

Brief Report of the Pilot Survey in Jaipur, Rajasthan

(COHED Project)

1. Introduction

- 1.1 More than half of India's citizens don't have access to proper healthcare facilities because of simple lack of availability or unaffordable prices of healthcare facilities in the country. Even when such facilities are available (whether in the public or the private sector), quality is often suspect. Consumers of healthcare services often get entangled in a vicious cycle involving commercially motivated doctors, pharmacists, diagnostic clinics and other providers in the healthcare value chain.
- 1.2 Consumer Unity & Trust Society (CUTS International) with support from Oxfam India has initiated a project to identify and raise awareness about collusive and deceptive practices in healthcare services in the country and advocate for appropriate (policy and regulatory) interventions. Greater awareness about the linkage between such practices and their effect of the quality and cost of healthcare facilities would empower consumers to demand appropriate healthcare facilities from the providers. CUTS would document the nature and type of these practices and their implications for consumers in parts of Assam and Chhattisgarh. Evidence gathered from this research would be used to enhance awareness among consumers and other stakeholders not only within the two states, but also across other parts of the country.
- 1.3 The evidence would be gathered in a two-stage survey to be carried out in three locations (each) in the two states. The first stage of the survey was designed to gather information from consumers about their experience of healthcare services obtained from public and private sector. Before the survey was carried out in the two states, a pilot survey was carried out in Jaipur (Rajasthan) to test the methodology and document challenges that might be faced by consumers in Jaipur. The project team was aware of the fact that healthcare services is a 'state subject' and there are variations in terms of the nature and type of such services (especially in the public sector) provided across the states. But this exercise was still undertaken in order to test the robustness of the survey methodology and its effectiveness in eliciting the necessary information.

2. Objective

- 2.1 The main objective of this survey is to gather evidence about some of the existing collusive/deceptive practices encountered in healthcare delivery in India. Appropriate documentation of the nature and extent of such practices would be used by CUTS to raise awareness of various stakeholders and facilitate actions in each of the (project) states.

3. Methodology

- 3.1 A (questionnaire) survey was conducted to gather information from a sample of 100 households in Jaipur belonging to different income classes to elicit information about various aspects of healthcare delivery from them, viz. household expenditure on healthcare, behaviour of healthcare providers, availability of healthcare services, prices of such services, etc.

Relevant qualitative information were also gathered that corroborate (and/or supplement) the information collected by administering the questionnaire.

- 3.2 **Sample** – a questionnaire was designed and administered on 100 adults (18 years and above) to gather information about the experience of members of families while seeking healthcare services from public and private facilities in Jaipur city.

- 3.3 **Selection of respondents** – selection of respondents was done (to the extent possible), such that they represent the following three income classes:

- a. High income group
- b. Middle income group
- c. Low income group

Visual enquiry skills were used to determine if the respondent belonged to the high, middle or low income groups. This was later supported by the household income data collected and cross-checked by the surveyor while filling-up the questionnaire.

- 3.4 Certain salient features of the survey were as indicated below:

- Special attention were paid to ensure that distribution of the above three classes within the sample population was in the right proportion (to the extent possible) – so that a larger picture can emerge
- Data was collected from consumers by visiting public and private hospitals in the selected city. 5 to 6 major hospitals were targeted, and identified such that they are well dispersed (on a spatial scale) in the selected city
- Consumers/patients were interviewed outside the OPDs, general and special wards of the hospitals
- Name, address and phone numbers were taken for necessary follow-ups (only of willing candidates)
- The questionnaire refers primarily to healthcare received by the household that the respondent represents in the recent past, with an emphasis on primary healthcare

- 3.5 The information gathered from the survey was analysed to develop this report. Effort was made to document issues that either directly or indirectly point towards the existence of collusive/deceptive practices among providers in the healthcare sector.

4. Result and Discussions

The key findings of the survey are presented below:

- i. It was clear that households belonging to the low-income class in the sample spent a larger share (11%) of their monthly income of healthcare related expenses. This is double the average (5.5%) spent by the entire sample population covered by the survey.

Income Classes	Average monthly health expense (INR)	Percentage of total monthly income
Low	635	11
Middle	1289	5.7
High	1827	3.65

- ii. On an average, Rs 82 was paid for consultation in case of primary treatment received from private sources, while it was Rs 208 for secondary treatment. Two third of the sample population believed that the consultation fee they were paying was 'fair'.
- iii. Private sources seem to be a favoured mode of treatment for a majority of the surveyed households. An interesting feature was that affinity for private healthcare was fairly high even among low-income families, as compared with the other categories. Half of the low-income (surveyed) households preferred private sources of healthcare.

SI No	Income Classes	Sources of Healthcare Delivery						
		Public Hospital	Private Clinic	Private Hospital	Public Hospital + Private Hospital	Private Clinic + Public Hospital	Private Clinic + Private Hospital	Others
1	High	23	61	8	0	0	8	0
2	Middle	38	30	21	2	5	4	0
3	Low	20	44	9	0	12	0	15

- iv. Proximity to a healthcare facility seem to be a deciding factor for one among every three households surveyed for choosing a particular provider. About 32% cited 'nearness to facility' as a reason for preferring a particular treatment, while 40% chose the provider on the basis of familiarity and satisfaction about the provider.

SI No	Reason for Preference (for a particular provider)	Percentage of households (%)
1	Good/Familiar doctor	40
2	Nearness/Proximity	32
3	No consultation fee	10
4	Free Medicines	6
5	Convenient situation	12

- v. Propensity among low-income population of choosing private providers of healthcare could be one of the reasons for high spending on healthcare services for those surveyed in this exercise. This also brings out that a lot needs to be done to motivate greater use of public healthcare services among the economically challenged sections. There is a common belief that a simple correlation exists between cost of (private) healthcare and its quality, which might be motivating these households to access private treatment. The survey was not able to identify the ‘type’ of private healthcare that the low-income people were using. Private healthcare suffers from a high degree of variation (from hi-tech hospitals to the private practitioner in the neighbourhood) in as far quality is concerned and there is hardly any enforcement by relevant authorities to maintain a minimum standard. While it would be highly unrealistic to expect that the low-income population would have means to access the hi-tech private hospitals (that are often extremely expensive), there is a high possibility of them visiting the healthcare provider in the neighbourhood (claiming to be a doctor).
- vi. A very high percentage (87%) of families surveyed were asked to get diagnostic tests done. An interesting pattern was noted when such references were disaggregated according to the income classes. The high-income households were asked to get diagnostic tests done on 97% occasions, the middle income group on 87% cases and the low-income 84% times. On more than half of these occasions a particular diagnostic laboratory was suggested by doctors. Only a quarter of these diagnostic tests revealed any serious illness.
- vii. A telling fact was that only about 24% people undergoing treatment in public hospitals obtained their drugs from the public hospital.

5. Key Findings

Some of the key findings have been summarized below:

- i. Low-income households spend a greater share of their monthly household income on healthcare expenses, as compared to the middle and higher classes. One of the possible reasons could be the fact that there is a high tendency among the low-class to seek healthcare from private sources.
- ii. It was also revealed that the low income population visited both the doctors and the diagnostic clinics on more occasions as compared to the other classes. So, the degree of exposure to any possible anticompetitive practice would be more as compared to others.
- iii. There is a very high tendency of prescribing diagnostic tests for all class of patients visiting a doctor for consultation. The rate of such referrals is directly proportional to the income of the patient.
- iv. While a majority of the population prefer visiting a private clinics for common ailments, a number of people (among those surveyed) also visited public hospitals for consultation.

- v. Choice of medical facilities visited for primary treatment is determined mostly by the familiarity of the doctor and proximity of the facility.
- vi. In spite of having prescribed diagnostic tests to over 8 patients for every 10 patients, the doctor only referred less than 2 out of these 10 patients to specialists. It could be inferred from here that either most of the diagnostic test did not reveal any serious illness that would have required the attention of a specialist or the doctor providing primary treatment resorted to providing secondary treatment for himself
- vii. Out of the people who visited public hospital for treatment, only 24.2% obtained the drugs at the public hospital. This could be due to two possible reasons:
 - i. drugs are not readily available at these public hospitals
 - ii. possible arrangement with chemists outside public hospitals (this is corroborated by the fact that a large no of chemists shops are located outside public hospitals in Jaipur)

6. Conclusions

- 6.1 Evidence collected through the survey shows that there is a need for greater consumer/public awareness on healthcare to ensure that consumers get affordable and quality medical treatment across the income groups. A change in consumer attitude towards healthcare is also cardinal to ensure that available (public) healthcare services are utilized to their full potential.
- 6.2 The survey revealed that consumers bought medicines from private sources, in spite of undergoing treatment in public hospitals. Further, tests in such situations were also done from a private laboratory. These findings point towards the possibility of vertical arrangements between service providers (at different levels) in the healthcare value chain to fleece consumers. The existence of such practices would increase the cost of healthcare services and make it unaffordable for the average consumers. Various reports have shown consumers having to take loans to pay for healthcare expenses, which further impoverishes them. The existence of such above-mentioned (vertical) arrangements/agreements among healthcare providers would need to be checked.
- 6.3 Healthcare costs are high because the healthcare industry does not operate in a free market. A free market requires informed customers who determine the need for a good or a service, to make a decision to purchase that good or service. Such decision is taken after proper processing of available information, especially comparing competing products on the basis of quality. Such a freedom of choice is not available to the consumer of healthcare services.
- 6.4 These results provides CUTS some idea about the contour of the next round of surveys/analysis to be undertaken under this project.