CHAPTER I

SOCIAL TRANSFORMATION OF 'NOT-FOR-PROFIT' MEDICAL CARE INSTITUTIONS
Social Transformation of 'Not-for-profit' Medical Care Institutions

Introduction

There is plurality in patterns of provisioning of medical care and the two major actors are the public and the private sector. The former is largely owned by the state or quasi-state actors and premised on the idea of citizenship and principles of equity, universality and social justice. Public institutions are set up by the state at various levels from district, state to the centre. The latter includes primarily all non-state owned institutions that include the market and can be categorised into 'for-profit' and 'not-for-profit' sectors. For the purpose of the thesis the terms 'not-for-profit' and 'non-profit' are being used interchangeably.

It is important to differentiate between the 'for' and 'not-for' profit sector. As the name suggests the former is guided by the motive of profit making and functions as any other commercial organisation. The ownership type of such a hospital could be private limited, public limited or sole proprietorship and are subjected to tax laws as applicable to the respective ownership type. Arrow (1953) states “The very word profit, is a signal that denies the trust relationship” unlike the ‘not-for-profit’ sector. The term ‘non-profit’ and ‘not-for-profit’ sector has come into usage in recent times but emerges from terms like the ‘charitable’ and ‘voluntary’ sector. Capital costs in the case of non-profits are much lower than the for-profits as the former benefits from private philanthropy and government subsidies. Scholars have attempted to distinguish the non-profit as the third sector that lies between the State and ‘for-profit’ in its present form. The non-profit is heterogeneous with varying objectives, sizes and the areas they cater to. Scholars have primarily raised issues of trustworthiness, fairness, and equity when discussing the non-profit hospitals. These institutions are perceived as engaging in ‘trustworthy’ behaviour that arises from the notion of them being held in trust for the public. Issues of community service, pricing, charity, meeting donor expectations, subsidised services, commitment to place and involvement in the community are also seen as characteristic of this sector. The organisations in the non-profit sector share distinct characteristics: they possess an internal organisational structure, they are structurally separate from the government, and they do not generate profits that are distributed to members. They are registered as public trusts and societies, are exempt from income tax as they are intended to provide charitable services and are supposed to utilise the

1 Kenneth Arrow (1963) and Hansmann's (1980; 1985) works look at the behaviour of non-profits and look at quality, efficiency and trustworthiness in non-profits
surplus generated for the maintenance and growth of institution, and work within a legal framework with a board of trustees or members (Robinson and White, 1997).

This thesis examines the evolution of 'not-for-profit' sector in medical care and its transformation from the late 19th century to the present times with reference to Delhi. Non-profit institutions have emerged from notions of charity and philanthropy and the idea of charity is intricately linked to major world religions.

**Charity and religion**

'Charity' can be defined as “a system of giving money, food or help free to those who are in need because they are ill, poor or homeless, or any institution which is established to provide money or help in this way” (Cambridge Dictionary). Thus, charity is a term that refers to the act of giving to people in need, providing relief for the poor and indigent. All major religions of the world recognise charity as an act of justice, right of every individual not to be deprived, an obligation or duty towards society and/or a way of attaining spiritual growth.

The concept of charity was institutionalised by major religions. For example, in Islam, charity is seen as an amplification of the ideal of community within the religion. The law of Zakat is to take from those who have wealth and give it away to those who do not. This rotation of wealth was seen as a way to reduce social inequality. It was considered an act of worship rather than social service. Islam has established this institution to make concern for the poor a permanent and compulsory duty. This means giving an annual contribution of two and a half percent of one's income for public welfare. Similarly, charity in Judaism i.e. Tzedakah is derived from terms like righteousness, justice or fairness. The obligation to perform tzedakah can be fulfilled by giving money to the poor, to health care institutions, to synagogues and educational institutions. Christian charity has been an integral part of European civilisation. Charity is seen as almost synonymous to love and kindness and not merely benevolent giving. In medieval Europe the Church bore the responsibility for organising and promoting poor relief and according to Christian theology is one of the virtues following faith and hope. In Hinduism, the concept of charity has been a significant aspect of an individual's religious duty and obligations. Daan is the Hindi term for Charity. In Hindu philosophy, daan (charity/donation to the poor) is one of the supports which hold up dharma (way of life or path of righteousness). The Buddhists believe that the daily act of offering alms-food to the Sangha (group of monks) is the main cause for the perpetuation of the
Buddha's teaching. They occasionally make other donations such as inviting the monks to their home and offering food and so on which is part of their dharma.

In most of the religions there is reference to what constitutes an act of charity and what does not and it is discussed through motives of the one who gives and the one who takes. There are those individuals who do not 'deserve' or 'qualify' as recipients of charity. Therefore, most religions define what they mean by charity and the ways in which it can be dispensed. Other than independent charitable acts, donations by individuals used to be mostly channelled through religious institutions like, church, mosque, synagogues or temples that set up educational, health and other institutions for the poor and deprived.

The study of charity and philanthropy raises certain key issues: the social and political contexts of giving, the motives and aspirations in play between various actors, the status of the charitable act in varying cultural environment. The motives of charitable giving have received considerable attention whether it is a way of social control, to achieve individual gains or simply a state of mind.

**Charity and role of the State**

The changing ideas of charity and philanthropy in varying contexts have shaped the present day non-profit sector and its institutions. History shows that charity has often been sustained by subsidies from religious institutions, nobility, monarchy and in more recent times, the welfare State. Charity therefore exists in all contexts but what is important to study is its changing meaning and practices as it adapts to changing contexts. This can be observed in the context of the major periods categorised as pre-welfare, welfare and the era of growth of markets.

In pre-welfare states, charity played a greater role as the State did not play a paternalistic role of providing to its inhabitants. Many services therefore were provided through voluntary efforts of individuals or religious organisations. The idea of citizenship and providing for citizens emerged with welfare State. With the beginning of welfare measures, the State took up responsibility of providing certain security measures for its citizens – employment, health, education and other social security measures. It is observed that the role of charity does not disappear with the strengthening of the welfare State across countries. The country experiences suggest that it changes and assumes newer forms. It is also observed that private charity was supported by the State through public subsidies for their financing and provisioning and both were mutually dependent. Private charity can also play an independent
welfare State became dominant post Second World War it assumed various forms and provided space in various ways to the private voluntary sector to play a role in social welfare provisioning. Welfare State has therefore, given space for the rise of a mixed economy and hence the existence of the non-profits. Gradually in the late 20th century with the further opening of markets, the State withdrew or minimised its role in several welfare sectors. The State therefore, gave further space to the private sector and this period saw the emergence of newer forms of charity, philanthropy and redefinition of this sector to being the non-profit.

**Charity in medical care**

The role of charity in medical care has been dominant in all cultures across the world. Medical charity has had institutional and non-institutional forms. The relationship between charity and medicine has been significant in history and pre-dates the welfare state.

Historically, the rise of non-profit medical institutions has been closely linked to charity and religious orders. Most hospitals before rise of the welfare state were charitable or voluntary, were meant for the poor and supported by religious organisations. Institutions were limited to being rest houses for travellers and provided palliative care for the sick poor. They were run by endowments from traders and religious institutions and were mostly faith-based. There was a close relationship between religious groups and setting up of hospitals. Historical records show that hospitals were established by Buddhists as early as 600 BC. Temples used to serve as medical schools and resting place for patients during this period. Islam and Christianity came later and in both religions the concept of establishing hospitals for the poor existed. In 335 AD Christian hospitals began being built with the spread of Christianity. Hospitals were an outstanding contribution of Islamic life. In Judaism too there is evidence of hospitals set up by synagogues across Europe (Turner, 1995).

Hospitals emerged in larger numbers with the rise of modern medicine when it was ascertained that cure was available in the later part of 19th century. Medicine as a profession gained status with the growth of medical science and technology. Simultaneously, existing voluntary hospitals transformed with the demands created by the profession and the middle classes who started entering these institutions. Hospitals also were able to sustain due to middle class endowments. With the coming of welfare State and the greater role played by it, many countries nationalised their health services system like UK. On the other hand many other countries who adopted a welfarist perspective either let the existing non-profit hospitals provide curatives services by bringing in state controls in funding and regulation or let them
function independently of the state. With globalisation and liberalisation of markets, there was a greater role played by the market. This led to changing values and aspirations in society and charity adapted new contexts. The market penetrated all sub-systems of the health services like medical education, financing, and technology. In the context of greater role played by markets in medical care, the non-profit sector in its present form is often clubbed with the for-profit sector and often both are referred to as the non-government sector. There has been therefore, a need to look at the complexity of charity and state; charity and economic growth and rise of markets; and charity and medical hegemony.

The thesis attempts to address the following questions —

- What has been the history of 'non-profit' hospitals- what were the values, aspirations and motivations that influenced their emergence?

- How has the State, the larger social structure, development of modern medicine and scientific knowledge shaped and influenced transformation of hospitals through time?

- In the era of commercialisation how have these institutions been redefined? How have the values and aspirations of providers of this sector transformed? How do old non-profit hospitals co-exist with the new non-profits and for-profit sector? How do non-profits behave and how is their behaviour different from profit-maximising for-profits? Does it have characteristics that could differentiate it from the for-profit sector in the present context and are the old non-profits different from the newer ones?

In order to address the above questions we believe that the study of social transformation of institutions is premised on an understanding that they are dynamic and ever changing and that there is a permeation of boundaries between the internal milieu and the external environment. This dynamism can only be fully understood if one takes a historical perspective that takes into account and explains the changing role and function of institutions within the changing socio-economic context. This study focuses on the social transformation of non-profit hospitals over the last hundred years in Delhi. It locates the transformation

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2 Rosengren (1980) states, "Note must be taken of the hospitals' fundamental general collectivity orientation, involving external democratisation, surrounding political and social pluralism, and a continued threat of boundary permeation by others...sacredness, scientism, professionalism, technocracy and bureaucracy - have at one point or other entered in to the hospital structure historically, remained there, and presently contribute the enormous asymmetry that now characterises the relationships of hospitals to their internal milieu and their external environments."
through the birth and evolution of these hospitals from the colonial period through the various stages of development during the post independence period right up to the present.

There is considerable variation in the history and evolution of the non-profit hospital sector across the world. Several studies show that historically, the evolution of the non-profit hospitals was rooted in notions of charity and voluntarism. These institutions may or may not have received subsidies from rulers and the state and were supported by religious groups, merchant guilds and/or public donations. The motivations were largely religious obligations, gaining identity and status, a means of social control and/or providing palliative services to the poor. Studies from Europe and North America also show that religious organisations played a major role in establishing voluntary institutions but the role of merchant guilds and the middle class was of equal importance in establishing and sustaining these institutions through endowments and paying for services. An important issue of debate was the access of these institutions for the poor. These institutions were not open to everyone and therefore not charitable in their true sense. But interestingly even the state had made these differentiations when they reformed the poor law as in the case of England. The poor houses evolved into asylums and hospitals to accommodate the sick and made the differentiation between the able and not-able bodied and hence those who did not deserve to get poor law benefits and those who did. Interestingly, scholars note that such classification of ‘deserving’ and ‘non-deserving’ seem to have a close relationship with the rise of a market economy and hence this is observed more in the context of industrial revolution in England (Barry and Jones, 1991).

Until the late 19th century, medical care and relief was largely in the hands of religious organisations and were non-profit in nature. Their presence was small and scattered in terms of location. State intervention in health services came much later. History of state’s role in health services in Britain and Germany shows that state intervention in health services began only during the latter half of the 19th century through the creation of the National Health Insurance and Social Health Insurance respectively. The state gave subsidies in the form of insurance for mainly the working classes. During this period there were very few medical institutions run by the government. In UK, it is only during the post Second World War period that the State through the Beveridge committee report invested in health service institutions and took over the non-profit institutions. In the United States on the other hand, public and private hospitals were distinctly kept separate. Public hospitals were stigmatising and served the sick poor unlike the voluntary hospitals that served largely the middle class population and ‘deserving’ poor.
The character of the so-called third sector gets revived as distinct with the onset of liberalisation and growth of commercialisation where the newer non-profit may have received subsidies from the government in the form of land, tax exemption, concessions for import of equipment and technology and medical research. The shifts in motivations are also visible as they no longer view themselves as being 'charitable' in the sense of the old institutions and many old ones have undergone change in their role and functions.

Rosenberg's (1992) and Starr's (1982) work on the transformation of institutions in the American context are important in terms of the theoretical and empirical findings. Rosenberg's (1992) study of Philadelphia almshouse to a general hospital and then the closing down of the hospital spans over a period of one and a half century. He explains this process by locating it within the way in which the socio-economic processes, growing acceptance of germ theory in late 19th century defined the changes in the role and function of the institution. The institution transformed along with the changing structures and values of the larger society through the 19th and 20th century America. He shows that "the institution’s internal order and its process of recruitment mirrored closely the values and relationships that reigned outside it". He argues that social class and location and severity of illness were important determinants in deciding who got admission in hospitals. This public almshouse and later the public hospital was always a last resort and had city’s poor as its inmates. He also locates the functioning of the hospital in relation to the voluntary hospitals in the city. A significant motivation of the rise of private hospitals and dispensaries was the desire to maintain distinction between the hardworking poor and the almshouse's poor. For the medical profession too, the public hospital appointment was less desirable than the private hospital. They saw the municipal hospitals as overcrowded and having very low standards and also lacked facilities that were available in a private hospital. He says, "Like any social institution, the Philadelphia almshouse-hospital was obviously a microcosm of the social values, structures and careers which characterised the larger society outside it". The hospital had the bulk of chronic cases and the aged because the other voluntary hospitals refused to take them. With the growing acceptance of germ theory, the municipal hospital also developed a clinical laboratory and radiological services by bringing the X-ray. The hospital therefore became a prominent research and teaching institution and by the First World War had at least a dozen specialties. Demands made by problems of age, race and chronic diseases in society put pressure on the hospital in the 20th century. Although the Philadelphia General Hospital reached its peak in the beginning 20th century it closed in 1977. Rosenberg sees it clearly as the outcome of the chasm in social value between the public and the private sector.
in America. Till the end, class and social location were the primary determinants of who would occupy the hospital beds.

Starr (1982) discusses the transformation of American medicine to its present form by taking a historical and structural perspective that looks at the underlying patterns of social and economic relations. He sees the development of medical care taking place in the fields of power and social structure and that the process of transformation has to be understood in reference to the changes in material life and social organisation.

This thesis draws the frame of reference from these two important studies and studies the social transformation of the non-profit hospitals in India. Based on a cross sectional survey of non-profit hospitals in Delhi, it attempts to reconstruct the evolution and change that this sector and institutions have undergone over the last century by building on Rosenberg’s and Starr’s framework. The historical and structural perspective provides the framework to analyse the transformation of these institutions. The key elements/markers that bring about these transformations include: the changing role of the state and the market, the changing social structure - rise of the middle classes and changes in expectations, beliefs and values; the changes in the knowledge base of medical practice, and changing demographic and epidemiological profiles. Each of these elements will be traced through three key periods that are significant to the analysis of this transformation: colonial period; post-independence (1947-1980) and 1981-present (opening of markets and liberalisation).

**Changing Nature of the State and Shifts in Medical Care**

The changing nature of state in welfare provisioning and the rise of market are imperative to understanding the transformation. The role of the state and the market is important to understand the emergence of different types of medical institutions and their influence on various sub-systems of health services like technology, medical education, and finance.

While during the colonial period, institutions were largely influenced by colonial ideologies of laissez faire where there was limited State funding for general population and greater role played by religious charity; post independence India adopted a welfare framework where the State was to assume the greater role. The idea of a welfare State emerged in Europe as a response to the risks of the industrial economy within the framework
of a nation state. In moral terms, the welfare state promised a more universal, classless and just society. Welfare measures before this was sporadic, not universal but targeted towards certain sections. It became political project of nation-building only post Second World War. A welfare State assumes primary responsibility for its citizens in providing for welfare measures like health, education, social security and so on. This responsibility in theory is that of comprehensiveness, universality and equity, because all aspects of welfare are applied to citizens as a right. Ideally a welfare State would encourage a dominant role of the State that is paternalistic in nature but even within this understanding there are variations. Epsing-Andersen (1990) has identified what he calls the ‘three worlds of welfare capitalism’; social democratic, conservative and liberal. The social democratic welfare states (for example the Nordic countries of Sweden, Denmark, Finland and Norway) emphasise universal welfare rights. The conservative welfare states offer generous benefits but these are based on employment status and the liberal economies leave most provisioning to the market as in United States and Canada but the State regulates and has some social security measures in place. In such dominant market economies there is minimum state intervention. Economy in welfare states, therefore, is mixed, with both public and private services where either one could play a dominant role in provisioning, financing, regulating and monitoring. The non-profit sector has existed in such mixed economies but it shapes and redefines itself along with the dominant ideology at a given time. Many countries post second world war became self-proclaimed welfare states more to foster national social integration. India was one of them. Although India declared its welfarist orientation post-independence, due to low investment in the social sectors the market got space to grow. The emergence and transformation of non-profit institutions therefore needs to be understood in the context of this changing role of the State and market.

Changes in the Social Structure, Rise of the Middle Classes and Change in Medical Practice

The changing social structure in society and the role of the middle class is the next important factor in the process of transformation. While each phase will look at the social basis of promoters of that period; it is the role of the middle class that will be brought to the forefront. The middle class identity has to be seen historically. Their role is critical to understanding transformation of non-profit institutions. Here, the analysis will emphasise on
the role of middle classes\textsuperscript{3} who emerged in large numbers and played a critical role in independent India. While in post-independence India they dominated public sector institutions, post liberalisation sees the emergence of a new middle class in a market driven economy. The role of the middle class is being seen as important to the changing values and aspirations in society that also gets reflected in the way the medical profession organises itself and their role as a class making demands on the health services system.

The phrase ‘the middle class’ covers a broad spectrum of people working in many different occupations, from employees in the service industry to school teachers to medical professionals. Members of the middle class, by merit of their educational credentials or technical qualifications, occupy positions that provide them with greater material and cultural advantages than those enjoyed by manual workers. While this distinction is useful in forming a rough division between the middle and working classes, the dynamic nature of the occupational structure and the possibility of upward and downward social mobility make it difficult to define the boundaries of the middle class with great precision. The middle class is not internally cohesive and is unlikely to become so, given the diversity of its members and their differing interests (Giddens, 2002).

The idea of the middle class in India was developed by K.N. Raj to argue that these social classes were important since they stood between the proletariat and the bourgeoisie and formed the bulk of the population whose prospects for growth had improved. He defines these middle classes as ‘all those who had income from property, earned along with input of own labour’, and calls them the ‘intermediate class’ (cited from Unni, J. 2006). Unlike the Marxist perspective that only includes tangible assets in property, he treats possession of certain types of education and skills that could be administrative, managerial, scientific or technical.

Deshpande (2006)\textsuperscript{4} states that in India the emergence of the middle class was related to the creation of multiple and intermediary rights in land, the need for subaltern

\textsuperscript{3} Class has different meanings in different contexts. According to Marx, class is defined as a relationship between two categories of people who need each other, in which one category dominates and economically exploits the other. For the present study it is important to understand that this concept derives from the close association of the dominant classes with the legal and economic power structure of the nation.

\textsuperscript{4} Deshpande (2006) states that ‘middle class’ is a popular term in lay and academic usage where the term is self-evident on one hand and has a wide variety of meanings on the other. He says that we are ill-informed about what constitutes the ‘non poor’ and the usage of the word ‘middle class’ within it seems to have acquired various meanings. Firstly, the term ‘middle class’ in popular usage has come to mean ‘people like us’. He says, ‘middle class has an almost universal appeal as a self-descriptive label. In other words, when given a choice
administrative-professional functionaries to assist in colonial governance, and the advent of western-style educational institutions. The middle classes also played a leading role in the anti-colonial struggle and they acquired a critical role in post-colonial state and society.

Changes in the Socio-demography and Epidemiology

An additional dimension to this conceptual framework of social transformation of non-profit hospitals will be the epidemiological and demographic transition. Omran (1971) first used the term ‘epidemiological transition’ to characterise the regular transformation of pattern of causes of death. He states, “Conceptually, the theory of epidemiologic transition focuses on the complex change in patterns of health and disease and on the interactions between these patterns and their demographic, economic and sociologic determinants and consequences. An epidemiologic transition has paralleled the demographic and technologic transitions in the now developed countries of the world and is still underway in less-developed societies.” (Omran, 1971)

Disease transition in society and understanding of causation of diseases has had a role to play in the way medical institutions shaped. Recent studies have shown that India is undergoing a rapid epidemiological transition as a consequence of social and economic changes. Studies indicate that the gap between communicable and non-communicable diseases is decreasing (GOI, 2005). Epidemiological transition also has to take into account the changing demography. Reduction in death rates and increase in life expectancy has resulted in demographic transition. As a consequence there is a larger cohort of elderly population who suffer mostly from non-communicable diseases. This cohort also needs services that are specific to this age group.

It is also important to discuss the dominant framework within which disease causation is situated at a given time. Different eras in epidemiology have emerged along with disease

about how to describe themselves, most people - no matter what their socio-economic situation - prefer to say they are ‘middle class’". Deshpande goes on to say that the basic meaning of ‘people like us’ has a variety of context dependent meanings. In many Indian contexts, middle class means ‘respectable people’ and is often used as a code for upper caste. Other connotations include being educated, well-off, and belonging to the ‘service class’. It involves the claim of being the ‘moral majority’ and a group that ‘deserves better’. The Indian middle class is definitely not a large proportion of the population but a very small minority. Or, more accurately, the social groups that are usually referred to by the label ‘middle class’ undoubtedly constitute a small minority of the Indian population, even if they may be significant in absolute numbers. Besides, what is popularly called the middle class is actually not in the middle but almost at the top of the income distribution.” It is evident from the expenditure data that he provides that the Indian middle class is located much higher in the income expenditure hierarchy (Deshpande, 2006).
transitions in society and with shifts in the understanding of causative factors. Susser and Susser (1996) categorise these eras into three periods - the first being the miasmatic era where the environment was seen as the causative factor; to infectious disease epidemiology where the germ was seen as the major causative factor and then to chronic disease epidemiology where causative factor is seen as the risk taken by individuals. Both epidemiological and demographic transitions and the dominant framework within which causative factors of diseases are located create demands on curative services which are an important factor in the way medical institutions shape.

There is a dialectic relationship between the larger transitions in society and medical institutions. On the demand side is the role of the state and market, change in social structure and values, change in knowledge base of medicine and epidemiological and demographic transition that influences the supply side by shaping the culture of institutions and bringing forth structural changes in terms of a) size of the institutions; b) scope of the institution like increase in specialisations and various departments; c) the composition of personnel in terms of numbers as well as their status within the institution and also their motivations, values and aspirations; d) patient profile of the given institution – who are included / excluded from these hospitals; e) the role of non-clinical staff like management and administration. The following figure provides a schematic understanding of the conceptual framework of the study and shows the complex process and interactions at various levels. The institutions supply and deliver care and attempt to fulfil the demand side but at the same time also create a supply-induced demand and hence this schematic representation has to be seen as an interactive whole.

Figure 1.1 - Social transformation of hospitals
Objective

The overall objective of the study is to look at the emergence, interactions and social transformation of non-profit hospitals.

The specific objectives are:

i) To provide an overview of the evolution of the non-profit hospitals in Europe, North America and India;

ii) To study the social basis of the promoters of non-profit hospitals in India and in Delhi and to understand their motives, desires, beliefs;

iii) To study the magnitude and characteristics of this sector in India and Delhi

iv) To study the factors influencing the process of transformation in the larger society and its impact on the infrastructural and cultural aspects of the non-profit hospitals through a cross-section of non-profit hospitals in Delhi.

Research Methodology

Study Design

For the purpose of this thesis, the non-profit in its present form is defined as those institutions that are registered either as a Society or Trust; are exempt from income tax; and are intended to provide some charitable services and/or cross subsidies. The terms ‘charitable’, ‘voluntary’, ‘third sector’, ‘non-profit’ and ‘not-for-profit’ are used interchangeably.

The study is divided into four parts -

1. Review of literature of emergence of non-profit hospitals and actors involved in the sector specifically for Europe and India
2. Research of archival documents to look at history of hospitals in colonial Delhi
3. The characteristics of the sector in Delhi have been mapped through a questionnaire survey. The broader design forms a cohort of non-profit institutions. A ‘cohort’ literally means a group with some common characteristics. Here the institutions are classified in to three separate cohorts based on their period of emergence.
4. The intent to understand the process of transformation has been largely guided by a qualitative research design. This has been carried out through in-depth interviews where individuals/actors make sense of transformation by understanding the contexts and processes. The study will look at the socio-economic and political contexts over a period of time. Prevailing structures of politics and society and also personal histories of particular individuals, families or groups are important to construct a period in time. The aim is to focus on the respondents' perceptions and experiences. This helps in the understanding of the complex interactions. The paradigm within which this study is based is primarily interpretivist where the goal is to understand the complex world of lived experience from the point of view of those who live it (Shwandt, T.A. 1998). The aim of interpretivism is to understand human action. In this approach, human action is regarded as being inherently meaningful, and hence to understand a particular social action, requires the inquirer to grasp the meanings that constitute that action. The aim is to ‘get inside the head of an actor to understand what he or she is up to in terms of motives, beliefs, desires, thoughts and so on’ (ibid., 1998).

The Procedure: Steps in Research

1. Sampling:

*Why Delhi?*

The name Delhi for this study refers to the National Capital Territory. The choice of doing such a study in Delhi is informed by various factors. Firstly, most of the non-profit hospitals are present in urban centres of India. Secondly, during the British rule, Delhi, being the imperial capital saw the emergence and rise of many institutions. The decade following the partition provides an important political and social context when numerous trust hospitals emerged in the capital. Delhi is the centre and hub of many activities and changes and policy decisions occurring in the changing socio-economic and political scenario are more visible. The post-liberalisation period has also seen the emergence of new trust hospitals particularly in urban cities. Lastly, the researcher has been born and brought up in this city and has been part of some of the transformations and shifts that have taken place in the city. *(Map I.1)*
Map 1.1 – National Capital Territory of Delhi: The Administrative Territories (2001)

Source: Census of India 2001

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The Universe and the Sample

For the purpose of the study only those allopathic institutions that were registered for the year 2006 have been taken. This study primarily focuses on secondary and tertiary level medical institutions.

Primary level institutions are the non-governmental organisations working at the community level. The primary level institutions working on health issues have been mapped through secondary literature and data available from various organisations. List of primary level non-profits in health services was gathered and compiled from various sources – Voluntary Health Association of India, Delhi chapter of the Jan Swasthya Abhyan.

For a comprehensive list of the universe of non-profit allopathic hospitals in Delhi, the researcher had to try out various methods. The Nursing Home Cell of the Directorate of Health Services (DHS) registers Nursing Homes and Hospitals under the Delhi Nursing Home Registration Act of 1953. All new private (for-profit and non-profit) bedded facilities have to register with the Directorate and all these private bedded institutions have to renew their registration annually. Within this the non-profits are those that are registered as trusts and societies, are exempt from income tax and are supposed to utilise the surplus generated for the institution, and work within a legal framework with a board of trustees or members. The final list of non-profits is based on the list of registered nursing homes and hospitals with the DHS for the year 2005-06. In 2005-06, 563 hospitals and nursing homes were registered in the list of private hospitals. Even though it is mandatory for all hospitals to register annually, it needs to be noted that all hospitals registered in a particular year might not register in the next year. Some may not re-register while some new ones may register. This has implications for monitoring and regulating the private sector as the total number of hospitals that register for a given year is much less than the total number of hospitals and nursing homes that actually exist.

For the purpose of collecting this data the researcher had to put in an application through the Right to Information (RTI) Act, 2005. This was applied at the DHS. The researcher received a list of 60 hospitals that were registered as societies and trust by putting in a request under the RTI Act. The list did not differentiate between those registered as trust and societies. The researcher added some obvious names of 14 more trust/society hospitals which were registered with the Directorate but was missing from the list. Thus, the final list of the non-profit hospitals was 74.
After getting the list of universe the next step was to send the questionnaires to the hospitals. The researcher sent letters to these 74 institutions with a cover letter explaining the purpose of the study and a brief questionnaire to cover the basic information about the institution (Annexure 1 and 2). These were followed up thrice through telephonic conversations with the institutions. The researcher received responses from 24 hospitals after repeated follow-ups. For the rest, some she gathered information from the internet; three institutions refused to participate and replied by stating their refusal; the rest were non-respondents. Finally visits were made to some of the institutions willing to talk or wanting to know about the research. In some cases the response was very positive while others refused to talk in detail. There were very few complete responses. Another RTI application was forwarded to the DHS to fill in the gaps. Many hospitals responded to the questionnaire when it reached them through the DHS.

From the data, the 74 hospitals were classified into three periods - Pre-Independence, 1950-80 and 1981-present. The pre-independence period is the colonial era, 1950-80 provides with the post independence and partition context and the post 80s is the opening of the markets and emergence of ‘new’ non-profit hospitals. When using the term ‘old’ non-profit hospitals for the study, the researcher is clubbing the hospitals that emerged pre-independence and those that emerged between 1950 and 1980 and the ‘new’ non-profits are those that emerged post 80s. These institutions were then categorised into a typology based on ownership –

i) Faith-based: Hospitals that are defined as faith-based are those that have been started by a society or group of individuals who are directly associated to an institution of faith and have received at time of establishment major funds from various faith-based organisations and they are managed by them; for example: the church, or a particular sect following a certain religious/spiritual order. The chairperson or main trustee of the hospital generally holds the top position in the faith-based organisation to which it is affiliated to.

ii) Those established by business houses: Traders and industrialists are clubbed in the business category and constitute of those individuals who have started a medical institution. Their motivations could also follow from a certain faith or religious order but these institutions have emerged as their individual effort and donations have come from the community rather than a faith-based organisation or are established as charitable/non-profit offshoots of their industrial houses.
iii) Others: Others are those individuals or groups who have started non-profit medical institutions but are neither a trader or an industrialist nor a faith-based society.

Newly established hospitals that have emerged post 1980s are further classified into those established by old trusts/societies (trusts and societies that emerged pre-1950s but their hospitals emerged post 1980s) and those by new trusts/societies. A sample of few institutions were purposively selected (depending on those willing to give an interview) from each phase and followed up with in-depth interviews.

2. Methods and Tools used in Data Collection:

**Background Details and Secondary Sources:** Secondary sources of information were used to gather historical data and background information. These sources provided rich material for the review chapters, the global experiences in transformation of non-profit hospital sector and the Indian experience.

- *Journal articles, Books and Reports* were accessed for review from libraries and JStor (a resource link having a collection of journal articles on the internet).
- *Newspaper articles* were accessed for the last few years to locate recent information on non-profit hospitals at the policy level.
- *The Internet* was a good source of information for those hospitals that had their websites and for other government data and documents.
- *Magazines* covering recent developments in the health sector in India and specific to Delhi were collected and were a source of information.

**Primary Sources of Information:**

*Archival documents* were accessed from the Delhi Archives to get the historical data of medical institutions that emerged in Delhi pre-independence and the socio-political context within which these emerged. This source provided interesting insights of the society, local elites, political class and their interaction with actors within institutions.

**Right to Information:** The Right to Information (RTI) Act, 2005 probably came at an opportune moment. It came into force in October, 2005. The first time the researcher visited the Directorate to interview an officer she was told to put in an application to the RTI to obtain any kind of information.
“The RTI is an Act to provide for setting out the practical regime of right to information for citizens to secure access to information under the control of public authorities, in order to promote transparency and accountability in the working of every public authority, the constitution of a Central Information Commission and State Information Commissions and for matters connected therewith or incidental thereto” (GOI, 2005).

According to the Act, ‘Right to Information’ includes the right to:

i. inspect works, documents, and records.
ii. take notes, extracts or certified copies of documents or records.
iii. take certified samples of material.
iv. obtain information in form of printouts, diskettes, floppies, tapes, video cassettes or in any other electronic mode or through printouts.

The RTI was as a tool to gather the list of the universe of non-profit hospitals. Some of the gaps in the questionnaire survey were filled by applying the RTI once more (Annexure: letters to RTI appended).

The Questionnaire method was used to get the preliminary set of data from all the non-profit institutions in the list.

A structured questionnaire was mailed to all the hospitals seeking some basic information on their emergence, ownership, services and personnel. The questionnaire was designed in such a way that the process of transformation could be captured. But due to limited response, the researcher had to narrow it down to the present status as more information was available about the present status. It was also easier for them to give data on the status quo than recall when the transformations happened. The questionnaire data was collected by repeated follow-ups by phone calls and visits. If even after three phone calls they did not respond, they were categorised as non-respondents. Another letter was forwarded to the DHS under the RTI Act to get information on the ‘non-respondent’ category of hospitals. The perceptions of transformation were left for the in-depth interviews.

In-depth interviews

Qualitative research covers a spectrum of techniques but central are observation, interviewing and documentary analysis.
"Interviewing is a paramount part of sociology because interviewing is interaction and sociology is the study of interaction" (Fontana and Frey, 1998). The researcher used the most common form of interviewing, that is, face-to-face verbal interchange. The interviews were unstructured. Unstructured interviewing provides a greater breadth than the other types, given its qualitative nature. Some important points while conducting interviews that the researcher had to keep in mind:

- The Setting: the setting was mostly a clinic or a hospital
- Understanding the language of the respondents
- Deciding on how to present oneself

Keeping the key elements and factors in mind – the interviews delved in to the gradual transformation in the hospitals over a period of time and linking them to the social context of the time. There was a checklist of issues that the researcher had with her but she let the interviewee speak in a narrative form and put forth questions in between these narrations. The checklist broadly included the following issues: recollect history of the hospital, original founder and motivations, values of those who set it up; major landmarks of growth and transition (infrastructure, growth in specialisation, change in management and so on) and why; donations and subsidies received from time to time; perception on how they see themselves different from for-profits, public hospitals and other non-profit hospitals; what they perceived as a primary factor of transformation – the role of market, epidemiological or demographic transition.

Table 1.1 - Number of in-depth interviews

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Pre-Independence</th>
<th>1950-80</th>
<th>1981-present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faith-based</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Business/Industrialists</td>
<td>-</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

For getting access to interviews calls were made to institutions who had responded to the questionnaire. Letters were also sent to FICCI (Federation of Indian Chambers of Commerce and Industry) to get access to key trustees of some of the hospitals. The response to this was few. This has been discussed in the section on research constraints and limitations of the study. Ten of the institutions between pre-independence and 1980 were willing to participate in the interview. Most of the hospitals that emerged post 1980s or the new non-profits were unwilling and either said a definite ‘No’ to participating or did not respond after
repeated calls. Since the older institutions were more willing to talk it was imperative that their story of transformation be captured from these interviews as they existed for a longer period of time.

**Observation**

Observation is one of the earliest and most basic forms of research and is used in conjunction with other methods. Though observations are made everyday by individuals, Adler and Adler (1999) say, "...what differentiates the observations of social scientists from those of everyday-life actors is the former's systematic and purposive nature....social science researchers study their surroundings regularly and repeatedly, with a curiosity spurred by theoretical questions about the nature of human action, interaction and society."

The researcher spent time observing the external and internal structures of the hospitals and the external surroundings. After the archival research, the researcher visited the hospitals that existed since pre-independence so as to reconstruct their story through observation first. These observations were either made before the interview time or separate visits were made to the hospital. During the interviews it was easier for the researcher to understand the structural changes that the hospital had undergone because of the observations made.

3. Analysis of Data Collected

**Analysis of documentary evidence**

Various documents were reviewed and have been used for analysis. Archival documents of Delhi were important for a historical analysis and to gain insights on the social context during pre-independence. This helped in reconstructing histories of some of the major hospitals that emerged pre-independence. Policy documents were important to help understand issues of importance and that were addressed by policy makers at a given time. Newspaper articles gave insights into current policy debates.

**Analysis of Questionnaire data**

The first set of analysis was done on the basis of information gathered from the structured questionnaire. From the questionnaire data a typology of these institutions was created based on their year of establishment and ownership. The questionnaire also provided with the characteristics of the present non-profit hospitals in terms of size, types of services, and source of funding.
Another tool used to understand the spatial distribution of the institutions was the GIS (Geographical Institutional Systems). The spread of the non-profit hospitals across Delhi gives the spatial distribution of the hospitals. GIS helped in looking at the district-wise distribution of all hospitals in Delhi; distribution of non-profit hospitals in Delhi by year of establishment and ownership.

**Analysis of interview data**

The study conceptualises some key factors of transformation for the analysis of in-depth interviews. The perceptions of transformation and the reasons behind them were categorised in terms of demands (markets, middle class, disease patterns) made on the hospital and the changes in the supply-side i.e. the hospital, that was a result of the impact of these demands. Consequently, both the supply and demand sides interact with each other and were seen as an interactive whole rather than a linear understanding of one leading to the other. The data from the interview is used to understand this interplay of demand and supply.

**Ethical issues**

There are a whole range of unexpected political and ethical issues related to "stress in the field situation, research fatigue, confidentiality, harm, privacy and identification, and spoiling the field" (Punch, M. 1999).

Questions have been raised about the purpose of this research: It was important to approach the participants in a non-judgmental and unbiased manner and brief them about the purpose of the study.

*Maintaining anonymity:* A letter signed by the researcher explaining the purpose and objective of the study and that the data would be used only for research purposes was stated. This was reiterated during the beginning of the interview. In few cases the interviewees were categorical that they and their institute should not be mentioned. One even said that he did not want to be quoted and asked how the data would be used and requested to see how his words would be used in the context of the study. In yet another case, the researcher was told that if the data was used negatively, legal action would be taken. Keeping these apprehensions in mind, while quoting those interviewed only those names are mentioned where the consent was there. The rest are not mentioned.
Power relations: All researchers are outsiders in the context of research but this was more pronounced in the present study. There existed unequal power relations between the respondents and the researcher. They saw the researcher as an outsider. Since this sector has been under constant scrutiny by the government the researcher faced a lot of scepticism from the participants.

Research Limitations and Constraints

Negotiating access at both the levels i.e. government and non-profit hospitals was an important process to gain entry and was the most difficult and most time consuming part of the study. The time the RTI letter was forwarded, the government was still grappling with issues and ways to make RTI function. The list of 60 hospitals was provided within a month but with some negotiations and convincing officials the purpose of such information. On meeting some government officials the researcher felt that their own understanding of this sector was limited. This has consequences for regulation and monitoring and it was evident that these were not in place as many institutions were missing from the list.

Negotiation at the institutional level was tedious, difficult and a long process. There are constraints of doing field work in institutions as institutional set ups though open systems remain closed when it comes to communicating with outsiders. In this case the researcher was the outsider. Private institutions and especially institutions registered as trusts and society are accountable to the public and in this regard one would think that they should be open to talking but this was not the case. One reason this was even more evident in a city like Delhi could be because these institutions have been under the scrutiny of the government for sometime now and any outsider wanting to learn about the institutions is looked at with suspicion. There were also different dynamics of the big and small institutions. Some big institutions refused to talk while others did with caution. The ones who were willing to talk were probably more aware of the legal aspects within which the institution was functioning and were powerful in that regard with their networks in place. These were also the institutions which seemed to be doing well. The smaller institutions probably felt targeted and more insecure hence refusing to talk or divulge much. It became difficult to break through these pre-conceived notions and suspicions generated regarding this study.

Researcher initially tried gaining entry through the administrators since the letters reached them even if they were addressed to the trustee, medical superintendent or the hospital director. Many of the administrators did not allow the researcher to get access to the
trustees and the senior doctors of the institutions. They provided me with some basic information and in some cases handed me some pamphlets about the institution. So then the researcher had to get access directly to individuals within institutions from various sources. In some cases the administrators were the main respondents. After three follow-ups whether for getting a filled questionnaire or for seeking an interview if there was no response the researcher would categorise them as non-respondents. Researcher also made a final attempt to get more interviews by sending letters to some FICCI members and was able to conduct two interviews through these contacts.

The interviews were varied with administrative staff, senior doctors, trustees, management people as interviewees. Though the checklist was ready, the researcher was not sure which way the interview would go. Barring a few, most of those interviewed were very defensive about their institution whether employed or holding an ownership. They were not forthcoming about the changes in the internal structures or newer mechanisms that were put in place. There was information on why they felt the change was necessary and how they as a provider perceived the change. The interviews were as in-depth as they could be in some cases.

The following will be the chapterisation of the study –

- **Social transformation of ‘not-for-profit’ medical care institutions:** The first chapter gave the introduction to the thesis and the rationale of the role of charity and philanthropy in the establishment of non-profits and the importance of looking at it in relation to changing contexts. It then provided with the conceptual and methodological framework of the study.

- **Social history of ‘not-for-profit’ hospitals:** The second chapter focuses on a social history of hospitals in Europe and North America. It looks at the emergence of non-profit hospitals in relation to the changing contexts of state, market, society, medicine and understanding of causation of disease. It also looks at the promoters of these hospitals and their motives behind establishing them.

- **History of ‘not-for-profit’ hospitals in India:** Taking from the global history of emergence of charitable hospitals, we look at this sector in India historically. Being a colonial state, the history of this sector in India is intricately wound and influenced by the ideologies of the British in India. This chapter attempts to look at the socio-
political context that shaped the non-profit health sector in India. This includes motivations of various actors in colonial and independent India and their interactions with the State.

- The chapter on **Social transformation of hospitals in colonial Delhi** follows from this larger history sketched for the country. It gives a historical overview of medical institutions in colonial Delhi and immediately after post-independence through the changing social compositions and political context of the city. This chapter largely draws from archival research.

- This chapter looks at the **characteristics of ‘not-for-profit’ hospitals** in India at present and attempts to map the size of this sector in India in relation to the for-profit and public hospitals and examines its characteristics.

- The chapter on **organisation of health services in Delhi** examines the organisation of government health services and distribution of hospitals across sectors (public and private) in the city.

- **Characteristics of ‘not-for-profit’ hospitals in Delhi** is based on data gathered on the present non-profit hospitals in the city and looks at their emergence; their distribution; the social basis of the promoters; types of services; source of funding; and mechanisms of cross subsidisations.

- Taking from the cross-sectional study of non-profit hospitals in Delhi, the final chapter analyses the **factors influencing the redefinition of not-for-profit hospitals** and discusses the causes of transformation and the impact of this on the hospitals.

- The concluding chapter discusses the future of the non-profit sector in delivery of medical care in India.