Private Health Sector in Maharashtra
A study of private hospitals

Padma Bhate-Deosthali and Ritu Khatri

Research Assistance
Sushma Gamre

Research Team
Chandrima Chatterjee
Suchitra Desai
Amita Pitre
Varsha Zende
Ravi Pillai
Amit Khandelwal
Santhi Nakkeeran
Habibullah Ansari

Cehat
Centre for Enquiry into Health and Allied Themes

Published in 2011

For additional Copies of this report, please contact:

Centre for Enquiry into Health and Allied Themes (CEHAT)
Survey No. 2804 & 2805
Aaram Society Road
Vakola, Santacruz (E)
Mumbai – 400055
Tel: (91) (22) 26673154, 26673571
Fax: (91) (22) 26673156
Email: cehat@vsnl.com

Website: www.cehat.org

Citation
Bhate-Deosthali, Padma and Khatri, Ritu. Private health sector in Maharashtra: A study of private hospitals. Mumbai: CEHAT, 2011

ISBN : *978-81-89042-54-7*

Cover design by : Wordcraft

Printed at:
Satam Udyog
Parel, Mumbai - 12

Table of Contents

Glossary/Abbreviations

BAMS	Bachelor of Ayurvedic Medicine and Surgery
BHMS	Bachelor of Homeopathic Medicine and Surgery
BNHRA	Bombay Nursing Home Registration Act
BMW	Biomedical Waste Management
CME	Continuous Medical Education
CPA	Consumer Protection Act
CPR	Cardio Pulmonary Resuscitation
DHMS	Diploma in Homeopathic Medicine & Surgery
DMO	Duty Medical Officer
GoM	Government of Maharashtra
GoI	Government of India
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
IPD	Inpatient Department
MCI	Medical Council of India
OPD	Out patient Department
OT	Operation Theatre

Blank

Acknowledgments

We would like to thank all nursing homes and those who participated in this research. The study has been possible due to their cooperation and support. We are grateful to the Health Department of Maharashtra, the District Health Officer/Civil Surgeon, offices of the Indian Medical Association, Medical Officers and staff from Primary Health Centres and Rural Hospitals, Municipal Corporations of the cities, the Public Works Department and Panchayat Samitis, Pharmacist Associations and the hospital owners association at the local level. Last but not least, our special thanks to local NGOs for their help during different stages of this study.

We sincerely acknowledge the contribution of all researchers who have worked on this project through its various stages: Amita Pitre and Santhi Nakeeran, who developed the research design based on an earlier study by CEHAT, Chandrima Chatterjee who anchored the project from data collection and also prepared a draft report with Suchitra Desai. Varsha Zende, Habibullah Ansari, Ravi Pillai and Amit Khandelwal for their contribution in data collection. All of them have contributed in various capacities and made this study possible. We thank Yashashree Keni for her research support.

The first draft of the study was reviewed by PDC (Programme Development Committee) members Dr Padma Prakash, Dr Vibhuti Patel, Dr Lakshmi Lingam and external experts, Dr Amar Jesani, Ravi Duggal and Dr Rama Baru. We thank each one of them. This draft report was substantially revised, incorporating new analysis, adding of chapters and in the presentation of data. It was again peer reviewed by Dr Padmini Swaminathan, Dr Padma Prakash, Dr Vibhuti Patel and Dr Lakshmi Lingam. The revised report was also sent to external reviewers Dr Sundari Ravindran, Dr Raman Kutty and Dr Anant Phadke and we are grateful for their invaluable comments. We have tried our best to incorporate all the feedback received and we hope that this report will lead to more enquiry into the private health sector.

Priyanka Shukla has ably coordinated the publication of the report. We are grateful to her for her painstaking effort. We also thank Dr Yashashree Keni, Suchitra Desai and Dr Anita Jain for their inputs in finalising the manuscript for publication. Many thanks to Dr Padma Prakash for editing this report and improving its readability.

Blank

Preface

Partnership between the public and the private sectors for a common goal is not a new concept or practice used globally. In the past, the governments used to give contracts for infrastructure development or grants for R&D of a publicly useful product. India has gone through swings of privatization (of infrastructure, transit, education, health care, pharmaceuticals, housing, power generation, banking, etc.) to nationalization of the same sectors providing public goods. Economic compulsions, political preferences, and learnings out of previous experiences (in that order) are the reasons for the public sector partnering with private sector to meet its obligations to the citizens.

Historically, investment by the government has not kept pace with the needs of the people for a variety of products and services. Such 'lagging behind' of organizations having the mandate to provide these products and services has led to their partnerships with those which can facilitate to achieve their goals. The underlying factor for such partnership is "...public sectors' inability to provide (these) public goods entirely on their own, in an *efficient*, *effective* and *equitable* manner because of lack of resources and *management issues*."[1] (Italics mine – DM)

Public Private Partnership (PPP)[2] in health and healthcare sectors is a comparatively new initiative globally. In countries like the UK, Germany, Canada etc. the governments, through widely different mechanisms, are 'buying' healthcare services from the private sector on behalf of their civil societies and make it available to them.[3]

Public ó Private Swing or peaceful co-existence as providers of health and healthcare services is a historical phenomenon in India. PPP existed in a limited area mainly in procurement of essential products for the public health sector (vaccines, pharmaceuticals, instruments etc.) from the private sector. Legal obligations of the private sector like licensing, registration, auditing and rudimentary regulation was obligatory in the partnership – a compulsory marriage, so to say - of the private sector with the public health sector. Now, PPP has started with a minimum common goal of providing quality healthcare services. Initially, the partnership is limited to M&E, R&D, providing specific services like institutional deliveries, implementation of NHPs and PHC etc. The result is mixed. There are successful models and not-so-successful ones in India.[4,5]

However, there are several learnings from these experiences. The learnings indicate that the best PPP should be built up on the following tenets:

- **Transparency:** All the processes of selecting, designing, costing and awarding contract to an individual or agency for partnership should be transparent. Monitoring of its implementation and its outcome should also be transparent and information should be available to the people immediately.
- **Impartiality between public and private sectors**: A PPP project should be designed and implemented with utmost concern that it does not compromise public health priorities. If not done carefully it will weaken the public sector's capacity to uphold regulations. If there is any shift with a bias for private against public

[1] Nishtar, Sania *Public – private 'partnerships' in health – a global call to action.* Health Research Policy and Systems 2004, 2:5 available on http://www.health-policy-systems.com/content/2/1/5

[2] http://blog-pfm.imf.org/pfmblog/2008/02/a-primer-on-pub.html#more

[3] http://en.wikipedia.org/wiki/Public–private_partnership

[4] DEA, MoF, GoI and ADB. Facilitating Public–Private Partnership for Accelerated Infrastructure Development in India - Regional Workshops of Chief Secretaries on Public–Private Partnership, December 2006

[5] Mankad, Dhruv; Thayer, Christine; George, Alex; Ramanan, Harish. Report On Good Practices And Their Cost Effectiveness (Reproductive And Child Health), MoHFW, GoI and EU, New Delhi, March 2004

health sector under the guise of partnerships, there is a danger of displacing the marginalized and may therefore be in conflict with the fundamental concept of equity in healthcare.

- **PPP as a part of social responsibility of the public sector**: PPP does not mean renouncing of responsibility by the public health sector. Failure of the state in such partnerships may result in a *laissez-faire* attitude, prejudicial to the civil society particularly the interest of the vulnerable groups.
- **Value for money**: After all, it is public money which is spent for providing public goods/services and so whether it is for or not-for-profit, it should be reasonably good both in content and its quality for the money spent. There were gaps found in good quality services at reasonably high cost in its economic sustainability. A low cost, good quality model is designed and implemented on BOT (Build-Operate-Transfer) mode. However, its post transfer O&M (operating and maintenance) costs are not included. This makes it a 'no value for money' project and hence it can become socially useless. The costing of a project should be able to balance between its current investment and its long term cost and needs.
- **Integration of healthcare services**: The purpose of PPP is to have a team approach with public health sector, private health sector and the civil society as key players to achieve a common goal of building up a universally accessible and affordable healthcare system. Any PPP project must ensure that competition and conflict of interests does not lead to further fragmentation of an already weak healthcare system. No doubt, the project must be designed in a way that it is mutually rewarding – economically as well as socially.[6]
- **Financially workable**: Integrated projects can be cost cutters, can be for or not-for-profit but never the less require a steady cash flow. Sharing costs, partial contribution or margin money etc. is just an assurance about the financial capacity of the contracted agency. But any pinch in amount, time or pace of cash flow undermines the partnership. Cutting corners reduces both its quality and its long term sustainability.
- **Fiscal clarity**: NRHM (National Rural Health Mission) is in a way large scale PPP between GoI and the State NRHM Society. It appears on Central Government budget but not on State Government budget. There are some accounting controls on it but a large scale PPP may not have as it is a long term investment and liability is transferred to future. Some clear accounting and control set ups should be set up to make a PPP accountable.[7]

Based on these tenets, recently a new concept has been developed particularly in Austria. It is named "public social private partnership" (PSPP)[8]. In essence, PSPP is not merely an extension of the PPP idea, but a precondition for ensuring that a PPP with a social goal:

- assures and implements the public aims, agendas and tasks in the sense of community benefit, welfare, etc.;
- adheres to and sustains the agendas and aims of co-operations in the mid- and long-term;
- plans and suitably applies the necessary conditions and resources (e.g. financing) for sustainable results.

There are 3 main characteristics of this concept:

- The "S" of the name indicates exactly the goal and purpose of the public or private financing : the servicing for social protection and support interests and activities for the improvement of health and healthcare for disadvantaged people
- A PSPP has the character of a financing or resource-generating mechanism
  Thus, the joint responsibility goes beyond just financing. It includes infrastructure, human resources,

[6] In other sectors, it has been found that a bundled contract is preferable for setting up a system with one agency rather than fragment it. E.g. building up a full EmOC system should be given to one agency as a whole. It could include setting up EmOC at a hospital level, making available required specialists and facilities, capacity building of the selected hospital staff, setting up a helpline and transportation system with appropriate capacity building, availability of flexifunds etc. If such services are available already then these should be integrated under a single system if feasible.

[7] http://bankwatch.org/documents/never_mind_the_balance_sheet_SHORT.pdf

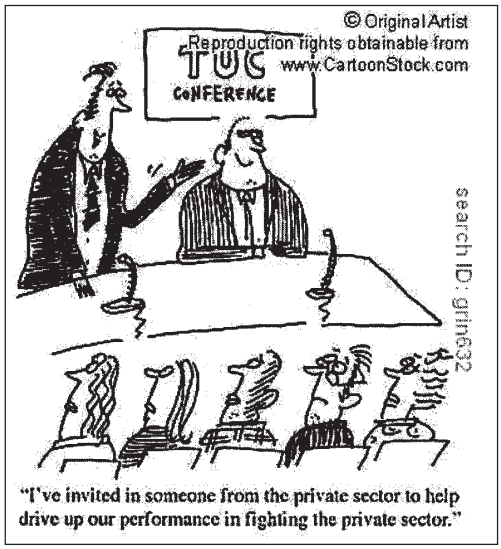
[8] http://en.wikipedia.org/wiki/Public/social/private_partnership

operational tools and mechanisms, regulation and monitoring mechanism of the services and products for fulfilling its social goals.

- "Partnership" means that the scheme really requires at least two partners to generate financial and other resources to achieve the common goal/s.

These should be the preconditions if the PPP has to become a PPSP.

PPP is on a crossroad when it is conceptualized for welfare or social services. All are not comfortable with its existing models - neither the government nor the providers nor the public. High expectations, delays in and inadequacy of cash flow, no improvement in effectivity or equity in health care services has lead to bitterness among all the three stakeholders about each other. One may agree with 'Kash', an Urdu e-poet [9] :



Adawat bhi mujhi se hai, rafaqat bhi mujhi se hai
Us shakhs ko be-intiha mohabbatbhi mujhi se hai

Tarif kari meri phir yeh khamosh ho gaya Shayad
kahna chhahata hai, muzallatbhi mujhise hai

(Hate with me and partnership, too
unlimited passion for me, you have!

You praised me and then, went quiet, so
May be you're saying - there's a problem with me, you have!

- A dialogue between public, private health sector and the civil society!)

PPSP is a more appropriate concept which needs to be contextualized with Kash's expressions when designing a PPP in health sector to ensure that finally, all is well!

CEHAT (Centre for Enquiry of Health and Allied Themes - a Research Centre of Anusandhan Trust) has co-ordinated an initiative to revive, review and facilitate rewriting the rules of regulation of private health care services, initially limiting to Maharashtra state. As a part of the initiative, the CEHAT team has conducted an exploratory study to assess the status of the private hospitals if the benchmarks (not rules, as it is in a draft form not having a legal status as yet) laid down under the BNHRA are applied. Its findings and conclusions have to be seen with the perspective of PPSP. It has shown the steps to be taken before the modified Act is actually implemented.

We hope that the study would generate a fruitful debate and to initiate further in depth studies on architectural, legal, social, financial and personnel context of PPSP. It should lead to the bells tolling - *Allizwel* !

Dhruv Mankad
Trustee, Anusandhan Trust

[9] http://www.yoindia.com/shayariadab/ghazals/adawat-bhi-mujhi-se-rafaqat-bhi-mujhi-se-hai-t54575.0.html

Blank

Executive Summary

The private health sector has grown rapidly in India over the last few decades. The sector comprises a wide range of providers in different systems of medicine; encompasses a variety of ownership patterns and ranges from very small institutions to huge hospitals. Given its size, complexity and volume of care it provides, it is ill- regulated with no proper legislation and guidelines on standards for care. In sum the sharply rising out- of-pocket expenditure on health care is not accompanied by even a minimal guarantee of quality of service. In these circumstances what is the kind of care on offer in the private institutions so rapidly growing in the country?

Maharashtra is known for the large and sharply growing private health sector. It is also among the states that has attempted to introduce some mandatory norms for the sector. This study was aimed at understanding just what is available to consumers of health care in small (less than 30 beds) hospitals in 11 districts of Maharashtra (including Mumbai). It also sought to find out what providers think of the state legislation-BNHRA (Bombay Nursing Home Regulation Act) and the issue of accreditation. In the context of the amendment to the BNHRA which made it applicable to entire state, it was pertinent to examine standards of care in private hospitals across different districts across levels of development and the size of institution.

The study was conducted across 261 private hospitals from 10 districts of the state, Nashik, Nandurbar, Pune, Satara, Thane, Ratnagiri, Osmanabad, Aurangabad, Amravati and Gadchiroli. Greater Mumbai was included for its unique features of complete urbanization, rapid expansion of the private medical sector, the huge population base with a high standard of living and very high real estate prices. The sample included 45 hospitals from Mumbai, 185 from developed districts and 31 from less developed districts.

Key Findings

The study provides a profile of private hospitals and private providers for the state of Maharashtra in terms of years of establishment, regional spread and size. It documents ownership and practice patterns. The bed occupancy in the state has shown a steady increase over the years indicating rising utilization of private care in health.

Most hospitals in the state are medium sized, providing multiple allopathic services dominated by medicine. Self – proprietorship is the dominant type of ownership but partnerships are increasing, especially in Mumbai, mostly operating from their own place. Multiple practices are common, not just in terms of doctors seeing patients in multiple hospitals but also in terms of ownership of hospitals.

The availability of adequate appropriate human resources is a prerequisite for provision of good care. In this study a large number of hospitals did not have any qualified staff; those that had qualified staff were severely understaffed. About half the hospitals had no duty medical officer (DMO) and where present, these doctors were non-allopaths. The average number of qualified nursing staff[10] for each hospital in our study is 1.68 nursing staff per hospital which is well below the minimum requirement for a hospital. We found that more than 50 per cent of hospitals did not have a single qualified nurse. The hospitals were found to be recruiting unqualified and untrained nurses. The study found

[10] Qualified nurses were ANM or B.Sc

that the status of other para- medical staff such as midwives, aayabai, ward boys or even technical staff at hospitals showed a similar picture. Some small sized hospitals located in less developed areas are struggling with infrastructure problems, especially human resources.

In the absence of any standards for small sized hospitals, it becomes a challenging job to assess standards of care in these hospitals. So, we have looked at certain minimum standards that are essential. The data collected is not very extensive but the study is able to capture major shortcomings in the quality of care which are of concern to a patient when he/she approaches a private health facility like: Functional plan in the hospital, emergency services, record maintenance and a grievance redressal system.

Even though 87 per cent of the hospitals reported providing emergency services, only 50 per cent provided round-the-clock services which were mostly provided by untrained staff for these situations. Only 5 per cent of the hospitals had ambulance services. Even though basic facilities like refrigerator, telephone line, continuous water supply and toilets are present, none of the hospitals follow the functional plan in their hospitals. Hospital feedback mechanism towards patients in terms of record maintenance, information given to patients and grievance redressal mechanisms are in bad shape in the smaller private hospitals.

This study provides a snapshot of standards of care in private hospitals as they exist presently. Earlier research has found that these hospitals fail to provide even basic physical standards like drinking water, ventilation and so on. We found that while they have reasonably improved these aspects, other components of service provision are poor.

The last section of our study looks at the awareness of private health providers regarding BNHRA and at the difference in the perception about the BNHRA and accreditation. The study found that only about 76 per cent of providers knew of the BNHRA Act. Even fewer providers registered an awareness of the Act in less developed regions.

Mandatory registration is obviously being seen as a mere formality and paper work. The awareness about accreditation is high in large hospitals and those located in Mumbai and developed districts. Hospitals located in less developed districts and those that were small in size expressed concern that costs would rise with self regulation.

The private health sector is growing rapidly across all regions irrespective of level of development. The BNHRA has been implemented in the state but is restricted to mere registration on paper without screening or monitoring of hospitals. We also found that standards of care are influenced by the market and competition has not necessarily led to better standards. Better compliance to other laws and guidelines as compared to the BNHRA that actually registers them as 'hospital' indicates the apathetic attitude towards this law.

We hope that the findings of this study will be useful for the state and the medical associations in understanding the current scenario of private hospitals and developing standards of care keeping in mind the needs of patients and the ground reality.

CHAPTER 1

INTRODUCTION AND METHODOLOGY

Blank

INTRODUCTION

The private health sector in India is a huge and expanding industry. The past few decades, particularly, have witnessed an enormous growth in the private health sector. A major reason for this was the underfinancing of the public health sector, which was clearly evident in the nineties[11]. To begin with, the private health facilities grew mainly in the metropolitan areas which had poor health care facilities and where public health facilities were failing to provide appropriate health care. Today, the private health care constitutes two-thirds of India's health care sector.

The private health sector is highly commercialized with an almost exclusive emphasis on diagnostics and curative services. This has created a big opportunity for the expansion of the market in pharmaceuticals, medical equipments and of medical insurance corporations in the health sector.[12] The decreasing government expenditure on health, the mushrooming of private medical colleges, and the numerous concessions to private concerns such as subsidies being provided on the import of medical equipments, cheap or free land to 'trust' hospitals have together played a significant role in promoting this growth.

The private health care sector comprises private medical practitioners from across different systems of medicine like the allopathy, ayurveda and homeopathy systems of medicine. It also comprises hugely hospitals including corporate and trust hospitals, maternity and nursing homes, and specialty hospitals[13]. These practitioners and hospitals are part of the formal private health sector. Diagnostic services and pharmacy shops may also be part of this sector. There is also an informal private health sector composed of quacks, bonesetters, dais, bhagats, vaidoos, witch doctors, herbalists, traditional healers, local disease/technique specialists like abortionists, white discharge experts, jaundice specialists, snakebite specialists, etc.[14] Most of the formal and informal health sector works for profit and is referred to as the "for-profit" private sector. The "not-for-profit" private health sector includes large tertiary care hospitals that provide care on a case to case basis and claim to be non-profit, charitable institutions whose work is a blend of the clinical and the social fields and institutions focused on creating a difference by identifying needs of the poor and those living in rural areas[15].

Other than the above, the pharmaceutical industries, the medical equipment and technology industry, medical and educational institutions, and the hospital construction industry are also in the private sector. Recent times have witnessed the setting up of large corporate hospitals. These super-specialty hospitals supported by NRI's and pharmaceutical companies are at the core of the burgeoning medical tourism industry[16]. The Investment Commission of India has estimated that the number of medical tourists has increased almost 20-fold since 2000 to about 1,80,000–2,00,000 in 2006. By 2012 medical tourism is expected to become a US$ 2.2 billion industry.

The health care system in India has two main components: the "financing" component and the "service provision" component. The former is explained briefly, followed by the latter, which is the main focus of the report. The clinics,

---

[11] Duggal, Ravi. Privatization of Healthcare in India, Novib Newsletter, The Hague, March 2003, 2 p.
[12] Baru, Rama. Privatization of Health Services: A south Asian Perspective, EPW, October 18, 2003
[13] Duggal Ravi, Nandraj Sunil. Regulating the private health sector.
[14] Duggal Ravi, Health Sector financing in context of women's health.
[15] P. Berman. Getting more from private health care in poor countries. *International journal for quality in healthcare* 2001. 13(4) pp. 279-280
[16] A.Venkat Raman. Private Sector in Health care Delivery in India. Reading material prepared from the report of National Commission on Macronomics and Health, 2005.

hospitals and pharmaceutical companies are financed through a fee-for-service mechanism, the insurance companies are financed through individual and company premiums and the charitable institutions through donations from government and the private households. The table 1 shows that the private health sector is essentially financed by household out-of-pocket expenditure.

Table 1. Private Health Care Provision and Private Health Care Financing in India[17]

Health Care Provision	Health Care Provided Through	Health Care Beneficiaries	Health Care Financing
1. Private hospitals	Hospitals owned by individuals/groups of individuals	Open to all	Fees for the services (Households)
2. Private dispensaries	Hospitals owned by individuals/groups of individuals	Open to all	Fees for the services (Households)
3. Physician consultants	Consultancy clinics and private hospitals	Open to all	Fees for the Services (Households)
4. Charitable hospitals / research labs	Hospitals owned by individuals/ trusts/ philanthropists	Open to all	Contributions from philanthropists / fees for the services on no profit basis (Households)
5. Private corporations (Joint Stock Companies)	Hospitals owned by them and reimbursements	Restricted to their employees	Profits, tax concessions, grants from government, and fees
6. Private corporate hospitals	Owned hospitals	Open to all	Fees for the Services (Households)
7. General insurance	Public hospitals/ private hospitals/ corporate hospitals	Open to all	Premiums from insurers (Households,corporations, institutions)
Medical insurance	Physician and Consultants		
8. Native doctors such as Vaidya, Hakims, Tantrics, Naturopaths, etc.	Own clinics	Open to all	Fees for the services (Households)
9. Pharmaceutical companies/surgical & opthalmological equipment manufacture companies, etc.	Medical stores and dispensing chemists/ hospitals (private and public)	Open to all	Fees for services and/ or supply of goods in question (Households)

Source: Charu C. Garg. Equity in health sector financing and delivery in India. June 1998

[17] Garg, Charu C. Equity in health sector financing and delivery in India. June 1998**. (***www.hsph.harvard.edu/research/takemi/files/rp144.pdf)* dated: 25/12/09

The National Health Accounts Report (2004-2005) of the Ministry of Health and Family Welfare shows that in India out of the 4.25 per cent of GDP spent as total health expenditure[18] (2004-2005), the private health expenditure constitutes around 3.32 per cent of the GDP as against the public health expenditure which constitutes only 0.8 per cent of the GDP. Out of the total share of private health expenditure funds, 71.1 per cent comes from the households[19]. Data from NSSO 52nd round indicates that in order to be able to access services from the private healthcare facilities, often users have to sell their assets or have to incur debts, which leads them more into poverty.

The second component, of the private health care sector is the service delivery component. Findings from NFHS-3 data indicate the wide utilization of the services provided by private health sector by households of the country. The data indicates that two-thirds (65 per cent) of the households in India seek services from the private health sector, 70 per cent in urban areas and 63 per cent in rural areas and the remaining one-third from the public health sector. Poor quality of services and unavailability of public health facility are the main reasons cited by the households for utilization of private services over public services.

An analysis of the utilization of private health care services shows that utilization of increases with increase in the wealth quintiles. However, percentage of utilization of private health care services among all the wealth quintiles was more than the utilization of public health care services.[20] Data from 60th round of NSSO shows a similar picture. For non-hospitalized medical treatment of ailments, the proportion of total ailments that were treated by private healthcare providers in rural and urban areas was 78 per cent and 81 per cent, respectively. Similar to the NFHS finding, the NSSO data finds a relative decline in the use of public health care providers as measured by proportion of ailments treated among the lowest to the highest MPCE class. In rural areas proportion of those who received treatment from government institutions for the highest (Rs. 950 and above) and lowest (less that Rs. 225) MPCE class was 30 per cent and 18 per cent respectively. In the urban areas the corresponding figures were 26 per cent and 11 per cent respectively. Similar were the findings for hospitalized medical treatment among both urban and rural areas with dominance of the private sector in treatment of the cases. The proportion of cases treated in private hospitals compared to public hospitals was also seen to hugely vary in some states like Bihar, Haryana, Karnataka, Maharashtra, Punjab, Tamil Nadu and Uttar Pradesh with a predominance of cases treated by private hospitals.[21]

Despite huge growth in terms of investment and size across all regions, the private sector functions without adequate legislation and standards of care. Also, there is no guarantee of even minimum quality of services for patients who have to incur out-of-pocket expenses to avail services from this sector. This sector is using the public money but not sharing the social responsibility of the national health goals and good quality universal healthcare. For example, the medical education has been highly subsidised and most graduates join the private sector. The huge and mostly unregulated private health sector in low-income countries raises serious concerns. The quality of drugs, treatment and care sold privately is often dangerously poor.[22] In the absence of national legislation or mechanism for registration of health establishments, it is left to the few states to bring order to this sector. But armed only with archaic laws for registration of private hospitals, which do not have sufficient provisions to regulate properly, this is an impossible task.

---

[18] Private health expenditure includes expenditure incurred by the households (including premiums for insurance, social insurance funds, NGOs and firms for financing both public and private healthcare services, whereas public health expenditure includes expenditure by the government)

[19] National Health Accounts India 2004-05(With Provisional Estimates from 2005-06 to 2008-09). Ministry of Health and Family Welfare, Government of India. (*http://www.mohfw.nic.in/NHA per cent202004-05 per cent20 Final per cent20Report.pdf.*) dated 29/12/09.

[20] Morbidity and Health care .Chapter 13.Volume 1.NFHS-3 National Report. *(http://www.nfhsindia.org/NFHS-3 per cent20Data/VOL-1/Chapter per cent2013 per cent20- per cent20Morbidity per cent20and per cent20Health per cent20Care per cent20 per cent28475K per cent29.pdf*) dated: 26/12/09

[21] Morbidity and Healthcare and the condition of the aged. NSS 60th round (Jan-June 2004). Report No. 507 (60/25.0/1)

[22] Bulletin of World health Organisation (2002)- Private sector health care in developing countries needs better stewardship, researchers say, 23 April 2002.

Other mechanisms governing medical practice like the MCI and the CPA are activated when there is medical negligence or serious malfunction. Due to lack of evidence, patients often are not able to pursue their medical negligence cases and the rigmarole of following up with courts, etc proves to be daunting for patients. Various studies have demonstrated the poor quality of care. Practices such as cut-practice, over-hospitalisation, unethical and irrational medical practices, excess use of technology in diagnosis and treatment, irrational drug combinations and over-dosage of drugs, no standardization of fee structure and no record keeping are prevalent. With respect to women's sexual and reproductive health, medical malpractice as seen in high rates of Caesarean section (C-sections) and hysterectomies in the private sector has been documented. A recent survey in Andhra Pradesh found high rates of hysterectomies in private sector (98 per cent) which is being prescribed for irregular menstrual periods to cramps, forcing menopause on women as young as 20 years.

There is evidence that MCI has not been able to deliver justice to patients. In spite of the mounting menace of cut practice, malpractice, taking direct, indirect bribes from drug companies, the MCI has hardly taken any action against doctors (Madhiwala and Roy, IJME) We therefore make a distinction between these and the need for legislation for regulation of private health facilities.

Context of health care in Maharashtra

Keeping the above background in mind lets now concentrate on the state of Maharashtra, located in Western India. Maharashtra is a huge state with a population of 9.69 crore as per the 2001 census, which is the second largest after Uttar Pradesh. Mumbai, the financial capital of the country is in Maharashtra. Though Maharashtra is the richest state in India, inequalities in access to healthcare across rural-urban areas, social groups and socio-economic classes are huge. Maharashtra also shows a higher utilization of the private health sector than of the public health sector. In fact, Maharashtra has the largest private health sector in India.[23]

With declining public health expenditure over the years, especially in the post SAP (structural adjustment programme) period, the private sector in Maharashtra has flourished and today forms is a major component of its health infrastructure. In the post SAP period the state curtailed investments in the public health sector and reduced health expenditures. In fact the government allowed the growth of the private health sector by reducing its expenditure on health, giving concession and subsidies on the import of medical equipments and giving land to private hospitals at very nominal prices. The availability of hospitals in the private health sector relative to the public health sector in Maharashtra is estimated to have increased from 68 per cent in 1981 to 83.4 per cent in 2005.The availability of dispensaries in the private health sector has seen an increase from 47.4 per cent in 1981 to 86.16 per cent in 2001 and the number of hospital beds in the private sector has increased from 37.4 per cent in 1981 to 50.3 per cent in the year 2005.[24]

In 1994 the 'Medico Friend Circle' (Bombay group) questioned the Health Secretaries of all states and union territories about the existence of any laws in the states for regulation of private hospitals and nursing homes and the exact nature of these. To their surprise they found that it was only Maharashtra and Delhi that had specific laws for registration and regulation of private hospitals/nursing homes. In Maharashtra, this Act, was enacted in 1949, and called the 'The Bombay Nursing Home Registration Act (BNHRA). The Act stipulates that "Every year the nursing home and hospitals are required to make an application for registration or renewal of registration to the local supervising authority, which could be the municipal corporation, district board, district panchayat and other such bodies constituted by the government. The applicant is supposed to provide detailed information on the staff strength and qualification, the availability and functioning of various instruments, space for accommodating patients,

[23] Duggal, Ravi, T. R. Dilip and Raymus, P. Health and Healthcare in Maharashtra. A status report. (2005)
[24] Mishra S., Duggal R., Lingam L.,Pitre A. A Report on Health Inquities in Maharashtra, 2008

operation theatre, sanitation facilities etc". In case the provider fails to do so then he/she might be liable to pay a certain amount of fee for non-obedience or even be charged with imprisonment.[25] In spite of the presence of this law, it has been poorly implemented in the state.

An active civil society has consistently raised issues related to non-implementation as well as the limited scope of the law. The result of this was that the Act was amended in 2005 to make it applicable to the entire state of Maharashtra and minor additions were made about floor-space per patient and nurse patient ratio. Regrettably, several other proposed amendments for inclusion of minimum standards of care and other regulatory mechanisms were not included. Responding to this criticism, the Government of Maharashtra (GoM) invited CEHAT to draft the rules for this amended Act. CEHAT prepared the draft rules through a consultative process involving several stakeholders and submitted them in June 2006. These draft rules included minimum standards of care for hospitals with ten beds as well as a Standard Charter of Patients' Rights and were posted at http://maha-arogya.gov.in/actsrules/nursing/BombayNursingHome.pdf (Available upto June 2009). Till date these rules have not been approved by the Health Minister, despite repeated appeals by several civil society organizations and hundreds of citizens. This is mainly because of the state's reluctance and the lack of consensus on minimum requirements/standards amongst members of the medical fraternity.

The required minimum standards of care have not been defined for the private sector by the state as the medical profession has always argued that factors such as the nature of services, location, availability of staff and cost make it impossible to have any uniform standards. Evidence from earlier studies has shown that the private hospitals provide poor quality health care. They are often housed in dilapidated buildings with very poor infrastructure. The absence of any accepted standards to assess the physical and clinical standards of private hospitals makes it even more difficult to assess the quality of care they offer.[26] In this scenario, the patient cannot be assured of good quality of services from these private hospitals.

The Bureau of Indian Standards prescribes standards for hospitals larger than 30 bed strength. But the standards for smaller hospitals are ill-defined, nor is there any incentive to upgrade standards. These are mainly the 0-30 bedded hospitals, majority of which are run by sole proprietors/practitioners. They mostly serve the urban and semi urban clientele and focus only on curative health care. The issues regarding the quality of care, cost of care and level of regulation among these facilities is of critical importance.

CEHAT undertook a study in Maharashtra to understand the standards of care offered by private hospitals and the perception of the private providers to regulate the sector. An earlier study by CEHAT in 1997 had examined the physical standards of private hospitals in one district, Satara. This study highlighted that the standards may vary with level of development. Given that the amendment to the BNHRA made it applicable to the entire state, it was pertinent to examine standards of care in private hospitals across different districts as per level of development and the size of hospitals.

Objectives of the study

1. To understand the physical standards and quality of care provided by the private hospitals in a representative sample of private hospitals in Maharashtra.
2. To understand problems and concerns regarding the existing BNHRA and accreditation among the hospital owners in Maharashtra.

---

[25] Jesani, A. and Nandraj, S. The unregulated private health sector. *Health for the Millions*, 2(1) February 1994, pp. 25-28

[26] Nandraj, Duggal, (1997) Muraleedharan (1999), Baru (1998)

RESEARCH METHODOLOGY

Definition of key concepts

Private hospital: Private hospital for this study is defined as any hospital that is providing in-patient services and is less than 30 beds. In Maharashtra, all such hospitals are registered under the Bombay Nursing Home Registration Act (Amendment), 2005 which defines such institutions as a Nursing Home where the premises are used or intended to be used for the reception of persons suffering from any sickness, injury or infirmity and providing of treatment and nursing for them and includes a maternity home.

Quality of care: This term is used in this study to assess the different constituents of care that the patients receive from the hospital. It includes both the physical and clinical standards. Some indicators include trained staff, infrastructure, record maintenance, biomedical waste management, HIV prevention and emergency services.

Sampling

***Representation of regions of state*:** In order to get a representative sampling, we selected two districts from each of the five geographical regions of the state, namely, Konkan, North Maharashtra, Western Maharashtra, Marathwada, and Vidarbha including Mumbai. Two districts from each of the above mentioned regions were arranged in ascending rank on the basis of the selected indicators[27] – and were divided in two equal groups (more developed and less developed). One district from each of the groups was selected randomly. Thus a total of 10 districts, namely, Nashik, Thane, Pune, Satara, Amaravati, Ratnagiri, Osmanabad, Nandurbar, Aurangabad, and Gadchiroli have been selected. The city of Greater Mumbai too is included in the selected districts, due to its unique features of complete urbanization, great expansion of the private medical sector, huge population base with high standard of living and very high real estate prices.

Table 1.1 : List of Districts with the Level of Development

Sr. No.	District	Level of development	Region
1	Thane	Developed	Konkan
2	Ratnagiri	Less Developed	Konkan
3	Pune	Developed	Western
4	Satara	Less Developed	Western
5	Amravati	Developed	Vidharbha
6	Gadchiroli	Less Developed	Vidharbha
7	Nashik	Developed	Northen
8	Nandurbar	Less Developed	Northen
9	Aurangabad	Developed	Marathwada
10	Osmanabad	Less Developed	Marathwada

Selection of tehsils

All tehsils in the sampled districts were ranked and classified into three groups (**high, medium and low development**) depending on their level of urbanization. We selected one tehsil from each of these categories. The difference in urbanization levels between the district capital and the next urban centre was very high. In order to address the fact that distribution of private health facilities are skewed towards urban areas, we selected purposely the district

[27] Districts were ranked and scored based on Level of urbanization, Hospital beds per one lakh population, under 5 mortality rate, Female literacy rate and District Domestic Product at current prices. Various data sources such as Human Development Report, Maharashtra, Revenue circle, Census, Reproductive and Child Health facility survey were used to get information regarding indicators.

capital to represent the high-developed tehsils, so that this area, with better private health care infrastructure is included. Two other tehsils, one randomly from each of the middle and less developed groups were selected. Totally 30 tehsils i.e. three from each district are selected for the study and three randomly selected wards from Mumbai were also included for the study.

Physical listing of the facilities

We did not find a list of private hospitals. So we had to create such a list for the selected districts by physically listing them However, this was impossible in large cities of some districts like Pune, Thane, and Mumbai because of the large numbers of hospitals. In these cities we listed the facilities for one municipal ward and estimated numbers for the city[28] and included 10 per cent of this estimated universe in the sample. Refer to **Table 1.2** for details.

Tools for data collection

The total sample for the study was 267 hospitals of which six hospitals refused participation. Hence the final sample of hospitals from where data has been collected for the study is 261 that were between 0-30 bedded. *Interview* of the facility In-Charge and Duty Medical Officer/Nurse Staff and *observation* of the hospital were the main methods of data collection. Interview Schedules and Observation Schedules have been used as a tool for the purpose. Semi-structured and open-ended questions were designed to collect information on the existing physical, structural and clinical standards of the hospital, their awareness of the BNHRA Act and issues, opinions and concerns regarding the implementation of the Act. Through the Observation Schedule, the availability and condition of mainly the physical and structural aspects of care were assessed. Two hospitals did not allow the research investigators to observe the labour rooms.

Two sets of questionnaire & one observation schedule were used for data collection

i. Information on the facility from the Hospital in-charge as well as his/her perspective about existing structure and process standards in the health care institutions, regulation and accreditation - *general information about the facility, general information about the provider, information about the facility, human resources, infrastructure in the hospital, information on admission procedures, information on knowledge update, information on awareness about registration and accreditation themes*

ii. Information from DMO or staff nurse on existing structure and process standards in the health care institutions – *emergency services, maternity services, comfort and privacy of patient, ICU facilities, infection control measures, blood bank, BMW, information on medical records.*

iii. Information from observation schedule to cross check the information taken from above schedules- *Physical condition in the hospitals, information on hospital infrastructure and essential services*

Plan of analysis

Data was analysed in terms of the development and the size of the facilities. Analyzing the data across the developed and less developed districts helped us see the difference across these districts in term of the size of the facilities, infrastructure, human resources and regulation. Looking at Mumbai, which is a metro city and has a concentration of private health sector, also helped us to understand the standards of health care and level of awareness and

[28] For listing in these cities we have selected randomly 3 Electoral Zonal offices conducted the census of all wards coming under them. On the basis of the actual number of facilities, we have calculated the average number of facilities in each single ward and multiply by the total number of wards in the whole city and got the overall universe and then from that universe we have taken 10 per cent which was finally selected from the list of the facilities we have got from the wards of three selected Electoral Zonal offices e. g. in case of Pune: total Electoral Zonal offices are 14, which comprises total 144 wards. We have selected three Zonal Offices- K B S Dhole Patile Road = 9 + Yerkheda Zonal Office= 9 + Aundh Zonal Office =9 total 27 in which we have done the census and got total 106 facilities. Then 106 was divided by 27 = 3.92 is the average no. of facilities in each wards. Then 3.92 was multiply by 144 total no. of wards= 565.33 (see table 1). Now this 565.33 is the universe for Pune city and we have selected 10 per cent of this that is 56.5 from which we have taken 57 facilities as round figure for our final data collection. Thus total no. of facilities in Pune Dist including two Tehsils found to be 600.3 (565.33 from the Pune City +23 from one Tehsil + 12 from another Tehsil). Now out 600.3 we have taken 10 per cent which is 60.3 so from Pune Dist total no. Facilities would be 60 (57+2+1) (See table no. 1). Likewise we have done for Thane and Mumbai.

understanding about regulation in the city. It is important to note that the state legislation that came in 1949 was restricted to this city and a few others in the state till 2005. The size of the hospitals is an important factor in determining standards of care.

Limitations of the study

The study findings are based on responses of the hospital owners on most of the indicators. Only some physical standards have been verified through observation.

1. We found no reliable source of information on private hospitals in the state. We made several futile attempts at procuring these from the corporations, health department and medical associations. We therefore had to list all facilities in representative wards and get an estimate. In doing so, the low presence of private sector in less developed districts was not factored in. Specific inclusion of more facilities from the less developed districts would have provided more information on the conditions of these hospitals in that region.

2. The absence of any standards for 0-30 bedded nursing homes posed a challenge during development of a tool and analysis. While certain gaps in compliance to the law are evident, it is difficult to conclude on poor quality of care at the facility level.

Table 1.2 : Final Sampled List of Facilities in Districts and Tehsils

SL	Name of the Region	SL	Name of the District	SL	Name of the Tehsil / City area	No. of Facilities	10 per cent of each	Selected No. of Facilities
1	Western Maharashtra	1	Pune	1	Pune City	106(565.3)*	56.5	57
			10 per cent of	2	Purandhar	23	2.3	2
			the total= 60.03	3	Mulsi	12	1.2	1
		2	Satara	4	Satara City	51	5.1	5
			10 per cent of	5	Wai	20	2	2
			the total= 10.5	6	Khatav	34	3.4	3
2	North Maharashtra	3	Nashik	7	Nashik city	368	36.8	36
			10 per cent of	8	Igatpuri	3	0.3	1
			the total= 38	9	Chandwad	8	0.8	1
		4	Nandurbar	10	Nandurbar	31	3.1	3
			10 per cent of	11	Shahade	21	2.1	2
			the total= 5.3	12	Akkalkuwa	1	0.1	1
3	Konkan	5	Thane	13	Thane city	97(388)*	38.8	38
			10 per cent of	14	Vasai	37	3.7	4
			the total= 43	15	Vada	5	0.5	1
		6	Ratnagiri	16	Ratnagiri city	30	3	3
			10 per cent of	17	Chiplun	26	2.6	2
			the total= 6.3	18	Guhagar	7	0.7	1
4	Vidarbha	7	Amravati	19	Amravati	232	23.2	23
			10 per cent of	20	Dhamangaon	1	0.1	1
			the total= 23.4	21	Nandgaon	1	0.1	1
		8	Gadchiroli	22	Gadchiroli	3	0.3	3
			10 per cent of	23	Desaiganj	1	0.1	1
			the total= 0.5	24	Kurkheda	1	0.1	1
5	Marathwada	9	Aurangabad	25	Aurangabad	174	17.4	17
			10 per cent of	26	Paithan	12	1.2	1
			the total= 19.2	27	Phulambri	6	0.6	1
		10	Osmanabad	28	Osmanabad	21	2.1	2
			10 per cent of	29	Tuljapur	6	0.6	1
			the total= 3.4	30	Kallam	7	0.7	1
6	Mumbai	11	Mumbai	31	W. Sub K/E Andheri E	39 (252.2)*	25.2	25
			10 per cent of					
			the total= 50.5	32	East Sub-N Ghatkopar	26 (145.2)*	14.5	15
				33	Mum City - F/S Parel	12 (108.0)*	10.8	11
						2600.7**	260	267#

* Projected on the basis of census of selected wards

** In summing up, the projected universe of Pune, Thane, and Mumbai have been included.

the number is higher than actual per cent because we taken all facilities in Gadchiroli Dist and other Tehsils where the number is just 1.

Blank

CHAPTER 2

PROFILE OF PRIVATE HOSPITALS AND PRIVATE PROVIDERS

Blank

PROFILE OF PRIVATE HOSPITALS AND PRIVATE PROVIDERS

This chapter provides details of hospitals in terms of their years of establishment, regional distribution, bed strength, services and bed occupancy. It also provides a brief profile of the medical practioners or the private health providers in terms of the system of medicine that the providers belong to, their qualification and nature of their practice. Due to poor registration, there is no reliable source on number of private hospitals in the state. Moreover ownership data is scarce and hospitals may be owned by an individual, a group, corporate, trust or voluntary organisation.

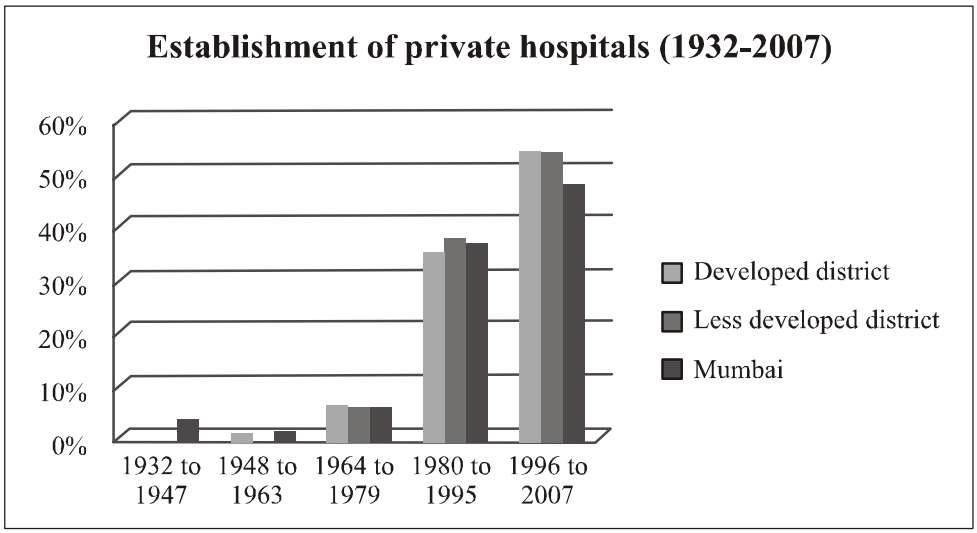
Of 261 hospitals, 71 percent (185) are located in developed districts, 17 per cent (45) in Mumbai and 12 per cent (31) in less developed districts. The sample is representative of the trends in the private health sector and their preference for the developed and urbanised areas. So, even though Maharashtra has one of the largest private sectors in health care in India, it is unevenly distributed across the state. There are fewer such hospitals in less developed districts. Of the 261 private hospitals, most (27 per cent) of private hospitals are in Western Maharashtra, which comprises of Pune and Satara districts and the lowest (9 per cent) in Marathwada, which comprises of Aurangabad and Osmanabad. (Table 2.1)

2.1 Establishment of hospitals

Amongst the 261 private hospitals, two were established in Mumbai before independence. Private hospitals began to grow in Mumbai between 1932 and 1947, followed by a similar growth in the developed districts in 1948-1963 and then in the less developed districts in 1964-79. But from 1980s onwards, the growth has been phenomenal in all the three region.(Table 2.2) While growth of private hospitals in urban and developed regions has been noted by others,[29] the present study highlights the fact that it is growing at equal pace in the less developed districts too. Graph 1 shows that the private sector in Maharashtra is growing after independence. Of late, the growth in corporate hospitals and other large private hospitals does not seem to have affected the growth of small private hospitals. 54 per cent (140) of the hospitals in our sample are established between year 1996 and year 2007. (Table 2.2) There has been a growth in the number of medical colleges in Maharashtra that facilitated this growth. There is a trend towards establishment of larger hospitals during the period 1996 to 2007 (Table 2.3). However, it has not replaced smaller and medium sized hospitals at all as they continue to grow too. While hospitals of all bed sizes show a rise in growth, the percentage of 11-15 bedded hospitals has declined slightly. This could be as these may have reached a saturation point. (Table 2.3)

[29] Nandraj,1997, Baru, 1998

Graph 1 : Establishment of private hospitals (1932-2007)



2.2 Size of hospitals

Overall, 77 per cent of the 261 hospitals are 6-15 bedded which truly represents the trend within private hospitals with less than 30 beds. The mean (12), median (11) and mode (15) values depicts the size of the hospitals in our sample. 49 per cent of the hospitals are 6-10 bedded. We find that developed districts have 6-10 and 11-15 bedded hospitals, while less developed districts largely have 6-10 bedded hospitals. Mumbai too has maximum number of 6-10 bedded hospitals (Table 2.4). The reason for the preference for small hospitals is that these are financially viable and easy to manage in terms of infrastructure and the doctors themselves run most of these hospitals without hiring qualified staff.

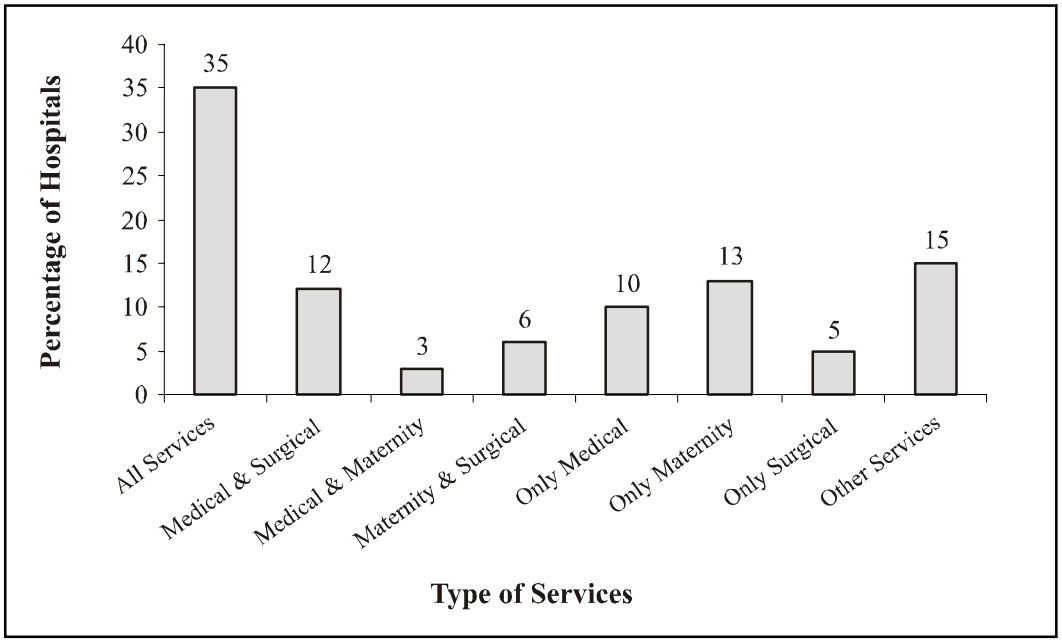
Setting up and managing large hospitals requires large capital and they are dependent on the paying capacity of the population. In less developed districts, 71 per cent of the hospitals were less than 10 beds, with only 2 having 21-30 beds and 1 with 16-20 beds. On the other hand, 35 per cent of Mumbai hospitals and 23 per cent of those in developed districts had more than 16 beds. Hospitals with more than 15 beds are concentrated in developed districts and Mumbai. (Table 2.4) These are viable in these regions as they are mostly run in partnership, provide multiple services and people in the developed region have higher paying capacity.

2.3 Types of services provided in the hospitals

Amongst the 261 hospitals, 92 are providing more than one type of services as shown in the graph 2. The study finds that combination of all types of services whether General Medical, Maternity, General Surgical services are available in hospitals. If we consider the hospitals providing only one type of services, the maternity hospitals are highest (34). The most common service provided by hospitals is medical. Most of the hospitals providing multiple services are located in the developed districts and Mumbai. Hospitals providing only medical services are concentrated in the less developed districts. The developed districts and Mumbai provide medical, surgical and maternity services in large numbers. In less developed districts, while 23 per cent hospitals provide all services, 26 per cent provide only medical services. More than 55 per cent of the hospitals in less developed districts do not provide maternity and surgical services. This indicates the lack of services available for maternal and surgical care in the less developed region. (Table 2.5)

Multiple services are provided by large hospitals with more than 15 beds. Exclusive services like only medical, only surgical or only maternity is provided by less than 15 bedded hospitals. Specialty services other than medical, surgical and maternity are largely provided by less than 5 bedded hospitals.

Graph 2: Type of services provided by hospitals



2.4 System of medicine in hospitals

The private sector is mostly dominated by the allopathic system, which is now more technology based and costly for the patient. The option of other systems of medicine, which are cheaper, is very limited for the patient. The study shows that 90 per cent (234) of the owners of the hospitals are from the Allopathic system of medicine. In the less developed districts, 97 per cent (30) of the hospitals belong to the allopathic system of medicine. There is only one Ayurvedic hospital in this region (Table 2.6). The scope for hospitals belonging to other systems of medicine in less developed districts appears to be limited. The hospitals of other systems of medicine are concentrated in the developed districts.

There are 10 per cent (26) hospitals from other system of medicine. Of the 14 ayurvedic hospitals, 13 are in developed districts. Of the 11 homeopathic hospitals, 8 are in developed districts and rest in Mumbai. In our sample there is only one Unani hospital that is situated in Mumbai (Table 2.6). Seven of the Ayurvedic hospitals are less than five bedded. In homeopathic hospitals we find that there are 7 hospitals that are less than 10 bedded. Only one unani hospital in Mumbai is 21-30 bedded hospitals (Table 2.7). The hospitals from other system of medicine may not be drawing the required number of patients to have a big hospital exclusively based on Indian system of medicine. The number of allopaths were found to be 96560 and non-allopaths were 93663 (CBHI, 2008) in Maharashtra. It is evident that they are almost in equal numbers and therefore there is need to look at the social background of doctors from other systems of medicine and their financial condition. Allopathy is also the dominant practice and it is obvious that there is limited market for hospitals from other systems of medicine.

The study of private hospitals in Satara (1997) had shown that 70 per cent of the hospital owners are from the allopathic system of medicine and the rest (25 per cent) were trained in other systems of medicine. These doctors from other systems of medicine were also practicing the allopathic system of medicine and were mainly located in the less developed area. The current study captures a decline in hospital owners from other systems of medicine to 10 per cent only. It indicates that dynamics of the private health sector are making it difficult for non-allopaths to set up hospitals.

2.5 Bed occupancy in hospitals

Bed occupancy is calculated by dividing the number of beds occupied on a daily basis in the last month by the number of beds in the hospital. The average bed occupancy in the hospital is found to be 57 per cent (Table 2.8). The Satara study had shown a bed occupancy of 51 per cent on a daily basis for a month. Our study has shown that the bed occupancy has further increased to about 57 per cent, indicating a trend towards higher utilisation of private health sector. The bed occupancy in the hospitals of developed districts (60 per cent) and Mumbai (58 per cent) in our sample is higher than that of hospitals from less developed districts (40 per cent). This considerable difference can be attributed to higher paying capacity among the people of developed districts as types of services are not very different (Table 2.8). As the number of bed increases in the hospitals, the bed occupancy decreases. (Table 2.9)

2.6 Ownership of hospitals

Hospitals are mostly run by doctors but it is important to look at the ownership pattern in the small hospitals. Our study highlights that most common type of the ownership pattern is self-proprietorship. 86 per cent (225) of the hospital owners are sole proprietors. Of these 207 are male and only 18 are female. While 13 per cent hospitals are owned in partnership, they are largely concentrated in Mumbai (Table 2.10). We found only one trust hospital in the study which was situated in Mumbai. But if we look at the first ownership we find that the 91 per cent (238) of the hospitals are owned by males. In the second ownership, there is slight dominance of female owners which is mostly marital partners. (Table 2.11)

Earlier studies (FRCH 1999)[30] have shown that the share of expenditure on heads such as rent, maintenance and salary is small or negligible. This is further reiterated by this study too. Firstly, most of the owners of hospitals are doctors. Secondly, the hospitals need to be under the management of a medical person according to the registration process in Maharashtra. In our study, we find that owners are also in-charge of the hospitals in 259 hospitals. In two hospitals, doctors have been hired as hospitals in-charge. In this way, hospitals reduce expenditure on salary to be paid to the human resource by playing the multiple roles of owner, in-charge and Duty Medical Officer.

In developed districts and places like Mumbai where the cost of running a hospital is high, we see that hospitals here are owned in partnership. This is probably to share the cost of setting up and running hospitals. But this partnership is seen among doctors only. This kind of partnership further reduces the cost incurred on the human resources. Similarly, as the number of beds increase in hospital, the cost incurred by the hospitals also increases. The study shows the trend for partnerships as bed size increases, with 74 per cent of the hospitals run in partnership being more than 10 beds. (Table 2.12)

2.7 Ownership of space of hospital

In the study, 87 percent (226) of the hospitals are housed in self-owned buildings and rest of the hospitals are housed in rented premises. Earlier studies have found that 60 percent of the hospitals were operating from rented places.[31] Despite the high cost of property in Mumbai, 93 per cent of the private hospitals in the city are self-owned. Out of the total sample from the less developed districts, 26 per cent (8) hospitals are in rented place. Amongst the private hospitals that are functioning from rented place, we find that they are largely located in less developed and developed districts (Table 2.13). It indicates that doctors who set up private hospitals belong to the high-income group where they can afford to purchase property for setting up of a private hospital. It also shows that running a private hospital is a good business.

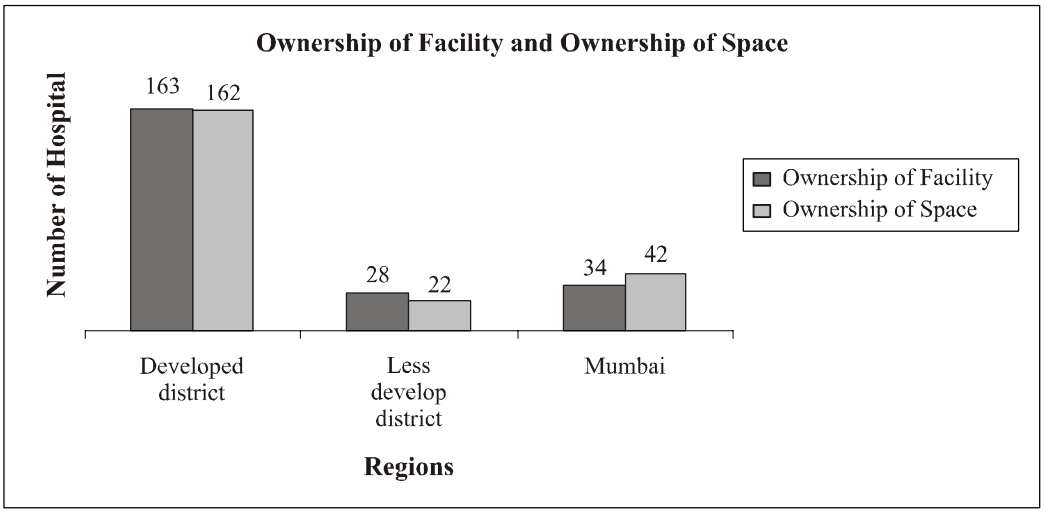
---

[30] Kavadi, S.K. (1999) Health resources, Investment and expenditure-A study of health care providers in a district in India, FRCH, Mumbai/ Pune
[31] Nandraj and Duggal, 1997

This shows that it is a profit making venture for doctors who largely belong to the higher class and are able to invest private capital in setting up such enterprises. The easy access and choices available for taking loans too, has made it easier for individual doctors to set up their own hospitals and support entrepreneurship.

We find that amongst the hospitals that are housed in rented premises, most of them (approx 50 percent) are small sized (up to or less than 10 bedded) which as earlier explained are concentrated in less developed districts. The paying capacity is much lower in the less developed region thus not making it a profitable venture. This is in direct contrast to developed region as well as Mumbai where even the large bedded hospitals are self-owned. Running private hospitals is definitely not a loss as they are sure of making good income and doctors are ready to invest huge capital in terms of purchase of building, etc. (Table 2.14)

Graph 3 : Ownership of facility and ownership of space



2.8 Multiple practices by practitioners

The doctors were asked if they practice in only one hospital or more than one hospital. Multiple practice means that the doctor is caring for patients in more than one hospital. As these are all in-patient facilities, their patients are necessarily admitted. In the study, 40 per cent (105) of the doctors said that they practice at another hospital also. This is more common in developed districts as compared to less developed districts. Only 4 doctors from less developed districts reported practice at another place (Table 2.15). The trend towards multiple practices is highest amongst larger hospitals that are more than 15 bedded. Larger hospitals usually provide multiple services and make it viable for visiting doctors and consultants to provide their services (Table 2.16).

In the study, there are 22 per cent (56) owners who own other hospital also. This practice is most common among the developed district hospital owners (Table 2.17). And most of the places the owners are the in-charge also.

In 47 per cent (123) of the hospitals, the in-charge is neither practicing anywhere else nor owns any other hospital. This means that the rest 53 per cent are seeing patients in multiple places. If the doctors are seeing patients at multiple places, the time spent per patient decreases. The patient may be seeing the doctor at one place but for treatment he/she may be sent to another place. This may increase the cost of treatment. Most importantly, the patient may have a problem in contacting the doctor in the time of emergency, which is a matter of concern as far as the treatment is concerned (Table 2.18).

In the study, none of the doctors practice in the public sector. Without any obvious dependence on patients from the government health services, it is evident that they are able to run their hospitals successfully. Other studies have found that doctors from public health facilities are engaged in private practice and refer patients from the government medical facilities to their private clinics. (Baru, 1998) In the last two decades the collapse of the public health services has made it possible for the private sector to run independently.

2.9 Knowledge update

The study explored the various means used to update knowledge by the hospital in-charge like journals, CME (Continuation of Medical Education), MR (Medical Representative), Astonishingly, except one doctor from a Mumbai hospital, all said that MR is the person who provided them with update on medical knowledge. 98 percent of them get information about drugs from the MR. Information about latest technology and new brands in equipments is also reportedly provided by the MR. However, 60 per cent doctors from developed districts said that they get information on technology and equipment from MR, followed by 26-29 per cent of those in less developed districts and lower in Mumbai. This dependence on the MR as a means of knowledge update is suspect as most of them are selling their own products.

67 per cent of the doctors reported that they update their knowledge by reading journals, which was most common amongst those in developed districts, followed by less developed and then Mumbai. CME involves more direct participation found to be more common among the hospitals in Mumbai and developed districts. Referring to book was more common amongst doctors in Mumbai and developed districts. The strong dependence on MR as the source of knowledge update is indicative of the far reach of the pharmaceutical industry. As no further questions regarding the importance/relevance/ quality of such information was asked to doctors, one cannot comment any further (Table 2.19, 2.20).

Summing up, we note that the establishment of less than 30 bedded private hospitals in all regions, less developed and developed has been increasing. The average bed size is 12 in the sample and the hospitals provide all types of services: medical, surgical and maternity, with medical being the dominant type of service followed by maternity. We also find that 90 per cent of the hospitals were from the allopathic system of medicine. Hospital owners are mostly the hospital in-charge also and ownership is dominated by men. They are mostly operating from their own place and not from rented places indicating that the sector is profitable. We of course note that access to loans too has become much easier in the past 10-15 years. Multiple practices are common not just in terms of doctors seeing patients in multiple hospitals but also in terms of ownership of hospitals. A large number (53 per cent) of the doctors, practice in multiple hospitals. The study could not capture the impact of this but it is a trend that needs to be studied further.

CHAPTER 3

HUMAN RESOURCES

Blank

HUMAN RESOURCES IN PRIVATE HOSPITALS

The availability of trained Human Resources in a hospital determines timely care and services for patients and is an important measure of the standard of care. There are no clear written guidelines defining the number of human resources per size of hospital.There are, however, some minimum, essential requirements for registration of private hospitals under the BNHRA. These are:

a. Qualified DMO(Duty Medical officers) is a registered medical practioner who works as a residential doctor at the hospital.
b. Qualified nurse
c. In case maternity services are provided, midwife is essential.
   But the numbers are not stated as per the size of the hospitals.

This chapter provides a glimpse into the inadequacy of human resources in these hospitals.

3.1 Medical officers/DMO

Duty medical officer is the resident doctor in the hospital. It was found that 54 per cent (141) of the hospitals do not have a DMO. Of the hospitals in the less developed district, 74 per cent (23) of the hospitals do not have any DMO. Similar is the case in Mumbai where 71 per cent (32) of the hospitals do not have a DMO. In developed districts 46 per cent (86) of the hospitals do not have a DMO. The presence of DMO increases with size of hospitals, with the medium and large sized hospitals (>10 bedded) appointing a DMO, (Table 3.1, 3.2). With regard to qualification of the DMOs, we found that 18 per cent (21) of the hospitals had DMOs from allopathic system, rest all belong to other systems of medicine, mostly to Ayurvedic system. Of these, doctors from allopathic system of medicine, 20 of them were employed by hospitals in the developed districts and one by a Mumbai hospital. None of the hospitals in the less developed hospitals had a DMO from allopathic medicine. 14 of these allopaths were employed by hospitals with more than 11 beds. Strictly by law, all allopathic hospitals irrespective of the size have to employ a DMO from the Allopathic system (Table 3.3).

The hospitals of the allopathic system are employing the DMO of other system of medicine to cut down on the cost. The increasing number of medical colleges does not support any argument for non-availability of doctors from the allopathic system. It is possible that there is a shortage of doctors seeking employment in in the less developed districts, but this cannot be the case in Mumbai where one finds these contraventions of the law. These are clear cases of the cross practices which is not allowed under the law. But with the shortage of qualified allopathic doctors especially in the less developed district, employing the qualified person may be from other system of medicine is better option than employing an unqualified staff.

3.2 Status of resident doctor facilities in hospitals

The above section clearly shows that DMOs are not being employed by hospitals. The hospital owners/in-charge play the role that is expected of DMO. All hospitals should have resident doctor facilities as they are all providing indoor patient facilities when they are admitting patients. This means that if a DMO is not employed then the in-charge of the hospital should reside in the hospital premises. It was found that only 48 per cent (125) of the owners/ in-charge reside in the premises of hospitals. Of the total hospitals in less developed districts, in 68 per cent of the hospitals the hospital in-charge lived on the premises. This is not the case in 76 per cent (34) of the hospitals in Mumbai. This was uniform across the size of the hospital with the 21-30 bedded hospitals being an exception.

Here 62 per cent of the hospitals did not do not have the in-charge living on the premises. However, the large hospitals in the developed districts were likely to have the DMO to provide the emergency services (Table 3.4, 3.5).

The earlier study conducted in Satara showed that doctors were mainly residing in the hospital premises or were residing very close to the hospital. However, this study clearly shows that more than 50 per cent of hospitals do not have the owners living in the hospital premises. Alarmingly, one fourth of the hospitals do not have any qualified doctor to provide round-the-clock services. Neither the hospital in-charge is living in the hospital premises nor there is a DMO available at the hospital (Table 3.6). This is a serious matter as far as health care is concerned as it means that in case of an emergency there is no doctor available.

The status of Mumbai hospitals is a matter of grave concern. Nearly 75 per cent of the hospitals do not have a live-in hospital in-charge and 71 per cent do not have a DMO. In developed districts, 50 per cent of the hospitals do not have DMO and 50 per cent do not have in-charge living in the premise. The less developed districts 68 per cent hospitals have the owner living in the premise but 74 per cent do not have DMO. DMOs, wherever present are mostly from other systems of medicines.

3.3 Nurses

Under the BNHRA, it is compulsory for all hospitals to have qualified nurses. Only 25 per cent hospitals had qualified nurses, 53 per cent did not have any qualified nurse and 13 per cent had qualified as well as unqualified nurses. It is important to note that 9 per cent hospitals had no nurse at all. (Table 3.7) The total percentage of qualified staff is 36 per cent (455) in our sample (Table 3.8). 56 per cent (147) hospitals do not have a qualified nurse at all. The law only states that there should be a qualified nurse but does not prescribe the numbers per hospital. The draft rules under the BNHRA, 2006 prescribe three nurses for 0-10 bedded hospitals.

In our study qualified nurses were ANM (Auxillary Nurse Midwife) or B.Sc (Bachelor of Science) Nursing. The average number of qualified nursing staff for each hospital was 1.7 nursing staff per hospital which is well below the minimum requirement in the BNHRA draft rules (Table 3.9). It was evident that the large hospitals recruited qualified nurses.

The overall availability of qualified nurses was 1.7 per hospital but a closer look showed that this was as high as 3.8 per hospital in Mumbai, 1 per hospital in developed districts, and 0.6 in less developed districts (Table 3.9). However, the hospitals reported that they recruit unqualified nurses. The presence of these unqualified nurses could pose a threat to the patient safety and life. Hospitals reported that they provide in-house, on-the-job training to such nurses. This raises several questions about their capacity as none of these trainings are accredited and therefore quality of such training remains suspect. Most of these nurses were in hospitals of the developed districts.

Table 3.9 : Availability of Nurses (Level of development)

Area	Qualified Nurse	Average per hospital	Unqualified nurse	Average per hospital
Developed District	262	1	633	3.4
Less developed District	20	0.6	81	2.6
Mumbai	173	3.8	109	2.4
Total	**455**	**1.7**	**823**	**3.6**

Table 3.10 : Availability of Nurses (Size of hospital)

Bed	Qualifed Nurses	Average Per hospital	Unqualified nurses	Average per hospital
Less than 5	22	0.5	67	1.5
6 to 10	110	1.3	188	2.3
11 to 15	116	1.6	247	3.4
16 to 20	68	1.7	203	5.2
21 to 30	139	6.6	118	5.6
Total	**455**	**1.7**	**823**	**3.2**

The average availability of qualified staff as well as unqualified nursing staff increases with the size of hospitals. For 21-30 bedded hospitals, the availability of qualified staff is as high as 6.6 per hospital. But this is not in proportion with the actual requirement for the size of the hospital. In the absence of any prescribed norm it is difficult to comment.

The picture is more or less clear and shows that the hospitals in the less developed and developed districts do not have qualified nursing staff. In comparison, Mumbai shows a better picture but the nursing staff here too are not in proportion to the number of beds. The patient ultimately suffers as the lack of qualified nursing staff would affect the quality of services negatively.

In Maharashtra, there are 14 institutions providing degree courses in nursing and 118 institutions providing training for ANM and/or GNM.[32] These are not able to fulfil the growing demand of the private health sector. This shortage of qualified nurses is an issue that has been raised at various platforms, but there have been no specific steps taken by the government to respond to it. In-house training cannot be accepted as a substitute as this training is not accredited and there are no norms for the same. For all purposes, they can be equated to untrained nurses. Some basic norms need to be set for such training and the government and hospital owners should come together on this.

3.4 Midwives

The recruitment of a midwife is an essential requirement under the BNHRA for maternity homes. However, of the 146 hospitals providing maternity services, 11 have midwives. This highlights serious non compliance of the law. The total number of midwives in our sample is 16.

3.5 Aayabais or ward boys

As per the law, hospitals must have either ayabais or ward boys. 14 per cent (37) of the hospitals do not have ayabais. 59 per cent (153) of the hospitals do not have ward boys. In this study 19 hospitals, do not have either. Again, the numbers available should be in proportion to the number of hospital beds. We found only about 4.06 staff per hospital which is nowhere in proportion to the beds (Table 3.11).

3.6 Other staff:

i. Pharmacist

Twenty-six hospitals have pharmacy shops and recruit pharmacists to man the shops. All pharmacists are in hospitals in developed districts. Of the 26 pharmacists, two are unqualified. It appears that hospitals that set up pharmacy shops are able to also recruit trained staff to run it.

[32] www.indiastat.com

ii. Laboratory staff

Some 33 per cent (85) of hospitals in our sample provide laboratory services. There are about 27 hospitals that have laboratories but do not have qualified staff to run it. Of the total sample of qualified staff in laboratories of hospitals of the developed districts, about 89 per cent (39) are DMLT qualified. One hospital boasted of a Pathologist with a post graduate qualification. Most of the qualified laboratory staff are in hospitals of developed districts and in less than 15 bedded institutions. Similarly the 21-30 bedded hospitals (36 per cent) have laboratories with unqualified staff as compared to the smaller hospitals (Table 3.12-3.14). All these findings suggest that hospitals are providing these services to patients without the qualified staff to run the laboratories.

iii. X-ray technicians

In the study 106 (41 per cent) hospitals had X-ray facilities. Of these, 45 (43 per cent) did not have qualified technicians. Of the 60 hospitals that have the staff, 37 per cent (22) of unqualified to run an x-ray machine.

A larger number of hospitals from less developed districts (58 per cent) had x-ray facilities than in developed district (36-38 per cent) and Mumbai. But only 28 per cent of hospital with X-ray facilities in the less developed districts had adequately trained staff. Developed districts have more qualified x-ray staff. Larger hospitals employ more qualified staff than smaller hospitals (Table 3.15-3.17). Hospitals in less developed district are more likely to have X-ray facilities but less likely to have trained staff .

Summing up, the findings suggest a paucity of qualified staff in private hospitals. It is alarming that the basic staff that is essential for provision of care and mandated by the law too, like doctors, nurses and midwives are so poorly available across hospitals. The issue of unqualified nurses in private hospitals needs to be discussed and steps should be taken to streamline training of nurses. Even more alarming is the fact that additional services like laboratory and X-ray too are being provided by untrained staff.

CHAPTER 4

STANDARDS OF CARE

Blank

STANDARDS OF CARE

The standards of care may be directed towards structure, process or outcome. Structural standards apply to things such as human, financial and physical resources. Process standards apply to activities that constitute care, service or management. Outcome standards refer to the end results of care, clinical as well as non-clinical.[33] In the absence of minimum standards of care for 0-30 bedded private hospitals, we have looked at certain minimum standards that are essential for ensuring basic quality of care. The data collected on standards of care may not be extensive but is optimal based on earlier work done by CEHAT on the private health sector.

This study has mostly looked at the structural aspects which includes functional plan in the form of separate space for each activity in the hospital, indoor staying facilities for patients, additional health services like O.T, ICU, ambulance services, record maintenance services and diagnostic services, basic facilities in the hospital in terms of infrastructure like toilets, water supply, lifts, ramps etc. In terms of process standards, availability of emergency services has been looked into. Some aspects of process standards in terms of information to patient, privacy, consent and grievance redressal have also been looked into.

4.1 Provision of emergency services

According to the Supreme Court, emergency services should not be denied to any body. The Supreme court observed that "Every doctor whether at the government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life." This makes it mandatory for all hospitals - public and private- to make provisions for emergency care. So any hospital that does not provide these services is violating the Supreme Court judgement. 87 per cent (228) of the hospitals reported that they provide emergency care (Table 4.1). In terms of type of emergency care, 52 per cent (119) provide accidental, 62 per cent (142) said they provide medical care and 63 per cent (143) provide surgical care in an emergency (Table 4.2). The Satara study (1997) found that only 2 per cent of hospitals were providing emergency care.

In developed districts, the most common type of emergency services provided is medical (64 per cent) followed by surgical (62 per cent). In the less developed districts, the most common type of emergency service provided is for accidents. In Mumbai, the most common type of emergency service provided is surgical (Table 4.3). Accident cases are usually medico legal cases and the overall reluctance to registering such cases and getting involved could be one reason why hospitals may be reluctant to provide care in accidents. This is lowest in developed districts (48 per cent) as compared to those in less developed districts (63 per cent) and Mumbai which is at (62 per cent). While medical emergency care is largely provided by large sized hospitals, the provision of accident and surgical emergency care shows an increase with the size of the hospital (Table 4.3).

Hospitals, dealing with medical emergencies, would essentially require better-equipped facilities and an ICU facility, which only 27 per cent of hospitals have, and are mostly located in Mumbai and developed districts and are characteristics of large size hospitals.

If there are no facilities for emergencies, first aid should be provided, or at least ambulance and trained staff is a must to shift the patient to a higher centre for further treatment. Therefore, the fact that only 40 per cent of hospitals in less developed districts provide care in medical emergencies is borne out. Most hospitals in the less developed

[33] Donabdian A 1988 as quoted by Nandraj and Duggal (1997)

districts do not have an ICU. On top of it, the ambulance services are totally absent at the less developed districts making the picture worse in this area.

Another question that was posed to the hospitals was related to the steps being taken to handle emergency cases. 81 per cent(184) of the hospitals reported that they quickly admit the patient and 72 per cent (165) of the hospitals also said that they give immediate attention to the patients. The hospitals predominantly from developed districts reported that steps they take to handle emergency situations efficiently are quick admission and immediate attention by medical staff. About 54 per cent (124) hospitals claim that they provide round the clock (24 hours) emergency services. And the highest percentage of the hospitals in this category is from the less developed districts (Table 4.4).

When hospitals were asked whether or not their staff was trained in emergency services, only 56 per cent (130) of hospitals reported that they had staff trained to deal with emergency situations. This was highest amongst hospitals in less developed districts and lowest in Mumbai (Table 4.5). The 21-30 bedded hospitals reported having largest number of trained staff for dealing with emergency services (Table 4.6). They further reported that the staff was trained by doctors of the hospitals. What was alarming was that only one 21-30 bedded hospital located in the developed district has staff trained for CPR.

Overall, it is evident that emergency care may be in the hands of unqualified/ untrained staff as only 56 per cent of the hospitals said that they have trained staff. Even where trained staff is available they are trained in-house. This raises question about what hospitals really define as "emergency care" when an overwhelming 87 per cent state that they do provide these services. Further, there are about 50 per cent of the hospitals which are not providing round the clock services for emergency. Only 23 per cent (61) of the hospitals have a emergency or casualty room. It therefore depicts a sorry picture as far as quality of emergency services is concerned. A critical aspect of care mandated by law is not being well implemented.

4.2 Infrastructure in hospitals

This section provides information related to the various options given by hospitals to patients with regard to the staying arrangement after admission, like rooms/wards. Along with this, it is important to look at the layout or functional plan of the hospital and the physical infrastructure like toilets, drinking water, ramp like facilities provided to the patient. We also look at some additional services provided at the hospital like diagnostic services, ICU and ambulance. This information is very important for a patient as he/she is paying for all this indirectly as a part of the treatment package.

i. Indoor facilities

The kind of indoor facility available at the hospital is dependent on the level of development and size of the hospital. The availability of separate wards for men/women and general wards increases with the size of hospitals and level of development. 61 per cent of the hospitals in less developed districts had common wards as compared to 51-57 per cent in Mumbai and Developed districts.

Small hospitals are more likely to have common wards (73 per cent in less than 5 beds) than separate wards. In fact, majority of over 15 bedded hospitals have an equal proportion of separate and common wards (Table 4.7, 4.8). Similarly, availability of general/ semi special/special and deluxe rooms increases as the level of development increases and as the number of beds increases in the hospital (Table 4.9, 4.10). With regard to semi special and special rooms, these facilities are largely provided by hospitals in Mumbai and in developed districts. These rooms provide better facilities in terms of a/c, attached toilet, etc in addition to the usual facilities in the general rooms. They are expensive and so are available only in areas where patients can pay. They mainly attract patients from middle and higher income groups. As the number of services and size of hospitals increases, the need to have

separate wards is evidently based on the requirement of services like maternity services that require separate female wards.

ii. Physical infrastructure available in the hospital

Ideally, all hospitals should follow a functional plan which means that there should be space for a separate record room, nursing station, treatment and dressing room, casualty/emergency room. This helps in better management of space and ensures smooth working of the hospital. It also aids in quick services to the patient. The availability of infrastructure like operation theatre, ICU, ambulance and diagnostic services helps us analyse the variety of services available to patients under one roof.

- There is no functional plan followed among the hospitals whether they are from the developed district or less developed districts. However, astonishingly the lowest among all is Mumbai. One of the often-quoted reasons is the property rates in Mumbai, which are phenomenally high. Most Mumbai hospitals scored poorly in terms of following a functional plan in their hospitals (Table 4.11).

- Amongst the various facilities, the availability of diagnostic services at hospitals like X-ray facilities (58 per cent) and laboratory services (42 per cent) is higher in less developed regions than in others. On the other hand, the availability of ICU services are comparatively higher in developed districts (30 per cent) and Mumbai (24 per cent) as compared to hospitals in less developed districts (17 per cent). With regard to size of the hospitals, the availability of all these facilities is higher in larger hospitals (Table 4.11). The availability is dependent not so much on the need but on the paying capacity of patients and the viability of providing such services. Except for less developed districts where independent/separate X- ray and laboratory facilities are less in number, it can be said that making these available within the hospital could ensure better access. As all the cost is borne by the patient, the possibility of over prescription for use of some of these facilities as they are housed in the hospitals itself cannot be ruled out. The absence of laboratory and X ray facilities in hospitals in developed districts and Mumbai indicates that patients are referred outside for these needs. The existence of cut practice has been documented well in other studies.

- The overall availability of ambulance services is only 5 per cent. Not a single hospital in less developed districts had one. This region has poor access owing to less number of health facilities. Therefore, an ambulance is critical for ensuring quick referrals. Several hospitals in developed districts have ambulance facility.

iii. Basic facilities

Most hospitals across the regions and size had facilities like refrigerators (89 per cent), telephone lines (99 per cent), continuous water supply (97 per cent) and toilets (100 per cent). Developed districts more commonly had continuous electricity supply than less developed districts. Therefore, the hospitals from less developed districts are more dependent on inverters and generators. (Table 4.12)

All hospitals are required to have a ramp and all those on the first floor and above should have a lift or ramp for the convenience of patients. The study showed that only 14 per cent hospitals had such ramps. While 161 (62 per cent) hospitals were located on the first floor only 19 per cent had a lift. (Table 4.13)

MATERNITY HEALTH SERVICES

A large number of private hospitals provide maternity services. Of the total 261 hospitals in the sample, 146 provided maternity care.

In terms of services, all the 146 hospitals provide indoor services, most of them (66 per cent) are less than 15 bedded, with 13 per cent being less than 5 bedded hospitals. Most of them 97 per cent (141) provide the entire gamut of antenatal services, however only 77 per cent (109) of them give an ANC card to the patient which is an important record to be maintained. Tests for Hb, HIV and urine investigations are advised by all maternity homes.

In terms of care, we found that 25 hospitals do not have a labour room, 32 did not have a delivery table for lithotomy position, 67 do not have a trolley for instruments and 48 did not have a tap with a handle which is required in a labour room. We also found that seven hospitals do not provide Caesarean sections but refer such patients to other hospitals. Of the 139 hospitals that provide C-Section, 60 per cent of them have a doctor in their own hospital providing it. The rest either refer patients to another hospital which is situated within a radius of 2 km or call a consultant who reaches the hospital within 30 minutes. Only 3 hospitals have an authorized blood bank and 7 maternity hospitals have blood storage centres. Only 8 maternity homes have ambulance services.

In terms of adherence to other laws, of 44 per cent (64) of the maternity homes that had the USG (ultrasonography) facility in their hospital 5 were not registered under the PCPNDT Act and 14 maternity homes did not display the signboard 'sex determination is not carried out here' which is mandatory by law. A large number 58 per cent (85) of the maternity homes are registered under the MTP act which means that they definitely provide abortion services too.

4.3 Adherence to existing laws governing private hospitals (Biomedical Waste Management and Universal Guidelines for HIV/AIDS)

Biomedical waste management

It is compulsory for all hospitals to follow the BMW (Biomedical waste management and handling) Act. It is for regulation of disposal of biomedical waste and lays down the procedures for collection, treatment and disposal of biomedical waste. The biomedical waste (management and handling) rules, 1998 contains rules for classification, the colour coding used for various types of waste storage and various methods for disposal of waste. It is applicable all over India and all those who handle biomedical waste come under its purview. As all these hospitals handle biomedical waste they are covered by the law.

Of the 261 hospitals, 89 per cent (231) of the hospitals are registered under Bio-Medical Waste Management and Handling Rules, 1998. 96 per cent (43) of the hospitals in Mumbai and 89 per cent (165) of the hospitals from the developed districts are registered under this Act. 23 per cent of the hospitals in less developed districts are not registered under this. The registration is also higher for the larger hospitals (Table 4.14). It indicates that implementation is best in Mumbai followed by developed districts. According to the BMW rules, all the hospitals should segregate the waste by following the colour coding. Out of total hospitals which are registered under this Act, only 18 per cent (47) of the hospitals are not segregating the waste according to the colour coding and most of them are in less developed districts. A higher percentage of hospitals from the developed districts segregated biomedical waste than did hospitals in less developed districts. Similarly, a higher percentage of the large sized hospitals are segregating waste in different categories than small sized hospitals. (Table 4.15)

The BMW rules spell out that hospitals should dispose different categories of waste in different coloured polythene. 77 per cent (163) hospitals used the method of colour coding for segregation followed by 19 per cent (41) who adopted the method of segregating wet and dry waste. All hospitals in Mumbai adopted the colour coding method for segregation of waste. However, in the less developed districts, only 43 per cent of the hospitals registered under the Act follow the colour coding method for segregation of waste. Again, the data suggest that colour coding as a method for segregating waste is adopted mostly by large and medium sized hospitals than the small sized ones (Table 4.16).

This shows that hospitals from less developed districts are not following the BMW rules properly whether in term of registration under this act, segregation of waste or using the colour coding method for waste segregation as mandated by the law. Similarly, small hospitals too do not follow the provisions of the Act properly. It is evident that Mumbai based hospitals fare the best. There is clear need for creating awareness about the law in rest of Maharashtra especially the less developed districts. The BMC is implementing this more stringently in Mumbai than have local bodies in other districts. In fact the BMC has trained all staff and also developed a manual on the subject.

Universal guidelines on HIV/AIDS prevention

HIV testing carried out on a voluntary basis with appropriate pre-test and post-test counselling is considered to be a better strategy and is in line with the WHO guidelines on HIV testing. Amongst all the 261 hospitals, only 4 per cent (10) of the hospitals reported they do not ask their patients to get HIV testing done on a routine basis. However, the reason that they cited for HIV tests makes it clear that this is just a 'politically correct' response.

Hospitals reported that they advised HIV tests for following reasons:

i. *As part of ANC, which is highest in Mumbai 69 per cent(31),*
ii. *Depending on the clinical situation of the patient which is highest in less developed districts 74 per cent(23).*
iii. *Compulsory testing for all operative patients in 41 per cent(106) of all hospitals.*
iv. *In Mumbai, 31 per cent (14) of the hospitals are going for the compulsory HIV testing for all their patients.*

(Table 4.17)

HIV testing carried out on a voluntary basis with appropriate pre-test and post-test counselling is considered to be a better strategy and is in line with the WHO guidelines on HIV testing. In our study, we find that only 57 per cent (144) of the hospitals take the consent for HIV testing and the highest consent taking is in the less developed district 86 per cent (25) hospitals. Rest of the hospitals either do not take consent at all or do so sometimes.(Table 4.18) Therefore, they are violating the universal norms. The hospitals need to understand the importance of counselling associated with the HIV testing. Lot of doubts are associated with the word HIV and counselling help in removing these doubts and help in developing the trust between the doctor and patient. 69 per cent (173) of the hospitals reported that they provide counselling before HIV testing, which is highest in the less developed districts (76 per cent) (Table 4.19). In 72 per cent (182) of the hospitals, the information/counselling is given after the HIV /AIDS test and 79 per cent (35) of Mumbai hospitals top the list. (Table 4.20). 91 per cent (229) of the hospitals give the report of the HIV/AIDS test to the patients. (Table 4.21)

The findings clearly highlight injudicious HIV testing by hospitals where they are compulsorily testing all ANC and operative patents which is not required and is also gross violation of Universal Guidelines for Prevention of HIV/ AIDS. Testing is also being done indiscriminately without informed consent. This raises a lot of doubt about what hospitals understand when they state that they are counselling patients. Counselling when something is made

compulsory, or consent is not taken has little meaning. The data indicates gross violation of the Guidelines and calls for better awareness about the issue. Many resources are being spent on creating awareness on HIV/AIDS, the Universal guidelines too have been popularised but it is evident that doctors of private hospitals do not seem to take this seriously. There have also been media reports of denial of health care to HIV positive patients by private hospitals.[34]

4.4 Medical records

There are certain medical records that are very essential for the patient as well as doctors and the hospitals should share this information with the patient. This includes the information of the patients, birth and death records and records of certain calculations in accordance with the national health goals. The Table-4.22 summarises the information about those records, which hospitals should maintain. Our findings of the study highlight that less developed district hospitals have better medical records maintenance with respect to OPD and IPD papers, investigation reports, file of every patient as compared to developed district. Mumbai hospitals have better record keeping in term of discharge papers, bill to the patient, OT and anaesthesia records. The hospitals with more number of the beds have better record maintenance as compared to small bed sized hospitals. 85 per cent of the hospitals do not keep record of notifiable diseases, 68 per cent do not maintain records fro communicable diseases and 54 per cent do not maintain records of medicolegal cases.

Table 4.22 : Information on Medical Records maintenance in the hospitals

Maintain records at hospitals	Frequency	Less developed district	Developed district	Mumbai
OPD Paper	214 (82%)	30 (97%)	146 (79%)	38 (84%)
IPD Paper	246 (94%)	31 (100%)	173 (93%)	42 (93%)
Investigation reports	194 (74%)	29 (93%)	125 (68%)	40 (89%)
Discharge papers	197 (75%)	27 (87%)	130 (70%)	40 (89%)
Bill of every patient	173 (66%)	20 (64%)	116 (63%)	37 (82%)
File of each patient	148 (57%)	24 (77%)	95 (51%)	29 (64%)
OT records	205 (78%)	18 (58%)	146 (79%)	41 (91%)
Anesthesia records	182 (70%)	15 (48%)	130 (70%)	37 (82%)

The hospitals have certain responsibility towards national health goals and record maintenance is required for that purpose. However, our study finds that it is not as good as records kept by the hospitals as seen in above table. Hospitals located in developed districts and Mumbai fare better in keeping records of birth and death as compared to less developed districts.

The only exception is in birth records, which are maintained largely by 6-10 bedded hospitals and these are mostly maternity homes. (Table 4.23, 4.24) Among those who maintain the records, it is highest among the developed districts and big hospitals. The BNHRA mandates that the birth and death records should be maintained. It is very clear that records, which are not mandated by law and not required by the hospital directly, are poorly maintained. For those hospitals which don't provide these records, there should be pressure from the demand side.

The system of record maintenance should be patient friendly and easy to retrieve. Hospitals use various systems for maintenance of records. Most common systems of maintaining the records are registers (56 per cent) and paper (24 per cent). Computer as a system of maintaining the records is used only in 8 per cent of hospitals. However,

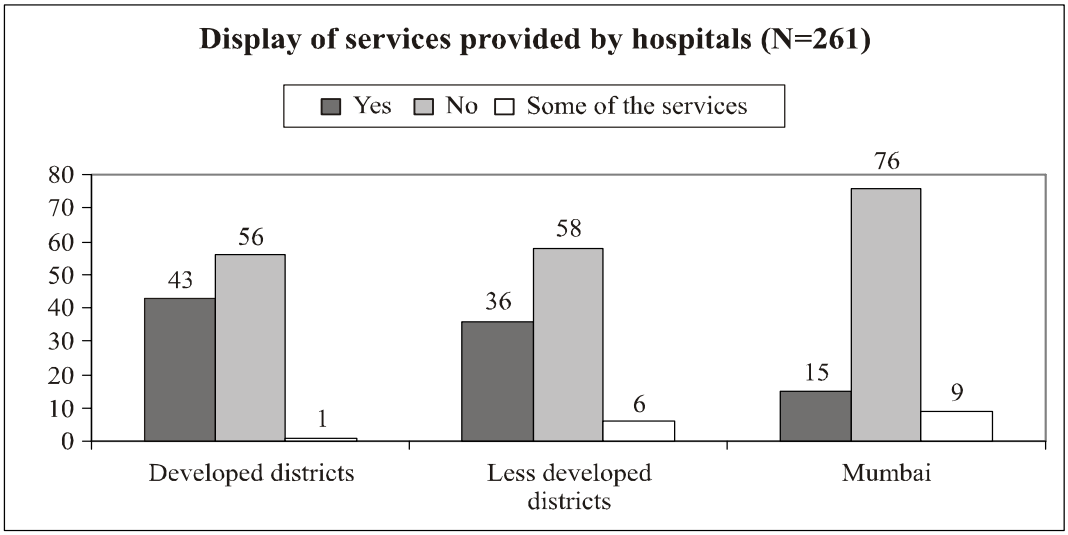
[34] (www.bio-medicine.org/.../Denial-of-Treatment-for-HIV-Infected-Child-Sparks-Outrage-21450-1/-on18/08/09, http://www.hindu.com/2007/06/14/stories/2007061455510300.htm on 18\08\09)

hospitals do not maintain separate files of the patients, which are easier to manage. The digital maintenance of records, which is easier to maintain, transfer and update, is low among the hospital owners. So, over all a patient friendly record maintenance system is lacking in hospitals (Table 4.25).

The hospitals have a responsibility to provide information and share documents with patients in addition to maintaining their records. The study found that hospitals scored poorly on this front. One fourth of the hospitals do not give IPD papers even on request, and half of them do not give OPD papers. About 9 per cent do not give discharge papers. One fourth of the hospitals do not maintain a file for the patients (Table 4.26).

4.5 Display/provide details about various services provided

It is the right of the consumer to know the types of services given by the hospital, though none of the existing acts make this mandatory. It is the first step towards better communication from private health providers. The following graph shows whether or not hospitals display information about the types of services provided by them. We found that larger hospitals display services more commonly than the smaller hospitals (Table 4.27).



Hospitals that reported that they do display information do so through various means like board, pamphlets, brochure etc. Most hospitals are displaying the services in the form of display board. The law must make provisions where it makes it mandatory for every hospital to display the services provided by the hospital along with the cost of each service provided. The means of communication can be different; the information provided should be in the language which the patients can comprehend easily. Only 37 per cent (97) of the hospitals provide information about the services available at the hospital. In most of the hospitals, this is done by para-medical staff.

The most common procedure for the admission in the hospitals is by filling the admission forms. 84 per cent (155) of the hospitals from the developed districts are using the admission form. Besides admission form, 22 per cent (10) of the hospitals from Mumbai keep record in the register or paper and 13 per cent (4) of the hospitals from the less developed districts use card for admission. (Table 4.28) For filling the form, some form of assistance is required. There is no one designated for doing this job. Anyone from the doctors, nurse, paramedical staff or receptionist does it. In the developed districts, in 56 per cent (103) hospitals, staff nurse on duty helps in the admission procedure. The clinical staff should not assist; instead there should be a receptionist to help in the admission process. (Table 4.29) In large hospitals, there is separate staff assigned to assist patients at the time of admission. But in small hospitals the care giving staff also performs the admission procedure. Multi-tasking by the staff in small hospitals, may result in neither work being done properly. Therefore, there should be separate staff for administrative and medical services. (Table 4.30)

4.6 Privacy and comfort during the examination of patients

As per the MCI code of medical ethics, privacy and confidentiality are the foremost rights of any patient, but not all the hospitals are respecting it. Nine hospitals (3 per cent) reported that they do not provide any type of privacy and stated that there is no need to provide the same. Most hospitals provide privacy in the form of separate rooms, followed by screen, audiovisual privacy. While separate rooms are available in hospitals of developed districts and Mumbai, hospitals in less developed districts provide a screen if separate rooms are not available. A separate room for privacy is most common in larger hospitals as compared to the smaller ones (Table 4.31).

Another parameter is the presence of female staff if a male doctor is examining a female patient. The study highlighted that 6 per cent (16) of the hospitals across regions do not have a woman doctor/nurse available during examination of female patients by male doctors. Nine hospitals did not respond to this question and four reported that they do so sometimes. It was surprising to find that 21-30 bedded hospitals are not respecting this. In the context of several cases of sexual harassment by doctors as reported by women patients, this is inexcusable (Table 4.32, 33).

It is the responsibility of hospitals to ensure audio-visual privacy for its patients and presence of a female if a male doctor is examining a female patient. It is left to individual doctors to decide upon how seriously they want to practce this. These are essential components of good ethical practice and should be demanded for by patients. This is one of the components of the Charter of Patients' Rights that has been proposed in the Draft Rules under the BNHRA, 2005 but has not been implemented.

4.7 Grievance redressal mechanism-

The GoM's recent ordinance (March, 2009) makes assault on doctors a non-bailable offence. This ordinance calls for all health establishments to set up mechanism for responding to grievances/medical negligence/problems with management and to aid and advice the patient.

In the current study:

- Nearly 62 per cent (161) of the hospitals reported that they have some grievance handling mechanism.
- Fifteen hospitals had a designated person to look into grievances of patients and these are large sized hospitals.
- About 81 per cent (130) of the grievance handling mechanism is in the form of complaints registered with the doctor. There is no independent mechanism for handling grievances against the owner-doctor.
- 9 per cent (15) of the hospitals display the information about the contacts of the concerned person. The large bedded hospitals provide more choices for the grievance redressal mechanism as well as seek feedback as compared to smaller hospitals. (Table- 4.34- 4.37)

In a grievance handling mechanism, the response time is very important as most the grievances are of immediate nature. Out of all hospitals which are providing the grievance handling mechanism, about 70 per cent per cent (101) of the hospitals handle the grievance immediately or within 5-15 minutes. The hospitals in the less developed districts and smaller hospitals give immediate attention to grievances as compared to hospitals from developed region and bigger hospitals. Those hospitals that are providing services and charging for it should have a grievance handling mechanism in place.

However, the mechanism to handle grievances is weak in the private healthcare sector. The patient is not provided a forum which he/she can immediately approach for her grievances, leading to more confusion and chaos, especially in an emergency. This is one of the major reasons for the strain in the doctor-patient relationship leading to an increase in assaults on practitioners, hospital property and staff. The findings related to the absence of an independent grievance redressal mechanism assumes significance in the context of the ordinance passed by the GoM for the protection of doctors.[35]

[35] http://www.moseve.org/MMSPB.pdf

4.8 Gross violation of patients' rights in the private health sector

The MCI code of medical ethics, and Draft Rules under the BNHRA 2005 (available on the Maharashtra Government website), awaiting the approval of the Health Minister, and other legal provisions confer some obligations on doctors vis-a-vis their patients. The BNHRA draft rules include a section on the Standard Charter of Patients' Rights. In the following section, we have highlighted the current status of private hospitals on certain patients' rights which have been included in these legal provisions and draft rules. This gives an idea about the gap that will have to be bridged when these draft rules are approved and become operational and other legal provisions are seriously enforced. The BNHRA draft rules were available on http://mahaarogya.gov.in/actsrules/nursing/BombayNursingHome.pdf till January 2009.

Right to emergency treatment: As per a Supreme Court Directive, a Patient should get emergency treatment irrespective of any legal or financial considerations.	o Approximately 87 per cent of the hospitals reported that they provided some form of emergency-medical/ surgical/ accidental care. o The most commonly provided emergency services are for medical and surgical emergencies. (~62 per cent) o Forty nine percent (130) of the hospitals reported that they have staff trained to deal with emergency situations. This was the highest amongst hospitals in less developed districts and lowest in Mumbai. o Only one hospital with 21-30 beds located in a developed district has staff trained for Cardiopulmonary Resuscitation.
Right to information: As per the draft rules, the patient or a designated representative should be provided with the necessary information about the likely cause of the illness, the investigations & treatment being planned, its cost, expected outcomes including likely complications, alternatives available and consequences of not taking treatment. The patient should have access to his/her clinical records at all times. On admission, the patient shall be informed about the treating doctor, rules and regulations of the nursing home, and approximate expenses that would be incurred. At the time of discharge the patient should get a discharge card containing the summary of clinical findings, investigations, diagnosis, treatment, state of his/her health at the time of discharge and follow-up of examination.	o Only 37 per cent (97) of the hospitals provide information about services available at the hospital. In most hospitals, it is done by para medical staff. o One fourth of the hospitals do not give IPD papers even on request, and half of them do not give OPD papers. o About 9 per cent do not give discharge papers. o One fourth of the hospitals do not maintain a file for the patients.
Right to confidentiality: The MCI code of medical ethics mandates that all the records of patients must be kept restricted to only the team treating the patient. This information can be disclosed to any person only with the patient's consent.	o Nine hospitals (3 per cent) reported that they do not provide any type of privacy and stated that that there is no need to provide the same. o About 16 hospitals (6 per cent) do not have any female present during the examination of female patients by male doctors.

Right to seek redressal: The GoM's recent ordinance makes it mandatory for health facilities to set up mechanisms for the redress of patients' grievances. Every nursing home should display the information on such competent authority prominently.	o Nearly 62 per cent (161) of the hospitals reported that they have some grievance handling mechanism. o Fifteen hospitals had a designated person to look into the grievances of patients and these are large sized hospitals. o About 80 per cent (130) of the grievance handling mechanism is in the form of complaints registered with the doctor. There is no independent mechanism for handling grievances against the owner-doctor.
In case of a HIV +ve patient: As per the draft rules, no person suffering from HIV should be denied care only on the basis of the HIV positive status. Not having a Voluntary Testing and Counselling Centre cannot become a ground to refuse care. For management of patient who is HIV positive, the nursing home would follow guidelines circulated from time to time by the NACO (National AIDS Control Organization)	o 13 per cent of hospitals indulge in compulsory testing for HIV. o 50 per cent conduct HIV test compulsorily for all operative patients and those seeking ANC. o Hospitals reported taking consent as well as provision of pre and post test counselling.

Summing up, the findings of this study show that private hospitals show a poor performance when it comes to adhering to certain minimum standards of care. The earlier chapter highlights the gross inadequacy in terms of availability of qualified human resources in the private hospitals. In this chapter, we find that quality of emergency care is provided by all hospitals is suspect, there is violation of Universal Guidelines for HIV/AIDS is rampant, maintenance of medical records is poor, information given to patients is even worse. Lastly the grievance redressal mechanisms are almost absent. This is a serious cause of concern. In the absence of any Law that has enshrined "Patients Rights", it is difficult for patients to demand certain basic information or even perceive certain denial as 'violation of right'.

CHAPTER 5

CURRENT LEGISLATION ACCREDITATION

PERCEPTIONS AMONGST HOSPITAL OWNERS

Blank

PERCEPTIONS ABOUT CURRENT LEGISLATION AND ACCREDITATION

The study explored awareness amongst owners of private hospitals about the BNHRA provisions and their opinions on it. As registration of private hospitals under this law is compulsory in the state, the opinions of hospital owners about the minimum requirements under the law, their perceptions with regard to compulsory registration, their problems if any with registration would provide some insight into the reasons for poor implementation as well as review of the law. It is important to know if they agree with what they are expected to comply with. In addition to this, their knowledge about accreditation and views about the same were also explored.

BNHRA and hospital owners:

The Bombay Nursing Home Registration Act is for the registration of private hospitals in Maharashtra. The Act was made in 1949 and was applicable only to Mumbai city. Later it was amended and made applicable to four districts of the state namely Mumbai, Nagpur, Pune and Solapur. Further through an amendment in 2005, it was made applicable to the entire state of Maharashtra. Even during field work which was two years after the amendment, we encountered several problems as districts did not have a list of hospitals. As mentioned earlier, we did not get any comprehensive list of hospitals from health departments of the districts.

5.1 Awareness and registration under the act

The awareness about the law amongst hospital owners is a prerequisite for proper understanding of the requirements and its implementation. Only 76 per cent (199) of the hospital owners were fully aware and 11 per cent (29) were partially aware about the BNHRA. The awareness about the Act was highest among the owners in Mumbai, 93 per cent (43), (both full and partially aware). This may be because the Act has been implemented in the city for many more years. 13 per cent (33) of the owners were not aware about the Act and most of them were located in the developed districts. (Table 5.1) Of the total number of hospitals, 197 were registered under the BNHRA and 16 hospitals had applied for registration and were in the process of getting their registration. While 228 hospitals were fully or partially aware of the law, only 197 were registered under it. Interestingly, 31 hospitals that had some knowledge of the BNHRA were not registered. (Table 5.2)

5.2 Opinions about registration and its minimum requirements

An overwhelmingly high number of hospital owners, 89 per cent (231) felt that registration was necessary (Table 5.3). This number is higher than the hospitals who have actually registered and those who are aware of the law. The hospitals that opined that registration is not necessary were mostly located in less developed districts and were small size hospitals, clearly indicating a trend that larger hospitals are more likely to favour registration. Almost 50 per cent of the hospital owners said that registration was necessary as it would stop illegal practices and bring in discipline in the sector. The highest percentage (69 per cent) is from Mumbai and is evenly distributed across different bed sized hospitals. About 34 per cent of the hospitals say that registration will bring in standardisation and uniformity in practice, which indicates concern about improving care in the private health sector. This group has the highest percentage from less developed districts (42 per cent) and across all bed sizes. Another 13 per cent of the hospitals opined that it is a government procedure and has to be followed. Only 4 hospitals stated that it will help in the enlisting of the hospitals (Table 5.4).

Why do hospital owners feel that registration is unnecessary? Twenty-seven hospital owners said that registration was not necessary. (Table 5.5) One opinion that emerged was that if they are registered as doctors with medical

councils or with their local authorities, there was no need for registration under this Act. The other opinion was related to problems with the BNHRA registration process, too much paper work and corruption.

5.3 Minimum requirements under the act

There are certain minimum requirements under the BNHRA that a hospital is expected to adhere to in order to get registration under the Law. The opinions about the minimum requirements and compliance to the same are important to understand. The hospital owners were asked if they know about the minimum requirements but were not asked to actually state them. Only 62 per cent (141) of the hospital owners reported that they were fully aware of the minimum requirements of BNHRA and 15 per cent (35) of the hospital owners were partially aware. The awareness about the minimum requirements was highest amongst hospitals in Mumbai and lowest amongst those in developed districts. The large and medium sized hospitals are more likely to be aware about the minimum requirements of the Act as compared to small sized hospitals. This highlights the fact that 21 hospitals (10 per cent of those registered) were registered without having any knowledge of the minimum requirements under the Act (Tables 5.6, 5.7).

Further to this, they were asked if they agreed with these minimum requirements. 67 per cent (118) of them said that they agree with the minimum requirements of the Act and about 26.7 per cent (47) partially agree. A large number of hospital owners from less developed districts agree with these. However, only 59 per cent of the hospitals in Mumbai agree with these minimum requirements (Table 5.8). The hospital owners were asked to cite reasons for their agreement with the minimum requirements under the Act. Almost 55 per cent (96) of hospital owners said that they agree with the Act because it is perfect in its present form. Another18 per cent (32) of the hospital owners said that they agree to most provisions except the one related to human resources as they face huge shortage of staff. This was reported mainly by hospitals in developed and less developed districts and especially the smaller hospitals. Another 21 hospitals feel that the act is not appropriate for small hospitals and 14 have stated that the minimum requirements should be as per the size and specialisation of the hospital. It was heartening to know that 11 hospitals stated that they agree with the minimum requirements because adherence to these ensures patients' benefit (Tables 5.9, 5.10).

The hospitals were asked whether they see any problem in enforcement of the minimum requirements under the Act. 44 per cent (78) of the hospitals expressed that this would create serious problems for hospitals like increase in cost, acquiring qualified staff and huge salaries, which could also mean closing down of the hospitals. (Table 5.11) This was the opinion of medium sized hospitals located in less developed and developed districts. 22 per cent (39) felt that there could be procedural problems like bribery, corruption, etc and these were mainly from Mumbai and large sized hospitals. Surprisingly, 30 per cent (53) felt that they do not see any problem in enforcement, and these are mainly located in Mumbai and developed districts. (Tables 5.12)

A large number of doctors do not agree with the Act or have problems with it. In a scenario where the monitoring mechanism is weak, there is hardly any chance that they would adhere to these minimum norms. About half of the hospitals especially from the developed areas and bigger hospitals have no objection to the act. Whereas some small size hospitals located in less developed areas are struggling with infrastructure problems especially human resources.

From the above discussion it is clear that the hospitals agree with the requirements and the Act but certain provisions clash with the ground realities. There is shortage of qualified staff and one of the preconditions for the registration is qualified staff in proportion to number of beds in the hospital. Similarly, the small hospitals or the hospitals in less developed region may have certain limitations regarding registration of their facilities.

5.4 Compliance to minimum requirements under the law:

The study was conducted by CEHAT in 2007, two years after the amendment. The following section presents the practices of hospitals registered under the law to minimum norms as mandated by the law. For this, a comparison between private hospitals registered (75 per cent) and those not registered (25 per cent) was drawn with regard to minimum requirements such as registration and display of registration, requirements of human resources and maintenance of birth and death records. The registration is highest in Mumbai (93 per cent), followed by developed districts (72 per cent) and then the less developed districts (68 per cent) (Table 5.13). The possible reason can be that the BNHRA is in place in Mumbai since 1949. Due to a long duration of implementation of the act, the awareness levels as well as implementation may be better in Mumbai. Again it is evident that implementation has been faster in less developed districts despite the fact they are in the periphery. This could be due to the fact that hospitals in less developed districts are less in number and so the pressure to abide by law may be higher.

Poor attainment to minimum requirements under the BNHRA

Display of registration number

Only 22.3 per cent of the registered hospitals displayed their registration number.

Human resources: *"Qualified doctor, qualified nurse for each hospital and midwife in case of maternity home"*

- Only 45 per cent of registered hospitals had a qualified DMO.
- The availability of qualified nurse in registered hospitals is 2 per hospital which is much below the actual requirement.
- Unqualified nurses are present in registered as well as unregistered hospitals.
- Of the 146 hospitals providing maternity services, only 11 had midwives.

Registration and maintenance of birth and death records: In terms of maintenance of records, no difference was found between the hospitals that are registered and those not registered. The registration of facilities does not ensure the proper maintenance of records.

(Table 5.14-5.18).

It can be concluded that registered facilities are not complying with minimum requirements under the law and this raises several concerns about the basis for registering these facilities and lack of monitoring of these hospitals post registration. It also gives us an idea of the gap that will have to be bridged when the rules are approved and become operational.

Registration of hospitals and infrastructure and facilities in the hospital

In addition to these minimum requirements, comparison between registered and non-registered hospitals with regard to other parameters was done. Ideally, all the hospitals should follow a functional plan in terms of space for a separate record room, nursing station, treatment and dressing room, casualty/emergency room. This helps in better management of space and ensures smooth working of the hospital. It also aids in providing quick services to the patient. The availability of infrastructure like operation theatre, ICU, ambulance and diagnostic services helps us analyze the variety of services available to patients under one roof.

It is important to look at the other infrastructure and services provided by the hospitals which are registered under the BNHRA and compare it with those that are not registered under the Act. The study highlights that there is hardly any difference in the infrastructure and services provided by hospitals that are registered and those that are not registered. In fact at some places in terms of qualified staff for laboratory (78 per cent-registered, 91 per cent-non registered) (Table 5.19) and X-ray (61 per cent-registered, 78 per cent -non registered) (Table 5.20), presence of ambulance (5 per cent-registered, 6-non registered per cent) (Table 5.21) - the unregistered hospitals depict a better picture.

The areas where some clear difference is visible are the availability of ultrasonography machine (34.5 per cent-registered, 14 per cent-non registered), (Table 5.22), provision of emergency services (91 per cent-registered, 75 per cent-non registered) (Table 5.23) and registration under the BMW Act which are more likely to be provided by registered hospitals as compared to the other services. The difference in these services is much sharper as compared to the difference in other services provided by registered and non registered hospitals. One common factor about the above services is that they are covered under some other legislative measures or Act and not the BNHRA. USG machine has to be registered under the PCPNDT Act. There is a Supreme Court judgement on emergency services which states a hospital cannot refuse emergency treatment to any person. So, a more striking difference is visible here as compared to other services between registered and non registered hospitals.

Among the non registered hospitals, 22 per cent are rented and 78 per cent are housed in self-owned building which is in contrast to the registered hospitals which are mostly housed in self-owned building. (Table 5.24)

The data clearly shows a trend that it is not registration under the BNHRA that determines the kind of services/ infrastructure or compliance to minimum requirements but the markets. Within each region whether it is Mumbai, developed districts or less developed districts, hospitals show similar trends with respect to standards and other characteristics.

5.5 Emerging issues

As the BNHRA is compulsory, the fact that 25 per cent of hospital owners in Maharashtra are not aware of it reflects the apathetic attitude of the medical profession, especially in the developed and less developed districts. While in Mumbai the picture appears good, the fact that one hospital owner was unaware about the Act, indicates that even private hospitals located in Mumbai may not be aware of the law despite the fact that it is implemented here for the longest period. This was borne out in the workshops that CEHAT organised where several doctors from other districts said that the BNHRA was not implemented in their districts and that they were registered under the Shops and Establishment Act when actually their districts were already registering nursing homes under the BNHRA.

Further to this, the trend as regards registration is similar to that of awareness about the law, where hospitals from developed districts and less than 10-bedded hospitals were the ones that were not registered. In these regions almost 30 per cent of hospitals were not registered. The fact that hospitals can actually function and flourish without even registering themselves as hospitals, as mandated by law is a cause for concern. This is rather serious and also indicative of the poor implementation of the law by the state health department.

However the fact that there were sizeable numbers of hospital owners who were aware of the law but had not registered their hospital indicates a complete lackadaisical attitude in adhering to the law. It is possible that in less developed districts where there are fewer hospitals in general, the implementing authorities are able to ensure registration and hospitals too are more likely to register to avoid any repercussions. However, the scenario in developed districts is of concern and it is obvious that there is apathy on part of providers as well as the authorities.

The study further highlights that there is hardly any difference in the infrastructure and services provided by hospitals that are registered and those that are not registered. In fact, in terms of qualified staff for laboratory and x-ray, and presence of ambulance, unregistered hospitals seem to be faring better. However, the availability of the ultrasonography machine, emergency services and registration under BMW is much higher amongst registered hospitals. These are covered under other legislative measures such as the Pre-conception and Pre-natal Diagnostic Techniques (PCPNDT) Act, the Supreme Court ruling on emergency care, the BMW Act and not the BNHRA. It is evident, that those are better implemented and therefore, have better compliance. Bringing all the laws governing private hospitals under one umbrella would ensure simplified procedures, better compliance and stricter monitoring.

There also appears to be a need to dialogue further with hospital owners on the BNHRA not just to create awareness but also to develop consensus on what the law lays down. The fact that only 59 per cent of hospital owners in Mumbai where the law is implemented for more than three decades, agree with the minimum requirements points to a gap between the ground reality and the law. The non attainment of the basic minimum requirement of qualified staff means that all such hospitals would have to close down once the administration strictly implemented the law. So if there is a genuine problem in adhering to certain requirements, they need to be discussed and appropriate changes brought in. It cannot be ignored as the study shows the sector is continuously growing and there is a need to regulate it and ensure that certain minimum standards of care are assured to patients.

Accreditation

Accreditation is the concept of self-regulation, which is a peer review based voluntary activity. It is a professional and national recognition to facilities that provide high quality of care. It is implicit that the particular health facility has voluntarily sought to be measured against high professional standards and is in substantial compliance with them (C.E. Lewis, 1984). This section looks at knowledge about accreditation of hospitals amongst the hospital owners and what advantages and disadvantages they see in accrediting their facilities.

5.6 Awareness about accreditation

66 per cent (172) of the hospitals owners were fully aware of accreditation. Of the hospitals from Mumbai, 93 per cent (42) hospitals had heard about accreditation whereas 42 per cent(13) of the hospitals from less developed districts had not heard about hospital accreditation (Table 5.25), rest of them either had no knowledge or partial knowledge. The larger hospitals located in developed districts seem to be more aware about accreditation as compared to smaller sized hospitals.

5.7 Opinions about accreditation

189 hospital owners had some knowledge (full or partial) about accreditation. Amongst them, 61 per cent (116) think that it is useful. The larger hospitals are more in favour of accreditation than smaller hospitals. The only exception is 6-10 bedded hospitals, where almost 50 per cent of the hospitals favour accreditation and 50 per cent do not (Table 5.28, 5.29).

Accreditation is about improving the services and quality of care. 62 per cent (72) of hospitals think that it will help in better delivery of services. The hospitals are mostly from Mumbai and developed districts and are big sized hospitals except 21-30 bedded hospitals. Another reason for accreditation of hospitals can be for recognition of the facility. There are about 28 per cent (32) of the hospitals which think that it is a good marketing strategy and would help in getting the recognition to the facility. These are mainly situated in less developed districts and are large hospitals. Only 8 per cent (9) hospitals owners think that it will help in terms of the quality of care provided by the hospital. There are about 3 hospitals from Mumbai and less developed districts, small in size that think that it is not useful for the rural people (Table 5.30, 5.31).

Of the 261 hospitals, 30 per cent (77) hospitals had no problem with accreditation; another 23 per cent (61) hospitals said that cost of accreditation was a concern for them. The hospitals who were worried about the high cost of accreditation are mainly from the less developed districts and are smaller hospitals. 9 per cent (24) of the hospitals feel that competition will grow. (Table 5.32).

The owners were asked specifically whether they would accredit their own hospitals. 62 per cent (161) of owners said that they will accredit their hospitals. 65 per cent (20) hospitals from less developed districts want to accredit their hospitals. However, 39 per cent (72) of owners from developed districts do not want to accredit their hospitals.

While 86 per cent of the 21-30 bedded hospitals want to accredit their hospitals, 46 per cent of the hospitals from 6-10 bedded don't want to accredit. (Table 5.26, 5.27)

Amongst those who do not want to accredit, 41 per cent (41) hospitals think that it is not relevant for them and especially for small places. These are mostly from the less developed districts and are medium sized hospitals. Not a single 21-30 bedded hospital thought that it is not relevant for them. The cost of accreditation is an issue with 29 per cent (29) of hospitals which mostly consist of hospitals from Mumbai and developed districts and are mostly bigger hospitals. (Table 5.33, 5.34)

Clearly, larger hospitals as compared to smaller hospitals would like to go for accreditation. The enthusiasm for the accreditation in our study is evident. Out of 172 who knew about the accreditation, 161 want to accredit their hospitals. This kind of enthusiasm is not there for BNHRA. The registration under BNHRA is compulsory but many hospitals despite knowing about the Act had not registered under it.

In less developed districts, there are fewer private hospitals and so the hospital is known by the name of the owner (doctor). So hospitals from the less developed districts recognise that accreditation would help in certification of their services thus attracting more patients. The hospitals from developed districts due to stiff competition value accreditation for the certification of quality of care, thus making a difference. Therefore hospitals from developed districts think that the accreditation would help in the delivery of better services. However, a large number of hospital owners especially from the developed and less developed districts were not able to comment on this. There is a need to create awareness among hospital owners about other processes available for providing good quality care.

Summing up, the study has thrown up several issues related to poor attainment of the minimum requirements of standards of care by hospitals with regard to the BNHRA. It also shows the gap that will have to be bridged when these draft rules are approved and become operational.

This also raises questions about the entire registration process. Currently, registration is mere enlisting, with no reference to any minimum requirements to be adhered to. Clearly this brings out that hospitals are merely being registered on paper under the law; no norms are being applied, no monitoring is being done. The gap between current practice and proposed standards is wide.

CHAPTER 6

DISCUSSION AND CONCLUSION

Blank

DISCUSSION

The study throws up some critical issues related to standards of health care in less than 30 bedded private hospitals in Maharashtra.

The private health sector is expanding in all regions across the state. This growth has been significant in the last decade as this is the period which has also witnessed a rise in corporate hospitals. The viability of and the demand for small ***sized*** hospitals (upto 30 bedded) does not seem to be affected by the entry of bigger hospitals. In fact small hospitals have been proliferating across all regions in the state (50 per cent of the hospitals have been established in the last decade).

The entrepreneurs in the private health sector are doctors themselves in contrast to corporate hospital which are owned by business houses/MNCs. The study found that most of the private hospitals were ***run and owned by doctors*** themselves which is in contrast to earlier studies where hospitals were housed in rented places. This is an indicator that this is a profit making venture for doctors who largely belong to the higher class and are able to invest private capital in setting up such enterprises. The easy access and choices available for taking loans too has made it easier for individual doctors to set up their own hospitals and support entrepreneurship. Multiple practices in the form of practicing at other hospitals or owning more than one hospital is common among doctors.

The ***availability of human resource*** in a hospital determines timely care and services for patients. The gross inadequacy in terms of availability of qualified staff across all cadres is stark. Hospitals are functioning without the required qualified staff particularly nurses, midwives and DMOs. In one fourth of the hospitals there is no qualified doctor to provide round-the-clock services. The availability of a qualified nurse per hospital is as low as 1.68 nurse per hospital. 56 per cent of hospitals did not have a single qualified nurse which is a critical indicator of standard of care. It emerges that shortage of qualified nursing staff is acute and there is a need to deliberate on this. More than 50 per cent of the nursing staff in these hospitals is trained in-house. In-house training essentially means on-the job training. Therefore, there is a need for the state, medical association, nursing association and hospital owners to focus on this and provide options for certified courses which are accredited and also look into the need for setting up of additional nursing colleges. One of the pre-conditions for the registration under the BNHRA in Maharashtra is to have qualified staff in proportion to the number of beds in the hospital. There is a shortage of qualified staff, which is the biggest hurdle in implementation of the BNHRA and the draft rules of BNHRA pending before the state cabinet as most hospitals would have to close down if the draft rules are approved and strictly implemented.

The ***physical infrastructure in hospitals*** with 0-30 beds, in terms of basic facilities such as electricity, ventilation, water supply and so on may have increased over the years, but these private hospitals fall short of specific services that are ***critical indicators of quality*** like emergency services, maintaining patients' records, mechanism to redress grievances and following other regulations like the BMW rules or Universal Guidelines for HIV/AIDS prevention. A functional plan that ensures demarcated space for essential services was found to be present in large hospitals and those located in developed districts.

The study found that ***Patients' Rights*** in term of standards of care are not being respected. The hospitals do not provide emergency care, privacy, consent or information to patients. This shows complete apathy of the medical profession to respecting patients' rights even while they have no qualms in demanding a law for their own protection.

The findings related to the absence of an ***independent grievance redressal mechanism*** assume significance in the context of the ordinance passed by the GoM for the protection of doctors. This ordinance calls for all health establishments to set up a mechanism for responding to grievances/ medical negligence /problems with management and to aid and advise the patient.

Overall, the study brings out poor attainment of the minimum requirements of standards of care by hospitals as compared to the draft BNHRA rules. It gives an idea about the gap that will have to be bridged when these draft rules are approved and become operational. It also points to abysmal implementation of the BNHRA so far. The registration is obviously being seen as a mere formality and paper work. Neither the state nor the doctors are taking this seriously.

Mumbai is an excellent example to highlight the complete apathy on part of both the parties towards adherence to any norms. Considering that even minimum requirements under the law are so poorly met by these hospitals, these findings raise grave concern over attainment of other essential parameters that are mentioned in the Draft BNHRA rules. Despite the fact that the law has been functional in Mumbai for over 60 years, non attainment of minimum requirements is inexcusable. This analysis further calls for better monitoring of registered facilities and stringent penalties for non-compliance on an ongoing basis.

The study shows that compliance to minimum requirements under the BNHRA as well as availability of infrastructure (standards of care) in private hospitals is dependent on the market and not on the status of registration.

The study sought opinions of hospital owners on the regulation of the private sector. Information was also collected on awareness and understanding of the BNHRA amongst doctors and their perceptions towards self-regulation. It was found that the awareness regarding BNHRA is 76 per cent in the sample. The awareness about the BNHRA is low in less developed regions. Almost 50 per cent of hospitals especially from the developed areas and bigger hospitals have no objection to the Act, whereas some small sized hospitals located in less developed areas are struggling with infrastructure problems, especially human resources.

The minimum requirements need to be thoroughly revised as they do not sufficiently ensure quality of care to patients. For instance, it is obvious that the requirements should be related to the size of the hospital but this is not currently so. The draft rules under the amended BNHRA 2005 have included both minimum standards of care as well as patients' rights. There is a crying need for immediate approval of these rules and implementation of these by the state.

The awareness about accreditation is high in large hospitals and those located in Mumbai and developed districts similar to BNHRA. Hospitals located in less developed districts and those that were small in size expressed concern that costs would rise with self regulation.

In addition to an apathetic attitude, the lack of awareness about the law and their opinions about minimum requirements would determine how seriously hospital owners take the law. The awareness about the BNHRA is low in less developed regions. It is clear that only hospitals owners in Mumbai and those of large hospitals were aware of self regulation and BNHRA. There is need for training and orientation of the medical profession on law, ethics and regulations.

Finally in the context of regulation of the private health sector, we recognise that private hospitals are governed by several laws-Medical Termination of Pregnancy (MTP), Pre-conception and Pre-natal Diagnostic Techniques (PCPNDT) Act, BMW, BNHRA, CPA and each of these are implemented by different departments of the state. In addition to this, private hospitals also need to conform to Universal Guidelines for management of HIV/AIDS.

We found that hospitals were violating many other laws in addition to not being registered under BNHRA, which is compulsory now for all private hospitals. This rampant flouting of laws is because there is no single department to monitor the functioning of private hospitals. All committees formed for implementation of various laws should be brought under one umbrella so that minimum standards are defined and there is better accountability on part of these hospitals.

CONCLUSION

Private hospitals have continued to be governed by the market. That the market will finally regulate the quality of services is questionable. Self regulation by the medical profession too has been negligible in India. The government must take steps to ensure that private hospitals adhere to minimum standards of care and provide good quality services. The government must move towards achieving universal access to health services by bringing both the public and private health services under one umbrella. How such a system can work requires a wider consultative process between civil society, health groups and medical fraternity. There are several lessons to be learnt from other countries like Canada, Brazil and the UK that have effectively organised their health systems.

Blank

CHAPTER 7

RECOMMENDATIONS

Blank

RECOMMENDATIONS

1. Violation of patients' rights demands immediate attention from the state. The state must set up independent grievance redressal mechanisms for patients accessing private health services and also legalise Patients' Rights so that they are justiciable. The GoM's recent ordinance (March, 2009) states that assault on doctors is a non-bailable offence and makes it mandatory for health facilities to set up mechanisms for the redress of patients' grievances. This caveat for setting up grievance redressal mechanisms recognizes that assaults on doctors can be prevented by ensuring better communication between the provider and the client. While assaults on doctors cannot be justified on any grounds, the reasons for such assaults lie solely in the poor quality of health services provided by private hospitals.
2. The minimum requirements of the BNHRA require to be overhauled as they are insufficient to ensure any standard of care to patients. Gaps between current practices and proposed standards are stark. There is a dire need for setting up a board consisting of various stakeholders to evolve minimum standards of care for private hospitals.
3. The poor adherence of private hospitals to even the minimum requirements under the law like recruitment of qualified staff underscores the need to enquire into the ground reality to understand if there are genuine problems in adhering to stated norms.
4. Hospitals are being registered under the law, with no norms being applied. No monitoring is being done. There is a need for better monitoring of registered facilities and stringent penalties for non compliance on an ongoing basis.
5. There is need for better co-ordination between the government at the centre, the state and the private health sector to bring in minimum level of uniformity across quality of care in the private health sector. The state must put in mechanisms for implementation of the legislation and monitoring of the registered facilities in consultation with the centre.
6. Hospital owners should be trained in various laws and universal guidelines governing their sector. Clinical standards should be evolved in tune with the national health policy and other universal guidelines. These should be made mandatory for all clinical establishments across various states. There is a need to develop a mechanism by which all laws/universal guidelines applicable to health facilities are implemented by a centralised unit in each state. This would remove the multiplicity of having to deal with several departments and would ensure better compliance and implementation.
7. Lastly, the problem of non-availability of qualified nurses needs to be discussed. The genuine shortage of qualified nurses should be taken up and more nursing colleges should be instituted. In-house training of nurses which is rampant needs to be standardized through developing a systematic curriculum, and certification or accreditation of such courses. The Nursing Council will have to be involved in this process because it is statutorily entrusted with regulation of the nursing profession.

Blank

REFERENCES

Blank

REFERENCES

1. Baru, Rama (2005). Private Health Sector in India - Raising Inequality. In Leena Gangolli; Ravi Duggal and Abhay Shukla (eds.), *Review of Health Care in India*, Mumbai : CEHAT, pp. 269-277.

2. Baru, Rama (1998). Private Health Care in India : Social Characteristics and Trends. New Delhi : Sage, 184 pp.

3. Baru, Rama. (2003). Privatization of Health Services, A South Asian Perspective. *Economic and Political Weekly*, 38(42), pp. 4433-4437.

4. Bandewar, Sunita (2002). Quality of abortion Care - A Reality. Mumbai : CEHAT.

5. Bhat, Ramesh (1996). Regulation of the Private Health Sector in India. *International Journal of Health Planning and Management*, 11, pp. 253-274.

6. Desai. M. and Chawla. D. (2007). Right to emergency Care, In Health Care Case Law in India - A Reader, edited by Desai M. and Mahabala K.B. : Mumbai : CEHAT, pp. 37-45.

7. Duggal, R. (2005). Public Health Expenditure: Investment and Financing under the shadow of a growing Private Sector. In Leena Gangolli; Ravi Duggal and Abhay Shukla (eds.), *Review of Health Care in India*, Mumbai : CEHAT, pp. 225-246

8. Kavadi, S.K (1999) Health resources, Investment and expenditure-A study of health care providers in a district in India, FRCH, Mumbai/Pune

9. Murlidhar, V. J. (1995). Proposed Minimum Standard for Private Hospitals / Nursing Homes : Upto 30 bedded Unit Providing Medical / Surgical / Maternity Services. In Workshop on Physical Standards in Private Hospitals/Nursing Homes, Kalina, University of Mumbai, April 23, 1995.

10. Nandraj, S., (1994). "Beyond the Law and the Lord: Quality of Private Health Care," *Economic and Political Weekly*, XXIX (27), pp. 1680-1685.

11. Nandraj, S. and Duggal. R. (1997). Physical standards in the private health sector : A Case Study of rural Maharashtra. Mumbai : CEHAT, 100 p.

12. Nandraj, S. (1997) Self Regulation of Private Hospitals and Nursing Homes in Mumbai City : Need for an Accreditation System. Mumbai : CEHAT.

13. India. Central Bureau of Health Intelligence. (2008). Health Finance indicators. In National Health Profile (NHP) of India. New Delhi : Central Bureau of Health Intelligence Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. Retrieved from http://www.cbhidghs.nic.in/index2.asp?slid=1000&sublinkid=706on

14. India. National sample survey Organisation, Ministry of Statistics and Programme implementation (2006). National Sample Survey (60th round). New Delhi : National sample survey Organisation, Ministry of Statistics and Programme implementation, Government Of India.

15. Rao, K. S.; Nundy, M. and Dua, A. V. (2005). Delivery of health services in private sector, section II: Delivery of healthcare services in India. In Background Papers - Financing and delivery of healthcare Services in India. New Delhi : National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Government Of India.

16. Yesudian, C. A. K. (1994). The Nature of Private Sector Health Services in Bombay. *Health Policy and Planning*, 9(1).

17. Bulletin of World health Organisation. (2002)- 'Private Sector Health Care in Developing Countries Needs Better Stewardship' Researchers say, 23 April 2002.

18. CEHAT. Draft rules of the Bombay Nursing Home Registration Act (Amendment) 2005. Available on http://www.cehat.org/go/uploads/Bnhra/bnhraDraft%20rules%20DGHS.pdf

TABLES

Blank

PROFILE OF PRIVATE HOSPITALS AND PROVIDERS

Table: 2.1 - Various regions of Maharashtra with number of private hospitals (sampling)

Region	Frequency
Western Maharashtra	70 (27%)
Kokan	49 (19%)
Vidarbha	30 (12%)
Marathwada	23 (9%)
North Maharashtra	44 (17%)
Mumbai	45 (17%)
Total	**261 (100%)**

Table: 2.2 - Years of establishment of private hospitals in Maharashtra (Level of development)

Area	1932 to 1947	1948 to 1963	1964 to 1979	1980 to 1995	1996 to 2007	Total
Developed district	-	3 (2%)	13 (7%)	66 (36%)	101(55%)	183 (100%)
Less developed district	-	-	2 (7%)	12 (39%)	17 (55%)	31 (100%)
Mumbai	2	1 (2%)	3 (7%)	17 (38%)	22 (49%)	45 (100%)
Total	**2 (1%)**	**4 (2%)**	**18 (7%)**	**95 (37%)**	**140 (54%)**	**259 (100%)**

Table: 2.3 - Years of establishment of private hospitals in Maharashtra (Size of hospital)

Beds	1932 to 1947	1948 to 1963	1964 to 1979	1980 to 1995	1996 to 2007	Total
<5	-	1 (2%)	-	15 (33%)	30 (65%)	46 (100%)
6-10	1 (1%)	-	6 (7%)	32 (39%)	44 (53%)	83 (100%)
11-15	1 (1%)	1 (1%)	6 (9%)	33 (47%)	30 (42%)	71 (100%)
16-20	-	2 (5%)	5 (13%)	10 (26%)	21 (55%)	38 (100%)
21-30	-	-	1 (5%)	5 (24%)	15 (71%)	21 (100%)
Total	**2 (1%)**	**4 (2%)**	**18 (7%)**	**95 (37%)**	**140 (54%)**	**259 (100%)**

Table: 2.4 - Size of hospitals (Level of development)

Area	<5	6-10	11-15	16-20	21-30	Total
Developed district	36 (20%)	53 (29%)	55 (30%)	27 (15%)	14 (8%)	185 (100%)
Less developed district	6 (19%)	16 (52%)	6 (19%)	1 (3%)	2 (7%)	31 (100%)
Mumbai	4 (9%)	14 (31%)	11 (24%)	11 (24%)	5 (11%)	45 (100%)
Total	**46 (18%)**	**83 (32%)**	**72 (28%)**	**39 (15%)**	**21 (8%)**	**261 (100%)**

Table: 2.5 - Services provided in the hospitals (Level of development)

Area	All Services	Medical & Surgical	Medical & Maternity	Maternity & Surgical	Only Medical	Only Maternity	Only Surgical	Other Services	Total
Developed district	67 (36%)	20 (11%)	7 (4%)	12 (7%)	17 (9%)	23 (12%)	10 (5%)	29 (16%)	185 (100%)
Less developed district	7 (23%)	4 (13%)	2 (7%)	2 (7%)	8 (26%)	1 (3%)	1 (3%)	6 (19%)	31 (100%)
Mumbai	18 (40%)	8 (18%)	-	1 (2%)	2 (4%)	10 (22%)	2 (4%)	4 (9%)	45 (100%)
Total	**92 (35%)**	**32 (12%)**	**9 (3%)**	**15 (6%)**	**27 (10%)**	**34 (13%)**	**13 (5%)**	**39 (15%)**	**261 (100%)**

Table: 2.6 - Type of system of medicine (Level of development)

Area	Allopathy	Ayurveda	Homeopathy	Unani	Not Qualified Doctors	Total
Developed district	164 (89%)	13 (7%)	8 (4%)	-	-	185 (100%)
Less developed district	30 (97%)	1 (3%)	-	-	-	31 (100%)
Mumbai	40 (89%)	-	3 (7%)	1 (2%)	1 (2%)	45 (100%)
Total	**234 (90%)**	**14 (5%)**	**11 (4%)**	**1 (0%)**	**1 (0%)**	**261 (100%)**

Table: 2.7 - Type of system of medicine (Size of hospital)

Beds	Allopathy	Ayurveda	Homeopathy	Unani	Not Qualified Doctors	Total
<5	36 (78%)	7 (15%)	3 (7%)	-	-	46 (100%)
6-10	75 (90%)	4 (5%)	4 (5%)	-	-	83 (100%)
11-15	68 (94%)	2 (3%)	2 (3%)	-	-	72 (100%)
16-20	36 (92%)	-	2 (5%)	-	1 (3%)	39 (100%)
21-30	19 (91%)	1 (5%)	-	1 (5%)	-	21 (100%)
Total	**234 (90%)**	**14 (5%)**	**11 (4%)**	**1 (0%)**	**1 (0%)**	**261 (100%)**

Table: 2.8- Bed occupancy (%) in the hospitals (Level of development)

Category	Total no. of Beds	Total no. of beds occupied in a month	Occupancy
Developed	2094	1254	60%
Less developed	418	170	41%
Mumbai	624	362	58%
Total	**3136**	**1786**	**57%**

Table: 2.9 - Bed occupancy (%) in the hospitals (Size of hospital)

Category	Total no. of Bed	Total no. of beds occupied in a month	Occupancy
0-5	196	325	166%
6-10	695	582	84%
11-15	982	476	48%
16-20	715	275	38%
21-30	548	128	23%
Total	**3136**	**1786**	**57%**

Table: 2.10 - Type of ownership of facility (Level of development)

Area	Self owned / Sole Proprietor	Partnership	Trust	Total
Developed district	163 (88%)	22 (12%)	-	185 (100%)
Less developed district	28 (90%)	3 (10%)	-	31 (100%)
Mumbai	34 (76%)	10 (22%)	1 (2%)	45 (100%)
Total	**225 (86%)**	**35 (13%)**	**1 (0%)**	**261 (100%)**

Table: 2.11 - Ownership of hospital by sex

Owners Details	Frequency no. & %		
	Male	Female	Total
Owner 1	238 (91%)	23 (9%)	261(100%)
Owner 2	42 (47%)	47 (53%)	89 (34%)
Owner 3	11 (79%)	3 (22%)	14 (5%)

Table: 2.12 - Type of ownership of facility (Size of hospital)

Beds	Self owned / Sole Proprietor	Partnership	Trust	Total
<5	45 (98%)	1 (2%)	-	46 (100%)
6-10	74 (89%)	8 (10%)	1 (1%)	83 (100%)
11-15	61 (85%)	11 (15%)	-	72 (100%)
16-20	31 (80%)	8 (21%)	-	39 (100%)
21-30	14 (670%)	7 (33%)	-	21 (100%)
Total	**225 (86%)**	**35 (13%)**	**1 (1%)**	**261 (100%)**

Table: 2.13 -Type of ownership of space (in which is housed) (Level of Development)

Area	Self owned / Sole Proprietor	Rented	Long lease	Any Other	Total
Developed district	162 (88%)	22 (12%)	1 (0%)	-	185 (100%)
Less developed district	22 (71%)	8 (26%)	-	1 (3%)	31 (100%)
Mumbai	42 (93%)	2 (4%)	-	1 (2%)	45 (100%)
Total	**226 (87%)**	**32 (12%)**	**1 (0%)**	**2 (1%)**	**261 (100%)**

Table: 2.14 - Type of Ownership of space (in which is housed) (Size of hospital)

Beds	Self owned / Sole Proprietor	Rented	Long lease	Any Other	Total
<5	34 (74%)	11 (24%)	1 (2%)	-	46 (100%)
6-10	69 (83%)	13 (16%)	-	1 (1%)	83 (100%)
11-15	67 (93%)	4 (6%)	-	1 (1%)	72 (100%)
16-20	37 (95%)	2 (5%)	-	-	39 (100%)
21-30	19 (91%)	2 (10%)	-	-	21 (100%)
Total	**226 (87%)**	**32 (12%)**	**1 (0%)**	**2 (1%)**	**261 (100%)**

Table: 2.15 - Information on practice at another hospital (Level of development)

Area	Yes	No	Total
Developed district	84 (45%)	101 (55%)	185 (100%)
Less developed district	4 (13%)	27 (87%)	31 (100%)
Mumbai	17 (38%)	28 (62%)	45 (100%)
Total	**105 (40%)**	**156 (60%)**	**261 (100%)**

Table: 2.16 - Information on practice at another hospital (Size of hospital)

Bed	Yes	No	Total
<5	19 (41%)	27 (59%)	46 (100%)
6-10	29 (35%)	54 (65%)	83 (100%)
11-15	28 (39%)	44 (61%)	72 (100%)
16-20	18 (46%)	21 (54%)	39 (100%)
21-30	11 (52%)	10 (48%)	21 (100%)
Total	**105 (40%)**	**156 (60%)**	**261 (100%)**

Table: 2.17 - Information on ownership of another hospital (Level of development)

Area	Yes	No	Total
Developed district	47 (25%)	138 (75%)	185 (100%)
Less developed district	2 (7%)	29 (94%)	31 (100%)
Mumbai	7 (16%)	38 (84%)	45 (100%)
Total	**56 (22%)**	**205 (79%)**	**261 (100%)**

Table: 2.18 - Information on multiple practice

Do you own another Hospital	Do you practice anywhere else		
	Yes	**No**	**Total**
Yes	23 (9%)	33 (13%)	56 (22%)
No	82 (31%)	123 (47%)	205 (79%)
Total	**105 (40%)**	**156 (60%)**	**261 (100%)**

Table: 2.19 - Sources of knowledge update (Level of development)

Area	Medical representative	Journals	Training Program / Continuation of Medical Education	Referring Books	Internet	Health Program on TV	Conference + Seminar + Workshop
Developed district	185 (100%)	141 (76%)	135 (73%)	63 (34%)	13 (7%)	-	36 (20%)
Less developed district	31 (100%)	18 (58%)	14 (45%)	4 (13%)	4 (13%)	-	1 (3%)
Mumbai	44 (98%)	17 (38%)	35 (78%)	13 (29%)	17 (38%)	1 (2%)	3 (7%)
Total	**260 (100%)**	**176 (67%)**	**184 (71%)**	**80 (31%)**	**34 (13%)**	**1 (0%)**	**40 (15%)**

Table: 2.20 - Information given by medical representatives (Level of development)

Area	Drugs	Latest technology	New brands in equipments
	Yes	Yes	Yes
Developed district	183 (99%)	109 (59%)	114 (62%)
Less developed district	31 (100%)	9 (29%)	8 (26%)
Mumbai	41 (91%)	5 (11%)	8 (18%)
Total	**255 (98%)**	**123 (47%)**	**130 (50%)**

HUMAN RESOURCES

Table: 3.1 - Availability of DMO (Level of development)

Area	Absent	Present	Total
Developed district	86 (46%)	99 (54%)	185 (100%)
Less developed district	23 (74%)	8 (26%)	31 (100%)
Mumbai	32 (71%)	13 (29%)	45 (100%)
Total	**141 (54%)**	**120 (46%)**	**261 (100%)**

Table: 3.2 - Availability of DMO (Size of hospital)

Bed	Absent	Present	Total
<5	40 (87%)	6 (13%)	46 (100%)
6-10	56 (68%)	27 (33%)	83 (100%)
11-15	26 (36%)	46 (64%)	72 (100%)
16-20	15 (39%)	24 (62%)	39 (100%)
21-30	4 (19%)	17 (81%)	21 (100%)
Total	**141 (54%)**	**120 (46%)**	**261 (100%)**

Table: 3.3 - Medical officers/DMO's qualification (Level of development)

Area	MBBS	MD	DHMS	BAMS	BHMS	Total
Developed district	18 (18%)	2 (2%)	1 (1%)	53 (54%)	24 (25%)	98 (100%)
Less developed district	-	-	-	7 (88%)	1 (13%)	8 (100%)
Mumbai	1 (8%)	-	-	9 (69.0%)	3 (23.0%)	13 (100%)
Total	**19 (16%)**	**2 (2%)**	**1 (1%)**	**69 (58%)**	**28 (24%)**	**119 (100%)**

Table: 3.4 -Information on the hospital in-charge staying in the hospital premises (Level of development)

Area	Yes	No	Total
Developed district	93 (50%)	92 (50%)	185 (100%)
Less developed district	21 (68%)	10 (32%)	31 (100%)
Mumbai	11 (25%)	34 (76%)	45 (100%)
Total	**125 (48%)**	**136 (52%)**	**261(100%)**

Table: 3.5 - Information on the hospital in-charge staying in the hospital premise (Size of hospital)

Bed	Yes	No	Total
<5	22 (48%)	24 (52%)	46 (100%)
6-10	43 (52%)	40 (48%)	83 (100%)
11-15	33 (46%)	39 (54%)	72 (100%)
16-20	19 (49%)	20 (51%)	39 (100%)
21-30	8 (38%)	13 (62%)	21 (100%)
Total	**125 (48%)**	**136 (52%)**	**261 (100%)**

Table: 3.6 - Availability of DMO with In-charge staying in the hospital premise

DMO	Yes	No	Total
Absent	72 (28%)	69 (26%)	141 (54%)
Present	53 (20%)	67 (26%)	120 (46%)
Total	**125 (48%)**	**136 (52%)**	**261 (100%)**

Table 3.7 - Qualification of Nurses

	Number	Percent
Qualified Nurses	64	25
Unqualified Nurses	139	53
Presence of both	34	13
No Nurse	24	9
Total	**261**	**100**

Table: 3.8 - Nurses in the hospitals

Nurses	Number
Qualified	455 (36%)
Unqualified	823 (64%)
Total	**1278 (100%)**

Table: 3.11 - Availability of Aayabai and Ward boy in private hospitals

	Aayabai	Ward boys
Present	224 (86%)	108 (41%)
Absent	37 (14%)	153 (59%)

Table: 3.12 - Availability of Lab. Technicians with laboratory

	Technician		
Laboratory	**Yes**	**No**	**Total**
Yes	58 (22%)	27 (10%)	85 (33%)
No	4 (2%)	172 (66%)	176 (67%)
Total	**62 (24%)**	**199 (76%)**	**261 (100%)**

Table: 3.13 - Qualification of lab staff (Level of development)

Area	DMLT	MD (Pathology)	HSC	Total
Developed district	39 (89%)	1 (2%)	4 (9%)	44 (100%)
Less developed district	7 (70%)	-	3 (30%)	10 (100%)
Mumbai	4 (50%)	-	4 (50%)	8 (100%)
Total	**50 (80%)**	**1 (2%)**	**11 (18%)**	**62 (100%)**

Table: 3.14 - Qualification of lab staff (Size of hospital)

Bed	DMLT	MD (Pathology)	HSC	Total
<5	1 (100%)	-	-	1 (100%)
6-10	14 (88%)	-	2 (13%)	16 (100%)
11-15	20 (83%)	1 (4%)	3 (13%)	24 (100%)
16-20	8 (80%)	-	2 (20%)	10 (100%)
21-30	7 (64%)	-	4 (36%)	11 (100%)
Total	**50 (81%)**	**1 (2%)**	**11 (18%)**	**62 (100%)**

Table: 3.15 - Availability of staff for x-ray services with X-ray facility

	Human Resources-X-ray Staff - Number				
X-ray facility	**0**	**1**	**2**	**4**	**Total**
Yes	45 (43%)	54 (51%)	5 (5%)	2 (2%)	106 (100%)
No	155 (100%)	-	-	-	155 (100%)
Total	**200 (77%)**	**54 (21%)**	**5 (2%)**	**2 (1%)**	**261 (100%)**

Table: 3.16 - X-ray facility (Level of development)

Area	Yes	No	Total
Developed district	72 (39%)	113 (61%)	185 (100%)
Less developed district	18 (58%)	13 (42%)	31 (100%)
Mumbai	16 (36%)	29 (64%)	45 (100%)
Total	**106 (41%)**	**155 (59%)**	**261 (100%)**

Table: 3.17 X-ray staff qualification (Level of development)

Area	Diploma in x-ray	HSC	Total
Developed district	32 (70%)	14 (30%)	46 (100%)
Less developed district	2 (40%)	3 (60%)	5 (100%)
Mumbai	4 (44%)	5 (56%)	9 (100%)
Total	**38 (63%)**	**22 (37%)**	**60 (100%)**

*** No information : 1**

STANDARDS OF CARE

Table: 4.1 - Do you provide services in emergency situations

	Frequency
Yes	228 (87%)
No	33 (13%)
Total	**261 (100%)**

Table: 4.2 Emergency services provided by hospitals (Size of hospital))

Bed strength	Emergency services provided in Accident situations	Emergency services provided in Medical emergency	Emergency services provided in Surgical emergency
	Yes	Yes	Yes
<5	12 (35%)	18 (53%)	13 (38%)
6-10	31 (44%)	34 (49%)	44 (63%)
11-15	38 (59%)	47 (72%)	43 (66%)
16-20	22 (58%)	25 (66%)	28 (74%)
21-30	16 (76%)	18 (86%)	15 (71%)
Total	**119 (52%)**	**142 (62%)**	**143 (63%)**

Table: 4.3- Emergency services provided by the hospitals (Level of development)

Area	Accident	Medical emergency	Surgical emergency
Developed district	78 (48%)	103 (64%)	100 (62%)
Less developed district	17 (63%)	11 (41%)	14 (52%)
Mumbai	24 (62%)	28 (72%)	29 (74%)
Total	**119 (52%)**	**142 (62%)**	**143 (63%)**

Table: 4.4 Steps taken to handle emergency situations efficiently (Level of development)

Area	Quick Admission	Immediate attention by medical staff	Round the clock availability
Developed district	147 (91%)	133 (82%)	90 (56%)
Less developed district	21 (78%)	21 (78%)	17 (63%)
Mumbai	16 (41%)	11 (28%)	17 (44%)
Total	**184 (81%)**	**165 (72%)**	**124 (54%)**

Table: 4.5 - Staff trained for emergencies (Level of development)

Area	Yes	No	Some	Total
Developed district	88 (54%)	67 (41%)	7 (4%)	162 (100%)
Less developed district	20 (74%)	3 (11%)	4 (15%)	27 (100%)
Mumbai	9 (23%)	28 (72%)	2 (5%)	39 (100%)
Total	**117 (51%)**	**98 (43%)**	**13 (6%)**	**228 (100%)**

Table: 4.6 - Staff trained for emergencies (Size of hospital)

	Yes	No	Some	Total
<5	13 (38%)	18 (53%)	3 (9%)	34 (100%)
6-10	32 (46%)	32 (46%)	6 (9%)	70 (100%)
11-15	42 (65%)	21 (32%)	2 (3%)	65 (100%)
16-20	14 (37%)	22 (58%)	2 (5%)	38 (100%)
21-30	16 (77%)	5 (24%)	-	21 (100%)
Total	**117 (51%)**	**98 (43%)**	**13(6%)**	**228(100%)**

Table: 4.7 - Types of IPD wards (Level of development)

Area	IPD Wards (Men)	IPD Wards (Women)	IPD ward (Common)
	Yes	Yes	Yes
Developed district	62 (34%)	76 (41%)	95 (51%)
Less developed district	12 (39%)	12 (39%)	19 (61%)
Mumbai	11 (24%)	20 (44%)	25 (56%)
Total	**85 (33%)**	**108 (41%)**	**139 (53%)**

Table: 4.8- Types of IPD wards (Size of hospital)

Bed	IPD Wards (Men)	IPD Wards (Women)	IPD ward (Common)
<5	4 (9%)	8 (17%)	34 (74%)
6-10	22 (27%)	29 (35%)	44 (53%)
11-15	29 (40%)	40 (56%)	31 (43%)
16-20	19 (49%)	20 (51%)	19 (49%)
21-30	11 (52%)	11 (52%)	11 (52%)
Total	**85 (33%)**	**108 (41%)**	**139 (53%)**

Table: 4.9- Availability of rooms (Level of development)

Area	General Room	Semi special Room	Special Room
Developed district	166 (90%)	82 (44%)	150 (81%)
Less developed district	31 (100%)	3 (10%)	20 (65%)
Mumbai	43 (96%)	29 (64%)	41 (91%)
Total	**240 (92%)**	**114 (44%)**	**211 (81%)**

Table: 4.10- Availability of rooms (Size of hospital)

Bed	General Room	Semi special Room	Special Room
<5	41 (89%)	9 (20%)	21 (46%)
6-10	72 (87%)	31(37%)	65 (78%)
11-15	69 (96%)	41(57%)	67 (93%)
16-20	38 (97%)	19 (49%)	37 (95%)
21-30	20 (95%)	14 (67%)	21 (100%)
Total	**240 (92%)**	**114 (44%)**	**211 (80%)**

Table: 4.11 -Infrastructure available in the hospitals (Level of development)

Infrastructure	Total	Less developed district	Developed district	Mumbai
Medical Records Room	72 (28%)	4 (13%)	64 (35%)	4 (9%)
Nursing Station	158 (61%)	17 (55%)	98 (53%)	15 (33%)
Treatment room/ Dressing Room	122 (46%)	18 (58%)	98 (53%)	6 (13%)
Casualty/Emergency Room	61 (23%)	6 (19%)	49 (27%)	6 (13%)
Operation Theatre	223 (85%)	25 (81%)	156 (84%)	43 (93%)
ICU	70 (26%)	5 (16%)	54 (29%)	11 (24%)
Laboratory	85 (32%)	13 (42%)	60 (32%)	12 (27%)
X-ray facility	106 (40%)	18 (58%)	72 (39%)	16 (36%)
Ultra Sonography	77 (29%)	11 (36%)	49 (27%)	17 (38%)
Ambulance/Vehicle to transport patient	13 (4%)	-	11 (6%)	2 (4%)

Table: 4.12 - Basic facilities in the hospitals (Level of development)

Essential Services	Total	Less developed district	Developed district	Mumbai
Refrigerator	231 (89%)	26 (84%)	165 (89%)	40 (89%)
Telephone line	259 (99%)	31 (100%)	183 (99%)	45 (100%)
Continuous water	253 (97%)	31 (100%)	180 (97%)	42 (93%)
Toilets	260 (100%)	31 (100%)	185 (100%)	44 (98%)
Continuous electricity supply	213 (82%)	17 (55%)	155 (84%)	41 (91%)
Generator:	125 (48%)	17 (55%)	100 (54%)	8 (18%)
Inverter	150 (57%)	29 (94%)	154 (83%)	12 (27%)
Lifts	55 (21%)	-	45 (24%)	10 (22%)
Ramps	36 (14%)	4 (13%)	31 (17%)	1 (2%)

Table: 4.13 - Number of floors in hospitals with lift availability

Detailed	Frequency
Total no of Nursing Homes having more than one floor	161 (62%)
Lift available for more than one floor	50 (19%)

Table: 4.14 - Registration status of the hospital under Bio-Medical waste (Level of development)

Area	Yes	No	In process of registration	Total
Developed district	165 (89%)	18 (10%)	2 (1%)	185 (100%)
Less developed district	23 (74%)	7 (23%)	1 (3%)	31 (100%)
Mumbai	43 (96%)	2 (4%)	-	45 (100%)
Total	**231 (89%)**	**27 (10%)**	**3 (1%)**	**261 (100%)**

Table: 4.15 - Segregation of Bio -medical waste among hospitals (Level of development)

Area	Yes	No	Sometimes	Total
Developed district	149 (81%)	36 (20%)	-	185 (100%)
Less developed district	20 (65%)	9 (29%)	2 (7%)	31 (100%)
Mumbai	43 (96%)	2 (4%)	-	45 (100%)
Total	**212 (81%)**	**47 (18%)**	**2 (1%)**	**261 (100%)**

Table: 4.16 - Segregation of Bio-medical waste among the hospitals-category wise (Level of development)

Area	Section 1.02 Colour Code	Medical & General Waste	Dry & Wet Waste	Biodegradable & Nonbiodegradable	Total
Developed district	111 (75%)	2 (1%)	35 (24%)	1 (7%)	149 (100%)
Less developed district	9 (45%)	5 (25%)	6 (30%)	-	20 (100%)
Mumbai	43 (100%)	-	-	-	43 (100%)
Total	**163 (77%)**	**7 (3%)**	**41 (19%)**	**1 (1%)**	**212 (100%)**

Table: 4.17 - HIV testing (Level of development)

Area	Compulsory testing for all	Compulsory for operative patients	Compulsory for all ANC patients	Depends on clinical picture
Developed district	17 (9%)	80 (43%)	100 (54%)	106 (57%)
Less developed district	4 (13%)	8 (26%)	12 (39%)	23 (74%)
Mumbai	14 (31%)	18 (40%)	31 (69%)	16 (36%)
Total	**35 (14%)**	**106 (41%)**	**143 (55%)**	**145 (55%)**

Table: 4.18 - Informed consent before HIV test (Level of development)

Area	Yes	No	Sometimes	Total
Developed district	94 (53%)	78 (44%)	6 (3%)	178 (100%)
Less developed district	25 (86%)	4 (14%)		29 (100%)
Mumbai	25 (57%)	18 (41%)	1 (2%)	44 (100%)
Total	**144 (57%)**	**100 (40%)**	**7 (3%)**	**251 (100%)**

*** No information : 10**

Table: 4.19 - Information/counseling given before the HIV/AIDS test (Level of development)

Area	Yes	No	Sometimes	Total
Developed district	122 (69%)	51 (29%)	5 (3%)	178 (100%)
Less developed district	22 (76%)	5 (17%)	2 (7%)	29 (100%)
Mumbai	29 (66%)	13 (30%)	2 (5%)	44 (100%)
Total	**173 (69%)**	**69 (28%)**	**9 (4%)**	**251 (100%)**

*** No information : 10**

Table: 4.20 - Information/counseling given after the HIV/AIDS test (Level of development)

Area	Yes	No	Sometimes	Total
Developed district	127 (71%)	47 (26%)	4 (2%)	178 (100%)
Less developed district	20 (69%)	6 (21%)	3 (10%)	29 (100%)
Mumbai	35 (80%)	7 (16%)	2 (5%)	44 (100%)
Total	**182 (73%)**	**60 (24%)**	**9 (4%)**	**251 (100%)**

*** No information : 10**

Table: 4.21 - HIV report given to the patient (Level of development)

Area	Yes	No	Sometimes	Total
Developed district	164 (92%)	13 (7%)	1 (6%)	178 (100%)
Less developed district	22 (76%)	5 (17%)	2 (7%)	29 (100%)
Mumbai	43 (98%)	1 (2%)	–	44 (100%)
Total	**229 (91%)**	**19 (8%)**	**3(1%)**	**251 (100%)**

*** No information : 10**

Table: 4.23 - Information on medical record maintenance in the hospitals

Details	Frequency	Less developed district	Developed district	Mumbai
Birth Record	143 (55%)	11 (36%)	102 (55%)	30 (66%)
Death Record	180 (69%)	17 (55%)	127 (69%)	36 (80%)
Notifiable diseases-	92 (35%)	13 (42%)	59 (32%)	20 (44%)
Other communicable diseases	84 (32%)	12 (39%)	52 (28%)	20 (44%)
Medico-legal cases-	119 (46%)	12 (39%)	78 (42%)	29 (64%)

Table: 4.24 - Information on medical record maintenance (Size of hospital)

Bed	Births	Deaths	Notifiable diseases	Other communicable diseases	Medico-legal cases
<5	19 (41%)	21 (46%)	9 (20%)	6 (13%)	10 (22%)
6-10	50 (60%)	54 (65%)	23 (28%)	21 (25%)	33 (40%)
11-15	43 (60%)	57 (79%)	29 (40%)	27 (38%)	37 (51%)
16-20	20 (51%)	31 (80%)	19 (49%)	17 (44%)	25 (64%)
21-30	11 (52%)	17 (81%)	12 (57%)	13 (62%)	14 (67%)
Total	**143 (55%)**	**180 (69%)**	**92 (35%)**	**84 (32%)**	**119 (46%)**

Table: 4.25 - System of maintaining the records (Level of development)

Area	On paper	Register	Files	Computer	Card (Note Book)	Diary	Total
Developed district	51 (28%)	94 (51%)	24 (13%)	13 (7%)	2 (1%)	1 (1%)	185 (100%)
Less developed district	10 (32%)	16 (52%)	2 (7%)	3 (10%)	-	-	31 (100%)
Mumbai	1 (2%)	36 (80%)	3 (7%)	4 (9%)	-	1 (2%)	45 (100%)
Total	**62 (24%)**	**146 (56%)**	**29 (11%)**	**20 (8%)**	**2 (1%)**	**2 (1%)**	**261 (100%)**

Table: 4.26- Information given to patient

Paper given to patient	Number of hospitals	percentage
OPD Paper	135	52%
Investigation reports	233	89%
Discharge papers	237	91%
Bill of every patient	230	88%
File of each patient	194	74%
IPD paper on request	64	25%
Given on request	47	18%

Table: 4.27- Information on display of the various services available (Size of hospital)

Bed	Yes	No	Some of the services	Total
<5	13 (28%)	32 (70%)	1 (2%)	46 (100%)
6-10	20 (24%)	59 (71%)	4 (5%)	83 (100%)
11-15	30 (42%)	41 (57%)	1 (1%)	72 (100%)
16-20	22 (56%)	15 (39%)	2 (5%)	39 (100%)
21-30	12 (57%)	9 (43%)	-	21 (100%)
Total	**97 (37%)**	**156 (60%)**	**8 (3%)**	**261 (100%)**

Table: 4.28 - Procedures followed for admission

Procedures	Frequency	Less developed district	Developed district	Mumbai
Admission form to be filled up	212 (81%)	20 (65%)	155 (84%)	37 (82%)
Each patient is given card	25 (10%)	4 (13%)	20 (11%)	1 (2%)
Other (Keep record on Register, case paper)	20 (8%)	3 (10%)	7 (4%)	10 (22%)

Table: 4.29 - Assistance/guidance in admission procedure of patient (Level of development)

Area	Receptionist	Para medical staff	Staff Nurse on Duty	Chief Doctor	Person designated to help in admission process
Developed district	62 (34%)	31 (17%)	103 (56%)	57 (31%)	2 (1%)
Less developed district	16 (52%)	9 (29%)	13 (42%)	9 (29%)	-
Mumbai	19 (43%)	4 (9%)	25 (56%)	6 (13%)	-
Total	**97 (37%)**	**44 (17%)**	**141 (54%)**	**72 (28%)**	**2 (1%)**

Table: 4.30 - Assistance or Guidance in admission procedure of patient (Size of hospital)

Bed	Receptionist	Para medical staff	Staff Nurse on Duty	Chief Doctor	Person designated to help in admission process
	Yes	Yes	Yes	Yes	Yes
<5	13 (28%)	9 (20%)	20 (44%)	14 (30%)	
6-10	24 (29%)	13 (16%)	59 (71%)	21 (25%)	1
11-15	24 (33%)	13 (18%)	36 (50%)	29 (40%)	
16-20	20 (51%)	6 (15%)	18 (46%)	7 (18%)	1 (3%)
21-30	16 (76%)	3 (14%)	8 (38%)	1 (5%)	
Total	**97 (37%)**	**44 (17%)**	**141 (54%)**	**72 (28%)**	**2 (1%)**

Table: 4.31 - Privacy and comfort during the examination of the patient (Level of development)

Area	Separate room	At least a screen available	Audio Privacy	No Need	Total
Developed district	171 (92%)	6 (3%)	3 (2%)	5 (3%)	185 (100%)
Less developed district	20 (65%)	6 (19%)	3 (10%)	2 (7%)	31 (100%)
Mumbai	43 (96%)	-	-	2 (4%)	45 (100%)
Total	**234 (90%)**	**12 (5%)**	**6 (2%)**	**9 (3%)**	**261 (100%)**

Table: 4.32 - Woman doctor/nurse availability during examination of a female patient (Level of development)

Area	Yes	No	Sometimes	Total
Developed district	166 (92%)	11 (6%)	3 (2%)	180 (100%)
Less developed district	25 (86%)	3 (10%)	1 (3%)	29 (100%)
Mumbai	41 (95%)	2 (5%)	-	43 (100%)
Total	**232 (92%)**	**16 (6%)**	**4 (2%)**	**252 (100%)**

*** No information : 9**

Table: 4.33 - Woman doctor/nurse availability during examination of a female patient (Size of hospital)

Bed	Yes	No	Sometimes	Total
<5	35 (81%)	7 (16%)	1 (2%)	43 (100%)
6-10	72 (91%)	5 (6%)	2 (3%)	79 (100%)
11-15	67 (96%)	2 (3%)	1 (1%)	70 (100%)
16-20	39 (100%)	-	-	39 (100%)
21-30	19 (91%)	2 (10%)		21 (100%)
Total	**232 (92%)**	**16 (6%)**	**4 (2%)**	**252 (100%)**

*** No information : 9**

Table: 4.34 Provision for grievance handling mechanism (Level of development)

Area	Yes	No	Total
Developed district	95 (51%)	90 (49%)	185 (100%)
Less developed district	26 (84%)	5 (16%)	31 (100%)
Mumbai	40 (89%)	5 (11%)	45 (100%)
Total	**161 (62%)**	**100 (38%)**	**261 (100%)**

Table: 4.35 - Mechanism for complaints registration in the hospital (Level of development)

Area	To the Doctor	Complaints Register Box	Person Designated	Suggestion Box	Patient Opinion Form	Other (Sister, Administrator)
	Yes	Yes	Yes	Yes	Yes	
Developed district	71 (75%)	14 (15%)	10 (11%)	11 (12%)	8 (8%)	2 (100%)
Less developed district	26 (100%)	-	-	-	-	2 (100%)
Mumbai	33 (83%)	1 (3%)	5 (13%)		4 (10%)	3 (100%)
Total	**130 (81%)**	**15 (9%)**	**15 (9%)**	**11 (8%)**	**12 (8%)**	**7 (100%)**

Table: 4.36 - Mechanisms for complaints registration in the hospitals (Size of hospital)

Bed	To the Doctor	Complaints Register Box	Person Designated	Suggestion Box	Patient Opinion Form	Other (Sister, Administrator)
	Yes	Yes	Yes	Yes	Yes	
<5	25 (96%)	1 (4%)	-	1 (4%)	-	-
6-10	45 (96%)	2 (4%)	1 (2%)	1 (2%)	1 (2%)	1 (100%)
11-15	38 (83%)	5 (11%)	4 (9%)	2 (4%)	5 (11%)	1 (100%)
16-20	13 (59%)	3 (14%)	3 (14%)	5 (23%)	2 (9%)	2 (100%)
21-30	9 (45%)	4 (20%)	7 (35%)	2 (10%)	4 (20%)	3 (100%)
Total	**130 (81%)**	**15 (9%)**	**15 (9%)**	**11 (7%)**	**12 (8%)**	**7 (100%)**

Table: 4.37 - Information on the display of contacts of the concerned officials (Level of development)

Area	Yes	No	Total
Developed district	13 (14%)	82 (86%)	95 (100%)
Less developed district	1 (4%)	25 (96%)	26 (100%)
Mumbai	1 (3%)	39 (98%)	40 (100%)
Total	**15 (9%)**	**146 (91%)**	**161 (100%)***

*** 161 Hospital reported some form of grievance handling mechanism**

PERCEPTIONS ABOUT CURRENT LEGISLATION AND ACCREDITATION AMONGST HOSPITAL OWNERS

Table: 5.1 - Awareness about the Bombay nursing home registration act (Level of development)

Area	Yes	No	Partially	Total
Developed district	136 (74%)	28 (15%)	21 (11%)	185 (100%)
Less developed district	21 (68%)	4 (13%)	6 (19%)	31 (100%)
Mumbai	42 (93%)	1 (2%)	2 (4%)	45 (100%)
Total	**199 (76%)**	**33 (13%)**	**29 (11%)**	**261 (100%)**

Table: 5.2 - Status of registration of hospitals under this act (Level of development)

Area	Yes	No	It is in processes	Total
Developed district	134 (86%)	12 (8%)	10 (6%)	156 (100%)
Less developed district	21 (78%)	-	5 (19%)	27 (100%)
Mumbai	42 (96%)	1 (2%)	1 (2%)	44 (100%)
Total	**197 (87%)**	**13 (6%)**	**16 (7%)**	**227 (100%)**

*** No information : 34**

Table: 5.3 - Necessity of registration of facilities (Level of development)

Area	Yes	No	Total
Developed district	164 (89%)	21 (11%)	185 (100%)
Less developed district	25 (81%)	6 (19%)	31 (100%)
Mumbai	42 (93%)	3 (7%)	45 (100%)
Total	**231 (89%)**	**30 (12%)**	**261 (100%)**

Table: 5.4 - Reason-Need for registration of facilities (Level of development)

Area	Discipline and stop illegal practices	Standardization & uniformity in practice	Govt. Procedure has to be followed	Help in Estimation of total number of private nursing homes	Total
Developed district	78 (48%)	59 (36%)	23 (14%)	4 (2%)	164 (100%)
Less developed district	11 (46%)	10 (42%)	3 (13%)	-	24 (100%)
Mumbai	29 (69%)	10 (24%)	3 (7%)	-	42 (100%)
Total	**118 (51%)**	**79 (34%)**	**29 (13%)**	**4 (2%)**	**230 (100%)**

Table: 5.5 - Reason-registration of facilities not necessary (Level of development)

Area	Registration not important	Problem with Procedure	Total
Developed district	5 (28%)	12 (67%)	17 (100%)
Less developed district	5 (83%)	1 (17%)	6 (100%)
Mumbai	1 (33%)	2 (68%)	3 (100%)
Total	**11 (41%)**	**15 (56%)**	**26 (100%)**

Table: 5.6 - Awareness of minimum requirements to be complied under the Bombay Nursing Home Registration Act (Level of development)

Area	Yes	No	Partially	Total
Developed district	91 (58%)	43 (27%)	23 (15%)	157 (100%)
Less developed district	18 (67%)	6 (22%)	3 (11%)	27 (100%)
Mumbai	32 (73%)	3 (7%)	9 (21%)	44 (100%)
Total	**141 (62%)**	**52 (23%)**	**35 (15%)**	**228 (100%)**

Table: 5.7- Awareness of minimum requirements to be complied under the Bombay Nursing Home Registration Act (Size of hospital)

Bed	Yes	No	Partially	Total
<5	18 (47%)	14 (37%)	6 (16%)	38 (100%)
6-10	48 (64%)	18 (24%)	9 (12%)	75 (100%)
11-15	41 (66%)	9 (15%)	12 (19%)	62 (100%)
16-20	23 (66%)	7 (20%)	5 (14%)	35 (100%)
21-30	11 (61%)	4 (22%)	3 (17%)	18 (100%)
Total	**141 (62%)**	**52 (23%)**	**35 (15%)**	**228 (100%)**

Table: 5.8 - Agreement of minimum requirements as required under the Bombay Nursing Home Registration Act (Level of development)

Area	Yes	No	Partially	Total
Developed district	78 (68%)	6 (6%)	29 (25%)	113 (100%)
Less developed district	16 (71%)	1 (5%)	5 (24%)	22 (100%)
Mumbai	24 (59%)	4 (10%)	13 (32%)	41 (100%)
Total	**118 (67%)**	**11 (6%)**	**47 (27%)**	**176 (100%)**

Table: 5.9 - Reasons-agreement with minimum requirements as required by the Bombay Nursing Home Registration Act (Level of development)

Area	Agree but difficult at local or small hospital	Agree but problem with Nurses	Not appropriate	Agree its perfect	Agree but should be according to specialization area and bed strength	It's required for patients benefit	Total
Developed district	9 (8%)	26 (23%)	1 (1%)	60 (53%)	8 (7%)	10 (9%)	114 (100%)
Less developed district	4 (18%)	5 (23%)	1 (5%)	8 (36%)	3 (14%)	1 (5%)	22 (100%)
Mumbai	4 (10%)	5 (13%)	-	28 (70%)	3 (8%)	-	40 (100%)
Total	**17 (10%)**	**36 (21%)**	**2 (1%)**	**96 (55%)**	**14 (8%)**	**11 (6%)**	**176 (100%)**

Table: 5.10 - Reasons- agreement with minimum requirements as required by the Bombay Nursing Home Registration Act (Size of hospital)

Bed	Agree but difficult at local or small hospital	Agree but problem with Nurses	Not appropriate	Agree its perfect	Agree but should be according to specialization area and bed strength	It's required for patients benefit	Total
<5	5 (21%)	8 (33%)	-	6 (25%)	1 (4%)	4 (17%)	24 (100%)
6-10	4 (7%)	13 (22%)	-	33 (57%)	5 (9%)	3 (5%)	58 (100%)
11-15	3 (6%)	9 (18%)	2 (4%)	32 (63%)	3 (6%)	2 (4%)	51 (100%)
16-20	2 (7%)	5 (18%)	-	17 (61%)	3 (11%)	1 (4%)	28 (100%)
21-30	3 (20%)	1 (7%)	-	8 (53%)	2 (13%)	1 (7%)	15 (100%)
Total	**17 (10%)**	**36 (21%)**	**2 (1%)**	**96 (55%)**	**14 (8%)**	**11 (6%)**	**176 (100%)**

Table: 5.11- Problems foreseen due to minimum requirements (Level of development)

Area	Problem with functions of Nursing Home	Procedure Problem	Lack of awareness about the act	No problems	Total
Developed district	53 (47%)	21 (18%)	5 (4%)	35 (31%)	114 (100%)
Less developed district	12 (55%)	5 (23%)	-	5 (23%)	22 (100%)
Mumbai	13 (33%)	13 (33%)	1 (3%)	13 (33%)	40 (100%)
Total	**78 (44%)**	**39 (22%)**	**6 (3%)**	**53 (30%)**	**176 (100%)**

Table: 5.12 - Problems foreseen due to minimum requirements (Size of hospital)

Bed	Problem with functions of Nursing Home	Procedure Problem	Lack of awareness about the act	No problems	Total
<5	10 (42%)	5 (21%)	-	9 (38%)	24 (100%)
6-10	33 (57%)	8 (14%)	3 (5%)	14 (24%)	58 (100%)
11-15	19 (37%)	11 (22%)	1 (2%)	20 (39%)	51 (100%)
16-20	9 (32%)	12 (43%)	2 (7%)	5 (18%)	28 (100%)
21-30	7 (47%)	3 (20%)	-	5 (33%)	15 (100%)
Total	**78 (44%)**	**39 (22%)**	**6 (3%)**	**53 (30%)**	**176 (100%)**

Table: 5.13 - Hospitals registered under the BNHRA (Level of development)

Area	Registered under BNHRA	Percentage
Developed district	134	72
Less developed district	21	68
Mumbai	42	93
Total	**197**	**75**

N=261

Table: 5.14 - Registration under the BNHRA and display of registration number (Level of development)

Registered Under BNHRA	Area	Display of registration number of the hospital		
		Yes	No	Total
Yes	Developed district	28 (21%)	106 (79%)	134(100.0%)
	Less developed district	7 (33%)	14 (67%)	21(100.0%)
	Mumbai	9 (21%)	33 (79%)	42(100.0%)
	Total	**44 (22%)**	**153 (78%)**	**197 (100%)**
No	Developed district	6 (12%)	43 (88%)	49 (100%)
	Less developed district	1 (10%)	9 (90%)	10 (100%)
	Mumbai	1 (33%)	2 (67%)	3 (100%)
	Total	**8 (13%)**	**54 (87%)**	**62 (100%)**

Table: 5.15 - Registration under the BNHRA and availability of a qualified DMO

	Qualified DMO		
Registered Under BNHRA	**Qualified DMO**	**Not Qualified DMO**	**Total**
Yes	89 (45%)	108 (55%)	197 (100%)
No	30 (47%)	34 (53%)	64 (100%)
Total	**119 (46%)**	**142 (54%)**	**261 (100%)**

Table: 5.16 - Availability of nurses with registration under the BNHRA (Level of development)

	Registered under BNHRA Act- Yes		Registered under BNHRA Act -No	
Area	**Qualified Nurse**	**Unqualified Nurse**	**Qualified Nurse**	**Unqualified Nurse**
Developd District	212	444	50	189
Less developd districts	17	45	3	36
Mumbai	173	104	-	5
Total	**402**	**593**	**53**	**230**

Total = 1278

Table: 5.17 - Registration under BNHRA with availability of birth records

Register under BNHRA	**Availability of Birth records**		
	Yes	**No**	**Total**
Yes	106 (96%)	4 (4%)	110 (100%)
No	32 (89%)	4 (11%)	36 (100%)
Total	**138 (95%)**	**8 (6%)**	**146 (100%)**

Table: 5.18 - Registration under the BNHRA with availability of death records (Level of development)

	Death records - yes/no		
Registered Under BNHRA	**Yes**	**No**	**Total**
Yes	142 (72%)	55 (28%)	197 (100%)
No	38 (59%)	26 (41%)	64 (100%)

Table: 5.19 - Registrations under the BNHRA with pathology lab staff - Qualification

	Human Resources-Technical staff units/ Pathology Lab Staff - Qualification			
Register under the BNHRA	**DMLT**	**MD (Pathology)**	**HSC**	**Total**
Yes	40 (78%)	1 (2%)	10 (20%)	51 (100%)
No	10 (91%)	-	1 (9%)	11 (100%)
Total	**50 (81%)**	**1 (2%)**	**11 (18%)**	**62 (100%)**

Table: 5.20 - Registration under the BNHRA with human resources - X-ray staff - Qualification

	Human Resources-X-ray Staff - Qualification		
Register under the BNHRA	**Diploma**	**HSC**	**Total**
Yes	31 (61%)	20 (39%)	51 (100%)
No	7 (78%)	2 (22%)	9 (100%)
Total	**38 (63%)**	**22 (37%)**	**60 (100%)**

Table: 5.21- Registration under BNHRA with ambulance/vehicle to transport patient

	Ambulance/Vehicle to transport patient		
Register under the BNHRA	**Yes**	**Section 1.03**	**No Total**
Yes	9 (5%)	188 (95%)	197 (100%)
No	4 (6%)	60 (94%)	64 (100%)
Total	**13 (5%)**	**248 (95%)**	**261 (100%)**

Table: 5.22 - Registration under the BNHRA with availability of ultra sonography

	Availability of Ultra Sonography-Yes/no		
Register under the BNHRA	**Yes**	**No**	**Section 1.04 Total**
Yes	68 (35%)	129 (66%)	197 (100%)
No	9 (14%)	55 (86%)	64 (100%)
Total	**77 (30%)**	**184 (71%)**	**261 (100%)**

Table: 5.23 - Registration under the BNHRA with availability of emergency services

	Availability of emergency situations		Total
Register under the BNHRA	**Yes**	**No**	
Yes	180 (91%)	17 (9%)	197 (100%)
No	48 (75%)	16 (25%)	64 (100%)
Total	**228 (87%)**	**33 (13%)**	**261 (100%)**

Table: 5.24 - Registration under BNHRA with ownership of space in which is housed

	Ownership of space in which is housed				
Register under the BNHRA	**Self owned/ Sole Proprietor**	**Rented**	**Long leased**	**Any Other**	**Total**
Yes	176 (89%)	18 (9%)	1 (.4%)	2 (1%)	197 (100%)
No	50 (78%)	14 (22%)	-	-	64 (100%)
Total	**226 (87%)**	**32 (12%)**	**1 (.4%)**	**2 (1%)**	**261 (100%)**

Table: 5.25 - Knowledge about the accreditation (Level of development)

Area	**Yes**	**No**	**Partially**	**Total**
Developed district	117 (63%)	57 (31%)	11 (6%)	185(100%)
Less developed district	13 (42%)	13 (42%)	5 (16%)	31(100%)
Mumbai	42 (93%)	2 (5%)	1 (2%)	45(100%)
Total	**172 (66%)**	**72 (28%)**	**17 (7%)**	**261(100%)**

Table: 5.26 - Willingness of hospital owners for accreditation of their hospitals (Level of development)

Area	**Yes**	**No**	**Total**
Developed district	113 (61%)	72 (39%)	185 (100%)
Less developed district	20 (65%)	11 (35%)	31 (100%)
Mumbai	28 (62%)	17 (38%)	45 (100%)
Total	**161 (62%)**	**100 (38%)**	**261 (100%)**

Table: 5.27 - Willingness of hospital owners for accreditation of their hospitals (Size of hospital)

Bed	Yes	No	Total
<5	25 (54%)	21 (46%)	46(100%)
6-10	44 (53%)	39 (47%)	83(100%)
11-15	46 (64%)	26 (36%)	72(100%)
16-20	28 (72%)	11 (28%)	39(100%)
21-30	18 (86%)	3 (14%)	21(100%)
Total	**161 (62%)**	**100 (38%)**	**261(100%)**

Table: 5.28 - Usefulness of accreditation (Level of development)

Area	Yes	No	Total
Developed district	87 (68%)	41 (32%)	128 (100%)
Less developed district	9 (50%)	9 (50%)	18 (100%)
Mumbai	20 (47%)	23 (54%)	43 (100%)
Total	**116 (61%)**	**73 (39%)**	**189 (100%)**

Table: 5.29 - Usefulness of accreditation (Size of hospital)

Bed	Yes	No	Total
<5	18 (67%)	9 (33%)	27 (100%)
6-10	29 (52%)	27 (48%)	56 (100%)
11-15	34 (61%)	22 (39%)	56 (100%)
16-20	21 (68%)	10 (32%)	31 (100%)
21-30	14 (74%)	5 (26%)	19 (100%)
Total	**116 (61%)**	**73 (39%)**	**189 (100%)**

Table: 5.30 - Usefulness of accreditation - reasons (Level of development)

Area	Deliver better services	Recognition of the facility	Patients can take decision	Useful but not in rural area	Total
Developed district	54 (62%)	23 (26%)	8 (9%)	2 (2%)	87 (100%)
Less developed district	4 (44%)	5 (56%)	-	-	9 (100%)
Mumbai	14 (70%)	4 (20%)	1 (5%)	1 (5%)	20 (100%)
Total	**72 (62%)**	**32 (28%)**	**9 (7%)**	**3 (2%)**	**116 (100%)**

Table : 5.31 - Usefulness of accreditation - reasons (Size of hospital)

Bed	Deliver of better services	Recognition of the facility	Patients can take decision	Useful but not in rural area	Total
<5	10 (56%)	5 (28%)	2 (11%)	1 (6%)	18 (100%)
6-10	18 (64%)	6 (21%)	2 (7%)	2 (7%)	28 (100%)
11-15	22 (63%)	9 (26%)	4 (11%)	-	35 (100%)
16-20	16 (76%)	5 (24%)	-	-	21 (100%)
21-30	6 (43%)	7 (50%)	1 (7%)	-	14 (100%)
Total	**72 (62%)**	**32 (28%)**	**9 (8%)**	**3 (3%)**	**116 (100%)**

Table: 5.32 - Problems with accreditation (Level of development)

Area	Lack of awareness	Problem with Cost of accreditation	Problem with procedure of Accrediation	Not useful for small Hospital	Competition will grow	No Problem	Not Asked	Total
Developed district	26 (14%)	47 (25%)	32 (17%)	6 (3%)	18 (10%)	52 (28%)	4 (2%)	185 (100%)
Less developed district	5 (16%)	9 (29%)	3 (10%)	3 (10%)	1 (3%)	10 (32%)	-	31 (100%)
Mumbai	4 (9%)	5 (11%)	12 (27%)	4 (9%)	5 (11%)	15 (33%)	-	45 (100%)
Total	**35 (13%)**	**61 (23%)**	**47 (18%)**	**13 (5%)**	**24 (9%)**	**77 (30%)**	**4 (2%)**	**261 (100%)**

Table: 5.33 - Reasons for not accrediting of their hospitals (Level of development)

Area	Not relevant for them as nursing home	High cost of accreditation	Not fully convinced about accredittation advantages	Competition among hospitals will increase	ISO could be best option.	Total
Developed district	31 (43%)	22 (31%)	14 (19%)	2 (3%)	3 (4%)	72 (100%)
Less developed district	7 (64%)	1 (9%)	3 (27%)	-	-	11 (100%)
Mumbai	3 (18%)	6 (35%)	7 (41%)	1 (6%)	-	17 (100%)
Total	**41 (41%)**	**29 (29%)**	**24 (24%)**	**3 (3%)**	**3 (3%)**	**100 (100%)**

Table: 5.34 - Reasons for not accrediting of their hospitals (Size of hospital)

Bed	Not relevant for them as nursing home	High cost of accreditation	Not fully convinced about accreditation advantages	Competition among hospitals will increase	ISO could be best option	Total
<5	8 (38%)	7 (33%)	5 (24%)	-	1 (5%)	21 (100%)
6-10	14 (36%)	11 (28%)	13 (33%)	1 (3%)	-	39 (100%)
11-15	13 (50%)	5 (19%)	6 (23%)	1 (4%)	1 (4%)	26 (100%)
16-20	6 (55%)	4 (36%)	-	1 (9%)	-	11 (100%)
21-30	-	2 (67%)	-	-	1 (33%)	3 (100%)
Total	**41 (41%)**	**29 (29%)**	**24 (24%)**	**3 (3%)**	**3 (3%)**	**100 (100%)**

ANNEXURES

Blank

Identification No			

Interview Schedule for Hospital In-Charge

हॉस्पिटल प्रमुखांची मुलाखात

Situational Analysis of the Quality of Care in the Private Nursing Homes in Maharashtra

(A study conducted in 11 districts)

महाराष्ट्रातील खाजगी नर्सिंग होम्सची पाहणी (अकरा जिल्ह्यांचा अभ्यास)

This study is funded by International Development Research Centre, Canada. The institutions/ Practitioners included in this study have been selected in a systematic stratified sampling scheme and are in no way a reflection of an individual /establishment and / Providers achievements or short comings. The names and identity of respondents will not be disclosed under any circumstances.

District: _____ **Taluka:** _____
जिल्हा : तालुका :

Date of the interview: _____
मुलाखतीची दिनांक :

Name of Facility: _____
हॉस्पिटलचे नाव :

Address of the facility: _____

पत्ता _____

Time at beginning of the interview: मुलाखतीची सुरुवातीची वेळ :	**Time at end of the interview:** मुलाखतीची शेवटची वेळ

Name of the interviewer: मुलाखत देणाऱ्याचे नाव :	

Date (mmddyy) दिनांक :	**Schedule Checked By:** प्रश्नावली तपासणारा :

CEHAT, ***Research Centre of Anusandhan Trust,***
Survey No.2804 and 2805, Sai Ashray, Aram Society Road, Vakola, Santacruz (East), Mumbai 400 055

Letter of Introduction For Health Care Provider / Facilities Seeking Informed Consent

Date:

To,

_____

_____

_____

Sub: Letter of Introduction and Consent for participation in the interviews to understand the Quality of Care at the Health Facility

Greetings! CEHAT (Centre for Enquiry into Health and Allied Themes) is the research centre of Anusandhan Trust, a non-profit educational trust. The research centre (CEHAT in hindi means health) is working in health and related areas. CEHAT does research, action, advocacy and service delivery on its theme areas of work which include- Women and Health, Health Services and Financing, Health and Human Rights, Health Legislation, Ethics and Patient's Rights.

Quality of Care in Health Facilities is an important area of work for CEHAT. We all know that now a majority of both in-patient and outpatient care is being given by private facilities. We understand that facilities provided at any private health facility are dependent on many factors such as where it is situated, paying capacity of patients, availability of doctors and development of general infrastructure in the area. We also understand that many private practitioners work under adverse circumstances. We think that it is important to conduct research and study the quality of care in private health facilities. Especially small nursing homes may be facing more difficulties and little is known about the services they offer. Therefore we would like to include your facility in the study.

The study involves interviewing the owner of the nursing home or in their absence the person in-charge. The focus will be to know about services and specialities available, staff and bed strength, other general information and your views on registration and accreditation of facilities. One more person working in the hospital such as Duty Medical Officer or senior nurse would also be interviewed to know more about all facilities available and to show us around the nursing home. We would like to observe and measure a few things, like how much space is available for the nursing home and how it is utilized. We would also like to interview any patient who has been discharged. *(This information will be for owner or in-charge of nursing home)*

With respect to the above-mentioned study, we would like to interview you. The objective is to gain from your experiences in providing services for people in this area. They will involve asking some questions, discussions and recording of answers on a sheet of paper. Your identity as respondent will be protected and will not be revealed at any point of time during or after the research. The names will never be made available for purposes of publication or quoting. Even so, you can refuse the interview or withdraw from the interview at any time in between, if you are uncomfortable in continuing. You also have the right to make more queries regarding the purpose of the interview and how this information will be utilized.

We request you to consent to the interview, take part in the discussions and feel free to ask any questions regarding the same. We assure you that information given by you will not be revealed to any government authority or will not be used in any way to take action against the facility. The information will be used only for research purposes and in the formation of a report of findings. Even within the report no mention

of names of participants will be done. We request you to permit us to use this information, without revealing your name, in any document describing the current quality of care in private facilities. We will make available to you the findings of this research, when the research report is ready.

Amita Pitre, Varsha Zende and Suchitra Desai, Habib, Ravi, Amit, Sushma form the research team. You may contact us for queries any time at the following contact numbers and' or address.

Thank you very much for sparing your valuable time and talking to us.

Warm Regards,

Investigators sign

Investigators Name

Contact us :
Centre for Enquiry into Health and Allied Themes
Survey No. 2804 & 2805, Aaram Society Road
Vakola, Santacruz (East)
Mumbai - 400 055
Tel. : 91-22-26673571 / 26673154
Fax : 22-26673156
E-mail : cehat@vsnl.com
Website : www.cehat.org

I have read the above letter and consent to the interview.

_____
Name and signature of respondent

(Investigator should note if consent is verbal & sign here)

महाराष्ट्रातील खाजगी नर्सिंग होम्सची पाहणी (अकरा जिल्ह्यांचा अभ्यास)

डॉक्टर / आरोग्य कर्मचाऱ्यांच्या मुलाखतीसाठी परवानगीचे पत्र

दिनांक :

प्रति,

_____

_____

_____

विषय : आरोग्य सुविधेविषयीच्या अभ्यासाबद्दल माहिती देणे व त्यासाठीच्या मुलाखतीमध्ये सहभागी होण्यासाठी सम्मती देणेबाबत.

'सेहत' हे अनुसंधान ट्रस्ट ह्या शैक्षणिक ट्रस्टचे संशोधन केंद्र आहे. हे संशोधन केंद्र आरोग्य आणि आरोग्यविषयक काम करते. 'सेहत'च्या कामाचे क्षेत्र - **स्त्रिया आणि आरोग्य, आरोग्य सुविधा आणि अर्थव्यवस्था, आरोग्य आणि मानवी हक्क आरोग्य विषयक कायदे, नैतिक मुल्य आणि रुग्णाचे हक्क आहे.**

आरोग्य सेवेतील सुविधांचा दर्जा हा 'सेहत'च्या अभ्यासाचा एक महत्त्वाचा भाग आहे. आपल्या सर्वांना माहिती आहे की, आजकाल बहुतेक आरोग्यसेवा ही खाजगी सुविधांकडून दिली जाते. कुठल्याही खाजगी आरोग्य सेवेमध्ये मिळणाऱ्या सुविधा ह्या बऱ्याच गोष्टींवर अवलंबून असतात. जसे ती सेवा कुठे आहे, डॉक्टरांची उपलब्धता आणि त्या भागातील सर्वसामान्य रहाणीमान, रुग्णांची पैसे देण्याची क्षमता किती आहे. आम्हाला असे वाटते की, खाजगी सेवेमधील सुविधांचा अभ्यास करणं महत्त्वाचं आहे. बरेचसे खाजगी डॉक्टर प्रतिकुल परिस्थितीमध्ये काम करत असतात. खासकरुन छोटे हॉस्पिटल किंवा नर्सिंग होम यांना जास्त अडचणींना तोंड द्यावे लागतं आणि ते पुरवत असलेल्या सुविधांविषयी फार थोडी माहिती असते, म्हणूनच आम्हाला तुमचे हॉस्पिटल ह्या अभ्यासामध्ये सहभागी करायचे आहे.

या अभ्यासात दवाखान्याच्या मालकाची किंवा त्याच्या गैरहजेरीत प्रमुख व्यक्तीची मुलाखत घेतली जाईल. मुलाखत मुख्यत्वे तिथे दिल्या जाणाऱ्या सुविधा आणि सेवकवर्ग, खाटांची क्षमता, इतर सर्वसामान्य माहिती आणि नोंदणीविषयक माहितीवरचे तुमचे विचार यावर केंद्रित असेल.

दवाखान्यात काम करणारे ड्युटी मेडीकल ऑफीसर किंवा नर्स यांच्याकडून सुविधांबद्दल अधिक माहिती घेतली जाईल. आम्हाला काही गोष्टी प्रत्यक्ष पहाण्याची इच्छा आहे. आणि काही गोष्टीची मापे घ्यावे लागतील, जसे इस्पितळातील दोन खाटांमधील अंतर. आम्हाला दवाखान्यातून बाहेर पडणाऱ्या रुग्णांची सुद्धा मुलाखत घ्यायची आहे. या भागातील लोकांना सुविधा पुरवत असताना तुम्हाला आलेले अनुभव किंवा अडचणी माहित करुन घेणे हाही या मुलाखतीचा एक उद्देश आहे. यात थोडे प्रश्न विचारणे, चर्चा करणे आणि उत्तरे लिहून घेणे हे असेल. मुलाखतदार म्हणून तुमची ओळख सुरक्षित असेल आणि संशोधनाच्या कोणत्याही टप्प्यामध्ये किंवा नंतर उघड केली जाणार नाही. प्रकाशनासाठी म्हणून नाव उपलब्ध केली जाणार नाही. तरीही, तुम्हाला वाटत असल्यास

मुलाखत देण्यासाठी तुम्ही नकार देऊ शकता किंवा मुलाखत मध्येच थांबवू शकता. तुम्हाला मुलाखतीविषयी आणि तिचा वापर कसा केला जाईल याबद्दल शंका विचारण्याचा पूर्ण हक्क आहे.

आम्ही तुम्हाला मुलाखतीत भाग घेण्याविषयी संमती द्यायची विनंती करत आहोत. चर्चेमध्ये भाग घेऊन मोकळेपणाने प्रश्न विचारा. आम्ही खात्री देतो की, तुम्ही दिलेली माहिती कोणत्याही सरकारी अधिकाऱ्यासमोर उघड केली जाणार नाही किंवा तुमच्या सुविधेवर कारवाई करण्यासाठीही वापरली जाणार नाही. हि माहिती वापरण्यासाठी परवानगी देण्याची आम्ही विनंती करतो. अभअयास पूर्ण झाल्यावर त्याचे निष्कर्ष तुम्हाला नक्की कळवू. अभ्यासाचे निष्कर्ष फक्त राज्यपातळीवर व विस्तृत विभागासाठी असतील व जिल्हा किंवा तालुका पातळीवर निष्कर्ष काढले जाणार नाही.

अमिता, वर्षा, सुचित्रा, रवि, अमित, हबीब, सुषमा व इतर हे ह्या संशोधनात एकत्र काम करतात. तुम्ही कधीही खाली दिलेल्या पत्त्यावर, किंवा फोन नंबरवव आमच्याशी संपर्क साधूता. तुमचा अमूल्य वेळ दिलात आणि आमच्याशी बोललात त्याबद्दल धन्यवाद.

आपले नम्र,

इनव्हेस्टिगेटरची सही

इनव्हेस्टीगेटरचे नाव

पत्ता : सेंटर फॉर इनक्वायरी इनटू हेल्थ अँड अलाईड थीम्स् (सेहत)
सर्व्हे नं. २८०४-२८०५, आराम सोसायटी रोड,
वाकोला, सांताक्रूझ (पूर्व), मुंबई - ४०० ०५५
फोन : ९१-२२-२६६७३१५४ / २६६७३५७१
फॅक्स : २२-२६६७३१५६
ई-मेल : cehat@vsnl.com
वेब-साईट : www.cehat.org

वरील पत्र वाचले आहे आणि मुलाखतीसाठी परवानगी देत आहे.

मुलाखतदाराचे नाव आणि सही _____
(तोंडी परवानगी दिली असल्यास
तसे लिहा व आपली सही करा.)

INTERVIEW WITH HOSPITAL IN-CHARGE

Section I : General Information about the facility सुविधेची सर्वसाधारण माहिती (दवाखान्याची)

1. Year of Establishment: स्थापनेचे वर्ष : _____

2. Status of Registration: नोंदणीची स्थिती:

1	Registered	2	Not Registered	3	Registration in Process
4.	Any Other (specify) इतर				

3. Year of Registration of the facility: नोंदणीचे वर्ष : _____

4. Registration Number (if any) of the facility: नोंदणी क्रमांक (असल्यास) _____

5. Registered by (Name of registering authority): नोंदणी कुणाच्या द्वारे _____

6. Name and qualification of the owner/s (incase more than one owner take details of all)
मालकाचे नाव व मालकांविषयी माहिती :

No.	Names	Qualification	Relationship among them
1			
2			
3			

7. Name of the In-charge (if other than owner) प्रमुख डॉक्टरांचे नाव (जर मालकाव्यतिरिक्त कुणी असेल तर):

_____

8. Ownership of facility: हॉस्पिटलची मालकी कशा प्रकारची

1	Self owned/Sole Proprietor स्वत:च्या मालकीचे	2	Partnership भागीदारी	3	NGO स्वयंसेवी संस्थेचे	4	Trust ट्रस्टचे
5	Other इतर						

9. Ownership of space in which facility is housed: सुविधा पुरविणाऱ्या जागेचा मालकी हक्क कशा प्रकारे आहे.

1	Self owned/Sole Proprietor स्वत:च्या मालकीचे	2	Rented भाड्याचे	3	Long leased दीर्घकाळ भाड्याचे
4	Any Other (specify) इतर				

10. Is there any financial support in establishing and running this facility ? हॉस्पिटल सुरु करण्यासाठी आणि चालविण्यासाठी आर्थिक मदत

1	No support काही नाही	2	Government grant शासनाची ग्रांट	3	Loan लोन	4	Donation देणगी
5	Any Other (specify) इतर						

Section II

General information about the in-charge प्रमुख डॉक्टरसंबंधी माहिती :

(If the doctor in-charge is not available to give the information, record all the details about the doctor in-charge and then also record all the following details about the respondent)

(प्रमुख डॉक्टरांच्या अनुपस्थितीत त्यांची व माहिती देणाऱ्या डॉक्टरांची दोघांची माहिती घ्यावी)

11. Qualifications of the in-charge of the Nursing Home / Hospital Exact Degree of Qualification (like MBBS/MD/DHMS/BAMS etc): हॉस्पिटलमधील प्रमुख डॉक्टरांचे शिक्षण :

_____

12. Specialization if Any (diploma, post-graduate degree with subject) विशेष अभ्यास (असल्यास)

_____

13. University /Board; विद्यापीठ/बोर्ड : _____

Qualification belongs to which System of Medicine: कोणत्या वैद्यकीय शाखेतील पदवी

1	Allopathy ॲलोपथी	2	Ayurvedic आयुर्वेद	3	Homeopathy होमियोपथी	4	Unani युनानी
5	Other इतर						

14. Does the hospital in-charge stay in the same premise? हॉस्पिटल प्रमुख हॉस्पिटलच्याच इमारतीत राहतात का ?

1.	Yes हो	2.	No नाही	3.	Other इतर

14A. If not, distance of place in Kms: जर नाही, तर किती किलोमीटर अंतरावर राहतात _____

15. Total number of years in private practice : खाजगी प्रॅक्टीसची एकूण वर्ष : _____

16. Do you own anyother hospital/clinic? दुसरीकडे कुठे दवाखाना/हॉस्पिटल आहे का ?

1.	Yes हो	2.	No नाही	3.	Other इतर

16A. If Yes specify जर हो तर कुठे आहे ? _____
(write name and address नाव, पत्ता लिहा)

_____

_____

_____

17. Do you practice anywhere else? दुसरीकडे कुठे प्रॅक्टिस करता का ?

1	Yes हो	2	No नाही	3	Govt. Job सरकारी नोकरी
4	Other इतर				

17A. If Yes specify जर हो तर कुठे आहे ? _____

General Information about the respondent (if in-charge is not available):
प्रमुख डॉक्टरच्या अनुपस्थितीत इतर मुलाखतदाराची माहिती :

18. Full name of the respondent: मुलाखत देणाऱ्याचे पूर्ण नाव : _____

19. Age of the respondent: मुलाखत देणाऱ्याचे वय : _____

20. Sex: लिंग : _____

1	Male पुरुष	2	Female स्त्री

21. Designation of the respondent: मुलाखत देणाऱ्याचा हुद्दा : _____

Section III : Information about the facility सुविधेसंबंधी माहिती :

22. What types of services are provided in your Nursing Home?
दवाखान्यामध्ये कोणत्या प्रकारच्या सोयी पुरविल्या जातात ?

		General OPD जनरल बाह्यरुग्णसेवा	Separate OPD वेगळा बाह्यरुग्ण विभाग	IPD आंतररुग्ण विभाग
1	General Medical जनरल वैद्यकीय			
2	Maternity Services/ Gynaecological मातृत्व/स्त्री रोग			
3	General Surgical सर्जिकल			
4	Speciality (specify) विशिष्ट सेवा			
5	Other (specify) इतर			

If Specialty services are provided then ask information about the consultants attached to the hospital and fill in the following table (विशिष्ट सेवा देणारे कन्सल्टंट भेट देत असल्यास त्यांची नावे, शिक्षण व स्पेशालिटी)

22 A.

	Name of the doctor डॉक्टरचे नाव	Qualification शिक्षण	Specialization स्पेशालिटी
1			
2			
3			
4			

23. What is the size of your Nursing Home in Sq.ft दवाखान्याचा आकार किती आहे ?

24. What is the bed strength _____ beds खाटांची संख्या काय आहे ?

24.A How many beds were occupied on a daily basis in the last month? गेल्या महिन्यात सरासरी किती खाटा भरलेल्या होत्या ? (दिवसात) _____ खाटा _____ टक्के _____

24. B How many beds are occupied daily on an average in rainy season पावसाळ्यात दर दिवशी सरासरी किती खाटा भरलेल्या असतात ? _____

24.C How many patients were in admission last night काल रात्री किती पेशंट ॲडमिट होते ?

25.A Information about the facilities available (infrastructure) उपलब्ध सुविधांची माहिती :

	Facilities **सुविधा**		**Yes/ No** **हो/नाही**	**Number** **संख्या** **राखीव**	**According to specific care** **विशिष्ट सुविधेसाठी**
1	I.P.D. wards आंतररुग्ण विभाग कक्ष	i) Men's General पुरुषांचा जनरल वार्ड			
		ii) Women's General महिलांचा जनरल वार्ड			
		iii) Common General दोघांचा एकच जनरल वॉर्ड			
2	Special rooms खास खोली				
3	Semi-special rooms निम खास खोली				
4	Store Room भंडार गृह				
5	Medical Records Room वैद्यकीय नोंदणी गृह				
6	Nursing station नर्ससाठी कामाची जागा				
7	Treatment room/Dressing Room उपचारगृह/ड्रेसिंग रुम				Not Applicable
8	Casualty/Emergency Room अपघातात जखमी/तातडीची सुविधा खोली				Not Applicable
9	Operation Theatre शस्त्रक्रिया गृह				
10	Labor room प्रसुती गृह				
11	ICU अतिदक्षता विभाग				
12	Other इतर				

25B. Information about the facilities available (infrastructure) इतर सुविधांविषयी माहिती

	Facilities सुविधा	**Yes/ No** सुविधा आहे/ नाही	**Separate Room Available: Yes/No** वेगळी खोली आहे/नाही	**Size** आकारमान	**If not, how far is the nearest facility** जर ही सुविधा नसेल तर जवळची सुविधा किती लांब आहे
1	Laboratory प्रयोगशाळा				
2	X-ray facility एक्स-रे खोली				
3	Ultra sonography अल्ट्रा सोनोग्राफी				
4	Ambulance/Vehicle to transport patient रुग्णवाहिका/पेशंटला घेऊन जाण्यासाठी गाडी				
5	Other इतर				

25 C. Supporting services- आधारभूत सुविधा

	Facilities सुविधा	**Facility available: Yes/ No** सुविधा आहे/नाही	**Separate Room Available: Yes/No** वेगळी खोली आहे/नाही	**Charge extra Yes/ No** त्यासाठी वेगळी आकारणी आहे / नाही
1	Laundry facility कपडे धुण्याची जागा			
2	Diet/ Kitchen facility स्वयंपाक घर			

25 D. Information about the facilities available (essential services) अत्यावश्यक सुविधा

	Facilities अत्यावश्यक सुविधा	**Yes/ No** आहे/नाही	**Number** संख्या	**Functioning: Satisfactory (01)/ Partially functioning (02)/ Nonfunctional (03)** स्थिती समाधानकारक/काहीशी समाधानकारक/असमाधानकारक
1	Refrigerator फ्रिज			
2	Telephone line दूरध्वनी लाईन			
3	Continuous water Facility अखंड पाणी पुरवठा			NA
4	Toilets शौचालय			
5	Continuous electricity Supply अखंड वीज पुरवठा			NA
6	Generator जनरेटर			
7	Inverter इनवरटर			
8	Lifts लिफ्ट			
9	Ramps उतरता रस्ता			
10	Other इतर			

25 E. Information about the human resources कर्मचाऱ्यांविषयी माहिती :

	Designation हुद्दा		**Number** संख्या	**Qualification** शिक्षण	**Training (Formal training/ in-house training)** प्रशिक्षण (रितसर/काम करतानाच प्रशिक्षण)	**Duration** किती दिवसांचे प्रशिक्षण
1	Medical Officers / DMO (other than in-charge and consultants) डॉक्टर/ड्युटी मेडिकल ऑफिसर					
2	Nurses नर्स	i) Qualified Nurse शिक्षित नर्स				
		ii) Trained Nurse प्रशिक्षित नर्स				
		iii) ICU qualified nurses अतिदक्षता विभागातील शिक्षित नर्स				
3	Untrained nurses अर्धशिक्षित नर्स					
4	Mid wives सुईण/दाई					
5	Aayabai आयाबाई					
6	Ward boy वॉर्डबॉय					
7	Sweeper झाडुवाला					
8	Pharmacist औषध विक्रेता					
9	Technical staff units तंत्रज्ञ	Pathology Lab Staff प्रयोगशाळेतील कर्मचारी				
10	X-ray staff एक्स-रे कर्मचारी					
11	Total Staff एकूण कर्मचारी					

25 F. Other staff इतर कर्मचारी

	Staff स्टाफ	Regular employee नियमित कर्मचारी	Periodic visit नियमित थेट	On call ऑन कॉल
1	Engineering Staff (Plumber, Electrician अभियांत्रिकी कर्मचारी			
2	Driver वाहन चालक			
3	Cook आचारी			
4	Receptionist (Administrator etc. specify)			
5	Other इतर			

<u>Information about the Admission procedures</u> हॉस्पिटलमध्ये दाखल करुन घेण्याची माहिती

26. What are the procedures followed at the time of admission in the hospital?
(Compulsory probe for each of the following response and note the details. Ask the respondent to show the admission form, and attach form) रुग्णाला दाखल करुन घेण्याच्या वेळेस कोणत्या कार्यपद्धतीतून जावे लागते ?

1	Admission form to be filled up ॲडमिशन फॉर्म भरणे	2	Each patient is given Card प्रत्येक पेशंटला कार्ड देणे
3	Other ***(specify).*** इतर		

27. Generally who assists/guides in admission procedure of patient in your Nursing Home / Hospital? *(Record the spontaneous response with out probing and note details. Categorize answer later according to list provided)* सर्वसामान्य हॉस्पिटलमध्ये प्रवेश घेण्याच्या वेळी पेशंटला कोण मदत/ मार्गदर्शन करतं ?

1	Receptionist रिसेप्शनिस्ट	2	Para medical staff इतर हॉस्पिटल कर्मचारी	3	Staff Nurse on duty नर्स
4	Chief Doctor डॉक्टर स्वत:	5	None कोणीच नाही	6	Person designated to help in admission process दाखल करुन घेण्यासाठी विशिष्ट व्यक्तीची नियुक्ती
7	Other ***(specify).*** इतर				

28. What are the options available to the patients regarding the stay- arrangement?
रुग्णांना हॉस्पिटलमध्ये रहाण्यासाठी काय पर्याय उपलब्ध आहेत ? *(Probe and record the response. Categorize answer according to list provided)*

1	General Room जनरल रुम	2	Special Room स्पेशल रुम	3	Semi-special Room निम-स्पेशल
4	Other ***(specify).*** इतर				

29. Do you display/provide details abut the various services available?
इस्पितळात उपलब्ध असणाऱ्या विविध सेवांविषयीची माहिती तुम्ही प्रदर्शित केली आहे का/पुरविता का ?
(Note and record in the observation schedule If details about some of the services are displayed, then mention the services)

1	Yes हो	2	No नाही	3	Some of the services काही सेवा
4	Other इतर (if out of print etc.)				

If Yes, then ask Q. 26A

29. A. How? कशाप्रकारे ***(Collect a copy of a brochure/booklet if available and attach it to the form)***

1	Booklet पुस्तिका	2	Brochure कार्ड	3	Other इतर

30. What kind of information is given to the patient at the time of admission?
रुग्णालयात आल्यानंतर रुग्णांना कोणती माहिती पुरविली जाते? ***(Record the spontaneous response with out probing and note details. Then compulsory probe for the following)***

_____

_____

_____

_____

30A. Deposit अनामत रक्कम जमा करण्याविषयी _____

30 B. Charges per day for room खोलीचा प्रतिदिवस दर _____

30.C. About visiting time of consultant खोलीचा प्रतिदिवस दर _____

30.D. About visiting time of patient रुग्णांना भेटण्याची वेळ

30.E. Supporting services सहाय्यक सेवा

30.F. Any concessions for poor/ needy गरिबांसाठी काही सूट

31. Whether prior information about estimated 'cost of treatment' is given to the patient?
रुग्णांना त्यांच्या उपचाराकरिता येणाऱ्या खर्चाबद्दल पूर्वकल्पना दिली जाते का?

1	Yes हो	2	No नाही	3	Sometimes कधीकधी

If No, or sometimes then ask reason *जर नाही किंवा कधीकधी, तर कारणे विचारा*

_____

_____

_____

_____

32. What are the payment options available to the patients? रुग्णांना पैसे भरण्यासाठी कोणते पर्याय उपलब्ध आहेत?

1	Compulsory Deposit सक्तीचे डिपॉझिट	2	Credit उधारी	3	Insurance/ Cashless/TPA विमा	4	Payment on discharge डिस्चार्ज झाल्यावर पैसे भरणे
5	Other ***(specify).*** इतर						

33. Is there any provision for grievance handling mechanism? तक्रार निवारण करण्याची व्यवस्था आहे का ?

1	Yes हो	2	No नाही	3	Other (specify) इतर

If 'Yes' then ask, Q. 33 A onwards

33. A. Where are the complaints registered? तक्रारी कुठे नोंदविल्या जातात ?

1	To the Doctor प्रत्यक्ष डॉक्टरशी भेटून	2	Complaints Register Box रजिस्टर ठेवले आहे	3	Person Designated विशिष्ट व्यक्तीची नेमणूक
4	Suggestion Box सुझाव पेटी	5	Patient Opinion Form		
6	Other ***(specify).*** इतर				

33.B. How does it work, after registration of complaint? तक्रार नोंदविल्यानंतर तिचं निवारण कशा प्रकारे केलं जातं ? ***(Record the spontaneous response and note details.)***

33.C. Whether contacts of the concerned officials are displayed? तक्रार असल्यास संबंधीत अधिकाऱ्यांचा संपर्क दर्शविलेला आहे का ? ***(Also note in the observation schedule)***

1	Yes हो	2	No नाही	3	Other (specify) इतर

33.D. Time required to resolve the grievance तक्रारीचे निवारण होण्यासाठी साधारण किती कालावधी लागतो ? ***(Record the spontaneous response and note details.)***

Section IV : Knowledge Update नवीन वैद्यकीय माहिती कशी मिळवता

34. How do you get information about new drugs/development? नविन औषधे आणि त्यातील घडामोडी याबाबत तुम्हाला माहिती कशी मिळते ? ***(Record the spontaneous response, compulsory probe for the source of information and note details. Then compulsory probe for the following)***

1	Medical representative एमआर	2	Journals मेडिकल जर्नल	3	Training program / Continuation of Medical Education (CME) प्रशिक्षण
4	Referring Books				
5	Other ***(specify).*** इतर				

35. Do you or your institution subscribe to any medical journals? तुम्ही किंवा तुमची संस्था कोणत्याही वैद्यकीय मासिकाचे सभासद आहात का ?

1	Yes हो	2	No नाही	3	Other इतर

If 'Yes', ask Q.35 A else go to Q.36

35.A. Which journals does your institution subscribe? तुमच्या संस्थेने कोणत्या मासिकाचे सभासदत्व घेतले आहे ? ***(Ask about the names of the journals)*** नावे लिहा

36. Have you undergone any Continuation of Medical education (CME) recently?
(within 1 year) गेल्या एक वर्षात तुम्ही कोणत्याही प्रशिक्षण कार्यक्रमात सहभागी झाला होता का ?

1	Yes हो	2	No नाही	3	Other इतर

If 'Yes', ask Q.36A else go to Q.37

36.A. specify the kind of training, you have undergone. ***(Record the spontaneous response and note details.)*** कोणत्या प्रकारचं प्रशिक्षण तुम्ही घेतलंत ते स्पष्ट करा

37. Do any Medical Representatives visit your facility?
मेडिकल रिप्रेझेंटेटीव्ह तुमच्या हॉस्पिटलमध्ये येतात का ?

1	Yes हो	2	No नाही	3	Other इतर

37.A. What kind of information is given by Medical Representatives?
मेडीकल रिप्रेझेंटेटीव्हकडून कोणत्या प्रकारची माहिती मिळते ?

1	Drugs नवीन औषधांची	2	Latest technology नवीन तंत्रज्ञानाची	3	New brands in equipments नवीन यंत्र
4	Other ***(specify).*** इतर				

Section V: Awareness about the Registration of Nursing Home
विभाग ५ : नर्सिंग होम्सच्या नोंदणीविषयीची माहिती

38. Are you aware of the Bombay Nursing Home Registration Act?
तुम्हाला (बी.एन.एच.आर.ए.) किंवा बॉम्बे नर्सिंग होम रेजिस्ट्रेशन कायद्याविषयी माहिती आहे का ?

1	Yes हो	2	No नाही	3	Partially काही प्रमाणात

If yes or partially, then ask Q.39 else go to Q. 40

39. Have you registered your Nursing Home under this act? तुम्ही तुमच्या रुग्णालयाची नर्सिंग होम कायद्याअंतर्गत नोंदणी केली आहे का ?

1	Yes हो	2	No नाही	3	It is in processes प्रक्रिया सुरु आहे
4	Other इतर				

40. Do you think registration of facilities is necessary? ***(Ask reasons for each of the response)***
तुमच्या मते रुग्णालयांच्या नोंदणीची आवश्यकता आहे का ? (कारणे विचारा व लिहा)

1	Yes हो	2	No नाही

40. A. Reason अ. कारण

41. Are you aware of any minimum requirements to be complied under the Bombay Nursing Homes Registration Act? बी.एन.एच.आर.अे. या कायद्याच्या तरतुदींची तुम्हाला माहिती आहे का ?

1	Yes हो	2	No नाही	3	Partially काही प्रमाणात

If yes then ask Q. 42

42. Do you agree with the minimum standards as required by the Bombay Nursing Homes Registration Act? *(Ask reasons for each of the response)* या कायद्यांतर्गत तरतुदी तुम्हाला मान्य आहेत का ?

1	Yes हो	2	No नाही	3	Partially काही प्रमाणात
4	Other (specify) इतर				

42. A. reasons कारणे

_____

_____

_____

43. What are the problems you foresee, if regulation is enforced? *(Record the spontaneous response with out probing and note details.)* जर हा किमान निकष बंधनात्मक केला तर कोणत्या अडचणींना सामोरे जावे लागेल असे तुम्हाला वाटते ?

_____

_____

_____

_____

44. Have you registered under any of the following acts? ***(Compulsory probe if registered under any other act)*** खालीलपैकी कोणकोणत्या कायद्यांतर्गत तुम्ही नोंदणी केली आहे ?

	Name of Act कायद्याचे ज्ञान	Yes/ No होय/नाही
1	PNDT Act (Pre-natal Diagnostic Techniques Act) गर्भलिंग चाचणी विरोधी	
2	MTP Act (Medical Termination of Pregnancy)	
3	Shops and Establishment act	
4	Bio-medical waste waste management	
5	Any Other***(Specify)***	

If Q.44 is yes, then ask Q.45 & 46 else go to Q.47

45. Did you face any problems at the time of registration under any of the acts?
या कायद्यातंर्गत नोंदणी करताना तुम्हाला काही अडचणी आल्या का ?

1	Yes हो	2	No नाही	3	Some थोड्या

If yes or some problems faced, then ask *(जर अडचणी आल्या असतील तर विचारा)*

45. A. what problems did you face? तुम्हाला कोणत्या अडचणींना सामोरे जावे लागले ?
(प्रत्येक कायद्याअंतर्गत आलेल्या अडचणींची नोंद करा)

46. Can you suggest any measures to reduce these problems? *(Record the spontaneous response with out probing and note details.)* ह्या अडचणी कमी करण्यासाठी तुम्ही काही उपाययोजना सुचवू शकाल का ?

47. Have you heard about hospital accreditation? रुग्णालयांच्या अकेडिटेशनविषयी तुम्हाला काही माहिती आहे का ? (अकेडिटेशन म्हणजे ठराविक निकषांच्या पातळीवर रुग्णालयांचे ग्रेडिंग करणे / नामांकन ठरवणे)

1	Yes हो	2	No नाही	3	Partially काही प्रमाणात

If Yes, then ask Q 47A. Onwards, else go to Q 48

47 A. Do you think it is useful? ते उपयुक्त आहे असे तुम्हाला वाटते का ?

1	Yes हो	2	No नाही	3	Other (specify) इतर

If Yes, then ask Q47 B. then ask Q.48 जर उपयुक्त असेल तर ***Q47 B*** विचारा

47. B. In what way do you think it is useful? *(Record the spontaneous response with out probing and note details.)* कोणत्या प्रकारे ते उपयुक्त आहे असे तुम्हाला वाटत ?

48. According to you, what are or could be the problems with accreditation? तुमच्या मते, रुग्णालय अधिकृततेमुळे काय किंवा कोणत्या संभाव्य समस्या निर्माण होऊ शकतात ? *(Record the spontaneous response with out probing and note details.)*

49. Would you accredit your hospital? ***(Ask reasons for each of them.)*** तुमचे रुग्णालय तुम्ही मानांकित /अकेडिट करुन घ्याल का ?

1	Yes हो	2	No नाही	3	Other इतर

49.A. If no, then why not, जर नाही तर का नाही ?

Thank You,

Investigator's Name :

Signature :

Identification No			

Interview of the DMO (Duty Medical Officer) / Staff Nurse

ड्युटी मेडिकल ऑफिसर/नर्सची मुलाखात

Situational Analysis of the Quality of Care in the Private Nursing Homes in Maharashtra

(A study conducted in 11 districts)

महाराष्ट्रातील खाजगी नर्सिंग होम्सची पाहणी (अकरा जिल्ह्यांचा अभ्यास)

This study is funded by International Development Research Centre, Canada. The institutions/ Practitioners included in this study have been selected in a systematic stratified sampling scheme and are in no way a reflection of an individual /establishment and / Providers achievements or short comings. The names and identity of respondents will not be disclosed under any circumstances.

District: _____ **Taluka:** _____
जिल्हा : तालुका :

Date of the interview: _____
मुलाखतीची दिनांक :

Name of Facility: _____
हॉस्पिटलचे नाव :

Address of the facility: _____

पत्ता _____

Time at beginning of the interview: मुलाखतीची सुरुवातीची वेळ :	**Time at end of the interview:** मुलाखतीची शेवटची वेळ

Name of the interviewer: मुलाखत देणाऱ्याचे नाव :	

Date (mmddyy) दिनांक :	**Schedule Checked By:** प्रश्नावली तपासणारा :

CEHAT, ***Research Centre of Anusandhan Trust,***
Survey No.2804 and 2805, Sai Ashray, Aram Society Road, Vakola, Santacruz (East), Mumbai 400 055

Letter of Introduction For Health Care Provider / Facilities Seeking Informed Consent

Date:

To,

_____

_____

_____

Sub: Letter of Introduction and Consent for participation in the interviews to understand the Quality of Care at the Health Facility

Greetings! CEHAT (Centre for Enquiry into Health and Allied Themes) is the research centre of Anusandhan Trust, a non-profit educational trust. The research centre (CEHAT in hindi means health) is working in health and related areas. CEHAT does research, action, advocacy and service delivery on its theme areas of work which include- Women and Health, Health Services and Financing, Health and Human Rights, Health Legislation, Ethics and Patient's Rights.

Quality of Care in Health Facilities is an important area of work for CEHAT. We all know that now a majority of both in-patient and outpatient care is being given by private facilities. We understand that facilities provided at any private health facility are dependent on many factors such as where it is situated, paying capacity of patients, availability of doctors and development of general infrastructure in the area. We also understand that many private practitioners work under adverse circumstances. We think that it is important to conduct research and study the quality of care in private health facilities. Especially small nursing homes may be facing more difficulties and little is known about the services they offer. Therefore we would like to include your facility in the study.

The study involves interviewing the owner of the nursing home or in their absence the person in-charge. The focus will be to know about services and specialities available, staff and bed strength, other general information and your views on registration and accreditation of facilities. One more person working in the hospital such as Duty Medical Officer or senior nurse would also be interviewed to know more about all facilities available and to show us around the nursing home. We would like to observe and measure a few things, like how much space is available for the nursing home and how it is utilized. We would also like to interview any patient who has been discharged. *(This information will be for owner or in-charge of nursing home)*

With respect to the above-mentioned study, we would like to interview you. The objective is to gain from your experiences in providing services for people in this area. They will involve asking some questions, discussions and recording of answers on a sheet of paper. Your identity as respondent will be protected and will not be revealed at any point of time during or after the research. The names will never be made available for purposes of publication or quoting. Even so, you can refuse the interview or withdraw from the interview at any time in between, if you are uncomfortable in continuing. You also have the right to make more queries regarding the purpose of the interview and how this information will be utilized.

We request you to consent to the interview, take part in the discussions and feel free to ask any questions regarding the same. We assure you that information given by you will not be revealed to any government authority or will not be used in any way to take action against the facility. The information will be used

only for research purposes and in the formation of a report of findings. Even within the report no mention of names of participants will be done. We request you to permit us to use this information, without revealing your name, in any document describing the current quality of care in private facilities. We will make available to you the findings of this research, when the research report is ready.

Amita Pitre, Varsha Zende and Suchitra Desai, Habib, Ravi, Amit, Sushma form the research team. You may contact us for queries any time at the following contact numbers and' or address.

Thank you very much for sparing your valuable time and talking to us.

Warm Regards,

Investigators sign

Investigators Name

Contact us :
Centre for Enquiry into Health and Allied Themes
Survey No. 2804 & 2805, Aaram Society Road
Vakola, Santacruz (East)
Mumbai - 400 055
Tel. : 91-22-26673571 / 26673154
Fax : 22-26673156
E-mail : cehat@vsnl.com
Website : www.cehat.org

I have read the above letter and consent to the interview.

_____
Name and signature of respondent

(Investigator should note if consent is verbal & sign here)

महाराष्ट्रातील खाजगी नर्सिंग होम्सची पाहणी (अकरा जिल्ह्यांचा अभ्यास)
डॉक्टर / आरोग्य कर्मचाऱ्यांच्या मुलाखतीसाठी परवानगीचे पत्र

दिनांक :

प्रति,

_____

_____

_____

विषय : आरोग्य सुविधेविषयीच्या अभ्यासाबद्दल माहिती देणे व त्यासाठीच्या मुलाखतीमध्ये सहभागी होण्यासाठी सम्मती देणेबाबत.

'सेहत' हे अनुसंधान ट्रस्ट ह्या शैक्षणिक ट्रस्टचे संशोधन केंद्र आहे. हे संशोधन केंद्र आरोग्य आणि आरोग्यविषयक काम करते. 'सेहत'च्या कामाचे क्षेत्र - **स्त्रिया आणि आरोग्य, आरोग्य सुविधा आणि अर्थव्यवस्था, आरोग्य आणि मानवी हक्क आरोग्य विषयक कायदे, नैतिक मुल्य आणि रुग्णाचे हक्क आहे.**

आरोग्य सेवेतील सुविधांचा दर्जा हा 'सेहत'च्या अभ्यासाचा एक महत्त्वाचा भाग आहे. आपल्या सर्वांना माहिती आहे की, आजकाल बहुतेक आरोग्यसेवा ही खाजगी सुविधांकडून दिली जाते. कुठल्याही खाजगी आरोग्य सेवेमध्ये मिळणाऱ्या सुविधा ह्या बऱ्याच गोष्टींवर अवलंबून असतात. जसे ती सेवा कुठे आहे, डॉक्टरांची उपलब्धता आणि त्या भागातील सर्वसामान्य रहाणीमान, रुग्णांची पैसे देण्याची क्षमता किती आहे. आम्हाला असे वाटते की, खाजगी सेवेमधील सुविधांचा अभ्यास करणं महत्त्वाचं आहे. बरेचसे खाजगी डॉक्टर प्रतिकुल परिस्थितीमध्ये काम करत असतात. खासकरुन छोटे हॉस्पिटल किंवा नर्सिंग होम यांना जास्त अडचणींना तोंड द्यावे लागतं आणि ते पुरवत असलेल्या सुविधांविषयी फार थोडी माहिती असते, म्हणूनच आम्हाला तुमचे हॉस्पिटल ह्या अभ्यासामध्ये सहभागी करायचे आहे.

या अभ्यासात दवाखान्याच्या मालकाची किंवा त्याच्या गैरहजेरीत प्रमुख व्यक्तीची मुलाखत घेतली जाईल. मुलाखत मुख्यत्वे तिथे दिल्या जाणाऱ्या सुविधा आणि सेवकवर्ग, खाटांची क्षमता, इतर सर्वसामान्य माहिती आणि नोंदणीविषयक माहितीवरचे तुमचे विचार यावर केंद्रित असेल.

दवाखान्यात काम करणारे ड्युटी मेडीकल ऑफीसर किंवा नर्स यांच्याकडून सुविधांबद्दल अधिक माहिती घेतली जाईल. आम्हाला काही गोष्टी प्रत्यक्ष पहाण्याची इच्छा आहे. आणि काही गोष्टीची मापे घ्यावे लागतील, जसे इस्पितळातील दोन खाटांमधील अंतर. आम्हाला दवाखान्यातून बाहेर पडणाऱ्या रुग्णांची सुद्धा मुलाखत घ्यायची आहे. या भागातील लोकांना सुविधा पुरवत असताना तुम्हाला आलेले अनुभव किंवा अडचणी माहित करुन घेणे हाही या मुलाखतीचा एक उद्देश आहे. यात थोडे प्रश्न विचारणे, चर्चा करणे आणि उत्तरे लिहून घेणे हे असेल. मुलाखतदार म्हणून तुमची ओळख सुरक्षित असेल आणि संशोधनाच्या कोणत्याही टप्प्यामध्ये किंवा नंतर उघड केली जाणार नाही. प्रकाशनासाठी म्हणून नाव उपलब्ध केली जाणार नाही. तरीही, तुम्हाला वाटत असल्यास मुलाखत देण्यासाठी तुम्ही नकार देऊ शकता किंवा

मुलाखत मध्येच थांबवू शकता. तुम्हाला मुलाखतीविषयी आणि तिचा वापर कसा केला जाईल याबद्दल शंका विचारण्याचा पूर्ण हक्क आहे.

आम्ही तुम्हाला मुलाखतीत भाग घेण्याविषयी संमती द्यायची विनंती करत आहोत. चर्चेमध्ये भाग घेऊन मोकळेपणाने प्रश्न विचारा. आम्ही खात्री देतो की, तुम्ही दिलेली माहिती कोणत्याही सरकारी अधिकाऱ्यासमोर उघड केली जाणार नाही किंवा तुमच्या सुविधेवर कारवाई करण्यासाठीही वापरली जाणार नाही. हि माहिती वापरण्यासाठी परवानगी देण्याची आम्ही विनंती करतो. अभअयास पूर्ण झाल्यावर त्याचे निष्कर्ष तुम्हाला नक्की कळवू. अभ्यासाचे निष्कर्ष फक्त राज्यपातळीवर व विस्तृत विभागासाठी असतील व जिल्हा किंवा तालुका पातळीवर निष्कर्ष काढले जाणार नाही.

अमिता, वर्षा, सुचित्रा, रवि, अमित, हबीब, सुषमा व इतर हे ह्या संशोधनात एकत्र काम करतात. तुम्ही कधीही खाली दिलेल्या पत्त्यावर, किंवा फोन नंबरवव आमच्याशी संपर्क साधूता. तुमचा अमूल्य वेळ दिलात आणि आमच्याशी बोललात त्याबद्दल धन्यवाद.

आपले नम्र,

इनव्हेस्टिगेटरची सही

इनव्हेस्टीगेटरचे नाव

पत्ता : सेंटर फॉर इनक्वायरी इनटू हेल्थ अँड अलाईड थीम्स् (सेहत)
सर्व्हे नं. २८०४-२८०५, आराम सोसायटी रोड,
वाकोला, सांताक्रूझ (पूर्व), मुंबई - ४०० ०५५
फोन : ९१-२२-२६६७३१५४ / २६६७३५७१
फॅक्स : २२-२६६७३१५६
ई-मेल : cehat@vsnl.com
वेब-साईट : www.cehat.org

वरील पत्र वाचले आहे आणि मुलाखतीसाठी परवानगी देत आहे.

मुलाखतदाराचे नाव आणि सही _____

(तोंडी परवानगी दिली असल्यास
तसे लिहा व आपली सही करा.)

General Information about the respondent :
मुलाखतदाराची माहिती :

1. Full name of the respondent: मुलाखत देणाऱ्याचे पूर्ण नाव : _____

2. Age of the respondent: मुलाखत देणाऱ्याचे वय : _____

3. Sex: लिंग : _____

1	Male पुरुष	2	Female स्त्री

4. Designation of the respondent: मुलाखत देणाऱ्याचा हुद्दा : _____

Section VI : Emergency Services तातडीच्या सेवा

5. Do you provide service in emergency situations? तातडीच्या परिस्थितीत तुम्ही सेवा पुरविता का ?

1	Yes हो	2	No नाही	3	Sometimes (specify) कधीकधी

If No, then ask Q.5 a. else go to Q.6, *जर हो असेल तर प्रश्न* ***5 a.*** विचारा, नाहीतर प्रश्न ६ला जा

5.A. ***Where do you refer patients in case of Medical Emergency?*** *तातडीच्या सेवेसाठी तुम्ही रुग्णांना कुठे पाठविता ?*

_____

6. Do you provide service in the following emergency situations? खालीलपैकी कोणत्या तातडीच्या परिस्थितीत तुम्ही सेवा पुरविता ?

1.	Accident दुर्घटना
2.	Medical emergency गंभीर आजार
3.	Surgical emergency शस्त्रक्रियेची तातडीने गरज
4.	Other ***(specify)*** इतर

7. What steps are taken by hospital to handle emergency situations efficiently?
तातडीच्या परिस्थिती हाताळण्यासाठी तुम्ही कोणत्या खास उपाययोजना रुग्णालयातर्फे घेता ?
(Record the spontaneous response and note details. Categorize answer according to list provided)

1.	Quick admission तात्काळ ॲडमिट करणे
2.	Immediate attention by medical staff डॉक्टर लगेच उपलब्ध करणे
3.	Round the clock availability of २४ तास डॉक्टर उपलब्ध असणे
4.	Efficient कर्मचाऱ्यांसोबत सुनियंत्रित हालचाली
5.	Other ***(specify)*** इतर

8. Has your staff been trained for emergency situations?
तुमच्या कर्मचारीवर्गाला या संदर्भात प्रशिक्षण दिले आहे का ?

1	Yes हो	2	No नाही	3	Some थोड्या प्रमाणात

8.A. If yes by whom? जर हो असेल तर कोणी दिले ?

8.B. What was the duration of the training? किती कालावधीचे दिले ?

8.C. Do you have any staff trained in CPR ie (Cardio-pulmonary resuscitation) /who can administer CPR? हृदयक्रिय बंद पडल्यानंतर तातडीचे उपचार देण्याचे प्रशिक्षण दिलेले स्टाफ तुमच्याकडे आहे का ?

1	Yes हो	2	No नाही	3	Other (specify) इतर

Section VII: Maternity Services प्रसूतीविषयक सेवा

9. Are Ante-Natal-Care services available in this facility?
तुमच्याकडे प्रसूतीपूर्व काळजीबाबतच्या सेवा उपलब्ध आहे का ?

1	Yes हो	2	No नाही	3	Other (specify) इतर

If yes, then ask, Q.10 onwards else go to section VIII

10. What are the different components that are provided under ANC? प्रसूतीपूर्व काळजीअंतर्गत कोणत्या सेवा तुम्ही पुरविता ? (तपासणी, औषधे, प्रसुतीपूर्व सेवेचे कार्ड इ. बद्दल विचारा)

1.	Iron and Folic acid लोहाच्या गोळ्या
2.	Calcium tablets कॅल्शियमच्या गोळ्या
3.	Blood group ब्लड ग्रुप
4.	Weight measurement वजन
5.	Blood Pressure checking ब्लड प्रेशर
6.	T.T. Injection धनुर्वाताचे इंजेक्शन
7.	ANC card is given प्रसुतीपूर्व सेवेचे कार्ड
8.	Other ***(specify)*** इतर

11. What are the routine tests done in pregnancy? गरोदरपणात कोणत्या नियमित तपासण्या केल्या जातात ?
(Probe)

1.	Hemoglobin हिमोग्लोबीन
2.	HIV एचआयव्ही
3.	Urine लघवी
4.	Other ***(specify)*** इतर

12. What information is given to pregnant women? (record spontaneous response)
गर्भवती महिलांना कोणती माहिती दिली जाते ?

1.	Information about nutrition पोषणाबद्दल माहिती
2.	Complications in pregnancy गर्भारपणातील गुंतागुंत
3.	Information about medicines औषधांची माहिती
4.	Precautions need to be taken घेण्याची काळजी
5.	Other ***(specify)*** इतर

If information regarding complications is given, then ask,

13. What information regarding complications / risks in pregnancy is explained to women?
गर्भावस्थेत काय गुंतागुंत/धोका असू शकतो याबाबत तुम्ही महिलेला समजाऊन सांगता का ?
(record spontaneous response)

1.	Fever ताप
2.	Swelling on feet पायावर सूज
3.	Fits आकडी
4.	Bleeding रक्तस्त्राव
5.	Pain in abdomen पोटात दुखणे
6.	Other ***(specify)*** इतर

14. Is there a facility for caesarean section?
सिजेरियन विभागाची सुविधा आहे का ?

1	Yes हो	2	No नाही	3	Other इतर

If yes, then ask Q.14.A. & Q.14. B. else go to Q.15

14.A. Who conducts it? कोण हाताळतात ? _____

1.	Doctor based in Hospital हॉस्पिटलचे डॉक्टर
2.	Consultant on call बाहेरचे डॉक्टर
3.	Other ***(specify)*** इतर

14.B ***If NO then how far is the nearest facility in kms distance***
जर नसेल तर सर्वात जवळची व्यवस्था किती लांब आहे _____

If consultant conducts the operation then ask,

14.C. How long does it take for the consultant to reach this facility?
डॉक्टरांना या सुविधेत पोहोचण्यासाठी किती वेळ लागतो ?

_____

15. What information is given to women on delivery?
प्रसूती नंतर महिलेला काय माहिती दिली जाते ?
(record spontaneous response)

1.	Information regarding diet खाण्यापिण्यासंबंधी
2.	Child care मुलाची काळजी कशी घ्यावी
3.	Breast feeding स्तनपानासंबंधी
4.	Contraception गर्भनिरोधनासंबंधी
5.	Signs of infection जंतुसंसर्गाच्या सूचना ओळखणे
6.	Other ***(specify)*** इतर

Section VIII Information regarding HIV testing

16. whom do you advice to do the HIV test?
तुम्ही एच.आय.व्ही. तपासणी करण्याचा सल्ला कुणाला देता ?

1.	Compulsory testing for all सर्वांना कंपलसरी
2.	Compulsory for operative patients सर्व शस्त्रक्रियेच्या रुग्णांना कंपलसरी
3.	Compulsory for all ANC patients सर्व गरोदर महिलांना
4.	Depends on clinical picture लक्षणे बघून
5.	Any other (specify) इतर

17. Do you take consent before the test?
तपासणी अगोदर तुम्ही रुग्णांची संमती घेता का ?

1	Yes हो	2	No नाही	3	Sometimes (specify) कधीकधी

18. Is any information/ counseling given before the HIV/ AIDS test?
एच.आय.व्ही./एडस् तपासणी अगोदर माहिती (देणे)/समुपदेशन केले जाते का ?

1	Yes हो	2	No नाही	3	Sometimes (specify) कधीकधी

19. Is any information/ counseling given after the HIV/ AIDS test?
एच.आय.व्ही./एडस् तपासणी नंतर माहिती (देणे)/समुपदेशन केले जाते का ?

1	Yes हो	2	No नाही	3	Sometimes (specify) कधीकधी

If Yes, or sometimes then ask Q.* 19.A. *else go to Q.20

19. A. By whom? कोण करते ? _____

20. Do you give report to the patient? रुग्णांना तपासणीचे रिपोर्ट देता का ?

1	Yes हो	2	No नाही	3	Sometimes (specify) कधीकधी

Section VIII <u>Privacy and Comfort of Patients</u>

21. How do you provide privacy and comfort during the examination of patients?
रुग्णाच्या तपासणीदरम्यान तुम्ही गोपनीयता कशी राखता आणि दिलासा कसा देता ?
(Record the spontaneous response with out probing and note details. Categorize answer later according to list provided)

1	Seperate room वेगळी खोली	2	Atleast a screen available पडदा	3	Audio Privacy बोलणे इतरांना ऐकू येणार नाही अशी खोली
4	Other (specify) इतर				

22. What special precautions are taken while examining women?
महिलांची तपासणी करताना तुम्ही काय विशेष दक्षता घेता ?
(Record the spontaneous response)

_____

23. Is there a woman doctor/nurse available during examination?
तपासणी करताना महिला डॉक्टर/नर्स उपलब्ध असतात का ?

1	Yes हो	2	No नाही	3	Sometimes (specify) कधीकधी

Section X : Infection Control Measures संसर्ग टाळण्यासाठी केलेल्या उपाययोजना

24. What is the frequency of disinfection procedures for Operation Theatres in your hospital?
तुमच्या हॉस्पिटलमध्ये ऑपरेशन थिएटर किती वेळा निर्जंतुक केले जाते.

1.	Daily रोज
2.	Weekly आठवड्यात
3.	After each Operation प्रत्येक ऑपरेशननंतर
4.	Any other इतर

25. What are the procedures followed to prevent infection in operation theaters?_ (Wait for spontaneous response and then probe. तुमच्या हॉस्पिटलमध्ये ऑपरेशन थिएटरमध्ये इन्फेक्शन होऊ नये म्हणून काय पद्धत आहे.

1.	Every week cleaning with carbolic acid/ phenol
2.	Swabs to be sent for culture
3.	Fumigation in case of culture turned out to be positive
4.	Every day and between the cases too mopping is done
5.	Restricted entry of the staff
6.	Cap, Mask, Gown
7.	Other ***(specify)*** इतर

26. What are the disinfection procedures followed in your hospital for equipment?
हॉस्पिटलमध्ये लागणारी उपकरणे निर्जंतक करण्यासाठी काय पद्धत आहे

1.	Chemical disinfectant (in case of heat sensitive equipments) रासायनिक पद्धत
2.	Autoclaving ऑटोक्लेव्ह
3.	20 minutes boiling of equipments २० मिनिट उकळणे
4.	Pressure cooker autoclave प्रेशर कुकर ऑटोक्लेव्ह
5.	Dry heat sterilization (for thermo stable items)
6.	Other ***(specify)*** इतर

27. When are the bed covers changed? खाटेवरील चादर केंव्हा बदलतात ?
(Record the spontaneous response with out probing and note details. Categorize answer later according to list provided)

1.	Every day रोज
2.	Alternate day एक-दिवसाआड
3.	When patient is discharged पेशंट घरी गेल्यावर
4.	Other ***(specify)*** इतर

Section XI Staff Protection कर्मचाऱ्यांची सुरक्षितता

28. Whether staff working in hospital is vaccinated for Hepatitis B infection? (probe for each)
शस्त्रक्रियागृहातील कर्मचाऱ्यांना काविळीचे (हेपटायटीस बी चे) लसीकरण झाले आहे का ?

1.	Yes, all staff हो, सर्वांना
2.	No नाही
3.	Only staff in OT फक्त ऑपरेशन थिएटरमधील स्टाफला
4.	Only doctors फक्त डॉक्टरांना
5.	Only doctors and Nurses फक्त डॉक्टर आणि नर्सेसना
6.	Any other इतर

29. What is procedure followed to disinfect syringes and needles?
सुया व व इंजेक्शन निर्जंतुक करायला कोणती पद्धत वापरता ?

1.	Use only disposable फक्त डिस्पोजल वापरतो
2.	Boil in sterilizer उकळतो
3.	Autoclave ऑटोक्लेव्ह
4.	Any other इतर

30. What items are used to protect the staff in operation theaters?
शस्त्रक्रियागृहातील कर्मचारी सुरक्षिततेसाठी कोणती साधने वापरतात ?
(Record the spontaneous response with out probing and note details. Categorize answer according to list provided)

1.	Protective goggles डोळ्यावर चष्मा
2.	Impermeable Aprons / gowns प्लास्टिक गाऊन
3.	Double gloving डबल हातमोजे
4.	Other ***(specify)*** इतर

31. What precautions are taken to handle needles/sharps?
सुया/धारदार (तीक्ष्ण) उपकरणं हाताळण्यासाठी कोणती काळजी घेतली जाते ?
(Record the spontaneous response with out probing and note details. Categorize answer according to list provided)

1.	No special precautions कोणतीही विशेष पद्धत नाही
2.	Using kidney trays to carry किडनी ट्रे वापरतो
3.	Using Chittle forceps चिमटा वापरतो
4.	Other ***(specify)*** इतर

32. How are sharps or needles disposed? सुया व तीक्ष्ण उपकरणांची विल्हेवाट कशी लावली जाते ?
(Record the spontaneous response with out probing and note details. Categorize answer according to list provided)

1.	Using general disposal container सर्वसामान्य पद्धतीने
2.	Separate sharp disposal container वेगळी जागा आहे
3.	Immense in chemical disinfectant before disposal
4.	Other ***(specify)*** इतर

33. Are you aware of the universal precautions about infection control?
संसर्ग नियंत्रणासाठी असणाऱ्या जागतिक उपाययोजनांविषयी तुम्हाला माहिती आहे का ?

1	Yes हो	2	No नाही	3	Partially awre काही प्रमाणात

<u>Section XII : General facilities</u> सर्वसाधारण सुविधा

34. Do you have authorized blood bank? तुमच्याकडे अधिकृत रक्तपेढी आहे का ?

1	Yes हो	2	No नाही

If no then ask,
34. A. How far is the nearest authorized blood bank? नजिकची रक्तपेढी किती अंतरावर आहे ?

---

35. Do you have blood storage centers? तुमच्याकडे रक्त साठा करण्याचे केंद्र आहे का ?

1	Yes हो	2	No नाही

If Yes then ask,

35.A. Do you have specially designed refrigerator for the same in your hospital for storage of blood? तुमच्या रुग्णालयात विशिष्ट पद्धतीचा (रक्तपेढीकरिता असणारा) फ्रिज आहे का ?

1	Yes हो	2	No नाही

36. Do you have a transportation facility of your hospital? तुमच्या रुग्णालयाची स्वत:ची वाहन व्यवस्था आहे का ? *(Probe about ambulance or any other facility available)*

1	Yes हो	2	No नाही

If No, then ask Q.36A else go to Q.37

36.A How are patients transferred? रुग्णांना इतर ठिकाणी कसे पाठविले जाते ?
(Record the spontaneous response with out probing and note details, then probe for each of the following)

36.B In case of an emergency? तातडीच्या परिस्थितीत

36.C For routine referral ? नेहमीच्या संदर्भसेवेदरम्यान ?

Information about the disposal of hospital waste

37. Is your hospital registered under Bio-Medical Waste (Management and Handling) Rules, 1998? तुमचे रुग्णालय हे १९९८च्या नियमानुसार, जैविक-वैद्यकीय कचरा (व्यवस्थापन आणि हाताळणी) अंतर्गत नोंदणीप्राप्त आहे का ?

1	Yes हो	2	No नाही	3	In process of registration

38. Do you segregate waste? तुम्ही कचरा वेगळा करता का ?

1	Yes हो	2	No नाही	3	Sometimes कधीकधी

38.A if yes, specify _____

39. What method do you adopt for waste disposal? कचऱ्याची विल्हेवाट लावण्याकरिता तुम्ही कोणती पद्धत अवलंबली आहे ?

1.	Chemical रासायनिक
2.	Autoclaving ऑटोक्लेव्ह
3.	Incineration इन्सिनीरेटर
4.	Deep burial खोल गाडणे
5.	*Burnt* नुसते जाळणे
6.	Other ***(specify)*** इतर

Section XII : Information about Medical Records

40. What medical records do you maintain at your nursing home? (probe)
तुमच्या नर्सिंग होममध्ये कोणत्या वैद्यकीय नोंदी ठेवल्या जातात ?

1.	O.P.D. paper बाह्य रुग्ण पेपर
2.	I.P.D. paper आंतर-रुग्ण पेपर
3.	Investigation reports तपासणी रिपोर्ट
4.	Discharge papers डिस्जार्च पेपर
5.	Bill of every patient पेशंटचे बील
6.	File of each patient प्रत्येक पेशंटची फाईल
7.	OT records ऑपरेशन थिएटरचे रेकॉर्ड
8.	Anasthesia records ॲनेस्थेसियाची नोंद
9.	Other ***(specify)*** इतर

41. Do you also keep records and reports of the following? तुम्ही खालील गोष्टींपैकी कशाच्या नोंदी ठेवता ?

Records रेकॉर्ड	Yes/No हो/नाही	Report to whom कोणाकडे रिपोर्ट करता	Time limit of record maintainance किती वर्षे नोंद ठेवता
1. Births जन्म			
2. Death मृत्यू			
3. Notifiable diseases नोंदणीकृत आजार			
4. Other communicable diseases इतर संसर्गजन्य आजार			
5. Medico-legal cases न्याय वैद्यकीय केसेस			
6. Other ***(specify)*** इतर			

42. Do you keep record of any of these calculations? हॉस्पिटलमधील खालील दराची मोजणी करता का ?

1.	Rates of death within 24 hrs २४ तासातील मृत्यू
2.	Maternal Mortality Rates माता मृत्यू दर
3.	Infant Mortality Rates अर्भक मृत्यू दर
4.	Patient Dissatisfaction rates पेशंटच्या असमाधानाचा दर
5.	Infection Rates within Hospital हॉस्पिटलमधील इन्फेक्शनचा दर
6.	Any other इतर

43. What is the system of maintaining the records? वैद्यकीय नोंदी ठेवण्याकरिता काय व्यवस्था आहे ?
(Record the spontaneous response and note details. Categorize answer later)

---

44. Where do you keep these medical records? तुम्ही ह्या वैद्यकीय नोंदी कुठे ठेवता ?
(Record the spontaneous response with out probing and note details.)

---

45. Which records do you give to your patients?
(Record the spontaneous response and note details. Categorize answer later)

1.	O.P.D. paper
2.	Investigation reports
3.	Discharge papers
4.	Bill of every patient
5.	File of each patient
6.	I.P.D. paper on request
7.	Given on request
8.	Other ***(specify)*** इतर

46. What details are specified in the discharge card?
(Record the spontaneous response and note details. Categorize answer later according to list provided)

1.	Diagnosis
2.	Investigations
3.	Findings
4.	Treatment given
5.	Follow up
6.	Dietary recommendations
7.	Advice
8.	Other ***(specify)*** इतर

Thank you,

Remarks: _____

Identification No			

Observation Schedule for Nursing Home

नर्सिंग होमकरिता निरिक्षण प्रश्नावली

Situational Analysis of the Quality of Care in the Private Nursing Homes in Maharashtra

(A study conducted in 11 districts)

महाराष्ट्रातील खाजगी नर्सिंग होम्सची पाहणी (अकरा जिल्ह्यांचा अभ्यास)

This study is funded by International Development Research Centre, Canada. The institutions/ Practitioners included in this study have been selected in a systematic stratified sampling scheme and are in no way a reflection of an individual /establishment and / Providers achievements or short comings. The names and identity of respondents will not be disclosed under any circumstances.

District: _____ **Taluka:** _____
जिल्हा : तालुका :

Date of the interview: _____
मुलाखतीची दिनांक :

Name of Facility: _____
हॉस्पिटलचे नाव :

Address of the facility: _____

पत्ता _____

Name of the observer:	

Date (mmddyy) दिनांक :	**Schedule Checked By:** प्रश्नावली तपासणारा :

CEHAT, ***Research Centre of Anusandhan Trust,***
Survey No.2804 and 2805, Sai Ashray, Aram Society Road, Vakola, Santacruz (East), Mumbai 400 055

OBSERVATION निरिक्षण			
Hospital Surroundings रुग्णालयाचा परिसर			
1	Location of Nursing Home (Note cleanliness of surrounding, garbage, open drainage, crowded locality, marketplace or specify) नर्सिंग होमचे ठिकाण (नमूद करा-परिसरातील स्वच्छता, कचरा, खुली गटारे, परिसरातील गर्दी, बाजाराची जागा किंवा अन्य लिहा)	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
2	Noise levels (Note on the basis of undesirable noise levels) आवाजाचे प्रमाण (अनावश्यक आवाजाच्या प्रमाणानुसार नमूद करा)	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
3	Display of hospital board (Clear and legible) रुग्णालयाचा दर्शनी नामफलक (स्पष्ट आणि सुवाच्य)	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
4	Accessibility of Nursing Home (Depending upon transport and road facilities) नर्सिंग होमची सुलभता (प्रवासाचे साधन आणि रस्त्याची सुविधा यावर आधारीत)	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
Remarks शेरा			

Building (Note whether independent building, flat in a building, residential area इमारत (स्वतंत्र इमारत, इमारतीतील फ्लॅट, रहिवासी क्षेत्र आहे का ते नमुद करा)			
5	Condition of building (Note condition of paint, cracks and general condition of building) इमारतीची सद्यस्थिती (रंग, भेगा आणि इमारतीची सर्वसाधारण अवस्था नमूद करा)	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
6	Number of floors किती मजले आहेत		
7	Lift if more than one floor एक मजल्यापेक्षा जास्त असल्यास लिफ्ट आहे का	Present आहे	
		Absent नाही	

8	Ramp for wheel chair if there are steps पायऱ्या असल्यास व्हीलचेअर्सकरिता उतरता रस्ता आहे का ?	Present आहे	
		Absent नाही	
Remark शेरा			

Reception And Waiting Area			
9	Space available for Reception and Waiting Area रिसेप्शन (स्वागत कक्ष) आणि प्रतिक्षेकरिता जागा उपलब्ध आहे का	Yes होय	
		No नाही	
10	Person / Nurse present to attend लक्ष देण्याकरिता माणूस/नर्स असतात का	Yes होय	
		No नाही	
11	Telephone दूरध्वनी संच	Yes होय	
		No नाही	
12	Drinking Water पिण्याचे पाणी	Yes होय	
		No नाही	
13	Seating / Arrangement बसण्याची व्यवस्था	Adequate पुरेशी	
		Inadequate अपुरी	
14	Environment पर्यावरण	Congested अपुरी जागा/गर्दी	
		Not Congested पुरेशी जागा	
15	Dustbin कचऱ्याचा डबा	Present आहे	
		Absent नाही	
16	Toilet attached संडास लागून आहे का	Present आहे	
		Absent नाही	
Remark शेरा			

Display दर्शनीय			
17	Registration number of the hospital रुग्णालयाचा नोंदणी क्रमांक	Yes होय	
		No नाही	
18	Broad fee structure for various services at eye level विविध सेवांकरिता दृष्टीसदृश फी आकारणीचा तक्ता सहज दिसेल असा लावला आहे का	Yes होय	
		Partially (Some are displayed, some are not) अधर्वट अवस्थेत (काही दर्शविले आहेत काही नाहीत)	
		None displayed दर्शविलेच नाहीत	

19	Display of services available सेवांची उपलब्धता दर्शविली आहे का	Yes होय	
		Partially काही प्रमाणात	
		None काहीच नाही	
20	Names of consultants at eye level तज्ञ डॉक्टरांची नावे सहज दिसतील अशी आहेतका	Yes होय	
		Partially काही प्रमाणात	
		None काहीच नाही	
21	The language/s of instruction in display. प्रदर्शनीय सूचनांची भाषा कोणती आहे	Local स्थानिक	
		English इंग्रजी	
		Other अन्य	
22	Signage appropriate (with directions and numbers of rooms, applicable for more than 10 bedded hospitals) अचूक दिशादर्शिका (विशेषत: दिशा आणि खोल्यांची संख्या, दहापेक्षा अधिक खाटा असणाऱ्या रुग्णालयांना लागू)	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
23	If USG Facility available check (if display shows 'sex determination is not carried out here!) जर सोनोग्राफीची व्यवस्था असेल तर "येथे गर्भलिंग चाचणी केली जात नाही" असा बोर्ड आहे का	Present आहे	
		Absent नाही	
Remark शेरा			

Condition inside the Nursing Home including wards (specify anything particular) नर्सिंग होमधील आणि वॉर्डमधील परिस्थिती (काही विशिष्ट गोष्टी स्पष्ट करा)			
24	Cleanliness स्वच्छता	Very Clean खूप स्वच्छ	
		Moderately clean मध्यम प्रमाणात स्वच्छता	
		Dirty गलिच्छ	
25	Well lit rooms खोल्या व्यवस्थित उजेड असलेल्या आहेत का	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
26	Cross ventilated rooms खोल्यांमध्ये खेळती हवा आहे का	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	

27	Condition of wall paint भिंतींच्या रंगाची स्थिती	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
28	Note condition of ceiling छपराची अवस्था नमूद करा	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
29	Note condition of floor इमारतीतील जमिनीची अवस्था नमूद करा	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
30	Height of ceiling (Note if less than 9 feet) छपराची उंची (९ फूटापेक्षा कमी असल्यास नमूद करा)	Adequate पुरेशी	
		Inadequate अपुरी	
31	Passages to take trolley and person alongside माणसांना आणि ट्रॉली नेण्याकरिता मार्गातील जागा कशी आहे	Adequate पुरेशी	
		Inadequate अपुरी	
Remark शेरा			

Consulting Room/ OPD तज्ञांची खोली /बाह्य रुग्ण विभाग			
32	Examination table तपासण्याचे टेबल	Present आहे	
		Absent नाही	
33	Condition of table टेबलाची अवस्था	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
34	Table (1) and Chairs (3) टेबल (१) खुर्च्या (३)	Adequate पुरेशी	
		Partially adequate काही प्रमाणात पुरेशी	
		Inadequate अपुरी	
35	Stool (revolving) स्टूल (फिरते)	Present आहे	
		Absent नाही	

36	Step stool (to climb examination table) पायरी सारखे स्टूल (तपासणी टेबलावर चढण्यासाठी)	Present आहे	
		Absent नाही	
37	Wash basin with long handled tap हात धुण्यासाठी लांब हँडल असलेले बेसीन आहे का	Present आहे	
		Absent नाही	
38	Medicine tray औषधांचा ट्रे	Present आहे	
		Absent नाही	
39	Dustbin कचऱ्याचा डबा	Present आहे	
		Absent नाही	
40	Privacy available during examination of patients. (Note presence of screens, partitions etc) तपासणीच्या दरम्यान रुग्णांना गोपनीयता असते का (मध्ये पार्टीशन, पडदा इत्यादींची नोंद करा)	Adequate पुरेशी	
		Partially adequate काही प्रमाणात पुरेशी	
		Inadequate अपुरी	
Remark शेरा			

Essential Facilities आवश्यक सुविधा			
41	Telephone दूरध्वनी संच	Present आहे	
		Absent नाही	
42	Generator जनरेटर	Present आहे	
		Absent नाही	
43	Inverter इन्व्हर्टर	Present आहे	
		Absent नाही	
44	Fire extinguisher अग्निशमन यंत्र	Present आहे	
		Absent नाही	
45	Oxygen cylinder ऑक्सिजनचा सिलेंडर	Present आहे	
		Absent नाही	
46	Trolley (to transport patients) ट्रॉली (रुग्णांना हलविण्यासाठी)	Present आहे	
		Absent नाही	
47	**Nursing Station** (Adequate space for Nurse to sit and work) नर्सिंग स्थानक (नर्सेसना बसण्यासाठी आणि कामासाठी पुरेशी जागा आहे का)	Present and adequate आहे आणि पुरेशी	
		Present but not adequate आहे पण पुरेशी नाही	
		Not present उपलब्ध नाही	
Remark शेरा			

General Wards वॉर्डस्			
48	Screens पडदे	Present आहेत	
		Absent नाहीत	
49	Toilet attached or very close संडास लागून किंवा जवळच	Present आहेत	
		Present but far away	
		आहेत पण लांब आहेत	
		Absent नाहीत	
50	Facility for each bed प्रत्येक खाटेकरिता सुविधा		
51	Space between two beds (measure) दोन खाटांमधील अंतर (मोजून)	_____ . ft. फुटांमध्ये	
52	Space between bed and wall on each side प्रत्येक बाजूच्या भिंतींमधील आणि खाटेमधील जागा	From side of bed to wall ____ ft. खाटेच्या बाजूने भिंतीकडे .....फुटांमध्ये	
		From head of bed to wall _____ ft. खाटेच्या टोकाकडून भिंतीपर्यंत .....फुटांमध्ये	
53	Bedsheets चादरी	Present आहेत	
		Absent नाहीत	
54	Pillows उश्या	Present आहेत	
		Absent नाहीत	
55	Bedsheets and pillow covers चादरी आणि उश्यांची खोली	Clean स्वच्छ	
		Dirty गलिच्छ	
56	Locker for each bed प्रत्येक खाटेकरिता कप्पा	Present आहेत	
		Absent नाहीत	
57	Stools for each bed प्रत्येक खाटेकरिता स्टूल	Present आहेत	
		Absent नाहीत	
58	Water Jug पाण्यासाठी जग	Present आहेत	
		Absent नाहीत	
59	Glasses फुलपात्र	Present आहेत	
		Absent नाहीत	
60	Bed pans बेडपॅन्स	Present आहेत	
		Absent नाहीत	
61	Cradles for maternity beds गरोदर बायकांच्या खाटांजवळ पाळणे आहेत का	Present आहेत	
		Absent नाहीत	

62	**Wards** (overall condition, cleanliness, congested, lighting, ventilation, write specific remarks if relevant observation) वॉर्डस् (एकंदरीत माहौल, स्वच्छता, गर्दी, उजेड, खेळती हवा, विशिष्ट निरीक्षणासाठी योग्य तो शेरा लिहा	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
Remark शेरा			

	Labour Room प्रसूतीगृह		
63	Labour or delivery table प्रसूतीचे टेबल	Present and with lithotomy position आहे आणि लिथोटोमी अवस्थेचं	
		Present but no lithotomy आहे पण लिथोटोमी अवस्था असलेलं नाही	
		Absent नाहीच	
64	Width of the door दरवाज्याची रुंदी (ट्रॉली आत येऊ शकेल)	Adequate पुरेशी	
		Inadequate अपुरी	
65	Space around labour table प्रसूती टेबलजवळील जागा	Adequate पुरेशी	
		Inadequate अपुरी	
66	Trolley for instruments साधनांसाठी ट्रॉली	Present आहे	
		Not present उपलब्ध नाही	
67	Wash basin with long handle tap धुण्यासाठी बेसीन ज्याला लांब हँडलचा नळ आहे असा	Present आहे	
		Not present उपलब्ध नाही	
68	Water running in taps नळांना सतत पाणी आहे का	Yes होय	
		No नाही	
69	Labour Room (Note general condition of walls, ceiling, leakage, cleanliness, lights and ventilation) प्रसूतीगृह (भिंतीची सर्वसाधारण परिस्थिती छप्पर गळते आहे का, स्वच्छता, उजेड आणि खेळती हवा)	Satisfactory समाधानकारक	
		Partially Satisfactory काही प्रमाणात समाधानकारक	
		Unsatisfactory असमाधानकारक	
Remarks if any शेरा अन्य काही असल्यास			

Sanitary Conditions आरोग्यविषयक परिस्थिती			
70	Total number of toilets available for admitted patients भरती केलेल्या रुग्णांसाठी एकूण संडास किती आहेत		
71	Total number of bathrooms available for admitted patients भरती केलेल्या रुग्णांसाठी एकूण स्नानगृह किती आहेत		
72	Separate toilets for men and women पुरुष व महिलांसाठी वेगवेगळे संडास आहे का	Yes होय	
		No नाही	
		One or more are reserved for women एक किंवा अधिक स्त्रीयांकरिता आरक्षित	
73	Separate toilet for staff कर्मचाऱ्यांसाठी वेगळे संडास आहे का	Present आहे	
		Absent नाही	
74	Separate bathroom for staff कर्मचाऱ्यांसाठी वेगळे स्नानगृह आहे का	Present आहे	
		Absent नाही	
75	Condition of toilets (cleanliness) संडासची अवस्था (स्वच्छता)	Clean स्वच्छ स्वच्छ	
		Partially clean काही प्रमाणात स्वच्छ	
		Unclean अस्वच्छ	
Remark शेरा			

Remarks: शेरा

Thank you for your cooperation आपल्या सहकार्याबद्दल धन्यवाद !