions:

A. Group-1: Relative strengths of private and public sector hospitals from the perspective of patients medical condition:

1. Chair person: Dr. (Mrs) Balamba
2. Rapporteur: Dr. V. Chandra Sekhar
3. Summary of discussions:

Medical condition per se is not the factor that decides the choice of people in choosing the type of service i.e., Private or Government. It is the ability to pay or afford that generally decides it. However during emergency conditions like a child birth for instance, people tend to choose any hospital depending basically on proximity.

Many private sector hospitals are quite well equipped, and have highly qualified doctors and specialist. However these services are provided only to the people who can afford them. Hence poor people do not always benefit. Sometimes the mandatory free services

may not be provided. The better quality etc., could be true, in a few private hospitals only. They are basically profit oriented. Some times unnecessary investigations, procedures etc., euphemistically called “defensive investigations” may be done. This has probably become an issue following the promulgation of C.P. Act. There may not be a hierarchy for redressal of public grievances.

In government hospitals, services are provided to all the people irrespective of their ability to pay, or the medical condition etc., Latest equipment may not be available, but all the other usual investigations etc. are generally available. There is a good hierarchy supportive team work, with pyramidal type of manpower distribution. Profit making is never the motive. Unnecessary or the so called defensive investigations are not done. However govt. hospitals suffer from resource crunch. They may not be well equipped, nor maintained well etc.

4. Summary of recommendations:

- i. We need a proper mix of private and public sector hospitals.
- ii. Proper accreditation system should be evolved.
- iii. Cost effective utilisation of expensive equipment is required.
- iv. Payment system in government hospitals where the money goes back to develop the hospitals needs favourable consideration.
- v. Referrals should be made to private hospitals only if it cannot be taken care of in public sector hospitals, so that public money is well targeted to the poorer sections of society.

B. Group-2: How to Assure Quality of Care of Hospitals in A.P?

1. Chairperson: Mrs Rama Baru

2. Rapporteur: Dr. P.V. Rao

3. Summary of discussions:

4. The group has discussed the whole range of issues related to quality of care in hospitals. In the beginning group members attempted to define quality. It was found that quality means different things to different people even in Health Care System. Quality can be used to mean medical technical dimension and / or the behavioural managerial dimension. For doctors quality may mean delivery of advanced knowledge and skill. For patients it could be courtesy, sympathy, comfort, satisfaction and relief. Health care administrators would imagine quality to mean provision of good physical facilities, trained skilled manpower, better equipment, amenities and management protocol. It was felt that primary focus should be on patient satisfaction. Hence the group discussed factors that are going to be influenced patient satisfaction such as initial contact in the hospitals, reception and patient guidance. It was recognised that satisfaction depends on the level of expectation and is fairly subjective in nature.
5. Group members were of the definite opinion that medical technical quality can be improved by good and effective continuing education programs at regular intervals not only for doctors but also to nursing and all kind of paramedical staff. Today market forces such as drug companies, equipment firms, are influencing the doctor’s prescription practices and diagnostic procedures and treatment plans. Reorientation of medical education is required. Management Skills will have to be included in the curriculum
6. It was felt that research facilities and service or working conditions to be improved. It is noticed that in private sector some of the institutions are displaying Boards as Research Centres without any real research (for various reasons to avoid taxes etc.).

7. Members also felt that there is strong perception on patients that they get maximum attention of the Doctors when they pay more money - which is not very different from Doctor's angle then they should get more money for more attention. On these and related issues, there is a need to educate patients. More awareness campaigns are required. Patient information system need to be improved.
8. Some members expressed views that poor payment structure to doctors and other paramedical personnel lead to poor-quality of services. Some members disagreed on this they say that it has not relation. Members also felt that competition among the private hospitals has to be increased to get good quality care. At institutional level in order to get good quality care there should be methods such as (1) Peer review (2) Medical Audit and Utilisation review (equipment, facilities and services). They serve as process standards procedures and members also expressed view that there should be good Medical record system.
9. All members are agreed that there should be basic and minimum standards for different categories of hospitals both depending on size (bed strength) and services (speciality wise) they provide. Members expressed views that in the initial stages there is a need to develop physical standards and process standards that are more explicit and measurable. There is need to develop clinical management protocols and practice guidelines. There was some difference of opinion as to whether this is the right time to ask for practice guidelines.
10. As part of consumer awareness, some members expressed views that charter of patients rights have to be developed. They also expressed view that information education and communication (I.E.C.) activities to be included in the hospital.
11. Different views were expressed regarding the mechanism of regulation. Some suggested voluntary body, independent and Autonomous. Some advocated a body consisting of representatives from Govt, private, professional bodies. Some other members expressed the view that all stake holders to be included such as health professionals, paramedical, nursing, health economists, health administrators, social workers, voluntary organisation representatives, consumer forum members and others.
12. It was felt that that the quality standards have to evolved through wide ranging discussions among all interest groups and stake holders. All members have agreed that there should not be any compromise on quality of care and there is a strong need to develop basic minimum quality standards for different sizes and categories of the hospitals. These standards should be based on both bed strength and speciality services provided by the hospitals. In order to assure quality of care, initially these standards can be structural that is physical standards such as physical facilities, staffing norms and equipment norms. Finally, it seems that everything is evolving - standards have to be evolved. There are no universal standards, and these quality standards have to matched appropriately to the kind of systems we adopt for comprehensive health care delivery.
13. Summary of recommendations:

- i. Hospitals and nursing homes should satisfy certain minimum standards.
- ii. 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.
- iii. Initially physical and process standards may be developed so that hospitals and nursing homes acquire skills to operate them. At a later date the concept of outcome standards can be introduced.
- iv. Standards should be developed by professional and research teams following wide ranging consultation among various stake holders.

V. Session-2 (May 24, 1998 9 am to 10.30 am):

A. Sunil Nandaraj - Accreditation system for regulation of hospitals:

1. Mr. Nandaraj outlined that he would cover the following topics:
 - i. Important elements and characteristics of accreditation of hospitals,
 - ii. Accreditation systems in other countries,
 - iii. Importance and relevance of accreditation system in the present context,
 - iv. Efforts in India with regard to standards and accreditation,
 - v. Details of the project on accreditation of private hospitals in Mumbai, and
 - vi. Issues of concern regarding setting up of an accreditation system.
2. Important elements and characteristics of accreditation of hospitals,
 - i. C. Louis defines accreditation as a professional and national recognition reserved for facilities that provide high quality health care. This means that the particular health facility has voluntarily sought to be measured against high professional standards and is in substantial compliance with them. In simple terms accreditation refers to a voluntary process where in the functioning of a participating hospital or nursing home is assessed, against set standards, by external review.
 - ii. There are four basic elements of accreditation:
 - a. It is voluntary,
 - b. Standards are laid down,
 - c. Compliance is measured by external review, and
 - d. Compliance to standards is rated.
 - iii. Various dimensions of accreditation:
 - a. Standards can be looked at in terms of structure, process and outcome. Structure would refer mainly to physical facilities, human power, equipment etc. Process is about how work is organised in the hospital. Outcome is what happens to the patient, for example mortality figures, infection rates etc.
 - b. Standards can be national or region specific. One omnibus standard may not reflect the regional peculiarities and requirement.
 - c. Requirement can be graded for example; minimum, optimum or excellent.
3. Accreditation systems in other countries:
 - i. The first initiative was taken by the American college of surgeons in 1930s. There were three phases in the development of US accreditation system, namely;
 - a. era of minimal standards 1917 to 1965,
 - b. era of optimal standards, 1966 to 1987
 - c. era of performance evaluation 1988 onwards.

- ii. The accrediting agency in the US is called the JCAHO. In Canada
 - iii. Australia and UK are some other countries which have an accreditation system.
 - iv. Countries in the process of setting up accreditation systems include; Spain, France, China, Pakistan, South Africa, Italy, Taiwan, Netherlands, Israel.
4. Importance and relevance of accreditation system in the present context:
- i. There is a need to provide good quality care,
 - ii. Accreditation system plays an educational role, stimulates and motivates hospitals to achieve higher standards,
 - iii. Rise of middle class has given rise to demand for good quality services,
 - iv. Entry of private insurance anticipated in the near future will push for accreditation systems. Insurers need to assure their clients some standard of care. Thus they will have to rely on accreditation systems.
 - v. Accreditation becomes important in the context of mal practice cases against hospitals under the consumer protection act.
5. Efforts in India with regard to standards and accreditation:
- i. It is strange to note that even after 50 years of independence private hospitals in most states continue to be unregulated except in states like; Delhi and Mumbai in Maharashtra. In Mumbai nursing homes are regulated under the Bombay Nursing Home Registration Act, 1949.
 - ii. A lot of state governments are trying to enact legislation for regulation of nursing homes. Such efforts are usually met with stiff resistance. As a result any one can set up a nursing home in any manner he or she likes without any reference to minimum facilities.
 - iii. In case of Delhi and Mumbai where laws exist for regulation of nursing homes, the same was not being enforced by the respective administrations. It took public interest litigation to start implementation of these laws. Even then these laws provide for registration of nursing homes only but do not envisage any standards.
 - iv. Hardly any standards exist in India for health facilities. Some efforts towards development of standards and setting up of an accreditation system in the public and non government sector are as follows:
 - a. Efforts in the public sector:
 - 1) The Bureau of Indian Standards (BIS) has come out with some standards for 30, 100 and 250 bed hospitals.
 - 2) The Mumbai municipal corporation and government of Delhi have started looking at standards. But these efforts are moving very slowly. There is a lot of resistance, especially in Mumbai, to laying down of standards by the government.
 - b. Efforts in the non government sector:
 - 1) The Lok Vignyana Sangham of Pune has laid down standards for routine preoperative investigations for certain minor surgery.
 - 2) The Centre for Enquiry into Health and Allied Themes (CEHAT) Mumbai, has developed minimum standards for private hospitals and nursing homes for surgical, medical and maternity facilities up to 30 beds. This covers infrastructure, space, human power, and the kinds of services to be provided. Here the only reference point was that patient care is of utmost importance and cost is not an issue. To that extent this document can be viewed as an ideal. This can be used as starting point to bring in local relevance and affordability aspects by scaling the requirements down or upward as the case may be.

- 3) The Indian Hospital Association made an effort to set up accreditation system in Mumbai and Delhi. The response was very lukewarm, as it did not involve various stake holders and constituents and sought to impose predetermined standards, fees and methods of evaluation.
 - 4) The IHS in Hyderabad has made efforts in many directions for setting up an accreditation system for health care. These include;
 - i) A study to assess demand for accreditation services through an exit interview of patients from private hospitals and nursing homes.
 - ii) A situation review of accreditation systems in India.
 - iii) Standards for reproductive services,
 - iv) etc.
 - 5) It is understood that there is, now, a proposal in MOH, GOI about accreditation systems.
6. Accreditation of private hospitals in Mumbai Project.
- i. Background to the project:
 - a. For quite some time some concerned citizens and organisations have been asking for regulation of private hospitals and nursing homes. However, the required legislation are not forth coming.
 - b. An alternative is to go for a self regulation system of accreditation by convincing various stake holders about the usefulness of accreditation systems.
 - c. Health insurance in some form or other is about to develop in the country. Administration of health insurance requires some accreditation system to assure the quality of services and facilities to insurance carriers who in turn can assure the same to their clientele. If an accreditation system does not exist there is the risk of it developing under pressure from insurers and in that case certain biases may creep into the system.
 - ii. Objective of the study:
 - a. To evolve a kind of partnership to collaborate and to provide a platform for an accreditation system,
 - b. To develop locally relevant standards, protocols and manuals instead of transplanting standards from accrediting bodies operating in other countries,
 - c. Examine the need, frame work and willingness of various constituents for an accreditation system in Mumbai city.
 - d. Constituents include;
 - 1) Hospitals owners or administrations, and association of hospitals.
 - 2) Specialist associations including association of obstetricians, paediatricians, anaesthetists, surgeons, nurses association and such others.
 - 3) Government at all levels namely municipal, state and central.
 - 4) Consumer organisations,
 - 5) Financial companies who are giving loans for setting up of hospitals.
 - 6) Insurance companies.
 - 7) Interview of patients to find out how do they make choices about hospitals.
 - iii. Methodology:
 - a. Ascertaining opinion of all stake holders through semi structured interviews,
 - b. Consensus development workshops,
 - c. Consumer opinion through mail questionnaire,

- d. Media questionnaire. A questionnaire is put up in the news paper to generate a debate. General public are invited to give their opinion using the questionnaire published in the news paper.
- iv. Nature of information being collected:
 - a. Profile of institutions and associations.
 - b. Whether there is a need for accreditation.
 - c. What is the relationship between various stake holders?
 - d. Whether hospital owners and managers are willing to participate in an accreditation scheme?
 - e. Opinion of stake holders regarding the organisation and structure of an accrediting body, its membership policy, decision making structure etc.
 - f. How monitoring and assessment should be done. Whether grading is preferable to pass fail type of accreditation?
 - g. Whether standards should require one set of facilities and practices or requirement should be graded to correspond with assessment like minimum, optimum and excellent.
 - h. Whether consumer complain redressal should be part of the accreditation system or not.
 - i. Who will bear how much of the accreditation costs?
 - j. What should be the role of insurance carriers?
 - k. The nature of organisation i.e. should it be a government organisation or non government organisation. In case of the later whether it should be a non profit organisation or a for profit company?
- 7. Work done so far and plans for future:
 - i. A workshop was conducted with participants from private hospitals, nursing homes, insurance company representatives and others. Most participants appeared to have a positive attitude towards accreditation.
 - ii. Efforts are being made to develop standards for hospitals.
 - iii. CEHAT is contacting various associations like medical consultants, nursing homes association, Mumbai Grahak Organisaition which is a consumer body.
 - iv. Ultimate aim of the project is to come up with a framework of an accreditation system in Mumbai. This is likely to be available by July 1998.

B. Lipika Nanda - The need and scope for regulation of service quality of the private health sector in AP:

1. Felt need of quality assurance in health sector can be expressed or implied. News papers and legislative assembly debates are an important source of expressed felt needs. Implied felt need can be ascertained through direct interviews and opinion surveys. The IHS study on assessment of demand for accreditation, being presented by Dr. Appala Naidu, targeted the unexpressed felt needs. The purpose of her study was to survey important media sources likely to contain expressions about quality assurance in health sector. She started with an hypothesis that if there is a felt need among general public for quality assurance it should show through at least to some extent in various public debates. The legislative assembly records provide full coverage of discussions in the legislature. Some of the public debate, discussions or expressions, outside the legislature is likely to be captured by the news papers.
2. Methodology:

- i. Content analysis of legislative assembly debates on health subject for the preceding five years. Altogether 29 speeches made in the assembly on health subject were analysed.
 - ii. Report of the AP Legislative assembly house committee on corporate hospitals.
 - iii. Content analysis of news reports on health related matters.
 - a. IHS regularly clips any health related article appearing in English news papers. These clipping are available from 1993 to 1998. These were browsed to identify articles dealing prima facie with quality assurance or related mater.
 - b. Database of English news clippings in the Eenadu library from 1993 to 1998.
 - c. Up to five year old news papers of a Telugu daily, namely “Eenadu” was also searched.
 - d. Around 50 news items related to quality of care issues in the private health sector were identified and their content analysed further.
 - iv. Review of the IHS study on assessment of demand for accreditation.
3. Findings:
- i. Assembly debates:
 - a. Quality of health care or quality assurance system in private hospitals and nursing homes was not discussed as such. Other issues appear to be of greater concern. These include;
 - 1) quality of health care In PHCs,
 - 2) budgetary allocation and release of funds to health sector,
 - 3) availability of doctors in rural areas including transfer and posting, recruitment etc., and
 - 4) reluctance of doctor to go and stay in rural areas.
 - ii. News papers:
 - a. The subject matter of statements made and reported in news papers include the following:
 - 1) continuing medical education,
 - 2) rational drug use,
 - 3) drug purchase policy
 - 4) support for consumer protection act,
 - 5) doctors negligence, medical malpractice,
 - 6) quality of services, improving standards of care, norms for physical facilities,
 - 7) regulatory body for private health sector,
 - 8) pricing and cost of health services,
 - 9) attitude towards patients, and
 - 10) the need for health policy.
 - b. Sources of such statements reported by news papers can be classified as follows:
 - 1) Professionals,
 - 2) Consumer interest groups,
 - 3) Health system researchers, and
 - 4) Ministers.
 - c. Maximum number of statements were about rational drug use and drug purchase policy, followed by quality of services including standards, norms for physical facilities, doctors negligence and medical malpractice.
 - iii. Highlights of the recommendations by the House committee on corporate hospitals are as follows:
 - a. Comprehensive legislation to regulate the private health care organisations.

- b. Minimum and not more than necessary investigations for each disease as per clinical manuals to have a cost-effective approach.
 - c. Proper maintenance of medical records to be handed over to patients at the time of discharge.
 - d. Appropriate use of disposables. Disposables should be used only once.
 - e. Minimum standard for health care organisations.
 - f. Regulation of nursing schools and schools for skilled personnel.
 - g. Registration and licensing of nursing homes and clinical establishments.
- iv. IHS study:
- a. Patients gave maximum importance to doctor's skill. This information was readily available to them in the market.
 - b. Next to doctor's skill patients attached importance to hotel services and facilities.
 - c. There was a felt need for a standard fee structure which could be used as a reference.
 - d. This was a pilot study and the sample size was small. So we can not attach much importance to the exact numbers and proportions obtained from this study.
4. Scope for regulation of hospitals and nursing homes:
- i. The word regulation can be interpreted at different levels. Broadly interpreted regulation would mean social and institutional system of check and balances in a society to ensure minimum quality of service. This interpretation would encompass within it both self regulation and legally mandated regulation by government. Self regulation is achieved if various stake holders mutually agree to develop certain standards and follow the same.
 - ii. Standards should define essential requirement and desirable facilities. Enlisting desirable facilities will encourage hospitals and nursing homes to continuously develop themselves. Standards should define requirement of
 - a. infrastructure facilities,
 - b. human power, and
 - c. equipment.
 - iii. Any accreditation system will have to put in place a mechanism for inspection and clearly make choices about:
 - a. scoring mechanism,
 - b. types of accreditation, and
 - c. frequency of inspection.
 - iv. Licensing and certification of health care organisations and health professionals:
 - a. At present some registering and licensing authorities do exist. For example, the professional councils like the Medical Council, Nursing Council etc. These authorities should play a more proactive role instead of remaining passive as is the case now. They should actively monitor compliance to licensing conditions, and respond to violations.
 - b. Maintenance of appropriate patient records is essential. The patient record format should be standardised. The basic idea behind quality assurance is to reduce variation, so that any problem is detected easily. Proper record keeping will allow retrospective allowance and monitoring compliance to standards.
 - c. Locally appropriate practice guidelines should be developed. Experience and methodologies followed by organisations elsewhere in the world to develop practice guidelines can be used. One such organisations is the US Agency for health care policy research (AHCPR).

- d. Continuing education is essential. A system of continuing education is required for building awareness and communication of practice guidelines.
- e. Renewal of registration, say every five years, should be required. Renewal should be linked to completion of continuing education, minimum practice requirement, reports about professional negligence if any, etc.
- f. A system of accountability in prescription of drugs and investigations.
- g. Patient satisfaction surveys may be conducted periodically for different health care organisations. These results should be reported and easily available to people so that they can know the feed back from people who already attended any hospital.
- h. Hospitals should be encouraged to implement protocols regarding how to inform and explain to the patient about his / her condition, treatment plan etc. in a language and manner that is easily understood by him / her.
- i. Pricing of services is an important issue. Some organisation need to be there to set prices for different services. Pricing may vary for different kinds of hospitals. But a price setting organisation should take a look at the basis of such pricing.
- v. Regulating bodies can be a government organisation, collaboration of professional bodies, health system research organisation like the IHS, or a coalition of government and non government organisations.
- vi. Concluding remarks:
 - a. So far, expressions about the need for quality assurance are mostly from medical professionals and health system researchers.
 - b. Though consumers are feeling the need for some form of quality assurance, such feelings are not verbalised due to lack of awareness about possible choices and the scope for regulation.
 - c. There is need to create awareness among people, medical and health professionals, about the role of quality assurance to improve quality of service in health sector.
 - d. Medical and health professionals should take the initiative to define standards and ask for its compliance. Other wise there is the risk of being overtaken by events with its attendant complications.
 - e. Total quality management (TQM) is meaningful only if a quality assurance system is in place. TQM should follow a quality assurance system. Without a quality assurance system, TQM has no relevance.
 - f. Quality assurance, in the long run is cost-effective.

C. Appala Naidu - Assessment of demand for accreditation services in Hyderabad. A pilot study:

1. Dr. Mahapatra informed that some time ago Sailaja Krishna and he did a pilot study. Sailaja, then a post graduate student from the Tata Institute of Social Sciences Mumbai, was spending some time with IHS. The study was a part of her course work. The study suffers from small sample size, since it was designed to be a pilot study. However the study helped develop the methodology for similar studies. Dr. Appala Naidu has agreed to present the main findings of the study. Dr. Appala Naidu then presented main findings of the study as follows.
2. Purpose of the pilot study, done during 1994, was to make a rapid assessment of demand for accreditation services by users of private health care institutions and to develop methodology for a full scale study.

3. Ten private hospitals and nursing homes in Hyderabad were identified from the APHIDB maintained in IHS. Data was collected from patients discharged from the selected nursing homes as follows:
 - i. a quick interview of the patient and / or attendant in the hospital at the time of discharge,
 - ii. follow up visit to the patients home for the main interview,
 - iii. The patient and one attendant were interviewed at the hospital and during home visit.
4. Objective of the interviews were to assess the patient and attendants' perception about quality of care.
5. Findings of the study:
 - i. 96% of respondents expressed that facilities in the hospital was adequate.
 - ii. 30% respondents said that the medical and surgical equipment was adequate. None gave below average rating for equipment availability.
 - iii. 12.5% rated the living conditions in the hospital as excellent, 27.5% gave a good rating and another 20% gave a fair rating. The rest 40% gave average rating.
 - iv. Factors given importance by patients to choose a nursing home included in order of importance; quality of doctors, living conditions.
 - v. Information regarding quality of nursing care, professional equipment and diagnostic facility are not easily available to patients.

D. Discussions:

1. Dr. Sham Sundar:
 - i. Looking at the matter from various perspective and his vantage position of having played roles as consultant in more than one hospital, office bearer of professional associations and administrative positions in health department he feels that there is a definite need for an accreditation system.
 - ii. Compliance to standards and accreditation can be achieved by enforcement or through a system of incentives. It will be desirable to build up a system based on incentives such that hospital managers and owners find it useful and attractive to seek accreditation. Thus voluntary system of accreditation will be preferable to regulation under some legal mandate.
 - iii. Regarding Lipika Nanda's point on continuing medical education (CME), now there is a realisation on the part of every one that CME is important. More and more organisations are now arranging CME programs. A common misunderstanding is that CME organised in teaching centres is for post graduate students. However PG students are in the stage of formal education. Question of continuing education arises after formal education is over. Hence CME programs organised in teaching centres are primarily meant for doctors already in practice and after formal education is over.
 - iv. It is understood that MCI has already taken a decision to require attendance in continuing education for renewal of license. In due course of time it would be desirable to introduce the concept of re certification examination. The decision to require attendance in CME programs as a precondition for license renewal is a positive development.
 - v. In case of the IHS pilot study presented by Dr. Appala Naidu, it is noticed that in almost all cases number of observations under below average category are zero. Obviously this is a selective survey. From what he has seen in most of these hospitals there are quite a few category of facilities where the hospitals would score below average. The sample appears to have been biased in favour of those who are satisfied with the hospital concerned.
2. Dr. P Venkateswar Rao:

- i. On the one hand as Mr. Sunil Nandaraj opined, accreditation should be voluntary. On the other hand he also mentioned about the resistance to accreditation system in Mumbai. How can we achieve voluntary accreditation in the face of resistance by most of the hospital owners / managers?
 - ii. Who should develop the standards? There should be some accrediting body for standards setting bodies. Otherwise any one could claim to have developed standards.
 - iii. The financing of standards and accreditation system has an implication on the quality of accreditation. If the hospitals and nursing homes who are candidates for accreditation pay for this service then there may be some bias and pressure to grant accreditation. How can this conflict of interest be avoided?
3. Sunil Nandaraj:
- i. The resistance to accreditation and quality assurance mentioned by him referred to the difficulties experienced in the earlier period characterised by reluctance to develop and adhere to any standards. Right now there is a lot of enthusiasm and people are coming forward. Moreover the resistance is from some sectors of the profession and the realisation about importance of quality assurance exist among a certain other section. So the task is to educate and inform people about the usefulness of standards and accreditation system.
 - ii. The question as to who should develop standards, and who should certify the standard setting authorities is in essence about legitimacy of standard setting authority. Instead of worrying about whether the standard setting body should appear first or the authority to certify the standard setting bodies should come first it will be desirable to start some where. More important is the question of legitimacy. The concerned authority should have a set up that is capable of developing standards, a mechanism to involve all stake holders and a consensus development process.
 - iii. Financing of accreditation system is an open question. Their preliminary findings is that it should be funded through membership and the standard setting authority should be a non profit body. Another alternative will be that insurance companies fund the accreditation system. The issue of financing is to be examined further.
4. Dr. Balamba:
- i. She cited the experience of Government Maternity Hospital in implementing the law regarding use of ultrasound for prenatal sex determination. This law requires all ultrasound facilities doing prenatal sex determination to register. However many facilities have not registered. Authoritative list of ultrasound facilities are not available to compare. From this it appears that voluntary compliance to accreditation may be difficult to implement. Instead accreditation and conformity to standards should be insisted as mandatory.
 - ii. Nowadays pharmaceutical companies and IMA branches are organising CME programs in very small places in rural areas. There is a good deal of enthusiasm among practitioners in rural areas to attend CME and update themselves with latest developments.
 - iii. In case of the IHS pilot study, she wondered how patients or their attendants could judge adequacy of surgical equipment? Do patients or their attendant have the competence to know about the nature of surgical equipment required?
5. Dr. Mahapatra: Competency exists at multiple levels and is of different types. The competency that a gynaecologist has to judge adequacy of equipment is different from the competency of a hospital administrator to judge the same thing. Any one who has a stake in some thing would develop some competency to judge it. Patients and their attendants have the competence to sense inadequacy of equipment from circumstantial evidences.

For example instances of delays in performance of a procedure explained away by hospital staff on account of lack of equipment, hurrying around to move the same piece of equipment from one patient to another can give some idea about this aspect. If a patient or their attendant did not perceive lack of equipment, we can not conclude that the hospital is well equipped. But events leading to a perception that equipment were inadequate can be given some prima facie weightage. Admittedly the sample was selective and biased in favour of the hospitals. Our assumption was that if there were to be any evidence of perceived inadequacy of equipment then it would be some significance.

6. Dr. Balamba:
 - i. Her experience is that patients and their attendants are usually satisfied if recovery was uneventful. If due to chance the recovery process is accompanied by some adverse event, patients perception on all aspects of the hospital tend to be adverse without any relation to the actual state of things in that hospital.
 - ii. There should be separate standards for nursing homes in rural, semi urban and urban areas. In IHS workshops on standards for reproductive services, standards were developed according to bed size of hospitals.
7. Dr. Mahapatra agreed with Dr. Balamba that patients experiencing adverse events during recovery would be biased against the hospital and those with uneventful recovery would be satisfied with most aspects of the concerned hospital. These biases can be compensated by taking up adequate sample size with appropriate sampling design. There is a tendency in medical profession to explain every thing away on account of uncertainty. It will be useful to recognise that there is no area of human endeavour characterised by certainty. In every field there is some element of uncertainty. People are developing mechanisms to evaluate their work using statistical techniques and sampling design. It will be desirable to develop some form of performance measure for hospitals and nursing homes instead of explaining every thing away on chance. It has been emphasised by various speakers that the IHS study suffered from small sample size. A lot of these concerns would abate in case a full fledged study with adequate sample size were to be taken up.
8. Dr. Venkat Rao:
 - i. MCI in 1997 has unanimously passed a resolution seeking amendment to the MCI Act. 1960 providing for registration for five year period at a time and requirement of continuing education before renewal of registration. The council proposes to use the funds generated from license renewal fees for purposes of continuing education. About 10 to 12 organisations have been identified by the council who can provide continuing medical education.
 - ii. For accreditation of hospitals an autonomous body can be formed at the state and national level. This body can function on similar lines as in case of various professional councils.
 - iii. Department of Science and Technology has done some work in collaboration with MARCH of Hyderabad about minimum requirement for diagnostic laboratories. The scheme being evolved by the department of S&T provides for quality control, in addition to checking of physical facility. Accredited laboratories send samples to regional centres where these are tested again and the result are compared with the original laboratory results. He felt that the department of S&T have done an excellent work and they are about to release the details of standards and quality system for diagnostic laboratories very shortly.
 - iv. Referring to Dr. Balamba's experience with registration of ultrasound clinics, he clarified that the Prenatal Sex Determination Act. requires only those clinics with

ultrasound equipment and doing prenatal sex determination to register. The Act does not require all clinics with ultrasound facility to register.

9. Dr. Sham Sundar:

- i. Regarding Dr. Balamba's suggestion for separate standards for hospitals in rural, semi urban and urban areas, he feels that urbanisation status of the place where a hospital is located may not be a valid classifying principle for purposes of standards. He gave the example of the Satya Sai Hospital which is located in a rural area and is providing high tech services in cardiology etc. Hence it will be desirable to classify requirement according to bed size and the nature of services offered by the concerned hospital.
- ii. He agreed with Lipika Nanda that in cases where medical negligence is established, renewal of license to practice should not be granted. In fact, he feels, in case of established negligence the license to practice should straight away be revoked.

10. Dr. Dayakar:

- i. As a matter of fact some amount of accreditation is already taking place informally. Some of the major industries with a large number of employees usually inspect hospitals and empanel them to administer employee medical benefits. An accrediting body could take over this responsibility so that employers straight away empanel accredited hospitals.
- ii. In the Armed Forces there are fairly well developed standards and guidelines. These can be used to build standards document for hospitals and nursing homes. Some of the important standards related literature used in the Armed Forces are;
 - a. Scales of accommodation, furniture etc. for health care units of various sizes right from clinic to big hospitals.
 - b. DGs memoranda for treatment of various diseases. These are like practice guidelines mentioned earlier.
 - c. Public health hand book previously referred to as the 'yellow book' and now it comes in red cover and hence called the 'red book'.
- iii. Regarding Dr. Balamba's remark about competence of patients to assess adequacy of equipment he referred to the JCAHO accreditation process which contains a chapter on patient satisfaction. Patient satisfaction surveys have to be done to meet the requirement of this section. Some of the question in these patient satisfaction survey ask the patient to judge competence of the doctors. Although there is some debate about it in America, the requirement is there and is being implemented.
- iv. In 1995 a copy of a 'citizens charter-USA' document was circulated by the State Ministry of Health. This charter gives useful guidelines and hints about measurement of patient satisfaction, how to improve the patient satisfaction. An effort was made to implement these guidelines in the Nizams Institute of Medical Sciences (NIMS) around 1995-96.
- v. Renewal of registration is already being practised by the Nursing council every five years. However these renewals are being done in a routine fashion without any active assessment of the persons skills. So just having a system of renewal of license is not enough. It will be desirable to have a system of skills assessment so that the renewal process ensures that the person has kept up with the required skills.
- vi. Regarding regulation of prices for various treatment services he referred to the diagnosis related groups used in the USA to reimburse hospitals. Some thing similar could be done. He noted that this requires very detailed work.

11. Mr. Nagarjuna:

- i. Recalling Dr. Balamba's remark about registration of ultrasound clinics he clarified that the requirement that clinics with ultrasound facility providing prenatal sex

determination services should register is legally prescribed. There is nothing voluntary about it. In fact this is an example where a legally mandated requirement to register is not successful. One of the reasons is that there is no machinery to implement the law. Apart from the need for a permanent bureaucracy to implement the law it will be desirable to provide some incentive to registered clinics. For example specialists could recommend only registered ultrasound clinics to their patients whenever an ultrasound is advised.

- ii. In case of the first referral hospitals project first standards for physical facilities were developed. They are being adhered to while setting up or upgrading the hospitals. However satisfying the physical facility, equipment or staff norms does not automatically guarantee good quality of services to people. To some extent continuing education programs will sensitise doctors to standard practice guidelines. Ultimately some outcome standards are required. Hence it will be desirable for all doctors and hospital managers in APVVP to keep this goal in mind and work towards improving quality of medical care.
12. Sunil Nandaraj: This work shop has brought within its fold representative from almost all stake holders like the public health officials, the Nursing Homes Association, IMA, Medical Council, Nursing Council etc. It will be desirable to have an action program.

VI. Session-3 (May 24, 1998 11 am to 1.00 pm):

A. Alex George - Women's perception of quality of reproductive care in private hospitals in AP:

1. This study was conducted to provide an input for the standard setting process which has now been completed for reproductive procedures like normal delivery, caesarean section, medical termination of pregnancy (MTP) and common gynaecological procedures.
2. Objective of the exit survey was to get patients expectation and perception regarding the four reproductive procedures. 555 patients were surveyed in four districts of AP, namely Krishna, Nellore, Cuddapah and Mahboobnagar. These districts were chosen on the basis of relative index of economic development formulated by the Centre for Monitoring of Indian Economy (CMIE), Mumbai. Krishna and Nellore represent economically developed districts; Cuddapah and Mahboobnagar represent less developed districts. Reproductive procedures were chosen for the standard setting process because these happen to be most commonly availed by people from the private hospital and nursing homes.
3. Findings:
 - i. Although, a large part of the deliveries in rural areas of AP are conducted in home, this study found that there is an emerging tendency on the part of people in rural areas to go for institutional delivery. This calls for development of standards for these services.
 - ii. Median distance covered by the respondents was 5 Kms. Two thirds of patients had to travel less than 3 Kms to reach the hospital.
 - iii. Factors considered by the respondents in choosing the private hospital include the following in order of the frequency of response:
 - a. Availability of lady doctors: 62%.
 - b. Availability of doctors : 50%
 - c. Nearness to place of residence: 36%.
 - d. Better behaviour by doctors and nurses: 37%.
 - iv. Nature of services availed by respondents from the private hospitals include:
 - a. Normal delivery: 61%.

- b. Caesarean section: 27%.
- c. Common gynaecological problems: 7%.
- v. More details about patient perceptions about facilities and services provided by the private hospitals are contained in the paper. While interpreting these findings, it will be useful to note that patients were not opening out in terms of their assessment of the hospital. There was a general reluctance to criticise the hospitals. So what ever critical responses are available need to be used to understand and identify areas requiring improvement.

B. Discussions:

1. Dr. Dayakar: Whether any importance can be attached to the figures about economic status of the respondents in terms of preference for private hospitals among the poor.
2. Dr. Alex clarified that this study did not compare between private and public hospitals. The figures about socio-economic status are give to describe the nature of clientele and no conclusion about relative preference for public or private hospitals among the poor can be made on the basis of this study.
3. Dr. Sham Sundar: A question was asked about availability of ambulance services. It will not be reasonable to expect small hospitals to have in house ambulance services. It will not be cost-effective for each hospital to have in house ambulance services. Instead some sort of a ambulance pool will be cost-effective.
4. Prof. Raghava Prasad pointed out that the sample contained some voluntary hospitals which cater to a different clientele. It will be desirable to form separate strata of voluntary and for profit private hospitals and analyse perception of their respective clientele.
5. Dr. Venkat Rao: While agreeing with Dr. Sham Sundar about the idea of an ambulance pool maintained by a separate ambulance service organisation, he suggested that it will be desirable for government to subsidise capital cost of ambulances and ask the ambulance service organisation to recover the operational expenses.
6. Sunil Nandaraj: Suggested that the variables measured in this study to assess patient satisfaction can be used to develop some indicator of patient satisfaction for purposes of quality assurance.
7. Mr. Nagarjuna: This study brings out the point of view of patients. It is interesting to find that patients concern does not match the perception of doctors whenever a question is raised about the effectiveness of hospitals. It will be useful for doctors to pay attention to the patients point of view while analysing causes of poor utilisation of health care facilities.

C. S.Srilatha - Standards and quality control measures in Andhra Pradesh Vaidya Vidhana Parishad:

1. The AP Vaidya Vidhana Parishad has devoted a lot of attention towards quality assurance systems and has contributed a large number of standards. It is the first public hospital system in India to have developed standards and quality systems.
2. Efforts to develop standards and quality systems in APVVP can be grouped in to the following three periods:
 - i. Pioneer period for hospital standards by government: 1977,
 - ii. Peak period for hospital standards and quality improvement: 1988 - 1990, and
 - iii. Continuation by First Referral Health System Project: 1994 onwards.
3. Taking stock of activities during all the three periods, standards and quality improvement processes developed by APVVP thus far can be listed as follows:

- i. Standard range of clinical and diagnostic services by hospitals.
 - ii. Hospital formulary.
 - iii. Yardsticks of hospital staffing.
 - iv. Hospital equipment norms.
 - v. Standards for hospital mattresses.
 - vi. Continuing education and practice guidelines.
4. Suggestions:
- i. A large number of standards or scales of equipment have been implicitly defined under the first referral hospitals project. It will be desirable to publish them as stand alone standards document.
 - ii. Bulletin of Hospital Services used to be published by APVVP earlier. Its publication has become irregular. It should either be published by APVVP regularly or some other organisation can be given responsibility to edit and publish the magazine regularly.
 - iii. Internal evaluation studies need to be taken up.

D. Prasanta Mahapatra - Understanding the evolution of private health sector in AP: planning for the future:

1. Purpose of this presentation was to clearly identify the understanding developed so far in the workshop and to list out emergent recommendations. This is done to enable serious consideration of the proposed recommendations during the panel discussion and help identify missing issues if any.
2. Factors contributing to development and growth of private hospitals and nursing homes in AP:
 - i. The most important among various factors that have contributed to development and growth of private hospitals and nursing homes in AP appears to be the fact that the state has reaped benefits of irrigated agriculture in many areas. This development enabled two things. Firstly it enabled consumers to pay for services. Seed capital for setting up nursing homes was forthcoming from within family circles. At a more general level it can be said that economic development has contributed to the growth and development of private nursing homes. This hypothesis is supported by data from the APHIDB which has shown that districts with higher index of socio-economic development have more private nursing homes.
 - ii. Generally Telugus have demonstrated good entrepreneurship in almost every area of economic activity. For example people in rural areas of Andhra Pradesh were very early to invest in stock market compared to other areas in the country.
 - iii. A lot of medical graduates from the state are practising in economically developed countries like the U.S.A. Their interaction with friends and contemporaries in AP and willingness to invest in medical ventures in the state has also contributed towards development and growth of the private health sector.
 - iv. Earlier hardly any doctor was willing to take up private hospital management as a career. As a result professional hospital managers were not available. This would naturally constrain the rate of growth of hospitals and nursing homes. In the recent past some interest and willingness among at least some doctors to choose hospital management as a career is visible. All this means availability, although still in small numbers, of full time hospital managers as opposed to part time hospital managers in vogue till recently.
3. Conditions required to sustain the development of private hospitals and nursing homes:

- i. Facilitate operation of the market: After-all the open market system has enabled developments in private health sector so far. Facilitating information interchange essential for a healthy market place will sustain the developments.
 - ii. Supplement possible gaps due to market failure: It is well known that the health care sector is particularly susceptible to market failure. Movement towards ideal conditions required for a market system are usually hindered in the health sector due to various reasons. A well known feature of the health care market is the fact that the provider is also the person who decides whether the services are consumed or not. Patients or their attendants may do some amount of market research before choosing a doctor or hospital. Once this decision is made patients usually hand their decision making function to the chosen doctor or institution and rely on the social institution of professional - clients relationship. Though it works quite often, motivation and interests of providers may influence the decision making process deliberately or inadvertently.
4. Dr. Mahapatra said that he would highlight the following few specific interventions and set aside discussion on other measures¹ to address market failure in health sector to a later date.
- i. A system of computerised public registries to increase availability of information on professionals and health care institutions to consumers.
 - ii. Quality assurance system to aid consumers in their effort to clearly identify the services that (s)he is seeking to purchase.
 - iii. Continuing education,
 - iv. Practice guidelines,
 - v. Health systems research, and
 - vi. No fault but strict liability system of compensation for medical injury instead of fault based liability that is gaining ground at present.
5. Public registry of hospitals and health professional:
- i. A public registry is a facility where information about registered entities are filed regularly so that people can search and retrieve such information when needed. There is no regulatory role for registries except to act as information ware houses. Three basic functions of a registry are:
 - a. Maintenance of a register i.e. database of the entities covered by it.
 - b. Provide facilities to log reports from various sources. Logging of information could be classified on the basis of the extent to which it is authentic. For example findings by judicial authorities, statutory regulatory authorities, public health officials and laboratories based on specific investigations would form one category. Findings and certification by voluntary accrediting agencies etc. could be another. Consumer opinions and replies by concerned registered entity would form yet another class.
 - c. Provide access to public to search and browse the database.
 - ii. It is important to make sure that access is real and cheap. The registry should provide multiple access to the computerised database, for example through dial up lines, the Internet, distribution through CD ROM and floppy diskette etc.
 - iii. Important health system entities for which public registries are required include;
 - iv. Medical practitioner's database, which essentially should be an extension of the state medical register. For example, in the US there is a national database of physicians. In

¹ For example regulatory mechanisms for collection, handling and administration of blood products had to be developed by the government to address certain serious public health issues. Another area requiring regulatory intervention would be disposal of hospital waste.

this database all court judgements in malpractice cases are filed. Hospitals are required to search this database while considering to recruit any physician. It is expected that hospitals would take into account findings from malpractice cases about specific physicians while considering recruitment.

- a. Health institutions data base where all health institutions are listed.
- b. Nursing practitioners database.
- c. Other professional databases.

6. Quality assurance system:

- i. Accreditation by a third party organisation other than provider interest groups is an important mechanism of quality assurance. to consumers. Various aspects of an accreditation system has been discussed during the course of this workshop. Briefly important elements of an accreditation system are;
 - a. an accreditation board,
 - b. a standards development process,
 - c. a set of surveyors to apply the standards to specific health care services, and
 - d. an office set up to do the processing.
- ii. Accreditation board should consist of medical professionals, nursing professionals, and other allied health professionals, health care organisations for example nursing home association, consumer interest and groups, public health officials. It will be wrong to assume that one can represent the other, because each one has an important role to play².
- iii. The standard development process should have some means of developing locally relevant standards. Research should be done to find out the concerns of stake holders and consumer needs while developing these standards. It is important to follow consensus development methods.
- iv. Surveyors are needed to apply the standards. Procedure for identification of surveyors, their training and certification and constitution of survey teams have important bearing on the quality, reliability and impartial character of the accreditation process.
- v. Finally a secretariat or some kind of office set up to handle the survey reports, process them and make it available to the board.

7. Continuing education system:

- i. The expression "continuing education" is used rather than "continuing medical education" to emphasise the need to continuously educate all members of a medical and health team rather than doctors alone. Continuing education is required for doctors, nurses and allied health professionals. There is need to develop continuing education centres in health care delivery institutions. Here again there is a case for some kind of accreditation system. Otherwise the continuing education programmes may deteriorate into rituals. Since the Medical Council of India is now going to require 30 hours of continuing education for licence renewal, there is a risk that many continuing education centres will spring up to provide required certificates for licence renewal. The University of Health Sciences should develop a mechanism for accreditation of continuing education centres and programmes. Some standard syllabus may be developed. In addition accredited continuing education centres could ask for approval of specific course syllabi developed by them. In addition to medical

² Incidentally, Dr. Mahapatra observed, a large number of hospitals, world over, are actually managed and run by people other than those with medical background. Doctors work in the hospitals but the hospitals are run and managed by groups and made available to doctors for their practice.

colleges, medium and large private hospitals, nursing homes, APVVP district and area hospitals, IMA branches are potential sites for continuing education centres. If a system of accredited continuing education centres is available then the Medical Council of India will feel encouraged to ask for certificates from accredited centres for purposes of licence renewal.

8. Practice guidelines:
 - i. The need for development of practice guidelines was highlighted by certain participants. It is necessary to have a mechanism for development of practice guidelines and their dissemination. Features of such a system should include;
 - ii. Networking of various institutions is required to develop practice guidelines. Multiple centres may be involved in development of practice guidelines. Each centre would work according to its area of interest. University of Health Sciences and the Medical colleges can play an important role. Practice guidelines can be developed in these institutions.
 - iii. A suitable consensus building process should be followed while arriving at practice guidelines.
 - iv. Encourage evidence based medicine. There is a large international movement advocating evidence based medicine. A large number of web sites dealing with evidence based medicine exist on the Internet. For example, there is an important collaboration Called Cochrane collaboration. It started as a collaboration of obstetricians and gynaecologists who wanted to take stock of various randomised controlled trials and make them available for easy reference by practising doctors.
 - v. Dissemination of practice guidelines should be linked to continuing education programme rather than the accreditation system.
9. Health systems research:
 - i. Research capacity should be built up to continuously analyse, evaluate and question the efficacy of various policy instruments, assess their impact etc. Possible research questions can be; to understand consumers felt needs, provider perspectives, to do action research, feasibility studies and pilot projects to implement different alternatives and to evaluate impact of various policies instruments.
 - ii. Some research activities of immediate relevance to development of a healthy private sector in health are;
 - a. Periodic assessment of the usefulness of the accreditation system. Particularly it will be desirable to understand how different stake holders are perceiving the accreditation system and its usefulness.
 - b. Monitor and evaluate awareness and utilisation of registries.
10. No fault but strict liability system for medical injury:
 - i. A system similar to the one recommended by the Harvard Medical Practice Study (Weiler et al, 1993) would be appropriate. Suggestions by one of the participants in the workshop are consistent with this system. Briefly the proposed system is as follows:
 - ii. Victims of medical injury are compensated from a medical injury liability fund once it is established that medical injury did take place instead of waiting to fix responsibility as to who caused it. Cost of remedial medical care, lost wages etc. are included in compensation but exorbitant claims regarding pain and suffering etc. are not supported.
 - iii. The medical injury liability fund can be built by using;
 - a. flat rate contribution or licensing fee from all health institutions, and

- b. Full or partial reimbursement by institutions for specific instances of medical injury related claims.
- iv. No fault assignment on medical or allied health professionals by the legal system. Instead this is left to the institution concerned.
- v. Why should institutions be required to bear medical injury related costs? Because remedy lies mostly at the institution level.

VII. Panel discussions (May 24, 1998 2.30 p.m. to 5.0 p.m.):

1. Chairperson: Dr. Sham Sundar, Vice Chancellor, AP University of Health Sciences.
2. Panellists:
 - i. Dr. Venkat Rao,
 - ii. Dr. Thyagaraja Reddy,
 - iii. Dr. Eswar Rao,
 - iv. Shri M.Nagarjuna.
3. Chairperson's introductory remarks:
 - i. Dr. Sham Sundar thanked the organisers and reiterated the importance of the workshop.
 - ii. Recalling earlier discussion about evolution of the private hospital sectors in Andhra Pradesh. Dr. Sham Sundar added his observations based on his personal experience as a surgeon practising in the Telengana area for more than 35 years.
 - a. Before 1968 there were hardly any hospital in Hyderabad city to do major surgery. Private nursing homes were few. Most of these provided maternity and gynaecological services. Just about two or three general nursing homes were available for procedures like a hernia, hydrocele or may be an appendix but not a thyroid or gastric, nor renal stones.
 - b. The period around 1968 was a kind of watershed in development of nursing homes in Hyderabad. Several factors must have contributed to the growth of nursing homes around this time.
 - 1) One of them was the ban on the private practice by doctors working in government hospitals. Several doctors left government service and started their own nursing homes. For the next about two years, when the ban was in force, number of other nursing homes did come up in the Hyderabad city.
 - 2) Around the late eighties, the corporate hospital culture started. Probably other factors like changes in the banking practices allowing hospitals to be given finance on a more liberal scale also contributed. A number of corporate hospitals were set-up around this time.
 - 3) The Nizam's Institute of Medical Sciences, set up around this time in the public sector, contributed to the credibility and viability of high tech hospitals.
 - iii. Similar developments seem to have taken place else where in the Telengana region. In the districts, when he was assistant professor and earlier when he was a post graduate student, a lot of patients used to come from far off places for simple things like hydrocele, hernia, and haemorrhoids. In emergency he would see patients with perforated duodenal ulcer, perforated appendix, strangulated hernia, glandular bowel and all that; coming from distances up to 100 and 150 kilometres. By the time they reach hospital they would have severe peritonitis or such other complication. Most of them could not be saved. But during the later part of his career one did not see many such patients. Such emergencies would be mostly from distances of about 30 to 40

kilometres, but not from 100 to 150 Kms. This was because, by that time the local hospitals had probably developed a little bit, some specialists were available, and many private hospitals had come up; so that such cases were being treated locally. Similarly, elective surgeries like hydrocele, hernias also stopped coming to Hyderabad from far off places.

- iv. Moving over to the data available from the APHIDB and the presentation by Dr. Mahapatra on private sector hospitals, he said that it will be interesting to see what percentage of patient's are being dealt with in the private sector as opposed to the Government sector. He meant the extent of bed capacity utilisation in the two sectors. For example the Osmania general hospital with about 1200 beds admits on an average about 40,000 patients every year (i.e. a turnover rate of about 33 per bed per year). If we pool 12 hundred private hospital beds in different places, will they be treating 40,000 inpatients in a year? Similarly one could compare the volume of out patients treated by hospitals in the private and public sectors respectively.
4. The panel chairperson then asked rapporteurs from the two groups to present the summary of the group discussions held the previous day.
5. Dr. Chandrasekhar presented a report of discussions on "Relative strengths of private and public sector hospitals from the perspective of patients medical condition" in group-1. Summary of discussion in the group and their recommendations have already been described earlier in this document. The recommendations are reproduced here for emphasis:
 - i. We need a proper mix of private and public sector hospitals.
 - ii. Proper accreditation system should be evolved.
 - iii. Cost effective utilisation of expensive equipment is required.
 - iv. Payment system in government hospitals where the money goes back to develop the hospitals needs favourable consideration.
 - v. Referrals should be made to private hospitals only if it cannot be taken care of in public sector hospitals, so that public money is well targeted to the poorer sections of society.
6. Dr. Venkateshwar Rao rapporteur of group-2 dealing with "How to Assure Quality of Care by Hospitals in A.P.?" summarised the group discussions, which have already been described above, and presented the following recommendations:
 - i. Hospitals and nursing homes should satisfy certain minimum standards.
 - ii. 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.
 - iii. Initially physical and process standards may be developed so that hospitals and nursing homes acquire skills to operate them. At a later date the concept of outcome standards can be introduced.
 - iv. Standards should be developed by professional and research teams following wide ranging consultation among various stake holders.
7. The panel chair person then invited each of the panellists to present their view points.
8. Panellist Dr. Venkat Rao presented his views while clarifying the following points raised by participants during course of the work shop.
 - i. Referring to the Consumer Protection Act, he clarified that if a government hospital is collecting fees even for a part of its patients the entire hospital comes into the purview of the Act.
 - ii. The Medical Council of India has changed the curriculum which has come into force only this year i.e. 97-98 and about which he would elaborate later. The revised

syllabus prescribes a core structure and allows the concerned university to further elaborate it to meet their local needs.

- iii. About long felt need for a separate teaching cadre, he drew attention to the fact that APVVP is now recruiting doctors for itself. Similarly the Directorate of Health is making separate recruitment for Primary Health Centres. As a result the teaching and non teaching cadres have become separated automatically.
 - iv. Earlier a participant had raised concern about private hospitals designating themselves as research centres. Though certain private hospitals have designated themselves as research centres hardly any research is going on there. Replying to this concern, Dr. Venkat Rao clarified that research can include clinical and operational research. If, for example, a hospital does ultra sound examinations of the abdomen, or the uterus or the tube-ovarian masses, and the doctors working there present a paper about the ultrasonic appearance of tubo-ovarian masses, that becomes a clinical research.
 - v. Regarding the suggestion to grade hospitals analogous to the number of stars in the hotel industry, he said that personally he is against such a thing. Instead, it will be desirable to prescribe minimum requirements for hospitals based on the number of beds and the speciality services offered by the hospital. One could then verify and say if a hospital meets the minimum requirement or not.
 - vi. In case of bigger hospitals having more than say hundred beds, the minimum requirement should ask for certain Committees like an ethics committee which will go into the practices that are happening in the hospital.
9. Panellist Dr. Eshwara Rao:
- i. He said that this workshop by which the Government is trying to understand both sectors, is the first of its kind. Although various people have been working towards this goal for sometime, the discussions during the last two days have brought people closer to this goal.
 - ii. The papers presented were very good quality, with appropriate perspective and keeping the common man's necessities in view. However many of the studies are based on small samples. It will be desirable to extend the studies to cover larger samples so that some representativeness in the data can be achieved.
 - iii. Most of private hospitals and nursing homes are in 15 to 25 beds category. It is important to keep the resource constraints faced by nursing homes of this size and the paying capacity of their clientele.
 - iv. Recognising the fact that private hospitals and nursing homes are not of uniform size the AP Nursing Homes Association has proposed separate standards according to the size of a hospital. The association has recently brought out a small booklet on minimum standards which categorises hospitals according to their bed capacity. These were done with the view of the economic viability of the institution.
 - v. The private hospitals have grown and have been perceived well, much recently, due to the improvements in paying capacity of some patients and the convenience of easy availability of care. So, the pressure on the major hospitals has been reduced to some extent. However chronic problems, serious conditions and emergency problems still have to be dealt with mostly by regional and district hospitals that are in the public sector. When small nursing home or hospital is presented with an accident case or such other patient it is not equipped to handle the hospitals would want to give first aid and then refer the case to a centre with required facilities. However people do not always understand this and patients attendant tend to create some law and order

problem. It will be desirable to educate people about the nature of cases a hospital is equipped to handle so that there is no misunderstanding on account of referrals.

10. Panellist Dr. Tyagarajareddy:

- i. He thanked the organisers of the workshop and agreed with Dr. Eshwara Rao about the usefulness of the deliberations this workshop in understanding the state of private health sector in AP, its role and linkages to public sector etc.
- ii. He agreed with Dr. Sham Sundar's observation about the history of development of private hospitals and nursing homes in Andhra Pradesh. Around 1968, when he completed his MBBS, in a big city like Warangal, there were hardly any surgical nursing home to perform abdominal surgery. Every one had to depend on the publicly owned MGM hospital.
- iii. Around 1970, when he set up his private practice in Prodatpur, he used to refer difficult cases to Kurnool General Hospital (a government hospital attached to the Kurnool Medical College). This is the nearest tertiary hospital for Prodatpur. Patients were happy and satisfied with the services provided there. Around 1974 - 75 things started changing and patients are asking to be referred to Madras (Chennai).
- iv. A large number of private nursing homes have come up in Prodatpur over the last 28 years. This would imply that there is definite encouragement from the public. He emphasises that people have started encouraging the private sector, for the reasons best known to them. Probably the immediate attention they get once in the private hospital. The urgency by which the investigations are done, the diagnosis, at the earliest, starting the immediate treatment and even the faster recovery.
- v. He agreed with the assessment that socio-economic development has contributed to higher expectation and willingness to pay for the convenience of a nursing home. However most of the private nursing homes and hospitals are coming up in taluks or district headquarters and cities. Still people in the rural areas are depending upon the Primary Health Centres and the Government hospitals. Whatever the minimum medical aid they are getting, they have to depend on them. People rush to the nearest hospitals for treatment. In rural areas government hospitals are mostly the ones available nearby.
- vi. Since the private hospitals and nursing homes have grown so much there people must have some assurance about the quality of their services. Moreover people have become conscious and expect hospitals to satisfy appropriate minimum standards. So the time has now come to standardise ourselves regarding the infrastructure what we must have in our hospitals. Instead of being forced by regulations, it will be desirable for practising doctors to take the lead and ask for minimum standards in hospitals and nursing homes.
- vii. Although most private nursing homes and hospitals have between 15 to 20 beds, they do possess very good operation theatres and are geared to handle emergencies like a caesarean sections. This is a good service to people. Earlier, in case of small towns, one had to transport a woman with difficult labour, to a distance of about 50 to 60 kilometres to have caesarean section. Now a days anaesthetists are also available on call.
- viii. It is important for medical practitioners to realise that people are resorting to the Consumer Protection Act, because, some members of the medical profession are doing unnecessary procedures, providing deficient services etc. It will be desirable for the medical profession to insist on certain minimum standards where ever one is practising, before the Government forces the same thing through legislation. He is encouraged to find that doctors in Andhra Pradesh are very forward looking. For

example the AP Nursing Homes Association have published a book containing minimum standards for hospitals. A second edition has been released recently. Further improvements to these standards is required. For this purpose help from institutions like the IHS can be taken.

- ix. With development of the private sector many technology intensive services have become available. For example renal transplant. Well to do people are able to afford such services. A common man, on the other hand, is not able to get them. Hence the Government must come forward and limit themselves to the care of poor people i.e. white card holders. It is a matter of concern that even the white card holders are not getting sufficient benefits.
- x. Costly equipment in many government hospitals are under utilised due to mismatch of equipment and operating personnel availability, lack of interest on the part of hospital administrators etc. Instead of buying such equipment government could utilise facilities from the private sector on unit of service basis so that maintenance of equipment etc. is taken care of by the private sector. For this purpose government should fix rates for unit services so that hospital administrators in the field can purchase the services from private sector. Similarly services of specialists in private sector could be utilised in public hospitals. The system of honorary surgeons i.e. private practitioners working in government hospitals part time on honorary basis should be reintroduced.

11. Panellist Mr. Nagarjuna:

- i. It is important to keep in mind the consumer's view point.
- ii. It has emerged from the group discussions that choice of private versus public hospital largely depends on one's buying power. At the macro level this translates into the relationship of socio-economic conditions of an area and the size of private health sector. Socio-economic development would mean that people have surpluses and hence can afford to spend on private hospitals. Therefore private sector would develop in the area. So whether we look at the micro point of view or from the macro point of view, by and large what we are getting at is, if a person has money in his pocket he is likely to go to a private hospital. Therefore it would be wrong to say that private sector is developing only because the government sector is not working very well.
- iii. A patient may make some efforts to identify the right doctor. But once he has made up his mind where to go, he puts himself in the hands of the doctor. That is all that anyone can expect the patient to do. There upon the doctor plays the role of provider as well as the indenter of services. It is well known that different doctors would handle the same case differently. A patient does not have any means of knowing whether what is done for him is the right thing to do. That is why consumers are anxious to ensure that the treatment paid for by them is the one they should be getting? They are anxious that if things go wrong, who is going to protect him? Which is why a consumer will always see the Consumer Protection Act as a source of some reassurance. Such a law becomes all the more important because there is no alternative forum where alleged mal practices by a doctor or negligence in a hospital can be scrutinised. This is why the issue of quality assurance in medical care is important.

12. Panel Chairperson Dr. Sham Sundar:

- i. There is a common misconception among people that the more money you pay you the more attention and better treatment you get. The reverse perception is also fairly

well prevalent. Most people or most patients are under the impression that if they get free treatment it is not good, it is not worthwhile, there is no value.

- ii. While designing systems to benefit the poor it will be desirable to attach some indicative price to each service and drugs to give some confidence to the users that the product delivered to them is valuable and also to convey the relative cost of such products. He narrated experience from his own practice and some very popular practitioners that compliance to totally free medication is usually lower than drugs given for at least some price.
- iii. Certain undesirable directions in which private sector may grow needs to be guarded. Private insurance for health services has a tendency to stifle professional freedom. For example, nowadays in U.S.A., most of the procedures require pre approval.
- iv. The problem of poor distribution of hospitals in rural areas is not peculiar to India, although it is probably a little more here. Probably one reason is viability of big hospitals in remote areas, since enough patients may not be forthcoming.
- v. Nowadays there is a tendency to put up a speciality hospitals or call it a super speciality³ hospital. Although a hospital can choose to set up facilities for one particular disease, a patient can't take his body part out and give it there. The patient is there as a whole. A cardiac patient may have a neurological problem or he may have some other problem. If you have a hospital which is exclusively meant for a particular condition obviously the staff there is not geared for treating other patients. The patient cannot get full treatment if he has accompanying problems. So, we have to treat the patient as a whole. The trend should be to encourage hospitals which can deal with all problems. In case of speciality hospitals there should be some minimum facility to look after some of these other requirements⁴.
- vi. Another important question is up to what extent government should pay for or provide medical services to its people. Should the government pay for renal transplant? Recently in a panel discussion on AIDS in Tirupathi, it was noted that certain drugs like zedovidine are very costly. In US zedovidine therapy would cost about twenty thousand dollars a year. In India with domestic manufacture of this drug the cost works to about 15 thousand rupees or so per month. In case of renal transplants, apart from the cost of the surgery a patient would require immuno suppressive therapy for life costing about Rs3000 per month. If the Government is to supply zedovidin to the AIDS patients and provide facilities for transplant there may not be any resources left to look after the other problems. There are many other problems, which are much more severe and are of much greater concern. An appendix done for 25-year-old man will save the patients life who can be independent and earn his own living without depending on anybody. On the other hand a patient with renal transplant is always on drugs for the rest of his life. Similar is the case of patient with AIDS. Any way this is a very complex issue and involves decision by society at the political level. Even in

³ Dr. Sham Sundar remarked that the nomenclature of “super speciality” is peculiar to India. All these are in fact subspecialties. For example cardiology is a sub speciality of medicine.

⁴ Unfortunately, Dr. Sham Sundar remarked, the problem is prevalent in the public sector as well. For various reasons we have E N T hospital, Eye hospital and all that. If a patient comes with multiple injuries to the Osmania hospital, say injury to the eye, fractures, and abdominal injury. No eye specialist is available in the same hospital. Services of a specialist will have to be requisitioned from the Sarojini Devi Eye hospital. When this specialists prescribes a medicine mostly used for eye service it will not be available in Osmania because they are not stocked. This increases co-ordination overheads and results in delay.

advanced countries, that are very affluent, there has been a lot of debate. In UK the debate is whether transplant and dialysis programme should be supported by the National Health Service or by the Government or it should be left to the private. Andhra Pradesh and India in the present economic status may not be able to support such heavy financial commitments.

- vii. Although Government hospitals are not having all facilities and there are deficiencies the only solution is to find ways to improve them. There is no point in running them down. Most doctors or almost all have been trained in Government hospitals. Most doctors in future are going to be trained in government hospitals. Hence it is important to improve them rather than bypass them.
13. The Chairperson then declared that the subject is open for discussion.
 14. Dr. Balamba:
 - i. Training of medical teachers in teaching methodology is important. That will help improve the quality of medical manpower. The University of Health Sciences had a programme of recruiting people who were trained already to be medical teachers. Such a practice should be continued.
 - ii. In reality the private and public sector hospitals complement each other. She gave the example of the Government Maternity Hospital which receives lots of referral from private hospitals. Concurring with the view of Dr. Sham Sundar she reiterated that “we should never run down each other”. Unfortunately, the in-thing seems to be, nowadays, to run down all the Government hospitals. But people must still understand that most of the care that the poor get are from Government hospitals. Although there may be deficiencies on account of poor administrative skills, the quality of professional skills are of a very high order.
 15. Dr. Sham Sundar informed that the UHS is planning to establish a Medical Teacher Training Centre at the University. It may take about two years to materialise.
 16. Dr. Venkateshwara Rao:
 - i. He referred to a suggestion earlier that the quality of medical care in hospitals depend upon the standards of teaching in medical colleges, and the present standards of teachers in medical colleges appear to have been diluted. That is the reason why teachers require training in teaching technology.
 - ii. The government and the private sector are not mutually exclusive and they should be complementary to one another. It will be helpful to define the role of hospitals in each sector. While doing so the consumers point of view should be kept in view since the patient is the primary focus of both the sectors.
 17. S. Srilatha asked Dr. Venkat Rao to clarify whether the Medical Council of India have any norms of competency of persons with different medical degrees to do various surgical procedures. Some M.B.B.S. doctors are doing all sorts of surgeries. One is not sure if they have the required training to do all those procedures.
 18. Dr. Venkat Rao clarified that at present there are no written norms. Even in the Consumer Act it doesn't say that a particular procedure has to be done by a specialist with a certain qualification. It depends on the area where the person is practising. If there is an emergency in a small place, for example a ruptured uterus and no qualified obstetrician is available and a M.B.B.S. doctor is confident enough to do the required surgery it will be proper for him to do so. A medical practitioner will have to weigh the chances of survival in case of referral to a more qualified specialist and immediate attention by a general practitioner. If, however, a specialist to deal with the problem is readily available within reasonable distance then the proper thing will be to refer the patient. Recently the Medical Council of India have published a booklet which describes the level of

competence with regard to procedure. This booklet was published in 1997 bearing title “Graduate Medical Education”. All procedures listed in this booklet can be performed by any M.B.B.S. doctor. In order to do procedures not listed in this booklet a medical graduate should fulfil any one of the three criteria:

- i. A formal degree or diploma in the concerned speciality, obtained from a recognised medical college, recognised university.
 - ii. The doctor has worked either in Government or private in a particular department where such procedures are routinely done and acquired the skill to do such procedures.
 - iii. Doctors who have already acquired the skill and have been performing such operations before the Consumer Protection Act, came into force need not stop practising such operations.
19. Lipika Nanda asked Dr. Eswar Rao about the extent to which all stake holders and interest groups contributed in preparation of the minimum requirements booklet issued by the AP Nursing Homes Association to their members.
 20. Dr. Eswar Rao informed that the booklet was produced as a voluntary programme to upgrade each institutions facilities and services and try to educate member nursing homes and hospitals about the minimum requirements. This was worked out after consultation with various hospitals and to some extent reference to available literature. This standards committee consisted of hospital management people, anaesthetists, surgeons and some other specialists. Most of the people have got working knowledge of the running of hospitals and they serve in their own hospital. Hospital administrators from the Apollo group also contributed to some extent.
 21. Lipika Nanda then noted that the standard setting committee consisted of mostly doctors. It would have been desirable to have a multidisciplinary team of persons and various stake holders representing all relevant points of view.
 22. Dr. Chandrashekar emphasised the need to reiterate the need for social justice in any health care system. Traditionally various institutional mechanisms have been used by the health sector to work towards social justice and equitability in accessibility to health care services. For example medical ethics to which all doctors are required to contribute gives importance to human dignity and equitable professional care to poor. The health sector has traditionally been dominated by non profit, municipal or public sector hospitals and health centres. However a lot of dilution in medical ethics and glorification of private corporate hospitals are being seen lately. The need for equity in accessibility to medical and health care is shared almost universally. It is difficult to imagine how reduced emphasis on medical ethics, tolerance of business and commercial approach to delivery of health care and too much reliance on private corporate hospitals can be consistent with the social justice objectives.
 23. Dr. Sham Sundar, referring to the question by Srilatha of legal definition of specialists competency to do various procedures, said one reason why the British Royal College was very late in awarding sub speciality fellowships was that a surgeon accepted as a fellow would be competent to do whatever surgery is required of him. Sub specialisation develops in the course of working and applying the surgical skills to a specific organ system. In any case there are a lot of grey areas about competency of various specialists. There are many procedures being done by different specialists. For example a procedure like hypospadias is done by plastic surgeons in some places, neurologists in some other places and by paediatric surgeons yet in other places. Moreover competency definition is also likely to create feelings of jurisdiction. It is up to the person. Supposing say hypospadias is included in the skill set of plastic surgeons. If a paediatric surgeon does

this surgery and something happens, he may have to face legal proceedings. Such questions cannot be answered in a general manner, It is better left to the discretion of the surgeon concerned. The surgeon should decide if he is competent to do a procedure keeping in mind his training and experience.

24. A participant asked about the implications of ISO 9000 certification. Mr. Nagarjuna replied that it is essentially a services standard. Dr. Venkateswar Rao said that the ISO900x certification is usually done by management consultancy firms who chose to provide this service. These standards are about the internal quality assurance system of a facility. Dr. Mahapatra opined that ISO900x standards may not be right place to start with in case of hospitals and health care facilities. The first step is to ensure that the core resources and inputs in medical care like professional skills etc. are available. The next step will be to set standards of performance by such qualified professionals.
25. Dr. Venkat Rao informed that a large number of medical graduates have settled in foreign countries. Till recently almost half of the medical graduates used to find some employment or practice opportunities abroad. Recently such opportunities have reduced. For example there are restrictions for doctors to enter into the USA. Recruitment of doctors by middle east countries have come down. This may be one reason for the growth and development of private sector hospitals and nursing homes in AP.
26. Dr. Venkat Rao noted how data gathered from the state medical register can be misleading. For example about half of the 45000 doctors registered by the State Medical Council so far have emigrated out of the country. Assuming that about a couple of thousand persons in the register would not exist due to mortality etc. the actual number of doctors in AP would be around 22000. However governments usually cite the total figure of 45000 and assume that all of them are available in the state. Changes in the legal framework of registration requiring periodic renewal of registration may help in obtaining more accurate account of doctors available in the state.
27. Dr. Mahapatra suggested that the register could be updated by computerising it for quick retrieval coupled with various validation approaches like mail campaigns, contact chains consisting of batch mates etc. An important result obtained by IHS in the context of the APHIDB is that it is possible to set up and maintain a database of health care institutions with more than 90% accuracy without any legal sanction requiring registration or renewal by the concerned institutions. This approach by IHS in setting up and maintenance of APHIDB could be suitably adapted to the needs of the state medical register.
28. Scope of collaboration between private and public sector hospitals was then discussed and many participants contributed their ideas about these, which are listed below:
 - i. Dr. Eswar Rao:
 - a. Private and public sector hospitals should complement each others services.
 - b. Government should use manpower, diagnostic and therapeutic services available in the private sector.
 - c. Some institutions like dispensaries, health centres and hospitals consistently suffering from lack of medical technical and managerial manpower can be given over to the private sector for management.
 - d. Management of ambulance services could be given to appropriate non government organisations. Government could provide capital cost of the ambulances and allow NGOs to manage them.
 - e. A scheme being discussed currently with government is that private hospitals will provide a special service package, in rural and tribal areas, to conduct normal delivery. The service package will include 3-4 ante natal check ups, minimum

investigations for management of normal delivery, one month post natal check up and immunisation of the child.

ii. Mr. Nagarjuna:

- a. In view of the recent knowledge about risks of transmission of many dreaded diseases through the blood products elaborate facilities are now required to set up a blood bank. As a result entrepreneurs find it beyond their means to set up blood banks. Here government hospitals can extend blood bank services to the private sector. In this connection Dr. Eshwar Rao of AP Nursing Homes Association recognised that recently APVVP have issued a letter to all hospital allowing them to give blood and blood products after following some norms.
- b. Under the first referral health system project a lot of facilities like modern operation theatres are being built in APVVP hospitals. Spare capacity of such facilities could be used by the private sector.
- c. About the suggestion to use services of private practitioner super specialists in government hospitals, he informed that some efforts were made in the specific situation of Rajahmundry but no result came of it. This idea could be pursued further.

iii. Dr. Venkat Rao:

- a. Ambulance service is an important area of collaboration between government and private sectors. Ambulance services provided by non government organisations could be located along major highways in the state. These ambulances will then be used to transport accident victims on the road and will also serve near by villages to transport all types of emergency cases.
- b. It will be desirable to have a system by which a private practitioner can avail the facilities in a public hospital. For example a private practitioner could bring in a case for surgery to a government hospital. The patient will pay to the hospital for hotel, anaesthetist, nursing and operation theatre charges. Some thing similar to the evening clinics in Nizams Institute of Medical Sciences can be thought of.

iv. Dr. Venkateswar Rao:

- a. Some of the above proposals in effect will allow private practice in PHCs and government hospitals. In that case it will be desirable to adopt a comprehensive policy. Government could not be banning private practice by government doctors posted to PHCs and hospitals and at the same time allow private practitioners to use facilities in government hospitals. Allowing private practitioners to use facilities of government hospitals will in effect allow private practice by government doctors.

v. Thyagaraja Reddy:

- a. Many private nursing homes are already providing immunisation services to people free of cost utilising vaccines made available by the public health department.
- b. Almost all private hospitals and nursing homes joined with the public health authorities to make the pulse polio program a success.
- c. Wherever doctors have been consistently unavailable government should explore the possibility of utilising the services of private practitioners.

- vi. Dr. Venkateswar Rao reiterated; if services of private practitioners are to be used in government hospitals and PHCs then private practice by government doctors should also be allowed.
- vii. Dr. Sudhakar Rao:
 - a. The role of public sector hospitals may be viewed as sources of fair prices medical care services.
- viii. Dr. Shyam Sundar:
 - a. Encouraging non government organisations to provide ambulance services is a good idea. He cited the example of Apath Bandhu, whose ambulance service in Hyderabad city is well recognised.
- ix. Dr. Mahapatra first asked if participants agreed with the summary and operational result of discussions about required policy initiatives, presented by him in the pre lunch session (session-3). Participants endorsed the summary of recommendations (future plan) presented by the workshop chairperson earlier.
- x. Dr. Mahapatra noted that most of the points included in the summary presented by him earlier was reiterated during the course of the panel discussion. He then proceeded to summarise additional point emerging out of the panel discussions as follows.
 - a. We should view, for purposes of clinical work, the private and public network as one. In other words when it comes to serving patients, the system should allow effortless movement of a patient from one sector to another. There should not be any barriers to clinical and professional interaction among doctors working in the two sector. In effect, however the compartmentalisation may continue to exist on account of choices made by patients. A patient may chose to stick with the public sector hospitals for personal reasons. Hence efforts should be made to build required institutional mechanisms to ensure this bi directional flow of patients.
 - b. However, in the name of trying to build a system to allow interchange between the private and public sector we should not inadvertently bring in policies which are known to have some difficulties. For example private practice by doctors in the public sector and service in government hospitals by private practitioners have similar implications.
 - c. Undoubtedly, there is a felt need for flow of services between the two sector. Diagnostic facilities and services in public sector can easily be utilised by private hospitals and practitioners on the basis of some pricing mechanism. Utilisation of government hospital operating theatres by private practitioners, however, is more complicated.
 - d. The case of sharing of skilled manpower is different. The scope to solve manpower shortage in public sector by taking help from private practitioners on a regular basis is limited. Only exception would be emergency handling.

VIII. Summary and recommendations:

A. Quantitative assessment of medical facilities in the private sector:

1. Latest data on the number of private hospitals and their bed capacity is not available. The best available information is from the AP Health Institutions Database (APHIDB) maintained by the IHS. This database provides fairly accurate information for the year 1994 till which time data validation was carried out. Data validation and updating could not be continued due to lack of funding for the database. According to the experience of workshop participants a large number of private hospitals and nursing homes have started

operating during the last three years i.e. after 1994. However the patterns emerging from out the data in the APHIDB would most likely hold as on date.

2. The state had about 79000 hospital beds in 1994. About 59% of these were in the private sector, 35% in the public sector and the balance 6% were maintained by non profit voluntary organisations.
3. There are significant regional differences in public private mix of the states hospital stock. Socio-economically developed areas tend to have more private hospitals.
4. In areas where private hospitals and nursing homes are more prevalent, about half of them are in mandal headquarters. These are essentially small towns.
5. A large proportion (87%) of private hospitals and nursing homes have 30 or less beds. Most (37%) private hospitals and nursing homes are between 10 to 20 beds in size.
6. Only four hospitals in the private sector had more than 250 beds. Three of the four hospitals with more than 25 beds were located in Hyderabad. Another 37 hospitals had beds ranging from 100 to 250 beds. Most of these are located in the state capital, regional cities and a few socio-economically more developed districts.

B. Nature of services provided by the private sector:

1. Obstetrics turns out to be one of the main services offered by the PHIs.
2. Many (47.35%) of the PHIs offer "all services" which include medical, surgical, obstetric and "other " services. After this comes the combination of medical, surgical and obstetrics (18.31%), medical (9.67%), and then medical and surgery (6.47%).
3. Emergency and casualty services are not so well developed in the private sector. There appears to be some reluctance among many private hospitals and nursing homes to refer accident cases to nearest public hospitals.

C. Range of medical interventions where private institutions have an advantage:

1. Most participants in the workshop believed that ownership of a hospital does not as such give any advantage or disadvantage in dealing with various medical conditions. Hospitals in both the public and private sector can handle almost all types of conditions. However, preferences for private or public hospitals do exist on other accounts, namely (a) paying capacity of the patient, (b) distance to be travelled to reach the hospital, (c) size of the hospital, etc.
2. Factors like size of hospitals, medicolegal implications, etc. do translate, at the macro level, into certain broad patterns of distinction between the public and private sector.
 - i. Most private hospitals and nursing homes are small in size. This usually restricts the range of services offered by them to reproductive services, abdominal surgery, general medical and paediatric cases.
 - ii. Small size implies that each hospital or nursing home is staffed by a few doctors. Usually there is one doctor focusing on a particular type of service and supplemented by part time consultants for other specialities.
 - iii. Private hospitals and nursing homes, for various reasons⁵, are usually not geared up to handle medicolegal cases. Since most accidents would have some medicolegal implication, ability of private hospitals to handle emergencies is compromised. In

⁵ Some of the reasons are; (a) additional burden on its staff to answer questions from states investigating agencies and to attend courts for giving evidence, (b) lack of staff to do additional documentation required for such cases.

case of smaller private hospitals, other factors like lack of equipment, etc. may also contribute.

- iv. Empirical data collected by the IHS and contained in the APHIDB shows that obstetrics is the most common service provided by the private hospitals and nursing homes.

D. Scope for regulation of the private sector:

1. There was a consensus about the need for a quality assurance system. A voluntary accreditation system supported by formal and informal incentives in favour of accreditation was recommended. Legislative support if any should enable a regime of voluntary accreditation system rather than a legally mandated government regulation.
2. Following characteristics will be desirable for the proposed accreditation system.
 - i. Mechanisms to develop minimum standards with following essential features:
 - a. The standards development should be done by an organisation with adequate research and documentation on the subject.
 - b. Standards should be developed by professional and research teams following wide ranging consultation among various stake holders.
 - c. 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.
 - d. Initially physical and process standards may be developed so that hospitals and nursing homes acquire skills to operate them. At a later date the concept of outcome standards can be introduced.
 - e. Accredited hospitals and nursing homes should satisfy the minimum standards.
 - ii. An accrediting institution with following responsibilities and characteristics.
 - a. Responsibilities:
 - 1) Identification, training and empanelling of surveyors who can apply the standards to specific situations and assess compliance by hospitals.
 - 2) Formation of an accreditation board with representatives from all stake holders.
 - 3) Organisation of a secretariat to process accreditation proposals and to service the accreditation board.
 - b. Desirable characteristics of an accrediting institution.
 - 1) A non profit organisation, so that it does not have a profit motive behind the accreditation process.
 - 2) Should not be representing a particular interest group.
 - 3) The accreditation set-up should not fully depend on the accredited hospitals for its financial sustenance. In that case there will be pressure on the accrediting institution to liberally grant accreditation so that its revenue can be maximised. On the other hand hospitals seeking accreditation should also pay for part of the cost to ensure that the process is voluntary and the hospital appreciates the value of accreditation service. The accreditation set up can be funded jointly by the hospitals seeking accreditation, through accreditation related fees, and major users of accreditation information like insurance companies, large corporations who may use accreditation status as a

criteria for empanelling of hospitals to provide medical care for their employees, and the government.

- 4) The organisation should have the capacity to develop standards.
- iii. Incentives to encourage accreditation:
 - a. Institutions responsible to provide medical care to their respective clientele and having a need to out source the same in part or full may be persuaded to empanel hospitals and nursing possessing valid accreditation for the concerned service. These institutions would include;
 - 1) Large employers both in public and private sector,
 - 2) Central Government Health Scheme,
 - 3) Insurance companies providing coverage for medical conditions,
 - 4) Employees State Insurance (ESI) scheme,
 - 5) and such others.
 - b. Build public awareness by taking up information, education and communication (IEC) campaigns through mass media and other forums.
 - c. 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.
3. Continuing education:
 - i. The idea of renewal of licensing and mandatory continuing education now broached by the Medical Council of India is a very positive step and when implemented will improve quality of professional services.
 - ii. The AP University of Health Sciences should have a program of affiliating and certifying continuing education programs so that the MCI recommendation is supported by complementary academic regulatory mechanism in the state.
 - iii. The Bulletin of Hospital Services started by the APVVP may be published regularly.
 - iv. Full co-operation between the public and private sector hospitals for purposes of continuing education. The practice of inviting local private practitioners to clinical seminars and discussions in APVVP hospitals may be continued and emphasised.

E. Monitoring changes in private health sector:

1. Public registry of hospitals and health professional:
 - i. A public registry is a facility where information about registered entities are filed regularly so that people can search and retrieve such information when needed. There is no regulatory role for registries except to act as information ware houses. Three basic functions of a registry are:
 - a. Maintenance of a register i.e. database of the entities covered by it.
 - b. Provide facilities to log reports from various sources. Logging of information could be classified on the basis of the extent to which it is authentic. For example findings by judicial authorities, statutory regulatory authorities, public health officials and laboratories based on specific investigations would form one category. Findings and certification by voluntary accrediting agencies etc. could be another. Consumer opinions and replies by concerned registered entity would form yet another class.
 - c. Provide access to public to search and browse the database.

- ii. It is important to make sure that access is real and cheap. The registry should provide multiple access to the computerised database, for example through dial up lines, the Internet, distribution through CD ROM and floppy diskette etc.
 - iii. Important health system entities for which public registries are required include;
 - iv. Medical practitioner's database, which essentially should be an extension of the state medical register. For example, in the US there is a national database of physicians. In this database all court judgements in malpractice cases are filed. Hospitals are required to search this database while considering to recruit any physician. It is expected that hospitals would take into account findings from malpractice cases about specific physicians while considering recruitment.
 - a. Health institutions database where all health institutions are listed.
 - b. Nursing practitioners database.
 - c. Other professional databases.
 - v. The proposed law for public registry of health care institutions should allow for more than one public registries by providing a mechanism for authorisation of such registries by a government agency which would act as a registry of registries i.e. a super registry. Each authorised registry will be responsible to maintain a register, periodically share its content with other registries and the super registry. Each registry will maintain a database of registered institutions to contain information from all registries in the state and provide public access to the database. This will avoid the bottlenecks and delays that may result from a single registry managed by the government and at the same time allow a centralised database of all registered institutions.
2. Strengthen the existing APHIDB in IHS by continuing the validation campaigns. Since the IHS has already developed methodological tools for validation and maintenance of the database supporting the APHIDB will be the quickest way of building up a mechanism to monitor changes in the private sector. Eventually IHS could be designated as a registry.

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An overview of private hospitals in Andhra Pradesh: Data from AP Health Institutions Database (APHIDB).

Dr. Prasanta Mahapatra¹

I. AP Health Institutions Database:

A. Origins

The AP health institutions database (APHIDB) is maintained by the Institute of Health Systems, Hyderabad. It is a database of all health care institutions in Andhra Pradesh. The public health institutions component of this database has its origins from the AP Vaidya Vidhana Parishad hospitals database. The private hospitals component of the APHIDB originates from a private hospitals survey conducted by the government of AP around December 1992 to January 1993. Data collected by the Director Health was obtained by the IHS and incorporated into the APHIDB. This data is being gradually validated by the IHS through periodic validation campaigns described below.

B. Validation campaign:

Validation campaign typically start with mailing of a letter to each private health institution (PHI) included in the APHIDB. A printout of the information pertaining to the respective PHI is enclosed to the letter. A request is made to the owner manager of the PHI to check the information furnished to them and make necessary corrections based on ground realities. Not all PHIs will, however, respond to the letter. For example the outcome of a mailing campaign in 1993 (table-1) shows that the postal address was incorrect in about 11% and only about 36% of the PHIs responded to the letter. Corrections made by the responding PHIs were carried out in the database.

Table-1 Outcome of 1993 mail campaign to validate PHI information in APHIDB.

Campaign event	#	%
Total letters sent	2,700	100
Replies received with some corrections or positive authentication	427	16
Replies received without any authenticating signature or remark.	551	20
Undelivered letters returned by postal authorities	302	11
No response	1,420	53

A field enquiry is then to supplement the mailing effort. Purposes of field enquiry include (a) check a sample of authenticated replies in mail to ensure that the information received by IHS can be relied upon, (b) check with those who returned the form but did not authenticate if the data is correct, (c) contact all those who did not respond at all, and (d) look for new health institutions if any that may not be in the database. Thus the specific tasks assigned to field investigators include:

1. Courtesy visit to the selected sample of PHIs who responded by mail and returned authenticated reports,
2. Courtesy and exploratory visit to PHIs who returned the printout unsigned and without any correction,
3. Collection of data about PHIs who did not respond,
4. Locating PHIs for which the letter returned undelivered, and

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5. Collect data on new PHIs which are not in the database (i.e. APHIDB). Each field investigator was provided with a sheet containing available information for each of the first four categories and is asked to update the information during the course of field enquiry. To locate unlisted PHIs the field investigators are given detailed guidelines to do a systematic enquiry. Some of the sources to be contacted by them are:

1. Municipal office,
2. IMA local branch,
3. Medical representatives of pharmaceutical companies,
4. Drug stores,
5. Distributors of IV fluids.

In addition the state, district and local associations of Medical representatives, Association of chemists and druggists etc. are contacted to obtain lists of health institutions maintained by them. These lists are compared with the information in APHIDB and the ones not found the later are listed out for field enquiry.

Validation campaigns usually result in an increase in size of the database. For example validation campaign by IHS in Hyderabad and RR districts during Feb 1994 to July 1994 resulted in an increase of 5% in the number of private hospitals and nursing homes. So far IHS has covered Hyderabad, Ranga Reddy, parts of Krishna, Guntur, and Chittoor districts.

C. Accessibility of APHIDB to public:

The APHIDB is maintained by IHS and is made available over its local area network to visiting public, researchers and health policy analysts for reference. Special queries have been written to meet specific requirement of researchers. Mostly people have used the database to generate list of hospitals at a chosen place, to generate a sampling frame of hospitals in a given area for purposes of research.

II. Overview of private hospitals in AP:

The term private health institutions (PHI) used in this report includes all private hospitals and nursing homes (PHN) and also some clinics.

A. Relative contributions to hospital stock:

Considering the state as a whole private sector hospitals are providing about 59% of total hospital bed strength and the public sector is providing about 35% of the total bed strength.

Table-1 Distribution of hospital beds by ownership type in AP and its regions.

Ownership	Coastal		Telengana		Rayalaseema		AP	
	#	Col %	#	Col %	#	Col %	#	Col %
Public	10,244	367.56	13,303	1,802.57	4,389	451.08	27,936	621.08
Private	24,193	868.07	19,212	2,603.25	3,145	323.23	46,550	1,034.9
Voluntary	2,787	100	738	100	973	100	4,498	100
All	37,224	1,335.63	33,253	4,505.83	8,507	874.31	78,984	1,755.98

Thus bulk of hospital stock appear to be in the private sector. There are, however regional differences. For example share of public sector and voluntary hospitals appear to be more in the Rayalaseema area. The regional differences become evident if we disaggregate to the district level (table-2). For example public sector hospitals account for more than half of the total hospital beds in the following seven districts, namely Srikakulam, Warangal, Visakhapatnam, Adilabad, Kurnool, Ananthapur, and Vizianagaram. In Chittoor district the

public sector and voluntary hospitals provide more than half of the hospital beds. In the rest 15 districts, private sector hospitals alone are providing more than half of the hospital beds.

B. Distribution of private hospitals by hierarchy of towns and settlements:

We find that a large number of private hospitals and nursing homes (PHN) in Andhra Pradesh-49.93% are functioning in *mandal* headquarters which are essentially small towns. The average bed strength of PHNs in *mandal* headquarters is only 14.24. Divisional (Commonly referred to as sub-division In many other parts of India) headquarters account for 10.82% of PHNs. Average size of PHNs at these places is 16.68.

C. Size of private hospitals:

A large proportion (87%) of private hospitals and nursing homes have 30 or less beds (Table 4). Most (37%) private hospitals and nursing homes are between 10 to 20 beds in size. Another 33% are in the 1 to 10 bed category. Only four hospitals in the private sector had more than 250 beds. Another 37 hospitals had beds ranging from 100 to 250 beds.

In terms of bed capacity about 58% of private hospital beds were in small nursing homes with bed capacities ranging from 1 to 30 beds. Large private hospital with 100 or more beds accounted for 17% of bed capacity.

Table-2 District wise distribution of hospitals stock by ownership type

District	Public	Private	Voluntary
Srikakulam	50.09%	46.28%	3.63%
Vizianagaram	79.46%	20.54%	0.00%
Visakhapatnam	57.85%	38.33%	3.83%
East Godavari	23.91%	70.15%	5.95%
West Godavari	12.93%	87.07%	0.00%
Krishna	26.74%	58.16%	15.10%
Guntur	25.56%	60.79%	13.65%
Prakasam	14.44%	82.39%	3.17%
Nellore	23.55%	69.09%	7.36%
Chittoor	48.11%	33.19%	18.70%
Cuddapah	31.40%	51.45%	17.15%
Ananthapur	69.37%	30.63%	0.00%
Kurnool	59.74%	34.42%	5.84%
Mahaboobnagar	41.03%	53.96%	5.02%
Ranga Reddy	31.43%	66.71%	1.86%
Hyderabad	43.15%	56.85%	0.00%
Medak	47.11%	52.89%	0.00%
Nizamabad	35.65%	62.13%	2.22%
Adilabad	59.36%	38.48%	2.16%
Karimnagar	25.97%	65.52%	8.51%
Warangal	52.33%	43.73%	3.94%
Khammam	24.44%	70.40%	5.16%
Nalgonda	29.98%	63.35%	6.67%

Table-3 Distribution of private health institutions and private hospital beds by place status.

Place Status	Institutions		Beds	
	No.	%	No.	%
District Headquarters	944	29.95	18264	39.23
Subdivisional Headquarters	320	10.51	4838	10.39
Mandal Headquarters	1533	48.65	19057	40.93
Village Headquarters	354	11.23	4391	9.43
Total	3151	100.00	46550	100

Analysing distribution by size class is important since hospital size tends to strongly influence the range of services offered by a hospital. Larger hospitals usually provide a wider range of services, have specialists from many disciplines and are better equipped to handle emergencies.

D. Nature of services offered by private hospitals

Many (47.35%) of the PHIs offer "all services" which include medical, surgical, obstetric and "other " services. After this comes the combination of medical, surgical and obstetrics (18.31%), medical (9.67%), and then medical and surgery (6.47%). Obstetrics turns out to be one of the main services offered by the PHIs. Among the various services of the PHIs listed, obstetrics figures as a component in as many as 6 combinations, apart from being reported separately from some specialised obstetric care PHIs.

Table-5 Services offered by private hospitals and nursing homes

Service	Institutions		Beds	
	No.	%	No.	%
OBS	49	1.55	590	1.26
SUR	40	1.26	527	1.13
MED	305	9.67	1,914	4.11
OTHERS	68	2.15	412	0.88
OBS & SUR	36	1.14	565	1.21
OBS & MED	105	3.33	774	1.66
MED & SUR	204	6.47	2,902	6.23
OBS & OTH	33	1.04	449	0.96
SUR & OTH	9	0.28	17	0.03
MED & OTH	90	2.85	472	1.01
MED,SUR & OBS	577	18.31	9,664	20.76
MED,OBS & OTH	64	2.03	470	1
MED,SUR & OTH	74	2.34	1,211	2.6
OBS,SUR & OTH	5	0.15	79	0.16
ALL TYPES	1,492	47.35	26,504	56.93
TOTAL	3,151	100	46,550	100

E. Socio-economic development and size of private health sector:

As per the CMIE index of socio economic development most of the coastal Andhra districts register a relatively higher score. We find that the coastal Andhra region with 9 districts are having 1920 PHIs with 24193 beds while the 14 less developed districts of Rayalseema and Telengana add up to only 1231 PHIs and 22357 beds in spite of a much larger population. The population of coastal Andhra Pradesh districts is 29 million while that of the districts in Rayalseema and Telengana is 11 million and 26 million respectively. The spread of bed strength in Rayalseema and Telengana also does not seem, to be as even as in Andhra region. It appears that the growth of small and medium PHIs is largely determined by the presence of a better off market for health care and the general socio- economic development.

The concentration of private health institutions is also dependent on the general economic development of the respective districts. Private hospitals and nursing homes of the more developed coastal Andhra region constitutes 66% to 83 % of all PHIs in as many as 7 out of 9 districts of the region. Among the four districts of the less developed Rayalseema region only one among them have more than 50% PHI component. In the Telengana region the PHI component in 6 out of 10 districts fall between 53 % in Nalgonda to the state capital district's 84 % which is uncharacteristic of the region.

Table-6 Corelation of socio economic development with size of private hospital sector in AP.

District	CMIE Index of Socio Economic Development	Private hospital beds per 1000 Population
Srikakulam	56	0.22
Vizianagaram	65	0.03
Visakhapatnam	92	0.49
East Godavari	93	1.05
West Godavari	115	1.25
Krishna	119	0.86
Guntur	114	1.02
Prakasam	86	0.94
Nellore	96	1.24
Chittoor	84	0.29
Cuddapah	83	0.41
Ananthapur	92	0.15
Kurnool	86	0.36
Mahaboobnagar	53	0.32
Ranga Reddy	25	0.59
Hyderabad	299	2.91
Medak	86	0.29
Nizamabad	104	0.56
Adilabad	66	0.22
Karimnagar	97	0.53
Warangal	80	0.38
Khammam	76	0.69
Nalgonda	71	0.41
ISED, Private hospital bed per 1000 population Correlation Coefficient		0.87

In bed capacity also a some what similar picture emerges: in 6 out of 9 districts in the Andhra region PHI's share in over all bed strength ranges between 61 % - 87 %. In Rayalseema, only in one district it crosses the 50% mark, while in 6 of the 10 districts of Telengana the PHI component in bed strength ranges between a moderate 53 % to 67 % respectively.

Most of the large 100 to 249 bedded PHIs are in the 7 out of 9 districts of Andhra region, the state capital of Hyderabad in Rayalseema and few other districts in Telengana. There aren't many PHIs with 250 or more bed capacity. Of the four which exist three are in Hyderabad itself. Among the small and medium hospitals also the districts of Andhra region have many more than the districts of Rayalseema and Telengana barring the exception of the State capital- Hyderabad (Table-7).

In rural as well as urban areas of A.P the coastal Andhra region is far ahead of the other two regions in both number of PHIs and bed capacity. While we analyse the data by place status which is a sharper indicator we find a substantial concentration of PHIs in the mandal towns particularly in the four districts of East Godavari, West Godavari, Krishna and Guntur.

Table-7 District wise availability of different size private hospitals.

District	1 to 9		10 to 19		20 to 29		30 to 99		100 to 249		250 & above	
	Inst.	Beds	Inst.	Beds	Inst.	Beds	Inst.	Beds	Inst.	Beds	Inst.	Beds
Srikakulam	20	104	16	176	5	110	3	120	0	0	0	0
Vizianagaram	6	30	5	53	0	0	0	0	0	0	0	0
Visakhapatnam	43	232	37	474	14	320	11	476	1	100	0	0
East Godavari	100	511	131	1628	46	1008	26	1268	2	350	0	0
West Godavari	116	570	111	1365	40	866	15	680	4	520	1	296
Krishna	89	490	94	1122	43	926	11	424	2	220	0	0
Guntur	72	385	105	1325	49	1009	23	985	3	492	0	0
Prakasam	29	140	56	721	23	514	25	976	2	250	0	0
Nellore	54	289	68	834	17	375	15	654	5	805	0	0
Coastal Andhra	529	2751	623	7698	237	5128	129	5583	19	2737	1	296
Chittoor	44	208	26	309	6	125	2	70	1	220	0	0
Cuddapah	22	123	12	160	7	159	11	397	1	100	0	0
Ananthapur	12	67	12	135	10	227	1	50	0	0	0	0
Kurnool	4	23	13	164	5	103	10	405	1	100	0	0
Rayalaseema	82	421	63	768	28	614	24	922	3	420	0	0
Mahaboobnagar	31	184	25	309	5	115	4	160	1	200	0	0
Ranga Reddy	46	284	36	486	10	220	13	515	0	0	0	0
Hyderabad	13	78	43	549	74	1671	107	4425	11	1568	3	862
Medak	17	99	24	308	11	242	0	0	0	0	0	0
Nizamabad	14	92	35	456	11	245	7	226	1	100	0	0
Adilabad	10	54	11	135	4	83	0	0	1	174	0	0
Karimnagar	36	190	54	674	26	558	6	195	0	0	0	0
Warangal	8	43	23	277	10	217	9	420	1	120	0	0
Khammam	56	276	33	393	20	440	10	392	0	0	0	0
Nalgonda	29	149	29	360	17	378	7	290	0	0	0	0
Telengana	260	1449	313	3947	188	4169	163	6623	15	2162	3	862

The bed - population ratio in respect of PHIs is 0.71 per 1000 as compared to the corresponding ratio for public hospitals of 0.43 per 1000. For rural areas the respective PHI figure is 0.22 per thousand as against 0.08 per thousand of public hospitals and for urban areas the PHI figure is 2 per thousand while the public hospitals' figure is 1.34 per thousand. The bed population ratios of PHIs in some districts are likely to undergo an upward revision since field validation usually adds up private hospitals and nursing homes not yet listed in the database. The magnitude of this upward revision is not expected to be as high at the state level, as it may be in some individual districts.

Reference:

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From Apathy to Awareness and Action - The Consumer Protection Act and Medical Profession, a Case in Point¹.

M.Eshwar² and P.Satyanarayana³

I. Introduction:

The debate generated by the recent decision to bring medical malpractice claims within the purview of the Consumer protection Act (CPA), 1986 has failed to examine the implications dispassionately and instead has only resulted in polarisation of views between the medical profession and the rest. There has been a lot of apprehension among doctors and other health professionals and hospitals, that the doctor who is treating or the institution which is admitting the patient may have to appear in the court along with a lawyer. At the same time, the standards in the medical profession are deteriorating, the pursuit of money rather than the pursuit of excellence, alone appears to be operating as a motive force[1].

II. From apathy to awareness:

The Consumer Protection Act (CPA), 1986 is born out of dissatisfaction and distrust of the people with the quantity, quality and cost of different kinds of services provided by various agencies, public or private[2].

In the health field, till recently all cases of negligence used to be filed either under the law of torts to claim damages or under relevant sections i.e. 304, 336, 337 and 338 of the Indian Penal Code to get the negligent punished. But, after the introduction of Consumer Protection Act, a drastic change has taken place and number of complaints are being filed by patients and their relatives in the district forum, state or national commissions created under the consumer protection act, against doctors and hospitals for negligence, possibly for the following reasons:

- a. Increasing knowledge and awareness of one's right as a patient.
- b. Doctors and hospitals are no more held in as high as an esteem as they were held earlier.
- c. There is no cost involved in this procedure.
- d. The complaint is expected to be decided in a short time of 3-4 months.
- e. Legal practitioners at times instigate patients to file cases.
- f. Consumer organisations have become active in motivating the people.
- g. Paradoxically, it is often found that doctors are motivating the patients against own colleagues.

The National Consumer Disputes Redressal Commission recently upheld that the medical profession can be taken to the consumers court in the event of any deficiency in the performance of service. The ruling was delivered by a four member panel of the commission, headed by Justice V. Balakrishna Eradi, hearing the review petition of the Cosmopolitan

¹ Originally published in Clinical Proceedings of NIMS, 9:2;7-10; April 1994 and reproduced here with permission.

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Hospitals Limited, Thiruvananthapuram and one of its senior consultant in Orthopaedics Dr. K. Venugopalam Nair[3].

A similar opinion has been taken by the Andhra Pradesh High Court, which, in April 1992, ruled that services rendered by doctors are maintainable under the CPA. Justice M.N Rao and Justice V. Neeladri Rao constituting a division bench of the high court gave the ruling while dismissing a batch of writ prohibition petitions filed by various medical practitioners (private) and the Indian Medical Association.

On the other hand, the judgements given by the Madras and Gujarat State Commissions established that patients are not consumers and hence the CPA is not applicable to the medical profession. However, the judgement of the Rajasthan State Commission has contributed to some confusion as on one side it acknowledges that the patients are not consumers and on the other hand states that those undergoing treatment in Government hospitals where the service is provided free of cost, the CPA cannot be evoked[4].

The medical fraternity is presently heaving a sigh of relief in the wake of the mid-February (1994) judgement of a Division Bench of Madras High Court holding that the services to a patient by a doctor or hospital by way of diagnosis and treatment cannot be constructed as 'Service' as defined in Sec-2 (1) (0) of the CPA act. The court also held that a patient is not a consumer within the meaning of the Act and judgement does not totally exonerate the doctors, since paramedical staff on whom the doctors depend upon continue to come under the CPA[5].

III. Negative action:

While consumer courts will greatly help reduce the odds being so heavily stacked against the Indian health consumer, such protection could lead to the pendulum swinging completely the other way. The medical profession is bound to shy away from those cases in which it may see the potentiality of such a litigation[6].

Doctors may resort to sending a patient to get all kinds of investigations done which otherwise may not have been necessary in the present set up, thereby imposing higher cost burdens on a patient. Afraid of being sued, many private doctors are refusing to issue receipts for payments made for their services, since the production of a receipt is of paramount importance while approaching consumer courts. Many medicolegal cases like accidents which need emergency care would be neglected due to the fear that if anything goes wrong, action would be taken against the doctor.

The doctor may also take up more insurance premia to provide for contingencies and the cost thereof will have to be passed on to the patient towards the cost of medical service, which will adversely affect the poorer sections of the society.

IV. Positive action:

A. Amending CPA:

The CPA needs to be amended with the following provision:-

1. A statutory provision, for associating an expert medical adviser to assist the three-man committee presided over by a retired judge, is essential.
2. The decision of the committee should be given by the Judge alone and not by the majority.

3. There should be a provision for deterrent punishment for unscrupulous litigation's if on inquiry the complaints turn out to be patently false, motivated and mala fide.
4. A time limit of 30 days should be imposed on the initiation of a complaint against a doctor so that afterthoughts and promoting by mala fide interests are discouraged.
5. Newspapers and the media should be prohibited by law from publishing the names of doctors against whom complaints are lodged, till such time as a verdict is given against them [5].

B. Understand the patient as a person:

It is as important to understand the person afflicted with a disease as it is to understand the disease afflicting that person. It is also important to know about the patient's perception of his illness and its progress. With empathy and a warm friendly attitude, the doctor should create confidence in the patient's mind so that he feels free to discuss fully any and all matters which may be of concern to him[7].

Doctors should be particularly cost-conscious because of the rising tide of criticism about modern medicine becoming more and more expensive.

C. Foster patient satisfaction:

Poor communication between doctor and patient is an important cause of the increasing frequency of complaint and litigation against doctors. The doctor-patient relationship is fiducial (built on trust). The very fact that a patient has chosen to go to a doctor implies that he trusts the doctor. Frequently, this trust can be amazingly naive and uncritical (and that is how quacks practice on such a large scale and succeed.)

Assess the intellectual, emotional and social capacities of the patient and pitch the contents of the conversation accordingly. Avoid a patronising or condescending air, whatever the patient's intellectual level.

The truth about the nature of the illness should be told in a manner that creates understanding of the problem, dissipates unwarranted fears and doubts, and creates confidence. It is important to take a close relative into confidence and make sure that he or she understands the truth. In hospitalised patient this fact should be documented, especially in serious and life threatening situations. By not doing this, many doctors in hospitals invite trouble for themselves.

D. Doctors' obligations:

1. The doctor must maintain his professional knowledge, skills and competence to deserve the trust reposed by the patient in him.
2. He must act towards the patient with the utmost good faith, and act with the best interest of the patient in mind.
3. He should not accept a case which is beyond his skill and competence. He should frankly tell his patient about this and suggest appropriate alternatives keeping in mind the best interest of the patient.
4. He has a duty to disclose immediately to the patient if some injury has been caused to him / her by inadvertence.
5. Once he accepts responsibility for the care of a patient he should be available until the treatment is no longer required.

E. Prevention against negligence:

A majority of medical negligence cases fall under a few common causes and it is always better to prevent them. The following precautionary measures are worth considering:

1. Do not criticise another doctor: In an ongoing study[8], it has been found that the most common cause of patient motivation for filing cases in consumer fora is the adverse criticism of the professional conduct of one doctor by another without a knowledge of the full facts.
2. Employ qualified staff and associate with good partners.
3. Update your knowledge.
4. Keep accurate and complete records with respect to history, present illness, physical examination, course of investigations, impressions about the case, treatment adopted and any consultation advised. Accurate and detailed medical records will never fail a physician in his hour of need even after a considerable lapse of time [7].
 - i. Do not use abbreviated words or symbols.
 - ii. Do not erase or obliterate any entry.
 - iii. Copies of all correspondence with the patient should be maintained.
5. Informed Consent: The patient must be competent in terms of mental stability, able to give consent and must understand all the risks and benefits inherent in the proposed examination, diagnostic or investigative procedure and treatment.
6. Apply reasonable skill and care: If a doctor fails to apply reasonable skill and care expected of his calibre, then he is liable to be held negligent.
7. Guard against therapeutic hazards: Doctors should always take precautionary measures regarding the drug effects, reactions to injections etc.

F. Miscellaneous measures:

1. Medical audit.
2. The Role of Administrators: The hospital administrator whose role is to see that efficient patient care is achieved must always be familiar with the responsibilities in respect of CPA [9].
3. The Role of the Medical Council of India (MCI): The MCI through IMC Act, 1956 which has been prescribing the standards of professional conduct and code of ethics for medical practitioners, should see that medical professionals and hospitals adhere to them to avoid litigation under CPA.
4. The Role of Indian Medical Association: Although the IMA has reacted strongly against the application of the CPA to the medical profession through its "DIRECT ACTION PROGRAMME" yet it needs to focus its main thrust on setting standard treatment and investigations schedule and safety standards and to standardise the doctors fees on a rational basis.

V. Conclusion:

Doctors have of late been agitating through the Indian Medical Association (IMA) to exempt the medical profession from the Consumer Protection Act. On the other hand the community at large feels that immunity to medical profession could amount to denial of fundamental rights to the aggrieved. The most pertinent question is whether the harm purported to be caused to the patient is real or perceived. Who can decide whether it is real or imaginary?

Naturally it has to be a court of law at least until one finds a professionally competent body which can decide on these issues. Meanwhile society must remember that doctor can cure sometimes, relieve often, but comfort always. As per William Osler, Medicine is a "Science

of uncertainty and art of probability ". In medicine we do not use the word - 'never', we say 'hardly ever'.

It is for the medical profession to wake up to the imminent threats posed by the Act and to initiate actions that take the profession back to the days of glory and esteem through the armamentarium of good care, good documentation and good communication.

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AP legislative assembly (10th) - house committee on corporate hospitals: Recommendations¹.

1. The Committee recommends that the Government should insist on monthly reports hereafter from all the corporate hospitals / private nursing homes / diagnostic centres who have obtained the concessions from various Governmental agencies as to whether they are treating poor patients as per the stipulations entered into by them at the time of availing the concessions. The Committee also recommends that Government should insist on monthly reports hereafter from the Deccan Medical Centre (Apollo) to check as to whether they are treating 15% of the inpatients who are poor at free of cost in terms of the conditions laid down in G.O.Ms. No. 517, Revenue (Q) Dept., dated 26-3-1981.
2. The Committee recommends that Government should insist on the corporate hospitals/ private nursing homes/ diagnostic centres to continue to fulfil the conditions laid down at the time of availing concessions by them and once a Law to regulate private nursing homes etc., is brought into being, even cancel registrations if they do not conform.
3. The Committee recommends that a referral system may be developed to refer the poor patients to corporate hospitals/private nursing homes by a Medical College or a General hospital or District Headquarters hospital or Primary Health Centre through District Collector.
4. The Committee recommends that the corporate hospitals/private nursing homes / diagnostic centres who availed the benefit of customs duty exemption and who are treating the poor patients at free of cost as per the terms and conditions, may be permitted to import spare parts at free of customs duty for that particular equipment.
5. The Committee recommends that Government should institute an enquiry by an officer of the rank of Secretary to the Government, into the alleged misutilisation / non utilisation of land to some extent out of the 30 acres which was alienated by the Government to Deccan Medical Centre (Apollo).
6. The Committee recommends that hereafter the Government lands should not be alienated to any private hospital/nursing home. The Government should give its land only on lease basis.
7. The Committee recommends that the referred poor patients accommodated into corporate hospitals/private nursing homes for free treatment shall be provided with the same degree of medical treatment as is given to other patients and they must be admitted along with other patients, but not in separate wards.
8. The Committee recommends that Government must take action to see that every corporate hospital/private nursing homes displays the chart of treatment charges for various types of diseases on the notice board and a copy of booklet containing the said information should be made available to the patients at the time of admission.
9. The Committee recommends that Government should take action in providing suitable accommodation locally to those private hospitals/nursing homes who come forward to treat the poor people by adopting the slums in cities and towns.
10. The Committee recommends that Government should encourage establishment of trust hospitals/charitable hospitals by extending some concessions like municipal taxes, water and electricity charges at domestic rates etc.
11. The Committee recommends that only doctors registered in a particular corporate hospital/nursing home have to attend on the patients of the same hospital. Outside doctors

¹ Extract from the full report published by and available from the AP Legislature Secretariat, Public Gardens, Hyderabad, AP 500 486. The report was presented to the house on 28 September 1996.

- should not be permitted. The Committee recommends that Government should cancel the registration of corporate hospital / nursing home which violate the stipulation.
12. The Committee recommends that Government doctors who are permitted under law to have consultancy in their chambers should not be allowed to do practice in corporate hospitals / private nursing homes / diagnostic centres.
 13. The Committee recommends that a comprehensive legislation should be brought out to regulate the private hospitals, nursing homes, diagnostic centres etc., by the Government and to issue licences to the private hospitals / nursing homes. The Committee also recommends that all those existing private hospitals / nursing homes should obtain the registration certification within a period of three months from the date as specified in the proposed enactment.
 14. The Committee recommends that a provision be made in the proposed comprehensive legislation to the effect that unnecessary investigations and unnecessary prescriptions of drugs should be avoided. The committee also recommends that minimum investigations should be done for each of the diseases as per the guidelines to be laid down in Clinical Manuals to be developed in consultation with Medical Council of India and other professional bodies.
 15. The Committee recommends that the Government should ensure that private hospitals / nursing homes must participate in national health programmes like Eradication of Malaria, T.B., AIDS, Polio and other activities like cataract operations etc., by organising medical camps and also during the outbreak of epidemics. The Committee also recommends that Government should extend monetary assistance to private hospitals / nursing homes only to the family planning operations conducted through medical camps but not for the F.P operations conducted electively within the premises of the respective hospital.
 16. The Committee recommends that all private hospitals / nursing homes must maintain in-patient and outpatient registers and case sheets with all relevant particulars and they must hand over a copy of the well maintained case sheet to the patient at the time of his discharge.
 17. The Committee recommends the all private hospitals / nursing homes should invariably use saline bottles, medicines, disposable syringes etc., with labels containing date of manufacture, date of expiry, cost etc. The Committee also recommends that disposable once used should not be put to reuse.
 18. The committee recommends that the Law should prescribe minimum standards for private hospitals/nursing homes in all aspects (buildings, equipment, medical staff, distance between the beds etc.) as per the guidelines of World Health Organisation.
 19. The Committee recommends that a kind of scrutinising mechanism may be evolved for conducting random and regular check-ups once in a year to see whether the private hospitals/nursing homes are following the minimum standards prescribed by Law.
 20. The Committee recommends that electricity charges and water charges may be collected at reasonable rates (domestic rates) instead of at commercial rates from those private hospitals / nursing homes which are extending free treatment to the poor people.
 21. The committee recommends that patients who are holders of white ration cards must be treated as poor. Apart from this , an individual whose income is less than Rs. 11,000/- per annum should also be treated as poor, provided he produces a certificate to that effect issued by the concerned Mandal Revenue Officer.
 22. The Committee recommends that there should be registration for both nurses and technicians who handle high cost equipment in various corporate hospitals / private nursing homes / diagnostic centres.

23. The Committee recommends that Government should take steps to regulate the Nursing schools existing in great numbers in order to produce skilled and well trained nurses and technicians.
24. The Committee also encloses a model draft Bill to regulate corporate hospitals / private nursing homes / diagnostic centres which can be considered by the Government appropriately, for bringing before the Legislature within a period of three months (Annexure-IV²).

² Not included in this extract.

Felt need and scope for regulation of the private health sector in Andhra Pradesh.

Lipika Nanda¹

I. Introduction:

Health care delivery is comparable with any other deliverable service, with a few exceptions. Since time immemorial, the medical community has been delivering patient care without any questioning finger towards them. There is a historical reason behind it. Health care delivery started with charitable organisations in the west. This resulted in the missionaries coming to developed countries like ours and rendering free care to the needy population. As a result the clinicians involved in this type of health care delivery enjoyed social status and recognition from its recipients. Gradually the charitable spirit has evolved into industrial spirit and the free service into a fee for service institutions.

There has been a multifold increase in the private health sector in almost all parts of India within the last decade. Considering the vast size of the population in Andhra Pradesh (about 66 million at the time of 1991 census), one can understand that it is not possible for the public sector to provide services for the health needs of the whole population. So, the present multiprovider system is absolutely necessary to cater to the large demand of health services. The basic question in such a multiprovider system is how to define quality of service and regulation applicable to different situations. Such appraisal should ultimately provide an opportunity for the consumers to make an intelligent assessment with assurance of quality of services offered by different private health care organisations.

Recently there have been concerns about the quality of service in the private health sector. There appears to be a felt need among people for some mechanism of assuring, quality, and price of services by the private health sector in Andhra Pradesh. In this study I seek to assess felt need for any kind of regulation of the private health sector in AP. Then, based upon the felt need, I will go forth to discuss the scope of and for regulation in order to assure quality of health care services in the private sector in Andhra Pradesh.

II. Methodology:

Felt need may be expressed or unexpressed. Separate methodological tools are required to assess each of them.

A. Assessing expressed felt need:

Expressed felt need refers to a concern openly communicated by people in public. People may express their own views or represent certain institutions relating to a group of people. Professional and institutional affiliation of people motivates and influences expressed concerns and opinions. For convenience I will refer to people expressing concern about health care as sources. I have classified them into professionals, the consumers of health care, ministers, private hospital owners and health systems research groups based on their known professional / institutional affiliation. A list of the sources encountered in this study is given in the annexe.

To assess expressed felt need, I did a structured study and content analysis of the following:

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1. The database of newspaper clippings on medical and health issues that is regularly collected by the Institute of Health Systems.
2. The database of the English newspaper clippings on medical and health from 1992-1998 at Eenadu library.
3. The database of Telugu newspaper clippings on medical and health from 1992-1998 at Eenadu library.
4. Legislative Assembly library for:
 - i. Zero hour debates in the legislative assembly for the last five years,
 - ii. Question hour debates in the legislative assembly for the last five years,
 - iii. Demand discussions for the last five years,
 - iv. House committee on corporate sector hospitals, and
 - v. Chief minister's address on medical and health for the year 1998.

B. Unexpressed:

Unexpressed felt need can be assessed by asking probing questions in the course of personal interviews. To assess prevalence of a certain felt need in a population sample surveys are required. Focus group interviews with different stake holders like, the consumers, attendants of consumers, medical professionals, hospital owners, health systems research groups, policy makers etc. can give in-depth understanding of the need felt by participants. Time and resources available for this study did not allow data collection to assess unexpressed felt need. However, I have made use of available literature to supplement findings from the expressed sources.

III. Results:

Altogether 29 speeches, in the AP legislative assembly during last five years, about medical and health field were studied. Content analysis of these debates revealed that main concerns among legislators were about quality of health care in the primary health centres, public hospitals, lack of doctors in the rural areas, shortage of funds in teaching and super-speciality hospitals, changes in the health policy, and medical care personnel transfer policies in order to make health care accessible to all strata of the society and especially the poor. There were hardly any discussions about quality of health care in the private sector. However one such debate lead to setting up of a house committee to study working of private corporate hospitals.

There were altogether 50 statements in the news clippings (table-1). Out of these 25 statements originated from medical and health professionals, 15 by consumer groups, 4 by health systems research group, 4 by ministers and 2 by private hospitals. Most vocal were the medical and health professionals followed by consumer interest groups. In terms of issues; the largest number of statements contained concerns about rational use of drugs, and drug purchase policy. Next in frequency were concerns about quality of services, improvement of standards, norms for physical facilities, quality control in equipment, protocols to reduce public health hazard, etc. Then there were the concerns about medical injury and malpractice.

Table-1: Subject and sources of news reports on health policy: Hyderabad 1993-1998.

Type of issues raised	Sources					Total
	Doctors	Consumers	Research	Minister	PHN	
Continuing medical education.	2					2
Rational drug use and purchase policy.	9	2	1	1		14
Support statements for CP Act.	1	2		1		4
Medical injury and malpractice.	3	5	1		1	10
Standards and quality of service.	6	3	1	1	1	12
Private sector regulation and renewals.	2					2
Cost and pricing of medical services.	1	1				2
Attitude towards patients.		1				1
Need for a health Policy.	1	1	1	1		4
All	25	15	4	4	2	50

Research: Health system research and policy analysis groups.

PHN: Private hospitals and nursing home managers, owners or interest groups.

The IHS study on the needs assessment for an accreditation system for AP gave some insight into the unexpressed concerns of some consumers and their attendants about health care in the private sector. It revealed that the doctors skills was the most important factor contributing to selection of a hospital. Flow of this information in the market, mostly through word of mouth, is relatively better than is the case for other aspects of the health care services. Patients take a lot of care to assess professional competence and empathy rating of doctors. Their next priorities were physical facilities and living conditions in the private hospitals. Most of them did not give much importance to the diagnostic facilities, nursing competence, and equipment in the hospital. Many did not have proper understanding of these aspects. When asked about the need for regulation, like an accreditation system, 86 % felt that a third party inspection of the hospitals / nursing homes for compliance to standards is desirable. Most of them also felt that it should be possible for the nursing homes to get their facilities assessed within their fee structure. They also expressed the convenience that consumer will have if there is some standard fee structure for all the private hospitals.

IV. Scope of regulation:

Public opinion and revealed concerns may be occasioned by various events namely; (a) specific instances of failure, (b) shared dissatisfaction about service characteristics (viz pricing), (c) deliberate analysis of social needs and trends (viz health systems research), etc. Recurrence of these call-attention events leads to a shared feeling that some sort of quality assurance in health services is required. The logical step forward is then to ponder, what is to be assured?

Ideally consumers of medical and health care services would want to be assured the outcome. Every person who approaches a hospital with an illness wants to return home fully cured. If somehow this outcome can be assured, nothing else would matter. However clinical outcomes are difficult to measure. Some times, even an adequate definition of outcome may not be available. Research is going on to develop patient outcome measures. All nations in the world with well developed quality assurance systems in health started with standards of physical and human resources (structural standards), then moved on to process standards and are now beginning to grapple with outcome standards. Reliability and validity of patients

outcome data is being debated. More over reliable and valid data required for patients outcome measures will be available only if a hospital is endowed with required infrastructure and skilled manpower and is following good management practices. Thus existence of a quality assurance system to satisfy structural and process standards is a prerequisite for development and implementation of outcome standards. I have restricted mainly to structural and process standards, since these are of immediate relevance to Andhra Pradesh. Ordering of quality assurance objectives discussed below is influenced to some extent by the frequency and intensity with which people's concern was reported in news papers and record of discussions in public forums.

A. Rational use of investigations and drugs:

1. The newspaper reports (Pioneer 95, 96; Deccan Herald 96; The Straits Times 95; Praja Shakti 94; Telegraph 94; Udayam 94; Indian Express 97b, 98a) reveal fairly intense concern about the incidence of irrational use of investigations and drugs. Irrational prescription of investigation as well as drugs is not only costly for the consumer but also costly for the health care organisation as well as the society in the long run. This may inflate the cost of health care delivery, as has been experienced in some developed countries in the west.
2. Irrational prescription of drugs may take various forms, including; drugs not required, overdose, lack of awareness about adverse effects, addiction, resistance etc.
3. Irrational use of investigations is usually motivated by the desire to fully utilise installed capacity within the hospital or by others having business affiliation with the hospital. Then more investigations result in business signals to increase capacity, resulting in a vicious circle of over provision. Ultimately this translates into very high cost of medical care.
4. Possible mechanisms to reduce irrational use of drugs and investigations include;
 - i. Regular audit of prescription for investigations and drugs on a random sample basis followed by suitable general and special corrective advices. Strong action should be taken against institutions and doctors habitually resorting to irrational use of drugs and investigations.
 - ii. Encourage development and use of hospital formulary. This is basically an essential drug list for use by all the physicians belonging to a particular institution. Hospital formulary usually include drugs and therapeutics required to manage the disease pattern of patients handled by the hospital. Currently, clinicians are having to rely on the drug companies to know regarding latest drugs. Sometimes it is a hit and trial process for the clinicians to know about the efficacy of a new drug. Hospital formulary is a physician desk reference containing list of clinically proven and cost effective medicines.

B. Medical injury:

1. Concerns about a state mechanism for protection of consumers are frequently being reported in new media (Indian Express 98c; Eenadu 97; Times of India 96b; Economic Times 96a). This is on account of growing concern about medical injury and malpractice. On the other hand doctors have highlighted the need to distinguish between medical negligence per se and complications that have not resulted from any negligence on account of the clinicians.

C. Behavioural characteristic of services:

1. Quality of behavioural services also constitute an important part of the total quality of health care services. Doctors appear to perceive that their role is to

deliver medical technical advice to patients. On the other hand patients expect a complete package consisting of medical technical advice interwoven with sharing of information, informed consent for therapeutic choices, reassurance, and prompt delivery of services incidental to the medical encounter. Unfortunately the divergence in role perception of providers and expectation of patients appear to be widely prevalent (The Hindu 96a). There appears to be a need to define minimum standards of practice regarding behavioural attributes of medical service that are relevant to overall patient satisfaction. Process standards to assure these may include:

- i. Informed consent for therapeutic action: The patient has a right to information regarding himself / herself. It has been seen that in many cases physicians see a patient, prescribe medicines and other regimen but do not explain things. Hospitals usually do not have any arrangement to explain things either. Standard protocols should be prescribed to inform patients and their attendants about the problem, treatment plans etc. Compliance to these protocols should be insisted. Where ever necessary informed consent and not merely formal consent should be required.
- ii. Standards about reception, enquiry services, sign posting and attendant handling need to be evolved and implemented.
- iii. Patient satisfaction surveys: Patient satisfaction surveys may be standardised for different category of private health care organisations. Every private health care organisation can conduct periodic patient satisfaction surveys. A report card based on these surveys may be publicly made available to consumers for their reference while selecting a hospital for their treatment. This will have an in-built incentive system for the private health care organisations to give emphasis to the patient's perspective in terms of the behaviour and convenience. They will be encouraged to have a patient-oriented approach rather than a physician-oriented approach. As a result the chances of a common person being harassed by any hospital authorities may be substantially reduced.

D. Pricing and billing practices:

1. There is growing concern among people about the need for some kind of rate setting or at the least transparency in pricing and billing practices. While technological developments have made diagnostic process incredibly accurate, lack of uniform pricing in the corporate sector has made it very difficult for the less affluent to enjoy the benefits of health care (Newstime, 96c). It is widely believed that the private organisations are arbitrarily charging very high fees for simple services by resorting to mystifying practices.
2. On the other hand pricing by regulatory bodies goes counter to a market system. Price setting by regulator bodies may result in monopolies and prevent innovations. Clearly there are market failures in this sector enabling providers to set prices and adopt billing practices unsustainable in perfect market environment. These two contradictory forces will have to be balanced while setting quality assurance objectives about pricing of health care services. Following are some pricing related quality assurance objectives that are likely to be consistent with delivery of health care by the private sector in an open market.

- i. Use of standard service codes.
- ii. Standardisation of billing practices.
- iii. Obligation of health care organisations to inform patients and / or the primary attendant about rates for various services and billing practices followed by them.
- iv. Public display of rates for frequently billed services.
- v. A system of rate setting by major buyers for services purchased by them.

E. Maintenance of appropriate Patient's Medical Records:

Patient records or medical records is one of the prerequisites for any retrospective analysis of quality of care rendered by any health care organisation. It is advisable to standardise the patient records so that useful information can be collected in a systematic manner.

Standardisation of patient records will also make cross comparison as well as sharing of the patient information in case of referrals meaningful

F. Quality of clinical Services:

1. This is the primary purpose for which patients seek help from health care organisations. Naturally people would like to be assured about the quality of clinical services. In case of planned medical events patients and / or their attendants do take a lot of care to identify a good doctor. One may be tempted to conclude from this behaviour that satisfaction about quality of medical care offered by a private hospital is inherent in the choice of that hospital by the patient. It is important, however, to note that clinical services are produced by medical and health teams of which the doctor is usually the leader. Overall quality of clinical services is a result of the combined effort of the medical team members, the internal processes and protocols followed by them, etc. More over the medical and health teams behind each service may be functioning at various levels. Some would be in immediate touch with the patient and some others would operate behind the scene. To some extent the team leader can be trusted with details of working of the teams. But the extent of this control will vary depending on the organisation structure and culture. That is why process standards to assure quality of clinical services assume importance. Following organisational processes usually help achieve a higher quality of clinical service.
 - i. Reference to practice guidelines.
 - ii. Continuing education programmes.
 - iii. Ensuring competency of practitioners.
2. Reference to standard practice guidelines: Organisational processes requiring doctors, nurses and other professionals to follow standard practice guidelines help in achievement and sustenance of a high level of clinical outcome for similar group of patients. Practice guidelines contain standardised treatment protocols usually arrived at by collation of available technical, clinical evidences followed by a consensus development process. Implementation of practice guidelines help reduce variations in treatment schedules among different practitioners. This will also reduce confusion in clinical practice. Medical knowledge is ever changing and new innovations in health care technology are occurring as a continuous process. Thus it is essential that these practice guidelines are revised at fixed time intervals.
3. Continuing education programmes: Continuing education is absolutely essential for medical practitioners for three important reasons. Medical technology is evolving rapidly. Continuing medical education serves as one of the best ways of enhancing the clinicians practical knowledge about, state of the art, technology

regarding diagnosis, management and prevention of the disorders, etc. It is therefore advisable for health care organisations to arrange for attendance by its professional staff in continuing education programmes. Continuing education programmes can be used to emphasise practice guidelines.

4. Public information about competency implied by license to practice: Registration with concerned professional council set up under respective laws is now required to practice. People generally assume that those practicing medicine would have some sort of licence i.e. registration. The licensing authority would have been satisfied about competency to practice. There are many problems with the present system of registration and licensing contributing to poor quality assurance of medical services. Following licensing related processes have important bearing on the quality of clinical services.
 - i. Periodic renewal of registration: The registration system now in vogue was conceived at a time when the rate of technological development was slower. More over it had anticipated some degree of voluntary action by members of the profession to continuously update themselves through the institution of various professional associations. Such a system had worked elsewhere with generally smaller size of national professional communities, and more affluent clientele group. In a large country like India, or for that matter the state of Andhra Pradesh, scope for operation of peer group pressure on a very large body of professionals is limited. The main purpose of registration is to satisfy about competency. Competence to do a procedure or provide clinical advise on a certain problem is a function of initial training, continuing practice and continuing education. With rapid technological development and appearance of newer procedures, competency can be assured only by periodical review of a professionals training, practice pattern and continuing education efforts. This is the rationale for periodical renewal of licenses. The exact periodicity will depend on many factors. My personal opinion is that renewal once every five years will be appropriate.
 - ii. Period of validity is one dimension of competence certificate. The other dimension is coverage. What kind of clinical work is a licensed professional competent to do? As on date the system of registration and legal mandate to practice is a all or non phenomenon. If you do not have registration you are not supposed to practice. If you are registered, you may practice any clinical and therapeutic procedure constrained only by your own assessment. Self assessment of competence may work if the decision to perform a procedure does not have any financial implications for the doctor. In case of private hospitals, however, the decision to do or not to do a procedure usually has significant financial motivations. Hence chances of doctors ability to dispassionately assess his / her competence to do a thing may get clouded. Thus some system of competency definition and enforcement is required. Process standards for competency definition and enforcement require action by the government and professional councils. At the hospital / institutional level quality assurance processes will require compliance with competency definitions for recruitment and affiliation of doctors. Competency related process standards will have to address the following three situations:
 - a. Competency definitions within a system of medicine. For example the list of procedures that a doctor with bachelor degree may do. List of procedures that a paediatric specialist may do and so on.
 - b. Cross practice: Cross practice among the medical professionals trained in other than what they are supposed to practice should be regulated. Some clinicians trained in one system of medicine are being seen to perform therapeutic

procedures and practices in vogue in another system of medicine. To some extent such inter disciplinary approach may be beneficial. However, if the procedure involves high risk of complications etc. then unsuspecting patients may end up exposing them to a person who is untrained as far as that procedure is concerned. In this confused state of affairs quacks mingle with qualified practitioners and make it difficult for the unsuspecting patients to anticipate what (s)he is getting into. Hence some degree of cross practice competency definition is required.

- c. **Illegal practice:** Prevalence of persons not possessing licence to practice a profession appears to be fairly high. For example many private hospitals and nursing homes recruit inadequately qualified or unqualified persons as nurses. Another category will be people practising medicine without any registration.

G. Physical infrastructure and structural standards:

Physical infrastructure has an enabling role. Minimum requirement of diagnostic, therapeutic equipment, skilled personnel, building space, etc. must be available for various processes to operate. Satisfaction of structural standards does not necessarily assure quality of services. But deficiencies do usually constrain ability of a hospital to operate respective clinical processes. That is why structural standards are the first to appear in any system of quality assurance.

V. Scope for regulation:

In the current scenario the private health sector provides a wide range of facilities and services. there has been a more than 100% increase in the number of hospitals, hospital beds during a time period of 16 years, from 1974-1990 (CBHI,1990). Very little information is available regarding their structure, functioning, quality of care and services provided. Range and quality of services in these hospitals vary widely. Appropriate mechanism for reliable information regarding conformity to standards and quality of care do not exist.

The word regulation is broadly interpreted here to include the full range of social institutional systems based on voluntary action at one end to strict enforcement of legislation at the other end. One extreme is a statutory regulation system where any assurance can only come through enforcement. On the other end is the system of social regulation that develops voluntarily, is widely accepted and owned by the private health sector as a result of their reasonableness and credibility. The essential difference between the two approaches is as follows. Statutory regulation is mandatory and is backed by punitive sanctions. Accreditation is based on voluntary participation backed by an array of irresistible incentives. Each of the two approaches have their pros and cons. Effectiveness of these systems in terms of cost and convenience trade-offs to gain a certain quality assurance depends on the specific objective sought to be achieved. Both approaches are discussed below.

A. Statutory regulation by the government:

1. Governmental regulation backed by appropriate law for licensing of health care organisations is one alternative. The law would provide for punitive action in case of violations.
2. Advantages of statutory regulation are;
 - i. Full legitimacy of the system and hence scope for full coverage and compliance,
 - ii. Certain objectives primitive to quality assurance may require full compliance, which can only be achieved by legislative authority, sanctions and government machinery to

implement. For example mandatory registration or enlistment in the state database of health care organisations.

- iii. Compliance with certain standards may be critically important from public health perspective. For example hospital waste disposal.
3. Disadvantages of regulation by government would include;
- i. bureaucratisation and slow response,
 - ii. gradual erosion of credibility, and
 - iii. restrictive of innovations in organisation of medical and health care services.

B. Accreditation system:

1. Definition: The concept of accreditation exists in various countries, as an affordable, effective and credible means of quality management. In adopting the general concept, each country has developed organisations and processes appropriate to the local health care funding, accountability, existing review mechanisms, political and legal background. Accreditation is a professional and national recognition reserved for facilities that provide high quality of care (Lewis, 1984). Particular health facilities voluntarily seek to be measured against high professional standards and are in substantial compliance with them. It is a vehicle for systematic external review of the managerial systems, procedures and physical infrastructure, which are good indicators of care.
2. Components of an accreditation system: Tessa Brooks (1990), in her review of Standards and Accreditation has summarised the essential features of an accreditation system. They are:
 - i. An accreditation board, consisting of representatives from the professional and health care organisations. In some countries it includes the government and consumer groups.
 - ii. Surveyors, chosen and trained to apply the standards to a specific health care service. This involves site visits by surveyors who suggest improvements and recommendations to national bodies or the board, whether accreditation should be granted or not.
 - iii. Development of essential as well as desirable standards: Relevant standards, appropriate to the local context, can be developed by adopting the NIH consensus approach (Fink et al, 1983). These standards will act:
 - a. As a tool for conforming to minimum standards
 - b. Offer the clientele a minimum standard range and level of services provided by the hospital
 - c. Help the management in monitoring the range & level of services
 - d. As a tool of financial analysis and project / program planning
 - e. Instead of developing just one type of standards, two standards will be developed; essential and desirable / optimal. For example, to conduct a normal delivery, a well trained midwife, a delivery table, suction apparatus, sterile disposable and oxygen would constitute the essential standards. On the other hand, a qualified obstetrician, adjustable delivery table, child resuscitation equipment, services of standby anaesthetist will constitute optimal standards. This will enforce some check on the health care organisation to provide for the required facilities before offering the service and also adding facilities that may not necessarily improve the process of care or have better health outcomes.
 - iv. Mechanisms of inspection and granting accreditation: This will involve deciding a number of operational issues like:
 - a. Frequency and timing of inspection,

- b. Types of accreditation,
 - c. Parameters of scoring, and
 - d. Accreditation decisions.
3. The accrediting institution: Accrediting institutions can assume many forms. In fact there can be more than one accrediting institutions. Some alternatives are discussed below.
- i. Government authority:
 - a. A government authority playing the role of an accrediting agency need to be distinguished from the regulatory role discussed earlier. The main difference is that in case of accreditation health care organisations have the option to seek or not to seek accreditation. Since accreditation envisages only positive incentives to accredited organisations, question of legal enforcement does not arise. For example most states in the USA do have a scheme of approving private hospitals fit enough to handle Medicare and Medicaid patients and claim reimbursement of fees for services rendered to these patients. The US Health Care Financing Administration (HCFA) recognises JCAHO accreditation as well as state government accreditation. Since JCAHO accreditation is usually more stringent and has higher credibility hospitals prefer to retain their accreditation. As the JCAHO accreditation is also good for claiming Medicare, Medicaid funds hospitals may not take interest to seek state accreditation. However, some times hospitals loose JCAHO accreditation. Availability of state accreditation helps them keep the flow of Medicare, Medicaid funds while they are working to get JCAHO accreditation back.
 - b. The government authority must have access to accreditation infrastructure described earlier.
 - ii. Non-governmental: A natural corollary to voluntary accreditation is a non government organisation. This type of regulation comes with a voluntary decision among various stake holders to develop standards and encourage spread of an accreditation system. Some possibilities are discussed below.
 - a. Professional associations: Professional associations usually have programs for certification of new members and continuing members. Credibility of hospitals and the doctors practicing in it mutually affect each other. Hence, members, during the course of their practice would like to affiliate themselves with hospitals and health care organisations following some minimum standards. In north America (USA and Canada) the accreditation system developed out of such a realisation. Some professional associations got together and set up the Joint Commission for Accreditation of Health Care Organisation (JCAHO) to develop standards and act as a quality assurance body. One potential problem with a professional association setting up accreditation system is about its credibility and impartiality vis a vis other stake holders. Associations are basically interest groups. Since these are professional associations, a lot of educational and training activities are taken up by them for benefit of their member. These educational activities have a positive effect on health care system and quality of service. Although professional associations do produce such public goods, interest of the membership is at the heart of such bodies. This is perhaps one reason why the professional associations in USA did not set up accreditation themselves. Instead they jointly set up an organisation for this purpose. So special care need to be taken to ensure that the institution retains credibility and legitimacy among all stake holders.

- b. Non aligned health system organisation: Voluntary health system organisations not aligned to any particular interest group will be in a better position to meet the need for impartiality in setting of standards, processing and grant of accreditation. For example an organisation, like the Institute of Health Systems (IHS) does not represent any particular interest group. The IHS has already been laying the ground work for an accreditation system in Andhra Pradesh for the last few years. It has already created a database of all the health care organisations in the private sector. It has also done a needs assessment of the felt need of patients and consumers through exit interviews. Further one of the major objectives during its formation during 1990 was to develop capacity for granting accreditation to health care organisations in Andhra Pradesh. So this may be the ideal organisation for granting accreditation to the health care organisations in Andhra Pradesh.
- iii. Coalition of government and the non-governmental sector to work synergistically: This may sound idealistic but is possible. Here government as well as the non-government sector work in a synergistic manner to achieve the over all quality assurance objectives. Each sector has some strengths and weaknesses. The ideal situation will involve trying to ascertain the responsibilities that are compatible with the strengths of that sector. In a market oriented health care system like that of US, the government has come to realise that certain quality management work is possible by forming coalitions of the state government and the managed care organisations in order to resolve the long standing issues. Without this co-operation and coalition it will be extremely difficult to regulate in isolation.

VI. Summary and conclusion:

Content analysis of news paper reports and AP legislative assembly debates on health subject was done to look for evidence of felt need for health service quality assurance and accreditation system. Top priority in legislators mind appeared to be quality assurance in the public sector, particularly the rural areas. For example, universal access to health care in the rural areas, need for a state health policy, availability of doctors in the PHCs /rural areas etc. However the legislature did show concern about quality of services and other aspects of private hospitals occasionally. One such instance lead to formation of the house committee on corporate hospitals. From the news reports it appeared that medical professionals were most vocal followed by the consumer interest groups, about the need for quality assurance. Expressions of concern for quality assurance in private health sector by the two most important stake holders, namely doctors and consumer interest groups suggests that time may be ripe for introduction of such a system. The general public are not so well informed regarding the concept of regulation of private health services.

Given the current situation what can be done to bring in some quality assurance system? First, general awareness needs to be created among the public or the consumers of health regarding concepts of quality assurance. Once the consumer is educated on the quality of care issues then they will demand it from not just the private sector but all the sectors. Unless there is a felt need among the consumers, no regulatory mechanism will sustain for long. Second, the medical community has to unite on issues of regulation in the private sector. They have to understand that unless they sit down and define quality of care today, they will eventually end up being dictated by someone else's definitions of quality of care. Third, the hospital owners have to understand that without any quality assurance, quality management is impossible. Today, many hospitals are going for total quality management measures without having satisfied the quality assurance / quality control measures. They will have to move

backward if they do so. Last but not the least once there is quality assurance in place this will result in reduction in cost of care.

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Annexe:

Details of the list of sources that were available from the newspaper clipping database

Doctors	Health systems research groups	Consumers	Private Hospitals	Ministers
Dr Naveen Shah, Chairman, American Physician Association	ICMR	Mrs. Uma Nair	Pramila Kidney and Urology Center	Dr. N. Janardhan Reddy, Heath Minister, AP.
Dr. A Gopal Kishan	NSS-IHS (National Sample Survey-Institute of Health Systems	Jahangir Lal (consumer representative at the round table)	Apollo Hospital	Mr. Chandra-Babu Naidu, Chief Minister, AP.
Dr. Girish Narayan	WHO (World Health Organisation)	Malathi Bolar		
Dr. Ramakrishna	World Bank	Ex MD (SBI)		
Dr. Sunil Keswani	IMA (Indian Medical Association)	Mr. Gupta		
Dr. Sitapati Rao		Argha		
Dr. K. Subba Rao (Director, NIMS)		Banerjee		
Health officials at enquiry				
Dr. Gopal Sharma				
Dr. Kamal Nain Bindra				
Dr. Shashikala				

Women's Perception Of Quality Of Reproductive Care in Private Hospitals in Andhra Pradesh.

Dr. Alex George¹

I. Introduction²:

Health services in India present a multiprovider scenario where the private and voluntary sectors play a key role in addition to the Government sector. In health sector today private practice has become the more accessible form of medical care that people have come to utilise (Duggal and Amin 1989, George A 1997). There are not many studies conducted in India regarding the exact role of private sector and still less on its role in reproductive care. In a case study of Delhi it was shown that in the private health sector, maternity service was the area of second highest return second largest profitable service after OPD (Nanda and Baru 1993).

It is true that institutional deliveries in Rural Andhra Pradesh was only about 23% of the deliveries, as per SRS 1992 and a little less at 21% for NFHS 1992-93, though it was remarkably high for urban areas at 79% for the same SRS while somewhat lower at 70% for NFHS (R.G.I 1992 & I.I.P.S 1995). But in the present study (George A 1997), which is the basis of this paper, we are not looking at deliveries alone, though a large number of normal of normal and caesarean deliveries have been represented in the sample. We are also concerned about patients who had medical termination of pregnancy and those who were suffering from common gynaecological problems. Secondly as is already pointed out maternity related services form an important component of the services offered by private hospitals. Thirdly and most importantly our sample for normal deliveries and caesarean contains 64 % of patients from the poorer classes, which indicate that institutional deliveries are increasingly being adopted even by the poor, though this may not be large enough to raise the overall rate of institutional deliveries. At the same time in absolute numbers institutional deliveries are substantially on the rise even among the poor. The present study will also take the next step towards generating an awareness for the implementation of standards which are being developed in the field of reproductive health care, by first identifying the quality gaps in this field of care, at various levels of hospitals.

II. Methodology:

An exit survey to understand the women's perception and expectations about the quality of reproductive health care provided at private hospitals in Andhra Pradesh was carried out in the households of selected women patients. The survey was conducted with a sample of 555 women who were affected by reproductive health problems and treated at the various private and voluntary hospitals and nursing homes. The study was conducted in hospitals of two developed districts and two less developed districts in Andhra Pradesh.

The selection of developed and less developed districts has been based on the Relative Index of Development formulated by the Centre for Monitoring Indian Economy (C.F.I.), Bombay. When we were planning the study the latest figures were available for 1993. The districts of

¹ Director Institute of Health Systems, Hyderabad.

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Krishna and Nellore in Coastal Andhra have been selected as the developed districts. Cuddapah being the least developed district in Rayalaseema and Mahboobnagar being the least developed district in Telengana have been included in the sample as the less developed districts (CMIE 1993).

The Andhra Pradesh Health Institutions Data Base (APHIDB) maintained by this Institute revealed that most of the hospitals in the private sector were in the 6-15 category in all the four districts. Therefore while giving substantial representation to these hospitals we also gave a minimum quota to represent other hospitals. Similarly the voluntary sector hospitals which are very often clubbed with private sector, were also separately represented. A larger number of hospitals were selected so that at least 15 hospitals in each district would co-operate and give the addresses of patients for the survey. The intention was that the targeted sample of 600 patients i.e. 150 per district should get divided as 10 patients per hospital.

Due to the non response and incomplete response, the sample came down to 555. Some of the incomplete addresses turned out to be untraceable also. The actual sample of 555 patients were selected from on an average of 16.25 hospitals in each of the four districts viz. 14 from Krishna, 17 from Nellore, 15 from Mahboobnagar and 16 from Cuddapah. All together patients of 65 hospitals were covered out of which 9 were voluntary hospitals. (Table-1) The latter number is small because voluntary hospitals are few in number. These hospitals were largely from mofussil towns and villages with only a small portion from district head quarters.

Table-1: District wise distribution of sample size by bed strength.

District	Bed strength (figures in parenthesis are the row %)							Total
	1-5	6-15	16-30	31-50	51-100	101-300	301+	
Mahabubnagar	24 (14.91)	61 (37.89)	41 (25.46)	17 (10.56)	0 (0.00)	18 (11.18)	0 (0.00)	161 (100)
Cuddapah	11 (8.73)	78 (61.90)	18 (14.28)	17 (13.49)	2 (1.60)	0 (0.00)	0 (0.00)	126 (100)
Nellore	7 (5.60)	20 (16.00)	22 (17.46)	33 (26.4)	4 (3.2)	39 (31.2)	0 (0.00)	125 (100)
Krishna	18 (12.58)	59 (41.26)	23 (16.08)	29 (20.28)	9 (6.30)	0 (0.00)	5 (3.50)	143 (100)
Total	60 (10.82)	218 (39.29)	104 (18.73)	96 (17.29)	15 (2.7)	57 (10.27)	5 (0.9)	555 (100)

Care was taken to see that more hospitals were from the rural areas and small towns than from the district head quarters. While collecting the addresses of patients for exit survey we have collected addresses of patients of normal delivery, Caesareans, medical termination of pregnancy (MTP) and gynaec problems, as these were the four aspects chosen for standard setting. And the survey was meant to give a field level feedback on the expectations of women patients of reproductive health problems for the standard setting process. These addresses of only In patients were available as the hospitals were maintaining only these, in howsoever, incomplete and inadequate manner. Since many patients of gynaec problems did not get admitted, the number of gynaecological patients in the sample is not as much as was expected. In the case of MTP, the hospitals were reluctant to give addresses fearing that some legal problems. However, in this case, in addition to the small number of MTP addresses we

got, we have also added the observation of our respondents, about the experiences of their relatives or friends who underwent MTP in private hospitals.

The field work was conducted from 11 August, 1996 to 31 March, 1997. Field work in each district had three phases. One in which the addresses from the selected hospital in each districts which were willing to co-operate were collected. The second phase in which the investigators were chosen and trained and third in which the data collection was carried out.

III. Findings:

A. Socio economic and demographic context:

Summary of some of the socio-economic and demographic characteristics of the sample provides the context for interpretation of this exit survey on women's perception of quality of reproductive health care provided in private hospitals. Due to space constraints wherever data can be presented without tables it has been done so. Only some of the important tables are presented.

The early average age at marriage for females in A.P which was 18.1 years and less than the national average of 20 years (I.I.P.S 1995) and the consequent early child bearing has brought down the median age of our sample which is constituted largely of delivery cases to 24 years. The mean number of children ever born 2.04 and the same for number of children living was 1.9. These low figures are due to the low average of the sample. The major chunk of 36% of respondents had been married for the last 4-6 years, an almost equally high 34% were married for periods up to 3 years (Table 2).

No of years of marriage	No	%
Up to 3 Years	187	33.69
4-6 Years	201	36.22
7-10 Years	113	20.36
11-15 Years	32	5.77
16-20 Years	15	2.7
21+ Years	7	1.26
Total	0	0

On a national level, an analysis of the 42nd round of the National Sample Survey (1989) showed that for outpatient care about 70% in both rural and urban areas sought treatment from private sector rather than from Public hospitals or PHC's. However, the case was reverse when it came to inpatient care. Only 39% of inpatients in the rural as well as urban areas sought treatment in private health sector. The figures for out patient utilisation of private health sector in A.P was 75% in rural areas and 72 % in urban areas, only slightly higher than the all India figures . However what was more important to note was the wide variation in private sector utilisation among In Patients between A.P and the All India figures. A.P figures being as high as 70% in rural areas and 62% in urban areas. The two lower classes constituted 64% of the sample. Lowest class alone came to 34 % (Table-3). This points to the fact that even a large section of the lower classes are also using the private hospitals and nursing homes. The utilisation of private hospitals and nursing homes in AP is even other wise higher than the national level figures. At the all India level it was found in the 42nd round of the National Sample Survey (1989) that for outpatient care about 70% in both rural and urban areas sought treatment from private sector. In Andhra Pradesh out patient utilisation of private health sector was

Classes	No.	%
Lowest Class	191	34.41
Lower Middle Class	164	29.55
Middle Class	142	25.59
Rich	58	10.45
Total	0	0

¹ Note: Method used for constructing the class variable is mentioned in foot note.

slightly higher at 75% in rural areas and 72 % in urban areas. But what was more noteworthy was that while in patient utilisation of private health sector was only around 39% in both rural and urban areas at the national level, it was 70% in rural areas and 62% in the State's urban areas (NSSO 1989).

Table-4: Distance of hospital from house.

The median distance of the respondents from the hospital was 5 kms. Being in patients, this distance was quite reasonable. As high as 53% of patients of reproductive care who approached the private hospitals had to travel only less than 3 kms (Table-4) . This probably points to the need to enlist the co-operation of private hospitals in reproductive care.	Distance in kilometres	No	%
		1-3	296
	4-7	87	15.68
	8-15	39	7.03
	16-20	4	0.72
	21-26	1	0.18
	27-30	7	1.26
	31-45	2	0.36
	46-60	1	0.18
	61+	12	2.16
	No response	106	19.09
	Total	0	0

Sixty two percent of respondents had approached private hospitals because of the availability of lady doctors. Another nearly 50% went because doctor was available all the time. Nearness was mentioned by 36% while 37 % felt the behaviour of doctors and nurses as friendly (Table-5).

Table-5: Reasons for choosing the private hospital

S.No	Responses	No.	%
1	Near by	199	35.86
2	Behaviour of the doctor / staff is friendly	206	37.12
3	Lady doctor is available	342	61.62
4	Doctor is available all the time	274	49.37
5	Good (hospital facilities)	251	45.23
6	Had facilities to treat emergency	238	42.88
7	Good nursing Care	219	39.46
8	Hospital charges are affordable or reasonable	161	29.01
9	Required facilities are not available in Government hospitals	160	28.83
10	Any other (Please Specify)	93	16.76

¹ Note:N=555 Multiple answer question Number of responses and percentages will not add upto N and 100.

A little over 61% of respondents had utilised the private hospitals for normal delivery. A substantial 27% of the sample had Caesarean section (CS). Those who had approached for gynaec problems was 7%. The large component of Caesarean Section cases in proportion to other aspects of reproductive care points to the overmedicalisation of deliveries taking place in the private hospitals. This indicates

that our including caesarean with normal delivery as a procedure for setting standards is justifies. The hospitals were rather reluctant to give addresses of MTP patients fearing some legal problems leading to only a few MTP cases in the sample (Table-6). However in order to collect data on a reasonably

Table-6: Health problems of respondents

Responses	No.	%
Normal delivery	327	0
Ceasearean section	136	0
MTP	12	0
Gynaecological problem	38	0
Ceasearean section with tubectomy	16	0
Tubectomy	13	0
Normal delivery with tubectomy	13	0
All	555	0

higher number of cases we asked the respondents to tell us about the experience of their relatives and friends also.

B. Perception of facilities and services in private hospitals:

In spite of our efforts, to collect information through a number of questions on different aspects of the facilities, equipment and services of the private hospitals only a small percentage of patients have come out and given critical responses. This could be because the private hospitals were probably the only or predominant service providers in several areas, whom the women did not want to displease. The respondents might have been also under the fear administration of these hospitals. They always compared with the Government sector and probably found that the private hospitals apparently provided better quality. In addition to these, since we were not allowed access to the case sheets by the private hospital management, we had to interview patients whose addresses were provided by them. It is likely that the management saw to it that only the addresses of satisfied patients were handed over to us for interviewing. True, we could have tried to do some sketchy interviewing of patients selected by us, within the hospitals or near them, but we felt patients may not talk freely in such atmosphere and therefore decided on the rather difficult route of collecting the patients addresses from hospitals, tracking them to their houses and interviewing them there. Though the critical responses to the structured questions were rather low, the small magnitude of these expressions of criticism should be identified as areas for improvement of quality. There is a better and more critical response for the open-ended questions, which we meticulously coded and painstakingly analysed. The answers to these questions, compensate in part of the inadequate quantum of critical responses to the structured questions.

IV. Perception on general services:

The study covers the women's perception on normal deliveries, Caesarean section, medical termination of pregnancy and common gynaecology diseases. In this section those aspects which have a common bearing on all four areas are covered. Those with specific relevance to each of these are dealt with in separate subsequent sections.

A. Perception on diagnostic & medical equipment:

Ten percent of sample did not consider these equipment as "so relevant" or relevant at all. It is interesting to note that an understanding of irrelevant technology is catching up in at least a small section of the respondents (Table-7) .

When analysed in relation with economic class and education it was found that only less than 2% among the rich class felt that these equipment in private hospitals were "not so relevant". Compared to this 10% of the lower class and 13% of the middle class felt that these equipment were either "not so relevant" or "not

at all relevant". It is among the illiterate families who are likely to be poor and in families with the highest educated person having high school or intermediate education only that the attitude of the equipment being not so relevant or not at all relevant was relatively high at 18%, 18% and 12% respectively. The better educated who are likely to be belonging to the

Table-7: Perception on the relevance of diagnostic and medical equipment

Responses	No.	%
Extremely Relevant	70	0
Quite Relevant	226	0
Relevant	201	0
Not so Relevant	52	0
Not at all Relevant	2	0
Do not know	0	0
Not Mentioned	4	0
Total	555	0

rich were not sharing the same feelings. The rich seem to have been getting more appropriate services.

The feeling that these equipment were not so relevant or not at all relevant was about 11% among the users of private hospitals where as it was only 5 % among the users of voluntary hospitals. Among the users of 1-5 bed category, the 27% respondents who said that the equipment were irrelevant or not so relevant would have been referring to inadequate of equipment in small hospitals whereas those from the medium and large hospitals who expressed these views may have been talking about the irrelevance per se. In the case of surgical equipment also a small section of the respondents who added up to 7% felt that these were not so adequate or not at all adequate. No cross tabulated tables are presented on account of space constraints. This applies to various aspects discussed below also.

B. Perception of infrastructural facilities:

As very high 98% and 97% were of the view that the number of beds in female and maternity wards respectively were adequate enough. It is likely that this may be true because maternity services are the second largest revenue earning activity of private hospitals (Baru & Priya 1993). Therefore they may be more sensitive in providing sufficient beds for maternity purposes than Government hospitals. However it has to be doubled also whether the women themselves distinguish between maternity beds and other female beds. A high 94% were also satisfied with the area per bed. A relatively high 15% of respondents were of the view that the space provided by private hospitals for attendants were either not so adequate or not at all adequate. A very high 32% respondents were not having lockers by their beds.

About 4% were of the view that water facility was either not adequate enough or not at all adequate. Most others were on different levels of satisfaction in this matter. In the case of electricity 6% said that either the supply was inadequate or not at all adequate, with the others contended on various levels.

Ambulance was not available in 83% of hospitals (Table-8). A bed strength wise analysis of respondents from the various hospitals for ambulance facility showed that 97%, 95% and 96% of them from hospitals with 1-5 beds, 6-15 beds and 16-30 beds were not having ambulances. This percentage declined to 67% each in the case of hospitals with 31-50 beds and those with 51 to 100 beds, and further came down to 33% in the case of hospitals with 101-300 beds. It is

Table-8: Perception on hospital's ambulance facility for emergency services

Responses	No.	%
Has Ambulance	82	0
Do not have	462	0
Don't know	1	0
Not Mentioned (NM)	10	0
Total	555	0

noteworthy that 33% of even the large hospitals with 101-300 beds were not having ambulance. Smaller hospitals of an area could get together in a pool for sharing ambulances. Analysis of the availability of ambulance by hospital type indicated that 90% of private hospitals were not having ambulance facility while only 44% of the voluntary hospitals did not have ambulance. But here we must also accept the fact that most of the smaller hospitals are in the private sector, where having an ambulance of their own may not be viable.

Relatively high 23% of respondents mentioned that there were no bed sheets at all on the beds. Another 4% said that sheets were not even changed weekly (Table-9).

Table-9: Perceptions on frequency of changing bed sheets

Responses	No.	%
Daily	328	0
Once in two days	59	0
Twice a week	13	0
Weekly	2	0
Not even weekly	23	0
No sheets on the bed	125	0
Not Mentioned	5	0
Total	555	0

C. Quality Of services provided by doctors & staff:

In the case of 99% of the respondents they could meet the doctor. This is not surprising as the inaccessibility of the doctor again a problem of the Government health services. The median waiting time was 20 minutes. In the Government sector which offers largely free care there are very long ques. The large chunk of 43% of our sample could see the doctor between 11 -30 minutes.

Around 9% of respondents felt that the doctor was either not cordial enough in his behaviour or not at all cordial. The rest were satisfied on different levels with the doctors behaviour. In the case of attention given by doctor also a similar pattern with very little dissatisfaction and high satisfaction levels was found. However regarding the privacy during consultation 7% felt that it was not so adequate or inadequate .

A slightly higher amount of criticism was found in the respondents' views on behaviour of nurses compared to doctors. The element of fear seemed to have prevented them from opening out against doctors. This seemed to be a little less regarding nurses. Nearly 16% of respondents felt that the behaviour of nurses was either not so cordial or not at all cordial, though the rest seemed to be satisfied at different degrees. In the case of attention given by nurses also a similar 16% held the view that it was not so adequate or not at all adequate.

D. Perception of good things in the hospital:

Among the respondents who answered to an open ended question on the good things they perceived in the hospitals, 43% mentioned - the doctors ability to treat well and behave well as the main good thing they found. For another 25% the facilities were good and nearby. Fifteen percent was happy with the nurse's behaviour while another 14% described them as kind. Fourteen percent mentioned about cleanliness.

E. Things disliked in the hospital:

The responses to an open ended question on things disliked in the hospitals yielded a better critical response than what was got for structured questions on specific aspects of care presented elsewhere in this paper. Fifteen percent of the respondents pointed out of that the fee was high. Nine percent was not happy about the behaviour of nurses. Five percent were critical about the doctors also. Another 4% of respondents mentioned the inadequacy of proper facilities and equipment. There were also other critical points made, though by smaller percentage groups of respondents about water supply, electricity, beds, cleanliness, room space, waiting time, waiting place, lack of privacy, need for lady doctor etc. These critical comments of respondents should not be trivialised by the small percentage of the respondents who were expressing them. They should instead be seen as the outward expressions of the problems existing in those areas, the real magnitude of which are not known exactly .

V. Perception of normal delivery & Caesarean services:

An answer to an open ended question on the expectations of good quality pre-natal care, 45% of women who had normal delivery in private hospitals mentioned the need for good nutritious diet and advice in that regard. The importance of health education by Doctors/nurses was emphasised by 11% of respondents. The need for monthly check up and to take T.T injections was felt by 9% and 6% of respondents respectively. Sixteen percent told that the doctor should treat well and conduct delivery safely.

As answers to another open ended question on expectations on good quality delivery care, the highest percentage of respondents who had normal delivery i.e. 23% said that the Doctor should treat them well and do the required tests. A little over 11% of respondents wanted the doctor and nurses to be available all the time to attend to emergencies. Nearly 9% expected the doctors & nurses to behave friendly. Another 5% of respondents who said that " Doctors, Nurses and Paediatricians are a must for safe delivery". A 3% said that a senior lady doctor should attend to delivery. The concern of the large section of respondents was on the availability of a doctor for delivery and that all the necessary tests which should be conducted. (Table-10).

Table-10: Expectations of good quality delivery care

Responses	No.	%
Mother and child should be fine / safe / healthy	80	23.53
Doctor should treat us well / do required tests properly	78	22.94
Doctor / nurses should be available all the time / should attend delivery / during emergency	39	11.47
Should have good facilities for delivery	34	10
Doctors should behave friendly / properly / well	30	8.82
It will be nice if nurses look after well during delivery time / should have patience	20	5.88
Doctors, nurses and paediatricians are must for safe delivery.	7	2.06
Doctors should follow aseptic techniques in conducting delivery / should use sterile equipment / should use sterile supplies to prevent infection.	14	4.12
Good doctor / specialist should attend the delivery.	7	2.06
Should tell about the diet to be taken / exercises.	7	2.06
Should prescribe good medicine.	10	2.94
Should tell us pros and cons early.	5	1.47
Doctors and nurses should give required boldness.	10	2.94
Nurses should give medicines in time / tell about medicines / proper attention.	8	2.35
Hospital should be neat / good / delivery room should be clean.	9	2.65
Equipment for emergency operation should be available / Facilities to tackle emergency should be there.	4	1.18
Should see baby if small and prescribe enough tonics for him / her.	1	0.29
Should explain delivery procedure earlier / post natal care.	3	0.88
Should check for proper position of the baby.	1	0.29
Senior lady doctor should be available.	10	2.94
Should treat with less fee and should not charge for T.T.	1	0.29

¹ Note: Percentage is calculated for 340 Normal delivery cases. Being multiple answer questions N will not add up to 340 and percentages will not add to 100.

Slightly over 7% of respondents were "not so satisfied" with the services provided during complications. Regarding the perception on availability of equipment to deal with complications in delivery, 14% of them who had complications felt that only some necessary

equipment were available, while 7% felt that only few required equipment were available. One of the reasons why most of the respondents seem to be apparently satisfied with the normal delivery services of private hospitals becomes clear when we see that 46% of the over all sample of 555 had gone to private hospitals for their previous delivery also. Government hospitals were used by only 4% of the sample for their previous deliveries (Table-11).

Table-11: Place of previous delivery

Responses	No.	%
Government Hospital	24	0
Private Hospital	256	0
At home by trained assistant	720	0
At home by untrained assistant	16	0
At home by relatives	152	0
Any other (Specify)	34	0
Not applicable	88	0
Not mentioned	120	0
Total	555	0

The respondents who underwent caesarean were most concerned about the facilities in the operation theatre, its equipment and the availability and the ability of a doctor who can operate efficiently. To an open ended question on the expectations about caesarean operation from the hospitals, twenty percent were concerned about the O.T facilities and equipment while 15% were concerned about availability in time and ability of a doctor to operate efficiently. Although the women or for that matter people at large may not know of the specifics of medical technology related to caesarean, they do have expectations about what is supposed to be delivered. Even though they put it in their own terms (Table 12).

Table-12: Expectations from the hospital about Caesarean operation

Sl	Responses	No.	%
1	Facilities in operation theatre should be good / equipment's for caesarean should be good / OT should be spacious.	31	0
2	Doctor should operate efficiently / doctors and nurses should be available for operation.	23	0
3	Doctor should have waited some more time before operating, try to avoid caesarean section, educate on care during pregnancy to avoid complications.	7	0
4	Should educate on why ceasarean section.	6	0
5	Everything should be fine for operation.	5	0
6	Hospital should have all facilities.	15	0
7	Doctor should treat us well.	16	0
8	Doctor s and Nurses should be nice to the patients.	6	0
9	Doctors and nurses should look after mother and child properly / provide good services.	1	0
10	Doctor and other staff should take good care.	13	0
11	Doctor and Nurses should be neat.	1	0
12	Doctor and Nurses should check the spread of any contagious diseases.	1	0
13	Expert obstetrician / specialist/ surgeon must / need more doctors.	9	0
14	Doctor should tell about post operative precautions.	2	0
15	Doctors should give boldness.	4	0
16	Mother and child should be healthy.	12	0
17	Child should born healthy.	1	0

¹ Note: Percentage is calculated for 152 Caesarean cases. Being multiple answer questions N will not add up to 152 and percentages will not add to 100.

About 5% of respondents who underwent caesarean, said that in their case it was not needed (Table-13). This shows an emerging awareness among women about the overmedicalisation

of deliveries. Of the 144 Caesarean cases which felt that the operation was necessary for them, 20% said that they did not have labour pains. Transverse baby position was mentioned by 17% of the respondents, while 12% cited the large size of the baby. Blood formation in womb, delayed labour and loss of amniotic fluid was stated as reasons for conducting caesarean by 8%, 7% and 6% of respondents respectively. Another reason mentioned by them was small pelvis which apparently endangered the mother in delivery (Table-14).

Table-15: Complications developed in Caesarean section

Responses	No.	%
Had Complications	54	0
Did not have	96	0
Not mentioned	2	0
Total	152	0

Table-14: Reasons for Caesarean operation where patient felt operation was necessary

Sl	Responses	No.	%
1	Transverse baby position/ Abnormal baby position.	24	0
2	Child is stout/ big/ baby head big.	17	0
3	Earlier deliveries were caesarean section.	15	0
4	Delayed Labour/ Prolonged Labour.	10	0
5	Crossed my nine months, crossed date.	5	0
6	Loss of amniotic fluid.	8	0
7	No labour pains.	29	0
8	Child was dead in womb.	1	0
9	Lump/ wound/ fibroid in uterus.	3	0
10	Breathlessness.	3	0
11	Doctor advised after scanning / Indication of Scanning report.	6	0
12	Doctor operated without informing us.	1	0
13	Doctor told to conduct caesarean/ Due to doctor's report.	19	0
14	Child legs and hands were out.	1	0
15	More amniotic fluid.	1	0
16	Cord around the neck.	2	0
17	Child changed the position in the womb.	1	0
18	Blood formation in womb.	12	0
19	Prolonged difficulties.	15	0
20	They operated for money.	2	0
21	Small pelvis / Mother's life in danger.	10	0
22	Over bleeding.	3	0
23	First delivery after long years of marriage.	3	0
24	Lack of baby movements.	2	0
25	Condition was serious.	2	0

¹ Note: Percentage is calculated for 144 Caesarean cases who thought operation was necessary for them. Being multiple answer questions N will not add up to 144 and percentages will not add to 100.

Even accepting that many of these reasons could be true, there was emerging feeling that caesareans are being conducted when they are actually not needed. Such views were expressed by 3 of 7 respondents who felt that caesarean was not needed in their case and pointed out that doctor's operated for financial reasons. Another of them said that the doctor operated without informing them. A substantially high 36% of the respondents who underwent caesarean, developed complications (Table-15). The complications were however attended by the resident doctors in 93% of cases and in 4% cases by the consultant doctors

VI. Perception on gynaecological problems and services:

Menstrual problems, bleeding in vagina, white discharge, white discharge with foul smell, abdominal pain and back pain were expressed as the generally felt gynaecological problems of women (Table-16). A substantially high 37% of women i.e 205 among them, when asked whether they were suffering from any gynaecological problems, said that they suffered from one or other of the above mentioned problems. Out of the 205 respondents who complained of gynaecological problems, as high as 39% did not consult any doctor for their problems (Table-17). It is quite evident that due to culturally imposed gender based prioritisation of morbidity with in the family, gynaecological problems do not get the attention they should get. Given women's lack of autonomy and decision making authority it is unlikely that sick women take the initiative in obtaining care themselves. The tendency to endure and particularly gynaecological morbidity as a fact of life and shyness in discussing these conditions with the providers is particularly high (Jejeebhoy, 1997).

Table-16: What they think are the common gynaecological problems women get

Sl	common gynaecological problems	No.	%
1	Menstrual problems (e.g Painful menstruation)	391	0
2	Bleeding vagina (severe)	347	0
3	White discharge	285	0
4	White discharge with foul smelling	91	0
5	Burning sensation near vagina	17	0
6	Itching near vagina	50	0
7	Something coming down from vagina (Prolapse of uterus)	7	0
8	Incontinence of urine feaces	15	0
9	Infection near vagina	21	0
10	Odema near vagina	18	0
11	Abdominal pain	468	0
12	Back pain	461	0
13	Any other (Please specify)	6	0

¹ Being multiple answer question, frequencies and percentages will not add up to 555 and 100

Table-17: Consulting a doctor for gynaec problems

S.No	Responses	No.	%
1	Consulted	124	0
2	Did not	80	0
3	Not Mentioned (NM)	1	0
Total		205	0

A very high 86% of those who had consulted a doctor for their gynaecological problems, visited a lady doctor in private hospital for the purpose (Table 18). Nine percent of the respondents had approached private hospitals which had provided their addresses. Out of those who went to private hospitals 8% were not satisfied with the services provided by the

doctor / staff in the hospital for gynaecological problems. Of the 51% respondents who went to the same private hospital 55% had some complications.

About 11% of those who had complications were "not so satisfied" with the treatment they got for gynaecological complications. Regarding the equipment to treat complications most of the 28 respondents who experienced complications felt that

equipment were available at the hospital. However, 21% felt that only some equipment was available and some not available, while another 7% felt that only few equipment were available.

Table-18: Personnel they consulted

Personnel consulted	No.	%
Lady doctor at government hospital	3	0
Male doctor at government hospital	2	0
Lady doctor at private hospital	107	0
Male doctor at private hospital	7	0
Lady doctor at private clinic	4	0
Not Mentioned	1	0
Total	124	0

A. Impressions on being treated by a male doctor in private hospitals for gynaec problems:

Table-19: Impressions on getting treated by a female doctor in private hospitals for gynaecological problems.

Sl	Responses	No.	%
1	For delivery lady doctor will be good/ required/ Preferred.	89	0
2	We can be free with lady doctor / express better / discuss better / She will understand better / will advise better.	148	0
3	Only to a lady doctor we can express our problems/ She can solve our problems/ To express our mental and physical problems lady doctor is good/ Can express all the problems.	147	0
4	Lady doctor will be fine to consult if any problem arise / Lady doctor will be good.	54	0
5	It will be easy to consult a lady doctor if a problem arise / Privacy will be there.	13	0
6	Lady doctors do delivery properly.	7	0
7	Lady doctors good for examinations and tests./ Can get examined easily.	29	0
8	Lady doctors write good medicines./ Treats well.	7	0
9	Lady doctors have more patience.	5	0
10	Any doctor can conduct the delivery.	26	0
11	Irrespective of sex, any doctor may should treat us well and prescribe good medicines.	9	0
12	Irrespective of sex, any doctor may should treat us well and conduct the delivery properly.	28	0
13	Don't know/ Not mentioned	8	0

¹ Note: Being Multiple Answer questions N will not add up to 555 and percentages will not add to 100.

Thirty Eight percent of the respondents held the view that they could express better to a lady doctor. Another 15% also said specifically that lady doctors would be good to express their mental and physical problems. Another 10% said that lady doctors will be better suited to conduct deliveries (Table-19). This is also an aspect for standards setting panel to discuss.

Would it not be desirable to have atleast one lady doctor in all hospitals above 15 beds and a lady gynaecologist in hospitals with above 30 beds?

B. Perception on services provided for medical termination of pregnancy:

A little over 48% i.e. 269 respondents knew where abortion was done. To a multiple answer question, 84% of them mentioned private hospitals as the places where it could be done.

Government hospitals was mentioned only by 30% of respondents, while notably traditional healers were mentioned by only 7% (Table-20). The data points out that abortions by traditional practitioners/ birth attendants etc. was becoming less common than it was before. Sixty eight percent of respondents out of 555 were of the view that abortion should be performed by a qualified doctor (Table-21).

Table-20: Known places where abortion is done

Responses	No.	%
Sub Centre	2	0
Primary Health centre	5	0
Government Hospital	80	0
Private Hospital	225	0
Private Clinic	27	0
At home (Traditional Healers)	19	0
Any Others (Specify)	0	0

Table-21: Who the respondents expect to perform abortion

Responses	No.	%
Qualified Doctor	376	0
Registered medical practitioner	0	0
Nurses	2	0
Dai	0	0
Traditional healers	0	0
Any other (Please Specify)	5	0
Not Mentioned (NM)	172	0
Total	555	0

¹ Being Multiple Answer Question, N will not add up to 269 and percentages will not add up to 100

In order to get a sizeable amount of information on abortions we asked the respondents whether any of their friends / relatives had also underwent Mtp. in addition to them. We found that when the former also, there were 73 cases on which respondents could give information (Table-22).

Table-22: Did they / their relatives or friend undergo medical termination of pregnancy

Responses	No.	%
Yes	73	0
No	450	0
Not Mentioned (NM)	32	0
Total	555	0

And of those 65 i.e. 89% had their Mtp done in private hospitals (Table-23). This justifies our taking Mtp as a procedure to develop standards for private hospitals.

Table-23: Facilities where they / their relatives or friend undergo medical termination of pregnancy

S.No	Responses	No.	%
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1	Subcentre	1	0
2	Primary health centre	1	0
3	Government hospital	2	0
4	Private hospital	65	0
5	Private clinic	1	0
6	At home (traditional healers)	3	0
Total		73	0

About 15% mentioned that only some of the required equipment for Mtp were available in the private hospitals concerned. However, around 18% i.e. 12 persons had developed complications with the Mtp. Four persons out of these said that they / their relative / friend were attended by a nurse during the complications, though 8 got the attention of a resident doctor. Except 2 of this category who said that they were "not so satisfied" the rest of the 10 were at different levels of satisfaction with the care received during the complications.

VII. Conclusion:

The following aspects which emerge from the exit survey need to be highlighted and they are of relevance for the now ongoing standards formulation process of this study also. Among the different aspects of the services offered by the private hospitals the items mentioned below are of important concern to the women patients of reproductive care.

Among the services generally used for all reproductive care procedures these included: Diagnostic, Medical and Surgical Equipment, Ambulance Facility, Cleanliness in general, particularly changing of bed sheets, Water Supply, Electricity, Room space, Room for attendants to wait, Need for lady doctors to attend to women's reproductive care problems and Behaviour of Doctors and Nurses including the Doctors' ability to treat.

Regarding the services used for normal delivery, availability of Doctors and Nurses round the clock in order to ensure their presence in emergencies was the main concern. Doctor's behaviour and ability to treat and in taking delivery was stressed. Doctor was expected to conduct all necessary tests & examinations also.

In the case of Caesarean section deliveries, a well equipped operation theatre was one of the main expectations. Availability and ability of Doctor to conduct caesarean was the next important concern.

As regards Gynaecological Problems the general preference to consult lady doctors for reproductive health problems was particularly expressed Menstrual Problems, bleeding in vagina, white discharge, white discharge with foul smell, abdominal pain and back pain were, among others the common gynaecological problems perceived by women. Though abortions by traditional healers/ birth attendants etc. may be still practised largely, it seemed that a substantial number of abortions were taking place in the private hospitals also. This calls for developing adequate standards for the Mtp procedures also.

VIII. Notes & References:

1. Class: The variable of class was constructed in the following manner. The *lowest class* consists of Agricultural labourers, Unorganised Sector labourers, Marginal Peasants Owing up to 2.5 acres land, Village Artisans and Unskilled industrial Workers. *Lower Middle Class* include Organised sector Labour, Attendants, Skilled Workers and Small Peasants Owing from 2.6 to 5 Acres, Household Poultry, Dairies,

Petty shops-up to Rs. 2500. Middle Class comprises White collar workers Middle Peasants Owing 5.1 Acres, Priestly Class, Retail shops and other medium scale trade and industries while under the Rich are covered Rich peasants with 15.1 Acres and above , Large scale industrialists, Large Scale Traders, Professionals, Rich Peasants and Large Scale Dairy and Poultry owners.

2. *Andhra Pradesh Health Institutions Data Base (APHIDB)*, Institute of Health Systems, Hyderabad.: This is by and large the only database in any state of India giving reasonably accurate basic data on private hospitals. According to APHIDB there are 2807 private and 51 voluntary hospitals in A.P adding up to a total of 2858. The bed strength of private hospitals is 47971 and that of voluntary hospitals is 4405 beds which together add up to 52376 beds. OF these the 1-5 bedded, 6-15 bedded, 16-30 bedded and 31-50 bedded hospitals constitute 16.93%, 48.95 % 24.56% and 5.32% of the total number of hospitals respectively. Most of the hospitals under 30 beds are concentrated in small towns and slightly developed rural areas.
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Standards and quality control measures in Andhra Pradesh Vaidya Vidhana Parishad (APVVP).

S.Srilatha¹

I. Introduction:

The Andhra Pradesh Vaidya Vidhana Parishad (APVVP) is an autonomous body established in 1986 by an Act of Andhra Pradesh legislature to develop hospital services by granting operational autonomy and enabling management development in the public hospitals. Various standards development and quality assurance activities in APVVP are to be viewed in the context of its goals and mission. APVVP requires that the mission of each of its hospital shall be to give Care, Comfort and Courtesy. Care refers to improved patient care through scientific diagnosis, cost effective regimen, consistency in availability of drugs, zero incidence of hospital infection and referral services. Patients stay is to be made comfortable by proper maintenance of toilets, continuous availability of water and electricity, ward cleanliness, linen supply and furniture maintenance. Courtesy to the attendant should be extended by showing concern, explain things, arrange for attendant's accommodation and ensure easy access. Efforts to develop standards and quality systems in APVVP hospitals can be grouped in to the following three periods:

- i. Pioneer period for hospital standards by government: 1977,
- ii. Peak period for hospital standards and quality improvement: 1988 - 1990, and
- iii. Continuation by First Referral Health System Project: 1994 onwards.

A. Pioneer period for hospital standards by government (1977):

1. An early effort to standardise public hospital facilities in AP was made during the 1970s by developing yardstick of requirement to set up or expand hospitals. Till then the hospitals in AP were following yardstick contained in the Madras Medical code. A study in 1970's, revealed that the staffing pattern was not revised subsequently even though certain high level committees such as Bhore Committee, Mudaliar Committee working groups of Planning Commission and Indian Medical Council made recommendations for strengthening the staff in the medical institutions. Obviously hospitals suffered from poor and inconsistent staffing. Actual need for various categories of staff in medical institutions was arrived at in consultation with the Director of Medical and Health services. Revised and upgraded staffing norms for Taluk and District hospitals were issued by government in G.O.Ps. No. 885, Medical and Health (C2) dated 27 the August 1977. Sri. Gangopadhya then Secretary to government in health department was primarily responsible for development and issue of these yardsticks. Hence the above government order used to be commonly referred to as "Gangopadhya GO".
2. Prior to issue of the above yardsticks order, separate proposals had to be made and posed to the finance department for release of funds for initial equipment and creation of posts after administrative sanction for the hospital was received. This government order fixed yardsticks and allowed automatic creation of posts,

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purchase of capital equipment corresponding to the size of hospital or expansion and in accordance with the yardstick.

B. Peak period for hospital standards and quality improvement (1988 - 1990):

1. In the history of APVVP the period from 1988-90 can be considered as remarkable and memorable. In August 1988 Dr. Prasanta Mahapatra, a physician and civil servant assumed office as Commissioner APVVP and continued till July 1990. During this period, APVVP has attained a firm position and has matured as an organisation by delivering its promises of high quality health care by introduction of concepts of standards and quality control measures. Mission and goals of APVVP were clearly enunciated and APVVP was presented as a service organisation. Quality of care received a high priority, along with improvements in efficiency and delivery of services.
2. An awareness about usefulness of standards for better management of hospitals was built up. Specific efforts were made to utilise available standards. A relationship with the local office of the Bureau of Indian Standards (BIS) was built up. Copies of all BIS standards in medical and health were obtained. Guidelines issued from the APVVP head office cited specific BIS standards wherever necessary. For example the guidelines on toilet maintenance (APVVP 1988) refers to about nine Indian Standards.
3. Standardisation and quality assurance efforts during this period lead to formal issue many standards. In addition management processes were put in place to improve and assure quality of services and satisfy requirements in formally issued standards. Both types of activities are listed below.
 - i. Standard range of services according to hospital size.
 - ii. Hospital formulary.
 - iii. Standard for hospital mattresses.
 - iv. Yardsticks of hospital staffing.
 - v. Hospital equipment norms.
 - vi. Continuing education:
4. All the standards formulated during this period were brought out as booklets. In order to disseminate and operationalise these standards all the book lets are circulated to the concerned personnel at the grassroots levels in various hospitals who are the actual service providers.

C. Continuation by First Referral Health System (FRHS) Project 1994 onwards:

1. About the FRHS Project: The process of standard, apart from other factors, contributed to the realisation that additional resources on a fairly large scale was required to improve and assure quality of services in the public hospitals. This and the realisation about very low hospital stock in the state lead to formulation of a comprehensive project to develop the first referral hospitals. In 1989 December external funding was sought in view of the large outlay required for its implementation. In October 1994, a loan of 438 crore rupees was sanctioned to implement the first referral health system project (FRHS).
 - i. Main objectives of the project are:
 - a. Improve efficiency in the allocation and use of health resources through policy and institutional development.

- b. Improve system performance of health care through improvements in quality effectiveness and coverage of health services at the first referral and secondary level to better serve the neediest sections of society.
 - ii. The project includes three components:
 - a. Institutional strengthening through policy reforms and development of implementation capacity.
 - b. Improving Quality, Access and Effectiveness of Services at District Hospitals.
 - c. Improving Quality, Access and Effectiveness of Services at Area and Community hospitals.
 - iii. Implementation of this project gained momentum under the leadership of Mr. M. Nagarjuna who assumed charge of the project in April 1996,
- 2. Major standards and quality improvement output: Various standardisation processes have taken place for implementation of this project. Most important contributions during the course of project implementation are;
 - i. Elucidation of the standard range of services by definition of clinical and diagnostic norms by type of hospital.
 - ii. Yardsticks of staffing of various types of hospitals.
 - iii. Hospital equipment norms.
 - iv. Continuing education & practice guidelines.
- 3. Following two important differences in approach between the peak period and the FRHS period are noticeable;
 - i. In the peak period, standards once developed were formally released and widely disseminated within the organisation. In the FRHS period efforts to release the standards document as such has been sporadic. For example the practice guidelines are being printed for release to staff. But the clinical and diagnostic norms etc. have not been formally released as standards, although the management is following them in their day to day work.
 - ii. Some of the quality improvement measures, mainly in the area of continuing education have not been pursued. For example publication of the house journal "Bulletin of Hospital Services" has not been regular.

D. APVVP standards as on date:

- 1. Note the continuity in standards development process. The only standard setting activity In the pre APVVP period was on yardsticks of staffing. This was continued in the next two periods. Two out of the six major activities during the peak period, namely hospital formulary and the standards for hospital mattresses had been fully developed in the earlier phase and their revision is not yet due. In the rest four areas substantial development work took place during the FRHS project implementation.
- 2. Taking stock of activities during all the three periods, standards and quality improvement processes developed by APVVP thus far can be listed as follows:
 - i. Standard range of clinical and diagnostic services by hospitals.
 - ii. Hospital formulary.
 - iii. Yardsticks of hospital staffing.
 - iv. Hospital equipment norms.

- v. Standards for hospital mattresses.
 - vi. Continuing education and practice guidelines.
3. More detailed description of each one of the above six activities follows.

II. Standard range of clinical and diagnostic services by hospitals:

A. Scope:

1. Hospitals are generally classified according to bed size or a combination of bed size and speciality services offered. People implicitly associate a certain range of services with a given hospital type. Explicit definition of the range of services that can be expected from hospitals of various types improves patient satisfaction and avoids confusion. In case of public hospital system such a standard helps in planning and program implementation. Recognising this need the Bureau of Indian Standards issued IS12377/1998 which is a classification and matrix for various categories of hospitals. The standards by APVVP defining normative range of services in various categories of hospitals are a specialisation of the concept in IS12377/1988.
2. These standards were developed in two stages:
 - i. Classification and standard range of services developed during 1988 - 1990, and
 - ii. Clinical and diagnostic norms developed during the course of FRHS project.

B. Classification, nomenclature and normative range of services in APVVP hospitals:

1. Primary objective in development of these standards by APVVP were two:
 - i. To offer to the public a minimum guaranteed range and level of services; and
 - ii. To secure appropriate, balanced growth and development of hospitals by;
 - a. provision of the prescribed minimum range and level of services for the respective category,
 - b. discourage investment in any facility outside the prescribed maximum range and levels,
 - c. resist local and political pressures, patronage and indifference, and
 - d. acting as an administrative tool for planning, execution and monitoring of hospital services.
2. This standard classifies public hospitals according to bed size as follows:

Hospital type	Bed strength
Community Hospital	30
Area Hospital	100
District Hospital	250
Upgraded District Hospital	500

3. This standard listed the minimum and maximum level of services to be offered by each hospital. Clinical and diagnostic services were grouped separately. Apparently the minimum level of services were specified to assure people a certain consistency and reliability in services offered by public hospitals of similar bed size. The upper limit of services was specified to discourage haphazard

development of hospitals and to channelise popular initiatives for development of local hospitals.

C. Clinical and diagnostic norms:

1. The norms for clinical, diagnostic services and equipment for each of the three levels for hospitals with in the APVVP system were reviewed in a workshop organised for this purpose. The workshop brought together senior clinicians, nurses and other technical staff with work experience at different levels of health care systems, senior planners, hospital managers and programme managers from Directorate of health.
 - i. The workshop has come out with a range of clinical and diagnostic services that should be available in the three types of hospitals in the APVVP, in particular distinguishing them from other services available at the primary and tertiary levels of care.
 - ii. Based on the proposed range of services recommended the norms for physical assets, equipment, instruments, furnishing materials etc. that would be needed to provide services of adequate quality were formulated.
 - iii. The resultant standard called by APVVP as the clinical and diagnostic norms for hospitals contain a detailed listing of various clinical and diagnostic procedures ought to be performed by different types of hospitals. It has enormous potential to improve patient satisfaction and streamline management of the public hospital system and facilitate referral. The list of clinical and diagnostic procedures can be a reference point for people to assess their local hospital and draw conclusion about the extent to which it is fulfilling its mission. Similarly hospital managers can review and monitor the extent to which a hospital is able to deliver the services expected of it and identify areas of weakness. Medical practitioners in PHCs and private sector can use the list to identify the level of hospital to which a specific case requiring some clinical or diagnostic procedure is to be referred.

III. Hospital formulary:

A. Background:

1. The concept of standardisation of drugs is not a new phenomenon in public hospitals. In these hospitals operating with limited and finite list of drugs and therapeutics was evolved in 1966 by Government of Andhra Pradesh (Hospital standing order para 375, G.O.Ms.No. 5 M & H, dated. 2-1-86 and G.O.Ms. No. 99, M & H dt. 6-2-86), However, these lists were not periodically revised. Another problem with these lists is that the entries are not adequately specific to facilitate inventory management by hospital. For example a single entry like say “erythrocin” is capable of being interpreted as 250 mg tabs, 500 mg tabs, syrup, erythromycin stearate, erythromycin estolate and so on.
2. The concept of rational drug use and cost-effective medical care has been gaining ground for some time. The WHO lists of essential drugs published form time to time is an effort at the international level to facilitate cost-effective medical care and ensure consistent availability of drugs. All India Drug Action Network (AIDAN) a forum working towards the adoption and implementation of a people oriented Rational Drug Policy in India, have envisaged that selection of the essential drugs should be followed by preparation of a graded drug list for different categories of health personnel and health institutions.

3. Most modern hospitals in the world have a formulary. Unfortunately interest and skills for hospital formulary development in India has not developed adequately. The National Formulary of India (NFI) was prepared to provide for specific needs of practitioners in India. Some voluntary hospital groups like the Catholic Hospital Association of India have developed formularies
4. to facilitate drugs and therapeutic management in their member hospitals. APVVP is the first public hospital group in India to have developed a hospital formulary for itself.
5. Subsequently government of Andhra Pradesh have adopted the hospital formulary developed by APVVP for other hospitals in the state including the teaching hospital. More importantly the hospital formulary development process adopted by the APVVP was commended by the government of AP for adoption by other wings of the health department (Govt of AP; GOMs277 HM&FW (M1) department, dated 12th May 1993). In this order government of AP adopted a set of guidelines for preparation of hospital / community formulary and approved product lists. These guidelines were largely based on the experience in preparation of hospital formulary in APVVP.

B. Process of formulary development:

1. Methodology and process used to develop the hospital formulary has been described in the preface to the formulary itself. Briefly it involved a dedicated team of core professionals, extensive study of literature by them, elaborate consultative and consensus building events to involve almost all physicians working in the APVVP hospital system. The steps taken to develop the formulary are briefly described below.
2. Initial draft was prepared by vast literature review. Various books, documents, Government orders, National and international standards, reports and research studies were considered in preparation of this draft.
3. This initial draft was put forth for discussion before professors, specialists working in teaching and non-teaching hospitals in respective areas. Personal visits to pharmaceutical shops and stores and collecting of first hand information from market were additional inputs in modifying this list.
4. Later a drug selection, formulation and standardisation committee was constituted, consisting of clinicians from APVVP for recommendations and finalisation of draft. This draft was circulated to all the APVVP hospitals for pooling suggestions, views and clarifications on the report from all the districts. Apart from these satellite seminars were organised by District Co-ordinator for discussing the draft report in their respective areas.
5. Simultaneously the draft was circulated for comments to State Drug Control Administration, Central Drug Control Administration, few experts in preparation of hospital formularies, Co-ordinator of All India Drug Action Network operating from the Voluntary Health Association of India. A final workshop was organised on Drug selection and hospital formulary in 1990 for approving the draft formulary.

C. Highlights of APVVP Hospital Formulary:

1. Unique features of the Approved drug list and hospital formulary:
 - a. Drug codes that would facilitate stocking and computerisation of inventory.

- b. Consumption classification: like fast moving, normal moving and slow moving which is used to draw up a rate contract for procurement of a drug or simpler purchase procedure and will be useful in determining the stocking level, reordering point for a drug etc.,
- c. Life saving status which is used to monitor the emergency preparedness status of a hospital
- d. Therapeutic category e.g. Anti malarial, Anti pyretic, Anti emetic etc. of each drug is included to facilitate reference by practicing clinicians.
- e. Budget classification has whether the drug is popular, basic and special.
- f. Preparation group like whether the drug is oral solid, small volume parenteral, Large volume parenteral, oral liquids, eye ointments, eye drops, ear drops, nasal drops, topical, oral drops, sera and vaccines, suppositories & pessaries, applicaps, vaginal tablets etc. were mentioned with relevant codes. This would facilitate inventory management.

IV. Yardsticks of hospital staffing:

1. The staff norms specified by government in 1977 served well for about a decade. During 1988-90 period staffing norms and job charts of certain categories of support staff was taken up. Mainly the effort was to consolidate multiple but compartmentalised role definitions into fewer categories. However comprehensive review of hospital staffing norms had to wait till the FRHS project period. Finalisation of clinical and diagnostic norms paved the way for formulation of detailed staffing and equipment norms.
2. In 1993 a workshop was organised to discuss the staffing norms. Detailed staffing norms for various categories of hospitals were finalised. Highlights of the new staffing norms include;
 - i. Increased cadre strength for laboratory and diagnostic services, increase in the number of senior and junior specialists, strengthening of biostatistics, addition of computer staff etc.,
 - ii. The concept of earmarking civil assistant surgeon posts as junior specialists was introduced. Earlier definitions did not distinguish junior level posts by speciality. Deployment of civil assistant surgeons to various specialities used to be done on an informal basis.
 - iii. Contracting out of certain facilities was suggested to improve the hospital functioning and to reduce the over heads. To reflect this change in management strategy certain posts were abolished. For example; carpenters, barbers, mechanics, cooks, refractionists etc.

V. Hospital equipment norms:

1. No comprehensive equipment norm for the public hospitals existed before formation APVVP. During the 1988-90 period a few equipment norms were developed mainly in response to casual requirements. These include the norms for deployment of ultrasound scanners, ECG machines, X-rays, hospital vehicles, telecommunication facilities etc. However more comprehensive equipment norms were developed during the FRHS period following the development of clinical and diagnostic norms.

2. Currently hospital equipment norms are defined for the following nine groups of equipment. These nine groups contain almost all kinds of equipment required by the hospitals.
 - i. Imaging equipment.
 - ii. Electro medical equipment.
 - iii. Pneumatic, hydraulic and mechanical equipment.
 - iv. Laboratory equipment.
 - v. Refrigeration and air conditioning plant.
 - vi. Hospital plant.
 - vii. Hospital furniture.
 - viii. Surgical instrument packs.
 - ix. Equipment required for administration and medical records.

VI. Standard specification of hospital mattresses:

1. Although Indian standards existed for coir mattresses, most of them are for house hold use. Mattresses have to specially designed for hospital use. For example full rexine coverage is required to prevent entry of any liquid or body fluids to which mattresses in hospitals are commonly used. Moreover standard specifications for the products like mattresses and linen will enable the hospitals to have assured quality of the products, to ensure better quality control on type of supply and will also facilitate comparison of financial offers made by different manufacturers and suppliers. Considering these points APVVP has prepared a standard specification of mattresses for hospitals. A Standards committee on Linen, Mattresses and Accessories was constituted in 1989 (Commissioner's proceedings No.H3/013135/ 88, dated 10-1-1989). The committee took up the task of developing the standards for mattresses first, as the need for standardisation in this area was maximum. Members were drawn from the Bureau of Indian standards, Hyderabad, the Coir Board, nurses and stores personnel in APVVP hospitals. Altogether standards for the 12 mattress products were developed. Each standard specification contains a description of its scope, material to be used, dimensions, construction, packing, and marking. Acceptance tests are described to facilitate clear and unambiguous handling of deliveries from suppliers by the stores personnel.

VII. Continuing education and practice guidelines:

A. Continuing education:

1. Quality of clinical service rendered by a hospital is primarily a function of professional competence of doctors and nurses practicing in the hospital. Maintaining high level of professional competence is possible only by continuing medical education. APVVP has been organising continuing education resources and activities with varying degree of success.
2. Following continuing education resources were organised during 1988-90:
 - i. District hospital libraries were established with specific budgetary allocation for purchase of books and periodicals. Six periodicals were identified for subscription by each district hospital library.
 - ii. A house journal, named Bulletin of Hospital Services, on monthly basis to disseminate information among professionals working in various hospitals.

Administrative authority and budget to pay for contingent expenditure for case report preparation. A system of district reporters was established to report news and events.

- iii. Monthly clinical seminars at every district hospital. Administrative authorisation and budget to facilitate attendance by doctors working in Community and Area hospitals in the clinical seminars on a rotation basis.
 - iv. Training programs for nurses, paramedical personnel, dental surgeons and medical personnel was organised at casual intervals to meet specific eventualities.
3. During the FRHS period training of personnel has been given a lot of importance. Upgraded hospitals are selected as training centres. Facilities for training have been set up with all teaching aids, libraries, and personnel. General duty doctors working in community hospitals, staff nurses, auxiliary nurses, radiographers, lab technicians, pharmacists, dentists, and doctors with post graduate degree who may be expected to manage condition in a sister discipline at Community or Area hospital of no specialist available in that discipline are being covered. Highlights of the FRHS project training effort would include;
- i. Training courses are designed after needs assessment. Training programs include; short course (week end, 1-2 weeks); placement at hospitals for practical training (few weeks), and distance learning packages.
 - ii. A training cell has been set up with Training Co-ordinator in Head quarters and in five District hospitals.
 - iii. Development of trainers from the existing cadres of civil surgeons through consultation at JIPMER, NTTC etc.
 - iv. Nurses training needs assessment was done with assistance from Academy for Nursing Studies. They also prepared training material and modules and training core group of trainees.

B. Practice guidelines (protocols):

1. To support the training activities FRHS project is preparing practice guidelines to correspond to each training program. These are to be viewed as study material for the training program and as practice guidelines to the participants. Till now books for the following two areas have been prepared and published.
 - i. Basic doctors manual: Obstetrics. Safe motherhood practices.
 - ii. Basic nursing concepts.

VIII. Some general observations and scope for improvement:

A. Scope for improvement:

1. Though APVVP has got many standards and quality control measures, if we clearly observe the trend of standardisation it is slowly getting diluted. The standards and standardisation processes formulated in 1988-90 were more practical, concrete, published and disseminated, but the present trend of standardisation methods and standards are a step backward few reasons could be assessed:
 - i. Under APFRHS project only the bidding documents, procurement policies, strategies of the project are considered as standards. Standards are not

disseminated to the grassroots levels / concerned personnel / service providers / standards executing members. No standards are published in a booklet / document form (for easy accessibility).

- ii. Poor library maintenance.
 - iii. Lack of in-house journal at present (though it was mentioned in the project implementation). The Bulletin of hospital services is not being published regularly. One alternative, to ensure regular publication, will be to assign editorial and day to day management responsibility to a health systems research organisation of professional publisher with some arrangement for publication of work done in APVVP hospitals and news reported from them.
 - iv. Hardly any internal evaluation studies were conducted or published which is one of the important quality control measure for various activities.
 - v. No annual reports are published to take stock of the status of the project or activities of project. It will be desirable to prepare annual reports. The annual reports can provide a regular forum for review and stock taking of activities during a year.
2. As the project is still going on there is scope to take corrective steps in response to the above feedback. On the whole it can be stated that compared to any other public hospital care system APVVP is providing best services in various areas. It is now in a position to take off and substantially improve the quality of its services if appropriate corrective and developmental steps are taken.

B. How to get APVVP standards:

1. APVVP has produced many standards. Some of these were formally released within the organisation. Some are yet to be formally released. But none are available for distribution outside of APVVP. Considering the importance of these documents and their usefulness to other hospital systems in the country, accessibility of these documents is important. Recognising this need and to meet its own research needs, the Institute of Health Systems has included most of these standards in its working paper series. Copies of IHS working papers can be obtained from the Institute's office either in person or by mail. A list of IHS working papers relating to hospital standards is appended to this paper.

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4. APVVP 1994; *A Note on Organisation and Achievements 1994*, Andhra Pradesh Vaidya Vidhana Parishad, Commissionerate of Medical services, Sultan Bazar, Hyderabad.

IHS workshop on Private Health Sector in AP

Sponsored by the AP First Referral Health System Project, Govt. of AP.

Day-1: May 23, 1998 Saturday

9.30 am to 10.30 am: Inauguration

Time	Speaker	Title of presentation
9.30a	Dr. Alex George, Director Institute of Health Systems	Welcome to guests and participants.
9.35a	Sri M. Nagarjuna IAS, Project Director, AP Health Systems Project.	AP Health Systems Project and private health sector in AP.
9.50a	Dr. Prasanta Mahapatra, Workshop Chairperson	An overview of private hospitals in Andhra Pradesh: Data from AP Health Institutions Database (APHIDB).
10.15a	Dr. Thyagaraja Reddy, President IMA.	Inaugural address.

10.30 am to 11 am: Tea break

11 am to 1 pm: Session-1

Time	Speaker	Title of presentation / subject of discussion	Reading material
11.15		Introduction of participants, choice of group for group discussion sessions	
11.30a	Dr. P. Mahapatra	Typology of health systems in OECD countries.	Paper with same title by P. Mahapatra
12.00a	Dr. P. Satyanarayana	Consumer protection Act and the health sector.	Paper with same title by P Satyanarayana
12.30p	Sri M. Nagarjuna	Report of the house committee on corporate hospitals.	None
12.3		Discussions & participants choice regarding discussion groups.	

1 to 2 pm: Lunch break

2 to 5 pm: Group discussions

Group and venue	Chair person	Title of presentation / subject of discussion	Rapporteur
Group-1	Dr. Balamba, Professor, ObGyn, Government Maternity Hospital	Relative strengths of private and public sector hospitals from the perspective of patient's medical condition.	Dr. Chandra Sekhar, Prof. SPM, Medical College Kakinada.
Group-2	Ms Rama Baru, Dept of Community Medicine, JNU, New Delhi.	How to assure quality of care by hospitals in AP?	Dr. PV Rao, Medical Superintende nt, NIMS

IHS workshop on Private Health Sector in AP

Sponsored by the AP First Referral Health System Project, Govt. of AP.

Day-2: May 24, 1998 Sunday

9 am to 10.30 am: Session-2

Time	Speaker	Title of presentation / subject of discussion	Reading material
9.00a	Sri Sunil Nandaraj, CEHAT, Mumbai	Accreditation system for regulation of hospitals.	Situation review and analysis of accreditation system in India, Sunil Nandaraj, IHS working paper #
9.30a	Ms Lipika Nanda, Lecturer in Hospital Administration, NIMS.	The need and scope for regulation of service quality of the private health sector in AP.	Paper with same title by Lipika Nanda. Designing an accreditation system for the health care organisations in AP.
10.00a	Dr. Appala Naidu, Institute of Health Systems	Assessment of demand for accreditation services in Hyderabad. A pilot study.	Assessment of demand for accreditation services in Hyderabad. A pilot study; Mahapatra P. and Shailaja Rajaratnam, IHS Working paper # VI.

10.30 am to 11 am: Tea break

11 am to 1 pm: Session-3

Time	Speaker	Title of presentation	Reading material
11.00a	Dr. Alex George, Director IHS	Womens' perception of the quality of reproductive care at private hospitals in AP.	Womens' perception of the quality of reproductive care at private hospitals in AP, Alex George.
11.30a	Ms S. Srilatha, IHS	Standards and quality control measures in Andhra Pradesh Vaidya Vidhana Parishad.	Standards and quality control measures in Andhra Pradesh, S. Srilatha.
12.00n	Dr. P. Mahapatra, Hon. President, IHS	Understanding the evolution of private health sector in AP: planning for the future.	

2 to 5 pm: Pannel discussion

Role of private health sector and enabling policy options:

Chairperson: Dr. Shyam Sundar, Vice Chancellor AP University of Health Sciences.

Pannelists:

- | | |
|---|---|
| 1.Sri M. Nagarjuna,
PD AP First Referral Health Systems Project. | Dr. Venkat Rao, Member Medical Council of India |
| 2.Dr. M.Thyagaraja Reddy, President IMA | 3.Dr. Eswar Rao,
Secretary Nursing Homes Association |

Program:

1. Presentation of group discussion reports
2. Pannel discussions,
3. Closing remarks by Chairperson.

Dr. Prasanta Mahapatra

IHS workshop on Private Health Sector in AP: May 23-24, 1998.

List of participants

1. Dr. P. Balamba, MD.DGO Government Maternity Hospital, Nayapool, Afzalgunj, Hyderabad.
2. Dr. U. Eswara Rao, M.S, General Secretary AP Private Hospitals and Nursing Homes Association. IMA Building, Sultan Bazar, Hyderabad-95.
3. Dr. Brahmeswarao MD Prof. & Head of the Dept. of SPM Osmania Medical College Hyderabad - 95.
4. Dr. Manimala Rao, Incharge Director, NIMS Panjagutta, Hyderabad 500 082.
5. Dr. A. Lakshmi MD DGO Commissioner APVVP Sultan Bazar, Hyderabad - AP 500 095
6. Dr. Prasanta Mahapatra M B B S;IAS. President Institute of Health Systems 5-9-22-27, Adarshnagar, Hyderabad - AP 500 063
7. Dr. Alex George Director Institute of Health Systems 5-9-22-27, Adarshnagar, Hyderabad - 500 063
8. Dr. Appala Naidu, M D, Faculty Institute of Health Systems 5-9-22-27, Adarshnagar, Hyderabad - 500 063
9. Dr. Mohd Rafiq, Dr.P.Ramachandra Reddy People's Poly Clinic, Shankara Agraharam, Nellore 524001.
10. Dr. M. Thyagaraja Reddy, President, Indian Medical Association, AP.State Branch, IMA Building, Sulatan Bazar, Hyderabad-95. Dr. M. Thyagaraja Reddy, Vijaya Nursing Home, Proddatur - 516 360. Cuddapah
11. Dr. Rama Baru, Lecturer, Dept of Social and Preventive Medicine, JNU New Delhi 110067
12. Dr. V. Brahma Reddy, People's Health Society Hospital, Dr. Brahma Reddy Nagar, Doopadu (PO), NH-7, Kurnool - 518218.
13. Dr. Raghavaprasad MD Prof & Head of the Dept. of SPM, SV Medical College, Tirupathi.
14. Dr. Chandrasekhar, MD. Prof of the Dept. SPM, Rangaraya Medical College, Kakinada.
15. Dr. G. Sham Sunder Vice-Chancellor, NTR University of Health Sciences, Vijayawada-8, A.P.
16. Dr. T.S.R. Sai Director, A.P. School Health Project, Gaganvihar, 11th Floor, Nampally, Hyderabad -
17. Dr. N.V. Lakshmi, Govt.S.B.B.H. Hospital, Shalibanda, Hyderabad.
18. Dr. B.V.S. Sarada, Govt.S.B.B.H.Hospital , Shalibanda, Hyderabad.
19. Dr. V. Prasada Rao, Govt. Civil Dispensary, Panjagutta, Hyderabad
20. Dr. K. Bhaskar Reddy, Area Hospital, KingKoti, Hyderabad
21. Dr. A.N. Vijay Kumar, Area Hospital, Kingkoti, Hyderabad.
22. Dr. C.S. Sai Ram Gopal, Govt. Area Hospital, Nampally, Hyderabad
23. Dr. P. Syamadevi, Govt.Area Hospital, Nampally, Hyderabad.
24. Dr. M. Sujatha, Govt. Area Hospital, Nampally, Hyderabad
25. Dr. D. Madhavi Latha, Govt. Area Hospital, Nampally, Hyderabad
26. Dr. M. Chandrasekhar Reddy, Govt. Area Hospital, Malakpet, Hyderabad
27. Dr. D. Venkateswara Rao, Govt. Area Hospital, Malakpet, Hyderabad
28. Dr. Ramesh, Joint Commissioner APVVP, Sultan Bazar, Hyderabad
29. Dr. T. Srinivas, Dy. Executive Bio-Medical Engineer,
30. Dr. Srinath, Dy. Commissioner APVVP, Sultan Bazar, Hyderabad
31. Dr. CH. Sudhakar, KingKoti Hospital, King Koti, Hyderabad.
32. Dr. Narayana, Medical Superintendent, King Koti Hospital, King Koti, Hyderabad
33. Dr.(Lt.Col) T. Dayakar Thota, Consultant Hosp.Plng & Mgt, A-34, Vedvihar, Subhash Nagar, Secunderabad, AP 500 015
34. Dr. P. Raji Reddy, Govt. Area Hospital, Kingkoti, Hyderabad
35. Dr. M. S. Madhusudhan Rao, Govt. Area Hospital, Kingkoti, Hyderabad
36. Dr. M. Aruna, H.No. 12-7-162/7/1, Mallupadu, Secunderabad

IHS workshop on Private Health Sector in AP: May 23-24, 1998.

List of participants

37. Dr. L.J. William, 26 C, Shantishikara Apartments, (Raj Bhavan Road), Somajiguda, Hyderabad.
38. Dr. N.G. Balaraj. Govt. Civil Dispensary, Dood Bowli, Hyderabad.
39. Dr. C. Sai Ram. S/o. C. Narahari. H.No. 3-6-779/6, Street No. 14, Himayathnagar, Hyderabad.
40. Dr. P. Vasantha Kumari. Govt. Civil Dispensary, Aliabad. H.No. 16-7-738/1/A, Chaderghat, Hyderabad.
41. Dr. G. Lakshmi. Civil Dispensary, Sanathnagar, Hyderabad.
42. Dr. A. Aparna. Area Hospital, Nampally.
43. Dr. B. Chandra Shekar. Civil Dispensary, Musheerabad, Secunderabad.
44. Dr. Pramila. Community Hospital, Vanasthalipuram, Hyderabad.
45. Dr. K. Subbalakshmi. Community Dispensary, Malakpet, Hyderabad.
46. Dr. P. Sridhar. Hospital Administration Trainee, NIMS, Punjagutta, Hyderabad.
47. Dr. V. Vishveshwara Rao. Area Hospital, Malakpet, Hyderabad.
48. Dr. S. Mathoor. Govt. SBB Hospital, Shalibanda, Hyderabad.
49. Dr. N. Jaya Prakash. Govt. Hospital, Malakpet, Hyderabad.
50. Dr. D. Srinivasulu. Dy. Civil Surgeon, Civil Dispensary, Yakut Pura, Hyderabad.
51. Dr. S. Prabhakar Rao. Civil Dispensary, Aliabad, Hyderabad.
52. Dr.C.L.Venkata Rao, Surgical Gastro Enterologist, Medwin Hospital, Nampally, Hyderabad.
53. Dr.P. Satyanarayana, Mediciti Hospitals, Hyderabad
54. Dr.P.V.Rao, Medical Superintendent, NIMS Panjagutta, Hyderabad 500 082.
55. K. Vijaya Lakshmi, N.G.O's Clinic, Nampalli, Hyderabad.
56. Mr. M. Nagarjuna IAS Project Director, A.P. First Referral Health System Project: A.P.V.V.P, Sultan Bazar, Hyderabad - 500 095
57. Mr.Sunil Nandaraj, 310, Prabhu Darshan, Swatantra Sainik Nagar, Amboli, Andheri (W), Mumbai
58. Mrs. Lipika Nanda, Lecturer, Dept. of Hospital Administration, Nizams Institute of Medical Sciences, Panjagutta, Hyderabad - 500 082.
59. Ms. Hema Nalini, Principal, College of Nursing Somajiguda, Hyderabad-500 049
60. Ms. Onili Salinis, Prinicpal, Princess Esin School of Nursing, D.No. 22-3-643, Purani Haveli, Hyderabad 500 002.
61. Ms. S.Srilatha Faculty Institute of Health Systems 5-9-22-27, Adarshnagar, Hyderabad - 500 063
62. Prof. Dr. G. Sreenaiah. APFRHS Project, APVVP, Sultan Bazar, Hyderabad.