Synopsis of Ph.D. thesis

“A Comparative Study of Public and Private Health Services in Mumbai Region – Availability and Utilisation Pattern”

Synopsis submitted to the SNDT Women’s University, Mumbai for the award of the Degree of Doctor of Philosophy (Ph.D.) in Economics

by

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Introduction:
‘Health is Wealth’ and Good health of population is the ‘Wealth of Nation’. Economists often think of available resources in terms of their utilization costs and cost effectiveness. Human resource of a country has to be analysed on the basis of these two concepts. Human resource in India is in abundance. What lacks is Good health. This makes this (human) resource a burden rather than a productive factor contributing to India’s growth and development. Each child born in a country is human resource who will add to the productivity and prosperity of a nation. However, the responsibility of converting this latent resource into active workforce lies with the Government, private sector and NGOs. A child suffering from poor health lacks attendance in the school. Workers who suffer from childhood malnutrition are less productive than healthy workers. India has one of the youngest populations in the world still it is unable to reap the economic benefits because there are always many more mouths to feed than hands working. India is experiencing high growth since a decade. The sustainability of this high growth rate requires huge investment in education and health care of the population.

Healthcare in India consists of a universal health care system run by the respective State Governments. The Constitution of India charges every State Government with ‘raising of the level of nutrition and the standard of living’ of its people and ‘the improvement of public health’ as among primary duties. The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002. Although, both these policies aimed to achieve “Health for All” within a specified time frame, the reality is different after decades of their implementation. In the absence of a proper policy framework, there is a heavy burden on government sector hospitals which are generally understaffed and underfinanced. Poor services at state-run hospitals force many people to visit private medical practitioners and private clinics and hospitals.

Government hospitals, some of which are among the best hospitals in India, provide treatment at taxpayer expense. Most essential drugs are provided free of charge to all patients in these hospitals. Government hospitals provide treatment either free or at minimal charges. For example, an outpatient card at AIIMS (one of the best hospitals in India) costs a onetime fee of rupees 10 (around 20 cents US) and thereafter outpatient medical advice is free. In-hospital treatment costs in these hospitals depend on financial condition of the patient and facilities utilised by him but are usually much less than the private sector. For instance, a patient is waived full treatment costs if he is below poverty line. Another patient may seek for an air-conditioned room, if he is willing to pay extra for it. The charges for basic in-hospital treatment and investigations are much less in public hospitals as compared to the private hospitals. The cost for these subsidies comes from annual allocations from the Central and State Governments. In addition to the network of public and private hospitals, there are charitable dispensaries and hospitals, many of which provide treatment and facilities parallel to those provided by private hospitals at highly concessional rates or in some cases free of costs to needy population.

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1 Government of India (2002), National Health Policy, Government of India.
Primary health care is provided by city and district hospitals and rural primary health centres (PHCs). These hospitals provide treatment free of cost. Primary health care is focused on immunization, prevention of malnutrition, care during pregnancy, child birth, postnatal care, and treatment of common illnesses. Patients who receive specialized care or have complicated illnesses are referred to secondary (often located in district and taluka headquarters) and tertiary care hospitals (located in district and state headquarters or those that are teaching hospitals).

In post-independence period, India has eradicated mass famines, but the country still suffers from high levels of malnutrition and disease especially in rural areas. Water supply and sanitation in India are also major issues in the country and many Indians in rural areas lack access to proper sanitation facilities and safe drinking water. However, at the same time, India’s health care system also includes entities that meet or exceed international quality standards. The medical tourism business in India has been growing in recent years and as such India is a popular destination for medical tourists who receive effective medical treatment at lower costs than in developed countries.

**Conceptual Background:**

**Health:** World Health Organization’s (WHO) constitution defines health as “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.” Necessarily, health has to be defined from a practical point of view and therefore, it has been defined according to life expectancy, infant mortality, and crude death rate, etc.

**Health Economics:** Health economics is the study of how scarce resources are allocated among alternative uses for the care of sickness and the promotion, maintenance and improvement of health, including the study of how health care and health-related services, their costs and benefits, and health itself are distributed among individuals and groups in society.

**Human Development Index (HDI):** The Human Development Index (HDI) is a comparative measure of life expectancy, literacy, education and standards of living for countries worldwide. It is a standard means of measuring well-being, especially child welfare. India ranked 134th among 187 countries ranked in terms of Human Development Index.

**Health Expenditure per Capita (PPP; International $):** Health Expenditure Per Capita is the sum of public and private health expenditure (in PPP, International $) divided by total population. The health expenditure per capita stood at 45 $ in the year 2009 in India, which lies much below the international standards.

**Out-of-Pocket Expenditure on Health (% of Private Expenditure on Health):** Out-of-Pocket Expenditure on Health is the direct outlays of households, including gratuities and in-kind payments made to health practitioners and to suppliers of pharmaceuticals, therapeutic appliances and other goods and services. The out-of-pocket expenditure on health stood at 74.4% as at the end of the year 2009.

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5 Retrieved from the official web-site of World Bank as on 30th June 2011.
6 Ibid.
**Equity in Health Sector:** Equity in health implies providing equal access to health facilities, equal use of services and equal health status for all by distributing health services on the basis of need regardless of income. There exist widespread disparities in India in providing health care services – disparities in health care infrastructure in rural and urban areas, disparities in access to health care services by men and women and also by rich and poor, disparities in health care expenditure by public and private sector and also be various state governments.  

**Morbidity Rate (Sickness):** Morbidity rate shows the departure from the ideal condition of health, i.e. a state of complete physical, mental and social well being. Morbidity rate is high in slum areas than non-slum areas. One of the obvious explanations for this high morbidity in slums is the degradation of the physical environment.

**Nutrition:** Nutrition refers to food substances required to keep the body in good working condition, and to supply fuel for energy. Good nutrition can help prevent disease and promote health. On an average, per capita per day calorie intake is 2,496 and the per capita per day consumption of protein is 59 grams. So far as the people below the poverty line are concerned, their average per day calorie intake is not even 1,500 and many of them do not get even 30 grams of protein per day.

**Illness:** Webster’s International Dictionary defines illness as a state of being ill or sick, bodily indisposition disease. It refers to anything affecting the total well-being of the patient. Communicable diseases, maternal, peri-natal and nutritional disorders constitute 38 per cent of deaths in India while non-communicable diseases account for 42 per cent of all deaths. Injuries and ill-defined causes constitute 10 per cent of deaths each.

**Primary Health Care (PHC):** The concept of Primary Health Centre was introduced by Bhore Committee in 1946 as basic health unit to provide health services to people as close to people as possible. Primary health care means essential health care based on practical, scientifically sound and socially acceptable methods and technology which is made universally accessible. Primary health care in India is provided through a network of over 147,069 health sub-centres, 23,673 Public Health Centres (PHCs) and 4,535 Community Health Centres (CHCs).

**Morbidity among Women:** Morbidity among women is the major issue in recent health policies. Women are more prone to sickness due to neglect during puberty and at the reproductive age. Due to poor financial condition women consume inferior quality and inadequate food which leads to anaemia. In the allocation of food women always neglect themselves. The work burden is always more.

**Significance of the Study:**

The role of healthcare in improving a nation’s wealth and spurring economic growth is well established. India is among the fastest growing economies in the world and is poised to become the second largest economy in the world according to a recent report from the

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8 Charu C. Garg, Equity of Health Sector Financing and Delivery in India, *Harvard School of Public Health, Boston, June 1988.*


10 *Alma Ata International Conference Definition.*

PricewaterhouseCoopers International Limited (PwCIL). India’s Human Development Index score, weighed down by poor healthcare indicators is, however, poor at 0.519, ranking India at 119 out of 169 countries just ahead of Timor-Leste and Swaziland. Several factors that contribute to poor healthcare indicators in India are:

1. India’s healthcare infrastructure is inadequate to meet the burden of disease. India has just 90 beds per 100,000 population against a world average of 270 beds.
2. India also has just 60 doctors per 100,000 population and 130 nurses per 100,000 population against world averages of 140 and 280 respectively.
3. Public spending on healthcare has also been less than 1% of GDP since independence.
4. India’s healthcare financing mechanisms are poor with 66% of healthcare expenditure being out of pocket.

Together, these factors result in a poor per-capita spending on healthcare at US$ 109. A slew of reforms are needed urgently to address these concerns. Mumbai is becoming a main centre of medical tourism with 282 private general hospitals, 14 multi specialty hospitals and three super specialty hospitals. There are special hospitals in Mumbai as well – five for cancer care and four heart institutes. Still the overall standard of healthcare facilities in India in general and in Mumbai in particular is poor. From macro-perspective also there are several reasons for promoting public health care facilities in India:

1. Higher growth improves health status and better health status reinforces trends and income growth.
2. Medical care is price sensitive goods. 1% increase in income is associated with 1.4% increase in medical care.
3. Improved health reduces poverty. Out of pocket medical cost alone may push 2.2% population below poverty line in one year in India.

Against this background, the present study compares and contrasts the standard of healthcare services provided by a public sector and private sector hospital in the city of Mumbai.

Scope of the Study:
The present study is restricted to the network of the healthcare facilities in the city of Mumbai. Mumbai, the commercial capital of India, is the largest city in the country carrying a population of 12.5 million people. The density of population in Mumbai is very high. Mumbai has a Population density of 30,000 persons per square kilometer which is relatively very high. The following table shows the demographic characteristics of Mumbai (Census 2011).

<table>
<thead>
<tr>
<th>Parameters</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population as per 2011</td>
<td>124,78,447</td>
</tr>
<tr>
<td>Density of Population (per sq. Km.)</td>
<td>30000</td>
</tr>
<tr>
<td>Literacy Rate</td>
<td>89.7</td>
</tr>
<tr>
<td>Sex Ratio (Number of females per 1000 males)</td>
<td>848</td>
</tr>
</tbody>
</table>

About 49% of population are residing in slums, characterised by shortage of living space, water supply and sanitation facilities. The health and sanitation conditions in slums are poor and the proportion of people falling sick is very large. Providing adequate, timely and cost effective health care services to such a huge ailing population from slums is a challenge indeed. This requires a comprehensive and well planned health policy that can co-ordinate the plans and programmes of the various public health care providers in India.

Mumbai city has hospitals and dispensaries run by Municipal Corporation of Greater Mumbai (MCGM), state government and private trusts. MCGM, the largest Municipal Corporation in India, is the major providers of public health care services in Mumbai. It has a network of 4 teaching hospitals, 5 specialised hospitals, 16 peripheral hospitals, 28 municipal maternity homes and 14 maternity wards attached to municipal hospitals with around 17000+ employees attached to these hospitals. Apart from that, there are 185 municipal dispensaries, 176 health posts to provide outpatient care services. In addition, the state government has one medical college hospital, 3 general hospitals and 2 health units, having total capacity of 2871 beds.

The scope of the present study is restricted to the public and private sector healthcare service providers and also charitable dispensaries and hospitals in Mumbai and the total population of the Mumbai city who is the consumer of these services. The study covers data for a period ranging from 2001-2002 to 2010-2011.

**Objectives of the Study:**

Against the above background, the study seeks to achieve the following broad objectives:

1. To review the literature on the determinants/policies that have influenced health expenditure pattern of poor population.
2. To examine the National Health Policy of the Government of India and its efficacy and the budgetary provisions during the Five Year Plans.
3. To compare and contrast the differences in healthcare standards and healthcare facilities in private and public sector hospitals in the city of Mumbai.
4. To study expenditure pattern of urban poor towards healthcare sector and their inclination towards private or public sector and reasons thereof.
5. To examines the problems faced by poor people in accessing public healthcare services and their compulsion of using high cost private healthcare services.
6. To examine whether any gender bias exists in health expenses of poor families in urban areas.
7. To draw attention of policy makers to lacunas in the public healthcare system and make suggestions for the betterment of healthcare infrastructure in the city.

**Hypotheses of the Study:**

On the basis of the above broad objectives, the study proposes to test the following hypotheses:

1. Poor families prefer private health services due to convenient timings, convenient location, quality services and user-friendly charges.
2. Availability of public health services in the city of Mumbai is inadequate in relation to market demand. Hence, poor are compelled to spend on private health services.

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19 International Institute of Population Sciences (IIPS) and ORC Macro (2001), ‘Life in Slums of India’.
(3) In Mumbai, transport cost to access public health service is much higher than the user charges.

(4) Poor families avoid treatment to save loss of their subsistence wages. They survive on Over the Counter medicines available conveniently at cheaper cost.

(5) There is a gender bias in the share of health expenses in families.

**Research Methodology:**
The various components of research methodology for the present research work are as under:

**A. Universe:**
All public, private and charitable hospitals located in the city of Mumbai and the entire population of Mumbai constitute universe for the present study. There are 70 government hospitals in the city of Mumbai which are owned by different government agencies such as the State Government, Railways, MCGM, etc.

Mumbai is the commercial capital of India and supports large population with a number of health problems. Since years there has been no expansion in the health care facilities in the city with ever-rising population. Mumbai houses the largest number of slum dwellers in the world with numerous health issues, both due to pollution and fast-moving lifestyle. According to the Census of India 2001, Mumbai is a place where more than half of its inhabitants (54.5%) live in slum areas.22

According to the ward-wise break-up of the slum and non-slum population as of 2001, S ward in the eastern suburbs, comprising Bhandup, Nahur, Vikhroli and Kanjurmarg, has the highest concentration of slum dwellers at 85.8 per cent. It is followed by L ward (Kurla) with 84.7 per cent, H/East ward (Santacruz, Mahim) with 78.8 per cent and M/East (Govandi, Mankhurd) with 77.5 per cent.

All the hospitals, private as well as public, and the people living in slums in the city constitute universe for the present study.

**B. Sample:**
A sample of 300 respondents has been selected randomly from slum areas in the following 5 wards to seek responses on healthcare services provided by the government hospitals vis-à-vis private hospitals and dispensaries in their areas.

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Regions</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>(Ward H/W) Bandra</td>
<td>20</td>
</tr>
<tr>
<td>2.</td>
<td>(Ward H/E) Khar, Santacruz</td>
<td>32</td>
</tr>
<tr>
<td>3.</td>
<td>(Ward P/N) Malad</td>
<td>57</td>
</tr>
<tr>
<td>4.</td>
<td>(Ward L) Kurla</td>
<td>88</td>
</tr>
<tr>
<td>5.</td>
<td>(Ward S) Bhandup (Including Nahur, Vikhroli &amp; Kanjurmarg)</td>
<td>103</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>300</strong></td>
</tr>
</tbody>
</table>

**Source:** Field Survey.

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The government hospitals, private hospitals and trust-run hospitals which are generally visited by people in the above areas for their health-related problems are:

**Government Hospitals:**
1. M. W. Desai Municipal General Hospital, Malad (E),
2. K. B. Bhabha Hospital, Bandra (W), and
3. K.M.J. Phule Municipal General Hospital, Vikhroli (E).

**Private Hospitals:**
1. Samarth Hospital, Vikhroli (W),
2. Shanti Nursing Home, Bandra (W),
3. Sanjeevani Hospital, Malad (E),

**Trust-run Hospitals:**
1. Sanjeevani Chandrabhan Agrawal Charitable Trust Hospital.
2. Mahavir Medical Research Centre.

The researcher found it difficult to collect information from illiterate and some aged respondents. Some respondents refused to part with information due to their severe and prolonged illness. Thus, wherever respondents refused to part with information or where the researcher found it difficult to extract information, such respondents were substituted with other respondents. The technique used to collect sample for the present research was random sampling technique.

**C. Types of Data:**
The present research study is based on data collected from both primary as well as secondary sources.

**D. Tools of Data Collection:**
Survey method has been used to collect primary data from 300 respondents, all of whom are the patients of the hospitals under consideration. A closed-ended questionnaire has been used to seek responses from the sample respondents. Opinions were also sought from hospital staff and government officers on the responses of the sample respondents.

**E. Presentation of Data:**
For interpretation of data, graphs and simple bar diagrams have been used. For comparison and analytical study, tabular presentation has been used. Bi-variate tables have been used for applying statistical tools like chi-square for establishing hypotheses and achieving objectives of the research.

**F. Analysis of Data:**
Data collected from primary sources have been analysed through appropriate statistical tools such as averages and chi-square test to establish the hypotheses under consideration.

**G. Limitations of the Study:**
The present study is constrained by the limitation of time and cost. The study is restricted to the public, private and charitable hospitals and dispensaries in the city of Mumbai. At the same time, individual capacity of researcher in exploring a crucial social sector, i.e. healthcare economics is a challenging task.
Despite all constraints and limitations, the findings and conclusions derived thereof and suggestions and recommendations given at the end of the study would go a long way in improving and enhancing health care facilities in the city. These suggestions will guide the health care policies of not only the Maharashtra government but also the State Governments of the other states in the country. At the same time, the results of the study will open new frontiers for young researchers to carry this study further to other regions and states of the country.

H. Chapterisation:
  (1) Nature, Scope, Objectives and Methodology of Research.
  (2) Review of Literature.
  (3) Healthcare Economics – Concept, Development, Growth and Constraints with Reference to Indian Economy.
  (4) Healthcare Sector in India with Specific Reference to Mumbai, State of Maharashtra
  (5) Analysis and Interpretation of Responses of Respondents on Healthcare Facilities in Public and Private Sector Healthcare Centres in the City of Mumbai.
  (6) Findings, Suggestions and Recommendations.

General Findings
(1) The Constitution of India charges every state government with ‘raising of the level of nutrition and the standard of living’ of its people and ‘the improvement of public health’ as among primary duties. The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002. However, the government sector is understaffed and underfinanced; poor services at state-run hospitals force many people to visit private medical practitioners.

(2) India’s Human Development Index score, weighed down by poor healthcare indicators is, however, a poor 0.519, ranking India at 119 out of 169 countries just ahead of Timor-Leste and Swaziland.

(3) India’s healthcare infrastructure is inadequate to meet the burden of disease. India has just 90 beds per 100,000 population against a world average of 270 beds. India also has just 60 doctors per 100,000 population and 130 nurses per 100,000 population against world averages of 140 and 280 respectively. Public spending on healthcare has also been less than 1% of GDP since independence.

(4) There are disparities in healthcare services in rural and urban areas and in public and private healthcare services. The rural-urban disparities in health outcomes in India are often attributed to urban bias in allocation of resources and location of health-care services. Statistics clearly show that the bed population ratio is higher in urban areas and that those regional inequalities have not seen any significant decline over time.

(5) Mumbai is becoming a main centre of medical tourism with 282 private general hospitals, 14 multi specialty hospitals and three super specialty hospitals. There are special hospitals in Mumbai as well – five for cancer care and 4 heart institutes. Still the overall standard of healthcare facilities in India in general and in Mumbai in particular is poor.

23 National Health Policy, Government of India, 2002.
25 www.mumbaidoctors.co.in/list-of-hospitals.
Profile of the Respondents (Total Respondents = 300):

(1) Most of the respondents for the field survey were selected from wards having high slum density as per the Census 2001. Accordingly, 34% respondents were selected from Ward S -Bahndup including Nahur, Vikhroli & Kanjurmarg), 29% from Ward L – Kurla, 19% from Ward P/N – Malad, 11% from ward H/E - Khar, Santacruz and 7% from Ward H/W – Bandra.

(2) The present survey was mainly conducted in slums and their surrounding areas. Therefore, 71% of the respondents lived in slums and the remaining 29% were from non-slum dwellers.

(3) Among the respondents, 46% were males and 54% were females and 69% of the respondents were married and the remaining 31% were not married.

(4) The age-wise distribution of respondents was 22% from the age-group of 18-25 years, 44% were from the age-block of 26-35 years and the remaining 31% were middle aged between 36-45 years.

(5) Of the respondents, 11% were found to be illiterate and 89% were literates. Among literate respondents (266), a large section, almost 89%, was educated up to less than SSC, 6% up to SSC, 4% up to HSC and less than 1% (2/266) were graduates.

(6) The income level of most of the respondents was up to Rs. 10000 a month. 22% of the families earned up to Rs. 5000 a month, 48% between Rs. 5000-10000 and the remaining earned above Rs. 10000.

(7) 69% of the respondents had more than five members in their families. These members reported to live in a small congested slum in unhygienic localities. 23% of the respondents had four to five members in their families while the remaining had small families with less than four members.

Responses of the Respondents on Healthcare Facilities in Public and Private Healthcare Centres in the City of Mumbai:

A. General Findings about the Respondents and their Accessibility of Health Services:

(1) Frequency of Visit to Doctor or Hospitals: It was revealed in field survey that 14% of the respondents visited doctor/hospital once in every 15 days for treatment while 66% of them reported to visit a doctor/hospital at least once in a month. Thus, 80% of the respondents were reported to fall sick frequently. Slums are characterised by open drains, lack of adequate sewerage, lack of civic amenities, unsafe drinking water and overall poor living conditions, combined with a high concentration of people. All these conditions are likely to favour a greater incidence of communicable diseases. These respondents held poor levels of hygiene, cleanliness and sanitation in urban slums to be responsible for their illness. They also reported that many of them survived on daily wages and therefore, it was not possible for them to afford good quality food. This was also one of the reasons for high incidence of health problems among these people.

(2) Considerations for Selecting a Dispensary or Hospital for Treatment: For almost all the respondents (99%) cost was found to be the most important criterion while selecting a dispensary or a hospital. Since, most of the respondents were daily wage earners; cost invariably becomes an important consideration. The
second most important criterion rated by 70% of the respondents was the distance that they had to travel in order to access a dispensary/hospital from the place of their residence. Most of these respondents preferred private clinics or charitable dispensaries in vicinity over public hospitals for minor illnesses as they could be accessed without incurring any additional cost on commuting. 41% of the respondents, who have rated time to be a factor in choosing a dispensary or a hospital, replied that they too relied on the services of local doctors and private clinics due to convenient timings of these clinics and quick treatment. In the absence of basic amenities of life, quality of services becomes a least important factor while availing any service including health services. This is clearly reflected in the poor responses (26%) to quality of services while availing health services.

(3) Tendency to Avoid Treatment on Falling Sick: It was found in the survey that most of the poor people have a tendency to avoid treatment on falling sick. 83% of the respondents reported to avoid treatment on falling sick for several reasons, major among them loss of subsistence. These respondents replied that in case of minor illness like cold, flu, cough, fever, headache, etc., they personally treated themselves by consuming some antibiotics prescribed by a local chemist or by following any home remedy and so wait for 2-3 days for self-recovery. They reported that since most of them were employed in unorganised sector and survived on daily wages, it is not possible for them to visit doctor during working hours and therefore many times they avoid visiting a doctor or hospital. Some of them also mentioned financial problems to be one of the reasons for delay in seeking medical treatment on time. Thus, on a whole it can be concluded that urban slum dwellers delayed treatment of their illnesses.

(4) Primary Source of Treatment on Falling Sick: The field survey revealed that 15% of the respondents preferred to treat themselves through home remedies on falling sick. 27% of the respondents primarily relied on the medicines prescribed by the local chemist while 41% of the respondents consulted local quacks for treatment on falling sick. These responses clearly indicate that most of the slum dwellers prefer to treat minor sickness in conventional way, i.e. either home remedy or by consuming medicines recommended by local chemist. It was also noticed during the field survey that local doctors, who are not qualified allopaths, are very popular among poor masses. Many of them give medicine at a very cheaper rate ranging from Rs.10 to Rs. 30. Only 17% of the respondents reported that they visited qualified doctors in private dispensaries or charitable dispensaries or government hospitals on falling sick. Thus, it can be concluded that a majority of poor population visit government hospital as a measure of last resort when they fail to obtain result from all other sources.

B. Reasons for Availing the Services of Private Clinics or Charitable Hospitals during Prolonged Minor Illness:

(1) Source of Treatment during Prolonged Illness (Minor): It was revealed in the field survey that most of the respondents (83%) avoided treatment on falling sick. They approach a qualified doctor only on being ill for long period. In case of prolonged minor sickness, 11% of the respondents preferred a government hospital
for treatment, 67% of them visited private clinics while 22% approached a charitable dispensary. It can be concluded from the above responses that urban slum dwellers generally prefer availing treatment from private practitioners over public hospitals for minor ailments. They attributed unavailability of medicines, distant location and inconvenient timings of government hospitals to be the main reasons for them preferring private clinics. Of all services of charitable dispensaries were found to be the most popular in the areas where their services were available.

(2) **Reasons for Availing Services of Private Clinics during Prolonged Minor Illness:** It is clear from the previous question that most of the urban slum dwellers preferred private clinics or charitable dispensaries over Government hospitals in case of prolonged minor illnesses. As per the responses of the majority of the respondents, private clinics are located within their locality (78%) and remain open until late in evening (89%) which makes it possible for them to approach these clinics after they return back from work in evening. Some of the private dispensaries were reported to be open till late in night (up to as late as 12 o’clock). On the other hand, the OPD timings in many government hospitals are in the morning, generally from 9.00 am to 1.00 pm. There were complaints of doctors reporting late for their duties. Thus, easy accessibility and convenient timings were found to be the most important reasons for most of the slum dwellers preferring services of private and charitable clinics over government hospitals. According to 67% of the respondents, private clinics were economical in comparison to government hospitals. According to them, the opportunity cost of accessing government hospitals in terms of money spent on commuting, buying outside medicines and work day loss due to time waste in government hospitals is very high. All these factors make accessing of government hospitals dearer for a common man. Private dispensaries in slum were reported to charge Rs. 30 to Rs. 40 for one time treatment.

(3) **Average Time for Accessing the Services of Private Clinics during Minor Illness:** In the field survey, 100% of the respondents reported that waiting time at private clinics and charitable clinics is less than 1 hour. As against an average of 2-3 hours, a patient gets treatment in less than one hour in private clinics or charitable clinics. When inquired in detail, it was revealed that waiting time at private clinics is not more than 15 minutes unless there is huge rush of patients but under any circumstance they get services of doctor within 30 minutes. Respondents also reported that these doctors report on time and give advance notice in case of their absence. Again every locality has private clinic and therefore patients need not to waste time in travelling.

C. Reasons for Not Availing the Services of Government Hospitals during Prolonged Minor Illness:

(1) **Awareness about Free Medical Services in Government Hospitals:** In all government hospitals – state managed as well as municipality managed – all medical services are provided free or at a very negligible cost. In government hospitals, patients visiting out-patient department are required to pay a nominal charge of Rs. 10 for registration or a case paper. All consultancy services and
medicines are provided free of charge, subject to their availability. In the survey, all 300 respondents had knowledge of these services.

(2) **Reasons for Not Availing Free Medical Services of the Government Hospitals during Prolonged Minor Illness:** Although out-patient services in government hospitals are provided at a negligible cost of Rs. 10, most of the prospective beneficiaries refrain from availing these services for several reasons. Lack of easy accessibility to Government hospitals and long waiting hours were found to be the most important reasons for non-preference of public hospital by about 77% and 73% of the respondents respectively. According to these respondents, time and cost wasted in commuting to these hospitals during rush hours and long queues in out-patient department of public hospitals result in long waiting time and loss of a day’s subsistence for these people. Therefore, many of them are reluctant to access these services. According to 48% of the respondents, the out-patient department in public hospitals operate during fixed hours, i.e. usually it is open from 10 am to 1 pm and in some hospitals in afternoon from 2 p.m. to 4 p.m., whereas private clinics open in the evening at 6.00 p.m. and operate till late in night. Thus, patients can avail services of these clinics conveniently after returning back home from their work. Thus, fixed timings of the government hospitals is also one of the reasons why prospective beneficiaries of free medical services of government hospitals are reluctant to actually use them. 41% of the respondents complained that it is costly to access government hospitals as many essential testing facilities and medicines are not adequately available in government hospitals.

(3) **High Commuting Cost as a Constraint in Accessing the Services of Government Hospitals:** Accessibility/location is a critical aspect of utilising public health care facilities. Without access to convenient locations, the population has to turn to alternative sources for availing these facilities. Majority of the respondents (93%) have attributed high cost of commuting to one of the most important reasons for them preferring private and charitable clinics over public hospitals. According to them, due to lack of adequate number of primary public health care centres in their vicinity, they have to spend a huge amount on commuting in order to gain accessibility to public hospitals. Thus, they preferred the services of local doctors to save huge travelling expenses as well as to save their time in travelling long distances.

(4) **Average Cost Spent on Commuting to Government Hospitals:** It was revealed in the field survey that 8% of the respondents spend Rs. 20–Rs. 30 on commuting to government hospital from the place of their residences, 22% spent between Rs. 30–Rs. 40 while 70% of them had to spent more than Rs. 40 on commuting to government hospital from the place of their residences. This suggests that the primary public health care centres are located at a very long distance from the urban slums because of which these respondents are not able to gain benefits of free medical services provided by these centres due to high cost of commuting.

(5) **Long waiting Time as a Constraint in Accessing the Services of Government Hospitals:** It was revealed in the survey that 96% of the respondents have attributed long waiting time at government hospitals to be one of the reasons why they do not prefer services of government hospitals. According to these
respondents, there is heavy rush of patients in out-patient departments of the
government hospitals, resulting in long queues and waiting time. The situation
becomes worst due to late reporting by doctors and sometimes doctors do not turn
up without any notice. As stated earlier, most of these slum dwellers do not have
fixed source of income and they survive on daily wages. If they waste their time in
waiting in government hospitals for long time, they are doubly suppressed. On one
hand, they have to wait for long time in queue and on the other hand they lose their
subsistence. Thus, most of the slum-dwellers prefer to take medicine from local
chemist or in case of prolonged illness prefer to visit a private clinic in the locality.

(6) Average Time Lost in Waiting in Government Hospitals: The waiting time at
government hospitals is exceptionally long. On an average a person is required to
wait for 2-3 hours for getting treatment at government hospitals. 40% of the
respondents reported that they have to wait for more than 3 hours to get treatment
for common problems like fever, cough, cold and like. Again, they have to report to
hospital early in the morning to get themselves registered and avail case paper.
Each government hospital has a specific quota, after which they stop issuing case
papers. Thus, they have to report to hospital early in the morning to avail case
paper. In addition to that the time wasted in commuting from the place of residence
to hospital and back to home may take away one full day, not only of the patient
but also of the one who accompanies him. Thus, it can be concluded that long
waiting time at government hospitals is one of the reasons why slum dwellers
prefer services of local doctors and chemists.

D. Reasons for Availing the Services of Government Hospitals during Major
Illness and Feedback on their Services:

(1) Source of Treatment during Major Illness: Affordability is the most important
criteria while selecting a hospital for treating major illnesses. It was revealed in the
survey that about 96% of the urban slum dwellers preferred public hospitals for
treating their major illnesses. According to them, private hospitals were beyond
their means. Thus, it can be concluded that though most of the urban slum dwellers
preferred private clinics for out-patient care whereas Government hospitals were
preferred by them for inpatient care due to financial constraints.

(2) Accessing Government Hospitals during Major Illness: It was found that
majority of the respondents (93%) have got themselves or any of their family
member admitted to a hospital for treatment of any major illness. Slums are
characterised by open drains, lack of adequate sewerage, lack of civic facilities and
overall poor living conditions, combined with a high concentration of people. All
these conditions are likely to favour a greater incidence of communicable diseases
in these areas. This is further ratified by 93% of the respondents reporting that
either they themselves or someone in their acquaintances had undergone
hospitalisation in government hospitals. This question was asked in order to seek
their responses on quality of services in government hospitals.

(3) Immediate Hospitalisation in Emergency in Government Hospitals: Timely
hospitalisation is necessary for saving a valuable life. While assessing the facilities
and quality of services of government hospitals, it was also necessary to assess the
promptness of government hospitals in providing these services. 62% of the respondents reported that they could avail immediate hospitalisation during emergency. However, they also reported that there is always a space crunch in these hospitals and many times they were made to adjust on extra beds adjusted on floors between two beds.

(4) **Feedback on Testing and Evaluation facilities in Government Hospitals:** Although 63% of the respondents reported that they could get hospitalisation on emergency basis in government hospitals, 72% of them reported that government hospitals lacked adequate infrastructure and evaluation and testing facilities. It was reported that X-ray machines and ECG facilities are often out-of-order. Many advanced testing facilities are not available in these hospitals and therefore, poor patients have to shell out huge money on getting these tests done from private hospitals and clinics. When inquired reason for such breakdowns, the hospital staff reported that there is heavy pressure of patients on these machines and therefore, they are used round the clock. They also reported that most of these machines are purchased through government rate contracts who generally supply substandard machines and instruments and there is no maintenance contract for these machines. For efficient functioning, these machines need regular upkeeping and maintenance. Under these circumstances, they have to recommend their patients to private hospitals and clinics for testing and evaluation.

(5) **Feedback on Standards of Cleanliness, Food, Sanitation and Hygiene in Government Hospitals:** On an average, most of the respondents (62%) found the standards of cleanliness, food, sanitation and hygiene in Government hospitals to be satisfactory but not at par with the hygiene and cleanliness standards maintained by private hospitals. While government hospitals are charitable institutions and in many cases refrain from adopting “scientific cleaning practices” as it comes at a price, the private set ups claim a handsome price for both treatment and the clean factors. But on the whole respondents were found to be satisfied with the standards of cleanliness and sanitation maintained by the government hospitals.

(6) **Feedback on Services of Doctors in Government Hospitals:** More than half the respondents (57%) who visited a Government hospital for treatment found the quality of services of doctors and their approach towards patients to be above average with 17% of the respondents rating it to be excellent and 40% rating it to be good. Empirical evidences show that patients are generally satisfied with the quality of services of government doctors and in many cases people have complaints against other staff and absence of infrastructural facilities in hospitals. 15% of the respondents who were dissatisfied with the services of doctors in Government hospitals were in-patients. Accessibility of a doctor is a vital factor, especially in case of emergency. But, according to these respondents, who personally or their family members utilised government hospital for treating their major illnesses, revealed that doctors were not accessible during emergency, although many of them were inmates.

(7) **Feedback on Services of Nurses and Administrative Staff in Government Hospitals:** On a whole, services of nurses and administrative staff in Government hospitals are found to be satisfactory which is supported by the responses of 70% of
the respondents. But when compared to satisfaction with the quality of doctors in government hospital, the satisfaction with quality of the services of nurses and administrative staff was found to be poor. 22% of the respondents who rated the quality of services of nurses and administrative staff to be poor reported that the nurses and administrative staff in government hospitals behave arrogantly and are insensitive and unsympathetic to the needs of patients.

(8) Feedback on Overall Services in Government Hospitals vis-a-vis Private and Charitable Hospitals: Empirical evidences through various researches have been suggestive of failure of public sector as one of the prime reasons for growth of the private sector in India. In the present study, majority of the respondents (76%) have rated the services provided by public hospitals vis-a-vis private clinics and charitable hospitals to be poor. The reasons for this are:

- Although services in government hospitals are free or are provided at concessional rate, long waiting time, long distance, inadequate infrastructure, irresponsible behaviour of staff (sometimes), comparatively poor standards of cleanliness and hygiene are some of the factors that contribute to the dissatisfaction of patients.
- On the other hand, proximity to place of residence, quality of sanitation and hygiene, polite behaviour of staff, quick services and convenient timings collectively contribute to high level of satisfaction among people with the services of private hospitals and dispensaries.

Those respondents who rated services of the government hospitals to be better cited a reason that these hospitals handle critical cases in more responsible ways than private hospitals. In order to defend their point of view, they cited a number of cases of failure and mismanagement in private hospitals as well.

E. Reasons for Not Availing 10% Quota for Economically Backward Classes in Private Hospitals during Major Illness:

(1) Awareness about 10% quota (either completely free or at concessional rate) for economically disadvantaged groups in private hospitals: As per the government policy, each private hospital in the state is required to reserve 10% of total intake capacity for BPL families. However, most of the prospective beneficiaries (85%) are not aware of such scheme. It was also observed during the field survey that some of the respondents who approached private hospitals during emergency for admission under this scheme were refused admission on the ground of non-availability of beds. The hospital administration reported that most of this quota is allotted to their own employees and their relatives as it becomes difficult for them to admit slum dwellers in their hospitals.

(2) Availing Free Hospitalisation in Private Hospitals under the Quota Reserved for Economically Disadvantaged Groups: It was revealed that out of 46 respondents who were aware of the quota for economically backward groups in private hospitals, only 15% of the respondents reported of having availed the benefit of free hospitalisation in private hospitals under quota reserved for them. If we calculate the percentage of beneficiaries who availed benefit of free
hospitalisation under quota reserved for economically backward people in private hospitals with reference to total respondent population, the actual beneficiaries are only 2% (7/300). The issue was probed in detail through personal interview and discussions to find out the reasons for poor accessibility to this ambitious scheme of the Government of Maharashtra. The following factors came to light why slum dwellers could not access quota reserved for economically backward groups in private hospitals:

- The main reason for this was the lack of adequate information and awareness among poor masses about such scheme. 85% of the respondents reported that they were not aware of such quota reserved for them in private hospital.
- The other reason that was cited for poor response to 10% quota for economically disadvantageous groups was that private hospitals were not keen on admitting slum dwellers in their hospitals. They try to avoid them in all possible ways and allot this quota to their own employees and their acquaintances.
- Some of them were found to be reluctant to use such quota as they said that it requires a number of documents and paperwork which many of them are not well versed with. Even poor masses refused to rely on such quota in private hospitals, especially when there is an emergency of hospitalisation.

F. Expenditure Pattern of Urban Poor towards Healthcare Sector:

1. **Average Monthly Family Spending on Medical Bills:** It was revealed in the field survey that each family spent on an average 5-10% of their monthly income on availing routine medical treatment. The sample selected for the present study has an average income range of Rs. 5000-1000 per month. They also reported that on an average at least one person per family is ill for an average period of 15 days during a month. Thus, expenses on availing medical facilities are high among these masses.

2. **Entitlement for Medical Leave:** A majority of respondents in the sample selected for the purpose of the present study worked in unorganised sector and some of them were daily wage earners. Therefore, they were not entitled to any sick leave or medical allowances. The same has been reflected in the responses of 94% of the respondents who reported of not getting any sick leave from their jobs. For them, leave from job means loss of subsistence for that particular day. Thus, many of them avoided treatment and were forced to work even though they were sick.

3. **Number of Man-days Lost Monthly due to Illness:** The field survey revealed that 22% of the respondents stayed at home (lose subsistence) for about 1-2 days in a month due to illness, 42% for 3-4 days, 25% for 4-5 days and 11% remained absent from their work for more than 5 days every month due to illness. The above data clearly indicates that the incidences of sickness are high among slum dwellers in urban areas and consequently the number of man-days lost is equally high. This loss cannot be viewed as a loss at the individual level but it is a national loss. Each man day loss due to sickness has its impact on productivity and ultimately on GDP.

4. **Avoiding Treatment to Prevent Loss of Subsistence:** It was revealed in the survey that 67% of the respondents avoided treatment of their illness to prevent loss of subsistence. One of the crucial impacts of staying sick for any person working
on daily wage basis is the wages he/she has to forego while being sick. Since, most of the respondents in this study were employed in day-to-day basis, the incidence of lost wages was quite high for such people. Therefore, 67% of the total respondents avoided treatment in order to prevent the loss of wages.

(5) **Awareness about Health Insurance and Those Having Health Insurance:** The responses of the respondents indicated that 74% of the respondents were not aware about medical insurance. Medical insurance is an essential requirement, at least for people living in urban areas due to high exposure to disease producing factors such as urbanisation, industrialisation, pollution, overcrowding, poor standards of health and hygiene, fast moving life, and like. Although medical insurance is a necessity in today’s fast moving urban life, none among the respondents who were interviewed for the present survey was medically insured. The penetration of health insurance in India has been low. It is estimated that only about 3% to 5% of Indians are covered by health insurance. In terms of the market share, the size of the commercial insurance is barely 1% of the total health spending in the country.

(6) **Awareness about the Rashtriya Swasthya Bima Yojana (RSBY) of the Government of India for BPL Families:** The Ministry of Labour and Employment, Government of India launched the Rashtriya Swasthya Bima Yojana to provide health insurance coverage for Below Poverty Line (BPL) families. Beneficiaries under RSBY are entitled to hospitalisation coverage up to Rs. 30,000/- for most of the diseases that require hospitalisation. Coverage extends to five members of the family, which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding. In the survey, none of the respondents was aware of this scheme. Therefore, the Government should undertake a mass drive to inform and encourage BPL families to enrol for the scheme.

(7) **High Health Expenditure Pushing Poor into Debt Trap:** Out-of-pocket spending in India is the main mode of financing health care whether for out-patient or in-patient care. It has been reported that people often have to borrow money for financing expenses of prolonged sickness, especially when they are admitted to hospitals for treatment. 71% of the respondents have reported of borrowing money to finance medical expenses of themselves or of their family members. Though, most of the respondents preferred Government hospitals in case of major illnesses, but due to lack of required facilities, they are compelled to get various tests done from private clinics. In addition to that the cost of medicines is equally high. Also lack of regulations and standard protocols for health care lead to a wide range of irregularities like unnecessary prescriptions, procedures and diagnostic tests, unnecessary surgeries, cross practice and other forms of malpractice. All these have financial consequences for the user in terms of increased costs of healthcare. In the absence of adequate provision for healthcare, these poor masses have no other option but to borrow from private source or dispose of their assets or belongings. These borrowings lead to large scale indebtedness and further poverty of masses.

(8) **Incidence of Borrowing for Meeting Health Expenditure:** The field survey established that 6% of respondents had borrowed up to Rs. 5000 for meeting
medical expenses of their family during last five years, 37% had borrowed Rs. 5000-10,000, 13% had borrowed Rs. 10,000-20,000 and 44% had borrowed above Rs. 20,000 during last five years for paying medical bills. It is a common notion that sickness involves expenditure that needs financing. Expenditures can range from insignificant amounts to very expensive ranges depending on the disease and kind of treatment sought. All the respondents have reported of borrowing money from non-banking sources with 53% of them borrowing from private moneylenders who are generally exploitative. Absence of formal employment make them ‘non-bankable’. Thus in addition to subsidised health services, poor also need easy access to credit on liberal terms at a concessional rate of interest as and when they need it for meeting medical expenses.

(9) Poor Government Expenditure on Health Sector – A Major Cause of Distress for Poor: It can be concluded from the study that high medical expenses are responsible for pushing poor population in a debt trap which is supported by 93% of the respondents. Health care is a matter of accessibility and more so of affordability. Spending in India’s health sector totals $32 billion, but only 15 percent of this comes from the government sector. The bulk of all money spent on medicine in India goes to private doctors and hospitals, which is encouraged by government policy. Barely 5 percent of Indians have insurance coverage, so the vast majority of this private medical expenditure is paid out-of-pocket.

(10) User-fee in Government Hospitals – A major Deterrent: Hospitals that receive subsidies from the Government are required to provide free or inexpensive treatment to those earning less than Rs. 50000 a year. In reality, these subsidies are rarely available to those who need it most. Again since 2001, public hospitals have introduced ‘user fees’ for inpatients to recover costs, except for BPL families. In addition to a fee for a case paper documenting a first visit, user charges are levied for all procedures, from X-rays to surgeries. While these charges are subsidized, they are a lot of money for the class of patients visiting public hospitals. User fees recover between 0.67 percent and 10.67 percent of the real costs of most procedures, deterring many from seeking essential care.

G. Gender Disparities in Health Services Accessibility:

(1) Secondary Status of Women in Indian Society: Women from infant stage to their old age get an unfair deal in matters of health. They are conditioned through generations to place themselves last within the family itself; though they put in the most labour without any financial gain. As such their health concerns also get a very low priority. The sex-ratio in India speaks volumes about the importance given to women in this country. If a man and a woman have the same problem requiring expensive treatment, it is invariably the man who gets the first attention, often the only one to get the attention. It is not just the poor who for want of resources and with the inherent preference for a boy are guilty of bias, even in well-do families parents tend to spend more on the health of the boys than the girls. It is the attitude which is responsible for ignoring the health of the women in India.

26Sandhya Srinivasan (2010), “India healthcare for under $ 30 per year”, World Policy Journal, August 5th.
Poor Share of Women in Health Expenditure: The National Sample Survey Organization (NSSO) data reveals that in the rural areas the money spent per illness episode for outpatient care were Rs. 151 and Rs. 137 respectively for male and female. The respective amounts for urban areas were Rs. 187 and Rs. 164. Gender variation is expenditure spent for in-patient care is also reported.\(^27\) In the survey, 20% of the male respondents and 63% of the female respondents reported that women are given secondary treatment in availing medical services.

Cost-Benefit Analysis of Visit to Private Clinics and Government Hospitals during Minor Illness:

(A) Time Consumption in Accessing Private Clinics and Government Hospitals:

Table No. 1.3

Table Indicating Comparison of Time Required in Accessing Healthcare Services of Private Clinics and Government Hospitals in case of Minor Illness

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Average Time Taken to Access Healthcare Services in case of Minor Illness</th>
<th>Private Clinic</th>
<th>Government Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Commuting(^*)</td>
<td>8 min.</td>
<td>25 min.</td>
</tr>
<tr>
<td>2.</td>
<td>Waiting(^*)</td>
<td>12 min.</td>
<td>90 min.</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>20 min.</td>
<td>115 min.</td>
</tr>
</tbody>
</table>

Source: Field data.

The above table indicates the comparison of average time taken to access healthcare services of private clinics and government hospitals. It can be seen in the above table that the average time taken to access healthcare services of private clinics is only 20 minutes on an average while it is around 115 minutes in the case of government hospitals. Thus, the time wasted in accessing healthcare services of government hospitals is around 6 times of that of the time taken to access the services of private hospitals.

Thus, it can be concluded on the basis of above analysis that it is time consuming to access government hospitals for minor illness.

(B) Cost Consideration in Accessing Private Clinics and Government Hospitals:

Table No. 1.4

Table Indicating Comparison of Cost Involved in Accessing Healthcare Services of Private Clinics and Government Hospitals in case of Minor Illness

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Average Cost Involved in Accessing Healthcare Services in case of Minor Illness</th>
<th>Private Clinic</th>
<th>Government Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Commuting(^*)</td>
<td>Rs. 0</td>
<td>Rs. 25</td>
</tr>
<tr>
<td>2.</td>
<td>Doctor’s Fees(^*)</td>
<td>Rs. 30</td>
<td>Rs. 0.</td>
</tr>
<tr>
<td>3.</td>
<td>Opportunity Cost(^*)</td>
<td>Rs. 0</td>
<td>Rs. 125</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>Rs. 30</td>
<td>Rs. 150</td>
</tr>
</tbody>
</table>

*Average cost.

**Opportunity cost is the cost of any activity measured in terms of the value of the next best alternative foregone. It is the loss of subsistence involved in accessing healthcare services.

Source: Field data.

The above table clearly indicates that although there are no charges in government hospitals, the cost involved in commuting and opportunity cost involved in accessing services of government hospital is huge. The cost of accessing government hospital for minor illness is at least five times the cost involved in accessing private clinics in local areas.

Thus, it can be concluded that most of the prospective beneficiaries of free medical services of government hospitals do not access those services due to high cost involved in commuting and equally high opportunity cost.

**Achievement of Objectives:**

The questionnaire was designed, considering the broad objectives of the research. Based on the secondary data and responses sought from in-patients and out-patients in private and government and charitable hospitals, all the objective of the research have been achieved.

**Objective 1: To review the literature on the determinants/policies that have influenced health expenditure pattern of poor population.**

The researcher has primarily relied on secondary sources for establishing this objective. The researcher has critically analysed all the committee reports right from Bhore Committee (1942) to Srivastava Committee (1975) and both the National Health Policies, of 1983 and 2002 in the chapter 3. It was concluded that the approach of most of these committees had been fragmented. Although most of these committees emphasized "Health for All", none of them made any specific recommendations as to how to reach there.

**Objective 2: To examine the National Health Policy of the Government of India and its efficacy and the budgetary provisions during the Five Year Plans.**

The researcher has also analysed the two health policies announced by the Government of India – the National Health Policy 1983 and the National Health Policy, 2002, in the chapter 3. Health parameters in India have considerably improved during the period of these policies, but they are much below the international standards.

The chapter 2 analyses the budgetary provisions for health sector in India during planning period from the First Five Year Plan (1951-56) to the Eleventh Five Year Plan (2007-2012). It has been noticed that the budgetary allocations of the Central Government has remained more or less stagnant over the planning period and has actually come down in the post-liberalization period. This makes the dream of “Health for All” a distant reality. The Central government has targeted to increase the health sector expenditure to 2.5% of GDP by 2017. This is likely to change the health scenario in India in near future.

**Objective 3: To compare and contrast the differences in healthcare standards and healthcare facilities in private and public sector hospitals in the city of Mumbai.**

The researcher has personally visited some of the private hospitals and public hospitals to assess the health standards and facilities provided to patients there. It was found that health standards and facilities in public hospitals were extremely poor with poor standards of cleanliness and hygiene, overcrowded wards, long queues of patients waiting for hours for doctors to arrive, non-functioning x-ray machines, etc. Chapter 4 deals with comparative study of public and private health care system in the city.
Objective 4: To study expenditure pattern of urban poor towards healthcare sector and their inclination towards private or public sector and reasons thereof.

The researcher has studied the expenditure pattern of urban poor through field survey and data personally collected from certain slum areas of Mumbai city. On the basis of the responses of the slum dwellers in Mumbai, it was found that each family in slums spent on an average 5-10% of their monthly income on availing routine medical treatment, 67% of the respondents avoided treatment of their illness to prevent loss of subsistence, none of them was medically insured, 71% borrowed money to meet medical expenses, 44% of them borrowed more than Rs. 20,000 during last five years for paying medical bills and 93% of them attributed high medical expenses in private and public hospitals to be a cause for pushing poor population in debt trap.

Objective 5: To examine the problems faced by poor people in accessing public healthcare services and their compulsion of using high cost private healthcare services.

The researcher also tried to find out the reasons why urban poor desist from using public health services. In the field survey, it was reported that 77% of the respondents did not avail the benefits of free medical services provided by the Government hospitals as these hospitals were situated away from the place of their residences, 73% avoided the treatment in Government hospitals due to prolonged waiting time, 48% avoided treatment in government hospitals due to fixed operating time, 41% attributed it to the lack of facilities while 11% to the poor quality of services in government hospitals to be a reason for not accessing services of government hospitals.

Objective 6: To examine whether any gender bias exists in health expenses of poor families in urban areas.

The chapter 2 details facts and figures about gender inequality in health care sector in India. The National Sample Survey Organization (NSSO) data reveals that in the rural areas the money spent per illness episode for outpatient care was Rs. 151 and Rs. 137 respectively for male and female. The respective amounts for urban areas were Rs. 187 and Rs. 164. Gender variation in expenditure spent for in-patient care is also reported.28 Glaring spatial disparities in health services and their outcomes are also found particularly in rural India.29

Objective 7: To draw attention of policy makers to lacunas in the public healthcare system and make suggestions for the betterment of healthcare infrastructure in the city.

The researcher has made an attempt to bring about lacunas in the public health system in the city of Mumbai and has laid bare the hollowness of the system in front of the policy makers. Although, the city of Mumbai has a huge network of public hospitals, these facilities are not adequate to cater to large population of the city due to lack of proper planning and controlling. In the chapter 6, the researcher has given some recommendations which, if implemented in right perspective, may go a long way in solving the health problems of the city.


Establishment of Hypotheses:
The researcher has made use of chi-square technique for establishment of hypotheses formulated at the beginning of the study.

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Hypothesis (H₀)</th>
<th>Accepted or Rejected</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Poor families do not give importance to distance that they need to travel while accessing health care services.</td>
<td>Rejected</td>
</tr>
<tr>
<td>(2)</td>
<td>Poor families do not give importance to quality while selecting health care services.</td>
<td>Rejected</td>
</tr>
<tr>
<td>(3)</td>
<td>Poor families do not give importance to time factor while accessing health care services.</td>
<td>Rejected</td>
</tr>
<tr>
<td>(4)</td>
<td>Poor people do not prefer the services of government hospitals due to introduction of user fees.</td>
<td>Rejected</td>
</tr>
<tr>
<td>(5)</td>
<td>In metropolitan city of Mumbai, the cost of accessing public health services is not as high as the user charges.</td>
<td>Rejected</td>
</tr>
<tr>
<td>(6)</td>
<td>Poor people do not avail the services of private or public hospitals immediately on falling sick.</td>
<td>Accepted</td>
</tr>
<tr>
<td>(7)</td>
<td>People do not discriminate while providing health care services to male and female members of their families.</td>
<td>Rejected</td>
</tr>
</tbody>
</table>

Suggestions and Recommendations:
It can be concluded from the above responses and analysis that Availability, Accessibility and Affordability should be the three pillars of any health policy.

1) **Availability:** Health facilities should be adequately made available to people quantitatively as well as qualitatively.

2) **Accessibility:** Health facilities should be accessible to people in their vicinity, round-the-clock as and when they need.

3) **Affordability:** Health services must also be affordable for all without any discrimination.

A. Suggestions for Making Health Care Services Available to All:

1) **Redesigning the Structure of Public Health Services in Mumbai:** The structure of public health services should be redesigned keeping in mind the local population and their needs. The researcher has proposed the following three-tire structure for public health services in the city of Mumbai:

   • Primary health centres for minor illness. Total number of primary health centres required is approximately 1250.
   • Secondary health centres providing specialized care for family welfare and child and maternal care, HIV/AIDS patients, TB patients, etc. The number of secondary health centres required in Mumbai is approximately 250.
   • Tertiary health centres should be multi-speciality hospitals dealing with critical cases only on the recommendations of the primary and secondary health centres. There are 70 big and small hospitals in Mumbai which are run by different government agencies. The administration of these hospitals should be merged under a single administrative body to avoid duplications.
There should be uniformity in the basic structure and services such as sanitation, electricity, waiting room and laboratories. Equipment, transportation, laboratory facilities and medical supplies for urban health facilities need to be standardized, and their availability ensured.

(2) **Infrastructure at Different Tiers of Healthcare Structure for Mumbai City:**

The researcher recommends the following facilities at different tiers of health structure recommended for the city:

<table>
<thead>
<tr>
<th>Healthcare Tier</th>
<th>Operating Time</th>
<th>Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health centres:</td>
<td>(9.00 am to 3.00 pm and 4.00 pm to 10.00 pm)</td>
<td>2 doctors + 2 nurses + 2 helpers during each shifts</td>
</tr>
<tr>
<td>(Two Shifts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary health centres:</td>
<td>24 X 7</td>
<td>As required</td>
</tr>
<tr>
<td>Tertiary health centres:</td>
<td>24 X 7</td>
<td>As required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthcare Tier</th>
<th>Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health centres:</td>
<td>Facilities for diagnosis of common illness and adequate stock of medicines for the same</td>
</tr>
<tr>
<td>Secondary health centres:</td>
<td>Facilities for maternal health and child care and facilities for diagnosis and treatment of specific diseases such as TB, HIV, etc.</td>
</tr>
<tr>
<td>Tertiary health centres:</td>
<td>Facilities for treatment of all types of diseases and well-equipped operation theatre.</td>
</tr>
</tbody>
</table>

The government should enter into tie up with private pathologies and test centres to undertake routine to all types of high cost tests. The private sector should provide these tests to government clinics and hospitals at concessional rates as per certain pre-determined agreement. The government may charge negligible charges for these tests to above BPL families and provide these tests free of costs to BPL families.

(3) **Strengthening Primary Health Care Services:** Primary healthcare is considered to be the backbone of the healthcare system. In Mumbai, though we have a strong secondary and tertiary healthcare infrastructure, the primary healthcare facilities are inadequate. The immediate effect of this is that there is heavy burden on secondary and tertiary health care infrastructure and consequently the poor and the disadvantaged not being adequately provided for. Therefore, there is a strong need for strengthening primary health centres in Mumbai.

(4) **Performance Guarantee and Maintenance Contract:** It was observed during the field survey that a number of medical equipments and facilities in public hospitals, although very hi-tech, do not function well or are out-of-order due to poor maintenance. The problem can be remedied by giving authority to individual health centres at each level to source their own requirements from private sources through open bidding. The tender notice must demand a minimum performance guarantee for these equipments and should also make maintenance contract with the suppliers.

(5) **Filling up Vacancies in the Government Hospitals:** The shortage of personnel – either because of under-staffing or because of rampant absenteeism among the support staff including nursing staff gravely affects the quality of services in the public hospitals. The problem can be remedied by:
• Decentralising appointments of staff at secondary and primary levels to tertiary level.
• Appointments for the tertiary tier to be made by the Mumbai Public Health Department (MPHD).
• Attendance in hospitals to be monitored centrally through bio-metrics and aligning salary calculation with entries in it.
• Setting a target of one month for fresh appointment as soon as a vacancy at any tier of the health services is created.
• Keeping a data base of job-seekers ready to fill up vacancy as and when it arises.

(6) **Partnership with the Non-government Organisations (NGOs):** The Non-governmental Organizations are critical to the government’s endeavours of ‘Health for All’. In the first stage, the Government should utilise the services of NGOs for providing primary health services to slum dwellers. The Government can provide these NGOs with subsidised premises, medicines, finance and trained staff for provisioning of primary health care in slum areas. In the second stage, NGOs can be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalised sections or in underserved areas and aspects, working together with community organizations and local government, and contributing to monitoring the right to health care and service guarantees from the public health institutions.

(7) **Not Only Encouragement but Popularizing and Making People to Use the Indian Medical Systems:** In March 1995, the Department of Indian Systems of Medicine and Homoeopathy (ISM&H) was created and re-named as Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) in November, 2003 with a view to providing focused attention to development of Education and Research in Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy systems. However, the practical applications of these systems are limited. If these systems are popularized and people are rightly encouraged to use these systems for their benefits, the huge burden of patients on allopathic system of medicine will reduce considerably.

(8) **Prevention rather than Cure:** Most of the budget of the state government and local government is spent on providing curative services rather than preventive services. If the same budget is spent on preventive treatment then huge sum of money wasted in treating diseases can be saved. The hygiene and sanitation conditions in slums are very poor which causes a number of diseases such as cough, cold, common fever, malaria, tuberculosis, etc. among slum dwellers. Another major cause of illness is the poor nutrition which also reduces their immunity. Again, a number of slum dwellers avoid visiting doctors immediately on falling sick due to high fees, waste of time and loss of subsistence. This makes the condition of a patient worse. If these factors are taken care of, the number of patients in public hospitals can be reduced greatly.
B. Suggestions for Making Health Care Services Accessible to All:
The Accessibility of health care services in Mumbai is manly constrained by lack of adequate infrastructure, distant locations and fixed operating timings. The researcher has made the following suggestions for making health care services in the city of Mumbai accessible to all.

1. **Restructuring of Health Infrastructure on the Basis of Need rather than Existence:** In past few years, there has been tremendous change in the composition and distribution of population of the Mumbai city. However, the number and location of public health centres in the city have remained more or less same. Population in some areas has reduced (South Mumbai), while in some other areas (North Mumbai) it has increased, similarly slums have readded in some areas while in some other areas number of slum dwellers has increased. Considering this, there is an urgent need for revamping and relocation of the public health care infrastructure in the city.

2. **Looking beyond Notified Slums to find Urban Poor:** It has been observed that the local bodies and state governments only focus on notified slums in urban areas while framing health care policies for poor population. It is suggested that a proper approach needs to be adopted to develop city level urban health plans which are responsive to the urban context. Comprehensive planning is critical to ensure that unlisted and invisible urban poor clusters or slums (which are also the neediest) are reached. The official slum lists should be updated regularly to include all slum dwellers, notified as well as non-notified, irrespective of their origin and background.

3. **Health for ‘All’ at the Doorstep of Needy of Population:** Among the three tiers of health care system, the primary health care centres should be located as close as possible to the needy population. The government should provide health services to people without any discrimination of race, religion, region of origin, caste and community. The primary health services should be provided to people in the periphery of 2-3 km of distance and where it is not possible to provide such services, 24X7 mobile health services will greatly reduce dependence of poor population on private clinics.

4. **Mobile Health Vans:** Mobile health vans, equipped with the basic diagnosis facilities and a doctor and a nurse, can go a long way in reducing the predicament of poor people. The concept of doctor-on-call can certainly help people to access public health facilities as and when required. Each secondary health centre should maintain at least one mobile health van while tertiary health centre should maintain at least two mobile health vans. There should be a centralised arrangement for receiving calls and informing the health van in the vicinity to attend to a patient.

5. **Point of Care Testing Facilities (POCT):** Point-of-care testing (POCT) is defined as medical testing at or near the site of patient care. The main objective of POCT is to conduct the test conveniently and immediately for the patient. There are a number of POCT instruments which are transportable, portable, and handheld instruments. These instruments give immediate results, are convenient and cost-effective and do not require much maintenance. POCT instruments are available for some of the common tests such as blood glucose testing, blood gas and electrolytes.
analysis, rapid coagulation testing, rapid cardiac markers diagnostics, drugs of abuse screening, and so on. Use of such devices can reduce expenses on testing and evaluation facilities and can also help in quick diagnosis of diseases.

C. Suggestions for Making Health Care Services Affordable for All:
The Affordability of health care services not only in the city of Mumbai but in most of the metropolitan cities is a major issue. The researcher has made the following suggestions for making health care services affordable for masses in the urban cities like Mumbai:

1. **Health Cess and Tax Incentives for Investments and Contributions to Public Health:** The Government should consider levying Health Cess in the budget in order to meet public expenditure on health sector. The Government should also provide tax rebate and tax incentives to individuals and corporate for making investments and contributions to the public health sector. This will give boost to investment in public health sector.

2. **Affordability of Healthcare Service during Minor Illness:** The government should ensure that people access Primary Health Centres of the government for treatment of minor illness. This can be achieved by:
   - Primary Health centres should be located as close to the people as possible as suggested in A-1.
   - Primary Health centres should provide free and quality services to people from 9.00 am to 10.00 pm.

3. **Affordability of Healthcare Service during Major Illness:** Medical expense during major illness is a major factor that pushes many families into debt trap and poverty. The cost of hospitalisation and subsequent follow up is huge. Middle class and lower middle class families cannot afford to get in-patient services of private hospitals and therefore, most of them depend on public sector hospitals for treatment. On the other hand, some private hospitals and clinics have excess capacity. This dichotomy in health care services in the city of Mumbai can be resolved through effective public-private partnership. There are many other means of providing in-patient services to the needy population. Some of them are health insurance, information helpline, tie-up with charitable hospitals and charitable institutions, etc.

4. **Financing of Mumbai Public Health Department (MPHD):** The activities of MPHD should be financed by different government agencies in proportion to the number of beds in each hospitals owned by them. Deficiencies, if any, can be met through user charges which should be charged on the basis of paying capacity. BPL families should be provided all facilities free of charge. The burden of subsidies given to BPL families should be borne by the Central government and the respective state governments in certain pre-determined ratio. The Central government should levy health cess, on the lines of education cess, to meet increasing demand for development of health infrastructure of international repute.

5. **Involvement of Individuals, Charitable Trusts, Professional Bodies and Corporates:** In a huge country like India with a creditable high income and middle income groups who consider charity for social cause a religious duty, the
government can certainly look up to them to fill up financial gaps in the health sector. Rich philanthropists, individual donations, donations from corporate and professional bodies may be the crucial requirement in areas to make the PPP initiative effective in delivering health care.

- Social clubs like Rotary Club and Lion’s Club have played a significant role in immunization campaigns, Pulse Polio campaign and other health care services.
- Under the CSR initiatives, the corporate sector has taken active part in advocacy efforts, funding NGOs for innovative interventions, introducing new schemes for the promotion of reproductive and child health services particularly family planning.
- A number of professional associations such as Indian Medical Association, Gynaecologists federation, nurses associations etc. have played a significant role in promoting new programmes such as Vande Mataram Scheme, Gaon Chalo project and immunization programmes.

Though in some states mechanisms and provisions are present for utilizing these private donations for improving local health situation, many other states lack these systems. Efforts have to be made to create simple and transparent institutional mechanisms to encourage donations to contribute to the growth and improvement in reproductive and child health services in their area.

(6) **Filling Information Gap through Medical Helpline:** A number of provisions such as quota in private hospitals, free facilities in charitable hospitals, medical aid given by charitable institutions, etc. are not known to poor population. This information gap should be filled by creating a 24 X 7 helpline for providing information like, availability of beds in hospitals, facilities in different government hospitals, availability of quota for BPL families in private hospitals, details of charitable hospitals and their services and medical aid provided by various private trusts, religious trust and corporates.

(7) **Health Insurance for BPL Families:** The Ministry of Labour and Employment, Government of India has launched the Rashtriya Swasthya Bima Yojana (RSBY) on 1st April 2008 to provide health insurance coverage for Below Poverty Line (BPL) families. Beneficiaries under RSBY are entitled to hospitalisation coverage up to Rs. 30,000/- for most of the diseases that require hospitalisation. However, the awareness among people about the scheme is very low. In the survey, none of the respondents was aware of this scheme. Therefore, the Government should undertake a mass drive to inform and encourage BPL families to enrol for the scheme.

(8) **Universal Health Insurance Scheme:** The Planning Commission has accorded a top priority to healthcare sector is the twelfth Five Year plan (2012-2017). In the 2012-2017 Plan, the Indian government aims to increase the spending on the healthcare from current 1% of the GDP to 2.5% of the GDP. This is paving the way for recognition of the “Right to Health” as a fundamental right. The Government should extend the Rashtriya Swasthya Bima Yojana (RSBY) to all individuals in the economy in order to make it more inclusive and recognise the basic right of people to good health. In order to achieve this, the government should lay down
different layers of premium for different categories of beneficiaries based on their paying capacity.

D. Administrative Reforms:
(1) **Demarcation of the Fields of Services of Primary, Secondary and Tertiary Health Care Infrastructure:** The roles and functions of the three tiers of health system in Mumbai should be clearly demarcated so as to avoid too much pressure on one level and too less on the other. It is recommended that the Primary Health Care Centres should only look after routine problems like fever, cough, cold, body pain and like. The secondary level centres should provide only specialized services like delivery services, child care, etc. and the tertiary level hospitals should deal with only major and complicated health problems such as heart diseases, renal failure, etc.

(2) **Establishment of Mumbai Public Health Department (MPHD):** An independent department dealing exclusively with public health in Mumbai city should be established to take over the administration all government hospitals, hitherto looked after by different agencies like municipality, state governments, railways, etc. However, the ownership of these hospitals should be vested with their owning bodies. This will bring about greater efficiency and transparency in the functioning of public clinics and hospitals. It will also avoid duplication of work and functions.

(3) **Building Co-ordination among Public and Private Urban Health Stakeholders:** There are multiple urban health stakeholders including Health and Family Welfare Department, ICDS, ULBs, DUDA, NGOs, CBOs, donor agencies, professional bodies (IMA, IAP), formal and informal private practitioners, corporate sector, charitable organizations, employee state insurance and local resources such as schools. These stakeholders operate in isolation with little coordination. They can benefit greatly by sharing resources, information and expertise and avoiding duplication of efforts. This co-ordination can be brought about by the Mumbai Public Health department (MPHD) by creating a data base of various stakeholders and securing their active participation in policy.

E. Quality Initiatives in Health Sector:
(1) **Establishment of a Healthcare Assessment Cell within the Mumbai Public Health Department (MPHD):** A Healthcare Assessment Cell should be established within the Mumbai Public Health Department for continuous evaluation and assessment of public healthcare system in the city of Mumbai. Such cell should supervise the public health care service at all three levels – primary, secondary and tertiary levels.

(2) **Improving the Quality of Health Services in Public Hospitals:** As well as being accessible and affordable, health services must be of decent quality. This means not only offering a good standard of care, but also reducing waiting times, making medicines available and treating patients with respect. In order to improve the reach and quality of health services, there is a need to provide motivational training to health providers to make them more sensitive towards the disadvantaged. Each urban child should be provided with health card to avail basic health services free of cost.
(3) **Adopting International Standards in Health Sector:** With increasing internationalisation and integration of the Indian economy with the global world, the Indian planners should also work on integrating Indian health sector with international. India should not only accept norms such as 4 hospital beds per 1000 population or 2 doctors per 1000 population as minimum targets, but should also focus beyond on how to achieve these benchmarks.

(4) **Compulsory Accreditation of Public and Private Hospitals:** The MPHD should create an independent agency for accreditation of hospitals in the city. While grading private hospitals more weightage should be given to their contribution to society in terms of provision of health care for poor segment and special categories such as backward classes, minorities, women and children and clinical research and observance of ethical standards. Accreditation of public hospitals should be based on their effectiveness in dealing with health problems of poor population, standards of cleanliness, attendance in government hospitals, maintenance of equipments and testing facilities, filling up of posts in the government hospitals, number of patients’ complaints and their resolution, etc.

(5) **Health Sector Data Base and Management Information System:** An Information Cell should be set up under the auspice of MPHD for collection of data and information about health sector in Mumbai city. The Cell should undertake mapping of the city to locate vulnerable population. It should detail the existing health facilities and identify gaps between the demand for and supply of health care facilities in the city. It should also collect data about proliferation of various diseases and existing facilities to treat these diseases.

**F. Human Resource Development Initiatives in Public Hospitals :**

1. **Improving Staff Attitude and Approach towards Poor and Neglected Class:** Along with quality of services, it is also important to improve staff attitudes towards poor people and their treatment. *For example*, by promoting listening skills, instilling in staff the idea that poor people have a right to health care and to be treated with dignity. The hospitals authorities should install a system to monitor staff behaviour and channels through which poor people can complain and get feedback.

2. **Incentives for Working in Slum Areas:** Most of the doctors and nurses avoid working in slums under unhygienic and poor environmental conditions. This is a problem often neglected by health policy. Therefore, the health policy must make provisions for imparting periodic sensitivity training for the staff in public hospitals in order to sensitise them towards the health needs of slum dwellers. Mere training will not suffice; they should also be given special allowances and incentives for working in slums.

**Summary and Conclusion:**

It can be concluded from the analysis of the responses of the respondents and secondary data collected from various published sources and the results of the hypotheses testing, that public health care system in urban areas is inadequate to meet the rising requirements of the city population. The government spending on healthcare sector continues to be low – at below 1% of GDP since independence. It is important to question whether it is only the low investment in
health that is the main reason for the present status of the health system or is it also to do with the framework, design and approach within which the policies have been planned.

Two important issues can be highlighted from the above discussion:

(1) The Government must increase health expenditure to a minimum of 2.5% of the GDP in order to achieve the objective of “Health for All”. This requires integration between the budgets of various local self government, state governments and the Central government.

(2) The present public health infrastructure in the city is not being utilized properly due to lack of centralized planning and innovations in the traditional pattern of health infrastructure. The entire system needs revamping to meet the existing health care needs of the city population.

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