

**WHITE PAPER**

**STUDY OF STATUS OF CHARITABLE  
HOSPITALS: REVIEWING OPTIONS  
FOR SUSTAINABLE PARTNERSHIP**

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## **Abbreviations**

ALOS: Average Length of Stay

BPL: Below Poverty Line

CEO: Chief Executive Officer

CMO: Chief Medical Officer

DGHS: Director General of Health Services

IPD: In Patient Department

NGO: Non Governmental Organization

OPD: Out Patient Department

PPP: Public Private Partnership

RNTCP: Revised National Tuberculosis Control Programme

## 0. Abstract

The National Rural Health Mission affirms that 25% of hospitalized Indians fall below poverty line because of hospitalization and related expenses. This clearly reflects that the developmental changes in the health sector have been beneficial to the upper and middle class Indians while the poorer sections remains deprived of comprehensive and good quality healthcare. The stressed governmental infrastructure has been inadequate in providing health care services which has diverted the poor either to non profit/charitable hospitals or for profit health institutions for acquiring secondary and territory level health care.

In lieu of the limitation of the faced by the State, it has encouraged the growth of Charitable/ for profit hospitals, with the principal object of assisting the State in the furtherance of its objective of providing free and subsidized treatments for weaker and deprived sections of the society in exchange of subsidiaries and other benefits to the charitable (private) hospitals. In the last decade, the functioning of charitable hospitals has seen a crucial paradigmatic change and increase in quality and commercial activities with more businesslike attitudes and strategies.

It was presumed that the partnering will address to the need for healthcare among the poorer sections of the community and to some extent address the need for healthcare services. However with changing scenario and advent of a market run economic system and rising competition among health care providers it is essential to view the above process from a new perspective, whereby the needs and interests of both the public and private partner are satisfied. The point of reference needs to be changed from the dimension of obligation of charitable hospitals to a realistic mutual partnership.

Considering private sector ( Profit and not for profit) organizations have significant resources to leverage toward expanding health services in developing countries and bring in the desired changes for the growth of healthcare sector, a new and well-defined understanding needs to be developed between the government and the private / charitable hospitals. In recent times there have been lot of scuffles between the State administration and charitable ( Private) hospitals over the misuse of the concessions and failure of the latter to live up to their commitment of providing free/subsidized treatment to the poor and under privileged population. This document attempts to provide insight into the nature of the original agreement and gives a fresh look at the possible options to enhance the performance of the charitable institutions and contribute thereby, to the welfare of the populace.

The broad objective of the study was to evaluate the status and functioning of charitable hospitals in the three major cities –Mumbai, Delhi and Bangalore. In continuation, the study tries to comment on the scope of a sustainable, feasible, realistic and committed partnership between the government and the charitable/ philanthropic hospitals. The study involves the survey of seven hospitals across India, along with conducting several key informant interviews of government officials, Doctors, Health activists, etc to get a clearer perspective of the concept.

The findings of the study have been indicative of the failure of ‘charitable’ hospitals in fulfilling their commitment of providing free or subsidized care to the deserving population. It was observed that the State not only lacks the infrastructure, manpower but also the political will to monitor and enforce accountability among the ‘charitable’ hospitals. On the other hand, the charitable hospitals are finding it increasingly difficult to sustain “charitable activities”- as defined by the government guidelines. The benefits and exemptions provided by the State are out-dated and need to be reviewed - considering the constant technological innovations in health care – need to be provided by the State. Most of the charitable and private sector hospitals are open to reconsider the understanding from the fresh perspective of “public private partnership”, if due consideration is given to a new, viable and realistic agreement. There is willingness of ‘resource sharing’ by the private/charitable institutions with the state, to improve the range, quality and effectiveness of health care services. The policy review needs to consider viability and provide scope for constant updation and up gradation of services to facilitate a continuous process of improvement of standards of health care. The State should bear in mind that “enforcement” needs to be supplemented with “facilitation” to promote the quality of care for the deserving population.

Involvement of the Judiciary and several committee reports in the context of charitable hospitals have provided significant clarity and direction to the processes involved; however there have been certain issues remain unaddressed. The attempt of the recommendations provided in this document is primarily to build upon the advancements that have already taken place and add value to them.

## 1. Preamble

Charity means the “act of benevolent” giving. The word derived from the old French word “*charite*” has been understood in modern times for helping those in need, an act of sympathy made by the rich to the poor and “unlimited loving kindness to all others”. From these theories have emerged the concepts of charitable organizations, trusts, companies and unincorporated associations, which become the means for individuals with altruistic motives to channelise activities that benefit the poor.

The term "charitable" hospital had its origin around the 19th century when non-profit hospitals were primarily engaged in providing ‘free care for the poor’. Within the early tax law regulations, "charitable" was interpreted in a narrow sense of ‘aid to the poor and suffering’. During independence, the internal disturbances within the country disturbed the socio economic conditions of the country, health care was neglected, as a consequence, preventable diseases also led to deaths. Missionary hospitals with ‘modern’ medical centres both at the rural and urban areas flourished, catering to the health needs of the people along with promoting religion. At the same time, Government at the Central and State level were struggling to make basic healthcare facilities for the public especially the poor accessible<sup>1</sup>.

Indian independence brought along changes in economic, social and political scenario, which gave an opportunity for the growth of the private sector. This coupled with advances in the health sector, promoted the growth of private ‘**for profit**’ hospitals across the country. Most of these hospitals were small with limited set of services; however, with the support provided by the State for initiation of ‘charitable’ hospitals, many saw an opportunity to start larger hospitals with wide range of services and greater scale of operations.

Corporate, the last to enter the health sector, around the mid 80s, mushroomed due to high demand for quality health services coupled with liberalisation of the market and economy. Till the early 1980s economic policies in the country did not allow the growth of ‘corporate hospitals’ with such massive scale of operations, as the government operated and managed major activities across the country, however, with liberalisation of the economic these changes, evidently permitted the growth of Corporate hospitals.

Over the years a number of Charitable Hospitals were established either with genuine commitments or to make the most of the opportunities available in the health sector. These hospitals transformed into super or multi- specialty hospitals providing high quality care with a broad spectrum of services. A number of these private institutions developed into centres of excellence for services like Cardiac care, Pediatric care, etc. The State didn’t directly contribute to the success of these institutions; however, the benefits and concessions provided by the State significantly facilitated the transformation of these ‘charitable’ hospitals. In the current era, with escalating costs of providing quality healthcare services and the limited input contribution made by the State, Charitable hospitals are finding it difficult to meet their commitments. A new dimension of understanding, with constant support from the State, is imperative to ensure the viability and sustainability of the agreements, once developed for the benefit of the general public. It is vital to consider the agreement from the context of partnership more so, as the onus of ensuring success of these ventures lies not just with the charitable institutions but the State as well. It is absolutely essential to considering other options in extension to the existing agreements.

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<sup>1</sup> Shyamprasad.K.M, Health, Education and Development, *POST MODERN CHALLENGES TO CHRISTIAN MISSION, Workshop during the Tranquebar Tercentenary Celebrations, Chennai* (<http://www.nlhmb.in/images/Mission%20and%20the%20Church.doc>, accessed on 17 August, 2007)

## 2. Judiciary Intervention

With escalating costs of providing health services and the growing population, Charitable Hospitals started defaulting in their commitment. The lack of adequate resources coupled with inaction on the part of the State and regulatory authorities, led to a lax monitoring and evaluating system. The poor governance has either lead to a non compliance by the ‘charitable’ hospitals to the terms and lead to providing ‘modified’ form of charity care, where the patients are expected to pay for consumables, Medicines and other commodities. The lax governance encouraged private entrepreneurs, to take advantage of the government’s offer, without ever having to comply with the terms and conditions of the agreement.

In recent times, the State to curb the non compliance took stringent action and pursued the legislative course of action to streamline the process. The intervention of the judiciary considerably changed the modalities of agreement between the State and the charitable hospitals, designed in the early 1980’s, to suit the present context. These modifications were based on the “Dhumal Committee Report” in Mumbai and the “Qureshi Committee Report” in Delhi. These Reports guided the course of action by the judiciary in both the regions and resulted in modifications the in the existing law governing the charitable hospitals in the two cities. The Table I below provides an overview of the difference between the two judgments.

An introspective and analytical look at the judgments, based on the committee report, indicate clearly that providing free/subsidized services, was considered as an obligatory premise for the charitable hospitals. Unfortunately, however, this unilateral approach may not be adequate to address to the issue. The committee reports have tried to safely, abridge the difference, without looking at the understanding from a fresh perspective of “Partnership”. Any effort made by the State to enforce, regulate and dictate terms to the charitable hospitals by the State Administration with either lead to dwindling of the “charitable hospitals” or further enflame the conflict between the two with contributing to the general and deserving population. A renewed consideration of the agreements, will help the State in optimally utilizing the existing infrastructure without over- burdening the charitable hospitals and maintaining the projects viable.

**Table.1. Difference in the Judgments made in Mumbai and Delhi**

Particulars	Mumbai Interim Order	Delhi High Court Judgment
Population to be served	‘Free’ services to be provided to individuals with income below Rs. 25,000 per annum  Concessional treatment provided to individuals with income below Rs. 50,000 per annum	‘ Free’ services provided to individuals with income below Rs 5,000 per month (an interim order, till the final committee provides its inputs)
Benefits to be provided	10% of the beds reserved for ‘Free’ Patients  10% of beds reserved for concessional patients	‘ Free’ Services to be provided to 10% of In patient cases and 25% of Out patient cases
Terms of the benefits	The order States that beds be reserved exclusively for the above mentioned activities and can not be	The order doesn’t make it mandatory to reserve beds however would require to provide the above mentioned specific

	utilised elsewhere	benefits
<b>Definitions of 'free' and 'concessional' treatment</b>	<p>'Free' not to include cost of consumables, medicines and non routine investigations like MRI, CT scan, etc which have to be borne fully by the patient.</p> <p>'Concessional' includes 50% of the bill, calculated based on the lowest class rates</p>	'Free' implies completely free treatment inclusive of medicines, consumables and everything required during the treatment. Patient is not expected to pay anything
<b>Funds to be created and managed by</b>	Indigent patients fund, with 2% of gross billing of the hospital (not including the bills of indigent patient group) to be included and the money to be used only for provided charitable care to the weaker sections of the society. The fund is at the dispersal of the hospital authorities.	'Central corpus/pool' to be created by DGHS. This would be used for the upliftment of health standards of the poorer section of the society in Delhi. However, no guidelines to creating a fund at hospital level
<b>Monitoring and Evaluation</b>	<p>'Monitoring committee', which will evaluate the functioning of each of the hospitals and meet at least once a month. The committee is also authorised to take corrective action against the hospitals that are defaulting.</p> <p>'Officer on Special Duty' be appointed to coordinate the activities between the Charitable Hospitals and government hospitals</p>	<p>'Special committee' to examine the records and make suggestions to subsequent implementation of the scheme. The committee would conclude within 6 months of the date of the order</p> <p>'Inspection Committee' to review the functioning of the Charitable Hospitals.</p>
<b>Referrals</b>	4-5 Charitable Hospitals to be networked with one public hospital	A detailed process of referral cases and its in terms of their treatment
<b>Review authenticity of cases</b>	Medical Social worker, would review records and documents, with a concerns over the fake documents	CMO/ Head of department would verify the genuineness of the case, within 2 days of a referral or it would be reviewed by the ' Special Referral Centres' at all the Charitable Hospitals
<b>Responsibility for monitoring</b>	Charity Commissioner to be responsible for the monitoring and evaluation	Director General of Health Services, Delhi, responsible for the evaluation of the services provided by the Charitable Hospitals

### 3. Rationale of the Study

The State has provided a range of concessions like free/ subsidized land, tax exemptions, subsidized water, electricity, etc are provided to the charitable hospitals under the conditionality that free and subsidized treatment would be provided to the under privileged population. The State now, is insisting that the charitable hospitals oblige by, providing subsidized care, as per the understanding and compensate for non compliance, for several years.

The current study reviews the understanding between State and 'Charitable' hospitals from the perspective of "true" partnership in health care while reviewing & recommending their future role. The study examines either sides in terms of evaluating the concessions provided to the Charitable Hospitals and the performance of the hospital and further, considers a fresh and rational view to the understanding to ensuring benefits to the public.

### 4. Objectives

- ❖ To review the role of private players in Charitable Hospitals in major cities in India
- ❖ To assess the extent to which the policy benefits provided by the government are being utilized by the Charitable Hospitals
- ❖ To assess the performance of Charitable Hospitals vis-à-vis laid down goals
- ❖ To assess the need and lay down the benchmarks for consider the "partnership" from a fresh perspective.

### 5. Limitations

1. The study was not free of limitations of time and resources, which were required to cover hospitals and key informants over a large geographical area.
2. Convenience sampling technique was used in identifying key informants; this might have created some selection bias in the study. However, efforts were made to minimize the bias.
3. The study captured the view points of the people in the health sector (administrators, activists, professors and lecturers), to provide an insight of their understanding of the option of partnership. The study had limited the ideas and inputs with regards to partnerships, due to none involvement of respondents from arenas other than health.
4. In order to safeguard interests of their institutions, most of the surveyed hospitals were not forthcoming with information related to their functioning and utilization of finances for the purpose of 'charity' by the hospitals. Due to the limited information it was difficult to make any comments on the issue directly, but only inferences have been drawn based on supplementary information collected. The study does not reflect the overall experience of the Charitable Hospitals in Bangalore as the team was unable to gather detailed information.
5. Though this study briefly provides an overview of the situation of Charitable Hospitals across the metros in India a follow-up study with a larger sample size and a pan India coverage, might be required for more elaborate and comprehensive information.
6. Most of the recommendations and suggestions provided by the study have been in consistency with the judgments passed on Mumbai and Delhi, with an attempt to define the processes more clearly. As the process of judicial intervention is ongoing, a number of judgments post study, would critically affect the findings and discussions of the study, thereby limiting the applicability of the study over an extended period.

### 6. Materials and Methods

For the purpose of the study, 7 charitable hospitals, with a bed capacity ranging from 100 to 300 were selected from three cities of Mumbai, Delhi and Bangalore. A detailed interview of the administrators/CEO/Trustees of the hospitals was conducted to understand their perspective and concerns over the agreements and guidelines set by the government.

Further a group of 31 elite professionals from healthcare, Government, Legal system and others were interviewed to get an in-depth understanding of the issues pertaining to charitable hospitals across the

country. The comments of the participants have been generalized and inferred based on commonality of the statements.

## 7. Discussion with Findings

The liberalization of the Indian economy and enhanced focus on development coupled with the increasing acceptance of the importance of cooperation and collaboration, has led to growing awareness amongst government and the general public about the potential role of non-profit organizations in development. To facilitate the non-profit sector in realizing its potential it is necessary to create an environment, which is conducive.

The study reflected a positive consensus<sup>2</sup> (93.5%) over the contribution of charitable institutions to enhance the health and the service given to deserving and deprived population. However, many agreed, that the misuse of provisions given to these institutions was equally rampant (87.1%), making it imperative for the State to design transparent and realistic procedures of monitoring and evaluation of the functioning of the charitable institutions. The informants insisted that these accusations made were relatively “accurate” (77.4%) due to the lax monitoring and evaluating system of the government, unplanned and hasty decisions, lack of reviews and separate bodies to govern charitable hospitals, have also made commensurate contributions to the failure of the system.

Institutional surveys<sup>3</sup> indicated that at the conception, charitable hospitals were provided by subsidized and free land (85.7%) along with other additional benefits like subsidized power and water supply. The findings suggested that as of now the support was in terms of subsidized land (57.1%), while additional support for registration and incensing was provided in some cases (14.3%).

On the other hand, the composite data from all the seven hospitals showed that over 4,86,840 OPD cases, 60,789 IPD cases (with average ALOS of 5 days) and 22,227 procedures were conducted free of cost during the year 2005-06). Though financial data, with regards to the charity component was not made available, as per the existing guidelines, hospitals in Mumbai utilized 2% of the gross revenue for charity purposes<sup>4</sup>, which was in addition to free beds, consultation and basic investigation, as per the Mumbai High Court (Interim Order) Guidelines. This as per the Mumbai hospitals resulted in more than 5% of the gross revenue in real terms, if all the costs were to be calculated. Further to this, some hospitals (57.1%) were involved in National health programmes like Pulse Polio, RNTCP, Malaria Programme, along with carrying out their own outreach free camps to benefit the poorer segments of the society.

Most of the charitable hospitals<sup>5</sup> (85.7%) stressed that the provisions provided by the State inadequate and recommended that the charitable hospitals should be supplemented with other benefits like subsidization of power, water, custom duty, etc, which were withdrawn arbitrarily, especially in Mumbai, under the pretext of disciplinary and corrective action by the State. It was insisted that, with exponential rise in cost of providing healthcare, most of the interviewees<sup>6</sup> (87.2%) emphasized on the need to re-assess the terms and conditions of agreement. There was an overwhelming consensus (66.67%) about the need to promote charitable hospitals to support PPP initiative, rather than making additional infrastructural investments afresh in the region.

There was an obvious rift in the way the charitable hospitals and state administrative departments viewed the situation. A lack of trust among the two parties has made it difficult to forge a partnership, though a new partnership agreement is considered as the best solution to achieve universal, comprehensive healthcare service system by most of the informants (71.8%).

Most of the charitable institutions (85.7%) were keen to considering a partnership understanding, provided the State may review the financial viability, increase budgetary allocation for support facilities and accredit

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<sup>2</sup> This is consolidated information from the key informant interviews of 31 participants.

<sup>3</sup> The institutional survey comprised on 7 hospitals in Mumbai(3), Delhi (3) and Bangalore (1)

<sup>4</sup> Of the three hospitals, one with an annual turnover of 39 crores spend 78 Lakhs as charity for the year, while the other two hospitals contributed approximately 25 lakhs annually as charity.

<sup>5</sup> Same as 3

<sup>6</sup> Composite data of institutional interviews and key informant interviews

and standardize the quality of care provided. It was insisted that the agreement needs to be looked at afresh from the perspective of “Partnership”, rather than as an “Obligation” of the charitable hospitals.

In lieu of the lack of physical infrastructure and limited resources the Government has been taking up several initiatives, under the umbrella of public private partnership across the country, to promote the development of infrastructure, improve managerial administration, quality of services, etc. These ventures include outsourcing the management of district hospitals to private/ NGO sectors to improve productivity and quality<sup>7</sup>, giving out Government hospitals, Primary Health Centres and Dispensaries on ROT (Renovate, Operate, Transfer) basis, to private Service Providers<sup>8</sup>, or operating medical college attached to the government hospitals<sup>9</sup>. All these models have been based on rational and realistic financial calculations, to ensure that the projects initiated on PPP module are successful. The success of the venture would further depend on the extent to which the projects meet the requirements of the stakeholders i.e. profitability for the private partner and the extent of subsidy for the BPL population from the perspective of the state.

The context of Trust Hospitals (registered under the Indian Public Trust Act, 1881 or other related act) is though, slightly different. Trust (Charitable) hospitals are not authorized to generate profits from their operations and any excess income needs to be re diverted to the hospital for charitable purposes. However, in their constant endeavor to enhance quality of services and expand the range of services, the financial requirement of charitable hospitals is extensive. On the other hand the contributions made by the State, were one time and limited in quantity, but even with rapidly escalating cost of healthcare the trust hospitals, are expected to continue providing uniform quality of treatment to all patients along with subsidizing BPL category of patients. It is becoming increasingly difficult for the trust hospitals to continue providing the exemptions<sup>10</sup> (85.7%) at per the guidelines set by the State Administration.

Most of the charitable hospitals (71.4%) insisted that it is vital for the State to calculate a precise financial benefit provided to these hospitals and its value when translated in terms of providing free/subsidized care to BPL patients. This will make the government realize the value of contribution made by the charitable hospitals. Charitable institutions also showed willingness to contribute to greater portion of subsidized care if the benefits provided by the State were expanded.

## 8. Recommendations and Conclusion

It is essential to empowering the community; provide adequate infrastructure support and developing a customized information system for a comprehensive and elaborate plan to ensure that health care services are made accessible to all. The state needs to usher a new understanding based on financial analysis of the “cost of health” against the “value of support “. This will give clear ground to validate the claims of the charitable institutions and the State and devise a clear plan of providing subsidized/free service to the deserving population.

The various committees and legal battles have drawn a roadmap towards developing a policy for charitable hospitals, keeping in mind the changes which have taken place in the health care scenario. One of the biggest issues reflected in the study is the inability and the lack of will on the part of the local Administration to reconsider the options available and making efforts to redefine the guidelines set decades

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<sup>7</sup> In Jharkhand, 14 First Referral Units have been given to NGOs/Private Service Providers to manage, repair and operate as per stipulated quality standards, in tribal region. The government is paying for all the recurring cost to the operating partner along with performance incentives.

<sup>8</sup> For up gradation and improvement of infrastructure, the Palanpur District Hospital, Gujarat, is being operated on PPP basis by Wocharkt Group of Hospitals and Guru Nanak Hospital, Mumbai is being operated by Fortis on PPP basis. The private partner earns revenue for provision of services, whilst providing stipulated number of patients (BPL and others) free or subsidized services.

<sup>9</sup> Jhalawar District Hospital, Rajasthan is to be up graded by the private partner, while the attached medical college is to be operated as a private college by the Private partner to earn revenue. State Administration has facilitated the private partner in getting the requisite clearance for the same.

<sup>10</sup> Institutional Survey data from Seven Charitable Hospitals

ago. Though the policy decision of providing referral network through government institutions is an option to be considered, it is worth while for the local administration to consider whether it would be able to ensure efficiency of its staff in the same regards considering the already overloaded public institutions. Even as the interim order of the High court, Mumbai slams the charitable hospitals for their failure to provide charity services to the population, the report also states that it is essential for the local administration and the State to give prime importance to the viability of the partnership, for the charitable hospitals.

Prior to considering a renewed effort for policy development, it is essential to consider the following,

- ❖ Charitable Hospitals incur substantial expenses to implement technological up-gradation, infrastructural renovations, etc and also rising costs of enforcing quality healthcare services<sup>11</sup>. In lieu of this the State Administration needs to consider some form of support to these institutions, for continued provision of subsidized care to the deserving population. The State Administration needs to change from its stand point of “enforcement” to “facilitation” and devise a new understanding, based on financial analysis.
- ❖ The current policy is based on generalized thumb-rule, which unfortunately is not the right strategy. Each charitable hospital needs to be viewed as a separate entity and calculations need to be made accordingly for each.
- ❖ The basic format of Public Private Partnership needs to be taken into consideration. A basic cost of project may be calculated based on the contribution by the State administration and charitable hospital. The value for the contribution made by the State may be accorded, as per current rates and the extent of charity can be calculated based on this contribution. ( This component is only for the contribution made by the State and any direct donations received by the charitable hospital, need to be in addition, as per the laws of Indian Public Trust Act)

The study is conducted with a neutral stand and attempts to identify the loopholes existent in the system and suggest alternative solutions for the same. The analysis is made from the final perspective of the beneficiary and provides recommendations with the sole objective of developing a framework for planning and participative decision making to develop a fool proof system aimed at providing ‘Universal and Comprehensive Health care services’.

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<sup>11</sup> The rise in cost of healthcare can be attributed to rise in pharmaceutical expenses, Expensive new technologies, changing demographic pattern with aging of the population, Increase in consumer demand and expensive healthcare labour