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HEALTHCARE SERVICES IN INDIA A CASE STUDY OF HOSPITALITY MANAGEMENT IN ESCORT GROUP OF HOSPITAL

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INTRODUCTION

The introduction and significance of health care service in India in perspective of urban and rural Indian with government and public private partnership scheme with review work ofprimary health care in India with this concept forms the basis for delivering healthcare in urban and rural. Although the concept has been eagerly promoted, there have been numerous problems that have prevented its progress to the extent, where it is perceived to be working on a suboptimal level especially in poorly performing states. The gravity of ill health faced by developing nations is severe and cannot be ignored. The low levels of investment on health havenot been helpful either. Therefore the measures taken to rectify problems in the primary health system should be promoted, however it has to be examined to see whether such actions are efficacious. Conducting research often follows a standard pattern, where it begins with the research design, then sampling, data collecting, data analysis, the results and finally the conclusions. In present study I had a clear idea of the topic my thesis would concentrate on, but choosing which method was most appropriate to elicit responses from the respondents and to present the research in a suitable format will need to be discussed and the reasons for the choice highlighted.

The present research will assess the effectiveness of the ongoing Healthcare services in **India (A case study of hospitality Management in Escort group of Hospital) to work in ESCOT** and how this fits in the wider concept of health care delivery in India. In theory this policy should have a dual effect of enhancing the doctors‟ prospects and accessing a higher level of healthcare. The question of how I have chosen which method is most appropriate to assess this point will be discussed according to the perspectives I got from the ESCORT doctors. Because of the fact that the doctors‟ in terms of one being a provider and the other potential consumersof healthcare; methods had to be adopted to suit the relevant groups with the exception of some techniques which have common characteristics? In contrast it transpired that most of the questions posed to the Consumer i.e. patient or relative of patient are admit for treatment in ESCOT were based on their experiences with the health system. Matters such as ethics and potential biases will also be discussed to ensure that the research is within the boundaries stipulated under the code of professional ethics.

REVIEW OF PREVIOUS RESEARCH

Historical Review of Health Policy Making -Ravi Duggal - Structured health policy making and

health planning in India is not a post-independence phenomenon. In fact, the most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946. This was the „Health Survey and Development Committee Report" popularly referred to as the Bhore Committee. This Committee prepared a detailed plan of a National Health Service for the country, which would provide a universal coverage to the entire population free of charges through a comprehensive state run salaried health service. Such a well-studied and minutely documented plan has not as yet been prepared in Independent India. The Bhore Committee proposals required implementation of structural changes in the then health care system, and had they been implemented they would have radically altered health care access and health status of the Indian masses, especially the 80 per cent population residingin rural areas. It is only an embarrassment for the Indian nation that more than half a century later there is no evidence of development of health care services to a level that the Bhore Committee regarded as a minimum decent standard. And neither has the health status of the masses altered very significantly – both in terms of the technology and means available as well as in comparison with developed countries today. The gap then and now has not changed much. Health services in India today in terms of accessibility are as inadequate and underdeveloped as they were during the time.

The Bhore Committee. The analysis of the health situation by the Bhore Committee in the early forties would hold good if a similar enquiry were undertaken today, over half a century later. Instead of the National Health Service that the Bhore Committee had envisaged, which would be available to one and all irrespective of their ability to pay, further commodification of health care services took place strengthening the operation of market forces in this sector. The enclave pattern of development of the health sector continues even today - the poor, thevillagers, women and other underprivileged sections of society, in other words the majority, stilldo not have access to affordable basic health care of any credible quality. Universal coverage of the population through some health plan is historically well established today, whether this is through health insurance or state run health services. There is no developed country, whether capitalist or socialist, which has not insured through either of the above means or a combination a minimum standard of health care for its population. In socialist countries the state provides health care, among other „social services", as a basic right of the citizen. In advanced capitalist countries social security has evolved under the concept of a welfare state and health care is one of the prominent elements.

A.L. Mudaliar. The terms of reference of this committee, popularly referred to as the Bhore Committee, were simple: (a) broad survey of the present position in regard to health conditions and health organisation in British India, and (b) recommendations for future development. The letter of appointment of the Committee further stated, "A survey of the whole field of public health and medical relief has not hitherto been attempted. The immediate necessity for initiating such a survey has arisen from the fact that the time has come to make plans for post- war development in the health field (A Post-war Reconstruction Committee, that later grew into the Planning and Development Department was set up in 1943 to make 5 year Plans for India"s development). The Government of India considers that such plans should be based on a comprehensive review of the health problem. One of the difficulties with which the committee

will be confronted is that of finance. Financial considerations clearly cannot be ignored. Plans based on assumption that unlimited funds will be available for recurring expenditure will have little practical value.

The Mudaliar Committee further admitted that basic health facilities had not reached at least half the nation. The primary health care (PHC) programme was not given the importance it should have been given right from the start. There were only 2800 PHCs existing by the end of 1961. Instead of the „irreducible minimum in staff" recommended by the Bhore Committee, most of the PHCs were understaffed, large numbers of them were being run by ANMs or public health nurses in charge.

Public Health Services in India: A Historical Perspective - Ritu Priya -"Each pattern of approach to health care emerges as a logical outcome of a given political, social and economic system. These forces generate an unwritten policy frame which influences the health of a population". Debabar Banerji Throughout known history, human beings have made efforts to explain illnesses and devised methods to deal with them, individually and collectively. Indian society has been no different. So when health service development was undertaken as a focus of planned activity by the state in Independent India, it was to add substantially to the existing systems of health care. The latter had not been able to grow over the years to meet the new challenges posed by the dynamic health situation. The knowledge systems of health care had gone into a decline and were incapable of adapting to the changing social and physical environment as well as the political and cultural context. The health status and morbidity profileand any major determinants in the population have to guide the structure and functioning of any public health system. These will to some extent also reflect the impact of the latter. All these dimensions require that health service development relate to the specific social andepidemiological context, with a necessary responsiveness to change as these parameters change over time.

ESTABLISHING THE FRAMEWORK OF PRIMARY DATA

In my field trips to hospital of ESCOT I had to explore the features of health care in relationship to the ongoing system of recruiting doctors by the ESCOT, with the view of presenting perspectives of providers and consumers of health care. Certainly I do not believe that I am an expert on ascertaining perceptions, nor do I know all about the underlying problems faced in the study area, but I have a strong inclination and hope of becoming a change agent. There is not a single method through which primary data can be collected; primary data is mainly collected by the following four methods, questionnaires, interviews and participant observation and focus groups. Though each of these methods has their own advantages and disadvantages it is appropriate to choose the most effective and appropriate method according to the merits.Perhaps even a mixture of all four techniques could prove helpful in measuring the outcomes.

Questionnaires in the context of human geography are a very important tool in collecting primary data, according to Parfitt (1997) "The questionnaire survey is an indispensable tool when primary data are required about people, their behaviour, attitudes and opinions and their awareness of specific issues". P.76. Questionnaires are good as the response can be easily measured and encoded for further statistical analysis. Closed and open-ended questions both

have their positive and negative aspects but both assume that those being interviewed are literate. However in the context of India, as literacy levels are low and it could prove an ineffective tool. Generally the measure used to check literacy levels in India is the ability of individuals to sign their name as opposed to giving a thumb impression. Hence a certain percentage of individuals classed as literate could still find it difficult to read and answer a questionnaire. Similarly questionnaires would seem to necessitate the arduous task of interviewing each and every respondent personally, as the option of using post and telephone services would be unreliable in rural India (De Vaus 2002). Interviews were the method, whichI was inclined to use, despite problems in measuring the outcomes of unstructured interviews. To avoid this situation I originally intended to interview using semi-structured tape-recorded interviews. Interviews can express all the complexities and contradictions and can be seen as a dialogue rather than an interrogation (Valentine 1997). With the doctors a blend of interviews, questionnaires, overt and covert observation and group discussion helped in gleaning relevant information.

Criteria needed to sample the Consumer (Patent or relative of patient) of ESCOT.

My intention to ascertain the views expressed by the Consumer of ESCOT did not mean that I randomly conducted research with anyone who came from outside. Only be difficult but impossible with the time and resources that I had whilst conducting the research. I needed to focus on a small but relevant reflection of the Consumer of ESCOT to carry out my research. I broadly adopted the following criteria to guide me to the kind of people to target. This was also done to include those who can be perceived to be in greater need of accessing healthcare as opposed to those who can easily access healthcare. This of course can be very subjective as healthcare is free to be accessed by all and everyone has an opinion. However I did not just want to get the opinion of those who rarely took decisions about using the ESCOT e.g. children,frail and elderly, but intended to contact those who generally can make independent decisions. My intentions were also to get the opinion of those people who influenced the decision making process of the family most. There is no set format for finding out such individuals as various factors of the house or by the dominant daughter-in-law. For instance if there is going to be a delivery in the household depending on the seriousness the decision is generally left to the women of the house whether it can be managed in the home or needs to be seen at the PHC and lastly whether they need to go to the urban centers. The only way in which I was able to gauge this was by my personal knowledge of the existing culture.

SELECTING THE STUDY AREA AND THE INTERVIEWEES

This section will concentrate on evaluating the policy of attracting doctors to work and simultaneously the effectiveness of doctors serving in ESCOT. Interestingly an observation I made whilst conducting this field session was to see that most of the positions for doctors in ESCOT were filled. This fact can also be substantiated by the information provided by the official information website of the ESCOT. I decided to conduct interviews with all those doctors working in hospital that have good infrastructure and easy accessibility to scholar. ESCOT with good access to urban centers have only a symbolic importance.

SIGNIFICANCE AND ETHICS OF CONDUCTING RESEARCH

The importance of ethics has been reiterated over the years and has been gaining momentum (Mitchell and Draper 1982). It is now an intrinsic topic to consider before conducting research in almost any field, as guidelines and strict laws have been incorporated to ensure that the study lies within well defined boundaries (Smith1997). In the past research conducted by theNazis in the name of science is now deemed as atrocious, unacceptable, and certainly criminal. Similarly the Tuskegee experiment where African Americans were deliberately denied effectivetreatment for syphilis (Brody, 1998) are just a few examples of why there is an outrage against such research and why we need to consider ethics before conducting any study Most research in human geography will be governed by the precepts of the deontological approach where the participants‟ rights are safeguarded. In contrast some medical sciences like human fertility and embryology may be granted permission under the utilitarian approach. My research is based on the deontological approach, in which all aspects of ethics will need to be given utmost importance. Aspects such as making participants aware about what will happen to information elicited, consequences of participation, confidentiality and finally publishing reports will needto be stated very clearly and mutually accepted with free will. “The goal of geographically masking a geo coded health data set is to reduce the potential for identification of affected individuals to acceptably low levels, while at the same time retaining sufficient geographic detail to permit accurate spatial analyses of the data”. (Zimmerman and Pavlik 2008) p.53. Zimerman and Pavlik show how and why masked and geo coded data helps conceal the identities of the participants yet with the ability not to lose the relevance of the data elicited. In my thesis I broadly differentiate ESCOT but have taken steps never to identify the interviewees neither specifically giving away their precise location, gender, caste and religion. With regards to the doctors and health authorities similar steps have been taken to ensure confidentially. However it must be noted, although guidelines can show a researcher what the boundaries are, that a lot depends on the researcher‟s personal moral reflexiveness and integrity (Molyneux and Geissler 2008). Aspects such as enhanced disclosure followed in western countries are not yet in practice in India hence I did not go through this process but I am aware of its benefits especially accessing vulnerable people.

METHODS USED FOR GAINING ACCESS TO RESPONDENT TO CONDUCT INTERVIEWS

The interviews were conducted over a period of ten weeks using a semi-structured questionnaire having both closed and open-ended questions. However there were various methods used to get into contact with each of these doctors. Initially I made contact with the personal in cabin or at home or in ward visit time. The present study was being done on an independent level with no affiliation with any government agency. However certain doctors required a bit more coaxing and assurance from other colleagues that it was all right to participate in the interview, for example one doctor only began to talk frankly after his colleague accompanied me to the interview and assured him about the confidentiality and independent nature of the study being conducted.

THE OBJECT OF RESEARCH

The scholar main object of this research is

1. To examine and established a new concept in Indian Health Care system by private hospitals / hospital group
2. To make a concept of medical tourism
3. To make suggestion for ESCOT for improvement in Hospitality facility with treatment.
4. To decide the role and importance of private hospital in health care system and medical tourism.

HYPOTHECATION

I had quite a clear concept of my research topic and whom and where to conduct the study but how to adopt the right methodology and give meaningfulness to the data collected were the questions that needed to be answered. There is not a single and stringent format to conduct research in as each method has its advantages and disadvantages. It becomes evident for the reasons I chose one method over the other. Conducting research in my home town had its advantage but I had to take into account potential biases and avoid any predetermined prejudices in order to give a free and fair assessment of the research. I decide a general hypothecation i.e. –

1. There is a satisfactory and bright future of private health industry in India

2. The ESCOT Fortis group hospital has good and adequate hospitality management in hospitals.

CONCLUSION

It will appear to be a daunting task to expect that changes will be enacted once my recommendations are made. Even with a clearer understanding of the views respondents have expressed, it will be highly optimistic to see any radical change. In countries like India to influence change the general pattern followed is normally through the long term strategies of social / religious and political movements that have harnessed the support of the people or made it possible to alter the thought process of individuals and the government. There are rare examples of an individual making vast differences e.g. Gandhi, but usually the previous sentence would hold sway in describing how things work in India.

This negative vein of thought can be applied to those conducting research on health care services with the intention of improving aspects by providing useful suggestions and hoping for better outcomes. Such intention then can be deemed unproductive. It could be suggested that writing about health care system in India, especially exposing the dysfunctional nature of certain aspects of the delivery of healthcare in India, will be critically analyzed and deemed futile with very little prospects of ever finding fruitful results.

Aspects such as corruption, absenteeism, lack of resources and poor management give the view of an unending downward spiral and a virtual incapacity for anything good to emerge from the present system. At present there always appears to be a plethora of problems plaguing the system, which often are interlinked and quite complex. Attempts to resolve a problem occasionally result in others arising or taking the place of the original problem. For example a problem of shortage of drugs was blamed for the poor functioning of hospital; however it transpired later that allegations emerged that these drugs were dumped or burnt but not supplied to the patients (DH 2005).

FUTURE SCOPE

The Bhora Committee report in 1946 is what has provided the basis of health service development in Independent India. It outlined the blueprint of a long term and short term plan for a health service delivery structure based on the principles of -

(i) equal access irrespective of the ability to pay,

(ii) rural areas to be the focus of services,

(iii) provision of comprehensive preventive and curative services, and

(iv) That co-operation of the people is sought by the service system which should be led by „the most highly trained type of doctor". This involved the setting up of medical colleges and „at least a few high quality advanced institutions" for research and training of health personnel. While these would be located in major urban areas, a three-tier health care delivery structure would serve each district, from the secondary level district hospital to the primary health centers and sub-centers at village level. In addition, major public health problems requiring urgent attention were to be controlled through special vertical programmes. The fields of above point are still untouched in public or private health service sector and its importance.

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