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Reproductive Health Matters 2011;19(37):32–41
0968-8080/11 $ – see front matter
PII: S0968-8080(11)37560-X

www.rhmjournal.org.uk

Poor standards of care in small, private hospitals in Maharashtra, India: implications for public–private partnerships for maternity care

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Abstract: *The private health sector in India is generally unregulated. Maharashtra is among the few states which require registration of private hospitals. This paper reports on a study of standards of care in small, private hospitals (less than 30 beds) in Maharashtra state, India, with a focus on maternity care, based on interviews with the hospitals' owners or senior staff, and observation. In the absence of reliable information on the number of private hospitals in the state, a physical listing was carried out in 11 districts and an estimate drawn up; 10% of hospitals found in each location were included in the study sample. We found poor standards of care in many cases, and few or no qualified nurses or a duty medical officer in attendance. Of the 261 hospitals visited, 146 provided maternity services yet 137 did not have a qualified midwife, and though most claimed they provided emergency care, including caesarean section, only three had a blood bank and eight had an ambulance. Government plans to promote public–private partnerships with such hospitals, including for maternity services, create concern, given our findings. The need to enforce existing regulations and collect information on health outcomes and quality of care before the state involves these hospitals further in provision of maternity care is called for.*
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Keywords: private health sector, quality of care, regulation, maternity care, public-private partnerships, India

INDIA has witnessed a rapid expansion of the private health sector in the past two decades. Central and state governments have played a critical role in this growth, by reducing public expenditure on health, allowing the mushrooming of private medical colleges, giving concessions and subsidies to "charitable trust hospitals"* to import medical equipment and selling them land to build new facilities at nominal prices.

The vacuum created by the deterioration and even, in some places, the non-existence of public health services is being occupied by the private (mostly for-profit) health sector, resulting in an increase in the number of private hospitals from 14% of all hospitals in 1974 to 68% in 1995.[1] By 2004, nearly 70% of all hospitals and 40% of all hospital beds in the country were in the private sector, but importantly, over 80% of these were in urban areas.[2] The utilisation of public sector hospitals has concomitantly been declining in several states, including Maharashtra.[3,4]

Low public health expenditure continues to characterise the Indian health system and is

*Hospitals registered as charitable trusts get concessions under various laws. They are required to reserve 20–30% of beds and outpatient services for the poor and weak.

lower than 1% of GDP. As a consequence the out-of-pocket burden on households has been the main source of financing of health care, accounting for 80% of total health expenditure. The deterioration of public health services due to reduced investments and expenditures, is increasingly forcing people to access health care from the rapidly expanding private sector.[5,6]

It is well established that the private sector is characterised by heterogeneity. At the primary level it consists of individual practitioners; at the secondary level there is enormous variation in the size of facilities, number of beds, and types and costs of services.[1,7] The secondary level consists of small and large private hospitals or nursing homes, providing both outpatient and inpatient care, the majority with less than 25–30 beds, mainly owned by doctors as sole proprietors.[8,9] Facilities range from modern, sophisticated hospitals serving the needs of the affluent classes to dilapidated rooms in slums run by semi-qualified persons. Tertiary speciality and super-speciality hospitals are mostly trust or corporate hospitals and comprise only 1–2% of the total beds in the private sector.[5,10]

Despite the huge growth in investment in the private sector across all regions, there is no proper regulation or required standard of care, unlike the public health sector, which has norms for all facilities, from hospitals to dispensaries. The regulatory and institutional mechanisms for promoting accountability are weak in both public and private sectors. Several studies have commented on the variable quality of public services due to lack of adequate infrastructure, human resources and indifferent public employees.[5,11] However, the assumption that private services offer superior quality is not adequately supported by hard evidence.[12] Serious concerns have been raised by health researchers and activists regarding access, cost, quality and equity in some private services.[13,14] Studies over the past 20 years have demonstrated the often poor quality of care, over-hospitalisation, excess use of technology in diagnosis and treatment, over-prescription of drugs, absence of standardisation of fee structures and poor record-keeping.[1,13–16] Official registration of private hospitals is also low. Researchers have found through physical mapping that there are 4–10 times more private hospitals than are registered in government records.[13] Due to poor registration, there is no reliable information on the exact size and nature of the private sector, let alone any data on quality or cost of care. Research on private hospitals therefore poses a huge challenge as accessing data from them is difficult.

With respect to women's sexual and reproductive health, high rates of caesarean sections and hysterectomies in the private sector have been noted.[17,18] A study in Trivandrum district, Kerala, found that caesarean sections were performed three times more in private hospitals than public ones.[19] Moreover, since the advent of a government health insurance scheme for the poor called Aarogyasri, doctors are being reimbursed directly for certain procedures, including hysterectomy, through a network of government and private sector services. A 2009 study among 1,097 women aged 25–40 in five districts of Andhra Pradesh, conducted by the non-profit AP Mahila Samatha Society, found an increase of 20% in hysterectomy cases since July 2008. They also found that doctors had told 30% of the women that they would die if they did not have the operation.[20] Because irregularities had been found in claims for laparoscopies in one district; the Society is concerned that some hysterectomies may have been unnecessary.

Despite these problems, the government has been promoting public–private partnerships (PPPs) for a long time. Evidence suggests that public–private partnership initiatives in India started mainly with family planning, described in the first five-year plan (1951–56). The private partners were involved in creating awareness and demand for family planning services through community mobilisation. Few were involved in provision of contraception and abortion services. Over the years, the nature of such partnership has evolved beyond a peripheral role for non-state partners to a formal role in provision of services. The National Health Policy 2002 as well as National Rural Health Mission mandate partnerships with the private sector to increase access to services.[21] However, analysis in 2008 and 2009 showed that such partnerships have led to fragmentation of health programmes and that they lack institutional mechanisms for ensuring accountability and effectiveness.[21,22]

In the case of the recent Chiranjeevi Scheme in Gujarat for delivery of Reproductive and Child Health services, the government provides

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