

Research Brief

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A Parallel Health Care market: Rural Medical Practitioners in West Bengal, India

Background

Despite a strong infrastructural base of the public health care facilities in many Indian states, the majority of outpatient services, especially in the rural areas, are provided by private health care providers, most of whom practice modern allopathy without any formal training. This section of medical practitioners is often identified as Rural Medical Practitioners (RMPs), "unqualified", "less than fully qualified (LTFQ)" providers, or simply "quacks". West Bengal is no exception, where, according to the National Family Health Survey (NFHS-II) conducted in 1995-96; about 60 percent of the households visited the private medical sector for outpatient care when they fell sick. Although NFHS-II did not classify "private doctors" according to their qualification status, researchers and policy makers alike concur that a large section of them belongs to "RMP" category.

Significant visibility of RMPs especially in rural outpatient care should logically make policy makers take a clear policy stand on RMPs. Indian policy makers are, however, conspicuously silent on this issue, the possible reason for being the inherent dilemma in dealing with these providers. On the one hand, their dominance is too prominent to ignore, while on the other, the legal and technical barriers are too strong to formally acknowledge RMPs and redirect their market power in a controlled and guided manner

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One of the principal factors behind the ambiguity in the health sector regarding the possible roles of RMPs is lack of adequate knowledge of their operational features both from demand and supply angles. Unfortunately, the area is much less researched in comparison to the public or private qualified sector. National surveys (such as NSSO or NFHS) hardly generate any data on the utilization of RMP's health care. This is especially true in the context of West Bengal where knowledge of this informal market is grossly inadequate to even initiate a policy dialogue on this issue.

This research brief attempts to present some recent evidences to help understand the role and relevance of RMPs in the context of West Bengal's health care system. It is based on the outputs of a study recently carried out by Institute of Health Management Research (IHMR) in three districts of West Bengal under a research programme titled "Future Health System: Innovations for Equity".

Data & method

The study is based on three primary data sources simultaneously collected from three districts of West Bengal, Malda, Bankura, and North 24 Pargonas: (1) a household survey covering 3152 households, (2) exit interviews of selected outpatients and inpatients in selected government health facilities, and (3) in-depth interviews with 71 RMPs. In each case the interview was conducted by using a structured questionnaire

The households in the household survey were selected by two-stage stratified sampling: first, from each of the selected districts, 35 primary sampling units (PSU) covering both rural and urban areas were selected through PPS (Probability Proportion to Size) method, and second, by selecting 30 households from each PSU through a systematic random process.

The RMPs in the three districts were tracked primarily on the basis of information provided by the clients of government health facilities who were contacted through exit interviews. In addition, in-depth discussions with the organized bodies of RMPs, such as RMPs' district associations, were carried out in all the three districts.

The study focused on those RMPs who practiced modern allopathic treatment without being formally trained to do so. The set includes those (1) who practice without any formal training on any stream (allopathy, homeopathy, ayurvedic, etc.); (2) who graduated in medicine from any unrecognized organization; and (3) who graduated in a non-allopathy stream but practicing allopathy.

Results

Where do people go for outpatient care?

Table 1 presents data on households' health care seeking behaviour in case of minor ailments (i.e., for which hospitalization was not required). The table is based on the detailed information on those household members who *actually* suffered from minor ailments and sought treatment in the last 90 days preceding the survey. The households were classified into five groups (poorest to least poor) according to their per capita expenditure and the number of ill persons and RMP clients were estimated for each group.

The strong presence of RMPs is quite evident in Table 1. Among the 5284 rural and 1450 urban patients, who sought treatment for their minor health problems from various sources, about 54 and 19 percents respectively, were treated by RMPs.

There is a common perception that treatment by RMPs is much cheaper than other alternatives; hence only poor clients visit them. The evidence, however, stands against this perception, especially in rural areas. As shown in Table 1, the utilization of RMP services in rural areas is almost uniformly spread across various socio-economic groups.

Equal distribution (with respect to socio-economic status) in utilization of RMP services in rural areas implies that it is not only lighter economic burden, but also some other factors, which direct the rural people to RMPs. This is also evident from Figure 1 where the average out-of-pocket payments for treating minor ailments are presented.

Figure 1 reveals that visit to a government facility in the rural area for non-hospitalized treatment would

Table 1: Percentage of affected persons actually sought treatment from RMPs, by per capita expenditure quintiles

% of persons sought treatment for minor ailments from RMPs	Rural		Urban	
	No. of persons treated	% of them treated by RMPs	No. of persons treated	% of them treated by RMPs
Poorest quintile	1,056	53.69	295	33.90
Next 20%	1,083	52.26	309	26.86
Next 20%	1,075	53.67	296	15.20
Next 20%	1,079	59.50	284	10.92
Least poor quintile	991	48.94	266	4.89
Total	5,284	53.69	1,450	18.76

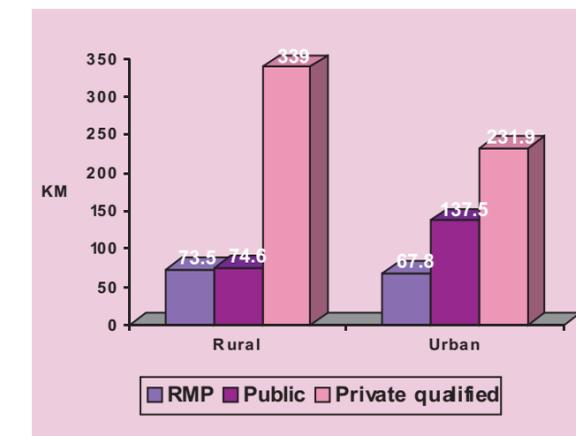
Source : IHMR FHS Survey 2007

cost as much as it will to a RMP (about Rs. 75) although the same can not be said about an urban government facility where it costs almost double. The question is: why do rural people across all categories prefer RMPs to public health care centres if both are equally cheap?

The study attempted to identify possible answers to the above question from the household survey. The three most important reasons for choosing RMPs (as identified by the percentage of respondents) are: (1) close location (74%); (2) always available (65%), and (3) cheap (61%). The other two reasons, not as important as the above three, are: (4) availability of medicines (27%), and (5) scope to pay later or by instalments (25%).

That proximity is one of the most important factors for the spread of RMPs is also evident from Figure 2 where the average distances of various sources of care from the respondents' residences are plotted. On average, a rural resident has to travel less than a kilometre (0.68 km) to visit a RMP; the distance becomes double (1.48 km) if it is a public health centre and about ten times more (6 km) if it is a clinic of a private qualified doctor.

Figure 1. Average out-of-pocket payments for treatment of minor ailments, by sources of treatment (in Rs.)

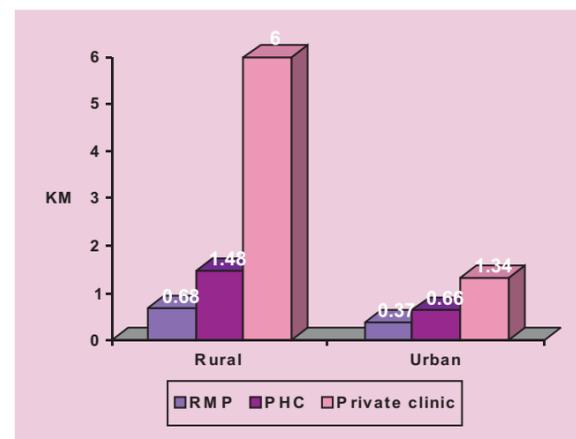


Physical accessibility, however, explains the demand side only partially. A public facility, even if it is closely located to a village, may be bypassed due to non-availability of a regular doctor. All medicines prescribed by a PHC doctor may not be available within the facility. Consequently, the patients have to remain prepared to pay upfront for the medicines they would purchase from private pharmacies. Moreover, the prescribed

medicines, which are purchased from pharmacies, may not always be of the cheapest brand.

The study, based on a series of focus group discussions and case studies with the villagers in selected PSUs of the three study districts, clearly points out that the RMPs feed on the above weaknesses of the public health care system. They are usually always available, closely located, and sell medicines as a part of their service often on credit. Clearly, their operations manifest the simple economic phenomenon that a market, when it fails to deliver, begets a parallel but efficient alternative. Clearly, their operations manifest the simple economic phenomenon that a market, when it fails to deliver, begets a parallel but efficient alternative. Despite the response bias (since data were collected from the RMPs), it is worth noting that only about 10% (1668 out of 16842 children) of the children were referred to formal providers. The children under "rest" category were not cured; however, due to data limitations it can only be assumed, but not confirmed, that most of them switched over to formal providers or to another RMP.

Figure 2. Average distance to sources of treatment for minor ailments, (in Kilometers)



The RMPs in West Bengal

The in-depth survey of 71 RMPs and their associations in the three districts identified the following characteristics of the RMPs:

- Most of them (58%) were non-graduates.
- On an average, a RMP treated about 600 cases

per month. About 14% of the users were children (below 5 years)

- More than half of them (56%) acquired some sort of "degree" from unrecognized private institutions.
- On an average, an RMP earned around Rs. 3250 per month.

Treatment by RMPs

The RMPs usually provided services for minor ailment although a minor fraction (6%) also provided preventive care (immunization). A majority of them (72%) also did minor surgeries. About one-third of them assisted in birth deliveries. Almost all of them (90%) responded to house calls.

Dispensing drugs with treatment is one of the key attractive services provided by RMPs. About 90% of the sample RMPs were found to follow this practice. A majority of them (70%) procured drugs from the local chemist shop. The other source was wholesale market from where one-fifth of them procured drugs.

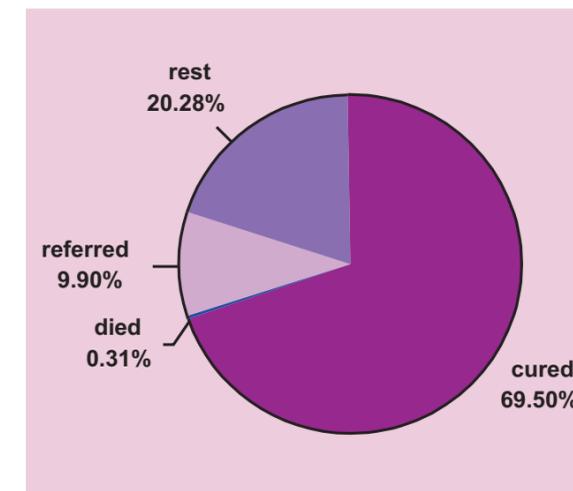
The most common diseases treated by the RMPs were: diarrhoea / gastro-enteric disorders (97%) and common cold / cough / fever (83%). The typical procedure for treating a child with diarrhoea was to put him / her on saline and give him / her anti-diarrhoeal medicine.

Referral practice

Do RMPs refer potentially or actual complicated cases to public facilities or qualified private doctors? The common perception is that they do it only when cases go completely out of their control.

Data collected from the selected RMPs partially confirm the perception. An RMP would hardly refer a case of common diseases such as diarrhoea or fever, irrespective of its potential complications or chronic nature. This is quite evident from Figure 3 where the sample RMPs' responses (about the status of children after they were treated by them in the last three months) are presented.

Figure 3. Distribution of children treated by the sample RMPs in the last 3 months, by status after treatment (total 16842 children)



Despite the response bias (since data were collected from the RMPs), it is worth noting that only about 10% (1668 out of 16842 children) of the children were referred to formal providers. The children under "rest" category were not cured; however, due to data limitations it can only be assumed, but not confirmed, that most of them switched over to formal providers or to another RMP.

Killer or savior?

Do RMPs act as a bunch of thorns in the existing health care system, or do they act as a good balancing factor in maintaining rural health? The study stops short of drawing any conclusion on this issue due to its limited scope, but available evidences highlight a few points:

1. Irrespective of health outcome, RMPs have established a strong network of health care, especially in rural West Bengal, primarily due to easy accessibility and attractive low-cost packaging. Since there is no effective barrier to entry into the market, the market share of these providers is likely to increase in future.
2. However, without any effective regulatory mechanism, the quality of care provided by RMPs remains completely uncontrolled. Consequently, the risk of doing harm is significant, especially in cases where

careful diagnosis or surgical operation is required (see Box 1). The risk is further aggravated particularly because many people do not even know that RMPs are not "real" doctors.

Box 1 A narrow escape

Akhil Pal, a rag-picker, visited Kaliachak BPHC (Malda district) with a swelling on his head. The doctor at the BPHC diagnosed it as a tumor and advised immediate surgery. Scared of operation and yet unable to bear the increasing pain, Akhil went to a local RMP, who is known to be a multi-therapist, practicing so many "pathies" simultaneously and healing multifold ailments. He guaranteed Akhil of a prompt cure, administered several injections around the tumor, and started operating upon the protruded part. Half-way in the process, and after the unkindest cut, he coolly informed that the operation may eventually end up in cancer, and called it quits. A frightened Akhil, still bleeding profusely from 'operated head' was taken again to the BPHC.

3. West Bengal is one of the few states where government hospitals have a much larger share of inpatients in comparison to their private counterparts. The household survey informed that more than 80 percent of hospitalized persons sought admission to government hospitals (see Research Brief # 1). However, a different picture emerges when one looks at the pre-admission phase of the hospitalized persons. About 60 percent of rural hospitalized persons had initiated their treatment with RMPs. They carried on pre-hospitalization treatment for an average of 33 days and spent Rs. 1400 on average. In other words, there is a strong indication that a large section of rural patients hang on with the RMPs before they get hospitalized probably with more complications developed. The implication of this finding is that the burden of disease and cost of treatment would be substantially reduced for a large number of hospitalized persons if their pre-hospitalization spell with RMPs could be minimized

4. Notwithstanding the risks involved in the spread of RMPs, their positive contributions to rural health can hardly be exaggerated. This is especially true where the alternative to RMPs' service is "no treatment" (see Box 2).

Box 2
An alternative to "no care"

Sumitra Mondal, a resident of Borosheyana village, was admitted to Taki Rural Hospital (N 24 Porgona) for birth delivery. Sumitra complained of severe abdominal pain and discomfort, but was not attended to by the hospital staff, who dismissed her complaints rendering it to be 'normal' in case of delivery patients. With increasing pain and still being unattended, Sumitra was taken back towards home. Back in her village she was attended to by a local RMP at his dispensary, who administered injections and medicines to ease her pain considerably. In the next few hours, the RMP assisted Sumitra to have a normal delivery.

Policy Implications

The study highlights the urgent need for addressing the silent but all-pervasive spread of RMPs in rural health care market. Two clear policy options emerge from the study:

1. Ensure adequate basic health care facilities with qualified health care providers who would remain available round-the-clock for basic curative services and birth delivery. The purpose, in this case, is to "crowd out" RMPs by government-sponsored competitors.
2. The alternative option is to internalize RMPs within the system and feed on their strengths in a guided manner. For example, a section of RMPs may be empanelled or franchised to help them operate as "gatekeepers" of primary health care.

The first option, despite its popularity among public health researchers, is seriously constrained by two factors: (1) perennial shortage of government doctors in rural areas primarily due to their reluctance to serve there, and (2) resource crunch in providing adequate

infrastructure, drugs, and maintenance inputs to meet the huge need for basic curative care. Further, supplying doctors and other inputs is not enough to compete with RMPs as long as RMPs excel formal providers in packaging their services.

The second option has clear advantages on these aspects the option allows the system to use a huge pool of resources (i.e., RMPs) which is being used by the people anyway. However, the risk, as mentioned earlier, remains in their huge potential to generate adverse health effects through immature applications of medical science. The additional barriers are (1) the legal aspects which may bar involving a RMP in formal medical care, and (2) the intrinsic profit motive of RMPs which may not adjust with the public health goals of the government.

Several experiments at the international and national levels demonstrated that minimizing the risk and overcoming the barriers is not an impossible task. The study strongly suggests such a strategic experiment, at least at a particular district as a prototype. The basic components of such an experiment might be:

- Empanel selected RMPs at each block as "Rural health gate keepers". Empanelment should be based on several essential quality indicators. The program may be initially started where public system is relatively weak. The role of the RMP will be to provide a set of basic curative services and refer cases immediately to formal providers as and when the patient crosses the identified "safe treatment" mark.
- Identify a set of basic curative and preventive services for which the RMPs will be given franchise right to operate as official gatekeepers.
- Involve civil societies (Panchayat or NGO) in implementing empanelment and mentoring the RMPs.
- Provide intensive training to selected RMPs on simple treatments, identifying potentially complicated cases and "danger mark" where they have to refer.

It is also important to devise an incentive structure (monetary and otherwise) for adopting franchise right and adhering to standard protocols.

Further Research

The present study is the first step towards understanding the role and potential of RMPs as a part of huge informal sector in India's health care market. Several issues emerged from the present study all of which could not be conclusively addressed due to its limited scope.

The limitations in the present study encourages Future Health System project to embark on exploring further on this issue with a broader canvas. The research questions for future research in this area could be broadly delineated as:

- How "safe" or "unsafe" are the current clinical practices of RMPs?
- What is the net impact of RMP practices on rural health?
- How feasible is it to integrate RMPs into existing public health care system?

The last question would require designing an operational research with a strategic intervention plan with RMPs which could be implemented in one or two districts of West Bengal. The intervention may be aligned to the steps outlined in previous section with appropriate

modifications.