



## AN ABSTRACT OF THE THESIS OF

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Abstract approved:

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The healthcare system of India can be categorized into three different sectors. The public sector can be characterized by lower cost and is financed through tax subsidies. The private sector can be characterized by diversity of techniques and niches. Costs associated with the private sector are generally larger than public healthcare. An additional sector that contributes to the health of India can be considered goodwill nonprofit firms. These firms are characteristically targeting an underserved segment of the population.

After studying in India with CFHI and doctors within the region of Dehradun, I observed characteristics of public, private and goodwill organizations. This thesis serves to determine whether the conventions of this healthcare system provide a mechanic to segregate populations. Does the Dehradun area healthcare system provide the care necessary to serve the population, or does it serve to perpetuate and exacerbate the socioeconomic differences among residents?

Recounting experiences and supporting such experience with literature and studies can identify many failures and merits of each sector. Utilizing this process, I determine that while a single sector may fail in a single regard, this weakness is countered by a strength by another sector. Thus, India's healthcare system works provide healthcare through specialization of sectors.

Key Words: India, Health Care, CFHI

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Mechanics of Northern India's Healthcare and Resulting Socioeconomic Effects

By

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# Mechanics of Northern India's Healthcare and Resulting Socioeconomic Effects

## Chapter 1: Introduction

The miracle of medicine permits human beings to extend and improve life. Thus, medicine is the backbone of social progress. Interestingly, cultures across the globe have evolved and maintained their unique take on healing. In part as a result of globalization and the increasing movement of people, ideas and culture across national boundaries, individual cultures have gradually evolved to relate and interact with other cultures. Differences that have developed between these interacting cultures serve to facilitate competing and dynamically changing views of health and belief systems in any particular culture. Many of the traditional health systems and worldviews have been overtaken by biomedicine native to Western cultures. Such is not the case in India. The culture of ancient Indian medicine continues to thrive throughout the country, especially in the foothills of northern India. However, biomedicine has also appealed to many of the citizens, creating a clear-cut divide between ancestral and modern healing preferences.

During the previous summer, I studied these many forms of healing through hands on experience and shadowing of doctors in India. During my ten-week internship through Child Family Health International (CHFI) and Nature Quest of India (NQI), I experienced the daily routine of doctors within four different cities of differing social and economic statuses. Rural and traditional medicines were the focus of this internship, which was designed to give participants like myself an inside look of the varying solutions to healthcare.

Dehradun, the capital city of Uttarakhand, is a city of over half a million residents. This was the first location of study. I spent four of my ten weeks assisting doctors, attending lectures of natural remedies, and shadowing doctors in Dehradun. In this portion of the internship I was exposed to cardiologists, obstetricians, general hospital practitioners, and Rekki specialists. Rishikesh focused on naturopathy during the one-week stay in their ashram. Mussoorie acted much like a residency for medical students. During this one-week portion of the internship, I lived within a Christian supported hospital, emulating the life of a resident physician. During this week I ate, drank, slept (or lack thereof), and assisted within the hospital.

The final location of the interview was that of Than Goan, a small village in the foothills of the mountains. The citizens of Dehradun, only a thirty-minute drive south, had never heard of it. Than Goan school and medical camp are completely supported by Child Family Health International and Nature Quest. I spent four weeks in this village, performing hygiene checks on school children, observing surgical procedures in low resource environments, and traveling with the sole physician on outreach programs. Than Goan's medical practices attempted to combine allopathic and Auyurvedic theories to maximize benefit to patients and maintain economically friendly costs.

Of the plethora of ancient techniques, I was exposed to only a few. Homeopathy and ayurveda are by far the most popular non-western philosophies in the Dehradun area. (Bhatia 2006) During my travels among the medical clinics of Dehradun, Rishikesh, Than Goan, and Mussoorie, I researched into the demographics that frequented specific medical facilities. Interestingly, each medical theory had a personality of its own presenting a stereotypical patient, if you will.

The differing systems of healthcare prompted a question. Does the Dehradun area health care system provide the care necessary to serve the population, or does it serve to perpetuate and exacerbate the socioeconomic differences among residents? I hypothesized that the gaps between quality care and affordable care were too large to provide sufficient coverage of poverty stricken individuals. Thus, excluding these people in the general advancement associated with health. To determine the answer to this query, I examined the differing theories of healthcare in depth, combined with an extensive examination of differences, failures and merits of the public and private healthcare institutions available.

In India, I consider there to be three sectors of healthcare; the public, private and extra-national nonprofit sectors. The government-run hospitals and clinics provide cheaper treatment, at the expense of nearly all other aspects associated with quality healthcare. Undoubtedly, a private sector which focused more on the needs of the consumer as an individual sprouted up to fill the vacant shoes of a more expensive but higher quality niche. Finally, an often-overlooked third sector of health care is the global and extra-national nonprofit organizations that privately fund clinics to assist those in greatest need. These clinics are the most variable in their service, resources, and costs. If characterized by generalities, these sources of healthcare are focused on basic survival treatment and the general advancement of the standard of living in sub par communities.

This thesis serves to recount the experiences and research completed during my internship in India, in conjunction with academic literature to examine the effectiveness of the current healthcare system in northern India. This paper has been completed in hopes of enlightening the public of the differences of healthcare in India, and prompt

more research into the field of underserved populations. Through anecdotal narrative of experiences, supplemented with recent literature on the subject, I plan to fully explore the concept of the medical field and the social implications that arise from such investigations.

Limitations of this study:

Prior to detailing the experiences and knowledge I have obtained during my research, it is important to explicitly describe the limitations that are associated with such a study. First and foremost, much of this thesis relies on my personal observations, which may or may not be corroborated by literature. Those comments that are not in conjunction with quotes or summaries from research and journals pertain only to my own personal experiences. These experiences are unique in fashion, as my situation, perspective and experiences are unable to be replicated. Noting such, these experiences simply serve to identify points that were highlighted by my own unavoidable personal/social bias. I do not contend that these experiences reflect the healthcare system as a whole, though they do accurately represent the events that assisted in shaping my thoughts on this topic

Location is a significant factor in this study as well. All of the experiences noted in this research were isolated to four distinct cities within the northern region of India. Rishikesh, Than Goan, Mussoorie, and Dehradun were the only sites extensively observed. Thus, any experiences that were derived from such may be contrary to findings or experiences located in another area of India.

Though much of the literature focuses on the location in which I studied, there is a lack of resources pertaining particularly to the region. As a result, literature that has focused on the whole of India, and the Himalayan range of Asia have been incorporated into this thesis in belief that the deviance from the actual values and theories are not significant enough to provide differing conclusions.

## Chapter 2: Cultural Background and Obstacles to Treatment

Prior to delving into the investigation, there are multiple cultural differences between the United States and India that pertain to the medical field, and are crucial to the comprehension of the following thesis paper.

Healthcare in any country adapts to the culture and complex needs of the constituents it serves. The population in India is currently second largest in the world, while population density in the cities is the highest of any nation with comparable size. (CIA World Factbook 2009) Within the major cities densities soar above one thousand people per square kilometer. Even considering the mountains that compose much of Uttarakhand, where this thesis paper focuses, the average population density remains between one hundred and three hundred people per square kilometer. (2009 Indian Census) For comparison, Oregon has an average population density of fifteen people per square kilometer. (US Census 2000) Noting this, there are obviously cultural differences that have developed from crowding.

Perhaps as a direct effect of high population density, the concept of patient privacy is unheard of in medical field of northern India. Issues and legislation dealing with disclosure of patient's histories and diseases are lax. (Kapadia 2005) A code of ethics provided by the privacy and right to information act describes the necessity of such laws and enforcement.

“ In the healthcare context, the importance of maintaining patients` confidentiality is clear. Patients must feel comfortable sharing private information about their bodily functions, physical and sexual activities, and medical history. This is information that they would not want widely known because it may be embarrassing or may have negative practical consequences.

If an individual has poor health and if the condition of his health is made public, he may have difficulty in finding a spouse, obtaining health or life insurance, or obtaining employment. Some health conditions are stigmatising and, if known, may cause an individual embarrassment or difficulty in interpersonal relations. Therefore, healthcare providers need to keep patients` health information confidential.

Respect for the confidentiality of personal health information requires that healthcare providers do not disclose this information to others without the individual`s permission. Sometimes even acknowledging that a particular person is, in fact, one`s patient may constitute a harmful breach of that person`s confidentiality. Medical professionals should not disclose any health information of the patient unless required by law or given permission by the patient.” (Mishra Et. Al 2005)

Yet, the observed practices involved assumed consent. While a patient is being explained of their condition, three more unrelated patients are commonly waiting for their turn with the physician in the room. Thus, it turns few heads if a doctor wishes to explain the situation to an outsider, or in my case, an intern.

Combined with this, practitioners are not required to completely disclose information. Western medicine tends to place an emphases on the knowledge and decision making of the patient, whether for fear of litigation, or simply because of their individualistic and autonomous culture. (Shubha 2007) Both public and private practitioners prescribed sugar pills to unenlightened patients in an effort to elicit the placebo response. Such practices would likely be cause for litigation if conducted in the States, though it is a common and acceptable practice in northern India.

Litigation is in its infancy when it comes to medical malpractice suites, allowing doctors to treat patients easily on the fly without requesting documents and procedures to protect their decisions. (Bhatt 2009) As a general rule, people of India view their doctors with respect and reverence. Malpractice suites are unknown in rural areas, and smaller cities. Because treatment is a privilege in India, few people take for granted the abilities of the doctor. Failures on the physicians` part only exemplify to reveal the degree of the

illness. Only recently have the metropolises of Delhi, and Mumbai starting to feel the affect of such litigation activities. (Patro et al. 2008)

Achieving understanding within the doctor-patient relationship is key to medical proficiency. (Fowler 2008) Achieving a cure at the expense of the patient's beliefs is not what true medical practice should be about. A physician must understand not only the issues that revolve in and around the physical body, but should also attain an understanding of the views and beliefs that are held within the mind.

India is home to an extensive collection of languages. In the Dehradun area, Hindi is most prevalent, followed by Punjabi. A large proportion, particularly in the upper class, speaks English although it is not an official language. It should go without saying that communication with a patient is essential to understanding their needs and providing applicable and effective treatment. The diversity of languages is clearly a barrier to many entering the medical field as an emerging physician. In many instances, the most successful doctors are the ones who are multilingual. Those who can fluently speak Hindi, English and Punjabi are in much higher demand than a physician who can only speak one language.

Interestingly, the words not spoken can speak louder about a person's views and culture than the words they choose. Individual's upbringing can affect not only the words they choose to say, but also the choices they make regarding medicine. In my experience, when asked a question in which an answer is not known, many Indians will opt to guess rather than say that they do not know. If you have a particular bond to them however, they are likely to take time out of their day to find the answer for you. The collectivist culture creates much stronger community bonds, making individual desires second to the

good of the group which helps to mold many of the decisions of the patients in a variety of health topics.

In addition to a large diversity of languages, Dehradun and its surrounding cities are home to a large diversity of religions. India is known for the Hindu religion, and rightfully so. Approximately 80% of the population identifies themselves as Hindus. Interestingly, despite the low proportion of the Muslim religion in India, 13.4%, India is known as one of the top three largest Muslim countries in the world. (CIA World Fact Book 2009) Sikh, though marginal throughout the entirety of India, is of relatively high abundance in Dehradun. This is likely due to proximity to areas of religious importance such as the Golden Temple and the Hemkund Sahib. Each of these religions instills particular cultural proceedings and mandates. Such mandates must be known and observed by the physician to prevent misunderstandings.

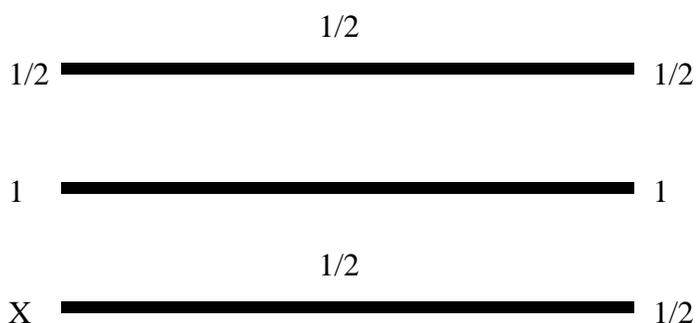
The physician should uphold barriers to effective diagnosis that are generated by religious teachings and mandates held by the patient. I witnessed the examination of a Muslim woman who was covered head-to-toe in cloth. Such is an obstacle that a physician should note, and utilize great caution to avoid contention and transgressions. Gender roles and manners must also be understood prior to examination to respect the wishes of the patient. But clothing and manners only scratch the surface of the implications on treating those with differing views. Imagine the complications of philosophical debates such as abortion, life support, and sterilization.

The philosophical debate of end of life scenarios has been a point of contention between doctors and patients. In the health field of India, “problems related to living wills, prolongation of life by extraordinary medical technologies and questions about the

quality of life are largely based on Western values. For instance, Western medical values tend to regard death as a failure and hence attempt to deter it as far as possible, but other traditions, such as Buddhist perspectives, are characterized by a tranquil and accepting attitude towards death, which is seen as natural and inevitable.” (Shubha 2007)

To compound the complexities that are a result of multiple cultures, the state of education and prosperity in the nation affect healthcare as well. Dwindling literacy rates in the lower social classes presents yet another challenge to doctors. This issue came as a surprise to me. When does a doctor need to convey something in writing to his patient? A doctor can explain the directions of a medication without any problem. However, upon leaving the hospital, the chances of forgetting the directions on the part of the patient are relatively high. In the US, we rely on printed directions on the box or the prescription bottle. Even the most common of medications we take can be confusing. Every time I get a headache I examine the bottle for instructions, despite having taken the same medication for years.

Interestingly, the solution was presented before I even realized the problem. In order to convey directions for medications, the private cardiologist, Dr. Gandhi, would draw a single line. On this line,



*Figure 1: Example of prescription instructions for illiterates.*

he would make a notation to represent taking a pill. The entire line represented the day as a progression of time from left to right. If there was a “1/2” marked at the beginning of

the spectrum, at the middle, and at the end, this indicated that the patient was to take half a pill in the morning, evening and at night. No matter the language spoken, or literacy rates, this intuitive design overcomes adversity and provides crucial instruction.

### Chapter 3: The Public Sector

The public system of healthcare in India is characterized by cost containment. Because of the immense population, and the propensity of disease in urban areas, this system is simply failing to provide the necessary resources in the face of overwhelming need. (Kumar 2008) During my stretch of research I observed an astonishing array of illnesses ranging from thresh to heart disease. In these public hospitals patients and their relatives are elbow to elbow in the hallways. Hundreds of people share a few cubic feet of floor space. This atmosphere is counterintuitive to the classical western school of thought that I have been accustomed to. My daily observations commonly contained queries of disease transmission, patient confidentiality, and general concern for stress induced or perturbed issues.

The public system of healthcare is guided by decentralized state and local governments. The Indian Constitution states that “the raising of the level of nutrition and the standard of living of its people and the improvement of public health” are maintained by the individual states. Uttar Pradesh, the area of study in this thesis, in 2002 was determined to be a “lower performing state” when examined by the National Health Policy of 2002 based on multiple statistics and indices of healthcare. (NHP-2002) India has issued several public policies called Five Year Plans, which focused on improving the health of the nation. The sixth five-year plan, enacted in 1980-84, focused on training of health workers, and most pertinent to this research, efforts to improve regional imbalances in the appropriation of health resources. (Bhavan et al 2008) The distribution of health care centers varied based on local socioeconomic factors. Uttar Pradesh is

India's largest state in terms of population, but contained only 735 hospitals in 1991. At the same time, Kerala, which had a population nearly five times smaller than Uttar Pradesh, had 2,053 hospitals. (Health.mapsofindia.org) Clearly, the appropriation of resources in healthcare has not been uniform, nor was it based on need.

Does this system improve the general health of the community or serve to propagate the issues? Surely the practices of emergency care, even in the poorest of categories, provide benefits to the health of the community. Yet, many conclude that the public system has been performing sub par. In a 2002, a committee examined the state of the health of the nation, releasing a report called National Health Policy of 2002. This report detailed many of the failures of health care systems, and worked to suggest the changes necessary to fix these issues. Sterility, while not a concern with surgical instruments, is a major issue within the facilities that was specifically mentioned within this report. Little is being done to prevent the proliferation of communicable diseases that are common in these areas. Seating areas are commonly dirty; soap and running water are luxuries not standard within such public institutions studied.

Interestingly, despite financial stresses, even the smallest sniffle or cold seems to deem a trip to the doctors. One of the doctors commented on the subject of patient traffic. "People only seem to be sick when it isn't raining". Within the lower class of Dehradun's population, visiting the doctor is not only for the ailing; it is also a sign of status. Those who can afford to make the visit are overwhelmingly willing to do so. There were several patients who seemed to be complaining about issues simply to shake the doctor's hand and chat. I suspect that the overload on the public system is exacerbated by this fact.

When examining the healthcare system it is easy to become engrossed solely in the affairs of the patients. However, the greatest insight into the failures of the system often comes from the physicians. Many issues on the physician side of healthcare were brought to my attention over the course of the internship. The spirit of benevolence commonly motivated the doctors that were shadowed and interviewed within this study. However, these doctors also expressed issues with the government's solution to their monetary reward system. In a study of Delhi physicians, 45.6% reported that their salary was "bad" when prompted to choose between bad, average, and good. (Kaur et al 2009)

Each doctor earns a base salary as designated by his or her qualifications, experience, specialty, location, and education. Within the public sector, "Policy levers to address quality disparities in health care must cover a variety of underlying causes. If geographic variations in practice quality reflect differences in provider competence, the solution lies in geographic incentives for doctors... If variations result from differing provider effort, stronger performance incentives are needed." (Jishnu Das et al. 2005)

Yet, when compared to the level of skill and expertise required of the physician, and the potential value of these skills in the private market, the salary does not add up. To bridge the gap between skill and compensation, the government has implemented a sliding scale subsidy package that rewards doctors based on the number of patients treated in a given amount of time. This mixed salary/bonus compensation schedule, in theory, should provide doctors with a base income, and benefit the hardest working physicians to the greatest extent. However, in practice, this system ignores a critical player in the healthcare relationship; the patient.

The concerns that develop from this incentive program are many. Perhaps the foremost issue of such a program; this compensation drives the question of effort within the relationship between the patient and the doctor. Jishnu Das and Jeffery Hammer conclude "...provider competence and effort both play a role in the quality of care. The data [of their study] indicate that what doctors actually do is very different from what they know they should do." (Jishnu Das et al, 2005) In order to expose such an issue, a hypothetical situation shall be posed. From the point of view of a government official or a hospital manager, effort and efficiency go hand in hand with patient volume. If effort is examined as a whole within the hospital, a certain doctor may be performing exceedingly high numerically. To achieve this numerical recognition, this doctor is likely to have a high patient turnover rate, providing good treatment numbers. Patient turnover is a significant factor when examining the issues posed to an overburdened health care system, but at what cost? With a compensation based on high traffic volume, more patients will be treated, but quality of the treatment comes into question. Once a patient becomes a job instead of a person, and time becomes the determining factor of diagnosis, the healthcare sector has lost its human element. Suddenly the patients have become the problem to be solved, rather than illnesses themselves.

Put simply, any physician looking to profit is constantly prodded to cut down on any time intensive procedures. The immense demand for the services, combined with the incentive program, channels the most auspicious of doctors into a formulaic cost benefit analyst. Studies have demonstrated that the relationship between physician and patient are critical to healthcare solutions. Because of these cost procedures, perhaps the most effective and important features of a physician visit have been stripped bare.

The obtaining of patient history can be one of the most important avenues a physician can pursue for leads on newly arising complications. Through understanding the whole picture, a physician notes connections between previous illnesses, observes past attempts to rectify the problem, thus increasing the probability of a correct diagnosis. An analogy of such a procedure within healthcare was provided to me within my experiences. “A doctor who ignores the patient, and their medical history, is putting a puzzle together without the picture on the front of the box. True, it can be done, but the efficiency and accuracy are slow to develop.” Much like transferring the pieces of a puzzle to a plastic bag, solutions of efficiency in one area (high patient volumes) can be a detriment to another facet of the service. Unfortunately, as a result of reducing time investment per patient, this process of patient history has been severely degraded.

In India, patients are in control of their own medical records. MRIs, ECG's, previous prescriptions and records of specialist visits are all files given directly to the patient. This outcome reduces filing services, eliminating the need for large databases, filing cabinets or charts. However, each patient has their own way of storing and maintaining such records. X-rays can be bleached by exposure to sunlight; prescriptions are commonly smeared and stained. The general disarray and lack of organization of these records is commonplace. True, some patients take great care in maintaining their documents, purchasing folders and paperclip these papers together. Yet, majority of the people who enter the hospital appear more worried about their condition than the condition of the papers they bring with them. Disorder of files can cause an increase in effort by the physician, something that cuts into the profitability and efficiency of the hospital.

To generalize the process that occurs within the public physicians office, the following statement was produced by a resident of the Doon Hospital; “The efficient public physician must be able to get a quick sense if a patient and their situation. A simple test or short chat provides most of the background the physician is willing to stake on this particular patient. Advice or a prescription follows and the patient leaves satisfied. All evidence of the previous patient is then wiped from the mind of the physician, and the process must start again.” I witnessed the turnover of patients within Doon Hospital first hand, and was amazed at the ability of the physicians to gather information. Dr. Joshi, a cardiologist, was able to determine heart rate, identify issues with cardiac rhythm, and carry on a conversation with the patient all at the same time. To comment on the adaptations produced by such a working environment, he was able to determine this information using a simple stethoscope in less than fifteen seconds. Speed of patient turnover was Joshi’s strong point, averaging less than three minutes per patient. Patient history was almost completely disregarded if the order of paperwork did not promote the expediency that was the focus of such a clinic, bringing only the most recent information to the knowledge of the physician. In many physicians this unsightly situation is the source of enormous frustration for the physician and the patient. Joshi speculated that many might be tempted to continue with the examination without the background information.

Secondly, driven by this propensity to expedite the medical process, symptomatic treatments are commonly resided upon. Such actions are taken by all sectors of healthcare, but are extremely pervasive within the public domain. The action of treating the symptoms of a disease appears, to the patient, to have immense benefits. However, in

a region in which tuberculosis and other serious diseases are prevalent, is this practice is doing more harm than good? In the case of poorly treated tuberculosis, a secondary infection and lung scarring occur. During my research, multiple x-rays of individuals who have suffered from the effect of tuberculosis scarring were identified. If the bacterium is able to escape the scar tissue, the likelihood that it spreads to other organs of the body increases many fold. By treating the symptoms rather than the source, the physician has put the patient at greater risk of severe debilitation and even death. To compound the problem, these individuals likely exposed additional people to the disease. (World Health Organization 2007)

Along the same lines as the symptomatic treatment that is common throughout the world. India has been implicated in the over prescription of antibacterial drugs. The symptomatic approach to healing can also encompass the act of prescribing antibacterial drugs for questionable ailments. Such a course of action has been identified as a primary causative agent that gave rise to extremely drug resistant tuberculosis in high proportions in India. In India and the US alike, patient culture and expectations mandate prescription in hand upon departure. Although the cultures of US and India differ in many ways, the basic sense of value within medicine appears to be common ground. In many patients' views spending the money to visit a doctor, a statement telling them to tough it out doesn't seem like expert advice or assistance at all. Combined with the expectation pressure from the patient, hospitals that are associated with a chemist are promoted to over prescribe the medicines as a source of additional revenue.

India spends an incredibly low percentage of its GDP on funding public healthcare when compared to other nations (such as china) (Mahal et al 2008).

Approximately one percent of the country's GDP is public spending on healthcare (Kumar 2008), one fifth of the total amount spent on healthcare (private spending fills the remainder) (Economist 2009). Thus, many of the public hospitals in northern India are failing to provide the necessary resources that the community and physicians need. This low budget approach is clear throughout hospitals by simply examining patient volume. Seating areas are consistently filled beyond capacity. Waiting rooms are packed as well. On particularly high traffic days in the ward, patients must be turned away due to lack of beds. Desks have been covered with a blanket and converted into a makeshift cot on more than one occasion.

Of the hospitals that I visited, all were relying on free samples of products provided by drug representatives. Such reliance illustrates the issue of funding within this community of public health services. When such a representative were to arrive, much of the normal business procedures are placed on hold. The top physicians attempt to convince this drug representative to provide additional samples to the hospital, and if successful, the entire staff's morale is boosted for the next few days. Surgical tubing, prescription drugs, IV bags, even medical towlette samples were hailed as the miracle of the evening. Once, a person giving out samples of Purell to doctors and their assistants was mobbed by the mass of patients as he tried to exit. Whether it was the idea of free samples that prompted the unruly action of the patients or a desperate plea for higher sanitation, one can only speculate.

The failures do not cease with the lack of resources provided by the government. Most of the prices of public health procedures are provided either at or below cost to the consumer. To continue to conduct business, the hospitals charge a premium price for the

nonessential, technologically based or time intensive procedures. Surgeries are also provided at a larger profit margin. The profits from these procedures are typically funneled to the areas within the hospital that are at or below cost. Such actions taken by the public hospitals in the interest of self-preservation will be acknowledged as a cross-subsidy.

The cross-subsidy has created some interesting results. Inadvertently, this system has created an artificial demand for such processes through the prescription and advisement by physicians. Returning to the previous motivation of increased patient turnover, the additional pressure to over prescribe moneymaking activities and pharmaceuticals can be overwhelming. In the interest of maintaining not only their own job, but also the continuation of the hospital, doctors are inclined to “not take any chances” and “get as much information as possible”.

This also can be shed in a benevolent light. The increased amount of MRI and CAT scans can potentially provide a wealth of knowledge to the physician that would not normally be obtained. Purely from the standpoint of preventative medicine, a full body scan can identify issues that were not even acknowledged at the time. Even so, many have identified such advice as a waste of resources. This utilization of high-cost-health is particularly draining on those within the lowest economic classes. In Dehradun, deciding between a food and health is an all too common situation, “most of these patients do not have the means to make out-of-pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition” (NHP-2002)

Publicly employed doctors are permitted by the state to open their own private practices. Many physicians utilize such opportunities to finance the failing public

hospitals that they run on their main shift. Doing so provides an increase in income, and a financial crutch to public hospitals. Could practices in this regard have negative repercussions? For one, doctors who work two shifts may be drained of their drive to provide excellent care. The effort required to shift between a low-paying, high stress public hospitals to the differing realm of for-profit hospitals is immense. Many doctors observe a difference in the care they give to those paying higher for their services and those who are paying less. This difference, though it may be an incentive driven problem, is likely a situational one. In the private realm, the doctor is in complete control of resources, including time available to see a patient. All of the cross-sector physicians questioned commented on the fact that their private hospital allowed for a greater diagnosis abilities and respective improvements of patient health. Private healthcare allows for doctors to change the atmosphere of their clinic to suit the desires and strong points to provide a higher quality of treatment.

As a final argument, a doctor who maintains a position in both the private and public sector has the ability and the motivation to refer the most lucrative or time intensive patients to their private practice. This process alleviates much of the pressure on the public system by exporting patients to private practice. As will be discussed later, the benefits of a private hospital environment can outweigh the negative increase in price.

#### Derived Benefits of Financial/Temporal Frugality

The benefits of keenness to accelerate the healthcare process should not be ignored. India has been a goldmine of cost reducing and time saving innovations.

Specifically, these innovated procedures included “beating heart” surgeries, which consist of bypass procedures while the patient remains fully conscious. (Economist 2009) This procedure does not require general anesthesia or blood thinners that are prevalent of the western complement. Patients who have undergone this type of surgery are typically healed in a significantly earlier timetable. According to The Economist, “This is just one of many innovations in health care that have been devised in India. Its entrepreneurs are channeling the country’s rich technological and medical talent towards frugal approaches that have much to teach the rich world’s bloated health-care systems.”

Dr. Jawali, a pioneer of these “awake” surgeries, comments on how the western system of healthcare is focused on maintaining technological superiority. His criticism of the western technological affinity focuses on the price to benefit ratio. To summarize his argument; the next generation of a machine or instrument is rarely significant improvement to the previous model, yet new units typically cost significantly more than the previous versions. The attitude towards having the best of the best is likely the reason that the United States is the leading country when comparing medical expenditures as a function of GDP. Innovative and cost effective procedures have resulted in a large influx of “medical tourism” in India. Certain comparable medical procedures in India cost ten percent of the cost of the United States. (Marcelo 2003)

Many facilities in India provide cheaper procedures when compared to the United States through lower labor costs and usage of outdated models. These hospitals can reduce costs by maintaining an older model of equipment instead of replacing it with the new standard only a few years later. The minute advances between models do not justify the increase in cost for Dr. Jawali. Patients are willing to sacrifice cutting edge for a

decrease in price flock to India for bank-breaking procedures. This influx of foreigners looking for health care is the definition of medical tourism, and the source of a large influx of cash to Indian markets.

Nosocomial diseases:

An avenue of research that appears to have incredible importance is the perpetuance and proliferation of infectious diseases within the public system. The combination of sick patients, failing sanitary conditions, close proximity between people, and prevalence of highly communicable tropical diseases provides an excellent medium for nosocomial transmissions. The rate of tuberculosis among hospital practitioners is more than double that of annual community based risk. While the transmission rate within the community was measured to be 1.5%, the annual risk of contracting tuberculosis as a healthcare worker is approximately 5%. Hence, the difference between these two numbers, 3.5%, can be directly attributed to the aspects developed in the healthcare system. (Aggarwal, 2009)

Such a study into the contraction risk of a healthcare worker has immense implications when factoring in the weakened state of the immune system in other patients within the hospital, and the prolonged exposure that these individuals may be unknowingly subjected to. “The problem is compounded by gaps in knowledge and awareness of both patients and providers. In general, there is a total lack of information and awareness about transmission in healthcare facilities in India. Most healthcare workers believe that such transmission is an unavoidable occupational hazard, and do not

even take the basic necessary precautions while handling infectious clinical material.”  
(Aggarwal, 2009)

To corroborate this point, the cardiologist I worked with explicitly made a point of shaking hands with all patients that come to see him. This practice was born out theory of building immunity. It was explained through the analogy of drinking water in India. “At first, everyone gets sick upon drinking water, but as the body fights the infection, it builds a tolerance to the microbes responsible for the nausea. After a few months of continually drinking the water, the person will have little or no negative effects.” His approach to his profession was quite the same. He explicitly and knowingly exposed himself to diseases through handshakes and complete disregard for sanitation practices in hopes that his body would build immunity to these diseases. Upon questioning of his possible role as a vector of nosocomial transmission through the handshake without sanitation between patients, the doctor realized that he had only been thinking of the consequences of his own infection.

#### Alienation of Target Patients:

Majority of public clinics are centrally located in the mid to large size cities in India. Being centrally located, the maximum number of potential patients can be reached by a single institution. Patients specifically targeted within the lower economic strata are increasingly moving to private practitioners. More than half of middle and lower income families frequent private hospitals. (Jishnu et al. 2005)

Those in need of medical care that live outside the city or in villages of the mountains are commonly forced to make the trip to the nearest city to receive the care

they need. In many cases the advanced diagnostic equipment such as MRI and X-rays are not located in the same town as the doctor they visit. Prescription of this imaging causes yet another issue with distance and travel. These rural residents are commonly in need of care that is simply unobtainable given the distances required to travel. Such medical journeys can stretch from hours to days, and places severe stress on the ailing individual seeking treatment. The public sector clearly fails to provide sufficient service to those who live beyond large city limits, and particularly with those who do not have access to motorized transport.

The final issue that will be brought to light in the fault of the public sector is the issue of choice. In India, the medical field is broken down into two distinct segments: western and traditional medical treatments. Within Dehradun and the surrounding cities, public funds have been directed almost exclusively toward the application of western medical treatments and hospitals. Hospitals and politicians cite scientific evidence of healing to support their single system approach. Biomedicine's well-documented advantages of symptomatic and emergency care make such institutions the prime candidate for state support. This focus can effectively alienate a large proportion of the population.

While not a set in stone, those who frequent the traditional medicine clinics of India are typically of a lower economic standing. Ironically, this is the economic strata that the public sector is designed to reach out to. Having observed such an issue, the NPH-2002 attempted to address such an issue, stating "India has a vast reservoir of practitioners in the Indian Systems of Medicine and Homoeopathy, who have undergone formal training in their own disciplines. The possibility of using such practitioners in the

implementation of State/Central Government public health programmes, in order to increase the reach of basic health care in the country, is addressed in the NHP-2002.” (NHP-2002) Continuing to pursue the “inherent advantages, such as diversity, modest cost, low level of technological input and the growing popularity of natural plant-based products...” NPH-2002 has initiated funding for evidence-based research as well as certification programs that take note of practices, effective dosages, and safety of traditional medical practices in an effort to support and propagate their usage.

#### Conclusion:

Public healthcare provides a necessary service, at a less than stellar quality. This system could be considered the backbone or foundation that serves to build the other sectors of healthcare. Issues that trouble the system are many, and the benefits are few. Counter intuitively; the facilities that are created by the government are typically centrally located within cities. The lower class that this sector of healthcare is targeting is commonly excluded from such centralized living accommodations. Thus, making centralized planning of hospitals fragmented and isolated from their target constituents. Crowding and the overwhelming of the public sector have also had an immense effect on the quality of each visit. To complicate matters, the financial schedule of public physicians appears to have amplified the trend of removing the human component from healthcare. The public system is providing positive value to the health of the community through basic and emergency services. However, the system is failing to lift the community and provide care to those who need it most.

Many world-renowned accomplishments and innovations have been the resultant of such resource driven healthcare behavior. Usage of technology that is not cream of the crop, but provides satisfactory results has had a major effect on the bottom line of public and private industries in India. The aversion to surgeries on a conscious person is absent from the minds of physicians in India, allowing for innovation of procedures to improve healing and resource management. (Jawali 2004) Despite their many failures as a publicly provided service, the public sector of healthcare is providing invaluable research and techniques that can benefit not only India, but also the world as a whole.

As a conclusion of a research paper into the value of private and public diagnosis by Jishnu Das and Jeffery Hammer, it is stated, “Poor households are better off visiting less-qualified private practitioners than more qualified public doctors.” (Jishnu Das et al. 2005) This statement highlights an interesting point that should be made about public firms. In general, private firms cost significantly more than their public counterparts. Yet, it has been determined that despite this price increase, a poor person would be better off going to a private clinic. It even stresses the fact that skills are not the defining factor in this decision, noting that the private physician could be less qualified than his public counterpart, and still provide a greater value to the consumer. This simple statement drives home the issues that have been discussed within this chapter. Clearly, the factors of infrastructure and lack of resources, time expenses, disengaging atmosphere, and crowding are weighing down the public sector to a point in which physicians cannot work to their potential.

## Chapter 4: Chemists

Chemists, the Indian equivalent to US pharmacies, provide their own set of obstacles. First and foremost, the consumer is not bound by a prescription. If a certain drug is desired, the chemist can provide it for the same price as someone who has the prescription. In essence, the prescription has become little more than professional advice. If one is experiencing similar symptoms of a disease previously examined by a doctor, they can simply bring the medicine, box, or previous prescription to obtain additional pills. No doctor involvement lowers the price for healing if these assumptions are correct, but the average chemist has little information of duration or specifics of the necessary treatment.

Speaking on the talents of the chemists, a permit is required to run the chemist counter. Obtaining such a license involves incredible investment into scholar institutions. Pharmacy schools throughout India offer training and certification programs that culminate in the awarding of a diploma, bachelors, or masters of pharmacy. Thus, intensive training and knowledge have been instilled in the majority of chemists. However, on multiple occasions, it was revealed that a chemist license could be bought and sold, just the same as some inspectors can be persuaded to look the other way. In the opinions of many doctors, the chemists in Dehradun are lucky to be literate, have little or no experience or knowledge of the product they are selling, and have no interest in pursuing such knowledge. To corroborate such claims, the one prescription I filled was incorrect. The man was identifying the pills by their color, and neglected to read their

name. Having been warned previously of possible incompetence I was able to correct such a mistake.

Some chemists sell their products by the pill, and have been observed removing almost all packaging. This action removes all instructions, most identification, and all of the warnings of the particular drug. The obvious, dangerous implications of an untrained supplier and ambiguous supply are many. The consumer could be issued an incorrect dosage, an incorrect product, or be unaware of proper consumption practices. In the health field, consumers assume that the physicians are looking out for their best health. Is this true when it comes to chemists?

Chemists are in the business of repurchasing unused medications. In theory, there should never be any excess medications. Assuming a medical utopia, compliance on the part of the patient would be complete. This would mean that prescriptions would be followed to the "T" and medication and treatment regimens would be completed to the fullest extent. It is well known issue that compliance in any country is far from one hundred percent. (Hayes) As patients begin to heal or overcome an infection, their drive to continue their medication regimen wanes. Ultimately, many patients will completely stop their medications prematurely. This blame does not simply fall on the shoulders of chemists or patients however. "Currently, non-governmental service providers are treating a large number of patients at the primary level... however, the treatment regimens followed are diverse and not scientifically optimal, leading to an increase in the incidence of drug resistance." (NHP-2002) In a country where every rupee counts, the prospect of selling unused medicine can be very intriguing. The chemist's buyback policy has been implicated as a factor increasing the rate of patient non-compliance.

Compounding all of these issues together, a window of opportunity for counterfeit drugs appears. The chemist is willing to buy unused medications, and has little knowledge of the products. Counterfeits can easily be slipped into the market through the selling of the medications to the chemists. Though, counterfeits can also be sold directly to the chemist for the fraction of the price of a brand name product. Tylenol has been a common target of counterfeiting, as I have been given explicit proof of this fact. Needless to say, counterfeit drugs can carry with it lower safety, unknown substances and distinct danger.

Overall, chemists have produced a multitude of issues. However, they also provide medications at a highly discounted rate when compared to the United States. Chemists can also provide treatment to the sick that do not have the money to take a visit to a physician. Finally, chemists provide only the amount of medication needed by the prescription, rather than a full box, lowering the price of prescriptions to levels that many families and individuals can afford, or providing the option of purchasing a daily amount as rupees are earned. Yet, with every positive benefit of these suppliers, there seems to have developed a negative.

## Chapter 5: Private Sector and Biomedicine

India's private healthcare sector can be characterized by the filling of a role not provided by the public healthcare system. Private hospitals come at a characteristically higher cost to patients, but generally provide a higher quality experience. These private practices commonly consist of hospitals or clinics that are specialized branches of medicine. Those branches of cardiology, pediatrics, gynecology, and podiatry were studied during research for this thesis. Private practices also delve much more into the traditional forms of medicine in India. Naturopathy, ayurveda, homeopathy, and the chakra sensing rekki clinics add to the specialization that is a key characteristic of private practice. If a patient wants a choice other than allopathic biomedicine treatment, private sector healthcare is often the only option.

Private practices are surprisingly abundant. One could even argue that village healers in the mountains are private practitioners. In this mindset, private practices are far superior to the centrally located public hospitals in regard to reaching the highest spread of people, and particularly their proximity to small isolated communities in which public facilities falter.

Private sector of India's healthcare's major draw back is the cost, particularly in the biomedicine field. The single most important detriment to this type of healthcare is so simple, that it yields little more than a few sentences of explanation. Each practice has complete control over their prices, regulated solely by market conditions. Procedures and overnight stays in hospitals can be billed at a premium, and consultations can have a varied rate attached. In leaving the determination of price up to the provider, a large

range of prices can develop through natural price lowering processes of competition and the price maintaining mentality of practice sustainability.

Interestingly, some private practitioners choose to charge different patients different amounts of rupees for similar procedures. During my observation, the key to such a discrepancy in prices between customers is the ability of private physicians to connect and converse with their patients. Typically, if a doctor is charging different prices for different people, it is on a sliding scale based on ability to pay, or even based on the extent of the friendship or kinship experienced and fostered by the community focused mindset of Indian culture. The private practice appears to blend better with the collectivist culture, which overwhelmingly resides in the community, by bonding the experiences of the patient and the physician through conversation as the examination progresses. However, it should be noted that many private practices are volume oriented, aligning their fallbacks much more closely to that of the public sector.

This sliding scale type of pricing can equalize the usage of private firms for all different economic demographics. In the most basic of sliding scale costs to the patient, the upper class is charged a premium. This premium can be justified by providing additional fringe benefits such as comfort that are not essential to the healing process. This premium is then utilized to subsidize the less-economically-fortunate's care. In a healthy private practice, a physician may be able to completely eliminate the costs for certain patients or even particular procedures. Having complete control over the hospital, the physician could even choose not to charge a more affluent customer for a visit if there was little work to be done (such as a checkup).

The cardiologist who owns and runs City Heart Medical in Dehradun, Dr. Gandhi, is a prime example of this practice. His hospital ward contains private rooms for those willing and able to part with the extra rupee. The highest quality of these rooms has an extra large cot, chairs for visitors, a flat screen television, and tile flooring. The average patient can pay to be placed in the medical ward overnight, which is constantly staffed by medical assistants. On the few occasions where need exceeds his ward's capacity, Dr. Gandhi has been known to offer his hallways and even his own desk as makeshift bedding. During his consultations, Dr. Gandhi repeatedly refused payment for his services, particularly for loyal patients and the less fortunate of his client base.

#### Dehradun: Homeopathy

Money and cost of practices can differ significantly between services provided. The procedure of a homeopathy doctor contrasts the biomedicine field in procedure and healing philosophy. During my stint of observing homeopathy with Dr. Nanda, the consultations were completely free to anyone, but the medicine was sold with a slight profit margin. I found this pricing scheme interesting because each new patient underwent a two-hour interview to determine their base personality before any medications could be prescribed. (An example of a distance interview via email has been provided in the appendix.) Once the patients instinctual personality has been determined, the return visits are typically one-hour consultations.

One would expect the medicines to be sold at exorbitant prices, but the average prescription in Dehradun was 200 rupees for a month supply. This is the equivalent of

slightly less than 4 US dollars at the time. This single room private practice had the potential of making only 1600 rupees (32 US dollars) a day if it was filled to capacity at all times. But we should not be converting this to US dollars if we are to determine the true value of such a practice. This is a staggering number when compared to the median income in India of 4500rs per month, placing one optimal days' work at nearly one-third the rupees earned per month by an average Indian. However, these numbers assume the practice is operating at full capacity, moving from patient to patient with little turn around time. In my experience the practice averaged only a little more than two customers per day, and ranged anywhere from a backlog of people to no patients for several days at a time. Thus, with these unstable and unpredictable income flows, price setting and profit margins are hard to establish. Needless to say, 200 rupees, while manageable for the average American, is a significant portion of the 4500rs the average Indian citizen earns within a month. Thus, this illustrates the exclusive nature of such a practice from the poor unless the physician makes concessions.

Because homeopathy is popular with the less fortunate, and not common within US healing practices, I feel that it is necessary to discuss the effectiveness of such treatment. If homeopathic treatment is substandard to biomedicine, this could be a vector of social separation. Thus, examining the legitimacy and theory of such, much as I have commented on the failures of the biomedical approach, is important to determining the effects of India's healthcare on the diverse population.

Homeopathy believes, among many other beliefs, in the "law of similia" that "like cures like" system of healing that counters the basic principals of biomedicine. To increase the confusion of the western scientific community, the medication that is given

by homeopathic doctors has been theoretically proven to not contain a single molecule of the cure within the dilutions provided to the patients. The medication in homeopathy revolves around dilutions, diluting a single solution to the point at which statistically, not a single molecule of the original cure is present. (Vallence 1998) This study has directed a severe blow to the homeopathic art of healing, but recent studies by supporters of homeopathy have implicated small ice crystals formed within the solution as the propagation of the healing method. As science has yet to rule out or affirm the homeopathic view, I refuse to pass judgment based solely on this criterion.

Whether science supports or detracts from the homeopathic ways, I have been witness to some amazing recoveries. Chronic problems that have been dismissed by western culture as incurable have been completely eliminated from the patients of Dr Nanda. This includes cancer, and even diabetes. Patients often swear by the homeopathic way, and doctor Nanda himself has not visited a biomedicine-focused doctor since his graduation from medical school, lending legitimacy to the field that he practices. This alternative to the expenses of the western fields can provide care that, in my experience, provides significant results, at a price practical to a much larger array of patients. Those who have chronic problems that require constant treatment through biomedicine for life are most benefited by homeopathy.

As stated, homeopathy has a focus on the chronic illnesses that plague humanity. To initiate every patient physician relationship, an all-encompassing interview must be completed. The questions posed in the interview range from desire of specific foods to emotional reactions to crowding and stress. All information gathered helps the physician ascertain the “personality” of the patient. This personality of the patient is then matched

up with an element, or remedy. Each remedy produced and tested by homeopathy carries certain characteristics, which have been empirically tested for such results and determined by the effect they would have in the body in a pure state. For example, arsenic is known to be an anxious cure, one of many different qualifiers listed under such a remedy. If a person is matched up with their personality-identifying cure, it is theorized to rid the body of numerous ailments. However, symptomatic and acute treatment can be treated through matching of symptoms. To continue the previous example, arsenic could be utilized to remedy a gastrointestinal irritation (as this is what would be caused via arsenic poisoning). Homeopathic remedies are not limited to poisonous or even harmful materials. Chocolate, milk, and even clay have been prescribed during my experience.

Without questioning or debating the validity of such theories, one can quickly identify the benefits derived from such an institution. The doctor creates a long lasting, deep connection to the patient. One cannot place a value on the relationship this fosters. This relationship will often assist in complacency of the patient, increase the trust of the patient, and promote the candid explanations of embarrassing symptoms or revealing issues. In doing so, the homeopathic healing process attains a purpose that is unique and essential to the meld of medical culture in India.

### Rishikesh: Naturopathy

Rishikesh has developed into a tourist-oriented city, and the standard of living has skyrocket for all manners of people. The influx of tourists provided hundreds of jobs and plenty of opportunities to make a quick rupee. Of all of the cities I visited, Rishikesh had

the lowest amount of visible poverty. In the private hospital in Rishikesh, which provides a plethora of naturopathic remedies, the price of treatment was comparable to that of treatment in Dehradun. If a patient purchases a room in their ashram, they are provided with three meals a day, and unlimited treatment for the duration of their stay. All of these amenities were priced at 200 rupees per night (competing hotels in the area charged 500-1000rs).

In terms of treatment, the options are extensive. Naturopathy focuses on remedies that have little or no medication, believing that the human body needs only to be coaxed into healing itself. The use of steam, water and human touch are critical to cease diseases. The central theme of this medical mentality is on the gastrointestinal tract. A clean healthy colon represents a clean bill of health. The colon is the area of the body that removes the wastes and harmful biotic invaders from the body. Therefore, the most commonly prescribed solutions to ailments include enemas to physically cleanse the body. Secondly, and possibly more significantly, diet is tightly controlled. Promoting the health of the body through the food we eat is believed to prevent diseases, and stimulate natural recoveries.

The theory behind the majority of treatments in this naturopathic hospital revolves around “like treating like”. This theme echoes the homeopathic ideals, though it focuses on the effects of the body rather than on medicine-based remedies. If a person suffers from poor blood circulation, the physician attempts to stimulate the blood vessels. The body will then naturally respond to the cold application by constricting of the veins and arteries. The mindset is to follow a long-term approach to healing. After weeks of consistent exposure to the cold, the body will begin to build more blood vessels and dilate

the existing blood vessels to counteract the cold affects and provide additional circulation to the affected areas. This desired affect will be a semi-permanent solution to the issue. I liken the process to the vaccination procedure in western medicine, teaching the body how to deal with the threats on its own.

This avenue of medicine, while theoretically and philosophically different from the biomedicine focus that Americans are accustomed to, focuses on remedies that are constant throughout many fields of healing. The concepts of diet, exercise and maintenance of the mind all are reciprocated within biomedicine. While I did not bear witness to the curing of ailments first hand, the prevalence of similar theories within the health systems to my knowledge lend legitimacy.

#### Dehradun: Biomedicine

Allopathic medicine, so described in Dehradun, is also quite common in the private sector, and specialization in this field is ordinary. In Dehradun, I spent four weeks in a cardiology hospital. Despite being a cardiologist, more than half of his patients sought advice on ailments that had no relation with the heart. On any given day, the ward was full of individuals with broken bones, thresh (a disease of the tongue), bacterial diarrhea, or even the flu. Upon inquiring why these patients would spend the extra money for the specialist, the physician explained that they are not only looking for healing, but comfort. All of these patients have been treated by this physician at a prior date, and found his service to be superior to any public hospital. The physician is more than adept at handling such cases, and gratefully accepts their business.

## The Devils Advocate: Imposing Views and Lacking Skills

The following section details the experiences that I witnessed and took part in over the course of my internship. While they may not be representative of the systems noted within this section, they do provide a counter-point to the previous accounts and benefits provided by the private healthcare realm. It should be noted that this section is through the point of view of a participant observer and recounted in a journalistic fashion through my own bias.

I had the privilege of living a week in the life of a resident in a Christian sponsored hospital located in Mussoorie. During which, I experienced the most devastating and confusing events of my life. This hospital requested a nominal fee for their services, and was equipped with exceptional technology. Grants were provided for Christian followers and those who frequented the hospital's church, but were unable to pay. All of the physicians who worked for the hospital were required to be Christian. They conducted mass within the church, sang hymns, and prayed two times a day. All seemed to proceed as expected of a religious based hospital.

Transgressions and impositions of the Christian religion by this particular hospital were issues that plagued my conscience. A baby was born to a couple in the hospital during the first night of my stay. This baby was born prematurely, and was unable to breathe on its own. The family was confidently against removing life support, but the administration did not see the merit in keeping the baby alive. Following what she thought was right, a resident volunteered to manually assist in the respiration of the infant. This compromise satisfied the family, and they returned to the ward to assist in the

recovery of the mother. As soon as the family was on the next floor, the resident was ordered to cease her activity, and eventually forcibly removed from the room. The baby died that night to the dismay of the family and the resident so invested in its life. The explanation given; “God didn’t want this baby to live.” Such strong words burned into my mind. This didn’t seem like the benevolent institution that hospitals are associated with.

Later, rounds with the doctors began. Immediately I could gather that they were not happy with their positions. Dissatisfaction with profession of physicians is not uncharacteristic. Of physicians surveyed in Delhi, 55.2% were dissatisfied with at least some aspect of their profession. (Kaur et al 2009) Of the seven doctors on the payroll at the time, only the pediatrician truly enjoyed his profession. Without thinking twice, each doctor would explain that they didn’t score well enough on their respective tests to enter the specialty school they wanted. Can a doctor who detests their position provide quality services?

In a single day I observed two surgical procedures fall to pieces. First, a two-year-old child with a suspected colon polyp was prepped for inspection and removal. The child was naked on the operating table, drugged to the point of muscle relaxation, but conscious. She was shivering. The doctor inspected the colon with his fingers, removing them in apparent disgust. The family had not followed the rules of fasting prior to surgery and fed the toddler the previous night. She was “full of stool”. Instead of coping with the situation, or leaving the operating room, the doctor proceeded to yell at everyone including the two-year-old patient. A nurse suggested that the procedure be postponed, and he accepted.

From the failed colon poly procedure, we transferred directly to the next surgery. This process was a hysterectomy on a middle-aged woman. The woman was to be the first patient these physicians had performed on without having the anesthesiologist on hand to oversee the general anesthetic. The general anesthetic was going to shut down autonomic breathing, so a mechanical respirator was to be put into place. In this procedure, the physician accidentally cracked the back teeth and jaw of the patient while placing the tubing in the airway. The problems continued to accumulate as the surgery progressed. Approximately halfway through the surgical procedure, the woman's leg twitched. This was the first of many signs that the anesthesia was wearing off, but no action was taken by any of the staff. After observing the woman begin to choke on the respirator, I removed myself from the room. Is this the type of treatment expected when placing complete trust in the professionalism of physicians? Clearly, there are instances even in the private sector that fail to flatter the system.

The quality of private health care has been shown in both a positive and a negative light. Yet, it appears that my negative experience is not uncommon within the private healthcare business. The regulations on private facilities are not near as stringent as the regulations on public facilities. A study was performed in rural Wardha, Maharashtra, to examine the competency of general private practitioners. They utilized the Primary Health Care Management Advancement Programme module for Assessing the Quality of Service checklist, to provide academically supportable findings. This study concluded a variety of detriments to the private health care system, though it provided no comparison to public systems. To outline just a few key issues, nearly 85% of cases the physician failed to conduct physical examinations of the patient. Of the ten practices they

observed, none of them had any antiseptic solution for hand washing, further supporting claims that have been demonstrated earlier in this thesis. (Ganguly 2008) Clearly, the private sector differs in quality just as much as it differs in the type of care given.

### Government Support

Upon recognizing that many private hospitals were providing a higher quality, and more sought after system of healthcare, the Indian government has since made several advances to assist in the production of private clinics in underserved areas. In the National Health Policy of 2002, it noted that “No incentive system attempted so far has induced private medical personnel to go to such [underserved] areas; and, even in the public health sector, the effort to deploy medical personnel in such underserved areas has usually been a losing battle”(NHP-2002) Tax incentives have been utilized to persuade entrepreneurial doctors to spread hospitals across underserved populations. The use of public funds to promote private companies is nothing new, but it demonstrates the government’s ability to recognize opportunities to capitalize on the natural progression of profit seeking firms. If tax incentives were not installed, these populations may continue to lack sufficient healthcare. The government can either choose to ignore the need, or spend taxpayer money to create a new public hospital. Having already determined that the public hospitals are sufficient at healing, but secondary to many private firms, the choice to promote such firms in place of creating new second-rate establishments is a step in the right direction.

## Conclusion:

Health does not simply imply wellness of the body, but of the mind and the spirit as well. The theories of medicine described previously were critical to the understanding of the benefits of the private sector. Belief systems, disregarding arguments of philosophy, have an incredible impact on patient health and recovery. By providing medical procedures that coincide with the beliefs of the patient, the private sector is providing an aspect of care left forgotten by public sector hospitals. The credibility of any medical institution should be based on the patients' outcomes and testimonials, not degraded by the battles of theory.

The private sector of healthcare has demonstrated adaptability crucial to success in the northern Indian region. While the public sector continues to meet bare minimum expectations, the private sector excels at catering to their target consumer. The incentive of profits, and the ability to reinvest profits into the hospital proves a powerful motivator. Even the Indian government has observed the benefits of promoting the private sector; dangling tax incentives in areas of underserved populations. "Accordingly, nearly four-fifths of all health services are supplied by private firms and charities—a higher share than in any other big country." Yet, even in the private sector, individuals can distract the generality of quality care. In conclusion, the private sector as a whole provides the majority of the healthcare in India, commonly providing niche specific, quality care.

## Chapter 6: Good-will Organizations and Conclusions

The third sector of healthcare in India is a subset of the private sector. I chose to separate the two sectors because of the incredible differences they produce. Global or extra-national organizations with the goals of providing care for underserved populations are the heart of this healthcare sector. For simplicity sake, this sector will be referred to as the good-will sector. Special interest groups, such as Child Family Health International, focus on particular segments of the population, and funnel resources to improve the conditions of this population.

This sector differs from the private sector because it is typically run from resources not collected in India. In addition, most of these organizations are running clinics in a non-profit market strategy. Because these organizations obtain their resources through means other than price of their services, the equipment they utilize can be vary widely. Donation and volunteer run operations such as the Red Cross and Mercy Corps are well established and maintain a high level steady income from other nations. These organizations can be expected to be more equipped than an organization that is less established and publicized.

CFHI and Nature Quest work together to create a good-will sector clinic in the rural village of Than Goan. A single-physician clinic runs in conjunction with a school for rural children are supported by these organizations. Rescued materials that would have been discarded by hospitals in the United States supply the clinic. The supplies are shipped, or carried by interns to the clinic. To supplement the inventory and healing ability of the clinic, auyurvedic remedies are grown and harvested on the property.

The clinic is free to anyone who wishes to utilize its services. All procedures, medications, checkups, and procedures come at zero cost to the patient. People from the surrounding villages and mountain homes will make the trek down to Than Goan for the treatment. There is a catch to all of this free treatment, patients can only take one week's worth of medicine with them for the way home. This single rule has many practical explanations. First, it ensures patient compliance. Secondly, the likelihood that the goodwill of this organization was used to turn a profit (by the selling of the free medicines) is severely diminished. Finally, this rule brings the patient back into the clinic for consistent check-ups and progress observations. If a certain remedy or medication is not improving the patient after a week, it can be changed with little effort on the part of the physician. The patient is shortchanged by this policy only in the regard to being forced to make the trip multiple times to be cured. Based on the popularity of the clinic, this is a small price to pay for health.

Understanding that there are those that simply cannot make the trip to the clinic, some additional outreach programs have been instituted. Once a week, the doctor and his assistants/interns take a hike to one of four villages. These hikes can take anywhere from thirty minutes on a road to hours of grueling mountain scaling trails. All supplies and medications are brought to the destination as well. Upon reaching the village, students will typically be removed from school to undergo a hygiene check. Subsequently, any person desiring treatment can approach the physician. By traveling to other villages, the distance patients have to travel for medication can be dropped dramatically. People who live in even more remote areas can trek to the camp location. Because the rotation of

villages completes after one month, the villagers know when and where the next camp will be.

Another interesting facet of the good-will sector is the fact that the most desperate communities, the most drastic of circumstances are typically the targeted areas. These organizations are looking for places and scenarios where their assistance will result in the greatest improvement of life. Thus, those areas that are simply impossible for private and public hospitals to reach are prime candidates for good-will clinics. Inversely, the higher the population or affluence of a location, the less likely a good-will clinic will be hosted there. In the case of a highly supported clinic such as the Red Cross, treatment available to the poorest or isolated may very well exceed the health treatment available to the more affluent. Thus this type of healthcare could be considered the antithesis of many private clinics.

The motivations and intentions are generally pure for those willing to work for such an organization. The physician in Than Goan has a family in the Dehradun area, but spends the entire week, nights included, manning the small clinic in Than Goan. On the weekends, his assistant acts a full physician, allowing the doctor to return to his wife and kids. The doctor continues to better the world, using a significant portion of his salary (which is paid for by Child Family Health International) to create a school in Dehradun.

As can be determined through the previous thesis, the evaluation of public, private and goodwill organizations has it's own sets of positives and negatives. Noting such, and the immense differences between sectors, I believe that simply stating that a single system is better than another denotes ignorance. All of these sectors tailor to a specific

need of a community. Thus, health of India is greatly benefited by the diversity of its healthcare.

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## APPENDIX

*Appendix I: An Example of Homeopathic Interview Process*

**Homeopathy Helpline**  
**Online Homeopathic Consultation**

Please answer the questions below in as much detail as possible and email the completed questionnaire to [drinanda@hotmail.com](mailto:drinanda@hotmail.com)

**1. Personal Details**

*I would be grateful if you could supply some personal details about yourself. I do not require all the information listed below, although your name and a valid email address is needed before we can proceed.*

First name(s):

Surname:

Address:

Zip or Post Code:

Country:

Email:

Telephone number:

Age & Date of birth:

Gender:

Marital Status & No. of Children (if any):

Height, Weight & Physical Description:

Are you working and if so what do you do?:

**2. Reason for Visit**

*I would like to begin with you telling me in your own words what has brought you here today. Please be as general or specific as you wish. Expand these spaces with as much information as you can.*

*I often ask my patients "And what have you been up to?" or "How can homeopathy help you?". So if you wish just sit back, relax, and write about yourself.*

*If you prefer, you may answer the questions that follow and come back to this question later. The questions are designed to jog your memory and show you what I need to understand about you.*

What is your reason for consulting me today?

### **3. Current Symptoms**

*Please try and describe all the current symptoms in your own words including if possible, the cause. To help you with your response, imagine that you are sitting in front of me and I ask, "So what brings you here today?"*

When did the symptoms begin? Can you suggest some factors that helped create these symptoms?

If this is not the first occurrence please describe any previous problems of this kind.

Please describe anything that you feel is associated with the current symptoms that is unusual, rare and/or peculiar or any other information which you wish to add.

It would also be very useful if you could describe any particular important events in your life. How did you feel about them at the time? Also, how you feel about them now?

### **4. General Symptoms**

*I am interested in what makes your body tick in general. For example, if you have cold feet that is a particular symptom, and is useful to me. Similarly, if you are always worse from cold or seem to lack vital heat that is a general symptom, and a small clue for me.*

*By answering as many of these questions as fully as possible, you are helping me interpret what your body and unconscious mind are doing, so that I can find a remedy for you.*

In which season do you feel less well?

How does fog affect you?

At what time during the day or night do you feel worst?

How do you stand the cold/hot/dry/wet weather?

What do you feel when exposed to the sun?

How does change of weather affect you? What about snow?

What are your reactions to north wind / south wind / the wind in general

How do you feel before, during and after a storm?

What about warmth in general, warmth of the bed, of the room, of the stove?

What about draughts of air and changes of temperature?

How do you react to extremes of temperature?

What difference do you make in your clothing in winter?

What position do you like best (Sitting / Standing / Lying)?

What about taking colds in winter and in other seasons?

How do you feel standing or kneeling in a church / mosque / synagogue / temple or other place of worship or meditation?

What kind of climate is objectionable to you, and where would you choose to spend your vacation?

How do you keep your window at night?

### **5. General Symptoms (continued)**

*We need to fill out your story with answers to whichever of the following questions are relevant to you. These questions are based on those used by Dr Pierre Schmidt, an eminent Swiss homeopathic physician who wrote on the art of taking cases.*

What sports do you play?

How do you feel riding in cars or sailing?

How do you feel before / during / after meals?

What about your appetite, how do you feel if you go without a meal?

What do you drink and in what quantity? What about thirst?

What are the foods that make you sick and why?

What about wine / beer / coffee / tea / milk / vinegar?

How much do you smoke in a day. How do you feel after smoking?

Are there any drugs which you are very sensitive too or which make you sick?

What are the vaccinations you have had and the results from them?

What about cold or warm baths, or sea baths?

How do you feel at the seaside or on high mountains?

How do collars, belts and tight clothing affect you?

How long do your wounds take to heal, how long do they bleed for?

In what circumstances have you felt like fainting?

## **6. Mental and Emotional Symptoms**

*The symptoms of the Mind are most important and should be carefully considered. Try to give all these symptoms fully as they are very important.*

*Please note that the questions and language here used are merely suggestive, and are simply intended to lead you to give all your symptoms.*

What are the greatest griefs that you have gone through in your life?

What are the greatest joys you have had in life?

In what circumstances have you ever felt jealous?

On what occasions do you weep? At music? At reproaches? At what time of day?

How do you cope with your worries?

What effect does consolation have on you?

On what occasions do you feel despair?

How do you stand waiting?

When and on what occasions do you feel frightened or anxious?

How do you feel in a room full of people or at church, etc or at a lecture?

Do you go red or white when you are angry and how do you feel afterwards?

How rapidly do you walk or eat or talk or write?

What have been the complaints or effects following chagrin, grief, disappointed, love, vexation, mortification, indignation, bad news, fright?

Tell me all about over-conscientiousness and over-scrupulousness, about trifles; some people do not care about too much details and too much order.

What about your memory? Your understanding? Your will? Your concentration? Any tendency to make mistakes?

At what time in the twenty-four hours do you feel the blues, depressed, sad, pessimistic?

In time of depression, how do you look at death?

## **7. Food and Sleep**

*I am looking for clues about you. For example, along with your sleeping patterns I am interested in what you like to eat.*

*Once a patient said she was hungry in my rooms, and asked if I minded if she ate a snack. I said fine of course. So she took out a tin of Tuna fish and a fork, and ate the contents of the tin. Then she took out another and ate that.*

*The result of this clue was a diagnosis of a complex endocrine problem, of iron and calcium and iodine, and I knew her remedy. So be sure to tell me what the regular medical people will ignore or scoff at.*

What is the kind of food for which you have a marked craving or aversion for?

What kind of food makes you sick or you are unable to eat?

What about pastry and sweets?

What about sour or spiced food?

What about rich or greasy food?

What about thirst and what do you drink?

How much salt do you need for your taste?

Do you have a 'salt tooth', e.g. do you add salt to food at the table?

Do you drink coffee / tea / wine / beer or other?

In which position do you sleep? How long have you slept in that position?

Where do you put your arms, and how do you like to have your head?

At what time do you wake up and how do you feel?

When are you sleepy?

What makes you restless or sleepy?

What about dreams?

What do you do during sleep? Talk? Laugh? Cry out? Weep? Be restless? Be afraid? Grind your teeth? Have your mouth open? Have your eyes open?

### **8. For Women Only**

*These questions may appear rather intimate. The answers will help me understand what is troubling you and how to help you. I do not accept the idea that menstrual troubles are something with which you have to live. Many women are told that nothing can be done. I am an optimist and I hope that something can be done, so please answer what you feel are relevant questions.*

At what age did your periods begin?

How frequently do your periods come?

Please describe their duration, abundance, colour, odour

Please describe any other significant details that may be relevant

At what time in the twenty-four hours do they flow most?

How do you feel before, during and after your period?

What about your character, feelings, or behaviour before, during and after your period.

### **9. Bodily Functions and Discharges**

*In all of these questions, I am interested in the sensations, their location, what modifies them and what accompanies them.*

*Skin symptoms need to be described as I cannot see them. Are they dry, moist, oozing? What is the nature of the discharge? Where did they start, and in which part of your body? And when - after a vaccination or after a grief? When do they come and go?*

Please detail what is normal and what is unusual or troubling for you in relation to temperature, sweat, mucous, smells, bowels, urine and genital functions.

Any problems of the senses, hearing, vision, smell, taste?

Do you have any problems in your mouth or dental problems?

Do you have any skin problems like eczema, warts, tumours, psoriasis or unexplained eruptions?

Has a diagnosis been made for any condition? If so by whom, what is it, detail any advice given.

Are you taking any homeopathic remedy, conventional medication, herb, vitamin or mineral supplement?

Do you take any exercise?

In case you did not mention it above, do you feel any pain?

Is the pain you feel burning, aching, numbness and/or throbbing or other sensation. Provide any other information.

Complete the sentence, 'It feels as if ...' about all your pains or discomforts.

### **10. Your Personal History**

*I often ask my patients to show me their tongue. As you need to be familiar with your own tongue and the changes that sometimes happen after a remedy, I ask the patient to look in a mirror and tell me what they see. You can do this now if you wish and add this to your message to me.*

*If you would like to ask family members or close friends to comment or observation about your problems and how they see things please ask them to send me a confidential email.*

Please detail your medical history since childhood as far as you can recall, including accidents, time in hospital etc.

Please provide as much information as you can regarding the medical history of your immediate family and grandparents.

Can you describe your home circumstances and important relationships?

What are your passions and leisure pursuits?

Are their important aspects of your life that have not been covered?

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Thank you for completing the questionnaire. Please email this questionnaire to [drinanda@hotmail.com](mailto:drinanda@hotmail.com)

