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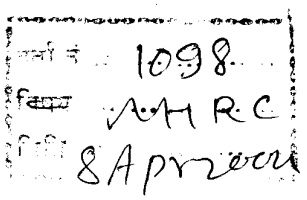
PUBLIC-PRIVATE-NGO PARTNERSHIP IN HEALTH SERVICES: REVIEW, ASSESSMENT AND RECOMMENDATIONS FROM A FOCUSED STUDY IN THE CENTRAL REGION OF NEPAL



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Bishnu Prasad Sharma
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ACRONYMS

AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
HA	Health Assistant
HMG/Nepal	His Majesty's Government of Nepal
INGO	International Non Governmental Organization
MOH	Ministry of Health
MOU	Memorandum of Understanding
NESAC	Nepal South Asian Centre
NGO	Non-governmental Organization
NPC	National Planning Commission
SWC	Social Welfare Council
UMN	United Mission to Nepal
VDC	Village Development Committee

Executive Summary

There is a global reassessment of the role of public and private sector in providing health services. In addition to the public and the private sector, there is a growing involvement of the NGO sector in the provision of health services. The government of Nepal has felt the need for a clear-cut policy for public-private- NGO collaboration in the health sector for maximizing the access to health services. The public-private-NGO mix should be oriented towards addressing the fundamental questions of how to uplift the health status of the people by mixing the public-private-NGO and how to improve access to all types of health services to the poor. The objectives of the study were to review the existing situation of public-private-NGO partnership in the provision of health services in the central region of Nepal; assess the present level of public- private-NGO mix; review relevant experiences of developed as well as developing countries on public-private-NGO mix; provide an analysis of relevant public–private-NGO mix in the context of Nepal and; recommend possible collaboration of public-private-NGO partnership on the basis of the above mentioned objectives. The methodology consists of analyzing the partnership between the public private and NGO sectors and their spatial distribution, the ratio of the patients and the health professionals, kinds of services provided and the prices of services provided etc of the public, private and NGO sector. This gives an idea of how efficiency and equity aspects are being addressed in the public and the private sector.

The study was based on both primary and secondary data. Both the qualitative and quantitative information were collected through administration of pre-tested questionnaire in two public hospitals and four private hospitals in Kathmandu and Lalitpur. Qualitative information was collected in course of discussion with planners and policy makers involved in the health sector of HMG/Nepal.

The study was based on the analysis of the private sector as the private for profit sector and the NGO as those service providers which are funded by national/ international NGOs. Similarly, public-private-NGO partnership was analyzed from two aspects: vertical and horizontal partnership. The three sectors working independently in a parallel way can has been considered as a horizontal partnership whose final target is improved health outcomes of the people. Another aspect of partnership was vertical partnership in which the private and the NGO sector working under funding and direction of the government.

The share of the expenditure made out of pocket to purchase services from the private sector providers was 35 percent in Nepal in 1996. In addition, if the expenditures on drugs people purchase out of pocket on the basis of prescriptions made by government outlets are included, this figures comes to be significantly large. The share of the expenditure of development partners and donors (I/NGOs) was about 14 percent.

Starting from two private hospitals and nursing homes in 1985, the number had increased to 104 by 2004 in Nepal with 71 percent of them in Kathmandu. Similarly there were 17 I/NGO working directly under the Ministry of health. The percentage of the I/NGO categorized as working in the health sector by the Social Welfare Council, the institution responsible for monitoring NGO activities in Nepal, were 8 percent of the total I/NGO in 1991 which fell to 2.2 percent in 2001. The four United Mission to Nepal hospitals alone claim of providing 29 percent of all inpatients and 22 percent of all inpatient care in Nepal. While manpower availability are high in public hospitals, the patient load were also 4.24 and 2.55 times higher in the public hospital compared to private hospitals for

outpatient and in patient category. The public sector was facing competition for health personnel with the private sector. The cost of services were high for both inpatient and outpatient category in private hospitals compared to public hospitals However, availability of the services of health personnel including specialist services of ones choice at the time of convenience, short waiting time etc are the factors that attract patients to the private service providers in spite of relatively high prices of services.

Free beds were also provided for poor patients in public hospitals while no such free beds were provided in private hospitals. Private hospitals reported of some services to poor at lower prices but there were no transparent records in this regards. The private sector considered themselves self sufficient in terms of availability of manpower and technology. However, they expected preferential treatment in the prices of electricity, water supply etc. from the government. In view of the rapid growth of the private sector, it was observed that market incentives are enough to attract them in business. It was found that several I/NGOs are providing health services to the people in the rural and urban areas of Nepal. However, it was found not mandatory for them to operate in regions allocated to them by the government. In course of the discussion about the scope and role of public–private-NGO partnership, most of the planners and policy makers emphasized partnership in the health system (narrow sense) rather than on partnership for improving national health status (broader sense). This issue deserves conceptual clarity as it is an issue that determines the role of the public sector. If the role of the private sector in improving the health status is recognized, the government will have responsibilities to regulate the private sector as well as contribute to its growth. The contribution of the private sector has been very important particularly in the provision of general and specialized health services at consumers' access; releasing the public sector from its responsibilities so that it can focus more on primary and essential health services to rural population; contribution to national income, output and employment etc. The government sector has increased role in regulating the private sector, developing measures to increase access of the poor on private health services and improving the transparency aspect of private sector for efficiency and distributional justice. Similarly, public-private-NGO mix can contribute to reform management of public health sector, improve efficiency and cost effectiveness and explore new areas to work with private sector.

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Chapter I
Introduction

1.1 Background

There is a global reassessment of the role of public and private sector in providing health services. This debate has also come to Nepal where the role of the public and private sectors are changing. In the past, the Nepalese government (i.e. public) sector had been the only provider of (formal) health services. This situation changed in the mid-eighties with the introduction of private sector involvement. Since then, there has been the establishment of a number of private sector health facilities whose trend significantly accelerated in the decade since the introduction of multi-party democracy in 1990. Presently fourteen non-governmental hospitals, five private teaching hospitals, 104 nursing homes exist in the country (MOH, 2003). Unfortunately in Nepal, the present policy of dealing with health services uniformly in developed and backward regions alike throughout the country, has led to unequal growth of health institutions with 72 percent of private health facilities being located in Kathmandu valley where specialized clinical health facilities of the government already exist. On the other hand the private sector involvement outside the valley is very minimal where the health services of the government are largely inadequate. This situation has provided a challenge for achieving quality health services which is accessible to all the Nepalese population. In addition to the public and the private sector, there is a growing involvement of the NGO sector in the provision of health services. Due to the lack of clear-cut policies regarding the involvement of private, public and NGO sector in health services, it is felt that an imbalanced growth has resulted in inequality for the access to health services. This research project attempts to fill this void by providing necessary and focused information.

1.2 Statement of the Problem

There has been a growing debate on whether health service is a public good or a private good or a combination of both. If health service is considered a public good, the government should be responsible to provide a broad range of health service. If health service is considered a private good, then the government will have a regulatory role while private sector provides all health services. The issue that if it is a combination of both, to what level or extent is it a public good and to what extent it is a private good, has given rise to a debate in Nepal, highlighted as far back as 1991 with the National Health Policy (1991), which had created confusion among policy makers. Similarly, health services have started to receive a status of basic human right (NPC, 1997). While the level or extent of the health

service as a public good or a private good may depend upon the level of development of a country, it is certainly true in Nepal that there is a need to identify what level of health service should be considered a public good and health services beyond it a mixed good. This will certainly help policy makers in the formulation of appropriate health policies for the country.

The government of Nepal has felt the need for a clear-cut policy for public-private- NGO collaboration in the health sector for maximizing the access to health services. His Majesty's Government of Nepal (HMG/N) has also recognized the need for identification and analysis of appropriate strategies for effective public-private-NGO partnership in each district. Unfortunately, HMG/N has not been able to develop effective programs for such a partnership which may be due to the absence of a comprehensive study in this area. HMG/N has tried to address this by proposing, in Second Long Term Health Plan (1997- 2017), to have "collection, analysis and synthesis of available information on the actual and potential contribution of public - private -NGO partnership." This has been suggested with a view of overcoming the lack of specific policies, strategies and plans to encourage NGO and private sector participation in the delivery of preventive and community health services and the need for the development of an effective mechanism to coordinate HMG, NGO/INGO and private sector preventive and community health services. This study, therefore, has its relevance in view of the need of HMG/Nepal, which is also consistent with the national health priority of Nepal, and proposed to provide preliminary information in this regard.

The public-private-NGO should be oriented towards addressing the fundamental questions: (i) how to uplift the health status of the people by mixing the public-private-NGO and (ii) How to improve access to all types of health services to the poor? There is a need to assess the level of public-private-NGO mix to examine whether public-private-NGO is being oriented towards addressing these fundamental questions. The objectives have been set to analyse these issues.

1. 3 Objectives

General Objectives

The general objective of this study is to provide an assessment of public-private-NGO partnership in the central region of Nepal.

Specific Objectives

The specific research objectives of this study are to:

- Review of existing situation of public-private-NGO partnership in the provision of health services in the central region of Nepal
- Assess the present level of public- private-NGO mix;
- Review relevant experiences of developed as well as developing countries on public-private-NGO mix;
- Provide an analysis of relevant public–private-NGO mix in the context of Nepal;
- Recommend possible collaboration of public-private-NGO partnership on the basis of the above mentioned objectives;

1.4 Limitation of the Study

The study has covered only the curative and preventive health services provided by public, private or NGO sector on their own or through some collaboration. Due to the rapid assessment nature of the study, the coverage of the study was limited to only two districts and six institutions. However, efforts have been made to ensure the scope for generalization of the study, as far as possible.

1.5 Outline of the study

Chapter I deals with the introduction part. It consists of the introduction, statement of the problem, objectives, limitations of the study and the outline of the study. Chapter II is the review of relevant experiences of developed as well as the developing countries . Chapter III deals with the methodology comprising of the conceptual framework and the methodology applied which elaboration on the research design and the methods of data collection. Chapter IV is the Findings and Analysis while the last chapter deals of conclusions and recommendations.

Chapter II

Relevant Experience of Developed and as well as Developing Countries

The question of either public or private participation in health services is not of recent interest whose history shows that preference of public or private participation has had many reversals across time. It may have initially been weighted to the public sector in ancient Egypt, shifted to the private sector during the next three thousand odd years, then come back full circle to heavy state involvement during the 20th Century; presently, there has been a move to the opposite direction in recent years with growing experimentation with market approaches.

The motivation for this move has been the inefficiency of the public health expenditure. This is empirically demonstrated in a paper by Filmer and Pritchet (1999) who looked at a health production function for a large number of countries using as the dependent variable measures of health outcomes (i.e. such as infant mortality rate, under-5 mortality rate etc.) and regressed this to the log of mean per capita income and the log of the share of public health as a fraction of GDP along with a number of other socio-economic factors. In sum, the empirical finding showed that public spending did not have a significant impact on health. The same conclusion was reached by Adhikari, Maskay and Sharma (2002) after looking at the health outcomes, i.e. child death rate, child morality rate, infant mortality rate and life expectancy rate, of Nepalese health policy over the period 1989/1990 to 1999/2000 from three perspectives: an input-output model, examination of extension of health facility and through results of an indicative regression. This result supports the study by Hotchkiss, Rous, Karmacharya and Sangraula (1998) who found that households in 1996 account for 74% of the total level of funds used to finance the health economy.

Because of this so called "inefficiency", there has been building frustration with public health expenditure which has resulted in a trend suggesting that a mix/partnership of the public and private sector, will necessary maximize the benefit to the nation's population (Preker and Harding, 2000). This has also been a topic of keen debate in international organization, such as WHO (Buse and Waxman, 2001), as well a topic of keen interest seen in international seminars such as that on *Global Public-Private Partnerships for Health and Equity* held in Rome, Italy on 23 – 24 November 2000, and those in Nepal most recently seen in the national seminar of *Private Investment in Health Sector: Opportunities and Challenges* held in Kathmandu, Nepal on 14 – 15 October, 2001 and in the *First*

Workshop on Health Systems Reforms: Towards A Health Sector Strategy held in Kathmandu, Nepal on 25 – 26 February 2002.

There are many examples that support this assertion that public-private partnership is beneficial. It may be appropriate at this time to focus on the Australia example, which is elaborated in Sperling and Parslow (1999). In the paper, the authors examine the case of the Australian health care where there have been decisive changes in the balance of public and private services. The authors initially use secondary data and research studies on commonwealth government and state and territory government before examining case studies on particular aspects such as the Department of Veteran's Affair etc. The purpose of the study is to examine the role of the sector in health care. The author concludes that (1) caution must be taken to ensure that overall objectives of the health care system are not undermined in a competitive market and (2) that the study suggests a need for public private partnership in the provision of health care as exists in Australia with Medicare.

Because of this, there is also a present debate in Nepal over the role of the public and private sector. Preker (2002), on one hand suggests that a systematic approach is necessary to deal with the private sector such as assessment of ongoing private sector activities, options of strategies to involve the private sector; and choice of instruments to achieve health objectives. It is worth mentioning that HMG/N has moved in this direction in three perspectives: first, in the Concept Paper of PRSP/10th plan; second, the Medium Term Expenditure Program to Operationalize the 1st Three years of the 10th Plan's Health Programmes; third the Second Long term Health Plan. Likewise, this had been discussed in the recent Nepal Health Sector Reform Strategy. All these plans and discussion attempt to put forth clear enunciation of public-private-NGO partnership in the provision of health care. However, it has been shown that most of the services of the private sector are in urban areas implying that there is an increase in inequality (anecdotal evidence but for a recent example see Rana (2001)). Further, the access to health services perceived by the households on the basis of place of residence is high in urban areas compared to rural areas, in the eastern and central part compared to the western and far western part and the hills compared to the Terai (Nepal South Asian Center, 1998, P.64). There are no clear factors behind this trend, because of this, there is a need to assess the present level of inequality to access in health care to formulate appropriate policies in this regard

Chapter III

Research Methodology

3.1 Conceptual framework

There is a general consensus that the public health sector is more oriented towards addressing the equity in health care services while it is generally believed to be weak from the efficiency aspect. The private sector on the other hand is recognized for better efficiency but is considered to overlook the equity aspect. The concept of public private and NGO partnership in the health care has received worldwide attention towards utilizing their respective complementarities in making health services efficient as well as accessible to all. The present study analyses the horizontal partnership of the public, private and NGO sector and its spatial distribution particularly in the central development region of Nepal. Further, the ratio of the patients and the health professionals, kinds of services provided and the prices of services provided etc of the public, private and NGO sector are also examined. This gives an idea of how efficiency and equity aspects are being addressed in the public and the private sector. Similarly, the private sector involvement in various aspects of the public health facilities and utilization of the private health sector facilities for the attainment of public health objectives are discussed. It is obvious that the quality of health services depends upon the knowledge and experience of health personnel, access to technology, efficient management, access to information to the patients etc.

3.2 Methodology Applied

3.2.1 The research Design

The study was exploratory and used a descriptive-analytical framework. The study was basically cross sectional with both quantitative and qualitative data used for this purpose. The study has also triangulated the information collected from health institutions with the existing practices and policy approaches of the government obtained through discussion with planners and policy makers toward appropriate policy recommendations.

3.2.2. Data Collection and Management

To fulfill the objectives of this study, primary as well as secondary data was collected. Secondary data was collected from different sources such as articles, reports, Ministry of Health and internet sources etc. Both quantitative and qualitative primary data was collected from the public hospitals, private hospitals/nursing homes and NGOs. Mainly, qualitative information was collected in course of discussion with planners and policy makers who were at least Gazetted first class officers involved in the health sector of HMG/Nepal to obtain required information for appropriate policy recommendation on public-private-NGO mix. in HMG of Nepal.

The study was based mainly on primary data collected from public, private and NGO hospitals. In view of the resource constraint, two districts Kathmandu and Lalitpur of the Central Development Regions were purposively selected. The required primary information was collected from one public hospital and two private hospitals selected at random from the list of public and private/NGO hospitals in the sampled districts from the information bulletin of MOH (2001). If any sampled institutions were not able to, or did not provide required information, an alternate was selected at random using "without replacement" method in its place. Qualitative information related to the inquiry was collected from five planners and policy makers selected at random from the list of such individuals in the Planning Commission and the Ministry of Health. The Chief Investigator and Co-expert conducted the discussions with planners and policy makers themselves.

Persons related to management and administrations of sampled public, private and NGO run hospitals/nursing homes were interviewed through administration of pre-designed and pre-tested structured questionnaire. Researchers were provided with training before conducting field surveys. Data collection process was directly supervised by the research team. The discussion with planners and policy makers was conducted guided by a checklist. The information was written down on a notebook. The raw data collected was then thoroughly checked, edited and tabulated to check consistency and make the data set suitable for analysis. Data processing was performed initially using excel program to facilitate analysis.

Simple economic and statistical tools were used to measure the nature and availability of the services through the three kinds of health service providers. The information obtained through discussions with planners and policy makers were coded and organized in accordance with appropriate themes to facilitate analysis and recommendations.

Chapter IV

Findings and Analysis

4.1 Background

The private health sector has been defined mainly from two aspects. It may be defined as comprising of all providers who exist outside the public sector whether their aim is philanthropic or commercial, and those whose aim is to treat illness or prevent diseases. From this approach, all large and small companies, groups of professionals such as doctors, national and international non-governmental organizations, and individual providers outside the public sector constitute the private sector (Mills et. al, 2002). On the other hand the private sector may be defined to include only those agencies that provide health services that operate on a 'for-profit' motive. This approach terms the private sector as private for- profit sector and leaves a separate scope for the non-governmental organizations (NGOs) working in the health sector apart from the public sector (Rana, 2001). The first approach is the most commonly used definition of the private sector. However, the present analysis is based on the second approach which distinguishes private for profit sector as private sector and NGO sector as those health service providers that are funded by national/ international NGOs

The services provided by the private sector in Nepal consists of hospitals, nursing and maternity homes, clinics run by doctors and paramedical workers, diagnostic facilities such as laboratories and radiology units, sales of drugs from pharmacies and unqualified drug sellers, general stores etc. Similarly, health services are provided in Nepal by some NGOs whose main focus is health sector or by others NGOs where health is an aspect of various services provided to the community.

The public sector, the private sector and the NGO sector have been involved in the provision of the health services in Nepal. The purpose of this involvement may be welfare, philanthropic or profit earning, however, this may be defined as a partnership whose final target is health outcomes in the form of reduced morbidity and mortality of the population. Such a partnership may exist in two dimensions: vertical partnership and horizontal partnership. The present state of participation of the public sector, private and the NGO sector in Nepal where all the three sectors are working in a parallel way can be considered as a horizontal partnership while the private or the NGO sector working under government funding and direction can be termed as vertical partnership.

Various instruments such as contracting, franchising, training etc have been suggested as a means in the hands of the government to pursue a range of health objectives. In that regards the efforts to work and utilize the capacity of the private sector to promote health objectives set by the government can be broadly categorized into three kinds: they are harnessing, growing and conversion (Preker,2002). *Harnessing* refers to enhancing or harnessing the contribution of the private sector towards the government's health policy objectives. This policy is considered relatively risk free compared to conversion of the public health facilities into private providers. *Growing,* on the other hand refers to assess

and identify those areas where private sector activities would contribute significantly to priority objectives. Accordingly, policymakers choose a set of instruments to encourage private providers expand or grow those activities in those areas. *Conversion* is a process of converting the public sector activities into private hands. This implies an alteration of the existing service delivery arrangement and is often full of risks where institutional development of the private sector has not been adequate.

4.2 Existing Situation of Public-Private-NGO Partnership in the Provision of Health Services

According to latest data there are 83 hospitals, 10 Health Centres, 700 health posts, 286 Ayurvedic dispensary, 3170 sub-health posts and 180 primary health posts funded and managed by the government of Nepal in 2002 (MOF, 2003).
The total number of Private Hospitals/Nursing Homes operating in Nepal were 104 by 2002 a few of which have closed. Additionally, there were seventeen I/NGOs working under the agreement with HMG/Ministry of Health, Nepal (with Management Information System, MOH). The private sector involvement in the health sector of Nepal has been a long time phenomena particularly in the form of health clinics, drug retail stores, pathological labs etc while provision of health services with inpatient services through nursing homes is somewhat recent that started only in 1985 with two nursing homes the number of which rose to 45 in 1996 (NESAC, 1998).

4.2.1 Contribution of the Private Sector

The contribution of the private sector in the health system could not be expressed in terms of some exact figures or ratios. However, an indirect approach was used for this purpose. Available data indicated that expenditures by the households account for over 76 percent of the total expenditure on health in Nepal. The share of the development partners and international donor is about 14 percent while the expenditure by the government accounts to only 10 percent (NESAC, 1998). Since it is evident that though people obtain medical advices through public institution such as hospitals, health posts etc, the procurements of drugs are made mostly through out of pocket from the drug stores. Available data suggest that 59 percent of the household expenditure on health is spent on accessing private health care outlets and for the procurement of drugs prescribed by such outlets. In addition, available data also indicate 35 percent of the health expenditures of households are made directly through private outlets. If the out of pocket payment by household to purchase drugs prescribed by public health facilities is considered as a proxy, the contribution of the private sector in the provision of health services emerges to be very large.

Table No 1. Percentage Share of Expenditure through Public, Private and I/NGO Outlets

Health/Medical Outlets	Percentage Share of Expenditures
Governmental Outlets	
Hospitals	27.46
Clinics	30.22
Mobile Camps	1.29
Sub-total	58.97
Private Outlets	
Pharmacies	6.67
Home visits	1.48
Other private facilities	26.86
Sub-total	35.01
INGO/NGO Outlets	0.85
Traditional Outlets	5.17

(Source: NESAC, 1998)

4.2.2 Trends (Development) of Private Participation in the Health Sector

Complete data on the distribution of private hospitals in the various development regions were not available though it was found that 75 private hospitals out of 104 private hospitals in the country were located in the Central Development Region. This makes about 72 percent of the total private hospitals in the country. Again, within the central development region, 71 percent were concentrated in Kathmandu, Lalitpur and Bhaktapur (MOH, 2004)). A time series distribution of establishment of private hospitals shows that most of the private hospitals were established during 1995-1998. The trend in the country as a whole shows that 13 private hospitals were established in 1995 and reached its peak to 15 in 1998.

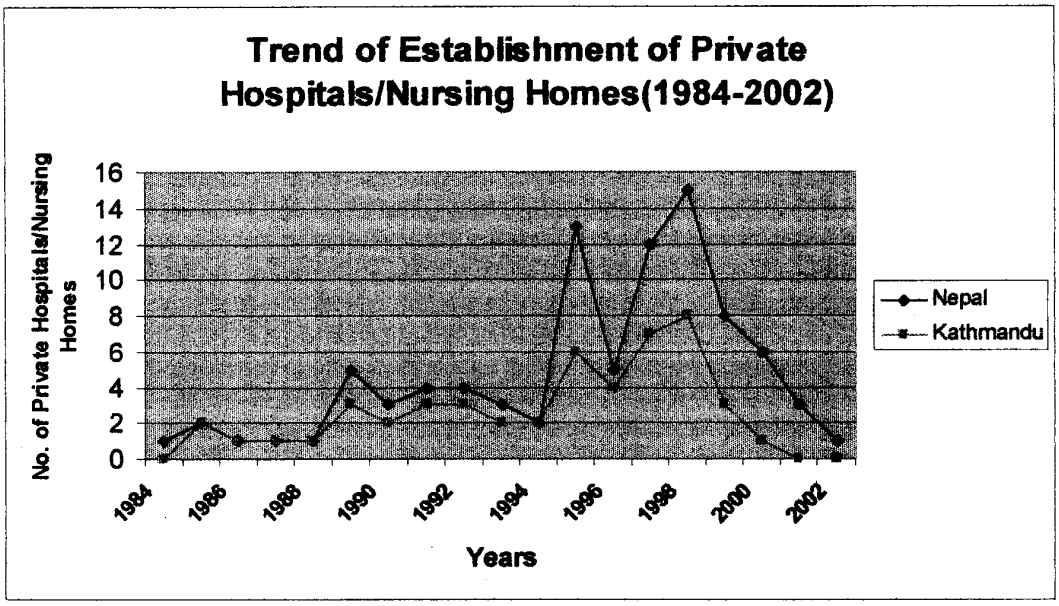

Fig 1 Trend of establishment of private hospitals/nursing homes in Nepal (1984-2002)
Source: MOH, 2003

The Social Welfare Council(SWC) which is responsible for monitoring NGO activities in Nepal has categorized NGOs working in Nepal into ten categories one of which is health related NGOs. According to SWC, the number of health related NGOs which were 8 percent of all NGOs in 1991 fell to 2.2 percent in 2001. However several other NGOs which are not classified as health related NGOs also provide health services. Some INGOs without getting affiliated to the SWC sign MOU with the Ministry of Health of His Majesty's Government (MOH/HMG) directly to work in Nepal. The four United Mission to Nepal (UMN) hospitals which fall under this category provided over 29 percent of all hospital outpatient and 22 percent of all inpatient care in Nepal in 1997/98 (MOH, 2000).

The correlation between the number of private hospitals in the different development regions and the life expectancy at birth of 59.3, 55.7 and 55.4, 51.2 and 51.2 years in the western, central, eastern, far western and mid western regions was found to be 0.222. Though weak, this positive correlation indicates that the role of the private sector in improving life expectancy at birth figures. The conclusion of a study that the contribution of the public sector expenditure in improving the health status is very poor also implies that the private sector has a greater role in improving the health status of the country (Adhikari et. al, 2001).

4.3 An Assessment of the Present Level of Public, Private and NGO Sector Mix

An assessment of the health services provided by the public and the private sector in Kathmandu and Lalitpur of the central development region of Nepal revealed different dimensions of health services in the public and private sector.

4.3.1 Kinds of Service

It was observed that both curative as well as preventive services were provided by public and private hospitals. Curative services were provided against a wide range of diseases while preventive services were provided in the form of immunization against a few diseases such as measles, tuberculosis, tetanus, etc. These services were provided free of cost in the public hospitals while fees were charged in the private hospitals. Some additional immunization such as against hepatitis-B were also administered in the private hospitals.

4.3.2 Distribution of Human Resource and Bed Capacity

The average human resources and physical facilities in the sampled health institutions in Kathmandu and Lalitpur district were high in the public health facilities compared to private health facilities. It was found that there were 135 and 37 doctors on an average in the sampled public and private hospitals respectively. This figure was large for other categories of health personnel too. In terms of the number of beds, the public health facilities had a bed capacity of a range of (289-426) while that of the private sector was in the range of 15- 150 beds. The average bed per doctor was almost 1.5 times higher in the public hospital compared to the private hospitals. The human resources in public facilities outnumber those in the private facilities not only in absolute number but also in terms of time period served as most of the manpower in the public health facilities are full time while those in the private hospitals are mostly part time. The following table shows the distribution pattern of human resources and bed capacity in private and public service in the sampled health facilities.

Table No. 2 Human resource and Bed Capacity in public and private health facilities

S.No.	Description of Services	Public Hospital	Private Hospital
1.	Average number of doctors	135	37
2.	Average number of HA/AHW	18	17
3.	Average number of Staff Nurses/ANM	179	38
4.	Average number of Adm./support staff	408	44
5.	Number of beds	358 (range:289-426)	67 (range 15-150)
6.	Average bed per doctors	2.65	1.81

Source: Field Survey

As public health facilities are very few in number compared to private services providers, the pressure of patients is high in public health facilities due to relatively high prices

charged on patients. This is even true in case of the few central hospitals of Kathmandu where patients referred from all over the country come to receive treatment. This has an important bearing on the quality of services provided from the public sector. On the other hand, approximately four dozen private hospital/nursing homes were registered in Kathmandu /Lalitpur/ Bhaktapur since 1984, with a few of them closed down. These figures ensure an availability of a wide range of alternatives to those seeking health services from private sector. Competition among private sector providers in terms of quality, prices etc have enhanced efforts to raise quality and efficiency. On the other hand, public health facilities that are founded on the concept of equity and distributional justice have a greater patient coverage.

4.3.3 Distribution of patient load

The distribution of the patient load on different manpower category is more important than the absolute number of health personnel in the institutions. The following table reveals that the doctors have an out patient load more than four times in the public health facilities compared to private health facilities. This difference is approximately two and a half times for inpatient services. These differences affect the time taken to examine each patient and the quality of services in the two kinds of service providers. Similar conclusions can be drawn for Health assistants/ Auxiliary health worker, staff nurse/ANM and administrative and support staffs. The ratio is high in public health facility compared to private health facility for health manpower in all categories. Long queues, inadequate care from the health personnel and lack of physical facilities in the public health facilities perceived by the patients are also due to greater workload in the public health facilities. The respective patient loads in the public and private health facilities are shown in the following table.

Table 3: Distribution of average patients load for different manpower categories in the sampled public and private hospitals in Kathmandu Valley.

S.No	Indicators	Public Hospital*		Private Hospital		public/private Ratio	
		Out patient	In-patient	Out patient	In-patient	Out patient	In-patient
1.	Patients per doctor	2246	107	530	42	4.24	2.55
2.	Patients per HA/AHW	18380	782	1168	91	15.74	8.59
3.	Patients per staff nurse/ ANM	1694	81	523	41	3.24	1.98
4.	Patients per adm./support staffs	1487	71	451	35	3.30	2.03

* Includes Patan Hospital which is a NGO managed hospital.
Source: Field Survey

Similarly, due to limited number of beds compared to the patient loads, acquiring inpatient services are quite difficult, except for emergency services, in the public hospitals while this service is easily accessible in the private hospitals

4.3.4 Supply of Manpower

The study revealed that health personnel are employed in public health institutions on a full time basis while they work mostly on a part time basis in private health institutions. A large number of health personnel serve the public and the private sector simultaneously. The health personnel are paid a salary on a monthly basis in the public health facilities where they receive a fixed salary while they are mostly paid on a contractual basis such as the number of patients examined, surgical operations performed, or on an hourly basis for other personnel providing technical services in the private sector institutions. For this reason, the out patient services of health personnel except for emergency services are available only for certain hours of a day within which the patients have to get registered in public health facilities whereas these services are available more flexible in the private health facilities. Many health personnel are available at call too in the private hospitals (from discussion with private health institutions administrations). Because of the rigid type of financial incentives, the public sector hospitals have to compete for efficient doctors with the private sector hospitals due to outright financial incentives provided by private sector to such health personnel.

As the health personnel are paid on the basis of the number of patients served, the obligations to satisfy patients and ensure regular flow of patients falls on the health personnel themselves requiring them to provide adequate time to listen to their problems and provide effective treatment. This has ensure better efficiency aspect in the private sector providers and contributes to the partnership with the government in providing secondary and tertiary health care to the population through the private sector at least in the urban areas.

4.3.5 Cost of Services

Cost of health services in the public sector are generally kept low as the major part of the cost of health services is financed from the revenue collected by the government from the taxpayers. In contrast, the cost of health services in case of the private sector is obtained from the users fee with some extra charges to meet overhead expenses and profits to keep the investors in business. From the demand aspect, households resort to public of private health services on the basis of the ability to pay, their consideration for efficiency and how they value their waiting time in these two kinds of health services. The following ranges of prices were observed in the sampled public and private sector health facilities.

Table No. 4 Range of prices of services in public and private health facilities

S.No.	Price of Services	Public Hospital (Rs)	Private Hospital (Rs)
1.	Registration fee	10-15	0-15
2.	Doctor's fee	No	200-275
3.	General bed	0-160	250-400
4.	Cabins	500-2500	450-3000
5.	Blood routine	40-60	40-100
6.	Blood culture	100-120	110-120
7.	X-ray chest	80-175	165-250
8.	Ultra sound	400-425	500-550

Source: Field Survey

A patients who visits a public hospital may obtain medical advice at a cost of Rs. 15 while a patient who visits a private hospital has to pay at least Rs. 200 for medical advice, except for any pathological tests and drugs for treatment. Similarly, a patients who remains an inpatient in a private hospital has to pay at least Rs. 250-400 per day while a patient who is admitted as an inpatient in a public hospital has to pay a minimum charge in the range of Rs. 0-160, except for pathological tests and drugs.

Availability of the services of health personnel including specialist services of ones choice at the time of convenience, short waiting time etc are the factors that attract patients to the private service providers in spite of relatively high prices of services. In the pursuit of economic rationality, people visiting the private sector outlets in an effort to avert physical discomfort, risk from prolonged sickness and greater opportunity cost of the foregone income during sickness become willing to pay relatively higher prices rather than seek treatment from public facilities that are relatively low cost, if their ability to pay permits.

The public hospitals provided services of health personnel, bed facilities, some medical supplies etc. almost free of cost while the cost of drugs and investigation were borne by the patients. The cost of investigation was generally meant to meet the cost of such services. Public hospitals had provision of paying beds as well as free beds. Poor patients were provided with beds, medical supplies, investigations cost and meals etc free of cost on the basis of recommendation from the VDCs or concerned authorities. The cost of drugs, however, had to be borne by the patients in general.

The private hospitals had no provision of free beds or free health services to the poor. In case of inability to pay full charges, health services were provided at reduced rates or some expenses were waved off on the discretion of the management. This phenomena of price discrimination was observed to be quite common in the private hospitals mostly in cases that incurred large costs such as surgical operations etc. The private hospitals reported that they sometimes organized free health camps in some rural areas

4.4 Analysis of public–private-NGO mix in the context of Nepal

The private and NGO sectors are working parallel to the public sector in Nepal in the form of horizontal partnership towards attainment of improved health status though the immediate objectives of these sectors are diverse. The private and the NGO sector work under the guidelines and regulations set by the government. There were no cases of vertical partnership of the public sector with private and NGO sector institutions in the study area. The public sector institutions have initiated involvement of the private sector in some supplementary activities for instance in case of obtaining services of security personnel, laundry services etc.

The private sector is more concentrated in the urban areas where ability to pay and willingness to pay are generally high. This is evident from the fact that 72 percent of the total private hospitals in the country are concentrated in the central development region and 71 percent of them concentrated in Kathmandu Valley alone. Due to the inherent efficiency of private providers in the supply side and adequate demand for such services created by both ability to pay on the one hand and inefficiency of the public sector on the other, private sector is expanding rapidly (Preker and Harding, 2000). The private sector considered themselves self sufficient in terms of availability of manpower, technology etc. and did not expect cooperation from the public sector in that regards. However, the private sector look for more preferential treatment from the government in terms of tax subsidies on import of medical equipment, prices of utilities such as electricity, water supply etc and provision of financing from banking sector. This expectation on the part of the private sector, however, cannot be justified at least from the trend of expansion. Their mushrooming growth in itself justifies that there is ample return in this sector and there is no need to attract the private sector through extra incentives. In contrast, the partnership between the public and private sector in terms of contribution of the private sector to address the equity aspect of the government through health services to the low income section of the society is quite poor. Some of the private health institutions reported that they provided some kind of medical services to deserving poor based on the assessment by the management of such institutions. However, due to very poor data records in most of the private health institutions, the exact magnitude of such services could not be assessed.

The NGO sectors which are mostly funded by foreign donors/INGOs are working in the provision of health services to the rural population where public sector provision are poor. Several NGOs provide such services in the urban and sub-urban areas of the central region too. Though the NGO sector serves as a partner to address the equity goal of public sector in the health sector, it was observed that it was not mandatory for the NGOs to work in the areas determined by the government. However, whether the poor have really benefited can be an issue for further inquiry. An example of successful public-NGO partnership is Patan Hospital of Lalitpur run under the United Mission to Nepal UMN.

Patan Hospital is basically a NGO run hospital managed by UMN that has been popular for its efficient management. Earlier, it was established as a mission hospital and was

merged with the district hospital of the government in 1982. It is managed by a Board of directors nominated by the Mission and is chaired by a government nominee. The government provides a fund of equivalent to fund allocated to district hospitals. Some fund is raised through payments by the patients while the rest is funded by charity fund provided by UMN. In the year 2003, the government had allocated 1.1 million. The hospital adopts various pricing policy. It charges high prices for patients who are able to afford luxury and charges affordable prices to common patients. The cost of treatment for the poor who are unable to bear the cost of treatment is met through charity fund based on the assessment of economic status of the patient by the hospital administration. The UMN had provided 9.6 million from such fund in 2003(source: Hospital administration).

4.5 Planners and Policy Makers view on public-private-NGO partnership

Public- private partnership in health sector has been conceived from two aspects. One aspect is to view public-private-NGO partnership as a collaboration towards improving the health status of the population where all three kinds of institutions work independently to contribute to a common goal. This is a broader point of view of partnership in which all the parties feel their respective responsibilities and complementarities. Another aspect of public-private-NGO partnership conceives partnership as providing health services jointly and views partnership in the narrow sense of working under one roof. The implication of this later view is that the public sector does not recognize the contribution of the private sector. Further, it holds that the role of the government is limited to regulating the private sector. In fact, public-private-NGO should be view ed from broader perspective and regulation and contribution should go hand in hand. Most of the planners and policy makers were found to perceive public-private-NGO partnership from the later concept and do not accept the present horizontal partnership as a collaboration towards improving the health status of the population. This has created some confusion among planners and policy makers. Obviously, when institutional development are at a low level, implementing public-private-NGO of the second category is obviously difficult, though less important.
Other aspects related to public-private-NGO partnership is the need for conceptual clarity regarding whether health services are public or private goods.

4.6 Discussion

There has been a considerable growth of interest in the activities of the public-private-NGO partnership in health sector in developing countries. This is because there is already an existence of large private and NGO sector in such countries. The public-private-NGO partnership is generally understood to mean a collaboration between the public sector and the private sector where the two sectors collaborate on particular health activities. Public-private-NGO partnership can however, be looked at from a broader sense too. The health outcome of the nation in the form of the health status of the population, life

expectancy at birth for instance, is also an outcome of the combined effort of the public and private sector. We shall discuss these two aspects of partnership separately so that it can assist planners and policy makers in the health sector.

4.6.1 Public-Private-NGO Mix in Nation's Health Outcome and National Economy

The public sector and the private sector are working independently but at the same time they are contributing jointly to improve the health status. Thus, this should also be considered as a public-private mix which is a more important aspect of partnership. This implies that the contribution of the private sector should be recognized appropriately. At the same time, the public sector should recognize its role as a regulator and motivator to the private sector health service providers. These policies technically referred as *harnessing* and *growing* are market friendly approaches to raise the contribution of private sector in health services with least government effort. We can explain the different dimensions of such type of partnership with the help of following points.

- Contribution of the private health sector to the health status
  There are more than a hundred private hospitals/nursing homes operating in different parts of the country providing wide range of health services from general to specialized services. The contribution of this sector can be measure simply by imagining a scenario of what would happen if there were no private sector providers at present. This would greatly overburden the public health services leading to a wide range of consequences. The past decade has witnessed an increase of ten years of life expectancy within the last decade. This is a great achievement and the private sector also has its contribution in this regards.

- Contribution of the private sector to the national economy
  The private sector in the form of private hospitals/nursing homes, private clinics, pharmaceutical companies have contributed significantly to the nation's output in terms of production of goods and services. The private sector is a direct provider of employment to a large number of health and non-health personnel and is indirect provider of employment to other wide range of activities. The availability of these services in the country has reduced not only the outflow of nation's resource in course of treatment abroad but has also generate inflow of foreign currency in some sectors such as eye care in Nepal.
- Changing Government Role
  The roles of the government have shifted from the producer and distributor of goods and services to a motivator and regulator of various economic activities. Accordingly, when more specialized services are provided by the private sector, the government can divert more resources in the provision of primary and essential health care services to the rural population. Because of the very nature of public goods (merit goods), the return of such expenditures are very high in reducing infant, child and maternal mortality and raising life expectancy.
- Regulation of the Private Sector

Due to asymmetry of information in there is likelihood of market failure in the health sector. This calls for regulation from the government to maintain quality. Similarly, there is a need to regulate the private sector to protect consumer's rights.

- Access of the Poor to Private Health Services
  The rich have access to health services not only within but also beyond the boundary of the nation and is not an issue of policy to the government. However, it is the responsibility of the government to increase the access to private health services to the poor. Though the government cannot compel the private sector for health services free of cost, the government should explore for mechanism based on market principle such as price discrimination, that increases the access of the poor in private health services.
- Transparency of Private Health Sector Activity
  The private health sector is a formal sector. This sector has its contribution to the government and the society through its revenue contribution. If the private sector is transparent, the contribution of this sector to the society will be more explicit. This will in turn increase the capacity of the private sector claim more facilities form the public sector.

4.6.2 Public-private-NGO partnership in Provision of Public Health Services

Another aspect of the public-private-NGO partnership is the synergy in improving the quality of public health facilities.

- Weak management of the public sector
  The public sector health sector is often considered to weak in management and there is ample scope to strengthen the management of the public sector. The management skills and experience of the private and the NGO sector are potential area of partnership in that regards.
- Cost effectiveness/efficiency/ equity/government role
  Providing services is not sufficient in a resource scarce world where different ends compete for means to fulfill them. The government has a wide range of responsibilities to a wide range of people. Each dollar saved in expenditure is equal to an extra dollar earned and obviously governments collect revenue by burdening the people with tax payments. Thus the cost of services should be made with the least expense possible. Management and technical collaboration are important areas of collaboration to implement efficiency and cost effectiveness practiced by the private sector into public sector. Another role of government is to ensure equity in access to health services so that equity and efficiency can also go together to some large extent.
- Areas of public-private-NGO partnership mix
  Public-private mix is a difficult practice in the health system when public sector is not adequately developed institutionally. Collaboration between the public and the private sector without adequate preparation can lead to even worse outcomes. However there can be some area for collaboration of the private sector in the public

sector that are characterized with low risks. Some areas of collaboration the public sector has been practicing with the private sector are provision of security services, laundry services, maintaining gardens in the hospitals through contractual agreement with the private sector providers. This has helped to reduce administrative expenses of the public sector in the long run while ensuring efficiency.

Chapter V

Conclusions and Recommendations

5.1 Conclusions

The public, private and the NGO sector has been working in the form of a horizontal partnership whose final goal is improvement in the health status measured in terms of increased life expectancy at birth, reduced infant, child and maternal mortality. This is evident from the fact that more than one third of the health expenses in Nepal are made through private and NGO sector outlets.

There was a rapid growth in the number of private sector hospitals/nursing homes during 1995-1998 due to adequate market incentives and liberal policies of the government. The distribution of private sector is however is largely concentrated in the central DR (72 percent of total) and Kathmandu in particular. The private an NGO sector provide mainly curative service and limited preventive services.

A comparison of the physical facilities and human resource endowment reveals that public hospitals in study area have large bed capacity (range: 289-426) and health personnel in them compared to the private sector hospitals/nursing homes (range: 15-150). However, the patient loads in the public hospitals are also significantly large compared to private sector. The outpatient load per doctor per year was 4.24 times and inpatient load 2.55 times higher in the public sector than in the private sector. Mainly, full time manpower is involved in the public hospitals while the nature of involvement in the private sector is part time. These health personnel serve the public and the private sector simultaneously. The duration of the service provided to patients is rigid in the public hospitals while they are more flexible in the private hospitals with health personnel's service available at call too. Due to outright financial incentives provided to health personnel, the public sector has to compete with the private sector for efficient manpower.

The cost of services are generally kept low in the public hospital as major part of the cost is finance from revenue collected by the government from the tax-payers. For instance, patients who visit a public hospital may obtain medical advice at a cost of Rs. 15 while a patient who visits a private hospital has to pay at least Rs. 200 for medical advice, except for any pathological tests and drugs for treatment. Similarly, a patient who remains an inpatient in a private hospital has to pay at least Rs. 250-400 per day while a patient who is admitted as an inpatient in a public hospital has to pay a minimum charge in the range of Rs. 0-160, except for pathological tests and drugs.

There are provisions of free beds and other services for poor patients while no such services are available in the public hospitals. The private sector also reported cases of reduction in charges (price discrimination) in some instances.

The mushrooming growth of private sector hospitals/nursing homes indicates that there is already enough market incentives and the government need not provide additional incentives. The government needs to give more thought in addressing the equity and efficiency aspects of these private sector service providers. How to induce private sector

towards balanced growth throughout all regions and how to benefit the poor from the existing private sector services deserve policy attention. The NGO sector is providing services in areas that are not served by either the private or the public sector. For instance the four United Mission to Nepal (UMN) hospitals has been providing outpatient and inpatient services to a significant portion of the population. It was however observed that it ha not been mandatory so far for the NGO sector service providers to work in areas determined by the government.

In course of discussion, planners and policy makers accept that the role of the public sector in the provision of health services is changing. There is a need to recognize the two aspect of public-private-NGO partnership: firstly as collaboration for the improvement in the health status of the population; and secondly, collaboration in the health system (working under one roof). Clearly recognizing the role of the private sector and NGOs in the health sector will help the public sector to formulate appropriate policies towards regulating the private and the NGO sector for achievement of both efficiency and equity goals of the society. Thus, responsibilities and regulations need to go hand in hand.

5.2 Recommendations

1. The private sector health services are more concentrated in the urban areas of Kathmandu. Policy incentives should be introduced to encourage their establishment at least in other urban areas of the country to increase access of greater proportion of the population.
2. The existing private sector has no provision to make their health services accessible to the poor. Since free health services are not possible practically from the private sector, efforts should be made for preferential treatment for the poor. The government may involve into some partnership to ensure provisions of health services at reduced prices (price discrimination) to the poor. The place of origin (citizenship of remote districts), referral from district hospitals may be the basis of such price discrimination.
3. The regulation of management norms in the private sector health providers deserves attention. All kinds of record keeping, including the financial record keeping are poor. Appropriate regulation of record keeping would ensure better efficiency and revenue contribution to the government. Similarly, there is a need to organize and regulate the NGO sector into different geographical regions to avoid duplication of works. Regulation should also address towards enhancing financial discipline of the NGO sector.
4. Another productive area of public-private-NGO partnership is management reform of public sector hospitals. The efficiency of the private and the NGO sector can be implanted in the public sector through management and technical collaboration. Appropriate incentive system to the health personnel based on market principles such as greater number of paying clinics, paying wards should be introduced while ensuring greater efficiency.

5. Participation of the private sector in activities such as security, laundry, cleaning etc can be assigned through contracts to the private sector to reduce administrative expenses and long term cost of permanent staffs.

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Appendix

Instrument for Data Collection

Questionnaire for data collection of Health Services Provided by Private Hospitals/ NGO

Name of Institution:……

Date of establishment:……..Address:……

1) General information on Manpower

1.1 No. of staffs:

Technical staff:

a) Doctors. No……

b) Health Asst/AHWs No……

c) Staff nurse/ANM No……

d) Lab technicians No……

e) Radiographer/Dark room assistant No……

f) Support staffs (peon, sweepers etc) No……

g) Others…… No……

Administrative Staffs

a) …… No……

b) …… No……

c) …… No……

1.2 No. of beds available

a) General bed Price rate ……

b)Cabin (categories)

i. Category..... Price rate.....

ii. Category..... Price rate.....

iii. Category..... Price rate.....

1.3 Type of services provided

a)Curative b)Preventive c)both

2. Curative services

2.1 What types of services are available:

a	Service of general physician	minimum price per visit (Rs.).....
b	Services of specialists	minimum price per visit (Rs.).....
c	Surgery	minimum price per visit (Rs.).....
d	ICU, CCU	minimum price per day (Rs.).....
e	Emergency Service	minimum price per visit (Rs.).....
f	Others (mention).....	minimum price per visit (Rs.).....
g	(mention).....	minimum price per visit (Rs.).....
h	(mention).....	minimum price per visit (Rs.).....

2.1.1. For which health service is the institution specialized :.....

2.2 Out-patient services

a. Registration fee Rs.....

b. Price per consultation for out-patient (Rs.).....

2.3 In-patient services

Minimum deposit for inpatients: Rs.....

2.3.1 Types of inpatient services	Price rate (excluding bed and drug charge)
a Bed visit	Price rate.....
b	Price rate.....
c	Price rate.....
d	Price rate.....

2.4 Pathology test and instruments available

2.4.1 Service available

a Blood routine Price rate Rs. .....

b. Blood culture Price rate Rs. .....

b Urine Routine Price rate Rs. .....

c X-ray (chest) Price rate Rs. .....

d Ultra-sound Price rate Rs. .....

e. CT Scan Price rate Rs.....

f. Others

(i) ..... Price rate Rs.....

(ii)..... Price rate Rs.....

(iii)..... Price rate Rs.....

2.5 Major equipments owned by the institution

1 .....

2 .....

3 .....

4 .....

2.6 Number of outdoor patients served

a. During last year.....

b. During last month.....

2.7 Number if in-patients served

(i) During last year.....

(ii) During last month.....

2.8 Are there any special provision for the treatment of the poor?

(a) Yes (b) No

2.8.1 If yes, what are the services

.....

2.8.2 What are the criteria for selection.....

3. Preventive services

3.1 Immunization facilities available against.....

3.2 Health Education facilities .....

3.3 Other facilities.....

4. Are there any plans for the extension of the services? _____. If yes, in what areas?.....

5 Are any services provided by this institution being supported by any I/NGO, Government or other donors?.....

	Facilities	Supported by
a	.....	.....
b	.....	.....
c	.....	.....
d	.....	.....

6. Does this institution provide any kind of support to the government in terms of
   a. Manpower Training .....
   b. Immunization programmes of HMG.....
   c. Conducting free health camps to remote areas.....
   d. Others.....

7. Are there any difficulties being faced to run the institution due to government regulations/policies etc?

.....

.....

.....

8. What other facilities(other than financial support) is expected from the government?

.....

.....

.....

9. What kind of support can this institution provide to the government ?

.....

.....

10 What are the problems being faced by your institution?

.....

.....

.....

11. In your opinion what is the role of the government in improving the quality of the services?

.....

.....

.....

12. Do you have experiences in public-private-NGO mix? If yes mention them.

.....

.....

.....

13. Do you have auditing report in your institution?

(a) Yes (b) No

If yes, please provide those reports.

Instrument for Data Collection

Questionnaire for data collection of Health Services Provided by Public Hospitals

Name of Institution:……

Date of establishment:……..Address:……

1. General information on Manpower

1.1 Number. of staffs:

Technical staff:

a) Doctors. No……

b) Health Asst/AHWs No……

c) Support staffs (peon, sweepers etc) No……

d) Staff nurse/ANM No……

e) Lab technicians No……

f) Radiographer/Dark room assistant No……..

g) Others…… No……..

Administrative Staffs

a) …… No……

b) …… No……

c) …… No……

d)…… No……

1.2 No. of bed available

a) General bed Price rate ……

b)Cabin (categories)

i. Category..... Price rate.....

ii. Category..... Price rate.....

iii. Category..... Price rate.....

1.3 Type of services provided

a)Curative b)Preventive c)both

2. Curative services

What types of services are available:

i	Service of general physician	minimum price per visit (Rs.).....
j	Services of specialists	minimum price per visit (Rs.).....
k	Surgery	minimum price per visit (Rs.).....
l	ICU, CCU	minimum price per day (Rs.).....
m	Emergency Service	minimum price per visit (Rs.).....
n	Others (mention).....	minimum price per visit (Rs.).....
o	(mention).....	minimum price per visit (Rs.).....
p	(mention).....	minimum price per visit (Rs.).....

2.1. For which health service is the institution specialized :.....

2.2 Out-patient services

a. Registration fee Rs.....

b. Price per consultation for out-patient (Rs.).....

2.3 In-patient services

2.3.1 Minimum deposit for inpatients: Rs.....

2.3.1	Types of inpatient services	Price rate (excluding bed and drug charge)
a	Bed visit	Price rate.....
b	.....	Price rate.....
c	.....	Price rate.....
d	.....	Price rate.....

2.4 Pathology test and instruments available

Service available

a Blood routine Price rate Rs. .....

b. Blood culture Price rate Rs. .....

b Urine Routine Price rate Rs. .....

c X-ray (chest) Price rate Rs. .....

d Ultra-sound Price rate Rs. .....

e. CT Scan Price rate Rs.....

f. Others

(i) ..... Price rate Rs.....

(ii)..... Price rate Rs.....

(iii)..... Price rate Rs.....

2.5 Major equipments owned by the institution

a .....

b.....

c.....

d.....

2.6 Coverage:

2.6.1 Number of outdoor patients served

a. During last year.....

b. During last month.....

2.6.2 Number if in-patients served

(i) During last year.....

(ii) During last month.....

2.7 Are there any special provision for the treatment of the poor?.....

2.7.1 If yes, what are the services.....

2.7.2 What are the criteria for selection.....

3. Preventive services

3.1 Immunization facilities available against..... .....

3.2 Health Education facilities .....

3.3 Other facilities (mention).....

4. Are there any plans for the extension of the services? _____. If yes, in what areas?.....

5. Are any services provided by this institution being supported by any I/NGO?.....

	Facilities	Supported by
a	.....	.....
b	.....	.....
c	.....	.....
d	.....	.....

6 What are the areas in which the private sector is involved ?

a. Security services .....

b. .....

c. .....

d. .....

Do you have experiences in public-private-NGO mix? If yes mention them.

.....

.....

.....

.....

.....