

## The not-for-profit sector in medical care

**I**N INDIA, HEALTH SERVICES ARE PROVIDED BY THE PUBLIC AND PRIVATE SECTORS. The public sector provides health services through the Central and State Governments, municipal corporations and other local bodies. The private health sector consists of the 'not-for-profit' and the 'for-profit' organizations. Individual practitioners from various systems of medicine provide the bulk of medical care in the for-profit health sector. The not-for-profit sector is heterogeneous, with varying objectives, sizes and the areas they cater to. Their activities could be multifunctional and include welfare programmes such as health, education, nutrition, family planning, water supply and housing, agriculture-related development programmes, livelihood programmes, etc.

The objective of this paper is to understand the nature and character of not-for-profit organizations in the delivery of curative health services in India. It seeks to gain insights into the spread of this sector within the country in the field of providing medical care, utilization of services, funding patterns and costs of care for the not-for-profit sector. In doing so, it seeks to define the role of these organizations in delivering curative health services and the way they can intervene to positively impact the health of the people.

### Defining 'not-for-profit'

The not-for-profit sector is generally said to comprise non-governmental organizations (NGOs), the third sector, and the voluntary or charitable sector. There is no clear definition as to what precisely constitutes a not-for-profit organization. However, it is important for the purpose of setting internal government policy that at least within a country a workable definition is adhered to.

In India, one of the criteria for a not-for-profit organization/NGO given in the Seventh Plan document is that the organization should have a legal entity. The Planning Commission considers societies, associations, trusts or companies registered under the Societies Registration Act, 1860; Indian Trust Act, 1882; the Charitable and Religious Trusts Act, 1920 or Section 25 of the Companies Act, 1956 as NGOs (Planning Commission 2002). Religious trusts and missionaries are usually governed by the Charitable and Religious Trusts Act, 1920. 'Charitable purpose' includes relief for the poor, education, medical relief and the advancement of any other object of general public utility but does not include a purpose that relates exclusively to religious teaching or worship. The Societies Registration Act, 1860 defines society as any seven or more persons associated for any literary, scientific or charitable purpose. Both trusts and societies are exempted from income tax. At present, almost every State has adapted its own Societies Act and Charitable Trust Act. For example, Maharashtra registers not-for-profit medical care providers under the Bombay Public Trust Act, 1950. Some States have retained the original Act. Public Trusts are constituted for the benefit of the public at large but the author of a Public Trust may restrict the benefit to a particular group or section of society, on the basis of caste, class, creed, sex, age, etc.

Ideologically, the development potential of the not-for-profit sector originates from the currently dominant neo-liberal perception that State organizations are inefficient. It is commonly argued that non-profit organizations constitute the 'third sector' located between the State and the market. Organizations grouped in the third sector are bound by an appeal to voluntarism. According to the proponents of the 'third sector', the organizations in this sector share distinct characteristics: they possess an internal organizational structure, they are structurally separate from the Government,

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and they do not generate profits that are distributed to members (Robinson and White 1997). During the 1980s, this sector grew worldwide in terms of size, scope, number and volume. The term NGO, which began to be used during this period, includes a kaleidoscopic collection of organizations differing in size, form, orientation, resources, target groups and ideological affinity (Valhans 1990).

## Methodology

Since there are no comprehensive documentation and databases to assess the spread of all the non-governmental bodies working on issues relating to health, the focus of this paper has been narrowed down to those not-for-profit organizations that are providing medical care. The data for the present paper have been compiled from various sources. A questionnaire survey through mail was undertaken for the present study to get a brief overview of the nature of the not-for-profit sector in health care. The objective of the survey was to gather insight into the nature and presence of not-for-profit organizations providing curative services. The questionnaire was brief and responses were sought on the location of the organization, number of beds, number of inpatients and outpatients, nature of funding, dispensing of drugs and presence of medical personnel (doctors, nurses, paramedics). The sampling was purposive as there was no comprehensive database available of not-for-profit organizations providing curative services. The questionnaires were sent to organizations whose addresses were available. The Voluntary Health Association of India (VHAI) is one of the major national networks of more than 4000 NGOs spread across the country. It is an association of voluntary agencies working in the area of health and development. Questionnaires were sent to the 27 State Voluntary Health Associations and they were requested to provide names of the organizations in their network that provide medical care. Other than these, many organizations were directly contacted (community-based NGOs/faith-based NGOs) and questionnaires sent to them and also to those organizations/individuals who could give us any further leads in the form of names of not-for-profit health providers. In all, 173 letters were sent and 86 institutions providing services at the primary, secondary and tertiary levels responded to the questionnaire.

Various Christian groups (Catholic Health Association of India, Catholic Bishops Conference of India and Christian Medical Association of India) were contacted as they form the largest network of health services in the not-for-profit sector. Secondary sources such as articles, books and various websites were accessed to gain more data on the spread of this sector in health care. An eight-district survey to map all health facilities/providers was conducted as part of the larger study. The eight-district health facility survey was conducted for the National Commission on Macroeconomics and Health. The survey mapped the entire universe of health facilities available in each of the districts. The districts were Jalna in Maharashtra, Kozhikode in Kerala, Khammam in Andhra Pradesh, Ujjain in Madhya Pradesh, Vaishali in Bihar, Nadia in West

Bengal, Varanasi in Uttar Pradesh and Udaipur in Rajasthan. Data were obtained on the not-for-profit sector in these districts. Data on the spread of not-for-profit health care services in the unorganized sector have been obtained from the 57th Round of the National Sample Survey (NSS). Data from all the above sources have been consolidated in this report and are attached as Annexure 1. For the utilization of medical services and expenditure patterns in charitable institutions, the NSS data for the 42nd and 52nd round were studied. Data on foreign funding of the not-for-profit sector were available from the Foreign Contribution Regulatory Act (FCRA) handbook.

## Limitations of the study

The exact number of health institutions in the not-for-profit sector in India could not be consolidated through the questionnaire survey due to difficulty in collating data by contacting all organizations within a short period of time. Many organizations did not respond to the questionnaire in spite of several reminders. Since the sampling for the survey was purposive, more responses were received from some States such as Madhya Pradesh, Karnataka and Gujarat. Several faith-based organizations were directly contacted and therefore, more responses were received from them. Some organizations gave the names of institutions providing medical care but no details. Due to lack of time, the questionnaire could not be sent to all these institutions to obtain further details about their institutions. However, they have been integrated into the table on the spread of the not-for-profit sector as providers. The results from various sources reiterate the fact that a more comprehensive documentation of this sector is essential.

## Role of the not-for-profit sector in India

In India, the role, activities and functions of the third sector, which originated outside the State structure, were previously performed by local governments and local voluntary efforts. The efforts and initiatives towards welfare and developmental activities came into prominence during the colonial period. The agents of these activities were called voluntary organizations.

Until the mid-1960s, the not-for-profit health sector was hospital-based but later expanded to include community health in developmental projects. Financial issues needed to be considered; setting up institutions for medical care meant involvement of large amounts of funds and subsequently, the question of their sustainability. A number of NGOs, therefore, took up health education as part of their community programmes. Often, health was used by NGOs as the entry point to communities. Many professionals moved towards the NGO sector in response to the growing disillusionment with the public sector. The characteristics of an NGO also underwent a change when these professionals entered the field. The projects now called for more involvement from the community and aimed at making them more self-reliant than adopting a paternalistic attitude as in charity (Sundar 1994). Structural adjustment policies also resulted in restructuring the

provision of health services, resulting in support of the private for-profit and not-for-profit sectors (Baru 1998). The efforts of the not-for-profit sector in health care today covers a wide range of activities and can be classified broadly into: advocacy, awareness and education, research, and actual provisioning of services. Several NGOs in India work on varied issues such as livelihood and poverty alleviation, women's empowerment, health awareness and education, improving water supply and sanitation, etc. other than those providing medical care. These wider developmental issues addressed through social mobilization, a more holistic approach to improving the health status of the population, are known to impact individual, family and community health.

### Response of the State to the role of voluntary organizations/NGOs in health care

The State has attempted to define the role of voluntary organizations/NGOs through the Five-Year Plans, national health policies and international commitments. After Independence, the Five-Year Plans were started to prioritize and allocate resources to developmental programmes. In the first two Plans, the emphasis was on the role of the State to provide welfare services. In addition, the Five-Year Plans have constantly recognized the role of the voluntary sector. The First Five-Year Plan stated that private efforts should be utilized for the promotion of social welfare. Voluntary organizations were recognized for their contribution to the tuberculosis and leprosy programmes from the First Plan itself. From the 1960s, the Government offered subsidies and grants-in-aid to various NGOs to assist the State in National Health Programmes such as the tuberculosis, leprosy and family planning programmes. From the Fifth Plan onwards, the Government encouraged NGOs to take over some health programmes. There were a number of initiatives at the governmental level to establish consultative groups of voluntary agencies in each State from the Sixth Plan onwards but they were not very successful. In the Seventh Plan, NGOs were given the freedom to plan their own schemes and follow the methodology they thought best to tackle social and economic problems. Individuals and NGOs working on rural development activities were appointed members of the governing body of the Council for the Advancement of People's Action and Rural Technology (CAPART). The Seventh Plan assigned an important role to voluntary agencies and sought their active participation in realizing the goals and objectives of the Plan, especially in the field of community participation and in the delivery of health services, as stated in the Indian Council for Social Science Research (ICSSR)/Indian Council of Medical Research (ICMR) report on Health for All (ICMR/ICSSR 1980). In the Eighth Five-Year Plan, it was proposed that grants-in-aid would be given to the NGO sector for experimental schemes. They were expected to help raise awareness of the small family norm, provide antenatal and postnatal care, etc. In the Ninth Plan, the Government, recognizing that NGOs were complementary in nature, handed over a number of primary health centres to NGOs. Each plan channelled a greater amount to NGOs for developmen-

tal programmes. The objective was to incorporate various elements of the approaches that NGOs adopted in government programmes and to utilize NGO efforts to implement government programmes. In the field of health care, the Government has used NGOs to train functionaries and has also given them the responsibility of delivering health services in their area. In the latter part of the 1980s, there was emphasis on NGOs playing a greater role, especially in delivering the national health programmes of leprosy, tuberculosis, blindness control, reproductive and child health (RCH) and later HIV/AIDS.

India was a signatory to the Alma Ata Declaration on Primary Health Care. The NGO report presented at Alma Ata in 1978 defined the role of the third sector more clearly and indicated that NGOs could:

- Provide assistance to develop and/or strengthen local NGO capabilities and activities with particular attention to local community development groups
- Conduct reviews and assessment of existing health and developmental programmes and assist communities in the exercise of their own role in such reviews
- Place primary health care in the context of comprehensive human development
- Ensure that their existing programmes and new initiatives promoted full participation by individuals and communities in the planning, implementation and control of these programmes
- Expand training efforts as in training of health workers, supervisors, administrators, planners and other development workers
- Extend their efforts to develop locally sustainable and appropriate health technologies, and the use of resources with particular attention to energy, water, sanitation and medical care.

Among the two National Health Policy (NHP) reports, the NHP of 1982 stated that: 'with a view to reducing government expenditure and fully utilising untapped resources, planned programmes may be devised, related to local requirements and potentials, to encourage the establishment of practice by non-governmental agencies establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the health field' (Government of India [GOI] 1983). The NHP of 2002 suggests policy instruments for the implementation of public health programmes through individuals and institutions of civil society. The State will encourage the handing over of public health service outlets at any level for management by NGOs and other institutions of civil society. The Policy highlights the expected roles of different participating groups in the health sector. Further, it recognizes that, despite all that may be guaranteed by the Central Government for assisting public health programmes, public health services would actually need to be delivered by the State administration, NGOs and other institutions of civil society. The attainment of improved health levels would be significantly dependent on population stabilization, as also on complementary efforts from other areas of the social sectors—such as improved drinking water supply, basic sanitation, minimum nutrition, etc.—to minimize health risks for the population (GOI 2002).

## Spread of not-for profit organizations in providing curative services

Not-for-profit organizations that are presently delivering curative services range from faith-based to community-based organizations working at the primary and secondary levels, and also a few at the tertiary level. In addition, big business groups have also established hospitals as trusts or societies, which qualify them for tax exemptions. Due to the heterogeneity and plurality of providers, the nature of services also varies across the providers in the not-for-profit sector; within this wide spectrum we have community-based organizations in rural areas that provide health services at the primary level. At the other end of the spectrum we have trust hospitals located mostly in urban centres providing secondary or tertiary care. The dominant system of medicine in most not-for-profit hospitals is allopathic. General health services are provided by almost all the institutions but very few provide only specialized and superspecialized services such as cardiology and neurology. From the 86 responses received through the questionnaire survey, 30% were dispensaries and health centres, and the rest were hospitals; 84% of the organizations provide general health services, 54% maternal health services and almost 30% paediatric services. Other special-

ized services include ENT, urology and dental, to very specialized services at the tertiary level such as cardiac surgery and neurosurgery. Of the institutions, 6% provided only specialized services at the tertiary level. Almost 50% of the institutions provide more than three services. Therefore, we conclude that multispecialty services are provided by several of these institutions. Many charitable institutions venture into providing specialized services for communicable diseases at the primary level. For example, in the Catholic network, there are 165 institutions providing services only for leprosy and 62 institutions for HIV/AIDS and TB, other than their hospitals and dispensaries. They also provide curative and rehabilitative services through 188 facilities for the disabled and 416 health institutions for the aged.

Various studies show that most not-for-profit health institutions are located in semi-urban/urban areas. Most of these organizations establish themselves in places where infrastructure is already present (Jesani et al. 1986; Baru 1993 and 1996). The questionnaire survey showed that 43% of the institutions were in rural areas, and the remaining in semi-urban and urban areas.

According to a study, the percentage of villages with any kind of NGO presence ranges from 1.4% in Uttar Pradesh to 34.4% in Maharashtra. For India as a whole, it is estimated that 10.6% of the villages have the presence of some type of NGO (Mahal et al. 2000) (Table 1).

According to another estimate by the Independent Commission on Health in India (VHAI 1997), more than 7000 NGOs are working in the field of health care.

The only official source that exists on the total number of hospitals and beds in the not-for-profit sector is the data from the Directory of Hospitals, published last in 1988. The num-

### Box 1

Faith-based organizations include missionary organizations that have a large network of health facilities (hospitals and dispensaries). The two biggest networks are the Catholic Health Association of India and the Christian Medical Association of India. Two smaller networks are the Emmanuel Hospital Association and the Seventh Day Adventist Hospitals. Other faith-based trusts have also emerged as health care providers at the primary, secondary and tertiary levels. The main providers of this kind include the Ramakrishna Math and Mission, Mata Amritanandamayi Trust, Sathya Sai Central Trust, Sri Chaitanya Trust, Swaminarayan Sanstha, the Aga Khan Health Service network, Chinmaya Mission, etc. Several faith-based charitable hospitals were also established after Independence by local philanthropists.

Several community-based NGOs provide services at the primary level. Due to their immense contribution and commitment to serve rural communities, some have gained credibility and recognition, and have been given the responsibility of running primary health centres so as to ensure better functioning. Examples are the Karuna Trust in Karnataka, SEWA-Rural in Gujarat, King Edward Memorial Hospital (KEM), Pune districts; Rural Unit for Health and Social Affairs (RUHSA), Kilvayattanan Kuppam Block in Tamil Nadu, Voluntary Health Services (VHS) in Tamil Nadu and the Kasturba Hospital in Sewagram, Maharashtra. Health services are integrated into preventive, promotive and curative services, and are just one aspect of their developmental and outreach activities. The most vital health personnel in these projects are the community health workers, and the delivery system follows a proper system of referral. These organizations cater to the rural and poor populations, and make health services accessible to them.

**Table 1**

### Percentage of villages with non-governmental organizations (NGOs)

State	Villages with NGOs (%)
Andhra Pradesh	21.2
Bihar	2.6
Gujarat	9.1
Haryana	7.8
Himachal Pradesh	6.4
Karnataka	11.1
Kerala	8.0
Maharashtra	34.4
Madhya Pradesh	8.8
Orissa	9.7
Punjab	12.9
Rajasthan	4.7
Tamil Nadu	14.5
Uttar Pradesh	1.4
West Bengal	6.4
Aggregate	10.6

Source: Mahal et al. 2000

ber of hospitals in this sector was estimated to be 937 (10% of all hospitals) and the total number of beds 74,498, comprising 13% of all beds in India (GOI 1988). It showed that 17% of all the private hospitals were not-for-profit and 42% of all the private beds were in this sector (Table 2).

Data available for the present study (the questionnaire survey on not-for-profit organizations alongside other existing data sources on the not-for-profit sector) show that 11% of all hospitals and dispensaries, and 18% of all beds are in the not-for-profit sector (Table 2). They also show that 17% of all private hospitals and dispensaries are not-for-profit and 47% of all private beds are in this sector. This corroborates the data for 1987. The more developed States of Kerala, Tamil Nadu, Karnataka, Maharashtra, Andhra Pradesh and Gujarat account for 50% of such institutions with 64% of beds of a total of 132,907 beds (Annexure 1). Christian missionary organizations lead in providing health services. States with a larger number of these organizations are Tamil Nadu and Kerala, and account for almost 30% of the total institutions; 42% of the beds in this network are in Kerala alone.

The eight-district facility survey conducted in 2004 shows that just 3% of all private providers (including sole proprietorships, corporate, partnerships and trusts) in these districts were not-for-profit (Annexure 1); 45% of these not-for-profit organizations were established between 1995 and 2004.

The data on economic and operational characteristics of unorganized enterprises in the service sector besides consumer expenditure, and employment and unemployment, collected by the NSS were also analysed. It took into account own-account enterprises (OAEs) and establishments and provided a differentiation between those that are for-profit and those that are not-for-profit. An own-account enterprise is an undertaking run by household labour, usually without any hired worker employed on a 'fairly regular basis'. The data show that there are 17,233 health providers in the not-for-profit unorganized sector (comprising only 1.32% of all health providers in the unorganized sector). They further show that only 3% of all health establishments in the unorganized sector are not-for-profit. State-wise data show that there is a concentration of these not-for-profit providers in West Bengal, Maharashtra, Assam, Punjab, Uttar Pradesh, Uttaranchal and Tamil Nadu (Annexure 1).

## Utilization of the not-for-profit sector in medical care

It is important to ascertain what constitutes the definition of a 'charitable institution' by the NSSO. However, due to the absence of a definition in any of the NSS reports it was difficult to reach any definite conclusion. The perception of a charitable institution is one that provides free care or provides care at an extremely nominal rate. But if, by definition, we say that it includes all those institutions that are registered as charitable trusts, then it would include a wide range of hospitals that may otherwise be perceived as for-profit private hospitals. Hence the data on utilization rates might be an underestimate. Some data from the 42nd and 52nd round of the NSSO on the utilization of health services in charitable institutions elicits the following:

Both the 42nd and 52nd rounds of the NSSO showed low utilization of charitable institutions for outpatient care (Table 3). This might be because the spread of charitable institutions, especially in rural areas, is negligible compared to the availability of private doctors. For outpatient care in rural areas, most people access a private practitioner. For the lowest income group, the primary health centre (PHC) is the next frequently accessed source of treatment after private providers. For outpatient services, the private doctor seems most accessible even in urban areas (NSSO 1998).

For inpatient care (Table 3), the 52nd round of NSS shows that there is an increase in the utilization of charitable institutions in rural and urban areas; but this does not mean that free care has increased. Only 2.8% of the rural population receive free inpatient care in the private sector (one assumes that this is due to some cross subsidization in the not-for-profit sector). For inpatient care in urban areas, only 3.5% receive free care in the private sector. For every 1000 inpatients treated in charitable institutions in urban and rural areas, more patients are from the higher income groups. Most of the poor seem to access public facilities when it comes to hospitalization (NSSO 1998).

## Financing of not-for-profit organizations

Not-for-profit organizations draw on a wide variety of sources for finance. These include donations, government funding

**Table 2**

### Share and growth of voluntary and not-for-profit hospitals and beds

	1987				2004			
	Hospitals	(%)	Beds	(%)	Hospitals and dispensaries	(%)	Beds	(%)
Government and local	4180	43	395,062	69	14160	37	4,36,208	61
Voluntary/not-for-profit	935	10	74,498	13	3979	11	1,32,907	18
Private	4488	47	1,04,018	18	19419	52	1,47,093	21
Total	9603	100	5,73,578	100	37928	100	7,16,208	100

Source: Directory of Hospitals in India, 1988, Misra et al. 2003  
Data for 2004: Survey data, data from missionary organizations; secondary sources: CBHI, GOI 2002

**Table 3****Percentage distribution for outpatient/inpatient care by source of treatment**

Source of treatment	Outpatient (%)				Inpatient (%)			
	Rural		Urban		Rural		Urban	
	1986-87	1995-96	1986-87	1995-96	1986-87	1995-96	1986-87	1995-96
Share of the public sector	25.6	19	27.2	19	59.7	45.2	60.3	43.1
Private hospitals	15.2	12	16.2	16	32	41.9	29.6	41
Nursing homes	0.8	3.0	1.2	2.0	4.9	8.0	7.0	11.1
Charitable institutions	0.4	0.0	0.8	1.0	1.7	4.0	1.9	4.2
Private doctors	53.0	55.0	51.8	55.0	-	-	-	-
Others	5.2	10.0	2.9	7.0	1.7	0.8	1.2	0.6
Share of the private sector	74.5	80.0	72.9	81.0	40.3	54.7	39.7	56.9
Total	100.1	99	100	100	100	99.9	100	100

Source: Sen et al. 2002.

as grants-in-aid, funding from foreign donors, corporate funding, and user fees. Only 65 of the 86 institutions that filled the questionnaire in the survey responded to the query on the source of income. Most of the organizations have more than one source of funding; 17 organizations get some funds from the Government, 21 receive foreign charity, 29 receive private donations and 44 stated user fees as a major source. Along with private and foreign donations, most hospitals charge user fees.

**Foreign funding**

Patterns of foreign funding have shifted. During the 1970s, the single largest funding for health came directly from the US Government constituting 57% of the entire funds, followed by UNICEF with 15.6%, the World Bank with 10.7% and the WHO with 6.3%. The European bilateral government funded 3.2% and American foundations 1.9%. These funds were channelled through the Government for a variety of disease control programmes and family planning. A few of the active bilateral agencies were United States Agency for International Development (USAID), Danish International Development Agency (DANIDA), Swedish International Development Agency (SIDA) and Norwegian Agency for Development Cooperation (NORAD). During the 1990s, there was an increase in funds from multilateral agencies and a decrease in funds from bilateral agencies. In fact, with the World Bank's growing presence, bilateral agencies have become secondary sources and have linked their funds to the Bank's programmes (Baru 1998).

Private individuals, business organizations and NGOs can receive funds under the Foreign Contribution Regulation Act (FCRA), 1976. Every dollar that comes into India as a grant does not automatically become foreign. There are numerous exceptions to this—the FCRA does not include aid received from the UN organizations and the World Bank. However, it is one of the formal sources that gives an estimate of the kinds of funds that flow through it. Foreign funds for the year 2001–02 through the FCRA were Rs 4872 crore, of which

Rs 542 crore (11.1%) was for the purpose of health and family welfare. FCRA data also show that the States of Delhi, Tamil Nadu, Andhra Pradesh, Karnataka, Kerala and Maharashtra received 74% of the total funds for the year 1999–2000 (Table 4). Of the 13,983 NGOs that received funds, 60% were located in these States. Among the top donors, the majority were Christian or Church-based organizations. The US, Germany and the UK were the largest fund givers (Account Aid 2002).

**Table 4****State-wise distribution of foreign contribution (1999-2000) (Rupees in crore)**

State	1999-2000 (Rs in crore)	Number of organizations receiving foreign funds
Andhra Pradesh	536.99	1616
Assam	24.35	163
Bihar	104.75	723
Delhi	636.11	735
Gujarat	126.95	551
Himachal Pradesh	68.20	77
Jammu and Kashmir	13.64	34
Karnataka	411.34	1154
Kerala	361.70	1483
Madhya Pradesh	84.57	432
Maharashtra	350.23	1198
Orissa	111.65	714
Punjab	35.22	70
Rajasthan	37.26	220
Tamil Nadu	572.51	2143
Uttar Pradesh	128.10	802
West Bengal	233.99	1212
Others*	87.08	656
Total	3924.64	13983

Source: Accountable handbook: FCRA, 2002

\* Includes north-eastern States and other Union Territories

## Role of not-for profit organizations in National Health Programmes

### Grants-in-aid released by the Central Government

The Central Government releases grants-in-aid to NGOs across the States for national programmes-tuberculosis, Reproductive and Child Health (RCH) Programme, leprosy, blindness and HIV/AIDS. Under the National Blindness Control Programme, approximately Rs 22 crore was dispersed to NGOs for 2001-02. Under RCH, Rs 18 crore was released for the year 2003-04. Comparatively, grants to NGOs for the Leprosy Programme and Revised National Tuberculosis Control Programme (RNTCP) were low at Rs 1 crore and Rs 61 lakh, respectively (Table 5). Some funds from foreign funding agencies are also channelled through the Government. For example, for HIV/AIDS, 40% of the funds allotted under the National AIDS Control Programme were from bilateral agencies (NACO 2004).

**Table 5**

### State-wise grants-in-aid to NGOs under the National Health Programmes (Rs in lakh)

	Leprosy (2002-03)	RNTCP (grants and honorarium) (2001-02)	Blindness Control (2001-02)	RCH (2003-04)
<b>Well-performing States</b>				
Kerala	9.25	3.57	59.03	104.34
Tamil Nadu	-	2.5	617.81	55.38
Andhra Pradesh	14.6	3.73	379.4	135.52
Maharashtra	10.96	7.75	58.53	145.95
Karnataka	4.09	3.39	148.57	30
<b>Moderate-performing States</b>				
Gujarat	-	10.49	50.88	23.64
West Bengal	28.13	18.8	85.57	159.84
Punjab	-	21.94	-	13
Haryana	-	0.57	20.41	47.3
<b>Poor-performing States</b>				
Rajasthan	-	1.8	109.89	5
Orissa	-	-	44.29	199.29
Madhya Pradesh	-	0.52	255.3	208.12
Uttar Pradesh	12.65	0.8	165.82	179.14
Assam	1.24	0.02	9.38	36.64
Bihar	-	2.76	12.75	180.73
India	99.39	61.8	2151.88	1807.17

RCH: Reproductive and Child Health; RNTCP: Revised National Tuberculosis Control Programme  
Source: Annual reports, MoHFW, various years

### User fees

As the responses to the questionnaire survey showed, user fees is one major source of revenue, particularly due to the gradual decrease in foreign funding. However, there has been concern that the levy of user fees may be affecting the utilization

of services by the poor, thereby undermining their principal objectives of serving the poor. An interesting insight in the not-for-profit financing system is cross-subsidization. It is observed that in some secondary and tertiary hospitals where services are provided at a cost, not-for-profit organizations tend to provide free services or charge lower rates for inpatient care from the poor and cross-subsidize them by charging higher rates from those who can afford it.

The results of the survey show that only 7 of the 86 providers who had responded supplied drugs free of cost; 16 responses stated that drugs were supplied free to the poor. In some cases, some essential outpatient drugs are provided free of cost while the rest are either dispensed at a cost or need to be purchased on prescription. NGOs have to buy medicines like any other commercial establishment directly from the market, which restricts access to drugs for a large section. To make drugs easily accessible to people by dispensing them for free or at a subsidized cost, Locost, a not-for-profit pharmaceutical company in Baroda, manufactures essential drugs at a low cost and distributes them only to NGOs which provide curative services to the needy. They have a distribution centre in Karnataka for the NGOs in south India (Locost 2004).

### Costs of care at not-for-profit facilities

According to the 52nd round of the NSS (1998) (Table 6), the average total expenditure per hospitalization in a charitable institution is less than in for-profit hospitals but higher than in public sector hospitals.

Further, the 52nd round of the NSS also brings out the fact that there was a decrease in access to free care from 19% to 10% between 1986 and 1996. This reflects the fact that user fees have been introduced in several public and not-for-profit health institutions during this period.

Studies have attempted to analyse whether not-for-profit health programmes are more expensive than government or the for-profit private sector. It is noted that the kind of aggregate figures presented for hospitals can be misleading. For instance, variation in the size and quality of services in hospitals is not considered here. A study among the not-for-profit hospitals, government hospitals and private hospitals

**Table 6**

### Average total expenditure per hospitalization (in Rs) by source of treatment

Type of hospital	Rural	Urban
Public sector hospital	2080	2195
Private hospital	4394	5524
Nursing home	4185	5749
Charitable institution	3808	3078
Others	3015	1630
Private sector hospital	4300	5344
All hospitals	3202	3921

Source: 52nd round, NSSO 1998

reported that, in general, the cost per hospital bed per day in the not-for-profit sector was very low compared to others. But this study included only community-based organizations in rural areas (Berman and Dave 1994). These not-for-profit institutions are able to achieve substantial 'cost savings' due to the following reasons:

- They give low wages. In some cases, they use the services of honorary physicians and these lead to a lower wage bill and lower overall cost. For example, the results of the survey show that 73% of the not-for-profit organizations had part-time medical personnel.
- Another example of cost control is observed where community-based organizations serving the poor purchase generic and essential drugs manufactured and distributed at a low cost by a not-for-profit organization (Locost 2004).
- Such community-based organizations focus on rational care by emphasizing on referrals and lessening the role of unnecessary technological interventions.

A study of four private hospitals was conducted in Delhi for the National Commission on Macroeconomics and Health to understand the financing patterns. A study of two charitable hospitals and one for-profit hospital in Delhi (2004) showed that the rates of some common procedures are lower in the charitable hospitals when compared to for-profit hospitals (Table 7).

**Table 7**

**Rates of some common procedures (in Rs)\***

Procedure	Trust I	Trust II	Private hospitals
Caesarean section	5850-7475	5750-11,500	7700-25,800
Cataract removal	4500-6500	6500-20,000	8400-28,000
Appendicectomy	2970-4290	4750-9500	6500-21,500

\*The rates vary according to the graded bed charges. The table gives the lower and upper limits.

## Recommendations and Conclusion

The objective of this study was to examine the characteristics, structure and spread of the not-for-profit sector in delivering medical care in India. The study shows that it is not possible to put the not-for-profit sector into one typology because of its heterogeneity in terms of organizational structure, pattern of funding, ownership, nature of services and its changing character. It is also scattered and disorganized.

The not-for-profit sector has its own constraints and limitations. Even if one wants to establish a charitable institution, for most of these organizations, especially those functioning in rural areas, the question of sustainability is central

to their existence. In order to achieve appreciable and sustainable results, NGOs have to make long-term commitments to the community. They frequently face difficulties such as shortage of trained staff, high turnover of middle-level workers, and dependency on donor agencies. For example, funding from foreign churches of the Christian network has reduced. User fees have therefore been introduced to take care of recurrent costs.

It is difficult to study each and every not-for-profit provider to assess the kind of services or cross-subsidies they provide to the poor. It is evident that in the wake of increased privatization and corporatization of health services, not-for-profit institutions have also faced demands and competition to improve their services by introducing technology and specialized services. Numerous trust hospitals have become more commercial in their operations, hence altering their character from a charitable institution to a private for-profit/corporate image. There needs to be greater transparency to see if they are adhering to the conditions of cross-subsidizing prescribed by the law, such as 20% free admissions and free outpatient services for the poor.

Curative services are just one aspect of the health services, which also include preventive, promotive and rehabilitative services. A study of community-based NGOs in West Bengal showed that simply health education and awareness do not improve the health status of people. In the absence of a proper referral service system, awareness and health education have little impact (Sarkar 2003). Several NGOs have made efforts to work and coordinate with the State Government, and have been successfully providing and managing primary health services. The experiences of these NGOs show that health services need to integrate preventive, promotive, curative and rehabilitative services and the issue of health has to be addressed as a part of the broader developmental goals with the involvement of the communities.

A 1990 World Bank study showed that limited numbers of NGOs are involved in health and family welfare in rural areas and they mostly had weak financial management and technical capacity (Misra et al. 2003). The macro picture shows that the not-for-profit sector is not present universally and, therefore, cannot be seen as taking over the responsibilities of the public sector. As the National Health Policy 2002 calls for expanding the coverage of services and strengthening primary-level health services through the third sector, the challenge is for the Government to intervene effectively and formulate strategies to assist those community-based NGOs/not-for-profit organizations committed to working in backward areas by providing adequate support and engaging them in not just implementing and managing National Health Programmes but in various health and developmental activities in the context of comprehensive primary health care.

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## Annexure 1

## Spread of not-for-profit organizations derived from various sources

States	Facilities by missionaries			Others	Christian missionaries and others			57th round, NSSO		Health facility survey			
	Hospitals	Dispensaries	No. of beds		Other facilities	Beds in these facilities	Total beds	Total facilities	Own-account enterprises (OAE)	Establishments	Total	No. of not-for-profit facilities	No. of beds
	1				2				3				
<b>Well-performing States</b>													
Kerala	257	288	35,832	28	2413	38,245	573	69	450	519	27	1451	
Tamil Nadu	100	361	6598	14	8790	15,388	475	132	879	1011	-	-	
Andhra Pradesh	93	177	7159	15	1327	8486	285	53	150	203	10	83	
Maharashtra	36	152	3878	24	2712	6590	212	1595	648	2243	12	474	
Karnataka	53	168	5691	14	1992	7683	235	384	28	412	-	-	
<b>Moderate-performing States</b>													
Gujarat	10	64	1503	87	7856	9759	161	39	224	263	-	-	
West Bengal	9	114	2465	4	824	3289	127	1794	654	2448	41	-	
Punjab	6	27	511	-	-	511	33	379	1399	1778	-	-	
Haryana	2	16	122	-	-	122	18	446	530	976	-	-	
<b>Poor-performing States</b>													
Rajasthan	23	29	993	32	264	1257	84	45	469	514	34	274	
Orissa	9	118	2420	1	147	2567	128	57	55	112	-	-	
Madhya Pradesh	26	130	1324	22	1596	2935	178	66	173	239	14	813	
Uttaranchal	5	12	43	5	181	224	22	0	1,162	1162	-	-	
Uttar Pradesh	41	121	4073	45	1809	5882	207	1013	551	1564	37	1147	
Assam	10	93	939	4	195	1134	107	1861	122	1983	-	-	
Bihar	15	114	2311	9	420	2731	138	120	130	250	4	75	
Others*	66	589	7712	60	2031	9743	683	1036	520	1556	-	-	
India	764	2575	83,598	332	32,557	132,907	3979	9089	8144	17,233	179	-	
					47% of all beds in private facilities (n= 2,76,000)	17% of all private hospitals/ dispensaries (n= 23398)	0.8% of all OAEs providing health establishments (n= 1,074,212)	3% of all health unorganized establishments (n= 230303)	1.32% of all health providers/services (n= 5788)	3% of all private health facilities (n= 5788)	18% of all private beds in the facilities (n= 24,241)		
* Includes north-eastern States, Union Territories and five States													
Sources:													
1. Data from the Directory of institutions, Catholic Bishops Conference of India 2003; Baru R. Missionaries in Charity 1996; Not-for-profit sector questionnaire survey; Directory of Hospitals in Delhi 2002; CBHI 2002 and various websites.													
2. Data obtained from CD-ROM of 57th round of unorganized services NSSO, 2002 (Note: OAE: own-account enterprises are run by the household without any hired worker, n = 1,074,212 Establishments that have at least one hired worker n = 230,303)													
3. Eight-district health facility survey conducted by NCMH (2004) in Kozhikode (Kerala), Khammam (Andhra Pradesh), Jalna (Maharashtra), Nadia (West Bengal), Udaipur (Rajasthan), Ujjain (Madhya Pradesh), Varanasi (Uttar Pradesh), Vaishali (Bihar)													